



Community and Wellbeing Scrutiny Committee

Tuesday 22 February 2022 at 6.00 pm

Conference Hall – Brent Civic Centre, Engineers Way,
Wembley, HA9 0FJ

**This agenda was republished on 18 February 2022 to include item 10, and on 21 February 2022 to include item 11*

Please note this meeting will be held as a socially distanced hybrid meeting with all members of the Committee asked to attend in person.

Should any member of the Committee be unable to attend in person please contact the meeting administrator (as listed below) so that alternative arrangements can be made. Please note that if a member is unable to attend in person and attends remotely it will not be possible to count that member as present for the purposes of quorum or for that member to participate in voting on any item that may be required during the meeting.

Guidance on the safe delivery of face-to-face meetings is included at the end of the agenda frontsheet.

Due to current socially distanced venue capacity, any press and public wishing to attend the meeting are encouraged to do so via the live webcast.

The link to view the meeting will be made available here: <https://brent.public-i.tv/core/portal/home>

Membership:

Members

Councillors:

Ketan Sheth (Chair)

Colwill (Vice-Chair)

Aden

Daly

Afzal

Ethapemi

Hector

Lloyd

Sangani

Shahzad

Substitute Members

Councillors:

S Choudhary, Conneely, Hassan, Hylton, Johnson, Kabir, Long, Miller and Shah

Councillors:

Kansagra and Maurice

Thakkar

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

For further information contact: Hannah O'Brien, Governance Officer hannah.o'brien@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit: www.brent.gov.uk/committees

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 or trade union).
- (b) The interests 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 meeting	1 - 10
To approve the minutes of the previous meeting as a correct record, and ratify any decisions made at the previous meeting.	
5 Matters arising (if any)	
6 Education and Wellbeing Recovery	11 - 26
To receive a report on the Council's management of the education and wellbeing recovery from the impact of the pandemic.	
7 London Borough of Culture Legacy	27 - 44
To receive a report on the delivery of the London Borough of Culture 2020 (Brent 2020) legacy.	
8 Northwick Park NHS Trust Maternity Improvement Plan Progress Update	45 - 92
To receive a report on the progress of the delivery of the Northwick Park NHS Trust Maternity Improvement Plan.	
9 Brent Housing Management Fire Safety Progress Update	93 - 104

To receive a report on the progress of works to improve the fire safety standard in the Council's housing stock.

10 GP Access Task Group Final Report

105 - 153

To receive the final report of the GP Access Scrutiny Task Group, which sets out the task group's findings and recommendations.

11 Transitional Safeguarding Task Group Final Report

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To receive the final report of the Transitional Safeguarding Scrutiny Task Group, which sets out the task group's findings and recommendations.

12 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 her representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: Monday 14 March 2022

Guidance on the delivery of safe meetings at The Drum, Brent Civic Centre

- We have revised the capacity and floor plans for event spaces to ensure they meet the social distancing guidelines.
- Attendees will need to maintain the required distance apart at all times.
- Signage and reminders, including floor markers for social distancing and oneway flow systems are present throughout The Drum and need to be followed.
- Please note the Civic Centre visitor lifts will have reduced capacity to help with social distancing.
- The use of face coverings is encouraged with hand sanitiser dispensers located at the main entrance to The Drum and within each meeting room.
- Those attending meetings are asked to scan the coronavirus NHS QR Code for The Drum upon entry. Posters of the QR Code are located in front of the main Drum entrance and outside each boardroom.
- Although not required, should anyone attending wish to undertake a lateral flow test (LFT) in advance of the meeting these are also available at the Civic Centre and can be booked via the following link:
<https://www.brent.gov.uk/your-community/coronavirus/covid-19-testing/if-you-dont-have-symptoms/>

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MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Monday 24 January 2022 at 6.00 pm
Held as an online virtual meeting

PRESENT (in remote capacity): Councillor Ketan Sheth (Chair), Councillor Kansagra (substituting for Councillor Colwill), and Councillors Aden, Afzal, Daly, Ethapemi, Sangani and Thakkar, and co-opted members Mr Alloysius Frederick, Mr Simon Goulden and Rev. Helen Askwith .

In attendance (in remote capacity): Councillor McLennan

1. Apologies for absence and clarification of alternate members

Apologies were received as follows:

- Councillor Colwill, substituted by Councillor Kansagra
- Councillor Shahzad
- Councillor Lloyd
- Councillor Hector

2. Declarations of interests

Personal interests were declared as follows:

- Councillor Sheth – Lead Governor of Central and NWL NHS Foundation Trust
- Councillor Ethapemi – spouse employed by the NHS
- Councillor Sangani – employed by the NHS

3. Deputations (if any)

There were no deputations received.

4. Minutes of the previous meeting

The minutes of the meeting on 15 November 2021 were approved as an accurate record of the meeting, subject to ratification at the next in-person quorate meeting.

5. Matters arising (if any)

There were no matters arising.

6. Brent Multi-Agency Safeguarding Arrangements for Children

The Chair invited the three Statutory Safeguarding Partners; Carolyn Downs (Chief Executive, Brent Council), Barry Loader (Det Sup, Met Police – NWL BCU), and Jennifer Roye (Director of Nursing, NWL CCG) to the meeting and asked them to introduce the report.

Carolyn Downs opened the report, detailing the membership of the Multi-agency Safeguarding Partners Executive Group for children, which included the three statutory partners, the Leader of the Council, the Lead Member for Children's Services, the Strategic Director for Children's Services, and Mike Howard (Independent Convenor of the Safeguarding Children Forum). She felt the new arrangements were working well, with collaboration between the police, health and local authority improving all the time. She reassured the Committee that the partners took a very proactive role to safeguarding and provided challenge where necessary. All 3 statutory partners were required to sign off rapid reviews into any incidences of child death or injury, and the partners read those reports in depth, commented on them and where not satisfied ensured actions were put in place. For example, most recently the partners had written to the Director of Public Prosecution where they felt insufficient action was taking place. Carolyn Downs finished her introduction by advising the Committee that the rapid reviews, written by Mike Howard and Wendy Proctor, were extremely helpful and informative in her role as a statutory partner.

Barry Loader agreed the partnership had a good healthy relationship which was constructive, with healthy challenge. Repeatedly, the partners saw good practice reports coming through the rapid reviews. He advised that the nature of rapid reviews was upsetting, as they arose when a child was seriously injured or had died, but from the feedback of partners locally and the National Review Panel it had been positive to show there were good systems of working and professional practice across all partners involved in children's safeguarding in Brent. The good relationship had helped with the response to 'everyone's invited' as evidenced in the report to Committee. He finished by assuring members there was a continuous cycle of training for those officers new in post, including specialist child protection training.

Jennifer Roye echoed the previous introductions and felt Brent had exceptional safeguarding processes. She had been in post for 6 months and had been welcomed at the Exec Group meetings she had attended with the statutory partners. She informed the Committee that the ethos for supporting and safeguarding children was very high on the agenda and the learning she had seen over the last 6 months in relation to training had been shared at the Health Quality Performance Committee.

In concluding the introduction to the report, Mike Howard (Independent Convenor of Brent Safeguarding Children Forum) agreed that rapid reviews offered extremely valuable learning opportunities looking at real life practice. The learning from rapid reviews was taken by health partners and developed into GP training. He pointed out that the tragic incidents that led to rapid reviews could be traumatic for the staff involved including the first responders, police, ambulance staff and case workers and it was worth considering that impact. He pointed to the report as to how the lessons from rapid reviews had led to changes of practice to improve safeguarding. Mike Howard felt that, over the period since the new arrangements had been in place, there had been a steady progression in partnership working with statutory partners and designated professionals, including a good number of school representatives who took part in the Children's Safeguarding Forum.

The Chair thanked the partners for their introduction and invited the Committee to raise comments and questions, with the following issues raised:

The Committee asked how effective the partnership working was, given the partners may be looking at different aspects of a particular case, and queried why there was no parental input. Carolyn Downs explained that parental involvement was not included as part of the government guidance on the partnership. She agreed that all partners brought something different to the table. She pointed to the priorities outlined in 3.14 of the report; serious youth violence, suicide prevention and mental health, and domestic abuse, and highlighted that all three partners had a different perspective and input into those agendas and were

fully engaged in those priorities. When the partners reviewed individual cases they looked at these from a different perspective and may make different comments. The partnership were very open with each other in terms of challenging where they felt something was not right. Barry Loader added that the partnership were also confident to challenge as a collective, such as the National Panel and Crown Prosecution Service. From a commissioner point of view, Jennifer Roye felt that the conversations between partners enabled her to think about what services might be needed going forward. The issues identified through rapid reviews could be taken back to commissioners to demonstrate the number of children who may have come to harm or potential harm, what the learning from that was, and then enabled her to commission services across the system to support Brent's children and young people. She added that she covered 8 boroughs across NWL and felt that Brent was one of the boroughs with the strongest partnership working for safeguarding.

Continuing to respond to how effective the partnership was, Wendy Proctor, Strategic Partnership Lead Officer felt that they could demonstrate the partnership was effective through sharing good practice. Brent had shared their good practice on how it conducted business with neighbouring boroughs who were less familiar with carrying out rapid reviews, who had looked to Brent to support them in their own boroughs to carry out rapid reviews as effectively as Brent. Those who Brent had shared their practice with, such as Harrow and Barnet, had provided positive feedback. She finished by advising the Committee that, as the partnership was open and transparent to learn lessons, it may be difficult to do that with parents involved in those discussions because of the ways partners worked and the sensitive nature of some cases, therefore parental involvement was encouraged in different ways away from the statutory arrangements. Gail Tolley (Strategic Director Children and Young People, Brent Council) reassured members that, where there were individual family circumstances, parents were involved in meetings and their views were sought and fed in to the process, but the multi-agency safeguarding arrangements were for statutory partners and those who delivered services.

The Committee queried whether the police as partners viewed safeguarding children as a priority and took their role on the partnership seriously, highlighting the disparity in funding between the partners. Carolyn Downs clarified that the funding for the partnership was not determined by the local or Metropolitan police, but by MOPAC, the Police and Crime Commissioners Office. She agreed it was an issue, but felt that the input the partnership received from colleagues in the police was better than Brent had ever had. She highlighted that Barry Loader had never sent a substitute to meetings and came to all meetings as a superintendent so the partnership got involvement at a senior level. Barry Loader agreed that the funding issue was a constant frustration and he would be addressing the issue the following day with the BCU commanders and lead for the National Police Steering Group. Brent had a higher number of rapid reviews than other boroughs, which all needed funding. Mike Howard added that the issue of funding had been raised on a London wide basis through the London Safeguarding Chairs Network with Sophie Linden, the Deputy Mayor for MOPAC, but the Mayor's Office had been adamant that £5k per borough would remain. Brent received the same funding as boroughs such as Kingston and Bexley, and London had the lowest funded safeguarding arrangements in the country. Councillor McLennan was working on advocating for further funding through her own networks as well as the Leader. She added that the NHS and police saw themselves as one of the anchor partners wanting to do the best to safeguard children, and in a short space of time she could see that ongoing work. Barry Loader offered to provide a supplementary paper on the work that happened on a daily basis to safeguard children, including information about training and how the police brought safeguarding to the forefront of their meetings, in order to reassure members and the community that safeguarding and the statutory partnership were a priority for the police.

In relation to the uptake for multi-agency training from police officers detailed in the report, Barry Loader explained that it was difficult to get officers to attend partnership training, which he advertised every week through his weekly updates. There was an expectation for child abuse investigators to attend a certain amount of partnership training per year, reviewed in their annual appraisal, and officers were required to undertake mandatory training locally and centrally.

The Committee discussed the role of prevention for the partnership. Carolyn Downs expressed that the whole basis of the safeguarding partnership was to prevent future harm. The partnership looked at what was happening to learn from that, and used that learning to take appropriate actions to prevent harm in the future. For example, the local authority did a large amount of work on knife crime in relation to prevention and support to young people. Gail Tolley added that the partnership did commission pieces of work from operational delivery levels, and most recently had asked for a report on children missing from placement, for that emphasis on preventative work following the learning from previous cases. The partnership did not always wait for the learning from a rapid review, for example the development of Family Wellbeing Centres in Brent was a result of learning from previous cases that supporting the whole family in terms of preventative work was a step forward. In relation to prevention, an Accelerated Support Team was now in place working with vulnerable adolescents on the ground, in homes and on the street. The focus of that particular work was on young people on the edge of serious youth violence and county lines in harmful circumstances.

Mike Howard spoke about his role in relation to prevention, which was highlighted in section 3.34 and 3.35 of the report. His role was to look at practice and procedures to see how they could be improved in order to do the prevention work, and there were a lot of things that did work. Small changes also made a big difference, such as ensuring family history was recorded when making a referral. Information sharing was important also, for example, where children living in other boroughs were known or suspected gang members, looking at the wider group of children and identifying if they were at risk of harm and putting immediate measures in place to mitigate that. Those measures had come about through learning from other cases and protected children from further harm.

Schools were a protective factor in safeguarding children and young people. The Committee were reassured that, of all 152 local authorities in the country, Brent had the fifth highest attendance of children at school during the pandemic. Gail Tolley advised that Brent had been highlighted as a national exemplar for attendance of children at school and had been asked by the Children's Commissioner to be involved in a project focusing on attendance. The Chair congratulated all schools on the achievement and asked for thanks to be passed on to school colleagues on behalf of the Committee.

The Chair asked the partners what progress and learning had been made in relation to the three priorities of the partnership. Carolyn Downs advised that in relation to the priority of serious youth violence, it was clear across London that serious youth violence remained a very difficult and prominent issue and Brent was not exempt from that, but the level of reduction of serious youth violence in Brent was the greatest in London. Two years previously, Brent would have been in the top 3 for serious youth violence, and was now around 13th, which was a good reduction. She attributed that to all partners, including voluntary and community organisations, schools, and faith organisations coming together to collaborate across the whole system to focus on that issue. That collaboration involved, on a daily basis, joint tasking meetings between the police and Council where particular resource was put into specific areas where there were serious concerns at that time about gang tensions and serious youth violence. She highlighted that she asked herself how she knew what was working to lead to that reduction, to which she reassured herself that the partners were putting the effort in, prioritising the issue, and had many different initiatives that together had resulted in a reduction.

