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Community and Wellbeing Scrutiny Committee

Wednesday 24 March 2021 at 6.00 pm

Online virtual meeting. The link to view the meeting will be available HERE.

Membership:

Members	Substitute Members
Councillors:	Councillors:
Ketan Sheth (Chair) Colwill (Vice-Chair) Aden Daly Ethapemi Hector Lloyd Sangani Shahzad Thakkar	S Choudhary, Hassan, Johnson, Kabir, Long, Mahmood, Miller, Perrin and Shah Councillors: Kansagra and Maurice

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

Observers
Brent Youth Parliament
Jenny Cooper, NEU and Special School observer
John Roche, NEU and Secondary School Observer
Vacancy, NEU Primary School Observer

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The press and public are welcome to attend this meeting. the link to view the meeting will be available HERE.

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

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 meetings 1 - 22

To approve the minutes of the previous meetings as a correct record:

- 24 November 2020
- 19 January 2021

5 Matters arising (if any)

6 A&E Performance at Northwick Park Hospital and St Mary's Hospitals 23 - 40

This report provides information to the Community and Wellbeing Scrutiny Committee on the A&E Performance at Northwick Park Hospital and St Mary's Hospital.

7 Primary Care and GP Services in Brent and Care Quality Commission (CQC) Ratings 41 - 56

This report provides accountability and transparency for quality standards and ratings in GP services in the borough as rated by the Care Quality Commission (CQC) and assurance that there are effective support arrangements for practices to improve.

8 GP Access Members' Scrutiny Task Group Scoping Paper 57 - 68

This report enables members of the Community and Wellbeing Scrutiny

Committee to commission a task group on GP and primary care accessibility in the Borough.

9 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: Thursday 29 April 2021

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 24 November 2020 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Aden, Daly, Ethapemi, Hector, Lloyd, Sangani, Shahzad, and Thakkar, and co-opted members and Rev. Helen Askwith and Mr Simon Goulden. ***All members were present in a remote capacity.***

Also Present (in remote capacity): Councillor McLennan and Councillor M Butt

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

Apologies for absence were received as follows:

- Co-opted member Mr Alloysius Frederick
- Co-opted member Mr Simon Goulden gave apologies that he would need to leave the meeting early to deliver a lecture
- Observers Jenny Cooper and John Roche (NEU representatives)

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Ketan Sheth – Lead Governor, Central and North West London NHS Foundation Trust, Board member for the Federation of St Joseph's Catholic Infant and Junior Schools, Board member for Harrow College and Uxbridge College, Board member for Daniel's Den
- Councillor Ethapemi – Spouse employed by the NHS
- Councillor Shahzad – Spouse employed by the NHS
- Councillor Sangani – Employed by the NHS
- Councillor Thakkar – Governor on Board at Phoenix Arch
- 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**

RESOLVED:-

That the minutes of the previous meeting held on 15 September 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 an urgent business item first, in accordance with Standing Order 60, which related to the matter of the imminent closure of the Wembley Ambulance Station.

7. **Any other urgent business**

Closure of Wembley Ambulance Station

The Committee heard that the Chair would take an urgent item in relation to the imminent closure of the Wembley Ambulance Station under Standing Order 60.

The Chair welcomed Pauline Cramner (Director of Ambulance Services, London Ambulance Service) and Khadir Meer (Chief Operating Officer and Deputy Chief Executive, London Ambulance Service) to the meeting and thanked them for joining.

Khadir Meer explained that the Wembley Ambulance Station was similar to a garage with a small porta cabin which had been closed since March 2020 as part of the NHS response to Covid 19. He advised that the station was on an old site owned by NHS property services, and the lease was coming to an end therefore they had been asked to vacate the site. The Committee heard that the building was not fit for purpose to allow crews to mobilise and conclude their shift from. Khadir Meer emphasised that the ambulance station was not a healthcare setting or somewhere healthcare was provided, but a garage where vehicles were prepared and crews started and ended their shifts, with all services provided on the road 24 hours a day, seven days a week. As a result of the request to vacate by NHS property services, who were looking to redevelop the site, the plan was to vacate the station from 1 December 2020 in advance of the financial year concluding.

The Chair thanked Khadir Meer for his opening statement, expressing gratefulness on behalf of the whole Committee to LAS colleagues who had worked hard over the last few months. He invited members of the Committee to raise queries, with the following issues raised:

The Committee asked for confirmation that the London Ambulance Service (LAS) was part of the NHS, which LAS representatives affirmed. The Committee further queried what the NHS constitution stated with regards to stakeholder engagement and public consultation. Khadir Meer responded that the constitution stated very clearly that there should always be communication and engagement with all stakeholders, particularly Health and Wellbeing colleagues within local government. He expressed that engagement with stakeholders was very important to him and during the pandemic the LAS had been working very closely with all of local government, particularly with the Low Traffic Neighbourhoods initiative. The Chair thanked Khadir Meer for his response, and asked what stakeholder engagement and public consultation had taken place thus far with regard to the closure of the station. Khadir Meer highlighted that the station had already been closed since March 2020 to ensure the LAS was providing resilient services to the NHS in North West London. Pauline Cranmer added that it was their absolute priority to ensure they delivered healthcare to Brent residents and ensure they were able to provide care as communities grew. She expressed that, regarding public consultation, for her it was about ensuring there was no change to the care delivered to Brent residents, and noted that they had been operating out of a different site in Kenton, in the London Borough of Brent, since March 2020 with no detriment to the care delivered to Brent residents.

The Committee noted that the site would be due for re-development, and queried whether that meant the LAS would have the option to move back to the site once it had been redeveloped. Khadir Meer informed the Committee that they were not aware what future plans NHS property services had for that site, so were not able to comment on the future of the site.

In relation to response times for emergency calls, the Committee queried what impact operating out of a different location would have. The Committee wanted to hear more about the forensic analysis of the move to a different site. Khadir Meer highlighted that since March 2020 when they vacated the site and moved to operate out of Kenton response times had actually improved, and resources in the London Borough of Brent had increased since March. Pauline Cranmer advised that there were 2 critical time categories the LAS was measured against; category 1 for those in cardiac arrest, and category 2 for those very unwell and emergency for example those suffering from chest pains. For category 2, the national standard performance target they were measured against was 18 minutes, and Brent month on month had been achieving around 13 minutes on average for response time for category 2 calls. The Committee noted that due to the pandemic the improved response times may have been a result of Wembley Stadium being closed.

Khadir Meer confirmed that they had not operated out of the site since March 2020, and that the lease for the site was being terminated by NHS property services at the end of the financial year with the LAS formally vacating as of 1st December 2020.

The Chair drew the item to a close and invited the Committee to make recommendations, with the following agreed:

i) That the formal closure of the Wembley Ambulance station be paused.

ii) That there be a stakeholder engagement and public consultation undertaken.

At the conclusion of this item the Chair offered thanks to Khadir Meer and Pauline Cranmer for joining the meeting, and expressed gratitude to their team for doing superb work for Brent residents.

8. **Brent Council's Management of the Impact of COVID-19 on Education and Children's Services**

The Chair welcomed the Children and Young People Department to the meeting, as well as 2 Primary School Head teachers and representatives from Brent Youth Parliament. He invited Councillor Mili Patel (Lead Member for Children's Safeguarding, Early Help and Social Care) to introduce the report.

Councillor M Patel informed the Committee that the report updated members on the work the Children and Young People's department had been doing to manage the impact of COVID-19 on children's services. The paper provided an update from the report received in March 2020. It updated the committee on the following areas; early years settings and schools, early help, children with Education, Health and Care Plans (EHCP), Looked After Children and Care Leavers, the Youth Justice services and the mental health and wellbeing of young people.

The Chair thanked the Lead Member for the introduction and invited comments and questions from the Committee, with the following issues raised:

The Committee expressed concern for young people's mental health and wellbeing during the pandemic and asked what assurances had been sought around the support offered to children and young people for their mental health and wellbeing. Councillor Patel drew the Committee's attention to section 10 of the report which detailed the Council-wide work led by Children's Services supporting young people's mental wellbeing. The Committee heard that counselling for Looked After Children and care leavers had been expanded with hours of support extended, and the Lead Member had heard further details of the support care leavers

and looked after children had received at the Corporate Parenting Committee on 21 October 2020. The lead member also highlighted partnership work with Brent CCG to develop Mental Health Support Teams as part of an expanded CAMHS offer supporting young people's mental health working closely with schools.

The Chair invited Georgina Nutton (Head of Preston Park Primary School) to share what Preston Park Primary School had been doing to support their pupils during the pandemic. Georgina Nutton informed the Committee that they had been focussing on ensuring children had staff members to talk to as part of the ongoing support to children as they accessed education either remotely or as vulnerable children on site in school. She described the effort to deliver an effective remote curriculum which had strong engagement from children, meaning come June when the school opened more widely to children they were able to progress well and "bounce back" when returning to a school environment. The Committee were informed that prior to all children returning to school in September, staff had planned a recovery curriculum and mapped any learning children had lost regarding their routine, to ensure a sense of normality around learning in the school environment. The full curriculum had now resumed whilst dipping in to the bespoke recovery curriculum where needed. To support pupil's mental health the school used Place2Be through which children could access counselling, and offered online parenting support classes and sent out a wellbeing newsletter. The school had been focusing holistically on mental health through the PSHE curriculum and had adapted the timetable to focus time specifically on PSHE. The Committee heard that the school had a behaviour charter with emotion coaching focused language that staff used, and trained families to use at home, which enabled individuals to acknowledge feelings and helped to equip children with the skills to be able to self-regulate, know that the feelings they had were OK, have their feelings validated and work through them to set behaviour limits where needed.

Enid Lewis (Head of Park Lane Primary School) was also invited to share what Park Lane Primary School had been doing to support pupils during the pandemic, including vulnerable children and children with Special Education Needs (SEN). She highlighted that vulnerable children and children with SEN had been in school during the initial lockdown as well as later phases of the pandemic and had the support of school staff and their social worker. Park Lane Primary School also used Place2Be to support children with their mental health. The Committee heard that since the full return to school in September the school had focused on ensuring children were given the opportunities to talk about the lived experiences they had during lockdown, and all staff had training in how to help and support children deal with loss and grief prior to their return to school, as the school had a large number of children who were impacted by the virus. Enid Lewis informed the Committee that the school had focussed on mental health and linked that to physical health, as during lockdown many children did not have access to the quality meals they would have had at school so the school were focusing on both. She expressed that the school staff had gone above and beyond to ensure they had been available to support children with their mental health and talk to them about the worries they had, and children were now back into a routine. She highlighted that some children had genuine concerns around COVID-19 and their experience during lockdown.

The Committee drew attention to section 7.4 of the report which detailed the increase in referrals received by the Family Front Door in October 2020. The Committee asked for assurances that the impact of the pandemic on children in need and children subject to a child protection plan had been managed effectively. Councillor Patel highlighted that the rise in referrals had been anticipated, as Children's Services were aware the majority of referrals came from schools and settings which were not accessible to the majority of young people during the lockdown. The department had prepared for the number of referrals to increase when schools reopened. Nigel Chapman (Operational Director Integration and Improved Outcomes, Brent Council), who is the Council's statutory social work practice leader, advised that the rise had been primarily led by the return of children to schools and had led to increased pressure on child protection work and referral work and was increasing the number

of looked after children. He explained that to mitigate the increased demand as a result of increased referrals he had implemented a new Family Front Door team to manage referrals more effectively and screen off some work that may not necessarily require a long term intervention by Children and Young People's services, and to provide a very quick and effective response, which had taken around 10% of unnecessary work away from the service. Another mitigation was to ensure staff leave was taken during the summer so that social workers were back in place in time for the anticipated rise in demand.

With regards to early years settings, early help and children aged 0-5 years old, the Committee queried what the impact of the pandemic had been and how the wellbeing of those groups had been supported. Gail Tolley (Strategic Director Children and Young People, Brent Council) drew the Committee's attention to section 4 of the report which detailed the work done in early years settings and schools. She highlighted that a number of early years settings did remain open during the lockdown, particularly for vulnerable children, and the early years team based in the Civic Centre continued to support settings including visiting provision. Whilst children's centres had not remained fully open they had remained open for the more intensive and specialist work for those vulnerable children aged under 5 and ensuring access to health visiting support. Sue Gates (Head of Early Help, Brent Council) added that the communication from Children's Centres and liaison with the early years team had been very good throughout the pandemic and they knew on a twice weekly basis which vulnerable children had attended settings and which had not, with any attendance issues or concerns followed up by CYP early years staff. Children's Centres provided significant support to families throughout the pandemic period, including the delivery of early learning packages, doorstep drops, online sessions both 1 to 1 and in small groups, and speech and language therapy. Councillor Patel informed the Committee that many of the private voluntary and independent sector providers of early years settings had been required to close during the pandemic due to their home based settings, and the Children and Young People department had brokered access to alternative settings for vulnerable children and children of key workers where needed. She advised that there remains significant financial pressure for those organisations with a risk that some may not reopen due to budget impacts on particularly smaller private sector providers of early years. Whilst the government had provided funding through to the end of December the Council had concerns regarding the sustainability of those settings for the following year. Councillor Patel was working with leads across London in a cross-party manner to lobby the government for extra funding to mitigate the impact of the pandemic period and to confirm continued funding for early years settings, and advised she would continue to raise the issue wherever she could.

In relation to Family Wellbeing Centres, Gail Tolley confirmed that the decision was taken the previous year to move from 17 Children's Centres and to set up 8 Family Wellbeing Centres and the work to implement that was underway.

Concern was raised with regard to safeguarding demand pressures and extra staffing costs. Gail Tolley acknowledged that there were demand pressures and that Brent, as with all other Councils, was in a resource challenge situation that would be more challenging going forward. The report set out how the Family Front Door team noted in discussions earlier were managing this demand and Gail noted that social workers were carrying larger caseloads than the department would like. This was being monitored carefully. The Committee were advised that the complexity of cases had increased since September and the easing of restrictions. Gail Tolley informed the committee that CYP are monitoring the resource impact implications of Covid related pressures and these were being reported in year, in the budget reports presented to Cabinet.

The Committee questioned section 6.8 of the report, regarding the assurances presented by the North West London (NWL) Integrated Care System (ICS) to the NHS that phase 3 expectations would be met, noting that ICS were not legal bodies. Brian Grady (Operational Director Safeguarding Performance and Strategy, Brent Council) confirmed that the ICS was

not a legal entity but a partnership arrangement by which the NHS was planning and delivering services across NWL. The partnership included the 10 NHS provider trusts and the 8 NWL CCGs, and was the planning footprint on which the NHS was reporting regularly to NHS England. Section 6.8 of the report referenced the assurances Brent Children's Trust (BCT), chaired by Gail Tolley, had been seeking and had received from the NHS system locally to ensure that every element of NHS delivery of services for vulnerable children had gone through appropriate rapid recovery and that the right services were in place for children and young people. Gail Tolley highlighted that she had chaired a BCT meeting the morning of this meeting where she received reassurance again from a CCG representative. At the meeting she received assurance that going forward or in the event of a second lockdown qualified nurses working in children's services would not be drawn into other acute services in Brent.

With regard to how well schools were supported to respond to incidents of Covid-19, Councillor Tom Stephens (Lead Member for Schools, Employment and Skills) advised that paragraph 4.11 set out the arrangements to support early years settings and schools in the case of positive tests for Covid-19 of either children attending a setting, pupils or members of staff. School attendance in Brent was higher than both the national and London averages. He advised that the Children and Young People's department had supported all Brent schools during the pandemic including support with reviewing school COVID-19 risk assessments.

The Chair drew the item to a close by inviting 2 representatives from Brent Youth Parliament to address the Committee. Their questions focused on the mental health of children and young people, in particular focusing on section 10.5 of the report regarding the NHS linking mental health support teams with schools. The representatives queried whether those teams were aimed to be preventative or aimed at supporting those already in, or heading towards, crisis. Brian Grady advised that the teams would focus on emerging need and there would be a focus on prevention, aiming to identify, respond to and prevent emotional health needs growing in the population. He added that there were other interventions supporting the wellbeing of children returning to education that would be worked on during the year so children should see enhanced mental health support for current mental health conditions, on a preventative basis.

The Committee expressed gratitude to the Children and Young People department, noting the fantastic work undertaken. Gail Tolley thanked the Committee and expressed that collaboratively the frontline staff in all children's services settings had been outstanding throughout the pandemic.

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

9. Update on Schools and Education, including the Action Plan for Raising Achievement of Boys of Black Caribbean Heritage

Councillor Tom Stephens (Lead Member for Schools, Employment and Skills) introduced the report which presented the overall school standards and achievement and the action plan for raising the achievement of boys of Black Caribbean heritage. He drew the Committee's attention to paragraph 3.16 of the report which noted there were no performance data for schools for the 2019-20 academic year following the Department for Education announcement that the summer 2020 primary key stage statutory assessments and GCSE, A Level and Level 3 vocational examinations would be cancelled. The background paper provided the 2018-19 annual school standards and achievement report presented to the Committee in March 2020. Councillor Stephens felt that overall the information showed impressive figures on standards and achievement, and Brent had met all but one of 3

Borough targets. Brent had missed 1 target by 1 percentage point regarding the achievement of boys of Black Caribbean heritage, and met the targets for more than 95% of Brent schools being judged outstanding and reducing the attainment gap.

The Chair thanked Councillor Stephens for his introduction and invited members to ask questions, with the following issues raised:

In response to queries regarding what impact the pandemic had on the achievement of boys of Black Caribbean heritage and what additional support those boys were being given to support their optimal achievement, Gail Tolley (Strategic Director Children and Young People, Brent Council) highlighted that there was no specific evidence as yet to show whether the pandemic had impacted the attainment outcomes for those young people as there were no public examinations during the year. Councillor Stephens added that there was nationally an anticipated impact on educational inequality as a result of the pandemic, but there was no current evidence to suggest whether that impact had been more severe for certain groups.

The Chair invited Enid Lewis (Head of Park Lane Primary School) to share how her school had been supporting the achievement of pupils. Enid Lewis advised that Park Lane Primary School had done a lot of work supporting all disadvantaged children, including where relevant for pupils of Black Caribbean heritage, working with an action research methodology. A lot of additional support had been put in place, including ensuring each pupil had access to relevant technology, and catch-up support was being put in place to narrow any gaps.

The Committee highlighted some national concerns that pupils of Black Caribbean heritage may not have the necessary equipment to participate in home schooling and had not been able to engage with online learning during the pandemic, and queried whether that was the case in Brent. Councillor Stephens agreed that the lack of digital access was part of wider socioeconomic circumstances which could impact negatively on children's education such as overcrowded households meaning some pupils did not have the capacity to sit through a whole series of lessons and learn in a quiet space. He advised that the previous report did highlight the work done by the Council to support vulnerable pupils with their learning and from April 2020, the DfE began to issue digital devices (laptops, tablets and 4G wireless routers) to local authorities to distribute to schools. In terms of more targeted support for boys of Black Caribbean heritage, Councillor Stephens highlighted the importance of Black Caribbean Achievement Champions in schools.