In relation to the priority on suicide prevention and mental health, there had been some very specific rapid reviews about young people who had self-harmed and attempted suicide, looking at how partners might have intervened at an earlier stage to get involved with that young person. That had included looking at the family's involvement in that process and there had been valuable learning from those.

Regarding the priority on domestic abuse, the Committee heard that 70% of Brent Family Front Door referrals involved domestic abuse. Many children who came into the Council's care were children who lived in families where domestic abuse was prevalent, and the partnership were clear that children who were living in households where domestic abuse occurred suffered the negative impact on their wellbeing and development. Changes as a result of learning around domestic abuse included management support, ensuring those responsible for delivering services to those families and individuals provided that service, and considering policies and procedures.

In relation to Operation Encompass, the Committee commended the number of schools who had signed up and asked what work was being done to increase the number of sign-ups from schools even further. Gail Tolley highlighted that schools had not been surveyed since November 2021 due to the outbreak of the Omicron variant, but she was aware, through the Safeguarding Children Forum, that there was continuous encouragement for all schools to sign up. The schools representatives who attended the Forum communicated back to schools to encourage them to join along with any other learning points from the Forum meetings, and Sonya Kalyniak (Head of Safeguarding and Quality Assurance, Brent Council) met with the Designated Safeguarding Leads for every school in Brent where she encouraged those schools not yet involved to sign up. Brent had the highest uptake from schools in London and would always encourage more schools to sign up, but she highlighted that this was a school leadership decision.

The Committee highlighted 3.58 of the report detailing the number of staff who had taken part in multi-agency learning and development sessions, which they felt was low. Wendy Proctor advised that the training was focused on multi-agency working together, and was the level above the basic training agencies were required to provide their staff in relation to safeguarding. She felt the reason the numbers were lower than they would like was because individual agencies already had a lot of safeguarding training.

The Committee queried whether there were any plans to reduce the number of rapid reviews because they were needed less. Carolyn Downs advised there were no plans to reduce those numbers. There was now a national pilot looking at good practice rapid reviews because places like Brent, who did many, had said how useful they had been, and the work would look to see if the good practice could be introduced to all areas where there had been serious cases. She felt that rapid reviews were the right thing to do, and while the partnership had been concerned when the legislation had first come through and despite the heavy workload, they had been invaluable. Mike Howard added that the guidance laid out when a rapid review should be conducted, and before Brent did any rapid reviews there was a discussion between the Head of Safeguarding, a Detective Inspector from the Met Police, and a Designated Health Professional to consider whether a rapid review was necessary, which had been picked up as an area of good practice by NHSE.

To conclude, the Committee queried what each partner would ideally want from each other to be working even better. Carolyn Downs advised that her want would be to get some more funding from police into the partnership. Barry Loader hoped to work with the partnership on Operation Horizon, which was a multi-agency joint partnership piece of work to reduce serious violence in the NW10 postcode. Jennifer Roye hoped to work across the system on the reduction of violence and gangs.

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

- i) To receive information on the work undertaken by the Metropolitan Police to address the key priorities of the Statutory Safeguarding Partners.
- ii) To receive information on the work undertaken by the Metropolitan Police to provide children's safeguarding training to staff and ensure take up of multi-agency training. For the Statutory Safeguarding Partners to provide evidential data on the outcomes of its work to address its priorities in future scrutiny reports.
- iii) For the Statutory Safeguarding Partners to provide information on how it assures itself that relevant agencies and other partners ensure they have captured the voices of children, young people and families in their work in future scrutiny reports.

7. Transfer of Community Services from London North West Hospital Trust (LNWHT) to Central London Community Healthcare NHS Trust (CLCH)

Steve Vo (Assistant Director Integration and Delivery – Brent, NWL CCG) introduced the report, which detailed the transfer of Community Services from Central and North West London NHS Foundation Trust (CNWL) to Central London Community Healthcare NHS Trust (CLCH). The transfer was completed in August 2021 and the paper provided an update on the mobilisation and transformation programmes within community services. He detailed the selection and award process, as outlined in the report, with a selection panel involving Brent CCG's Accountable Officer, the Local Authority Chief Executive, and NWL CCG Chief Financial Officer. Contract award notice had been published to ensure transparency and compliance with the lawful process. There were 2 phases to mobilisation of services – phase 1 being the shifting of existing services, which was complete, and phase 2 being transforming services, which CLCH were now working on. CLCH had identified 3 main priorities for transformation, which were heart failure, respiratory services and diabetes. He finished by highlighted the new Ageing Well Fund, which was an additional fund allocated by the government for 2021-22, and recurring for 2 years with incremental increases. Within those bids, proposals had been submitted to put that additional funding into diabetes, care homes and anticipatory care, all services supported by CLCH.

The Chair thanked Steve Vo for the introduction and invited comments and questions from those present, with the following issues raised:

Regarding the mobilisation of services, the Committee queried how the feedback from patients, service users and carers had been sought and used by the Joint Mobilisation Groups and what learning had been taken from that feedback. Fana Hussain (Borough Lead Director, Brent – NWL CCG) advised that the model was lift and shift, therefore services had not changed for patient facing services and patients should not have seen a difference in the way they were provided. Janet Lewis (Director of Operations, CLCH) advised that the feedback from staff had been very positive, and that it had been a very amicable move of services between partners who had a good working relationship. The Joint Mobilisation Groups had been important to ensure everything went well for the transfer of staff, and that the patients and carers being looked after did not experience any challenges. She highlighted that staff were very happy and settled, and CLCH were working and engaging on how CLCH could work with staff to improve service delivery for the future. Overall the transfer had been seamless but there had been some IT issues due to a move in networks, which had since been resolved.

In relation to what was learned during the mobilisation period, Janet Lewis highlighted that the transfer had been done very quickly. The plan had been to move services in April 2021,

but when the Mobilisation Group had convened they had realised that was not safe or feasible, so the transfer was delayed until 1 August 2021 which was felt safe once all the different workstreams had been reviewed. She advised there was a large amount of hard work on everyone's part to complete the transfer which took place mid-pandemic and felt that the learning was around the timescales that providers set themselves, as well as working together in partnership.

There was a CLCH divisional base at Wembley Centre for Health where the management and leadership team of CLCH were based, although they were usually in the community within Brent most of the week. CLCH provided services in a lot of the big health centres in Brent such as Willesden, Wembley, Hillside and Chalkhill and were starting to work more with primary care directors to help patients remain close to home for neighbourhood level care. CLCH also worked in the Family Wellbeing Centres. Services would be delivered in the same places they had been delivered with the previous provider. CLCH provided some services in Westminster but not Camden, and the leadership team worked across Brent, Harrow and a small bit of Ealing. Dedicated staff were Brent centric and there were separate teams for Harrow and Ealing.

In relation to staff changes for paediatricians, the Committee were advised that 4 paediatricians had been transferred from the previous provider and a further paediatrician had been appointed during the transfer. Staff across the provider remained the same and there had been an increase in the team for children with complex needs in order to bring that service from a 5 to 7 day service. There was also a designated asthma nurse linking between the Acute Trust, schools and community services to co-ordinate provision.

The Committee discussed the Task and Finish Groups for diabetes, heart failure, respiratory services, rehabilitation and reablement, querying how they were going and how the work would transform the offer to the community. Janet Lewis advised that those were the areas identified and prioritised by the Community Services Executive Group for improvement, which was a subgroup of the Integrated Care Partnership (ICP) under the community services priority. She advised that services were already good but this looked to improve them further. The task groups were working with a group of professional staff from the primary care directorate, local authority, and other agencies, along with Healthwatch to see how user perspective could be brought into those groups. For diabetes, there was a NWL specification and CLCH were looking to see how that could be delivered in Brent while maintaining a Brent-centric model. The focus for the groups was on short to medium term changes as well as a longer term piece of work to see what services might look like in the future. Janet Lewis had hoped for changes from the task groups to be in place by 1 April 2022, however, due to the outbreak of the Omicron variant, and the need to implement business continuity measures due to staff shortages, this had been delayed. CLCH were now in a position of standing those transformational Task and Finish Groups back up and hoped to see them making changes early in April 2022. Robyn Doran (Director of the Integrated Care Partnership, NWL) added that this work formed part of the overall integrated working in the Brent place and was one of the 4 ICP priorities overseen by the ICP Exec, which reported to the ICP Board and Health and Wellbeing Board.

In relation to waiting times, the Committee queried whether there were any targets or timelines in place to reduce the waiting times. For many services that were not rapid or urgent care, the current waiting time was in excess of 20 weeks, and CLCH were working closely with the acute trust to reduce that. Community nurses and rapid response had no waiting lists but there was a variety of different services that had different waiting lists and times. Anyone requiring urgent care, for example diabetes patients requiring podiatry, would be seen with a priority as patients were being carefully and clinically triaged. Specifically in relation to the longest waiting lists for paediatric services, it was confirmed that this was for treatment following initial assessment for those with an Autism Spectrum

Disorder, which was around a 6 month wait. CLCH had recruited a locum doctor for additional capacity in that service to reduce that time. CLCH were keen to start working on the longer waiting lists as it entered another recovery phase following the further outbreak of the pandemic, and were working through those lists to ascertain whether any additional resources might be required. The provider were also waiting for funding information for the following year to be received to know whether there would be any additional resource they could put towards reducing waiting times. The provider could then ascertain a trajectory for how long it would take to get those lists to the correct level.

The Committee queried whether the provider needed more money in order to reduce waiting times. Janet Lewis felt that there was not a need for more money currently but for more staff into the workforce. She highlighted that staff were tired as a result of the pandemic and were not always willing to do additional shifts, and that their health and wellbeing was essential to support. Fana Hussain agreed that CLCH were experiencing workforce number issues like the majority of the NHS system. She advised the system was struggling with recruitment and retention and many GPs and nurses were due to retire. As a result, the workforce was being moved around the system and there was a focus on training, education, and upskilling of existing staff. One example of that taking place was the upskilling of Health Care Assistants into nursing roles through on- the-job accredited training. Robyn Doran agreed to provide information to the Committee in 2 months' time which included the waiting list baselines and clear trajectories, once the funding for the following year was clear, to establish and distinguish whether there were any issues caused by shortages of staff or shortages of financial resource.

In relation to the impact of Covid-19 on staff, Janet Lewis advised that it had been particularly challenging over Christmas and New Year but the provider was now moving out of that phase. The sickness rates were still around the 6% mark, but only 3% of that was related to Covid-19 currently and they were seeing improvements in Covid-19 related sickness rates. Where possible, staff were able to work from home through the virtual model, ensuring any digitally excluded patients were not disadvantaged.

The Ageing Well fund was discussed, and Robyn Doran highlighted that the ICP wanted to lever as much new money into Brent as it could to target the areas that they knew had been underfunded in the past. Considering the Ageing Well Fund areas of diabetes, care homes, and St Luke's Hospital, those areas had been stipulated by central government and included a national specification for delivery. Providers had worked together as a partnership to ensure the money would enhance Brent services, targeting where they felt the gaps were e.g. podiatry and mental health in diabetes. In terms of measuring outcomes to understand whether the Ageing Well money had led to improved outcomes, Janet Lewis advised that there were set metrics monitored across all areas that would show whether CLCH were achieving good health outcomes and reduced health inequalities.

The Committee highlighted the increase in the Ageing population, including increases in mobility difficulties, dementia and Parkinson's, and wanted to understand how that was being addressed. CLCH were revisiting their frailty pathway for people in those categories. There were a lot of small services provided by CLCH, and Janet Lewis felt it was possible to rearrange them together for a ward type model with patients in their own homes and communities.

In terms of performance overall, the Committee queried how that would be monitored and reported going forward. Robyn Doran advised that the ICP had some expectations on performance and could include this in the report being provided to the Committee in 2 months' time. Janet Lewis advised that, currently, CLCH were trying to regroup with the Patient Experience Group and were looking at patient stories, Friends and Family Test,

Complaints and Compliments, for a wide range of qualitative metrics to share with commissioners as well as quantitative data and metrics.

The Chair thanked those present for their contributions and brought the discussion to an end. The Committee RESOLVED:

- i) To receive a report on the progress of the transformation programme at the Community and Wellbeing Scrutiny Committee to be held on 14 March 2022. This report should include:
 - a) Comparative data on community waiting lists across North West London and action being taken to address long / hidden waiting times in Brent
 - b) Monitoring and evaluation processes for transformation proposals
 - c) Timescales and checkpoints for transformation proposals
 - d) Information on the community services provided for infants, children and young people.

8. RESCHEDULED- GP Access Scrutiny Task Group Final Report

The Chair advised the Committee that this paper had been deferred and the final version would be coming to the next Committee meeting. He was grateful for the work done by the task group and Chair of the task group, Councillor Daly, and looked forward to receiving the final report at the following meeting.

9. Transitional Safeguarding Task Group Interim Report

The Chair of the Community and Wellbeing Scrutiny Committee advised the Committee that there had been a number of good sessions looking at the area of transitional safeguarding. He highlighted that it was a very complex area and it had been helpful to have an expert, Dez Holmes, give context and background into the area so that the task group had a fuller understanding. Evidence had been taken from a variety of stakeholders, both internal and external, listening to how transitional safeguarding work was being developed in Brent. The report detailed the draft recommendations emerging from those evidence sessions, and the task group were working to finalise them. The task group hoped to bring the final report to the February 2022 meeting.

In considering the report and draft recommendations, the Lead Member for Children's Safeguarding, Early Help and Social Care confirmed that she was happy to take those forward with the Lead Member for Adult Social Care and health and social care partners and discuss further outside of the meeting.

The Chair thanked colleagues for their input, and drew the item to a close. The Committee RESOLVED:

- i) To note the contents of the report and the progress made by the Transitional Safeguarding Scrutiny Task Group.

10. Any other urgent business

None.

The meeting closed at 8:00pm
COUNCILLOR KETAN SHETH, Chair

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 Brent	Community and Wellbeing Scrutiny Committee 22 February 2022
	Report from the Operational Director, Safeguarding, Partnerships and Strategy
Education and Wellbeing Recovery	
Wards Affected:	All
No. of Appendices:	0
Background papers	Community and Wellbeing Scrutiny Committee report: Brent Council and Covid-19: Service Response and Recovery, July 2020 Community and Wellbeing Scrutiny Committee report: Update on schools and education, including action plan for raising achievement of British boys of Black Caribbean heritage November 2020 Community and Wellbeing Scrutiny Committee report: Brent Council's Management of the Impact of Covid 19 on Education Settings and Children's Services, November 2020
Contact Officer(s): (Name, Title, Contact Details)	Brian Grady Operational Director, Safeguarding, Partnerships and Strategy brian.grady@brent.gov.uk Jen Haskew Interim Head of Setting and School Effectiveness jen.haskew@brent.gov.uk Shirley Parks Head of Forward Planning, Performance and Partnerships Shirley.parks@brent.gov.uk

1.0 Purpose of the Report

- 1.1 This report updates members on the recovery of children and young people's education and wellbeing in response to the Covid-19 pandemic in Brent. This report adds to the reports provided to the Community and Wellbeing Scrutiny Committee on 24 November 2020 and 21 July 2020 that gave an overview of the collaborative work between the local authority, schools and other partner organisations to support the education and wellbeing of Brent children and young people in the earlier phases of the pandemic.

2.0 Recommendations

- 2.1 Members of the Community and Wellbeing Scrutiny Committee are asked to note and comment on the content of this report.

3.0 Detail – Background to Settings and Schools Recovery

- 3.1 Further to the reports to Community and Wellbeing Scrutiny committee on 24 November 2020, Covid has continued to have a significant impact in Brent settings and schools throughout 2021. Schools and early years settings fully re-opened in September 2020. There was a further lockdown in spring 2021, but schools have remained fully open since March 2021 with full or partial closures of individual schools only in response to localised cases. Since the beginning of the autumn term 2021 and updated government guidance supporting the full reopening of schools for all pupils, with the continued support of the local authority, schools have successfully focused on ensuring high attendance, re-establishing routines for learning, delivering the curriculum and closing identified gaps in pupils' learning. Since schools returned in January 2022 there has been a marked increase in notifications from schools of the number of positive cases of staff and pupils exceeding the published thresholds for notification in Government guidance, further illustrating the ongoing challenge which Covid (Omicron) presents to settings and schools recovery.
- 3.2 The comprehensive support arrangements provided by the Local Authority to schools and settings reported to Scrutiny committee in November 2020 have remained in place and have been built upon and developed, with positive feedback from schools and settings on the support being provided by the Local Authority. The Strategic Director Children and Young People has continued to convene regular meetings with headteachers, Chairs of Governors and early years providers in response to the changing phases of the pandemic, with an increased focus on education recovery. The Director of Public Health has been a regular attendee, providing public health advice and advising schools on changing government guidance and protective measures, for example mask-wearing in secondary schools. These arrangements have continued to support resilience in the sector and facilitated the sharing of good practice. Regular written briefings have also been provided to settings and schools. Feedback from early years settings and schools has been very positive regarding both the webinars and published briefings provided by the Council.
- 3.3 The CYP Department has worked with settings and schools to implement a comprehensive education and wellbeing recovery plan. Recovery planning has focused on all children and young people, but with particular focus on vulnerable children known to CYP (including Children in Need, Children subject to a Child Protection Plan, children with an Education, Health and Care Plan, young people known to the Youth Offending Service and Looked After Children and care leavers).
- 3.4 Multi-agency governance boards have continued to provide oversight of delivery for children and families, including the Health and Wellbeing Board, the Children's Trust, and the Strategic School Effectiveness Partnership Board. The Strategic Director is chairing monthly meetings of the Children's Services Leadership Team to oversee the coordination of work to support education and wellbeing recovery with a focus on vulnerable children.
- 3.5 During autumn 2021 and since January 2022, in the context of the Omicron strain of Covid-19, schools have seen an increasing number of children, young people and staff absent due to Covid-19. Schools have responded by putting in place additional protective measures, on the advice of the CYP Department, Brent Public Health and

Public Health England. These have ensured that no school has had to close to all pupils and that only a very small number of classes or year groups have had to be taught remotely for a short period of time.

- 3.6 The local authority has been acting as the key liaison between schools and the North West London CCG Covid-19 Vaccination Group following the national extension of vaccinations to 12-15 year olds. The school based vaccination programme for 12-15 year olds in Brent began on 12 October 2021 and all mainstream secondary schools had hosted a vaccination session by 4 November 2021. 4,990 first doses were administered throughout the autumn term, which equates to 39% of the eligible pupil population. Second dose visits are currently taking place and will run until 14 March 2022. The local authority has also encouraged parents to book first or second doses at a range of local vaccination sites, including pop up sites that have operated in evenings and weekends to encourage uptake.
- 3.7 At the end of the academic year 2020-21, 96% of Brent schools were judged good and outstanding by Ofsted. This is above the national average of 83% and the London average of 93%. Whilst the proportion of good and outstanding provision is high compared to the national and London averages, there are two primary schools and one secondary school not yet judged good or outstanding. Ofsted returned to a full programme of inspections from September 2021. In the final days of the autumn term inspections were cancelled to allow schools to consider their Omicron contingency measures for January 2022. Inspections have now resumed. Ofsted has a deferral policy in place that allows settings and schools to ask for their inspection to be deferred in exceptional circumstances. The CYP department and the Director of Public Health have supported three Brent schools who successfully requested a deferral due to the impact of Covid-19 on pupils and staff.

4.0 Early Years

- 4.1 Throughout the pandemic, early years providers have experienced lower than usual demand from parents for free entitlement places, lower income from fee-paying parents and the challenge of keeping settings open with staff teams reduced due to staff illness and self-isolation. Overall recovery has been slow in the sector, with attendance having only returned to near pre-pandemic levels at the end of December 2021. Take-up in the PVI (private, voluntary and independent) sector has remained stable, but take-up in the maintained sector has reduced. The one area that has seen an increase is the number of 30 hour places being taken up by parents, indicating that working parents have continued to use their entitlements even when working from home.
- 4.2 The statistical data return to DfE in November 2021 has indicated that approximately 4114 under 5s were attending early years settings in schools, PVI and childminding settings. This is an increase on early autumn figures, although this increase is partly due to the inclusion in the data for the first time of the number of under 5s attending school based provision.
- 4.3 Brent Early Years Service has continued to provide tailored support to assist the recovery of the early years sector. The service has helped providers to navigate changing government guidance and has provided both a virtual and face to face training offer, as well as support on provider organisation and advice on how to meet the needs of children with Special Education Needs and Disabilities (SEND). The Early Years teams have continued to disseminate the latest national guidance and relevant updates across the sector, signposting providers to national and local funding streams that could support their sustainability. Providers have also been supported on how to manage Covid-19 cases in their settings through the Early Years single point of contact and the Brent Public Health team.

- 4.4 Information obtained from settings has continued to demonstrate a wide variance in business planning capacity and demonstrated that there is a significant business support need during the recovery phase. Providers have reported that they have accessed both national and local support opportunities, such as business rates holidays, small business grant schemes, the Coronavirus Job Retention Scheme (CJRS), the Coronavirus Business Interruption Loan Scheme. Childminders have also accessed the self-employment income support scheme.
- 4.5 While numbers are slowly returning close to pre-pandemic levels, some providers are concerned about their ability to remain financially viable without an increase in children taking up places and/or an increase in the funding rate for the free entitlement in the context of rising business costs. Providers have also reported that they are facing severe difficulties in recruiting staff (both qualified and un-qualified). Nationally there are reports that practitioners have left the sector to take up posts in retail or other fields that are deemed to be lower risk for higher financial reward. The Local Authority is continuing to work with providers to support them with recruitment advice and guidance and through advertising vacancies via the Council.
- 4.6 There has been a decrease in the number of childminder providers in the borough with 36 childminders de-registering since March 2020. Reasons for these include a move out of the borough, retirement and in some a longer-term decision expedited as a result of COVID related concerns. This decrease is mirrored nationally.
- 4.7 Seven group based PVI providers, ranging from small family run provision to larger commercial operations, have closed in the period March 2020-November 2021. Again reasons for these are varied, including failed lease renewal negotiations, rental increases coupled with a reduction in demand and some have reported being unable to re-open due to Covid-19. A few providers have moved premises in order to expand and some new providers are entering the market, which indicates ongoing demand for places.
- 4.8 In 2022, as providers adapt to a changing landscape with reduced financial support by way of national and local grants, a key area of focus of the Early Years Service is supporting sustainability in the sector. A programme of management workshops for the year has commenced with the first session focusing on successful recruitment and retention, encouraging the sharing of existent good practice. Overall sufficiency will continue to be monitored. While some providers have left the sector and others have set up new provision in the borough, the long-term impact of the pandemic on the sector is yet to be seen.

5.0 Schools

- 5.1 Brent has maintained a focus on vulnerable pupils throughout the pandemic period. Brent's definition of vulnerable children is:
- Children who are assessed as being in need under Section 17 of the Children Act 1989, including children and young people who have a child in need plan, a child protection plan or who are a looked-after child
 - Children who have an education, health and care plan or who are identified as requiring SEN support
 - Children who have been assessed as otherwise vulnerable by educational providers or at the local authority's discretion (including children's social care services). This might include children and young people on the edge of receiving support from children's social care services, adopted children, those at risk of becoming NEET (not in employment, education or training), those living in temporary accommodation, and those who are young carers.

- 5.2 From the outset of the pandemic, Brent schools have been assessing their pupils to identify the gaps in their learning which has informed on-going modifications to the delivery of the curriculum. To support schools to close the gaps the DfE announced the Covid-19 Catch-up Premium in July 2021. This is additional funding to support pupils who fell behind in their learning during the first lockdown period. Schools are using the funding to accelerate progress through tailored teaching activities which include small group or one-to-one tuition and extra teaching capacity including after school lessons.
- 5.3 School leaders have continued to access support and guidance from the local authority on how to interpret new government guidance and to continually update their risk assessments. As a result schools have been able to mitigate Covid-19 related risks by implementing control measures and all have contingency plans in place should they need to consider additional protective actions.
- 5.4 Brent's self-improving school system has been strengthened with a number of new developments recognising the strength of Brent schools leadership in the past year. The North West London Teaching School Hub led by Wembley High Technology College and the Behaviour Hub led by St Gregory's are excellent examples of schools taking a leading role in supporting school effectiveness. Where the local authority needs to intervene in schools to bring about rapid improvement it commissions and brokers school-to-school support from its partners: Brent Schools Partnership BSP, National Leaders of Education (NLEs) and National Leader of Governance (NLG), and the leaders of outstanding and good schools.
- 5.5 From September 2021 the North West London Teaching School Hub based at Wembley High Technology College became one of 87 National Teaching School Hubs. Teaching school hubs are school-led centres of excellence for teacher training focusing on training to support teachers and leaders to become more effective. Teaching School Hubs lead on the delivery of six National Professional Qualifications (NPQs) in Senior Leadership, Headship and Executive Leadership as well as NPQs for teachers and school leaders who want to broaden and deepen their expertise in specialist areas.
- 5.6 From September 2021 The Department for Education (DfE) has nominated St Gregory's Catholic Science College as one of 20 National Behaviour Hubs. The Hubs will support improved pupil behaviour in identified schools, using the Hub as an exemplar of behaviour practices. The St Gregory's Behaviour hub will work with identified schools, supporting them by providing training on specific issues, common problems and effective approaches that can be implemented within the school. The hub will also host open days so partner schools can observe good systems and approaches in action and provide ongoing support, mentoring and coaching to support leaders in implementing lasting change.
- 5.7 During the pandemic, the Brent school clusters (Harlesden, Kilburn, Kingsbury, Willesden and Wembley) have played a key role in providing mutual support in addressing the extraordinary issues that have impacted on the leadership and operation of schools. The clusters have in a short space of time re-established themselves as a key component of the borough's school-to-school support. Two case studies are included which highlight the work being undertaken and the dynamic and supportive arrangements in place between Brent schools. Both clusters include special schools, PRU, primary and secondary and all forms of governance in school members – Voluntary Aided, community schools, and academies. Both case studies highlight the importance of a safe supportive space for school leaders.
- 5.8 Case study in collaboration: Kingsbury Schools Together**

KST has been a collaboration of a cluster of schools in the Kingsbury area over the past ten years. Over the time of its existence, the cluster has undertaken academic collaboration (for example group moderation) and enrichment collaboration (for example, the Kingsbury carnival, with a range of shared activities, and an environmental project in partnership with Brent Council and Veolia, “love where you live.” During the pandemic period the cluster strengthened even further, not just in managing the response to the pandemic but in setting higher ambitions for pupils. Following the declaration of a climate emergency by Brent Council and supported by the introduction of the climate champion network in Brent schools, KST have held an eco conference to coincide with COP26, with participation of pupils from all schools in the cluster. Enrichment activity and curriculum resources were shared between schools in the cluster in preparation for the conference, which involved the local authority. Actions have come out of the conference which will directly contribute to the carbon net zero campaign in Brent, for Brent schools and for the wider community.