The Committee heard that the Black Caribbean Achievement Champions referenced in the report had been funded by Brent Council through the Schools Forum and these champions were school staff determined by the schools themselves. Gail Tolley highlighted that very often the role was not assigned to someone in senior leadership teams but that champions held different roles across Brent schools, so that raising the achievement of boys of Black Caribbean heritage was seen as a whole school responsibility. Enid Lewis informed the Committee that the role was to liaise with senior leaders, parents, and other stakeholders to ensure the achievement of Black Caribbean boys was on all agendas and to look at the quality of education boys of Black Caribbean heritage were receiving.

The Committee asked whether the voice of the parents of Black Caribbean boys had been considered in the report. Gail Tolley explained that as part of the funding for the project to increase the achievement of boys of Black Caribbean heritage parents had been working with the Brent Schools Partnership to design and set up a portal driven by parents of boys of Black Caribbean heritage. John Galligan (Head of Setting and School Effectiveness, Brent Council) informed the Committee that the portal had gone live and all parents had been given passwords, with the Champions working closely with parents to enable them to get the best out of the portal. He added that parents had welcomed the additional meetings specifically

focused on their children and improving their children's outcomes, and drew the Committee's attention to section 3.43 which detailed feedback received.

The Committee wanted assurance that partnership working was effective to ensure every boy of Black Caribbean heritage was achieving in all educational settings at all key stages. Councillor Stephens confirmed that this work was being done through the Brent Schools Partnership. Gail Tolley (Strategic Director Children and Young People, Brent Council) added that the partnership approach for this work was driven through the Strategic School Effectiveness Board, which she chaired and which included representative primary, secondary and special school headteachers, governors and the Brent School Partnership. She advised that partnership working with schools continued to be highly effective, and that through the pandemic period that she had convened a regular webcast meeting with high levels of engagement and attendance from Brent headteachers to keep that partnership working strong. In addition, schools had been supported to organise into local clusters and were working well together. Georgina Nutton (Head of Preston Park Primary School) felt that throughout the pandemic, partnership working had strengthened and schools had been required to innovate for how they would engage with each other. She advised that Gail Tolley had engaged well with them and had brought people together and communicated information effectively, and noted the partnership with the Family Front Door and social work teams had been important to ensure families were kept safe during the pandemic. She also noted that all schools were engaging with the work to raise the achievements of boys of Black Caribbean heritage and it was always high on the agenda at meetings such as the cluster group meetings. Her school was looking at how they could engage the wider community with the project such as through artists, local galleries and authors.

The Committee queried how the percentage of disadvantaged pupils in Brent was broken down in section 3.6 of the report. Gail Tolley advised that the percentage was the percentage of pupils eligible for pupil premium funding in schools, and that schools would know what proportion of those pupils were of Black Caribbean heritage, which would have been part of the data that went into the audit.

In relation to Key Stages, the Committee asked how Key Stage 1 (KS1) was performing in relation to reading as there appeared to be issues at that stage. John Galligan advised that KS1 was the only key stage that was completely teacher assessed and there was an action plan to look at the moderation of that Key Stage and understand potential factors; including whether teacher unconscious bias played any contributory part. The Local Authority had a statutory responsibility to moderate and were going to use the summer moderation of KS1 as the opportunity to look into why some groups might not be doing as well, however there had been no statutory assessment that year for them to look at so schools were looking at this independently. John Galligan added that the Brent Schools Partnership had led in delivering unconscious bias training and a number of schools had signed up to that training.

Drawing the item to a close, the Chair invited representatives from Brent Youth Parliament to address the Committee. The representatives focussed on digital poverty and what consideration Brent Council had given to support people locally affected by digital poverty who might not have been able to engage in lessons and online services as effectively as other young people. Councillor Stephens agreed that digital provision was an issue and the Children and Young People's department were in discussion with schools about digital provision in their areas. There was government funding available to address digital poverty but it was not sufficient to meet the need.

As no further questions were raised, the Chair thanked education colleagues for their contributions and led a round of applause in thanks to education and settings based staff.

10. **Brent Youth Offending Service Post Inspection Action Plan Implementation**

Councillor Mili Patel (Lead Member for Children's Safeguarding, Early Help and Social Care) introduced the report which provided details of actions taken from the 4 recommendations that arose from the Youth Offending Service inspection in 2019. She explained that the report gave further information on the performance of Brent YOS in general and the impact of COVID-19 on the service. She felt that the Children and Young People's department had made some major strides in implementing the recommendations through staffing restructure, proactively identifying external funding in order to support recommendations such as the Mayors Fund, and had secured substantial funding recently for a 3 year grant from the Youth Justice Board to deal with the impact of COVID-19 in BAME Communities. Councillor Patel also highlighted the introduction of Family Wellbeing Centres, and the Roundwood School, which would provide further spaces to work with young people within a community setting.

In relation to courts and criminalisation the Committee wanted reassurance that unnecessary criminalisation was not an issue for Brent. Nigel Chapman (Operational Director Integration and Improved Outcomes, Brent Council) advised that Brent's relationship with the Magistrates' Court, which was where most YOS work went through, was very effective and had continued to operate at a good level throughout the pandemic, and the Court had been very supportive of the work. In relation to the random sampling of cases involving out of court disposals, he advised that Brent YOS had made good strides with the police where previously they felt police were offering too many conditional cautions instead of cautions, which was felt unsuitable for some young people and led to the Court finding young people breaching those cautions leading to a criminal offence being committed. He advised that the cohort size was relatively small therefore the sampling approach was effective and provided a more tailored approach.

Committee members noted that there was a lot of input required from CAMHS from the service and queried what the current waiting times were. Sue Gates (Head of Early Help, Brent Council) advised that she recognised that waiting lists with CAMHS were an issue elsewhere but highlighted that Brent YOS had their own dedicated CAMHS worker who kept up to date with all work and never had a young person waiting, with an assessment conducted as soon as a referral was made. There was also input from a staff member working on a project around mental health, seeking to identify those who may need additional help around mental health, anxiety and wellbeing early. The staff member saw the young people in the police station, in their home, via video link, in court cells or wherever the first place they were identified was.

The Committee were encouraged by the reduction in court order sentences, but queried whether that could be as a result of court closures and whether the pandemic had an impact on the number of youth offending. Nigel Chapman advised that there was less activity in the court system and less crime committed, which was noted in London and nationally and the court systems did reduce their capacity. He added that the overall picture on youth offending generally was that there had been a significant reduction in young people entering the youth justice system over the last 8 years. In response to whether any mentoring system was in place which may have contributed to the reduction, Nigel Chapman advised of a number of factors at play including building trusted relationships between the young person and their YOS case worker, or the young person's mentors, or a combination of the 2, and working closely with the young person's parents. He advised that primarily the service was based around understanding a young person and helping them with employment, education and thinking through their offending behaviour.

Regarding how the YOS could work with voluntary sector substance misuse services to support the work of YOS further, Sue Gates highlighted that they had worked with Each Brent and the Westminster Drugs Project for a considerable length of time and had a very good relationship with them. She expressed that they did more than was required of them, were

co-located with YOS workers, and were seen as part of the team. They saw most young people that came through the system and worked with families and siblings.

The Chair drew the item to a close by noting the positive feedback highlighted in paragraph 7 of the report received from the YOS survey of young people and their families which had 76 participants.

11. **Contextual Safeguarding Update**

Councillor Mili Patel (Lead Member Children's Safeguarding, Early Help and Social Care) introduced the report which provided an update on the development of contextual safeguarding in Brent arising from a task group report by the Community and Wellbeing Scrutiny Committee agreed by the Committee in March 2019. She advised that the report showed how contextual safeguarding was now embedded in the work done around safeguarding and young people, and noted the section on the impact of COVID-19 due to the fact contextual safeguarding related to safeguarding outside of the young person's familial area. As a result of the lockdown some of the complex issues that young people might usually face were reduced.

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

In relation to the progress of the recommendations, Councillor Patel advised that there were restrictions due to the pandemic which meant some recommendations had not progressed but were ready to be actioned as soon as restrictions lifted, such as the TFL and school travel planning recommendation.

The Committee queried whether the growing use of digital technology by young people had an impact on contextual safeguarding. Gail Tolley advised that whilst there were links to digital behaviours, contextual safeguarding related to significant safeguarding issues that took place outside of the home. Sonya Kalyniak (Head of Safeguarding & Quality Assurance, Brent Council) acknowledged there was a risk to young people using technology especially when young people were groomed into exploitative behaviour, and that the safeguarding team were working with schools around improving digital safeguarding for children and young people.

The Committee highlighted section 3.7 of the report which detailed the increase in the number of young people going missing regularly. Gail Tolley agreed that it gave a sense of the vulnerability of those young people and the complexity of cases social workers were carrying. Sonya Kalyniak advised that this was monitored carefully throughout the lockdown and the trend of extremely vulnerable young people continuing to go missing led to the service conducting comprehensive vulnerable adolescent risk assessments for each of those young people to understand very clearly what the risks were and put individual safety plans in place for them.

The Committee asked what level of confidence the Committee should have that Brent Officers had effective working relationships with health colleagues. Councillor Mohammed Butt (Leader, Brent Council) highlighted that all Brent Officers would ensure due diligence was carried out at all levels, and that as a matter of process Officers worked with partners, colleagues, stakeholders and neighbouring Boroughs to share and collaborate. He added that the Council of the Year, which Brent Council had been awarded in 2020 by the LGC, stated that a Council would achieve that status because it exemplifies the best standards and levels of oversight.

In relation to contextual safeguarding work being done pan London which could assist Brent, Councillor Mohammed Butt (Leader, Brent Council) advised that each Borough was working

within its own boundaries but that the sharing of information and data would take place between the Children and Young People Directors. Nigel Chapman (Operational Director for Integration and Improved Outcomes, Brent Council) highlighted the Rescue and Response Programme which was a pan London response to issues of county lines. The programme was funded to help all London Boroughs support young people at risk of gang exploitation. A bid to the Violence Reduction Unit for a project called “My Ends” had also been submitted, supported by the Council, which would provide funding for some micro community based support projects for young people most at risk, using street based interventions. Councillor McLennan advised that by working with a pan London approach she was looking at how to get additional funding for children’s services particularly the offers that children’s services were providing that were not being funded. She was also a member of the London Council’s Grants Committee which was looking at funding projects pan London regarding digital exclusion and poverty amongst young people.

The Chair drew the item to a close and led a round of applause for Children and Young People colleagues.

The meeting closed at 8:02

COUNCILLOR KETAN SHETH, Chair

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MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 19 January 2021 at 4.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Kansagra (substituting for Councillor Colwill) and Councillors Aden, Daly, Ethapemi, Hector, Lloyd, Long (substituting for Councillor Sangani) and Shahzad, and co-opted members and Rev. Helen Askwith, Mr Alloysius Frederick and Mr Simon Goulden. ***All members were present in a remote capacity.***

Also Present (in remote capacity): Councillor McLennan and Councillor M Butt

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

Apologies for absence were received as follows:

- Councillor Colwill, substituted by Councillor Kansagra
- Councillor Sangani, substituted by Councillor Long
- Councillor Thakkar

2. **Declarations of interests**

Personal interests were declared as follows:
- Rev. Helen Askwith – daughter part owned a property with Network Homes
- Mr Simon Goulden – spouse a governor at a 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 24 November 2020 be deferred to the following meeting so that members of the Committee had time to go through them.

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

There were no matters arising.

6. **Brent New Council Homes Development Programme and Affordable Housing**

The Chair invited Councillor Southwood (Lead Member for Housing and Welfare Reform, Brent Council) to introduce the item for discussion. Councillor Southwood highlighted that the paper included information on the Council's own new Council homes building programme and information on where the Council was working with other providers to increase the number of affordable homes in the Borough. She advised that just over 230 properties had been built and let, there were sites going through planning, and officers were looking at other schemes that may also be viable. Over 600 homes were on site, making Brent consistently the highest of all the London homes being built. The paper drew information from the recent

Cabinet report, and Councillor Southwood hoped the paper gave the Committee confidence about the programme, its achievements to date and what the pipeline looked like.

John Magness (Head of Housing Supply and Partnerships, Brent Council) added that more handovers had taken place the previous day, increasing the number of new properties to 255. He advised these numbers changed on a daily basis.
The Chair thanked the housing team for their introductions and invited the Committee to raise comments and questions, with the following issues raised:

The Committee wanted assurance that the affordable housing referenced in the report was genuine affordable housing and that it would meet the local needs including the different types of accommodation needed, the size of homes needed, and housing need in light of the findings of the Brent Poverty Commission report. Councillor Southwood expressed that she would be happy to provide that assurance and noted that the good thing about the Council doing its own infill for council homes was that it had control and flexibility over what that looked like. When the team looked at potential sites they talked to the housing needs service to determine what Brent actually needed and doing infill development meant the Council could design those schemes to meet actual need. For example, sometimes the Council had opted to build fewer homes at larger sizes to cater to that need for larger homes. All new build Council homes were at London affordable rent and all new schemes, including those where the Council worked with partners, would seek to deliver rent levels either at London affordable or social housing rent levels.

The Committee asked what definition of affordable housing the report was using. Councillor Southwood explained that the reason affordable was used was because there were different types of rent levels, for example any new build was rented at London affordable rates, but legacy developments or Section 106 developments could differ. Hakeem Osinaike, Operational Director for Housing, added that before the programme began the department first wanted to understand what affordability meant to Brent residents therefore commissioned research by Cambridge University, so that the Council were clear what rent levels would apply to the majority of people the Council knew were of housing need. Therefore, he explained, when the report referred to affordable it did not refer to the Mayor of London's initiative but affordable in respect to the residents of Brent. He advised that from the research they knew social rent may not be affordable to the majority, for example, 65% of the Council's tenants were receiving housing benefits. The housing department was now negotiating with colleagues in planning so that when planners negotiated Section 106 agreements they negotiated a reduction to 65% of market rent rather than just "affordable", as for the developer "affordable" meant 80% of market rent which was not affordable for most residents in. It was understood that that could mean fewer homes but it would mean the homes were affordable. He felt that the Council had been successful at applying the research commissioned to determine affordability.

Infill new council housing was discussed by the Committee. It was noted that the report stated there would be consultation with ward members and residents about proposed infill with those views taken into consideration, but some colleagues were not aware of any proposed infill or consultation. Councillor Southwood highlighted that the housing department acknowledged that when the Council built infill schemes it could be disruptive for local residents and local councillors, and that they had learnt a lot from previous infill schemes. She explained that there was a clear process enabling people to know when they would be engaged and a 6 point commitment to engagement. She advised that every time infill went through the feasibility stage, ward councillors would be the first to know, and if they did not know about an infill proposal that would be because it was just an idea at that stage. Hakeem Osinaike (Operational Director Housing, Brent Council) expressed that they understood very clearly that the more people engaged meaningfully the better chance of building those homes, and they would not want to force homes on anyone so where they had built had been with the support and encouragement of local residents and ward councillors. He informed

Committee that there were several ways to engage, such as the Scrutiny Committee, Cabinet, and listing sites being looked at to encourage members to come forward with any issues they knew of to iron out before residents were consulted. The housing department carried out consultation pre and post planning permission and he gave the example of Watling Gardens, which had not been designed yet or gone to planning but which residents had been consulted on for months.

The Committee queried whether there had been feasibility studies completed on the sites listed in the report and when the housing department consultation would be likely to take place with residents on the sites listed in the report following the feasibility studies. John Magness clarified that feasibility looked at whether it was possible to build on a plot of land, whether that land was designated for a particular use, and then what was possible to build on the land. Regarding financial feasibility, he explained that the Council would look to see whether they could get grant funding from the GLA, whether they already had allocation they could use, whether they could borrow money and finance would support that, and whether it was what they were looking at to house the people that were in housing need. Once all of these questions had been considered it was then put into the programme and most were properties that would not be handed over for more than 3 to 5 years. Once they thought they could deliver it that would start the consultation process, and the next stage was to get planning permission.

The Committee queried whether objections that had been received in the past when developers been unsuccessful in applying for infill would be taken into when the Council considered infill. Councillor Southwood explained that the Council proposed developments had to go through the exact same process as any proposed development, including going through planning and abiding by planning regulations, and going through planning meant objections could be made which she felt was a good opportunity to receive additional feedback on the schemes. She reminded members that planning was a quasi-judicial process.

Discussion was had on the practicalities of building infill, for example how current residents were compensated for loss of parking if the proposals were to remove garages and build flats instead, and how waste storage and disposal was taken care of. Regarding waste, John Magness advised that the Council had an ongoing contract with Veolia so that new schemes could be added as they were developed. He advised that it had been a learning curve getting the processes up and running such as taking new stock into the portfolio and recording information for asset management. He highlighted that the practicalities of ensuring waste disposal timings should be part of the process when the Council negotiated through the process with residents. Regarding parking, Councillor Southwood agreed that it was a perennial challenge on estates particularly on infill and was where most residents had the most anxiety. The housing department actively addressed this through consultation in terms of whether it should be a 0 car development, how they could increase parking provision as part of re-landscaping, or whether parking control schemes should be implemented. The housing department would begin piloting parking control schemes on some estates in the near future, with another round of consultation having been completed with the 5 pilot areas. It was noted that it had been a lengthy process and resident views were mixed, and that the cost of permits for estate parking had been reduced to be less than street parking. John Magness highlighted that building in London did involve a level of compromise, therefore he could not promise that going forward they could provide full parking for anyone who wanted to use it. It was also a significant issue at planning as the policy direction in London was to reduce parking and the use of individual cars.

The Committee noted the table in 3.7 of the report that under developer led property there were 12 this year. Hakeem Osinaike advised that under section 106 agreements developers were required to provide affordable homes but often sold those homes to registered providers, which was why the table in the report showed a higher number of homes coming

through registered providers rather than developer led, and why there were 12 developer led homes rather than a larger number.

One Committee member felt that the Council had lost a large amount of stock in the past to housing associations who could sell off properties after ten years of providing housing, and wanted assurance there would be clauses for any new properties done in partnership with housing associations that they could not be sold for profit after so many years. Hakeem Osinaike advised that he could not comment on political decisions made in the past but right now the Council was very keen to build its own stock and had no plans to go into partnership with housing associations or registered providers to jointly own stock. The Council did work with registered providers to encourage them to build in the Borough or to use their knowledge and capacity to help the Council build its own homes but there were no deals to jointly own properties.

Discussion was held around the types of people in housing need, with members noting that there was a cohort of people in their fifties and sixties in the private sector that were always liable for eviction. The Committee wanted to know what plans the Council had to build housing for older people and those with learning disabilities. Councillor Southwood agreed that the need was evolving and, although the current housing need was larger families, through covid the housing department had seen more single and older people, some of whom would need support. Not everyone would need intensive NAIL support, so wrapping support around those living in accommodation was one option. John Magness agreed that they were always conscious of the whole range of needs in Brent and were exploring a number of solutions for older people such as extra care facilities in the design thinking of Windmill Court and Kilburn Square ranging from no need at all to significant need. The potential of a retirement home was also suggested, although it was highlighted that people wanted to make their own choices and increasingly people wanted to live within their own communities when they were older so putting support around them to ensure they could carry on living around their local networks was also important.