5.9 Case study in collaboration: Harlesden cluster

The Harlesden cluster started as a model to support headteachers, developing strong relationships between school leaders and creating a supportive network of colleagues. The pandemic brought Harlesden schools closer together, particularly in supporting remote learning and supporting the wellbeing of staff and children as well as school leaders. Responding to the Brent Black Community Action Plan, the Harlesden Curriculum has emerged as a key element of the collaboration. The curriculum aims to streamline teaching and learning in Harlesden so that there are increasingly clear links between teaching and learning in primary and secondary schools, so that schools are not re-teaching. The curriculum will deepen the knowledge and understanding for pupils in Year 6 in identified subject areas, tapping into specialisms in individual schools.

- 5.10 Brent schools quickly developed their on-line teaching platforms and resources to teach pupils remotely early in the pandemic. They also provided teaching and learning packs for children who did not have the required access for on-line learning. The development of remote learning has been on-going to ensure that when pupils or teachers have to isolate because of Covid-19 outbreaks, their learning and teaching can continue as seamlessly as possible. This online digital learning offer now allows schools to continue to teach the curriculum if Covid-19 restricts attendance for staff or pupils. The development of remote teaching now sits within curriculum planning and not only allows for remote teaching to be put in place as part of contingency delivery plans, but also complements face-to-face learning and home learning/study.
- 5.11 Despite remote learning and the continuation of face-to-face teaching for vulnerable pupils and the children of key workers, the pandemic has inevitably impacted on learning. From the beginning of the pandemic Brent schools have continued to assess their pupils to identify the gaps in their learning which has informed on-going modifications to the delivery of the curriculum. As a result, Brent Council and schools have developed a deeper shared understanding of vulnerable pupils which will be the basis of increasingly effective targeted support for every Brent pupil to succeed.
- 5.12 Work has continued in Brent schools to support the delivery of the Brent Borough Plan 2019-2023 priority to raise the attainment of particular groups and narrow the gap with their peers for Boys of Black Caribbean heritage. The “Update on schools and education, including action plan for raising achievement of British boys of Black Caribbean heritage” report, presented to Scrutiny Committee November 2020, set out an overview of the work that had taken place to support raising the achievement of boys of Black Caribbean heritage and other priority groups. This work has been maintained as follows:

- 5.13 78 BCA champions in 73 Brent schools have continued to be supported by Brent Schools Partnership to drive forward improvement strategies in their school. The leadership capacity created through the designation of a BCA Champion continues to make a significant contribution to ensuring that raising achievement is a strategic priority in schools leading to a range of actions aimed at tackling the legacy of underachievement of this group of pupils.
- 5.14 68 schools have had a BCA audit supported by a Brent Schools Partnership (BSP) School Improvement Specialist. An analysis of the issues identified through the audit across Brent has been carried out, and has informed the content of the training and support available for schools.
- 5.15 The Parent Resource Portal went live in the autumn term 2020, and is being promoted to parents by schools and their BCA champions. Parents and community members have recognised that the resources are of great value.
- 5.16 DfE-funded summer schools were held in 13 Brent secondary schools in 2021, aimed at supporting the transition of children from Year 6 to Year 7.
- 5.17 On 12 July 2021, Brent Full Council agreed the establishment of an additional reserve budget of £17M as part of the Borough's COVID-19 recovery plan. The reserve budget funds programmes that build on the success of Brent Council's immediate response to the pandemic and take Brent forward to a sustainable, inclusive recovery, aligned to Brent Borough Plan priorities, under four themes:
- **Supporting Communities** (£1.4M of programme funding aligned to the Borough Plan priorities "Every Opportunity to Succeed" and "Strong Foundations")
 - **Supporting Businesses** (£10.6M of programme funding aligned to the Borough Plan priorities "A Future Built for Everyone, An Economy Fit for All" and "Strong Foundations"),
 - **Reducing Health Inequalities** (£0.5M of programme funding aligned to the Borough Plan priority "A Borough where we can all feel safe, secure, happy and healthy") and
 - **The Green Recovery** (£4.5M of programme funding aligned to the Borough Plan priority "A cleaner more considerate Borough").
- 5.18 Wellbeing and Education recovery support for Brent children, young people and families is at the heart of Brent's recovery programme, with a range of initiatives funded to support children and families, including £520,000 over 2 years to provide a two year programme of evidence-based education recovery action with Brent schools. The aim of the funding is to support Brent children to not only recover to where they were educationally, but to support a "recovery for childhood", to help Brent children to progress to where we want all Brent children to be.
- 5.19 The government has chosen to fund limited elements of the Government's Education Recovery Commissioner's recommendations, including: training for Early Years staff to support recovery; the National Tutoring Programme and funding for school-led approaches to take on local tutors; training for early career teachers and expansion of access to National Professional Qualifications; Continuous Professional Development support for teachers regarding mental wellbeing and STEM; and Catch-up and Recovery premium funding to support individual schools' recovery planning. Brent Council's programme is intended to support the gap between the funded government programme and the other proposals that the Education Recovery Commissioner recommended.

- 5.20 Recognising the disproportionate and unequal effect of the pandemic and acknowledging the anticipated impact of the pandemic in wider gaps of inequality, funding will prioritise vulnerable pupils and priority groups of pupils including boys of Black Caribbean heritage. School clusters, with the support of the Setting and School Effectiveness Service, are leading on the implementation of the Brent Education Recovery Programme to ensure it meets the needs of the pupils attending their schools.
- 5.21 Brent schools were invited to provide suggestions and proposals for the programme to the acting Head of Setting and School Effectiveness and Operational Director, Safeguarding, Partnerships and Strategy in October 2021. School Effectiveness Partnership Board representatives then met to consider proposals for the development of the recovery programme in November 2021, which were reviewed and agreed by the Board on 17 November 2021.
- 5.22 The funding made available by Brent Council is substantial but broken down to a school by school level this funding will only make an impact through focused and coordinated action. As such, to help promote engagement at a Brent school cluster level and a shared commitment and approach to recovery across all Brent schools, funding will be provided at a cluster level, with match funding contributions from clusters encouraged. The Board agreed that funding should focus on evidence based actions which directly impact on education recovery and that the programme should have a focus on curriculum, to include curriculum training, resources and support in particular for middle leaders to drive subject leadership and secure accelerated recovery for pupils. Learning from the success of the Raising Achievement of Boys of Black Caribbean Heritage programme, the programme will aim to secure a named education recovery leader in every Brent school to provide overall leadership and to report on the progress and impact of the programme, alongside the wider context of education recovery actions in Brent schools.
- 5.23 Following the Board meeting of 17 November 2021, the Interim Head of Setting and School Effectiveness has met with all five school cluster headteacher leads to develop the programme as agreed by the Strategic School Effectiveness Partnership Board. Each of the five Brent school clusters discussed the indicative allocation of the total fund, to match with cluster school held funds, to develop the recovery programme within each cluster. All schools in each cluster are being given the opportunity to engage in the development and delivery of the programme. These meetings have confirmed the establishment of Recovery Practice Leaders network in every Brent School, with proposals delivering a year- long programme of evidence-based evidence based recovery initiatives.
- 5.24 Elements of the programme developed so far include:
- A programme to address the decline in children's language development arising from the pandemic through a structured programme that starts in the Early Years and also supports older students.
 - A 'Brent Writes' programme designed to address the decline in children's writing arising from the pandemic from Early Years through to Sixth Form
 - A knowledge-rich humanities programme for teaching history, geography and religion in Years 3 to 6, with curriculum resources together with training, support and ongoing programme-related professional development for primary school teachers. The full programme is being finalised week commencing 28 February 2022.

- 5.25 The full programme, to include a model of impact monitoring to ensure that the recovery programme fund makes a maximum impact for Brent pupils, is being finalised week commencing 28 February 2022.
- 5.26 Senior leaders in CYP have been monitoring and promoting school attendance since September 2020 to ensure a full return to school. Overall attendance at Brent schools has been good over the past 2 years, with attendance above the national average. Over the autumn term 2021, average attendance was 91% with attendance at several schools 95% or over. The attendance of vulnerable children – children with a social worker and children with an EHCP has also been above national averages. Due to this strong performance, Brent is one of 10 local authorities selected by the Children's Commissioner in January 2022 to participate in a deep dive into attendance to develop shared learning. The Education Welfare Service has been working closely with schools to support the recovery of attendance levels of children and young people who are persistently absent. This combines supportive interventions with enforcement action, with the aim of ensuring persistently absent pupils re-engage. Many of the pupils who are struggling to maintain consistent attendance are those who have SEND or had pre-existing behavioural issues and persistent absenteeism prior to the pandemic. Some pupils have emerging mental health issues.
- 5.27 Brent Virtual School has responded quickly to the implementation of new duties from September 2021 to support the attendance and attainment of all children known to children's social care in settings and schools. With the recruitment of a secondary advisory teacher and two education officers, the Virtual School works with school leaders to understand how to best meet the needs of children and families with a social worker, as well as acting as a bridge into schools for social care teams. The impact has been to support schools to adjust the application of school policies including attendance and exclusions, enabling children to remain in mainstream and build their attendance and behaviour as part of a coordinated child and family centred plan. School and setting staff also have access to a wide set of training opportunities available through the Safeguarding Children Partnership to help them understand how partnership working can help to support this cohort of children and young people. The Virtual School is also working with a group of young people of secondary age who have multiple vulnerabilities and have experienced a significantly fractured educational history and who require targeted support.
- 5.28 Following the cancellation of the summer 2020 and 2021 examinations by the Department for Education, being replaced by Centre Assessed Grades in 2020 and Teacher Assessed Grades in 2021, there have been no published data on pupil outcomes for the past two academic years. For the 2021/22 academic year all existing statutory KS1 and KS2 assessments will return following their usual timetable. However the DfE has announced that school-level data from the KS2 national curriculum assessments will not be published in performance tables in 2022. Results will be shared securely with primary schools, academy trusts, LAs and Ofsted to inform targeted improvement work
- 5.29 GCSE, A Level and vocational qualification examinations are also scheduled to take place with a later start time to give schools more teaching time. The examinations are being modified to give schools and the pupils optional questions to assess the parts of the subject syllabus that were taught, with contingency plans put in place in the unlikely event of further impact of the pandemic on planned examinations in Summer 2022.

The Brent Strategic Framework for School Effectiveness has been refreshed and extended for the period 2021-22 and sets out Brent's vision for education. A new Brent Strategic Framework for School Effectiveness 2022-25 will be developed later this year

in consultation with partners and informed by the Education White Paper and SEND Green Paper expected to be published by the DfE later in the spring.

6.0 Holiday or after-school clubs and other out-of-school settings

- 6.1 Brent Council does not have responsibility for after-school clubs, but local schools and settings have endeavoured to keep provision running despite the pandemic, especially where these support vulnerable groups. Community and voluntary sector organisations have maintained a presence supporting vulnerable children and young people throughout the pandemic and an expansion of out-of-school activities has supported the education and wellbeing recovery of Brent's most vulnerable children and young people.
- 6.2 As restrictions have lifted from September 2021, schools have not only reinstated high quality face-to-face classroom teaching, but they have also endeavoured to reinstate the enrichments that play such an important part in the educational experience of Brent pupils. Pupils are once again active in their local communities visiting libraries and using local services. Trips are taking place including to the Gordon Brown Centre and the Brent Music Service is delivering tuition and performing for live audiences.
- 6.3 Roundwood Youth Centre's current activities have been developed as part of the Roundwood Alternative Provision school which opened in January 2021. A new and exciting offer for young people has been developed, offering in 2022 a range of activities including theatre, music, dance and sport.
- 6.4 The Brent Youth Strategy 2021-23, agreed by Brent Cabinet in September 2021, sets out the Council's vision to provide a wide range of positive activities for Brent young people, with a commitment to working closely with schools and the voluntary sector to promote a wide range of accessible activities.
- 6.5 The Brent Local Cultural Education Partnership was established in 2021, as part of the legacy of Brent's year as London Borough of Culture 2020, bringing together schools and arts and culture organisation partners, with the aim that all Brent children have access to a wide range of cultural enrichment opportunities.
- 6.6 On 8 November 2020, the government announced that the Holiday Activities and Food Programme (HAF) would be expanded across the whole of England in 2021, building on a pilot programme from 2018 to 2020. Following the Government's comprehensive spending review, the government has confirmed funding for a further 3 years to 2025. The programme makes available free places in holiday clubs to children of school age on benefits-related free school meals for the equivalent of at least 4 hours a day, 4 days a week over 4 weeks during the summer and a week during the Easter and Christmas holiday periods. The local authority secured agreement from the DfE to broaden the reach of the HAF programme beyond children on FSMs through agreement that up to 15% of the budget could support children and young people considered to be vulnerable by schools and other professionals.
- 6.7 The Brent HAF programme was shaped by a collaborative steering group that included representatives from the Young Brent Foundation, Public Health, Community Safety, representative headteachers, and officers from Children and Young People. To maximise participation, the HAF operating model has been flexed in line with government Covid-19 guidance. While the Summer 2021 programme offered only face-to-face activities, the Easter and Christmas holiday periods offered a mix of face-to-face and online provision.
- 6.8 Over the Easter, Summer and Christmas holiday periods in 2021 the authority commissioned around 50 schools and voluntary sector providers to deliver a

comprehensive and varied programme. In the summer for example just under 3000 places were made available, and 2325 children attended a HAF provision. A wide range of activities were on offer to attendees at HAF clubs. These included: multi-sports and games, arts and crafts, dance, drama, music, coding, gardening, podcasting, kayaking, horse riding, surfing, swimming, cooking and baking, amongst other activities. Many children and young people had new experiences. The offer was fully inclusive and children with SEND were supported to access specialist provision or were able to access mainstream provision with additional funding support. The programme also funded supplementary activities to run alongside holiday clubs. For example, 64 children and young people were able to attend a half-day kayaking activity alongside the holiday club they were attending.

- 6.9 To meet the programme aim that the families who participate in the programme develop their understanding of nutrition and food budgeting, online and in person healthy food workshops have been delivered at Family Wellbeing Centres. In addition, an information and resource pack for participating families was developed, and a directory of online and at home activities was made available on Brent's website.
- 6.10 Brent's Family Wellbeing Centres are hosting a variety of activities and programmes through strong partnerships with voluntary sector and health providers. Activities include homework clubs, staffed by appropriately qualified staff.
- 6.11 Brent Virtual School has continued to offer an enrichment programme for Looked After Children during school holiday periods, including residential trips. Other vulnerable groups have continued to be supported with holiday activities, including children with disabilities through holiday play schemes and Young Carers. Church Lane and Three Tree's FWCs host a range of activities for young carers every month and offsite trips, and a peer support group, facilitated by Brent Gateway Partnership. There is a wide range of activities for children and young people which on offer at Family Wellbeing Centres, including drama therapy (12-16 year olds), Global Thinking (for girls at risk of exploitation), It Takes A Village (education project), after school art and craft workshops, access to sports and Fun Fit Families
- 6.12 Brent has a good understanding of the number, type and characteristics of out-of-school settings. Regular Brent out-of-school setting network meetings are providing support and advice and guidance to out-of-school settings. Through this network, the local authority has supported out-of-school settings to navigate national Covid-19 guidance and has ensured that there is effective dialogue on a range of organizational issues with the sector to support recovery.

7.0 Mental health and Wellbeing Recovery

- 7.1 Brent has the lowest access to mental health services for Children and Young People in North West London, despite high demand. The NWL CCG has recognised that both additional resources and service redesign are essential to address this inequality in CAMHS delivery. Mental Health and Wellbeing has been identified as a key priority for the North West London Integrated Care Partnership (ICP). The Children's Trust is actively monitoring the system wide response for children and young people who have social, emotional and mental health needs in response to or exacerbated by the adverse social and environmental factors linked to the pandemic (e.g. increasing domestic violence, poverty and isolation). The Chief Operating Officer of CNWL (Brent CAMHS provider) joined the Children's Trust in October 2021 to ensure there is senior officer oversight of service development.

- 7.2 Referrals to mental health and wellbeing services have increased during the pandemic, with a 35-45% increase in referrals in 2021 to specialist CAMHS for those presenting with a range of needs, including emotional well-being concerns, autism, learning disabilities and eating disorders. This has put pressures on CAMHS crisis support as well as routine appointments. A local CAMHS Service Recovery Plan has resulted in additional resources being deployed to manage assessments during working hours, evenings and weekends to reduce waiting lists. There remain waiting lists of several months for treatment and Autistic Spectrum Disorder (ASD) assessment. There is an agreement by the NWL CCG of the need to increase specialist clinical capacity to provide more timely assessments and interventions. Local pathways are being reviewed and aligned to ensure a more comprehensive system-wide response to needs.
- 7.3 To meet the increasing demand from children and young people whose needs do not meet the threshold for specialist services, from September 2021 the local authority has expanded the Wellbeing and Emotional Support Team (WEST), commissioned by the LA and delivered by the Anna Freud Centre. The service is supporting children and young people with mild to moderate mental health and wellbeing needs in identified vulnerable groups (such as Looked After Children, children and young people at risk of exclusion or displaying complex behaviours, and children with disabilities). The School Nursing Service continues to provide advice on children identified to have low level mental health needs. Schools are continuing to offer established support for pupils' wider well-being e.g. delivering nurture provision, commissioning access to services provided by organisations such as 'A Place to Be' and referring children to the WEST service provided by The Anna Freud Centre. The Educational Psychology Service is continuing to support schools to access initiatives aimed at increasing school capacity to support the mental health and well-being of children and staff:
- Grants for Senior Mental Health Leads Training for someone in a strategic leadership role in school or college (a headteacher, deputy head, pastoral lead, SENCO or teacher), who will support development of a whole school or college approach to mental health and wellbeing in the setting. The recently established Brent MH Leads network met for the first time in November 2021.
 - Following the Wellbeing for Education Return Programme launched by DfE in August 2020, the DfE launched Well-being for Education Recovery programme, backed by a further £7m of investment. The programme provides funding for Local Authorities to set up a tailored local programme, including support and guidance. In Brent this funding is being used to build on the Wellbeing for Education Return training delivered by Brent Educational Psychology Service, which includes parent drop-in sessions and workshops and focussed sessions for school staff on topics such as managing transition.
 - To support staff wellbeing, the DfE published an Education Staff Wellbeing Charter. Brent Educational Psychology Service have offered support to all Brent school staff through drop-in sessions based on the charter.
 - In 2021, Brent secured funding to be part of the national Link Programme, delivered by the Anna Freud Centre, which aims to bring together MH professionals and schools to support children and young people's mental health and wellbeing by ensuring they can get the help and support they need, when they need it. The Link Programme offers structured sessions to identify local priorities and agree goals to promote and support good mental health and wellbeing. The programme commenced in January 2022 and will deliver tailored support sessions focussed on improving joint working between education and mental health professionals, based on the local needs assessment.
 - There are currently Mental Health Support Teams (MHSTs) working in 8 Brent schools – one is a locality team based in Harlesden/Stonebridge and one works across 4 secondary schools. They deliver brief evidence-based interventions to

support children and young people with mild-moderate mental health problems and support schools in developing their whole school approach to mental health. An additional team is being rolled out in January working with 2 primary and 2 secondary schools. The scaling up of the programme will commence from September 2022.

- Since September 2020, it has been a statutory requirement that all schools in England and Wales are teaching Relationship and Sex Education (RSHE) as a fundamental part of the curriculum. Recently, the DFE have added a new module to the curriculum for primary and secondary schools specifically designed to focus on mental health. This important addition will enable much-needed conversations about mental health to happen inside the classroom. Brent's Inclusion Service is supporting Brent schools with development and delivery (network meetings, sharing resources, training)
- Mental Health First Aid Training developed by Public Health England provides online training for all school and college staff that provide resources and content to teach young people about managing their mental health and wellbeing, including clear examples of good practice.
- As part of the recovery curriculum, nurseries have been supporting children's wellbeing through the personal, social and emotional development strand of the Early Years Foundation Stage.

- 7.4 Brent was awarded funding (along with Newham) from the Youth Justice Board to set up the Brent BAME / Covid Pathfinder project, which offers a range of targeted services for young people from Black, Asian and Minority Ethnic heritage groups aged 10 to 17 years who have been adversely affected by Covid-19. The project is funded by the Youth Justice Board until 31 March 2023 and aims to support young people to re-engage or engage with education; support their emotional wellbeing; implement whole family interventions to reduce risk of issues escalating (safety and peer mapping); empower young people to offer feedback on the services they have used and provide young people with access to a range of positive activities. 160 children and young people accessed the outreach project in the period October 2020 to October 2021 (with a target of 375 children by 2023). 80 young people completed safety mapping in the period January to September 2021, which reduces the likelihood of young people being inadvertently exposed to contextual safeguarding risks as a result of their participation in the Pathfinder or other community engagement. As part of the Brent Pathfinder Young People's Panel, 26 Black, Asian and Minority Ethnic heritage group children and young people are supported by a Youth Participation Worker to share their experience of Covid-19 and identify activities and interventions that can reduce its impact.
- 7.5 The Council has provide additional recovery initiative funding of £270K to extend the capacity of mental health specialist expertise in Brent schools, building on and extending the Mental Health Support Teams model. In consultation with schools, a package of training is being developed for support staff and some specific whole school training to help with resilience building, that will cover trauma informed practice for schools, children's anxiety about COVID-19, exam anxieties, self-harming, eating disorders, and suicide prevention. Specialist ASD pre-diagnostic support has been jointly commissioned with the NWL CCG providing support for children and families both in schools and Family Wellbeing Centres. Autism training in schools is being piloted in two Brent schools funded by NHSE and a full training programme to support schools to build capacity in meeting SEND needs earlier and to implement a new Brent Graduated Approach is being piloted via funding from the Dedicated Schools Grant. .
- 7.6 The Council has also provided £180K of recovery initiative funding to develop community based mental health and wellbeing peer support. Plans have been developed to train young people (aged 16+) as Mental Health First Aiders with young people identified via community groups and voluntary sector providers and to train

youth workers in the voluntary and community sector as Mental Health First Aiders. An expansion of a pilot project of peer to peer support in schools is also being progressed. This complements work being undertaken in the BCAP steering group regarding targeted peer support. Funding has also been made available to put in place direct interventions and support for former UASC with low-level mental health and emotional wellbeing issues.

8.0 Financial Implications

- 8.1 The council has provided recovery initiative funding for the following projects: £520K for education recovery which will be devolved through school cluster groups; £270K to commission services that provide mental health support in schools and £180K for community based mental health peer support.

9.0 Legal Implications

- 9.1 Changes to regulations during the Covid-19 pandemic have now lapsed and the local authority is operating under the standard regulatory framework.

10.0 Equality Implications

- 10.1 The council's responsibilities under the Public Sector Equality Duty as set out in section 149 of the Equality Act 2010 requires the Local Authority when exercising its functions to have due regard to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, to advance equality of opportunity and foster good relations between those who have a protected characteristic and those who do not share that protected characteristic. Protected characteristics include ethnic or national origins and colour or nationality. The Council has paid due regard to children and families' protected characteristics in providing targeted and risk assessed support based on child and family need throughout the pandemic period.

11.0 Consultation with ward members and stakeholders

- 11.1 During all phases of the pandemic period, the Strategic Director CYP has participated in the regular Member webcast briefings to provide answers to any questions members have had regarding children, families and schools. The Lead Member for Children's Safeguarding, Early Help and Social Care, and Cabinet Member for Schools, Employment and Skills are regularly briefed on children and young people's education and wellbeing recovery.
- 11.2 Early years settings and schools in Brent have been actively supported and engaged throughout different phases of the pandemic. The Strategic Director has met regularly with headteachers and Chairs of Governors as described in Section 3 of the report. Engagement with settings and schools has shaped and will continue to inform the development of education recovery and wellbeing recovery projects, funded by the Council.
- 11.3 The Children's Trust, chaired by the Strategic Director CYP, has been the formal governance structure for engagement with health partners to ensure that services for vulnerable children are supporting their wellbeing recovery. The Setting and School Effectiveness Partnership Board has been the formal governance structure for engaging with setting and schools in relation to education recovery.
- 11.4 Union representatives have been regularly engaged in regular meetings with the CYP Operational Director to discuss operational issues in settings and schools.

12.0 Any Other Implications (HR, Property, Environmental Sustainability - where necessary)

12.1 There are no specific HR, Property or Environmental Sustainability implications.

Report sign off:

Brian Grady

Operational Director, Safeguarding, Partnerships and Strategy

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 Brent	Community and Wellbeing Scrutiny Committee 22 February 2022
	Report from the Strategic Director of Community Wellbeing
Brent 2020 Legacy	

Wards Affected:	All
Key or Non-Key Decision:	Non-Key Decision
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	0
Background Papers:	0
Contact Officer(s): (Name, Title, Contact Details)	Zerritha Brown Brent 2020 Legacy Manager Email: Zerritha.Brown@brent.gov.uk Tel: 0208 973 5313

1.0 Purpose of the Report

- 1.1 In 2020 Brent was the London Borough of Culture; engaging and empowering the community through cultural experiences and placing young people front and core of the programme. 2021 signalled a move into delivery of the core legacy projects from the Brent 2020 programme as well as a new council wide approach to embedding culture into service delivery.
- 1.2 This paper provides:
- A summary of the first year of the Legacy programme, covering Council projects, new relationships with partners and the creation of Metroland Cultures
 - An account of the new ways of working with culture across the Council
 - Plans for 2022, including a cultural calendar for the year.

2.0 Recommendation(s)

- 2.1 To note the legacy ambitions from the Brent 2020 programme and the progress made to date

2.2 To note the cultural work programme for 2022

3.0 Overview of the Brent 2020 Borough of Culture

3.1 The Brent 2020 programme set out to explore the stories, art and emotions that hold life in Brent together, uncovering and celebrating the borough's untold tales and unheard voices. It was a year planned with care, hope and ambition designed to put Brent on the map and bring a new sense of optimism to people and place. As the 'Borough of Cultures' the community were an integral part, bringing local knowledge and diversity of thought to the programme engaging in areas such as the volunteer programme, community advisors, the Blueprint Collective and the community cast in the opening event, Rise.

3.2 In a year which saw disruption, uncertainty and a prompt pivot to the digital landscape, the programme continued to successfully engage and reach audiences as detailed below:

- 843,481 audiences (209,338 physical live and 634,143 non live digital)
- Vent podcasts reached 13.3m across all platforms with 74,450 listens at a 73% listen through rate.
- Brent Locked In films made by the Blueprint Collective achieved 447,890 views
- 256 volunteers gave 1,281 hours of support
- 489 artists joined the Artist Network
- 446 young people and 8342 pupils took part
- 1021 artists engaged with the programme.
- Brent 2020 grew a cultural and creative database from zero to 10,000+ and 11,000+ on social media, with 125,000 visits to the new website since its launch in November 2019 with the highest traffic generated by NBLH in November 2020 when visits more than tripled.
- 649 items of media coverage

4. Brent 2020 Legacy Programme

4.1 The Brent 2020 programme was the first step in a systemic change to an approach to arts and culture for the council and borough. The year established the arts and culture as a viable approach for community engagement, regeneration and place- making and demonstrated that arts and culture are an effective method to engage and challenge young people from across the borough.

4.2 Over the duration of the programme, a framework evolved which helped to structure the ambition into distinct and yet overlapping objectives that have been broadly grouped into four areas:

- **Pride:** raising pride in the borough by working to ensure all residents are proud to come from the borough. We do this by platforming histories, residents and culture from the borough through ambitious and exiting art programmes

Projects which illustrate how this priority has been taken forward in the legacy include Metroland Cultures and the Brent Biennial; Local Cultural Education Partnership involvement in the cultural programme for 2022; and the Kiln Theatre NW Trilogy and Wife of Willesden productions.