The Committee noted the importance of community facilities to help foster a sense of community. Councillor Southwood highlighted that a high proportion of the most recent infill developments did include community facilities which was one of the aspects that residents appreciated being involved in designing. She gave the example of Braven House.

The housing department were not yet clear what the impact of the Government's Housing White Paper would have on section 106 agreements but hoped they would be able to gain more property out of any replacement for section 106 agreements.

During the discussion, several requests for information were made, which included:

i) To receive the strategic asset review of infill sites, setting out possible or identified infill housing sites in the Borough.

ii) To receive a list of the proposed rent levels of the developments listed in the report, how the housing in Table 1 of the report could be categorised by type of affordable housing, such as London Living Rent or Social Rent.

iii) To receive further information on what is expected to happen to housing supply as a result of government changes to Section 106.

The Chair drew the item to a close and invited the Committee to make recommendations, with the following agreed:

i) That in any ward where infill housing was proposed the housing department should write to Ward Councillors to inform them of the proposals and draw it to their attention.

ii) For future new builds, to consider including community centres or, where space did not allow, provision for access to community facilities to be made available within the neighbourhood.

7. **Homelessness and Rough Sleeping Strategy 2020-2025**

Councillor Southwood (Lead Member Housing and Welfare Reform, Brent Council) introduced the report which provided the committee with details of the past year regarding rough sleeping, the various activities undertaken and where the department were now in terms of the various ways the cohort of people who were part of the Everyone In initiative were gradually moving into more sustainable accommodation. The initiative was set up by the Government, working with local authorities. The report also updated the Committee on the homelessness and rough sleeping strategy, and Councillor Southwood noted some of what had been planned had not been possible due to the pandemic however in other ways the opportunity to bring people off the streets and offer a level of support they may not ordinarily have had was huge.

The Committee asked what impact the pandemic had on homelessness across the Borough. Councillor Southwood advised that for many residents who were at risk of homelessness, such as sofa surfers, the Everyone In strategy offered them the opportunity to go through the Council to access emergency accommodation on a temporary basis, and she felt that for a lot of those people that was a huge opportunity. For people in quite an insecure existence regarding homelessness, Councillor Southwood informed the Committee that many were now in a better situation than they would have been prior to covid. She highlighted that rough sleepers were hugely exposed to covid and the new virulent strains caused worry because for rough sleepers it was hard to self-isolate and often they would have underlying health conditions. She acknowledged that a report in the news suggested a lot of rough sleepers had since returned to the streets, but assured Committee that at the time of the meeting that return to the streets had not been seen in Brent and the overnight rough sleeping count conducting in November showed a reduction in numbers compared to the previous year. Laurence Coaker (Head of Housing Needs, Brent Council) advised Committee that the pandemic had the biggest impact on single homeless people, and that Brent now had historically low numbers of people on the streets. This had been helped by the implementation of the severe weather protocol where the homelessness service had block booked hotel rooms for single homeless people to go, whereas in previous years the Council would have relied on community winter shelters to shelter homeless people which was no longer viable due to the pandemic.

The Committee also discussed the impact of the pandemic on homeless families. Laurence Coaker advised that the main driver for homelessness was affordability and evictions from the private sector, therefore because of the eviction ban the number of families that presented as homeless reduced significantly. This was now beginning to pick up and there was worry that going forward with the economic downturn, more people out of work and the lifting of the eviction ban there would be a spike in family homelessness coming in the calendar year. Councillor Southwood explained that the Council were trying to tackle the anticipated spike by identifying anyone they thought might be in trouble to reach out and be proactive, for example those applying for Council tax support or the resident support fund, and intervening at an early stage. Laurence Coaker advised that they were gathering as much data as they could from various sources to identify families who might find themselves in this financial situation and were filling 2 posts to focus on this.

In response to a suggestion that the Council may need to buy its own land in order to reduce homelessness in the Borough, Councillor Southwood acknowledged that at some point the Council may run out of its own land and at that point would look at buying land and other options. She highlighted that that would not solve the problem on its own. The Council were currently looking at buying its own temporary accommodation and a paper had been presented to Cabinet the previous week approving the procurement of 200 self-contained rooms to provide temporary accommodation. The homelessness team kept a look out for the opportunity to buy big properties and big blocks. Councillor Mohammed Butt (Leader of the Council, Brent Council) added that they were doing all they could to ensure they sought enough properties and accommodation at appropriate sizes and were having conversations regularly with companies such as Quintain and Barclays Homes around this. In addition the Council were now looking to house key workers to attract staff into the Borough.

The Committee asked for more information on grants and funding, in relation to paragraph 6.7 of the report in particular and the delivery of 24 homes. Councillor Southwood highlighted that where there was capital funding, and the Council invested, that asset became part of the Council's future and was a longer term sustainable option. Laurence Coaker added that the grant funding for delivery of 24 homes in paragraph 6.7 was a specific pot of money the GLA made available for capital bids and the Council were successful in securing £3m funds, with part of that bid to purchase 2 privately owned blocks of flats that would equate to 24 units of accommodation used for move on accommodation for rough sleepers coming out of supported housing. One block was on track to be completed by 31 March 2021 with appropriate support however the vendor had pulled out of the second block therefore the Council were looking for a new block.

In relation to those with no recourse to public funds, specifically non-EEA, (European Economic Area) citizens Councillor Southwood advised that their absolute priority was to encourage those 9 people to get free legal advice to regularise their immigration status. There was no obvious or easy way to support that vulnerable group of people and they were exactly the type of people the Council wanted to help. Laurence Coaker advised that, of the 9, the Council had 2 results referring people for free legal advice where the person had secured indefinite leave to remain. He highlighted that the majority of this cohort were not rough sleepers but in some kind of sofa surfing arrangements, and if it was not possible for officers to resolve their immigration status a potential plan B was to reconnect them with the people they were living with prior to the lockdown. Councillor Butt added that as part of his role in London Councils they had been making representations to government regarding those with no recourse to public funds. He advised that there was a lot of spend across London Councils on no recourse to public funds, with approximately £54m that Councils did not get back. He highlighted that London Councils did provide help, support and guidance to those individuals but did not get compensated for that spend, which caused tension in relation to what was needed to be done.

Committee members raised concerns about the exploitation of homeless people, giving the example of HMO landlords who converted small family homes without permission and filled them with homeless men to live in and claim benefits, sometimes trafficking these people across Boroughs to claim benefits in more than one Borough. The Committee requested that the housing department, homelessness department and planning department began to monitor those processes. Councillor Southwood agreed that it was exploitation of vulnerable homeless, and the Council did uncover victims who this had happened to, often through planning and licensing enforcement work. It was also noted by Committee that many landlords put en suite bathrooms and hobs in rooms so that they were no longer categorised as HMOs as they were classed as self-contained. This meant it was hard to monitor the quality of that accommodation as it was no longer subject to licensing regulations unless it was within a selective licensing area. Councillor Southwood advised that selective licensing was only available in 5 Brent wards at the current time and was due to expire in 2023,

therefore there was a need to consider whether the Council should apply to extend and / or expand selective licensing across the Borough. Councillor Southwood advised that she would welcome a recommendation from the Committee for a strategic focus on this, raising awareness of the issues.

In response to Committee members' proposals that the Council should work with good friendly landlords, Councillor Southwood advised that the Council kept a good landlord database of over 4,000 landlords and also held the landlord forum, which was looking to begin meeting again after covid restrictions. It was agreed that information on how the Council worked with landlords would be circulated to the Committee, and agreed that the Council needed good landlords who were a huge part of helping to reduce homelessness in Brent.

A member of the committee asked about support for vulnerable homeless single people and households and referred to the SMART team in the Appendix of the report. Laurence Coaker confirmed that there was a Housing First scheme in Brent which had been running for a few years. The Council used their own 1 and 2 bed properties for the scheme and St Mungo's to provide the very high level support for the most vulnerable entrenched rough sleepers. The Council acquired more money through a GLA bid recently for increasing capacity for more support, meaning the number of units was going up to 18 flats to be used for Housing First. Councillor Southwood added that Housing First may not be realistic for some people the Council were supporting therefore it would not be appropriate to adopt the approach all the time.

In response to a question regarding whether the Council reported homelessness to the Home Office, Laurence Coaker responded that the Council did not report any information to the Home Office about individuals and neither did St Mungo's.

During the discussion several requests for information were made which included:

i) To receive information about how the Council worked with good landlords and encouraged excellence among landlords.

As there were no further questions, the Chair thanked Committee and invited recommendations, with the following recommendations agreed:

i) To develop a strategic focus on developing awareness of the hidden issues of homelessness, such as exploitation of the vulnerable homeless by landlords

ii) To recommend adopting a greater joined up approach and work with external agencies to assist those who made need greater housing support services due to drug or alcohol substance misuse.

8. Delivery of Affordable Housing by i4B

Councillor McLennan (Deputy Leader, Brent Council) introduced the report, explaining that i4B was set up as an organisation to address Brent's homelessness needs. She explained that between 2010 and 2015 homelessness doubled in Brent, so alternatives were looked at for the community. It was felt that the accommodation being secured at the time was unaffordable and unacceptable and the Council did not want their residents to be living in those conditions, therefore the Council set up a private Company in 2016 to address the issues, support the housing market and ensure people were placed in decent homes and had security. The report highlighted where i4B was, i4B's performance and its future.

Martin Smith (Chair of i4B) agreed that i4B's principal purpose was to provide good quality, genuine affordable housing in properties that were managed by a responsible and decent landlord. The mechanism whereby the Company looked to do that for that past 4 years was to buy property on the open market, mainly in Brent, refurbish them to a good standard, and then let to people who may otherwise be placed in temporary accommodation. He advised that all properties i4B let were at rent levels no greater than the local housing allowance for the relevant location and were therefore genuinely affordable. By the end of the last calendar year i4B had purchased 302 properties and provided homes for 297 families with 713 children. He felt certain that without the Council's initiative to set up i4B all of those people would be in temporary accommodation. He also noted that over the past 12 months i4B had been progressing a purchase on a Quintain block in the Wembley Park development with the specific purpose of providing affordable accommodation for key workers in hard to recruit areas, with properties rented at a discount. I4B expected to start letting those properties in February. He noted that this was a different sort of product to what the Company had been doing but that it contributed to the overall objective of increasing the proportion of Brent housing stock that was genuinely affordable to people in different parts of the market. The Company's plans for the future were broadly to continue along that route and look for other opportunities that became available. I4B currently had just over 350 properties, with an additional 153 properties from the key worker block, and it was expected that another 180 properties would be added to the portfolio over the next few years, so by 2023 the Company should expect to have around 600 properties.

Peter Gadsdon (Company Director, i4B) added that the Company had been through the Audit and Standards Advisory Committee, with questions about the difference between i4B and Croydon's Brick by Brick. He clarified that the Companies had very different models with very different risk profiles, and i4B purchased properties on the open market, refurbished them and let them, working around a net yield model over 30 years meaning the Company would not buy properties it could not afford and were not trying to sell properties on the open market to make the business model work.

The Chair thanked Councillor McLennan, Martin Smith and Peter Gadsdon for their introduction and invited members to ask questions, with the following issues raised:

In response to whether the Company had viability to buy large 4-5 bed properties, deal with housing problems for larger families and apply for DFGs when adaptation was needed, Martin Smith explained it was much more difficult for i4B to buy the larger properties particularly in Brent. The initial approach was to buy larger properties in the home counties, but those properties had been the least successful stock and were less popular with tenants than anticipated so the Company stopped buying home county properties around 18 months ago. The Company worked with Laurence Coaker's team in the homelessness department to ensure they were still buying properties that met the housing need, and increasingly the Company were looking for properties that might suit some of the most difficult to home families including people with disabilities, therefore Martin Smith believed they could apply for DFGs and this was something the Company were looking at currently.

The Committee discussed the new Key Worker Block purchased on the Wembley Park development. A Committee member noted that if Brent was paying the living wage Brent employees should be able to afford to rent on the private market, and asked whether this was a form of jumping the queue. Councillor McLennan emphasised that the allocation of key worker housing was for staff doing day to day vital roles for residents that the Council wanted to ensure remained in Brent. She emphasised that not all Brent workers had the type of income that could afford market rent, and noted that Hakeem Osinaike had stated earlier in the Committee meeting that a lot of residents could not afford social rents, and that included people undertaking key work. She explained that the roles they were looking for to fill the key worker block were those that were difficult to recruit to, many of whom may not have the income to rent on the private market. There was an income limit for those eligible

to seek the accommodation as well as a salary threshold. Martin Smith added that the normal i4B policy could not have been applied to the block due to the section 106 agreement with Quintain and it would not have been financially viable to do so, therefore i4B looked at other ways the block could benefit Brent. He also added that the block would improve i4B finances over time, enabling the Company to buy more properties for the housing needs it was trying to supply for. The discounted rent would be at 65% of market rates.

Further discussing the key worker block, Peter Gadsdon advised that Committee members and anyone interested could find the allocation policy on the Brent Council website. The allocation had 2 tiers; the first tier included key worker roles such as social workers, occupational therapists, educational psychologists, planners, surveyors, architects, health visitors, nurses, midwives and speech and language therapists; roles which he advised were critical public sector roles that would be at the lower end of the pay scale and who would find it hard to work and live in the area they provided services for. Tier 2 would bring in a wider range of public sector workers. Those applying for the key worker housing needed to be earning at least £31k for a one bed property due to the financial assessment undertaken to ensure people could afford the rent, and there was a salary cap also. The salary range was linked to the government rules around key worker housing.

The Committee asked what independent executive oversight of the Company took place. Martin Smith advised that Cabinet oversaw i4B through a number of mechanisms, such as the sign off of the Company's annual business plan. In addition the Audit and Standards Advisory Committee oversaw the risk and financial components of i4B, with directors attending regularly, and there were regular shareholder meetings where the Chief Executive of Brent Council and the Director of Finance at Brent Council represented the Council's interests and met with the directors of the Company for operational and strategic oversight of the Company.

In response to a query regarding the net yield model, Martin Smith agreed to provide a worked example of the net yield outside of the meeting. He explained that the principal reason for its increase was because the Company worked out midway through the life of i4B that the yield was not sufficient to keep the company financially viable over the medium and long term, therefore they toughened the criteria slightly to get a better yield which was now flowing through into its portfolio.

The paper included performance of the Company, and did not differentiate between providers. It was noted there was not a substantial difference between the different providers, and the most difficult area in performance had been the home counties properties as they were the most difficult to let. Regarding plans for energy performance, Martin Smith confirmed the Company had set goals early in its tenure but now needed to update those to take into account the Council's recent aspirations which it was planning to do next year.

Regarding what happened with residents if their housing needs changed while they were i4B tenants, Martin Smith advised that they would go into the Brent housing needs system and i4B would try to look favourably on people in their properties whose needs changed either by adapting the property or trying to accommodate them in another.

The Company had no plans to move into HMO management.

During the discussion a number of requests for information were made, which included:

i) To receive a worked example of the i4B net yield model, or the annual return, on a property owned by i4B, and the yield on all i4B properties.

ii) To receive information on the value of the portfolio of properties owned by i4B.

iii) To receive data on when the last 4 or 5 bed property was bought by the Company.

iv) To receive information on the strategic oversight on the entire housing policy.

The Chair moved on to invite Committee members to make recommendations, with the following recommendations agreed:

i) To recommend a review of the governance arrangements of i4B to ensure it is robust and challenging and there is accountability and oversight.

9. **Any other urgent business**

None.

The meeting closed at 6:02

COUNCILLOR KETAN SHETH
Chair

Brent	**Community and Wellbeing Scrutiny Committee** 24 March 2021
	Report from the North West London Collaboration of Clinical Commissioning Groups

A&E Performance at Northwick Park and St Mary's Hospitals

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Appendix 1 - Elective surgery and cancer performance at Northwick Park and St Mary's Hospitals
Background Papers:	0
Contact Officer:	Jonathan Turner, Borough Lead Director, Brent CCG Jonathanturner2@nhs.net 0794 725 4871

1.0 Purpose of the Report

1.1 To provide accountability for the performance of Accident and Emergency (A&E) services at two local hospitals against key national standards, and provide the scrutiny committee with assurance that pressures on services in recent years have been managed, and the present challenges of the Covid 19 pandemic for A&E are being managed and addressed.

To update the committee with information about changes to national standards piloted at one of the hospitals, and the implications for A&E from changes to the health economy.

2.0 Detail

2.1 National Standards

The NHS Constitution contains the pledge that all attendances at an Emergency Department should involve 'a maximum 4-hour wait in A&E from arrival to admission, transfer or discharge'.

The 4-hour measure was introduced in 2004, the standard was initially set at 100% but the standard amended to 95% in 2010.

It was recognised that the A&E 4 hour standard has had a transformational impact, but it has limitations.

In June 2018 there was a clinically-led review of NHS access performance metrics. New emergency care standards are being piloted at 14 Trusts nationally, including Imperial College Healthcare NHS Trust (ICHT). All Trusts involved in the pilot are not yet able to report performance publically.

The recommended new emergency care standards from the pilot are below:

Service	Measure	Rationale
Pre-hospital	999 category 2 Response Time - 90th centile	Measure of efficiency of pre-hospital response. Category 2 calls include a number of critical conditions that are also covered in the Critical Time Standards so this ensures that those patients are appropriately managed from the moment 999 is dialled.
	Conveyance rates to Emergency Departments by 999 ambulances	Measure of efficiency of pre-hospital response. Reducing avoidable conveyance to Emergency Departments is a key contributor to avoiding nosocomial infection, and alternative pathways of care including treatment at scene, referral to appropriate services or conveyance to an alternative care setting can all reduce conveyance.
	Percentage of interactions with NHS 111 receiving clinical input	Measure of effectiveness of local Integrated Urgent Care Services. We know it is important that there is clinical oversight of 111 calls in order to make sure patients are appropriately triaged and signposted to the right local service for their needs.
A&E	Percentage of Ambulance Handovers within 15 minutes	Measure of efficiency and flow into Emergency Departments. It is essential that patients can be quickly transferred into the care of hospital teams to ensure that treatment can be initiated quickly and ambulances can be released back onto the road in order to deal with new emergencies.
	Time to Initial Assessment - percentage within 15 minutes	Measure of efficiency of streaming and triage of patients. This provides assurance that patients needs are quickly assessed and in order that they may be treated in the right place and at the right time.
	Mean Time in Department - non-admitted patients	Measure of efficiency of A&E Services. While we want to ensure the sickest patients are treated most quickly, it is also important to ensure that efficient services are provided for patients who do not require admission into hospital. This is important in ensuring departments do not become crowded.
Hospital	Mean Time in Department - admitted patients	Measure of efficiency of hospital services. It is important that those patients requiring ongoing acute hospital care spend no longer in emergency departments than is necessary.
	Clinically Ready to Proceed	Measure of efficiency and flow out of the Emergency Department. In order to ensure patients receive timely onward care and to reduce crowding in departments it is vital that there is continuous flow out of Emergency Departments into acute / general medical and specialty services.
Whole System	Percentage of patients spending more than 12 hours in A&E	There is no valid reason why any patient should spend more than 12 hours in an A&E department. Any incidence of patients spending this length of time in A&E is suggestive of wider system problems as patients are unable to be transferred to services more appropriate for their needs.
	Critical Time Standards	Measures of the effectiveness of services for the critically ill who require immediate assessment and treatment in order to ensure good clinical outcomes. These services are not just delivered by Emergency Department, but also by wider specialist hospital services.