- **Movement in Thinking:** to ensure the council and borough stakeholders recognize the unique cultural power of Brent and mobilise it within their work

Projects which illustrate how this priority has been taken forward in the legacy include self-organising in the Artist Network; Being Brent which looks at heritage through the lens of wellbeing; the formation of a borough wide cultural coalition; and the councils move to a new way of working with culture.

- **Skills:** to support young people, artists, communities, schools and teachers to develop skills to harness cultures.

Projects which illustrate how this priority has been taken forward in the legacy include the Local Cultural Education Partnership developing a CPD programme for educators and facilitating training and work placement opportunities for young people through the cultural programme; The Royal Philharmonic Orchestra programme work in adult social care; and development opportunities for the Artist Network.

- **Infrastructure:** to create new places and equip them with creative and cultural certainty

Projects which illustrate how this priority has been taken forward in the legacy include artist residences at Metroland Studios; the proposed refurbishment of Harlesden Library; plans to animate vacant units through the Strategic Priorities Transformation fund; and establishing the cultural coalition to strengthen the social cultural infrastructure.

This framework underpins the Brent 2020 legacy programme and has also been adopted by Metroland Cultures as the *Metrolanding Framework*.

- 4.3 2021 signalled a move into delivery of the core legacy projects as well as developing a new council wide approach to embedding culture into service delivery. The legacy programme is wide ranging and includes all parts of the council and partners in delivering the core projects and new opportunities which is detailed in the following section.

5. Brent 2020 Legacy Projects

The Local Cultural Education Partnership

- 5.1 Brent 2020 saw young people placed front and centre of the programme, from the Blueprint Collective to the Education Programme. To build on this, the council committed to establishing a Local Cultural Education Partnership (LCEP), a cross-sector strategic partnership aimed at embedding culture in

teaching and learning and unlocking creativity and critical thinking in children and young people through access to cultural opportunities. The LCEP sits within the Children and Young People (CYP) team (led by the Operational Director, Safeguarding, Partnerships and Strategy), where it will be incubated for an initial 18 months with the long term aim of the LCEP becoming an independent entity embedded in the cultural infrastructure. During 2021 the CYP team and Brent 2020 Legacy Manager began the process of setting up the LCEP, recruiting the LCEP Manager in July 2021 to lead on the day to day management of the programme and establishing the LCEP Leadership Group in September 2021. Members of the group include cultural organisations and schools to shape and steer the programme, bringing a wealth of cultural capital and the education sector to the table: The Kiln (Theatre / Community arts); the Royal Philharmonic Orchestra; Brent Music Service; Metroland Cultures; Mahogany Arts (Carnival Arts); Fubu Nation (Dance); Fawood Nursery; Manor Special School; Alperton Community School; University of Westminster; ICMP (Institute of Contemporary Music and Performance); Young Brent Foundation and LCEP Ambassadors. A Youth Advisory Board has been established to ensure that youth voice drives the LCEP. Young people who have been recruited to the Youth Advisory Board are meeting monthly with the LCEP Ambassadors (young adults working in the creative industries from the Blueprint Collective) to develop an innovative creative and cultural offering in Brent that is accessible and culturally resonates with Brent's children and young people.

5.2 The LCEP's ambitions are that:

- Every child and young person in Brent engages in arts and cultural experiences that build a strong sense of identity and wellbeing
- Young people's life opportunities are enhanced through access to pathways into the creative industries
- Arts and culture stimulate critical thinking across the curriculum

5.3 The LCEP aims to raise the aspirations of Brent's children and young people through a range of arts and cultural experiences, access to seminars and workshops, work experience placements and internships.

- ***Communications and Reach*** - The LCEP communication strategy has been shaped by a request from teachers for information about local cultural organisations and access to artists, funding opportunities, workshops, subsidized theatre tickets and cultural opportunities across the borough. A monthly LCEP newsletter that promotes cultural projects and work experience opportunities is disseminated widely across the local education sector and professionals who work with children and young people and a directory of local creative and cultural institutions and businesses is being developed. In re-establishing an education cultural leads network, communications about the LCEP have been circulated to all schools and colleges. The LCEP manager has had direct contact with around 70% of nurseries, schools and colleges over the past 6 months and currently around 35 schools are actively engaged. The LCEP manager is also engaging with services that support Brent's most vulnerable young people, including Brent Virtual School, Looked After Children, Carer Leavers, the Youth Offending Service and Family Wellbeing Centres.

Infrastructure: physical and social

- 5.4 **Infrastructure** - The Brent 2020 programme highlighted the lack of spaces across the borough for artists and creatives and the need to look at how we can potentially harness opportunities through the council's infrastructure projects. Metroland Studios in Kilburn Square was the Council's first venture into exploring the viability of repurposing a building into a temporary place for artists. Fourteen studios have been made available for artist residencies until autumn 2022.

During 2021 initial discussions began within the (Housing Building Management) New Council Homes programme with the potential of identifying sites as part of the housing supply infill programme, which could be repurposed and offered as temporary spaces for performance or artist studios. There are also opportunities for visual arts commissions in the public realm through the programme. The Brent 2020 Legacy Manager will continue conversations with colleagues in Housing Management as well as contractors to move these projects forward. In the long term, the NCHP programme will aim to deliver temporary space on an ongoing basis over the next 5 years.

- 5.5 **Artist Network** - During Brent 2020, the Artist Network proved to be a much needed resource for creatives in the borough to network and access training and employment opportunities. The evaluation of Brent 2020 highlighted the need to sustain and develop the Artist Network as part of the Legacy. In June 2021 the council received a £5k grant from the OPDC Small Grants Fund to undertake a research and development (R&D) project with the Artist Network to understand the needs and aspiration of creatives in the borough. Brent based creative organisations Mindspray Associates and Jeanefer Jean Charles Associates were commissioned to deliver this between June – December 2021. Their work included facilitating network and consultation sessions along with growing the network which attracted a further 50 members during this period. This revealed a strong desire amongst the Network to gain access to a building for creative activity and to become a self-led and incorporated organisation. Work has begun on both areas. The Network is now meeting independently and individuals are coming forward to form a collective to take on its management. Metroland Studios have offered the Artist Network a studio until autumn 2022 and there is an aspiration that the Preston Road unit will be a creative hub which they can part of developing. The Brent 2020 Legacy Manager will continue to support the network to build their capacity and explore sustainable operating models.

- 5.6 The Artist Network has created a space for opportunities, collaboration and employment for creatives in the borough. Following a major call out, FubuNation, Mahogany Carnival Design, Brent Youth Theatre, Word Up and Yasmin Nichols were commissioned by Wembley Park and the Royal Philharmonic Orchestra to create content for their inaugural event, Wembas Dream in September 2021 which was attended by nearly 1500 people. Brent based Other Cinemas, an organisation who support Black and non-white filmmakers were commissioned by Brent Museum and Archives after a successful call out to run workshops for

young people as part of the From 'The Ground Up' exhibition, a collaboration with the National Portrait Gallery. And visual artist Kinga Markus, a new member of the network was appointed as artist in residence at Brent Archives after seeing the opportunity via the artist network.

Metroland Cultures

- 5.7 Brent's bid to be the Borough of Cultures was centered around building a legacy for the borough to ensure culture, arts and the creative industries continue to thrive and to establish Brent as a key cultural destination in London after 2020. To deliver this, a trust - Metroland Culture Limited ("Metroland") - was established. An investment of £1million over 3 years was committed by the Council to support Metroland to establish itself.
- 5.8 The investment is managed under a grant agreement over a four year period and there is an expectation for Metroland to be sustainable beyond the investment period and to demonstrate accountability for its investment to the council. The Metroland programming team have monthly meetings with the Brent 2020 Legacy Manager, with the Director of Public Health and Culture meeting with the Metroland Director monthly. A wider meeting with the full Metroland Team, the Chair of Metroland Cultures, Lead Member for Public Health, Culture and Leisure, Strategic Director of CWB and Director of Public Health and Culture take place every six months. The first one was in December 2020 where the proposal for the Biennial was presented, more information on this can be found in section 9.7. In general these meetings will be used to update on programme activity, milestone and targets (including fundraising) with a full activity and impact report due each year.
- 5.9 The first six months of 2021 was overseen by the Trustees and delivered by a skeleton team of one full-time member and 3 part time members of staff focused on wrapping up Brent 2020. This consisted of reconciling the budget and completing a series of in-depth evaluations for publications which were then handed over to the council and used as the basis for the delivery of the Legacy of the year. Alongside this Metroland Cultures ran a recruitment campaign, drawing on specialist support to attract a diverse and inclusive field of applicants, from January to April. A number of new team members took up post in June 2021. The planned appointment of a new Director did not proceed, however the post will be readvertised in spring 2022 and the Interim Director will remain in post until summer 2022. In addition, Metroland provided studios and professional development support for 14 Brent based artists alongside hosting a social space and gallery space.
- 5.10 'Making Myself Visible' was Metroland's first onsite programme which ran between September 2021 and January 2022 and brought together a series of exhibitions, talks, weekenders, workshops and schools workshops delivered in the Kilburn Square building. The premise of the programme was to explore how Metroland can be a useful organisation in the borough while platforming the artists in the studio building. It delivered three exhibitions, one Community Day and two Public View evenings. Alongside this 150 young people from Kilburn Grange Primary took part in workshops with Betty Leung; 12 women from the

Asian Women's Resource Centre took part in a workshop with resident artist Simitri Mheta; and there were over 1000 visitors across the programme.

5.11 Metroland have refined the 5 key pillars of work that will be a focus over the next 3 years:

- **The yearly artistic programme** taking the form of a festival: a Brent Biennial and Biannual Music Festival in alternate years, as a key summer programme and the most visible programme to audiences and visitors to the borough.
- **Metroland University** a 5 month paid development programme for 20 young people from Brent age 18 – 24.
- **Artist-led programme** at Metroland Studios –providing free space and professional development to 14 Brent based artists for as long as they have the space.
- **Artist Development Programme** - a yearly cohort of artists will be recruited from Brent with a focus on visual arts and music in line with the Biennial and Music festival cycle.
- **Advocacy and Partnership** work for the borough's organisations that want to work with artists in the communities they serve. Metroland bring key skills, expertise, and support to help these discussions.

6. Partnerships and Key Partner Projects in 2021

6.1 ***Beyond Brent 2020 Legacy Celebration Event*** - In October 2021, the Council and the Mayor's Culture and Creative Industries team co-hosted a hybrid event which brought together a small group of key stakeholders at the Kiln Theatre to celebrate the achievements of Brent 2020. Delivered in two parts, the first half (which was also live streamed) highlighted key achievements from the programme and took the audience through the legacy ambitions. The second part saw break-out sessions, focused on each of the four legacy commitments, creating space for stakeholders to explore how they can contribute to the delivery of the legacy. Many cultural partners were involved in delivering the event including Kiln Theatre, Royal Philharmonic Orchestra, Mahogany Carnival, Metroland Cultures, along with members of Blueprint and Artist Network. Representatives from pan London organisations such as National Lottery Heritage Fund, Arts Council England and Historic England also attended. A hundred key stakeholders attended the event in person and nearly 500 people watched the recording. Forty eight tickets to a performance of NW Trilogy were gifted to local artists and community members. Brent based speakers, freelance artists, emerging professionals and facilitators were commissioned with a budget of £4000 in line with sector Arts Council England fair pay guidance. This was to ensure the event was inclusive and took into consideration the particular issues faced by the self employed creative workforce and those in low-paid creative jobs.

'Self-employed workers in the arts tend to be high-skilled but relatively low-paid. Although two-thirds of creative freelancers hold a university degree, average income is under £20,000.' (Centre for London, 2021).

- 6.2 **The Royal Philharmonic Orchestra** - (RPO) celebrated its 75th anniversary last September by announcing a permanent move of the Orchestra's headquarters to Wembley Park. The Orchestra have been working in Brent for more than 20 years with Brent Music Service but ahead of their move are eager to embed their work into the wider Brent community. The council has been working with the RPO to facilitate meaningful and exciting opportunities for Brent communities. In October 2021 the RPO delivered a Relaxed Performance at the Civic Centre for a playful interactive introduction to orchestral music. The event featured 25 musicians and internationally renowned presenter Tim Steiner performing a range of music specially designed for people who may find traditional concerts challenging to attend, including adults and children with learning disabilities, movement disorders, autistic spectrum disorder, other neurological conditions, or those with young children or babies. The performance included interactive elements, close-up experiences of the musicians, BSL interpretation, Makaton singalong, and gentle sensory elements creating a safe space for attendees to enjoy the event without any pressure. Ahead of the event, RPO musicians attended Manor School, Millennium Day Centre and Elders Voice to deliver R&D performances and workshops where they tried out a range of techniques to connect with different audiences. Approaches that worked across all three sites were further developed to be used during the public concert event. Seventy primary-age pupils from Manor School along with 40 adults from the day centres participated in the workshops with the main event attended by an audience of 135.
- 6.3 The RPO have secured funding from the Baring Foundation to pilot a 12 month arts and mental health programme of activity in Brent. The project will be targeted at adults and young people who in the first instance have had a mental health diagnosis along with health and social care teams. The Council have worked collaboratively with the RPO to develop the programme which will include monthly creative music sessions for people in contact with CAMHS and Adult Community Mental Health, training to empower community health and care staff to use creative techniques in their daily delivery and a scheme to identify and provide training and work shadowing opportunities to local residents from ethnically diverse backgrounds to develop music and mental health creative leadership skills. Teams in Adult Social Care and Children and Young People have supported the RPO with taster sessions which began in December at Ashford Place, with the full programme to be rolled out this year. This is a new partnership born out of the Brent 2020 legacy ambitions to ensure that all our communities in the borough have access to high quality cultural experiences.
- 6.4 **Kiln Theatre** - Delayed due to the pandemic, the Kiln Theatre were finally able to deliver the NW Trilogy and The Wife Of Willesden which took place from September – January 2022. Both productions were planned as part of the Brent 2020 programme and embedded the heritage and cultural life of the borough. The Kiln welcomed 6,000 people to NW Trilogy and 12,000 bookers to The Wife

Of Willesden, of which over 50% were from Brent (an increase of 20% on the usual pattern of booking). Two thousand tickets were sold at a reduced rate to Brent residents, 400 local students came with a school group, 1,000 £10 tickets given to Under 26-year-olds, and 400 free tickets given to Brent NHS Frontline workers. The Young Brent Foundation bought 200 tickets to distribute, and they worked with Ashford place to offer free tickets to matinee performances. Both NW Trilogy and The Wife Of Willesden hit their financial targets and ended above 95% of capacity, with The Wife Of Willesden being the fastest selling and highest grossing production in the venue's history.

'NW TRILOGY is so many things: a tribute to the local communities, comic and tragic commentaries on the immigrant experience, sharply observed with a deep understanding of love' Audience Member.

'Zadie Smith's THE WIFE OF WILLESSEN is a celebration of local legends, of telling a good story and living a life worth telling.' The Guardian.

'This is Kiln's joyful invitation to its local multicultural community to come back and come round to rejoice.' Libby Purves

7. New ways of working with culture across the Council

- 7.1 During 2021, the Brent 2020 Legacy Manager has worked with Regeneration and Environment to develop cultural projects which animate high streets. £165k has been secured from the Strategic Priorities Transformation Fund to reactivate up to three vacant units on high streets across town centres for cultural programming which could include exhibitions, workshops and performance. Local artists/organisations will be offered free use of the space, be involved in shaping the programme and be able to access workshops to capacity build their practice.
- 7.2 A vacant council owned asset in Preston Road (a former sports/entertainment bar, 3-7 Lincoln Parade) has been identified as a potential space for cultural activation during 2022. We are currently seeking an organisation who can manage and programme the space in collaboration with Brent artists/creatives until December 2022.
- 7.3 Regeneration and Environment are working with the Brent 2020 Legacy Manager to secure two additional units across town centres to bring into cultural use for summer/autumn 2022. Landlord engagement has been challenging due to both a lack of available sites and genuine interest from landlords, however further engagement will be undertaken over the next couple of months to identify sites which are suitable and can be used for up to 6 month cultural use.
- 7.4 As part of the legacy the council committed to a shift in thinking across the organisation with arts and culture being viewed as an instrumental tool working across council policy. Culture has been included in the Draft Joint Health and Wellbeing Strategy within the Healthy Places priority and has been included in the Youth Strategy with the work of the Local Cultural Education Partnership feeding into this. In addition the Brent 2020 Legacy Manager has participated

in a community engagement internal stakeholders workshop hosted by the Transformation and Strategy and Partnerships team sharing examples of best practice from the Brent 2020 programme of which a couple were put forward as case studies for inclusion in an internal document developed to outline Brent's approach to community engagement. Over the year the Brent 2020 Legacy Manager has been working closely with colleagues to identify opportunities for cultural collaboration. Examples include working with the Climate Emergency Strategy Manager and the Lexi Cinema to develop a film programme for the Brent Climate Festival as well as brokering relationships with artists to support the development of the 'Let's Talk Climate' sustainable fashion workshop. Collaborations are also happening with the Black Community Action Plan, with culture as a key vehicle to start a dialogue around the contested heritage of Gladstone Park and the opportunity to present a balanced history through public art. And as highlighted previously, there is a continued relationship with Regeneration and Environment, with cultural animation of high streets through vacant units and a summer programme of high street events a key area of the Strategic Transformation Fund. A Culture Working Group has been established with colleagues from Children and Young People, Public Health, Economic Development, Communications and Libraries and Heritage who come together monthly to identify and join up cultural opportunities.

- 7.5 ***The Cultural coalition*** Through the Brent 2020 programme, extensive groundwork was undertaken to build relationships and trust with local and national cultural organisations. Throughout 2021, these relationships have continued to be nurtured with regular meetings with Brent based organisations and seeking out opportunities for collaboration between them and the council. In Summer 2021 the council took a collaborative approach to creating a cultural programme, working with cultural partners such as the Kiln Theatre, the Lexi Cinema and Wembley Park. This was the first joint curated programme which set out our intention for a more collaborative approach to culture and realised our ambition for 'Pride' within the legacy framework. A cultural coalition comprising of Kiln Theatre, Metroland Cultures, Mahogany Carnival Design, Royal Philharmonic Orchestra, Wembley Park, The Lexi Cinema, Brent Music Service, Young Brent Foundation, Fresh Arts and The Artist Network has been established with the aim of a strategic approach to culture, which through collaboration strengthens the boroughs ability to advocate for resource and investment.
- 7.6 ***Priority Place and Area of Focus*** Brent has been identified by both Arts Council England (ACE) and National Lottery Heritage Lottery Fund (NLHF) as an area of historical under funding by those organisations. Both bodies have made a commitment to prioritise resources and investment into the borough to develop the cultural infrastructure and work with the Council to develop sustainable models.
- 7.7 As an 'Area Of Focus' for NLHF, the Heritage Service were able to secure £250k through a solicited application for the Being Brent project and have received continued support from the NLHF Engagement Team. Brent will continue to be an Area Of Focus until 2024, presenting the borough with an

opportunity to build strategic partnerships with cultural and voluntary sector and secure inward investment.

- 7.8 In November 2021, Arts Council England announced 54 'Priority Places'; areas across England where their investment and engagement has been low, but the opportunity for them to effectively increase investment and engagement is high. Brent is one of the areas selected and will be a Priority Place until 2024.
- 7.9 As a result, the Council has been able to secure solicited funding from ACE to create a high quality cultural social prescribing of arts and culture development programme. The aim is to support local artists and cultural practitioners, social prescribing link workers, health professionals, including GPs and youth inclusive teams, to develop their understanding of the prescription of creative and cultural activities to people with unmet health and social needs. The programme will be delivered by the Clod Ensemble's well established and internationally recognised Performing Medicine team. The Council will work with partners, creatives and health care professionals to develop and roll the programme out this year.
- 7.10 Early discussions have begun with ACE who are keen to see a strategic and collaborative approach across the cultural sector in the borough with the Council in a lead, facilitating role. The Council are working with the cultural coalition to identify a set of borough priorities starting with the four themes of the legacy framework whilst exploring broader themes such as health and wellbeing. From this, the council will lead on developing a delivery plan, shaped by the coalition and the wider creative sector to be submitted to ACE by the end of March. The plan will inform ACEs approach to Brent and on where their investment/resources can best support the borough.
- 7.11 The Library Service are working with council colleagues on a capital development plan which will increase the capacity and opportunity to work with local artists and creatives and deliver more high quality cultural experiences to residents in library spaces across the borough. The first long term plans have just been agreed by Capital Programme Board to develop Harlesden Library (subject to confirmation of funding stream). The project will completely refurbish a disused classroom and convert it into a community and creative space to make it more accessible, welcoming and flexible to accommodate a broader offer of events and programmes.
- 7.12 In 2020, the Heritage service were awarded £250k from National Lottery Heritage Lottery Fund (NLHF) to lead a large scale project which explores health and wellbeing through the lens of heritage. The team have worked with the community to co-produce the '**Being Brent**' programme which includes a community grants programme designed to empower communities to self-organise and explore their individual heritage stories. Twelve individuals and organisations have been awarded funding by the Being Brent Steering Committee through the specially created Heritage Wellbeing Fund and have received on-going support and training including support and signposting to future funding opportunities.

- 7.13 Being Brent has created the opportunity for the Heritage Service to develop new strategic partnerships with the community and voluntary sector as well as focus on the development of the museum and archives so that it is reflective and representative of the changing environment and communities. Volunteer opportunities have been created through collaborations with charity partners Crisis, B3 and Mind where new volunteers have been recruited and have gained skills in hands-on museum collections care and computer skills through research and cataloguing. 68.5 hours of time have been donated to the project with a new cohort of volunteers who are new to Brent Museum and Archives.
- 7.14 The immersive theatre piece Coal Dole and Dinner Ladies hosted at The North London Tavern in Kilburn was hugely successful with sell out performances and 249 people attending over the course of the run. Through ticket sales and additional donations £1000 and 15 bags of food were collected for Mutual Aid Food Willesden, exceeding all expectations.

Two of three spotlight films, Being Green and Being Alive, which explore green spaces and environment and faith and religion respectively, have been created with the third film Being Brave (focussing on home and identity) due to be released in Spring 2022.

- 7.15 In conclusion, in 2021 the Council has made good progress in the first year of the legacy programme and in delivering the key projects. The LCEP has mobilised creatives, young people and educators to work strategically to unlock opportunities and support schools with embedding culture. The artist network has created a platform for collaboration and self-organising within grass roots creatives. Metroland Cultures has established itself, recruited to its permanent team and delivered its first programme. Building partnerships with the RPO and The Kiln has enabled the Brent 2020 Legacy Manager to broker relationships with other council departments, encouraging culture to be integrated into service delivery, but it has also supported both organisations in better understanding the local needs. Having two world class cultural organisations in Brent by default will attract wide ranging footfall but through their programming they have been able to use this as a vehicle to showcase the history and uniqueness of the borough to national and international audiences. Developing and building the cultural infrastructure remains a key priority for the council. Whilst progress has been made in facilitating meanwhile interventions, there is still a need for permanent creative space in the borough.

8. 2022 Cultural Programme

- 8.1 As we emerge from the pandemic, 2022 will hopefully see the return of audiences to events and activities. A rich and exciting programme is being delivered across Brent's cultural sector which will see activity take place between February – October 2022. The programme will provide opportunities for young people and the wider community to engage as participants and audiences, raising pride in the borough, with the aim of attracting local, national and international audiences.

Below is a summary of key projects followed by a timeline of wider activity:

- 8.2 **UEFA Womens EUROS 2022** - in July 2022, England will stage the UEFA Women's EURO (WEURO) of which Wembley Stadium will host the final (31st July 22). Brent is involved in a unique partnership of 10 Host Cities which includes Brighton & Hove, Hounslow, Manchester, Milton Keynes, Rotherham, Sheffield, Southampton, Trafford and Wigan & Leigh. Two ambitious large - scale arts projects, one small scale and one library programme have been commissioned by the FA and Host Cities that will leave a tangible legacy of community engagement; cultural leadership; health and wellbeing; civic pride and a changed national understanding of women's football and its parallels with the development of rights for women. The Royal Philharmonic Orchestra will create a bespoke musical anthem that audiences around the country can engage with to celebrate the tournament and visual artist Emma Smith will develop a large-scale public realm project which will capture, via green screen technology, film of women and girls from Host City communities moving in routines usual for them and will turn the images into holographic portraits. The holograms (subject to R&D) will be seen across 11 monolith structures forming a day-long visual arts installation in an open air space. Alongside the arts programme, an outdoor exhibition, which will run for a combined 67 weeks, reaching 600,000 people, will be augmented through each city working with their communities and girls' football teams to collect and curate local stories which will appear on a further two monoliths. Brent Museum and Archives will work with students from University Campus of Football Business (UCFB) to gather oral histories capturing stories of women in sport. These stories will be designed and edited into a sound installation positioned under the Bobby Moore Bridge and as part of an installation of historic Wembley stadium seats with embedded listening posts, located on the Wembley Park estate (supported by Quintain) for the duration of the tournament (June-July 22).
- 8.3 The date for the Emma Smith installation is yet to be confirmed, however the 30th July (day before the finals) has been earmarked. The council are working with the FA and Wembley Park on the locations for the arts programme across the estate. Brent and Hounslow will be the key London locations for the FA cultural programme expected to draw a significant footfall. The FA were successful in securing £500k from National Lottery Heritage Fund and £800k from Arts Council England to deliver the cultural programme across the 10 host cities; an investment of circa £130k per region. In addition the GLA have committed £30k to be split across Brent and Hounslow for the cultural programme. The Council has committed £40k match funding which will be taken from the annual Quintain Commercialisation funding for cultural animation which the council receives along with £19k from S106 for the Heritage programme.
- 8.4 **Gladstone Park Art Commission** - in 2020 The Mayor of London announced the Commission for Diversity in the Public Realm to review statues, street names and landmarks to ensure they reflect London's rich and diverse history and represent all Londoners. Brent undertook a review which identified Gladstone Park, named after Sir William Gladstone whose family were the

second biggest slave traders in the UK. After consultation with the Black Community Action Plan Leadership and Youth Reference Groups, a decision was made to not rename the park and surrounding streets but instead to develop a public art commission in partnership with the community to both acknowledge the park's link to slavery whilst reflecting, celebrating and amplifying hidden histories and Black leaders from or who have had an influence on Brent. Ideas are at an early stage and are currently being explored with the community.

- 8.5 Engagement has taken place with key stakeholders which include the Black Community Action Plan Leadership and Youth Reference Group, Brent Council Park Service, Friends of Gladstone Park and Willesden History Society as well as wider engagement with communities (through an online survey and public sessions), all of which have agreed with the approach and will continue to be involved in the process. Appointed artists will be expected to work with the community throughout, with workshops, volunteer and training opportunities embedded in the project. The aim is for the artwork to be installed August and October to align with the International Day for the Remembrance of the Slave Trade and its Abolition (23 August) and Black History Month. However the long term vision of the project is to create a space for learning, reflection and continued conversation with the community so this is embraced as part of the boroughs history.
- 8.6 ***Brent Biennial*** - The second iteration of Brent Biennial will happen between July and September 2022. Curatorial team is led by Eliel Jones along with 3 Brent connected artists Abbas Zahedi, Jamila Prowse, and Adam Farah.
- 8.7 ***Location of the Biennial*** - The Visual Arts Biennial and Music Festival both provide platforms to showcase the borough and its cultural and creative offer not only through its commissioning programme but also through the co-ordination on borough wide projects and responses in line with the Biennial theme and dates. The programmes will have visibility both in the borough, across London, the UK and internationally. They have the potential to work towards establishing Brent's tourism offer, attracting people to the borough and orienting Brent as arts and culture capital for London.
- 8.8 How Metroland locates the specific artworks it commissions and the communities they are presented in are important to funders and thus to the long-term sustainability of the organisation, the following considerations are key factors:
- **Engagement they want to create around the artworks:** Their approach across the programme is create art that is produced with communities, in direct response to specific communities or that will involve constant involvement with the communities where it is situated.
 - **Partnerships:** the 5 partnerships with community organisations provide them with the basis of long-term collaboration and the start of an MOU, working closely with them and where their audiences and services users are will allow us to reach those we haven't reached in the past.