A consultation on the new standards took place in December 2020.

2.2 Local A&E Services

Brent has a number of urgent and emergency care services. The two most used A&E departments are at Northwick Park Hospital on the border between Brent and Harrow in the far north of the borough, and at St. Mary's in Paddington, which patients in the south of the borough tend to access more. There is also the A&E department at the Royal Free Hospital in Hampstead, which some of the patients in the east of the borough sometimes access. These are all major consultant-led units that are open 24 hours per day, 7 days per week all year round.

For type 2 (specialist A&E services) there is an emergency department at the Western Eye Hospital in Marylebone, which is run by Imperial College Healthcare NHS Trust. This operates between the hours of 8.30 until 20.30.

Type 3 attendances relate to urgent treatment centres. The departments at Northwick Park both have Urgent Treatment Centres, which are primary care-led organisations that are able to filter out conditions that do not require the support of a full-service A&E department. They are trained to deal with common ailments that people tend to attend at A&E departments for. At Northwick Park, the UTC is run by Greenbrook Healthcare and at St. Mary's the UTC is run by Vocare Group. These UTCs are a "front-end" to A&E and patients who do not arrive in an ambulance will first be triaged at the UTC to check whether they can be seen there, or whether they need to go through to A&E. Patients arriving by ambulance arrive at the ambulance "pit-stop" in A&E. The UTCs are open 24/7 in the same way that the A&E departments are.

Additionally, there is a UTC at Central Middlesex Hospital that operates from 8am until midnight. However, there is no A&E department at CMH. This is also run by Greenbrook Healthcare.

NHS 111 services and GP Out of Hours services are working together as part of an integrated urgent care model, which allows for improved streamlining, so that patients are able to access services in the right place and at the right time.

How Services Changed as a Result of the Pandemic - Imperial College Healthcare St Mary's Hospital: Urgent and Emergency Care During Covid-19 Second Surge

The usual demands of the winter period on urgent and emergency care were magnified this year because of additional prevention and control measures for Covid-19 during the second surge in hospital admissions – especially physical distancing. We streamlined care in our A&E departments to avoid unnecessary delays and crowding.

Our largest number of Covid-19 positive patients during the second surge was on 20 January 2021, when we were caring for 492 patients who had tested positive for Covid-19 on their current admission. One hundred and thirteen of these patients were being cared for in intensive care.

In response to increasing demand across London, especially since early January 2021, we expanded our intensive care capacity significantly, up to 150 beds. As well

as expanding our permanent adult intensive care units and acute respiratory units across all three main sites, we transformed most of our children's intensive care unit at St Mary's into an adult unit (while the majority of children's intensive care was consolidated temporarily at Great Ormond Street Hospital) and created additional intensive care units at each of our three main hospital sites.

With greater clinical understanding of Covid and more treatments available, we have been able to care for more patients on general acute wards during this second wave of infections. This has put more pressure on our wards, with up to 23 wards set up to provide care for Covid-positive patients. Our capacity expansion has relied on almost 1,000 staff being able to take on temporary new roles, for some or all of their time. In addition, we were very grateful to clinical staff from the military who, under the supervision of our clinicians, are helping to run one of our additional intensive care units at Hammersmith Hospital. We have also had to postpone all but time-critical planned care for January and February.

We have worked hard to ensure safe and high quality care for all patients, putting in place a wide range of infection prevention and control measures, including physical distancing and pathway separation within our A&Es and wards, regular inpatient testing, enhanced cleaning, careful compliance with personal protective equipment requirements and combining an expanded reception service with dedicated hygiene stations and support at key entrances. We also ensured we optimised the 'flow' of care, expanding our 'same day emergency care' to avoid unnecessary hospital stays and working closely with partners to ensure patients who were well enough to be discharged from hospital had the support in place to be discharged promptly.

We made a number of adaptations and improvements within our urgent and emergency care services, supported with £1.4m additional capital funding to enable estates work where necessary. The developments include:

- Improving facilities for mental health patients at both St Mary's and Charing Cross hospitals
- Providing more 'same day emergency care' to avoid unnecessary admissions
- Repurposing office space to provide more clinical assessment areas at St Mary's across both the paediatric and adult A&E
- Additional access to GP care at Hammersmith Hospital to support 111 referrals
- Investment in software to enable us to offer more online – or remote – care
- Increasing 'fit to sit' space for patients who do not need lie down.

Since May 2019 our Trust has been part of the NHS England pilot testing new access standards for urgent and emergency care. Although this means we are no longer being monitored against the national 'four hour' target, we have committed to treating and discharging all 'non-admitted' patients within three hours and admitting 'admitted' patients within four hours. We also became part of the NHS 111 First approach from 1 December 2020.

2.3 A&E attendances

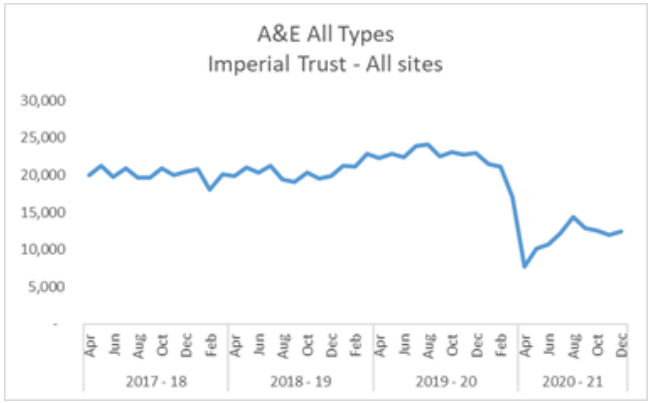
The graphs below show that the number of A&E attendances at both Trusts reduced significantly at the start of the pandemic, and then increased somewhat during the summer of 2020 as COVID levels subsided – however activity has not yet returned to pre-Covid levels. During the pandemic, COVID-related attendances increased, whilst non-COVID related attendances decreased. We can also see that where data for January and February 2021 is available, activity dipped again as wave 2 of the pandemic resurged.

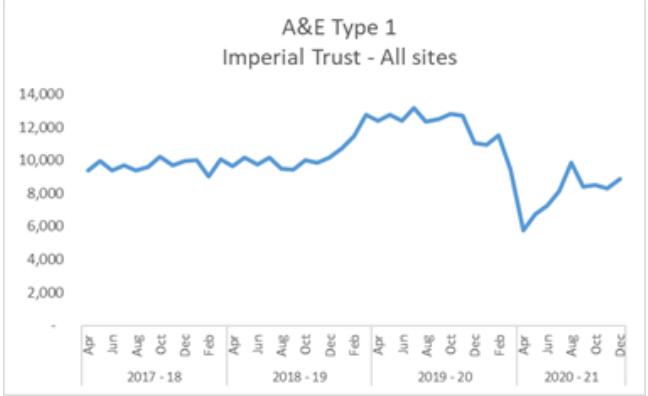
COVID-19 has led to significant changes in the way people are using NHS and social care services, and emergency care is no exception.

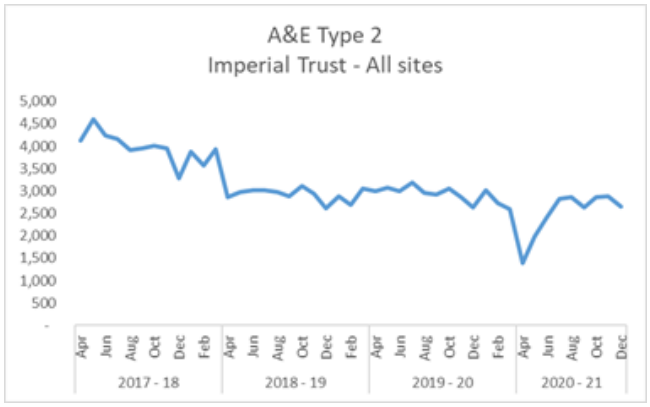
Likely reasons behind the changes include changes in how NHS services operate, changes in patient behaviour and changes in the prevalence of conditions. For example, nationally there has been a big reduction in the number of minor injuries such as sprains/ ligament injuries and muscle/tendon injuries. This may reflect the changed conditions of the lockdown and the lack of availability of opportunities for recreational activities, or reductions in movement of people. Part of the reason is likely to be concern about COVID-19 and people choosing to stay away from A&E when they have less serious conditions. They may also be keener to access alternatives such as GP practices or extended access hubs.

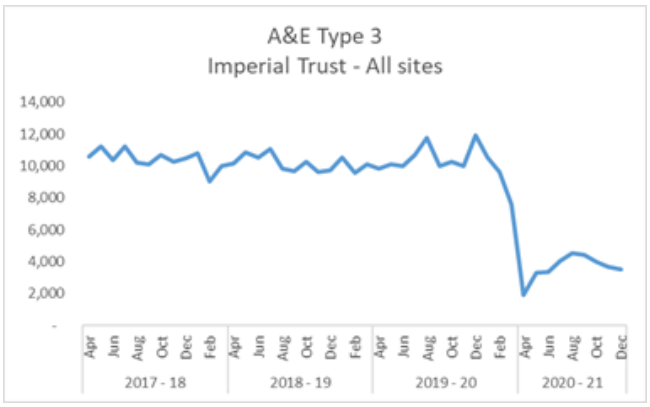
The pattern of A&E attendances (type 1) are shown below for the last 4 years of data available:

Imperial A&E attendances (validated):



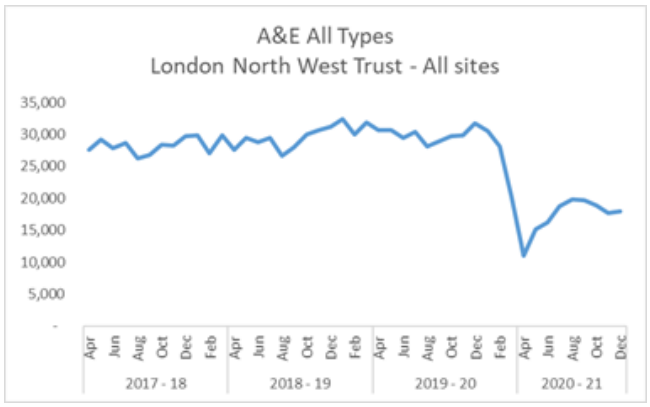


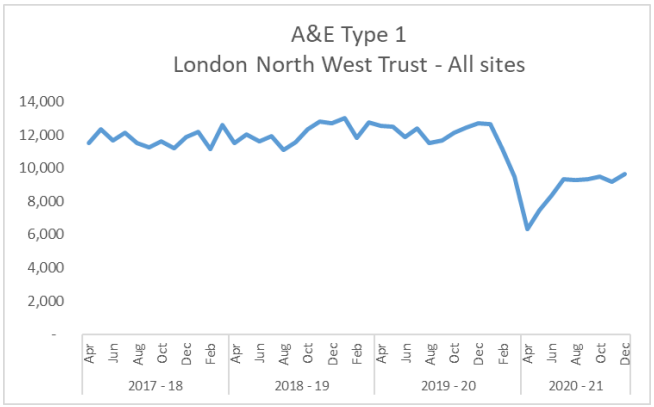


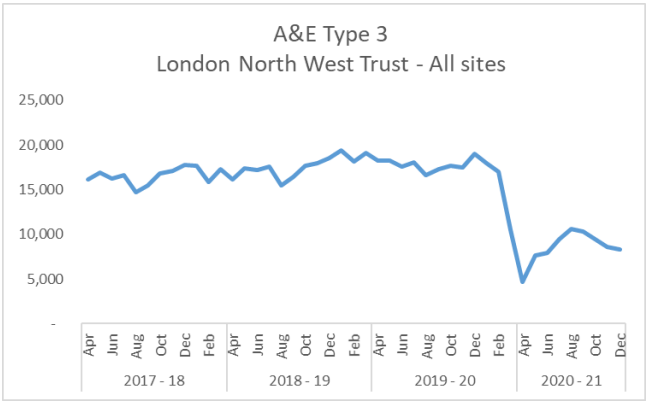


Data Source: *NHSE Joint Activity Report (JAR)*
Caveats: *Validated / Not available at site level*

London North West A&E Attendances (validated):



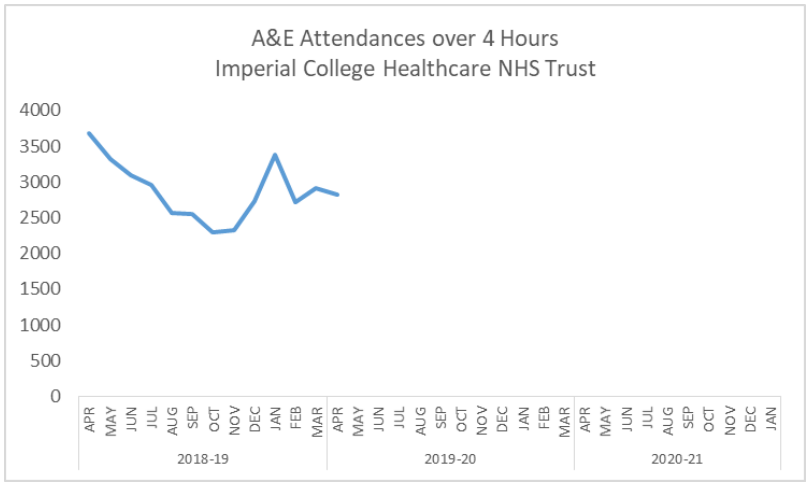


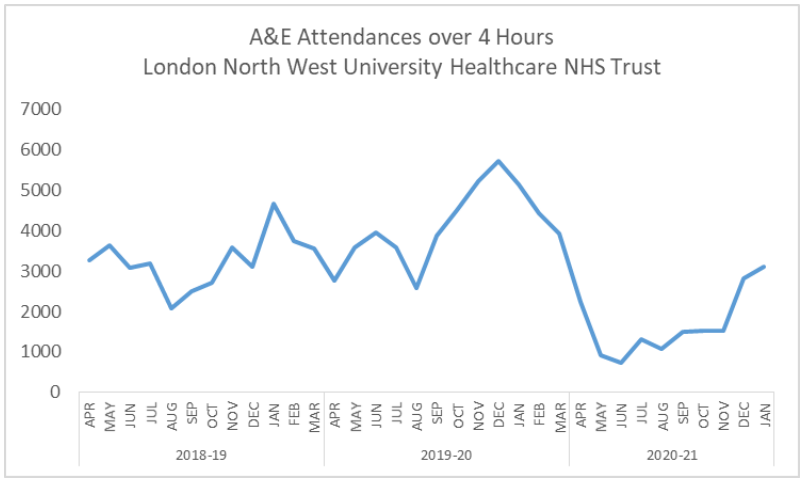


Data Source: *NHSE Joint Activity Report (JAR)*
Caveats: *Validated / Not available at site level*

A&E Attendances over 4 hours (validated):

The 4-hour A&E waiting target is a standard set out in the NHS Constitution. The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The Imperial data for this metric stopped being collected from April 2019/20 onwards due to participation in a national pilot for new emergency care standards. Site level data is not available for the 4-hour wait. The data is showing a large reduction at LNWHT of A&E attendances over 4 hours from the start of the pandemic, which is presumably due to the lower volume of A&E attendances overall. As we went into the winter of 2020, the numbers started to increase, but never returned to the highs of the pre-pandemic levels.

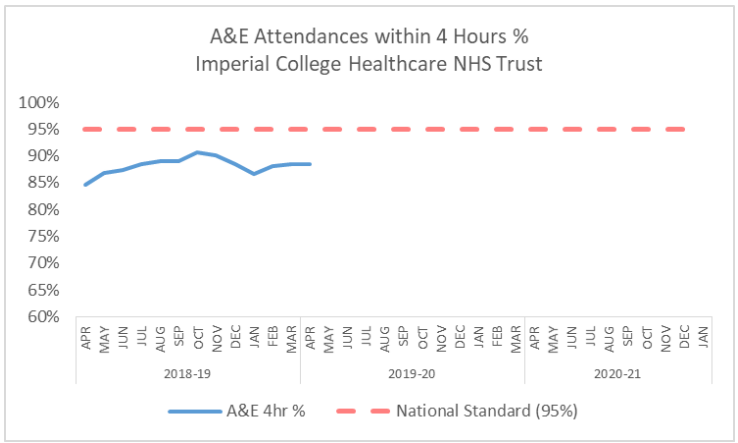


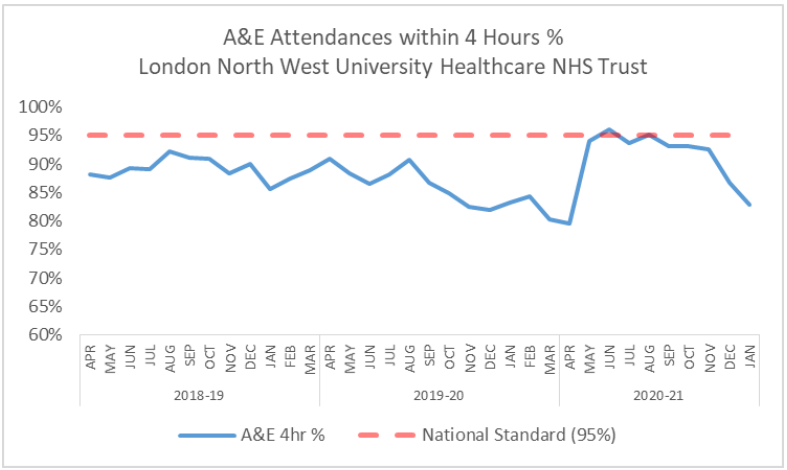


Data Source: *NHS Statistics, A&E Attendances and Emergency Admissions*
Caveats: *ICHT stopped reported in 19/20 due to pilot of new emergency care standards*
Provider-level data only, site-level data not available in national dataset

% of A&E Attendances within 4 hours (validated):

With regard to the A&E attendances within 4 hours, this took a dip as we first entered the pandemic in February and March 2020, but then increased significantly during May and into the summer as the first wave reduced in size but numbers of A&E attendances continued to fewer than pre-pandemic levels. The percentage then started to dip again during the pressures of wave 2 of the pandemic in December 2020 and January 2021.





Data Source: *NHS Statistics, A&E Attendances and Emergency Admissions*
Caveats: *ICHT stopped reported in 19/20 due to pilot of new emergency care standards*
Provider-level data only, site-level data not available in national dataset

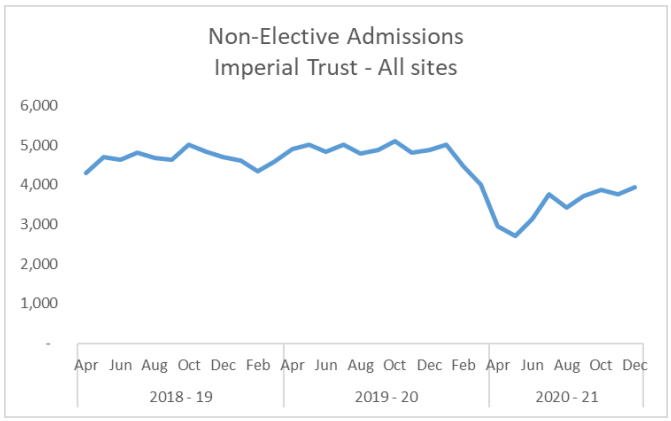
In the 34 months between April 2018 and January 2021 LNWHT achieved the 95% standard in 2 months – June 2020 and August 2020.

LNWHT currently has the best performing A&E services against the 4 hour-target in the whole of England as of March 2021, which is a combined figure for the Northwick Park site and the Ealing Hospital A&E departments. LNWH has also moved to no.3 nationally (Emergency Care Intensive Support Team UEC Dashboard), the two trusts that are above LNWH are children sites (Sheffield children & Alder Hey). The trust has also been recognised for its improvement in Hospital-level Mortality Indicators nationally from October 2019 to September 2020 – No. 7 in London. The length of stay performance continues to improve: 10% occupying a bed 21+ days (sector range 10% to 29%) and 20% occupying a bed 41+ days (sector range 20% to 39%). Staff survey – percentage response the highest level since the start of the survey plus more staff recommended the trust as place to work.
The Trust combined performance against the 4 hour A&E standard was 94.7% in Feb 21. The Trust's 4 hour A&E standard rose to be the highest performing in London and rated between 3rd and 7th nationally for weekly emergency care performance as per the Emergency Care Intensive Support Team Urgent & Emergency Care Dashboard. The 2020/21 year to date position is 91.7% compared to the 2019/20 year end position of 85.9%

2.4 A&E emergency admissions

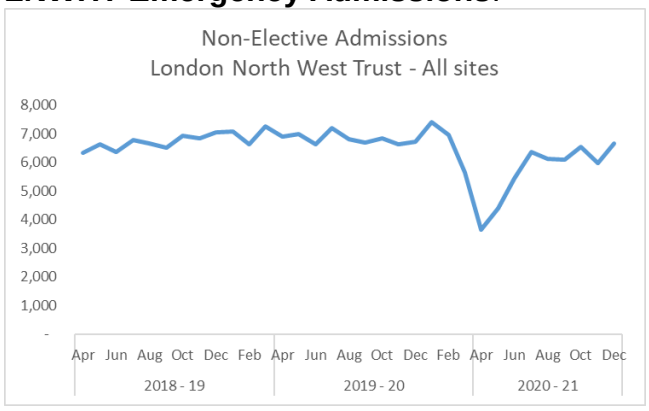
Emergency admissions are admissions that take place following an attendance at an A&E department. They are not planned admissions. The patterns in the graphs shown below indicate that admissions dropped during the initial wave of the pandemic in March 2020, and never returned to pre-pandemic levels. This is likely due to a number of factors, including an overall reduction in the number of A&E attendances and a higher threshold for admission during the peaks in waves, where a concentration of focus was required to manage COVID patients in ITU and on COVID wards.

Imperial Emergency Admissions:

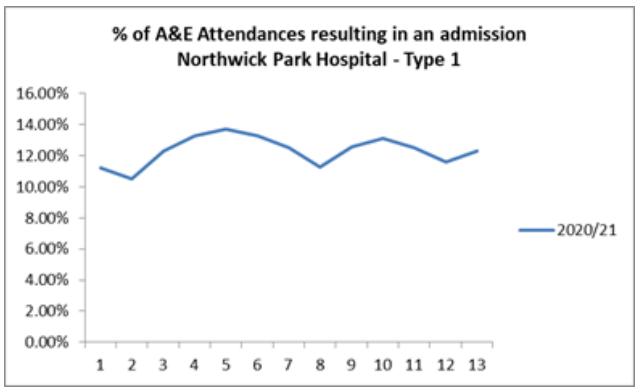


Data Source: *NHSE Joint Activity Report (JAR)*
Caveats: *Validated / only available at Trust level / unable to split at Type 1, 2 or 3*
Contains all emergency admissions, unable to identify emergency admissions via A&E in national dataset

LNWHT Emergency Admissions:



Data Source: *NHSE Joint Activity Report (JAR)*
Caveats: *Validated / only available at Trust level / unable to split at Type 1, 2 or 3*
Contains all emergency admissions, unable to identify emergency admissions via A&E in national datase



Data Source: *NWL Emergency Care Dataset; NPH Trust local data*

Caveats: Data only covers patients registered to a GP practice within the 8 NWL CCGs; NPH data excludes zero day admissions to SDEC and CDU

2.5 A&E demand

Primary and community care has stepped up to manage demand in A&E during the COVID pandemic.

During March 2020, the CCG set up a COVID Escalated Care Clinic, which sees patients with moderate COVID symptoms. GPs were able to support people with mild symptoms to manage their condition at home without needing further intervention. Those with moderate breathlessness and moderate reduction in oxygen saturations were managed by the COVID Escalated Care Clinic (otherwise known as the "Hot Hub") and treated by GPs operating to a North West London clinical protocol. Patients were monitored at home using pulse oximeters and the results reported 3 times per day to ensure that patients were not deteriorating and were making a good recovery. Escalation routes into A&E were set up. The ECC hub capacity and hours were flexed up and down to accommodate the peaks and troughs of COVID presentations, operating from 8am-10pm during the peak of waves 1 and 2.

Additionally, capacity at our Extended Access Hubs was increased, so that the number of sessions were doubled during weekends and the hours were extended during weekday evenings. The Extended Access Hub phone lines were made directly available to patients during weekends when the GP practice phone lines were closed.

During wave 1, the Extended Access Hubs also helped the 111 service to triage calls and to redirect them to a more appropriate setting when they did not need to be seen in an acute setting.

General practice has continued to be available during the pandemic, and although more appointments have shifted into virtual appointments, including telephone or e-consultations, general practice has remained open to see patients who need to have a face to face consultation or examination.

An enhanced level of support has been offered to care homes through Brent's "Enhanced Care in Care Homes" team. This has offered daily ward rounds of care homes to proactively care for patients and to avoid unnecessary admissions. Proactive asymptomatic testing of care home staff and patients has also been taking place to get a grip on any COVID infections that have started to limit their spread.

2.6 Patient Experience

The Friends and Family Test is the main way in which patient experience is measured for A&E departments. The outcomes below from February 2021 show that most people are satisfied with the performance of their A&E department. Slightly more people are dissatisfied with St. Mary's than with Northwick Park.

Feb-21 **A&E Friends and Family Test**	**Response Rate**	**Percentage Recommended**
Northwick Park Hospital	7%	88%
St Mary's Hospital	9%	82%
England	**9%**	**85%**

Data Source: Friends and Family Test, NHS England

2.7 A&E collaboration and the wider Integrated Care System (ICS)

Daily updates on A&E status, ITU capacity and pressures for each acute site have taken place via morning NWL Gold arrangements chaired by the Medical Director for Imperial. This has been followed by daily afternoon surge calls throughout the latest wave of the pandemic. Trusts have worked together as a 'system' with mutual aid agreements regarding LAS intelligent conveyancing arrangements where required. Given the improving position with regard to this latest wave of surge, these arrangements are currently reviewed.

Each site in NWL has operated 'red' covid ED areas and 'green' non COVID ED areas in order to minimise the risk of transmission throughout the pandemic.

Same day emergency care pathways have been maintained across all acute sites to support those presenting with specific ambulatory conditions to be seen, treated and discharged.

Direct booking from 111 into UTC/ED timed appointment slots, where an emergency department outcome has been indicated via 111 assessment, has also been established to reduce risk of overcrowding and nosocomial transmission of illness in waiting areas.

Urgent and emergency care is a key priority for the NWL Integrated Care System. The work is overseen by the NWL Acute Care Programme and the Urgent and Emergency Care Boards, of which all acute Trusts are represented.

<u>NWL Local Care Programme</u>

Covid Response working collaboratively with our partners. The following schemes have been in place to support flow and admission avoidance where possible.

- Discharge hub operating with established team– benefitted specifically from medical leadership in discharge process. There is NWL learning from the GP in reach work supported by MC Patel to assess potential for primary care to support discharge
- During the surge of wave 2 daily sector calls were set up between acute providers to support the management of Level 3, level 2 care through mutual aid as required. This included transfers of Level 3 patients to neighbouring organisations as well as working with LAS to manage conveyances to the sectors in the most effective safe way
- Covid Oximetry remote monitoring - delivered Virtual Ward, including clear pathway of ED referrals to Hot Hub for Covid @ Home
- Opportunity for extending remote monitoring approach to other LTC with links to hot hubs now part of the planning in terms of how we take the benefits from oximetry remote monitoring forward
- Development of Post covid clinics requires on-going support – both specialist assessment clinics and the MDT/SPA in the community. It is acknowledged that there are capacity constraints and also concerns about potential demand, however the NWL approach is to get started and use experience of delivery to inform how we address these challenges
- Recognising that the transition of community services, later in year means that there is a continued need to work with wider community system in short term to ensure consistent NWL approaches.

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Appendix 1

Elective surgery and cancer performance at Northwick Park and St Mary's Hospitals

Elective Surgery and Cancer Waiting Lists

Overall, NW London has maintained a greater portion of elective activity in Wave 2 of the pandemic compared to Wave 1. We were able to care for COVID patients and treat the more clinically urgent elective patients (those who are clinically assessed as needing treatment within 4 weeks, including patients on cancer pathways).

This was achieved through:

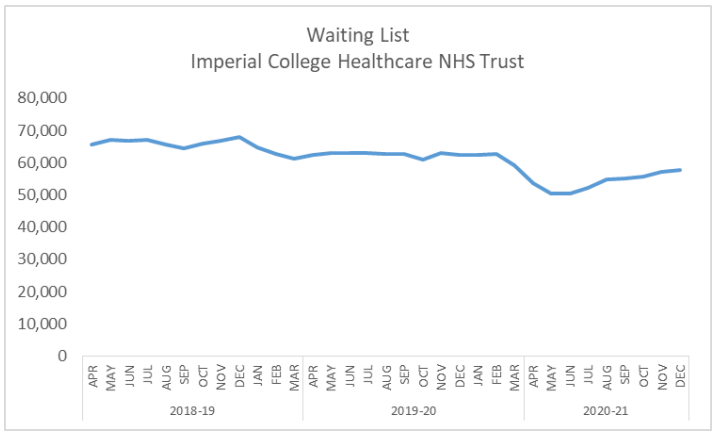
- adoption of virtual outpatient consultations by patients and healthcare professionals where appropriate
- the strengthening of integrated working across primary, secondary and community care
- treating patients across NW London based on clinical priority and using mutual aid across organisations, including more use of the independent sector, where appropriate.

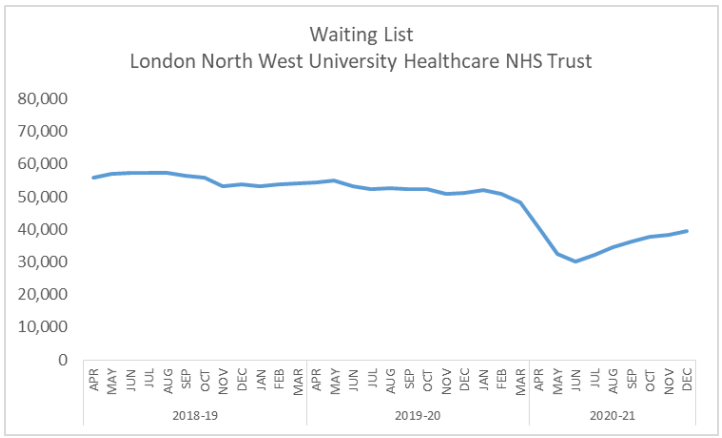
Waiting times for patients awaiting routine care have increased across the NHS, including at both ICHT and LNW. In particular, we now have a significant number of patients who have been waiting over 52 weeks.

Within the North West London Integrated Care System, the four acute trusts are working together to develop a co-ordinated 'reset and recovery' plan for all services as we emerge from the Covid-19 second wave. As well as a detailed action plan to bring down waiting times again, this includes a particular focus on avoiding and minimising harm, ensuring equality of access across the sector and ensuring we are prepared for any further surges in urgent demand. We are also being very mindful of the need for our staff to have time and support to rest and recuperate and to expand the involvement of our patients and wider stakeholders in future planning and improvements.

Our latest published waiting time position, by trust, is as below:

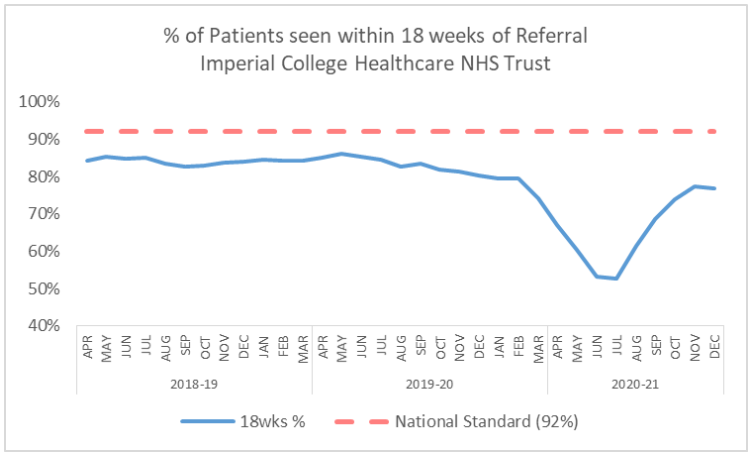
RTT Waiting List:

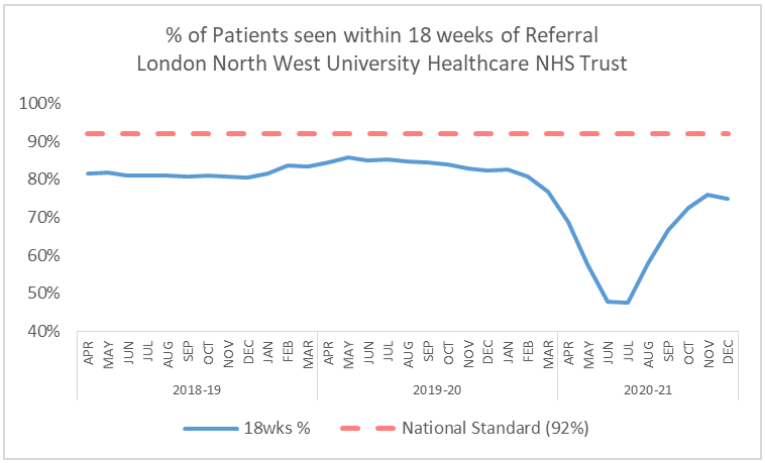




Data Source: *Consultant-led Referral to Treatment Waiting Times, NHSE Statistics*
Caveats: *Provider-level data only, site-level data not available in national dataset*

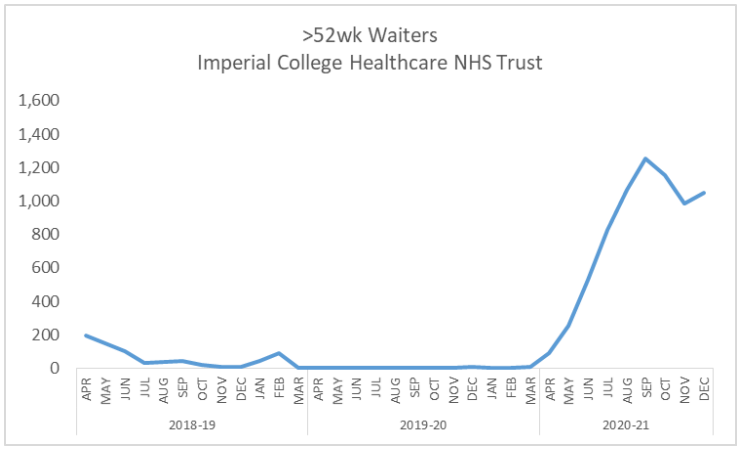
RTT % seen within 18wks:

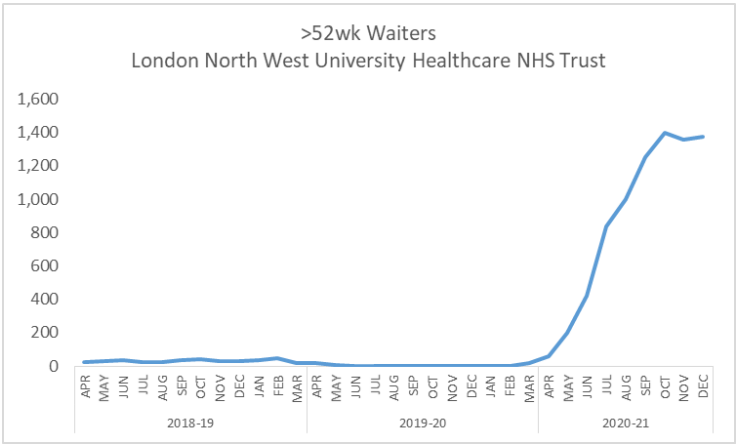




Data Source: *Consultant-led Referral to Treatment Waiting Times, NHSE Statistics*
Caveats: *Provider-level data only, site-level data not available in national dataset*

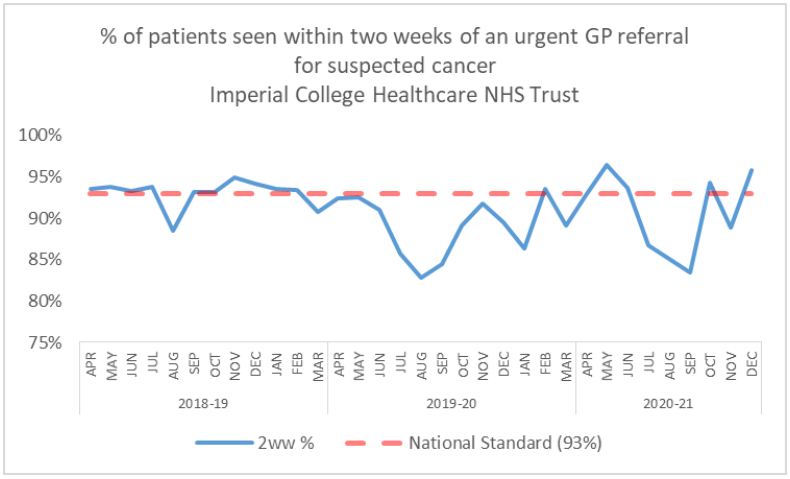
RTT >52wks waiters:

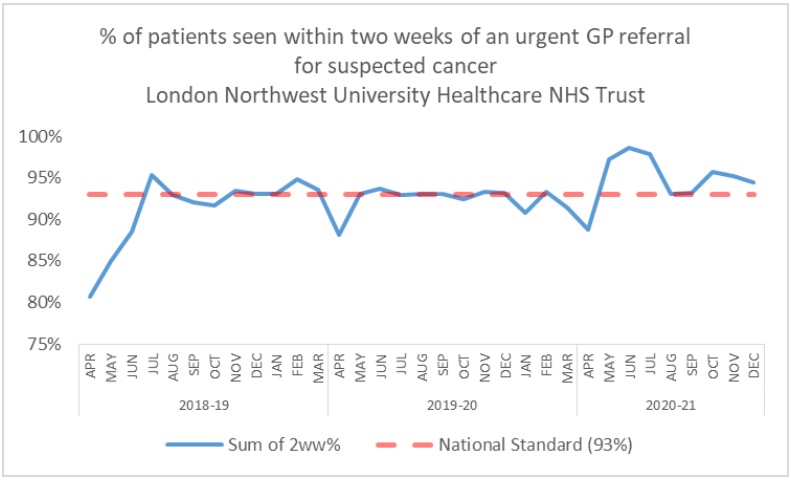




Data Source: *Consultant-led Referral to Treatment Waiting Times, NHSE Statistics*
Caveats: *Provider-level data only, site-level data not available in national dataset*

Cancer 2 week waits:





Data Source: *Cancer Treatment Waiting Times, NHSE Statistics*
Caveats: *Provider-level data only, site-level data not available in national dataset*

Brent	**Community and Wellbeing Scrutiny Committee** 24 March 2021
	Report from the North West London Collaboration of Clinical Commissioning Groups

GP Services and Care Quality Commission (CQC) Ratings in Brent

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer:	Fana Hussain, Assistant Director of Primary Care Delivery Fana.hussain@nhs.net

1.0 Purpose of the Report

1.1 To provide accountability and transparency for quality standards and ratings in GP services in the borough as rated by the Care Quality Commission (CQC) and assurance that there are effective support arrangements exist for practices to improve.

2.0 Recommendation

2.1 The committee is requested to note the content of the reports and receive assurance on the management and support structures in place to improve standards of care in GP practices in Brent

3.0 Background and context to commissioning primary medical services

3.1 General practice is widely recognised to be the foundation on which NHS care is based. Local and international studies of the NHS have shown general practice in the United Kingdom in a positive light and most patients report high levels of satisfaction with the services they receive from general practitioners (GPs). There is also evidence of variations in the quality of services provided within general practice, variation in delivery of services, variation in uptake rates and variation in outcomes. Alongside the variation there has been an increase in the workload experienced by primary care over the past years, with more consultations being undertaken in general practice than in previous year.

3.2 The core purpose of general practice, as stipulated in the national contract, is very broadly described as the services that GPs must provide to manage their registered list of patients when they are ill. These services involve direct consultation and examination, and/ or making available further investigation as appropriate, including referral to specialists. GPs usually deliver services in partnership with other GPs, leading a number of nurses and other support staff who all together comprise the primary care team.

3.3 In addition to this core function, GPs also play a crucial role in the provision of extended primary care services, such as prevention, screening, vaccinations and immunisations, and some diagnostic services. Part of this role is to help patients navigate through the wider health care system and access care appropriate to their needs. GPs also help to ensure effective co-ordination of care for their patients, including social care and services within and outside the NHS.

3.4 GPs work as independent contractors under the terms of a national contract since the inception of the NHS, reflecting the deal struck between the British Medical Association (BMA) and the post-war Labour government under which GPs should not become salaried employees of the state. In the past 15 years there has been a substantial growth in the number of GPs employed on a salaried basis, usually by fellow GPs who as independent contractors are partners who own their practices. Around 9,000 GPs in England are now salaried, comprising one quarter of all GPs and representing a seven-fold increase since 2002 (Health and Social Care Information Centre 2013).

3.5 There are several ways that GP practices currently receive payment for delivering services – through their core GP contract for the delivery of essential services and through enhanced or extended service contracts, agreed both nationally and locally. An important innovation in 2004 was the Quality and Outcomes Framework under which a proportion of pay is linked to the quality of care they deliver to patients. In addition to these contracts, GPs are eligible to opt in to provide locally commissioned services procured by the Clinical Commissioning Group (CCG) – either independently or in partnership with other providers.

3.6 There are currently three main types of core contract: *General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)*. GMS is the contract agreed nationally and stipulates essential services to be provided. These essential services are set in legislation (managed in practice through the contract), and specify that the general practice must provide services (during core hours) to manage their registered list of patients and temporary residents, who are: ill with conditions from which recovery is generally expected; terminally ill; or suffering from chronic disease. These services involve direct consultation and examination, and/or making available further investigation as appropriate (including referral) (The National Health Service (General Medical Services Contracts) Regulations 2004). GMS funding is made up of the global sum (capitated payments) based on the age and gender of patients and other factors, and lump sum allowances, for example, for premises and IT.

3.7 Personal Medical Services (PMS) is the contract negotiated locally and allows greater flexibility than GMS to respond to the variations in need between areas. PMS Plus may include a wider range of services than GMS, for example some community services and services that would usually be provided in hospitals. The Alternate Providers Medical Services (APMS) contract allows the organisations responsible for commissioning primary medical care services to contract with a wide range of providers including those in the independent sector. It has been used to encourage innovative models of care as well as new providers to enter the general practice

market. Like PMS, the APMS contract is more flexible than GMS, allowing commissioners to tailor services to local needs. The total numbers of each contract type are set out below:

Contract type	Total number of contracts in Brent
General Medical Services	37
Personal Medical Services	10
Alternate Providers of Medical Services	4
Total	51

3.8 In April 2019, the GP contract changed further with the establishment of Primary Care Networks (PCNs). A primary care network is a group of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Networks typically serving populations of at least 30,000 and while an initial upper target was set at 50,000, it has since be recognised that larger population sizes provided additional benefits of working at scale. PCNs are required to be small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience and support the development of integrated teams. Initially in Brent, the GPs established ten PCNs; the benefits of working at scale have led to the reduction of PCNs to seven, as set out below

PRACTICE	PCN AREA	MANAGERIAL LEAD	CLINICAL DIRECTOR
Brentfield Medical Centre	Harness South	**Managerial Lead:** Caroline Kerby	**Clinical Directors:** Subash Jayakumar / Mousoumi Mukherjee
Church End Med Centre	Harness South		
Stonebridge Medical Centre	Harness South		
Aksyr Medical Centre	Harness South		
Hilltop Medical Practce	Harness South		
Oxgate Gardens Surgery	Harness South		
Roundwood Park Medical Centre	Harness South		
Walm Lane Surgery	Harness South		
Park Royal Medical Centre	Harness South		
Freuchen Medical Centre	Harness South		
	Total Harness South		
The Surgery	Harness North		**Clinical Directors:** Sachin Patel / Milind Bhatt
Pearl Medical Practice	Harness North		
Wembley Park Drive Medical Centre	Harness North		
SMS Medical Practice	Harness North		
Lanfranc	Harness North		
Sunflower Practice	Harness North		
Church Lane Surgery	Harness North		
Willow Tree Family Doctors	Harness North		
Preston Road Surgery	Harness North		
Sudbury & Alperton Practice	Harness North		
	Total Harness North		
Kilburn Park Medical	Kilburn Partnership	**Managerial Lead**: Germaine Brand	**Clinical Director:** Dhanusha Dharmarajah / Candice Lim
Chichele Road Surgery	Kilburn Partnership		
Staverton Medical Centre	Kilburn Partnership		
Mapesbury Medical Centre	Kilburn Partnership		
Willesden Green Surgery	Kilburn Partnership		
The Law Medical Centre	Kilburn Partnership		
	Total Kilburn		
Gladstone Medical Centre	K&W South	**Managerial Lead**: David Hunter	**Clinical Director:** Nigel De Kare-Silver
Willesden Medical Centre	South		
St George's Medical centre	South		
Burnley Practice	South		
St Andrews Medical Centre	South		
The Lonsdale	South		
	Total K&W South		
Neasden Medical Centre & Greenhill Park	North		**Clinical Director:** Sadik Merali
Uxendon	North		
Jai Medical Centre	North		
The Fryent Way	North		
Kingsbury Health & Wellbeing	North		
Brampton	North		
Kings Edge Medical Centre	North		
	Total K&W North		
Forty Willows Surgery	Central		**Clinical Director:** Shikha Gosain /Raja Intkhab
Tudor House Medical Centre	Central		
Chalkhill Practice	Central		
Ellis Practice	Central		
Preston Road Medical	Central		
Sudbury Surgery	Central		
	Total K&W Central		
Premier Medical Centre	West		**Clinical Director:** Mohammad Haidar
The Wembley Practice	West		
Hazeldene	West		
Alperton	West		
Lancelot	West		
Stanley Corner	West		
	Total K&W West		

3.9 In Brent, all seven PCNs are led by GP Clinical Directors (CDs) with some PCNs appointing two job shares to enable CDs to provide leadership to their Network practices to improve the quality and effectiveness of commissioned services. The traditional model of the 'single handed' GP has now been eroded, with more GPs now opting to hold a salaried position, with most younger GPs holding a portfolio of roles which span a number of NHS and non NHS organisations. Preference for salaried

position rather than take on partnerships means they are not obliged to take responsibility for the management of the practice as a small business or purchase equity in it. Where a GP contract is led by one GP partner, a number of salaried and long term GPs would support the delivery of services along with nurses, health care co-ordinators, clinical pharmacists, social prescribers, healthcare assistants and many more. From April 2021 the introduction of Mental Health Therapists and Paramedics further compliments the team. There are currently 11 GP practices where the contract is held by a sole practitioner.

3.10 **Brent General Practice Workforce**

Brent has 51 GP Practices affiliated to 7 Primary Care Networks (PCN) in three localities Harness, Kingsbury and Willesden (K&W) and Kilburn (table 1).

Table 1 - Brent General Practice Workforce manual data collection (Headcount)

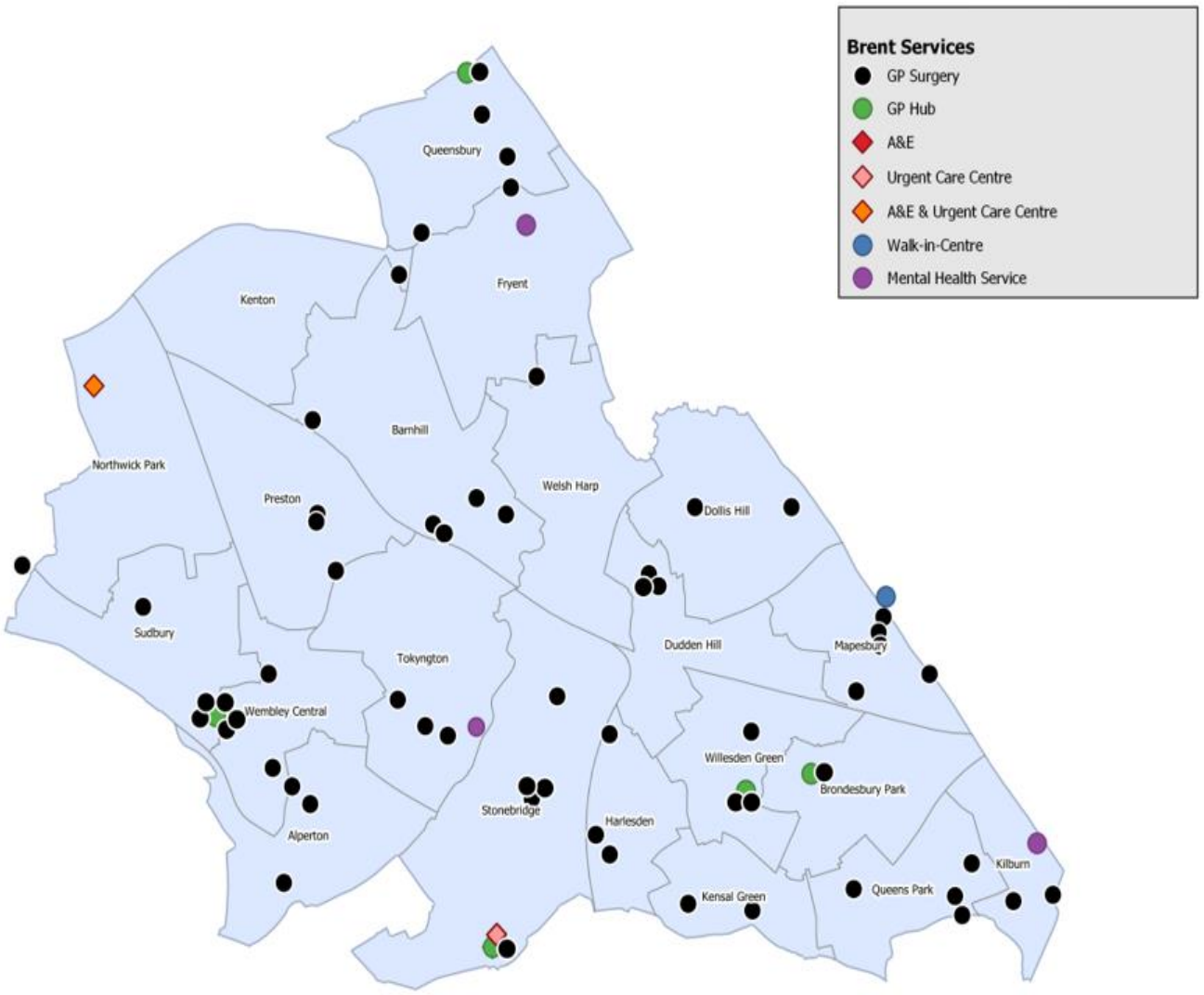
Practices	GP Partners	GP Salaried	Practice Managers	Nurse	HCA	Pharmacist	Physician Associates
51	116	114	72	77	64	51	5

From NHS Digital data, Brent was ranked as the 7th under doctored CCG in London with a decreasing and older GP workforce and identified as having the most patients per nurse in NWL as well as the greatest proportion of nurses over 55. However Brent has a large and growing direct patient care workforce of Clinical and Practice Based Pharmacists Health Care Assistants and Physician Associates. Brent probably employs the highest number of Clinical pharmacists of any London borough. The introduction of the Additional Role Reimbursement Scheme in 2020 will also see a continued increase in the direct patient workforce with the introduction of new roles such as nursing associates, paramedics, pharmacy technicians, mental health therapists and physiotherapists.

3.11 Recruitment and retention programmes are being introduced to reverse the decline in the GP and GPN workforce with fellowships for newly qualified and experienced GP and GPNs, CPD training opportunities, clinical skills development, staff education forums and mentorship and supervision

3.12 Brent CCG population continues to grow with a current registered population of 414,023. Brent comprises of 51 GP practices across 59 sites and they form into seven separate PCNs. Map 1 illustrates the spread of 51 Brent GP practices (59 sites) in Brent.

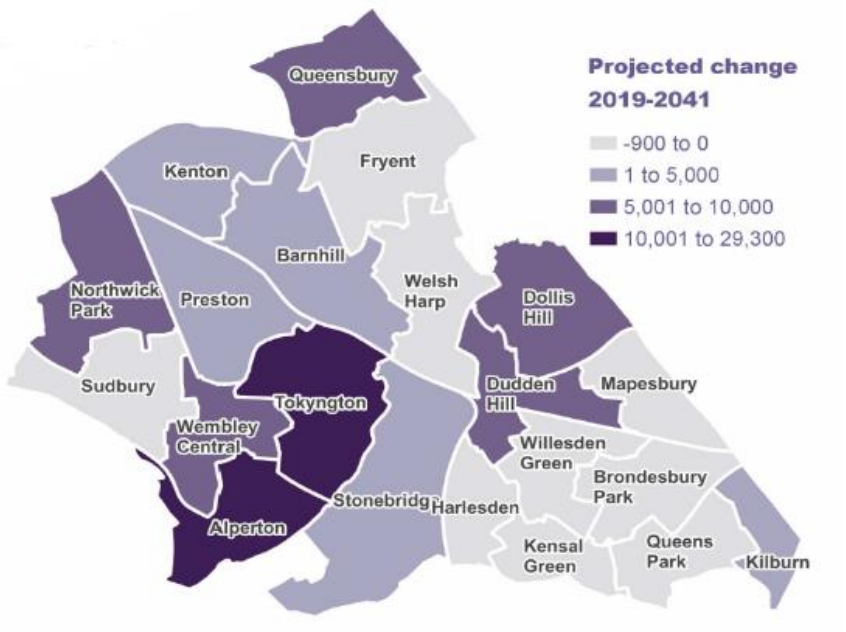
Map 1: Brent GP Services



4. Population health and health inequalities

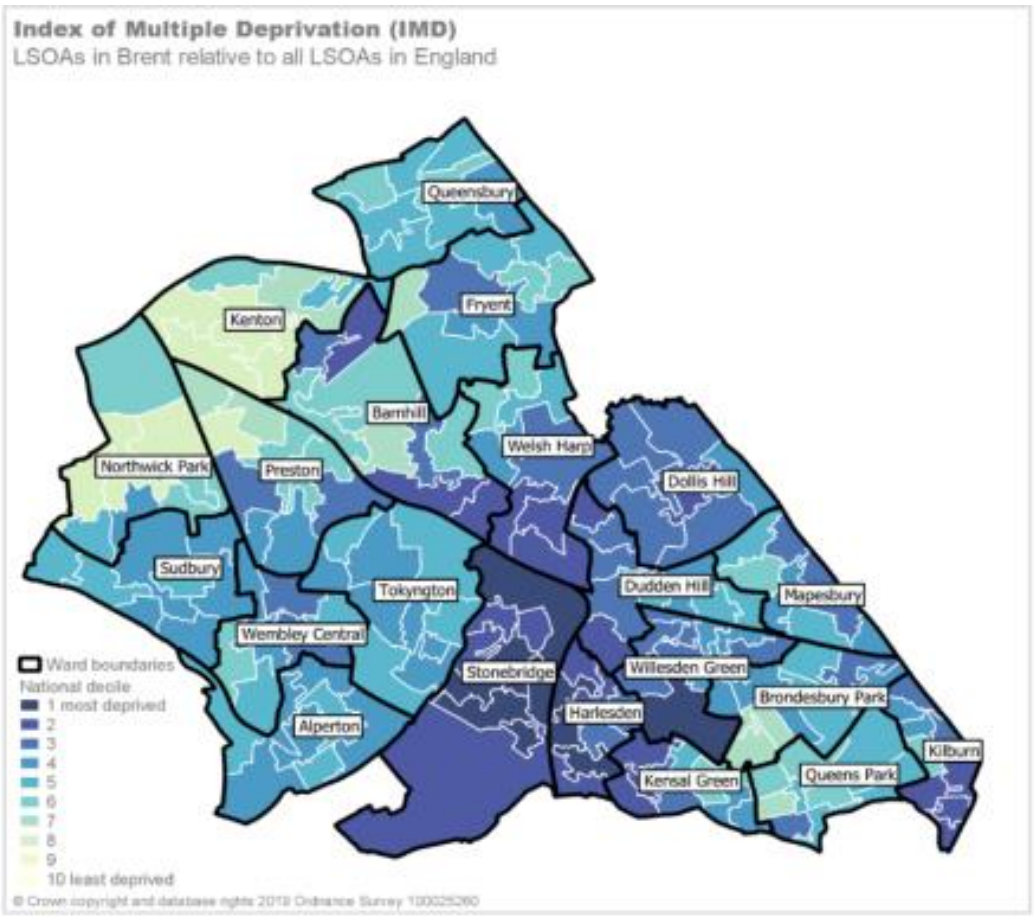
4.1 Brent is a densely populated and a large borough in London. It has a high turnover of the population with a young population. The Brent population has been growing strongly since the early 90s. During 1998-2018, the population grew by 27% – an increase of 70,900 residents. By 2041, the population is expected to grow by another 25% - an increase of 84,800 residents. The two fastest growing wards are Tokyngton and Alperton, which are expected to accommodate 47,600 more residents by 2041.

Map 2: Projected Population Growth by Wards



4.2 Map 3 shows the deprivation levels by ward. The most highly deprived areas in the borough are concentrated in Stonebridge and Harlesden. The least deprived areas in the borough are located in the North West, in the wards of Kenton and Northwick Park.

Map 3: Projected Population Growth by Wards



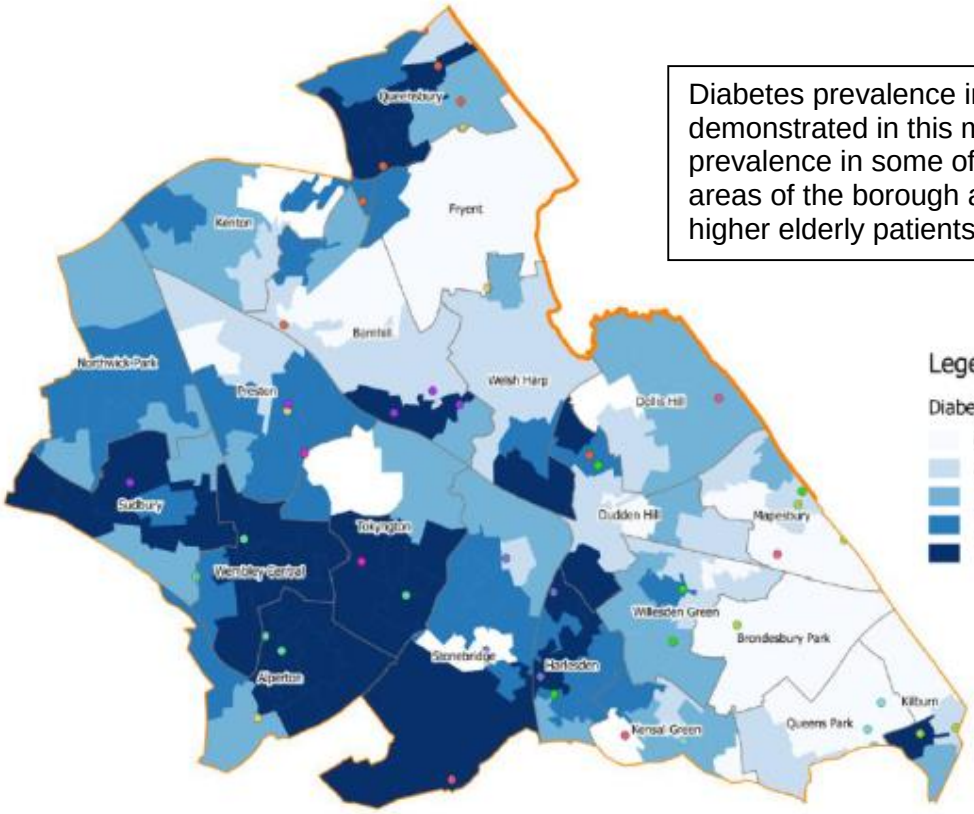
5. Increasing demand on GP practices and primary care

5.1 England's population is both expanding and ageing. The combined impact of these two demographic changes has been to increase the pressures on the NHS in general and on primary care in particular. These pressures are compounded by the increasing prevalence of long-term conditions in the population and the impact of risk factors like smoking, alcohol misuse, obesity and drug misuse, which tend to cluster in certain communities. Rising public expectations are adding to the workload of frontline staff.

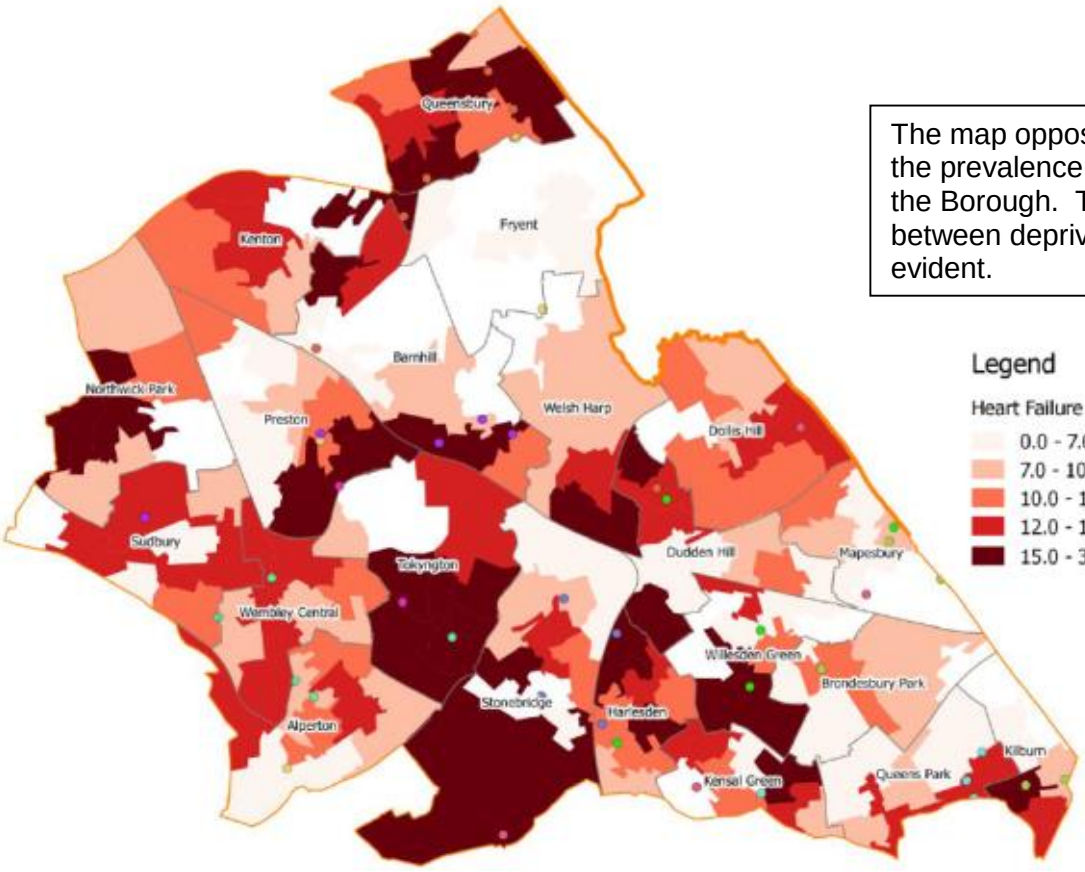
5.2 Of particular importance is the increasing number of people with more than one long-term condition and especially those with several. The challenge of multi-morbidity lies behind the increasing needs of frail older people. Its existence underlines the importance of services being well co-ordinated in order to provide timely and high-quality care for people who are in contact with many health and social care professionals. Increased prevalence of dementia in the population highlights the need for mental health services to be at the heart of such care.

5.3 New innovation and advances in health care, provides an opportunity to improve health outcomes of our patient population. The pandemic itself has expanded the advancement of remote monitoring and remote consultation by at least 18 months, more patients are now able to consult remotely with their GP practices through electronic consultations platforms and through video consultations with their GP. The expansion of the remote monitoring platform now enables 'time poor' patients (such as carers and the working population) to receive care and advise on management of their Long term condition, through more efficient and appropriate platforms. The expansion on the home oximetry, blood pressure and diabetes management platforms opens up a more patient centred access model. Efficiencies have also been released at practice level, where patient enquiries are able to be directed to the most appropriate team member in the practice, with more patients receiving care through this model as opposed to the traditional face to face model.

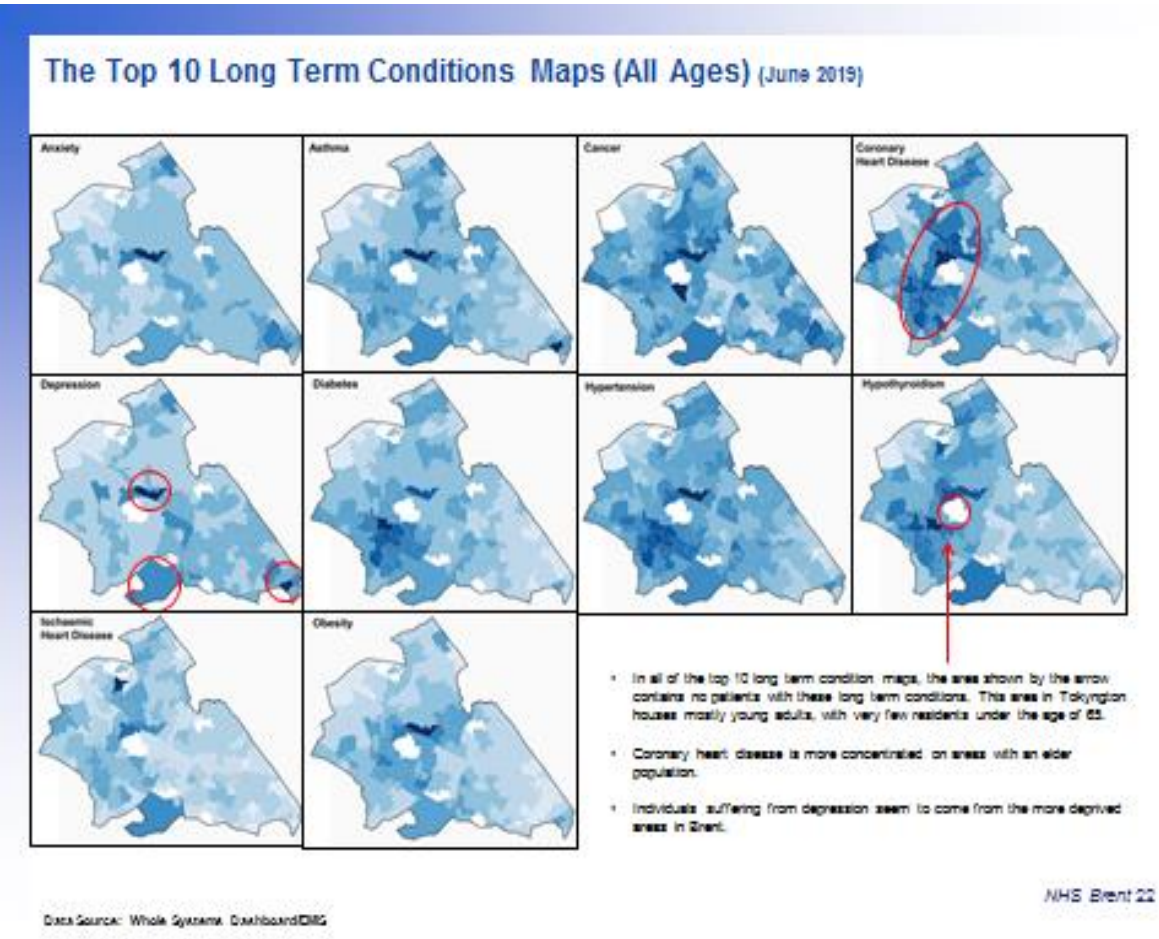
5.4 Increasing demands arising from the ageing population and changing disease burden has placed additional pressure on general practice. The shift in activity from other NHS services to primary care, such as early discharges from secondary care, the increasing demand on community nursing teams and therefore limited support to primary care has also contributed to the challenges faced by primary care. The increased focus on proactive care, to anticipate needs and setting in place more effective interventions is another example of the increasing workload experienced by GPs working in primary care setting. This shift in activity is likely to increase over time as delivery of services at PCN level are further expanded



Diabetes prevalence in Brent, is demonstrated in this map. With higher prevalence in some of the more deprived areas of the borough and in areas with higher elderly patients



The map opposite demonstrates the prevalence of Heart Failure in the Borough. The correlation between deprivation and LTCs is evident.



K&W North has one of the highest prevalence for Hypertension and Diabetes, which could be due to the PCN also having a greater population of 64+yrs.

The South of the borough has higher level of depression and anxiety this is particularly prevalent in the Kilburn PCN

Tudor Medical Practice has the highest obesity prevalence, followed by Wembley Park Drive Medical Centre and Freuchen Medical Centre.

There are no records of LTCs in the Tokyngton area, as this area houses mostly young adults, with very few residents under the age of 65.

6. Care Quality Commission

6.1 The Care Quality Commission (CQC) is an independent regulator of health and adult social care in England. CQC monitors, inspects and regulates services such as GP practices, dental practices, care homes etc. to make sure they meet fundamental standards of quality and safety. These are published on the CQC website and by law; care providers are required to display the ratings given, in the place where they provide care, somewhere that people who use the services can easily see them. Providers are also required publish their ratings on their website.

6.2 GP practices are rated for five key questions (safe, effective, caring, responsive and well-led) and for six population groups (older people; people with long term conditions; families, children and young people; working age people, including students and those recently retired; people whose circumstances may make them vulnerable; and people experiencing poor mental health, including dementia).

6.3 GP practices rated as inadequate for one or more of the five key questions or six population groups will be given a specified time period for re-inspection. This will be no later than six months after the initial rating is confirmed. This period will give the practice a fixed time during which they must demonstrate improvement, ahead of another CQC inspection.

6.4 After re-inspection, the practice have failed to make sufficient improvement, and continue to be rated, the CQC may place the practice into 'special measures' for a second time, or may take other enforcement action (e.g. termination of registration).

6.5 GP practices are usually placed into special measures for six months. Being placed into special measures will represent a decision by CQC that a practice is required to improve within six months to avoid steps to cancel their registration.

6.6 At the end of the special measures period, the practice has not met the standard set by the CQC inspection requirements; the CQC may begin proceedings to cancel the provider's registration. If there are escalating concerns, this may be via a fast-tracked process through court enforcement action, or through a slower process whereby the provider is provided the CQC's notice of decision with 28 days' notice plus an additional 28 days for appeal and is subject to the usual representations process.

6.6.1 In 2019, the CQC changed their model of inspection to undertake a more focused approach to CQC inspections. For those practices that have received an overall rating of 'good' or 'outstanding' these practices would be inspected at least once every 5 years. In addition, every year, the CQC carries out a formal review of the information they hold about the practice. The *formal annual regulatory review* helps them to priorities their inspections where the information suggests that the quality of care at a GP practice has changed since their last inspection. This can be either a deterioration or improvement, an inspection may be arranged initially through a telephone interview and if required a formal visit. It enables the CQC to carry out more focused inspections that concentrate on the areas with the most change. This also allows them to focus where there is the most risk while supporting practices to improve.

6.7 If a GP practice is rated as 'requires improvement' or 'inadequate', the annual regulatory review process and provider information collection call does not apply. In this instance, the CQC would continue to inspect:

- within six months for a rating of inadequate
- Within 12 months for a rating of requires improvement.

6.8 During the pandemic months, the routine scheduled CQC visits have been placed on hold, these inspections have continued where risks have been identified. Remote login to clinical systems and telephone/ Microsoft Team meetings have been utilised to enable continued management and monitoring.

6.9 While discussions are held on availability of access into the practice, as yet the formal monitoring of remote consultation and remote monitoring of patients is yet to be formalised into the review. The digital access into general practice forms part of NHS E's strategy to improve access to primary care, it is expected that all practices offer digital access to patients, both at practice and PCN level for extended access. The Covid 19 pandemic has served to accelerate the digital offer to patients and more innovative partnership with third party organisations are in trail stages to improve access to remote monitoring of care.

6.10 Table 1 below provides a summary of Brent GP Practice CQC ratings as at the time of this report, with Chart 1 providing a summary of CQC ratings in the borough.

Table 1: Brent GP Practice CQC Rating and Population Size

PCN	Practice Name	E-Code	RAW PRACTICE LIST SIZE 01/10/2020	CQC Rating (latest review)						
				CQC Inspection Date	Overall Summary	Safe	Effective	Caring	Responsive	Well-Led
KWH Central	Forty Willows Surgery	E84002	6790	24/05/2018	Good	Good	Good	Good	Good	Good
	Tudor House Medical Centre	E84684	3,918	19/01/2017	Good	Good	Good	Good	Good	Good
	Chalkhill Practice	E84033	7,134	06/12/2018	Good	Good	Good	Good	Good	Good
	Ellis Practice	E84032	8,917	17/09/2019	Good	Good	Good	Good	Good	Good
	Preston Road Surgery	E84620	6,926	03/02/2020	Good	Good	Good	Good	Good	Good
	Sudbury Surgery	E84685	8,726	13/12/2018	Good	Good	Good	Good	Good	Good
KWH North	Neasden Medical Centre & Greenhill Park	E84665	9,572	07/12/2020	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
	Uxendon	E84007	5,485	27/11/2020	Good	Good	Good	Good	Good	Good
	Jai Medical Centre	E84020	6,346	03/12/2020	Good	Good	Good	Good	Good	Good
	The Fryent Way	E84048	8,348	01/08/2019	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
	Kingsbury Health & Wellbeing	E84078	4,607	07/04/2020	Good	Good	Good	Good	Good	Good
	Brampton	E84049	5,177	28/02/2019	Good	Good	Good	Good	Good	Good
	Kings Edge Medical Centre	E84699	3,610	10/01/XXXX	Good	Good	Good	Good	Good	Good
KWH West	Premier Medical Centre	E84003	8,968	03/11/2016	Good	Good	Good	Good	Good	Good
	The Wembley Practice	Y02692	13,920	22/05/2018	Good	Good	Good	Good	Good	Good
	Hazeldene	E84066	19,283	05/07/2019	Good	Good	Good	Good	Good	Good
	Alperton	E84638	5,868	14/03/2019	Good	Good	Good	Requires improvement	Good	Good
	Lancelot	E84063	7,004	07/07/2017	Good	Good	Good	Good	Good	Good
	Stanley Corner	E84051	6,063	08/03/2016	Good	Good	Good	Good	Good	Good
KWH South	Gladstone Medical Centre	E84036	9,366	20/11/2019	Good	Good	Good	Good	Good	Good
	Willesden Medical Centre	E84021	13,581	31/01/2018	Good	Good	Good	Good	Good	Good
	St George's Medical centre	E84704	2,244	08/11/2017	Good	Good	Good	Good	Good	Good
	Burnley Practice	Y00206	9,328	02/11/2017	Good	Good	Good	Good	Good	Good
	St Andrews Medical Centre	E84011	1,871	12/01/2017	Good	Good	Good	Good	Good	Good
	The Lonsdale	E84025	22,987	26/07/2017	Good	Good	Good	Good	Good	Good
Harness South	Brentfield Medical Centre	E84031	9,041	23/01/2019	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
	Church End Med Centre	E84013	7,970	11/04/2019	Good	Good	Good	Good	Good	Good
	Stonebridge Medical Centre	E84028	7,259	30/10/2017	Good	Good	Good	Good	Good	Good
	Hilltop Medical Practce	E84637	4,177	23/02/2016	Good	Good	Good	Good	Good	Good
	Oxgate Gardens Surgery	E84076	6,703	21/03/2016	Good	Good	Good	Good	Good	Good
	Roundwood Park Medical Centre	E84656	4,590	02/02/2016	Good	Good	Good	Good	Good	Good
	Walm Lane Surgery	E84086	7,930	29/02/2017	Good	Good	Good	Good	Good	Good
	Park Royal Medical Centre	E84645	7,841	30/04/2019	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement
	Freuchen Medical Centre	E84074	8,453	11/08/2017	Good	Good	Good	Good	Good	Good
Harness North	The Surgery	E84635	5,533	16/02/2016	Good	Good	Good	Good	Good	Good
	Preston Hill Surgery	E84030	5,140	02/05/2017	Good	Good	Good	Good	Good	Good
	Pearl Medical Practice	E84701	4,812	18/02/2020	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
	Wembley Park Drive Medical Centre	E84709	12,379	11/05/2017	Good	Good	Good	Good	Good	Good
	SMS Medical Practice	Y01090	5,121	31/08/2017	Good	Good	Good	Good	Good	Good
	Lanfranc	E84083	6,073	13/01/2017	Good	Good	Good	Good	Good	Good
	Sunflower Practice	E84626	3,136	22/05/2018	Good	Good	Good	Good	Good	Good
	Church Lane Surgery	E84067	9,125	06/03/2019	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
	Willow Tree Family Doctors	E84015	15,997	24/11/2016	Good	Good	Good	Good	Good	Good
	Preston Medical Centre	E84678	4,328	25/01/2018	Good	Good	Good	Good	Good	Good
	Sudbury & Alperton Practice	E84017	8,789	25/02/2020	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Kilburn	Kilburn Park Medical	E84042	8,528	08/06/2019	Good	Good	Good	Good	Good	Good
	Chichele Road Surgery	E84674	5,644	10/12/2020	Requires improvement	Good	Requires improvement	Good	Good	Requires improvement
	Staverton Medical Centre	E84080	8,971	09/01/2020	Requires improvement	Requires improvement	Requires improvement	Good	Good	Good
	Mapesbury Medical Centre	E84012	9,020	28/03/2019	Not Yet Monitored					
	Willesden Green Surgery	E84702	5,911	16/03/2018	Good	Good	Good	Good	Good	Good
	The Law Medical Centre	E84006	18,001	29/05/2019	Good	Good	Good	Good	Good	Good
	Brent Total		406,511							

CQC ratings over past years

The CQC ratings of GP practices in Brent over the past years are detailed below

Year	Practices requiring improvement in 1 or more domains	Practices assessed as inadequate	% of practice
2021	9	0	17.6%
2020	7	4	21.6%
2019	10	1	20.6%
2018	4	2	10.5%*
2017	13	2	33.3%**

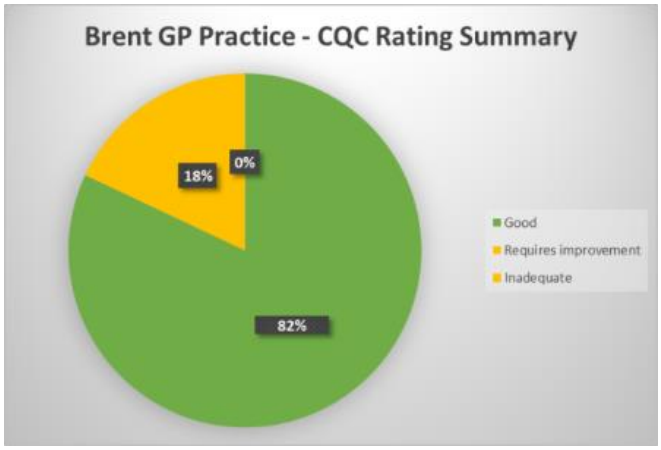
*57 practices in 2018

**45 inspections were undertaken

The numbers of practices who are rated as 'inadequate' have dropped to zero for the current year. The remaining practices which have been identified as 'requiring improvement', have developed action plans and timescales to address areas identified for by the CQC.

The CCG continues to work the closely with the CQC to identify early intervention and support to practices

Summary of Brent GP Practice CQC Rating



6.11 As independent contractors, it is ultimately the practice's responsibility to address any problems identified at inspection and to ensure improvement. However, as Clinical Commissioning Groups (CCGs) when co-commissioning we ensure there are clear and transparent improvement plans in place and support appropriate interventions if services to patients are at risk.

6.12 To support practices the CCG investments in providing supports to GP practices through:

- Regular workshop on the inspection requirement, the preparatory work and evidence collation that CQC would expect to view on the day of the visits
- Mock CQC inspections with external trainers
- Learning from past visits is shared with particular emphasis on recurrent themes.
- Shared CQC and GP practice events, these are held by the primary care team and prescribing teams
- Supporting Primary Care Networks to provide dedicated support to individual practices within their grouping, supporting the standardising policies on recruitment, prescription storage, controlled drug monitoring etc.
- Practices are able to receive one to one support from external provider to address issues identified by CQC inspectors, this forms part of the Resilience support offered to all practices. The CCG have invested in procuring providers to deliver on site one to one support, for those practices rated as inadequate or requires improvement. This support is tailored to the individual practices need and may span any or all of the areas identified in the five CQC domains.

6.13 The CQC's powers under the Health and Social Care Act 2008, (Regulated Activities) Regulation 2014 are far reaching and under the Act the CQC hold the right to terminate contracts where it is identified that patient safety is at risk.

6.14 The CCG as a commissioning organisation plays a dual role in holding providers to account in line with their contractual obligation as well as supporting the development of GP practices. To support its monitoring role the CCG have developed a benchmark dash board aimed at reducing unwarranted variation in care. Practices identified as performing below expected levels are supported and empowered to improve. Early warnings signs from this dashboard and close working with GP practices aims to

identify those practices that would benefit from intervention. As outlined early as independent contractors the GP practice holds the prerogative to refuse this support.

6.15 Having received delegated responsibility from NHS England for the management of GP practices, the Primary Care Commissioning Committee (PCCC) was established to oversee delegated responsibility, reporting directly to the Governing Body in its role and providing assurance on the discharge of this responsibility. The CCG's Quality and Performance Committee receives reports of cases where intervention of this committee is required. As the CCG moves to a single structure, cases will continue to be monitored at local level with regular reports to the NW London Primary Care Commissioning Committee being presented for oversight and direction.

7.0 Financial Implications

7.1 No direct financial implications

8.0 Legal Implications

8.1 No direct legal implications

9.0 Equality Implications

9.1 Equality of access has been set out in the report

10.0 Consultation with Ward Members and Stakeholders

10.1 Not applicable

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Jonathan Turner – Borough Director
Brent Clinical Commissioning Group

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Brent	**Community and Wellbeing Scrutiny Committee** 24 March 2021
	Report from the Assistant Chief Executive

Scrutiny Task Group Review: Accessibility of General Practice and Primary Care in the London Borough of Brent

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Appendix 1 - Scope of Scrutiny Task Group Review
Background Papers:	None
Contact Officer:	James Diamond Scrutiny Officer, Strategy and Partnerships james.diamond@brent.gov.uk Tel: 020 8937 1068; Pascoe Sawyers Head of Strategy and Partnerships pascoe.sawyers@brent.gov.uk Tel: 020 8937 1045

1.0 Purpose of the Report

1.1 To enable members of the Community and Wellbeing Scrutiny Committee to commission a task group on GP and primary care accessibility in the borough.

2.0 Recommendation

2.1 To agree the scope of the scrutiny task group review including the membership and terms of reference as set out in Appendix 1 of the report.

3.0 Detail

3.1 General practice is fundamental to the NHS. It plays a key role in promoting health, preventing illness, and helping patients to manage long-term conditions. A GP practice is the main point of access to other parts of NHS care such as

acute and community services. The importance of the role of general practice and the right of patients with regard to GP services are set out in the NHS Constitution. [1]

3.2 General practice in Brent faces demographic pressures. Information from NHS Digital published in October 2020 shows that the London Borough of Brent has 52 GP practices and approximately 406,903 registered patients. [2] There has been a growth in the number of registered patients in the last decade or so as the borough's population has grown.

3.3 Deprivation is a key issue in terms of health inequalities and primary care. According to the indices of deprivation, Brent has significant cohorts of the local population experiencing poverty, and in particular has high indicators of poverty in terms of housing with high rates of overcrowding, homelessness and issues with housing affordability. [3] This dimension of poverty linked to housing and barriers to housing was a key finding of the Brent Poverty Commission. National studies suggest that GP practices serving deprived areas have increased workload associated with greater population health needs in poorer areas. In addition, a GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving more affluent areas, according to the study. Single-handed practices are also overrepresented among practices serving patients in the poorest fifth of neighbourhoods. [4]

3.4 According to other national studies, while public satisfaction with general practice remains high, in recent years patients have increasingly reported, through the GP Patient Survey, more difficulty in accessing services including a decline in good overall experience of making an appointment with a GP. [5] Furthermore, a report by the Health Foundation, suggests that the Covid 19 pandemic is leading to change nationally in how GP access is being organised. During the lockdown there was a reduction nationally in consultations by GPs. The trend before lockdown was a slight fall in face-to-face consultations and an increase in remote consultation with technology, However, after the first lockdown there was a shift nationally with far more consultations done remotely. [6] NHS England in September this year wrote to all GPs nationally to reiterate

[1] www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
[2] www.digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/october-2020 figures released on 1 October 2020
[3] Brent Joint Strategic Needs Assessment, 2019
[4] *Level or Not?* Health Foundation (September, 2020) www.health.org.uk/publications/reports/level-or-not
[5] www.england.nhs.uk/gp/gpfv/redesign/improving-access/
[6] www.health.org.uk/news-and-comment/charts-and-infographics/use-of-primary-care-during-the-covid-19-pandemic

the importance of patients being able to access face-to-face appointments and to ensure information about access to services is clear. [7]

3.5 Brent is one of the most diverse local authority areas in London and the country. The Covid 19 pandemic has also exposed the extent of health inequalities with high rates of mortality in wards such as Alperton and Harlesden, and a disproportionate impact on the Black and Minority Ethnic (BAME) population. In response to the effects of the pandemic on the local population Brent Clinical Commissioning Group, with the support of the local authority, has started a health inequalities pilot which will extend primary care and GP services to wards and areas in which local residents have been most affected by Covid 19. [8]

3.6 The local NHS has invested significantly to improve access to primary care. GP access hubs began as a pilot, under a national initiative, with nine hubs from 2013. This was re-designed in 2018 to operate from five locations on a model of a service offer of seven days a week and opening to 8pm. This model is intended to offer a consistent service offer across Brent, balance capacity and demand, and ensure better booking of appointments and management of pressure on the system is at the main peak times. [9] According to NHS England guidance, In order to be eligible for re-current funding, commissioners need to demonstrate they are meeting seven core requirements for improving access. These are timing of appointments, capacity, measurement, advertising and ease of access, use of digital approaches, addressing inequalities, and ensuring access to wider NHS services. [10]

3.7 The last in-depth review by overview and scrutiny of primary care was in 2015. The scrutiny task group reviewed Brent's primary care, including access hubs. It looked at the ability to meet demand and provide fair and equitable access and recommended investment in access, development of innovative ways to meet and manage demand, and encouraging residents to support themselves where possible in terms of improving their own health and wellbeing. [11]

3.8 For the reasons set out above, in terms of the pressures on primary care and the changes which the pandemic is bringing about, it is felt to be timely for a members' task group and report to review access to GP services. However, the outcome of a scrutiny review is not just about the outputs of a report and recommendation-making. The Centre for Governance and Scrutiny (CfGS) also highlights the key role non-executive members can play through a scrutiny

[7] NHS England and NHS Improvement letter, 14 September 2020

[8] *Brent Covid 19 Health Inequalities Pilot: Bringing Primary Care to the People*, Brent CCG Governing Body 23 September 2020

[9] *GP Extended Access in Brent*, (Brent Clinical Commissioning Group, Governing Body, 10 January 2018)

[10] www.england.nhs.uk/gp/gpfv/redesign/improving-access/

[11] Access to Extended GP Access in Brent, (Brent Council Overview and Scrutiny, September 2015), pp.7-8

committee in helping to provide a voice for local residents in reviewing the provision of important local services. [12] The way in which this review will be undertaken, including the terms of reference and suggested key lines of enquiry are set out in Appendix 1.

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 stipulates that a health scrutiny committee may make reports and recommendations to an NHS organisation. These reports and recommendations must include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review, and an explanation of the recommendations made.

6.0 Equality Implications

6.1 The scrutiny review will consider equalities duties as part of the general duty set out in the 2010 Equality Act.

7.0 Consultation with Ward Members and Stakeholders

7.1 Ward members who are also members of the task group will take part in this scrutiny review and there will be consultation and engagement with external stakeholders through the evidence sessions organised by the task group.

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Shazia Hussain
Assistant Chief Executive

[12] www.cfgs.org.uk/revisiting-the-four-principles-of-good-scrutiny/

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APPENDIX 1

Scope of Scrutiny Task Group Review

Membership

Cllr Mary Daly, Chair

Cllr Abdi Aden
Cllr Tony Ethapemi
Cllr Claudia Hector
Cllr Gaynor Lloyd
Cllr Ahmad Shahzad

Terms of Reference

i) To gather findings based on quantitative data and information about GP accessibility based on face-to-face appointments, physical and digital access, and qualitative information from patients' experiences with particular reference to those who are older, have mental health needs or a disability, and who have long-term health conditions.

ii) To review the overall local offer of GP services, including the extended GP access hub service, and evaluate any variation in accessibility by practice and the underlying reasons for any variation with particular reference to clinical capacity and nursing.

iii) To evaluate the local demand to access primary care, changes in demand during the Covid 19 pandemic and changes in access to GP services during the pandemic with particular reference to digital accessibility and face-to-face appointments.

iv) To understand the role of primary care in addressing health inequalities by gathering findings on population health, deprivation and demographic trends in the borough with particular reference to Black and Minority Ethnic (BAME) patients.

v) To develop a report and recommendations for local NHS organisations and the local authority's Cabinet based on the findings and evidence gathered during the review.

Information Requests

To progress the review and gather findings the task group may want to request information from Brent Clinical Commissioning Group and local NHS organisations. The following proposed requests will enable the members to gather findings about different types of access to primary care as well as waiting times and access issues.

Physical Access

Access type	**Information Requests**
Availability	Number of GPs per 100,000 of the population
	Number of GP practices in Brent; list size per GP practice and by Primary Care Network in the borough.
Proximity	Percentage of population within 15 minutes of a surgery or GP practice on foot or by public transport
Premises	Compliance with 2010 Equalities Act by GP practice
Telephone	Proportion of people who found it very or fairly easy to get through on the telephone to GP surgeries by practice
Home visits	Percentage of home visit requests
Face-to-Face appointments	Percentage of patients able to request face-to-face appointments

Digital Access

Access type	Information Requests
Online	Availability for patients to book appointments online by percentage of practice
	Percentage of patients who find it easy to access information online by GP practice
	Availability for patients to order repeat prescriptions online by percentage of practice
	Access to medical records online by percentage of practice
Email	Can patients communicate directly with GP or practice staff via email.
Digital consultation	Consultations with a GP available digitally.
Apps	Do GP practice work with patients to provide access to apps and digital tools to allow them to manage conditions

Timely Access

Access type	Information Requests
Appointment	Proportion of people able to get an appointment with a GP within 48 hours
	Proportion of people able to book at appointment more than two days ahead
	Proportion of patients satisfied with surgery appointment times
	Patient satisfaction with choice of appointment offered by GP practice
Out of Hours	Patient satisfaction with out-of-hours GP services
	Patient satisfaction with out-of-hours GP services
Waiting times	Proportion of patients who state that they wait a bit or far too long in a surgery
	Proportion of people able to see a GP quickly

Source: Adapted from *A Rapid Review of Access to Care* (The King's Fund), and *Who Gets In?* (Health Foundation)

Evidence Sessions

In carrying out the scrutiny review, the task group will invite a range of partners, patient representatives and stakeholders to contribute through evidence sessions so that they can share their opinions and experiences of services. The evidence sessions will be meetings with key officers from Brent Clinical Commissioning Group, Brent Council, London Ambulance Service and the Local Medical Committee. The evidence sessions will also involve Healthwatch Brent, GPs, and patient advocacy groups as well as representatives from Brent's local voluntary sector, and community representatives as well.

It is suggested that there are five evidence sessions for this task group. The proposed structure for the meetings will be meetings with representatives from NHS organisations and GPs for evidence session 1 and evidence session 2, meetings with Healthwatch Brent and patient advocacy groups for evidence session 3, and a meeting with the voluntary sector and other relevant community organisations for evidence session 4. There will be a meeting with community organisations for evidence session 5.

Key Lines of Enquiry

To structure the evidence sessions, the scrutiny task group will focus on particular key lines of enquiry to ensure there is accountability about local primary care services.

These will include, but not be limited to, the following suggested key lines of enquiry.

1. What is the local demand for GP services and what are the particular needs of Brent residents, including vulnerable patient groups, in relation to accessing GP care?
2. Is there sufficient provision of GP services in the London Borough of Brent based on local population health needs and the growing population in the borough and is there a difference in provision or accessibility between the north and south of Brent?
3. What has been the long-term trend in how GP services are accessed and what has been happening during the Covid 19 pandemic in terms of the balance between remote appointments using digital technology and face-to-face appointments?
4. Is there a danger of exclusion from primary care services for those patients who are not able to use the digital or online options and rely on face-to-face appointments?

5. What strategy is needed to address variation and ensure that there is fair and equitable access to GP services available to Brent residents across the borough?

6. What does benchmarking data show about primary care and GP performance in Brent compared with the other clinical commissioning groups in North West London?

7. What is the role of Patient Participation Groups in addressing accessibility issues?

Reports and Other Sources of Information

In addition to the evidence sessions, the task group will also gather key pieces of data and information to inform their understanding of GP accessibility and local services.

This evidence gathering will include, but not be limited to, the following sources and reports:

- Brent's Joint Strategic Needs Assessment
- Brent's Pharmaceutical Needs Assessment
- Reports produced by Healthwatch Brent on patients' experiences of primary care
- National guidance from NHS England in relation to primary care access
- Demographic data in census 2011 and published demographic reports
- NHS Digital reports on GP and patient numbers in Brent
- Data from the Quality Outcomes Framework (QOF) for primary care
- Reports to Brent CCG's Primary Care Commissioning Committee and Governing Body
- Reports to the Joint Committee of the Collaboration of North West London Clinical Commissioning Groups
- Reports on examples of best practice in neighbouring boroughs.
- Reports and information from the Care Quality Commission.
- GP Patient Survey 2020 and in previous years.