- **Travel across the borough and Transport:** They want to attract audiences from both inside and outside the borough to Brent, ensuring audiences can travel easily and safely between a number of commissions will be key to ensure a good experience of the programme and that audiences feel like the time they invest in coming to see the programme is well spent.
- **Repeat visits:** They don't think it would be possible to see all the commissions in one trip across the borough so want to ensure if audiences can only come once there is enough of a volume of commissions close by to get an experience of the borough and the biennial.
- **Covid:** They are still working on contingency plan should another lock down come in place this would see a shift of focus to local audiences being able to walk around commissions in the public realm so a consistent micro narrative for each group of commissions would be important.
- **Partners Strategic Focus:** Focusing programming in areas of low artistic engagement is major priority focus for investment and funding. There is also a similar focus of investment from the National Lottery and Heritage Fund into work with communities located in areas of higher deprivation.
- **Resource:** The Biennial programme does not have the resources to ensure there is something in every part of the borough so taking an approach not only in the siting of the artwork but in partnerships, recruitment to the development programmes (Metroland university and artist development scheme) alongside matching this alongside wider plans for the Music Festival in 2023 creates a model where over 3 years of investment from the council we can work across the entire borough.

8.9 **Local Cultural Education Partnership** - In 2022, the following programme of activities are planned for the LCEP:

- **A programme of CPD for teachers** - Schools have shaped a programme of CPD focused on embedding creativity into the curriculum and expanding the cultural offer in schools. The programme will link schools with local artists and collaborative projects. It will cover how the arts can support mental wellbeing; funding opportunities and bid writing; the Black Curriculum; and upskilling school staff in Arts delivery and Arts Mark.
- **Branding Agency** - Working alongside a Brent based graphic design company, young people aged 16-21 will participate in a design agency creating branding strategies for the LCEP and LCEP partner activities. The aim is to draw on the wealth of art and design talent of Brent young people and to help them apply their talent in a work experience setting. The selected group of young people will be guided to not only develop the LCEP branding, but also their own portfolio. The aim is to have finished products by early summer 2022.
- **LCEP involvement in 2020 cultural events** - 13 July 2022 will see Brent Makes Music return to the SSE Wembley Arena for the biennial event organized

by Brent Music Service (BMS). The LCEP has recruited a creative producer to work with BMS to create additional creative content (dance, carnival, photography and film) and work placement opportunities for young creatives in the borough as part of the event. Fifteen hundred young people will perform and the aim is that at least 200 young people are involved in designing and delivering the event. Secret Cinema will be presenting 'Bridgeton' an immersive cinema experience in Wembley. The LCEP will be working with them to offer workshops and work shadowing for secondary schools as well as an adapted age appropriate Secret Cinema experience for up to 500 young people from Brent schools. Mahogany Arts will be including Brent young people in preparation for and participation in a showcase of carnival in the Queens Jubilee parade down the Mall in June.

8.10

2022 Activity Timeline	
Date	Activity/Event
February – May 2022	RPO WEURO22 workshops
March 2022	Priority Places Delivery Plan and delivery plan submitted to Arts Council England
March – April 2022	Kiln Theatre present Black Love
22 March 2022	Secret Cinema present Bridgeton screening for secondary schools
April 2022	Secret Cinema present Bridgeton workshops for secondary schools
April 2022	Commission artwork for Gladstone Park
May 2022	Kiln Theatre new production
May 2022	Vacant Unit project starts in Preston Road
June/July 2022	WEUROS22 Heritage project installed in Wembley Park
June/July 2022	Kilburn High Street Cultural Programme
June/July 2022	Kiln Theatre new production
23 June 2022	Windrush programming at Willesden Library
July 2022	Brent Biennial starts
13 July 2022	Brent Makes Music
30 July 2022	WEUROS22 RPO Hype Day and Emma Smith installation
July 2022	Wembley Park Busking
July 2022	Kilburn, Neasden and Willesden High Street Cultural Programme
August 2022	Install of artwork at Gladstone Park begins
August 2022	Brent Biennial
September 2022	Brent Biennial ends
September 2022	Church End and Harlesden High Street Cultural Programme

October 2022	Gladstone Park artwork installed with programme of activity
October 2022	Vacant Unit animation – Locations tbc

- 8.11 The Brent 2020 Legacy Manager will work with the Head of Communications to ensure that the cultural programme is promoted across the borough and to wider audiences. The WEURO22 cultural programme will be amplified by a robust communications campaign which the FA and GLA will lead on. As a host city, the council will be able to capitalise on this exposure which will drive footfall to the borough. In addition, the council will collaborate with cultural partners to curate a brochure distributed through libraries, sports centres, and GPs for local audiences.

9.0 Financial Implications

- 9.1 The Brent 2020 Legacy Manager is responsible for managing the £1m grant to Metroland over 3 years.
- 9.2 The Council has committed £165k from the Strategic Transformation Fund which the Brent 2020 Legacy Manager will oversee with colleagues from Regeneration and Environment.
- 9.3 Funding has been secured via the FA for the WEURO2022 Cultural programme of which circa £130k has been allocated to Brent. This budget will be held directly by the FA along with £30k from the GLA.
- 9.4 The Brent 2020 Legacy Manager is responsible for managing the £125k commercialisation funding from Quintain for cultural activation.
- 9.5 The Local Cultural Education Partnership has been awarded £50k from the Arts Council via the organisation A New Direction, conditional upon match funding from the Local Authority secured from Community Wellbeing.
- 9.6 Over 2021, the council has continued to see financial benefit from being the borough of culture, attracting new partnerships and funding to deliver culture across the borough. The table below illustrates the investment in culture:

Summary of All Funding Streams	
Source	£'000
Grant to Metroland	1,000
Strategic Transformation Fund	165
FA funding for the WEURO2022	130
GLA funding	30
Quintain commercialisation funding	125
Arts Council funding via A New Direction	50
Total	1,500

- 9.7 The Brent 2020 Legacy Manager will continue to work collaboratively with stakeholders and the cultural coalition to attract inward investment from Arts Council England, National Lottery Heritage Fund and other funding sources which strengthens the cultural infrastructure.

10.0 Legal Implications

- 10.1 Given the nature of the report, the legal implications arising from it are limited.
- 10.2 There are a number of initiatives forming part of the Brent 2020 legacy that will require ongoing input from the local authority. For example, the establishment and funding of Metroland Culture Limited by way of a grant funding agreement that requires appropriate outputs and the involvement of a council representative on the Board will require ongoing monitoring during its 4 year term. The establishment of a Local Cultural Education Partnership with the intention that it become an independent entity will require legal input for its formation and operation. Also, the intention to make use of premises for meanwhile space will require the ongoing issue of leases and licences, with such flexibility of use supported by the Brent Local Plan.

11.0 Equality Implications

- 11.1 There are no equality implications arising from this paper

12.0 Consultation with Ward Members and Stakeholders

- 12.1 N/A

13.0 Human Resources/Property Implications (if appropriate)

- 13.1 N/A

Report sign off:

Phil Porter

Strategic Director of Community Wellbeing

	Community and Wellbeing Scrutiny Committee 22 February 2022
	Report from the London North West University Hospitals NHS Trust
Maternity Services at Northwick Park Hospital	

Wards Affected:	All wards
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	Two: - Appendix 1 – CQC Inspection Progress Update February 2022 - Appendix 2 – CQC Northwick Park Hospital Inspection Report October 2021
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Lisa Knight Chief Nurse London North West University Healthcare NHS Trust lisa.knight17@nhs.net

1.0 Purpose of the Report

- 1.1 To provide the Committee with an update on progress with delivering the CQC Improvement Plan for Maternity Services at Northwick Park Hospital following the inspection in April 2021.

2.0 Recommendation(s)

- 2.1 To note the progress with delivering the CQC Improvement Plan and to receive and discuss the CQC follow up Inspection Report issued on 24th December 2021.

3.0 Detail

3.1 Executive Summary

The LNWHT Trust Board at its January 2022 Public meeting received a progress report on delivery of the original CQC inspection report Improvement Plan developed following the inspection in April 2021 which was reported and discussed at this Committee in August 2021. The link to the latest version of this Improvement Plan is detailed in the attached report. In addition, the CQC undertook a follow up unannounced focussed inspection of the Maternity Services in October 2021. The report was published on 24th December 2021 with an improved rating for the Maternity Services, from 'inadequate' to 'requires improvement'. The CQC did not identify any 'must do' actions. Some 'should do' actions were identified.

Rating	August 2019	April 2021	October 2021
Overall	Requires Improvement	Inadequate	Requires Improvement
Safe	Requires Improvement	Inadequate	Requires Improvement
Effective	Good	Not rated	Good
Caring	Good	Good	Good
Responsive	Good	Not rated	Requires Improvement
Well led	Requires Improvement	Inadequate	Requires Improvement

The report identified 16 'should do' actions which were already being addressed by the Maternity Services through the Maternity Improvement Plan. The progress of completing these actions will continue to be monitored through the Maternity Improvement Group (MIG) and the Divisional Clinical Governance Group (Section 2 of the report).

Should do actions	Complete	In progress	Overdue
16	4	12	0

The CQC's full report is attached for information along with a progress report on delivering the Maternity Improvement Plan.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Equality Implications

6.1 To ensure maternity services provide equal access, care and quality of services to all the patients it serves.

Report sign off:

Lisa Knight

Chief Nurse

London North West University Healthcare NHS Trust

CQC maternity services inspection 25-26 October 2021

Progress update, February 2022

1 Introduction

The CQC undertook their second unannounced focussed inspection of LNWH Maternity Services on 25 and 26 October 2021.

The report was published on 24 December 2021 with an improved rating for the Maternity Services, rising from 'inadequate' to 'requires improvement'. The CQC did not identify any 'must do' actions during this inspection. They did identify some 'should do' actions, which are examined in more detail in Section 2.

The overall ratings for the Trust have not changed as a result of this inspection.

Below is a comparative table of the maternity unit's last three inspections.

Rating	August 2019	April 2021	October 2021
Overall	Requires Improvement	Inadequate	Requires Improvement
Safe	Requires Improvement	Inadequate	Requires Improvement
Effective	Good	Not rated	Good
Caring	Good	Good	Good
Responsive	Good	Not rated	Requires Improvement
Well led	Requires Improvement	Inadequate	Requires Improvement

2 Progress so far

The 'must do' actions which had been identified in the report following the April 2021 inspection were completed in June 2021. The maternity service continues to embed these improvements.

The latest CQC report noted further improvements across several areas, including sharing learning from incidents, updating risk assessments for every patient and the improvement around audit with the appointment of an audit midwife. The CQC particularly complimented the new divisional leadership team, whom they felt understood and managed both the priorities and the issues of the service.

Inspectors also found that staff had a greater understanding of the cultural and religious needs of people in our local communities.

The 'should do' actions from the latest report, with allocated deadlines, have been incorporated into the Trust's [Maternity Improvement Plan](#) and will be monitored monthly at the Maternity Improvement Group.

Action Plan

The report identified sixteen 'should do' actions. The main areas for improvement include having skilled and experienced staff, being up to date with mandatory training, keeping equipment clean, operational and stocked-up, documentation and improving triage and induction pathways.

The table below summarises the progress with completion of these actions.

Should do actions	Complete	In progress	Overdue
16	4	12	0

Immediate actions

Four actions have been completed and processes are in place to monitor compliance through spot checks and audits. The four completed actions relate to:

- Maintaining infection prevention and control standards by ensuring equipment is clean and marked as clean. ***Daily spot checks are being undertaken to monitor compliance.***

- Ensuring that the resuscitation trolleys have in date equipment and products. ***Daily spot checks are being undertaken to monitor compliance.***
- Ensuring that cold cots are repaired and in good working order. ***All old cots have been replaced with new cots.***
- Ensuring that the triage log sheets are secured within women notes. ***This has been put in place and will be monitored through audits.***

Medium-term and long-term actions

Actions related to compliance with mandatory training, drug storage and documentation are part of the medium-term plan.

The service is reviewing the governance structure, induction of labour pathway and identifying the appropriate platform to restart the antenatal classes as part of the long-term plan. The maternity service continues its journey to embed the improvements already commenced.

3 Next steps

The progress against the actions will be monitored through the Maternity Improvement Group and reported at the Women's and Children's Divisional Clinical Governance Meetings.

The quality assurance and compliance team will work with the service to provide assurance on the progress with the action plan.

Attached: CQC's Full Report

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London North West University Healthcare NHS Trust

Northwick Park Hospital

Inspection report

Watford Road
Harrow
HA1 3UJ
Tel: 02088643232
www.lnwh.nhs.uk

Date of inspection visit: 25 October 2021 and 26 October 2021
Date of publication: 24/12/2021

Ratings

Overall rating for this service

Requires Improvement 

Are services safe?

Requires Improvement 

Are services effective?

Requires Improvement 

Are services caring?

Good 

Are services responsive to people's needs?

Requires Improvement 

Are services well-led?

Requires Improvement 

Our findings

Overall summary of services at Northwick Park Hospital

Requires Improvement   

London North West University Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospitals and community services across Brent, Ealing and Harrow.

London North West University Healthcare NHS Trust operates hospital services from three main hospital sites:

- Northwick Park Hospital
- Ealing Hospital
- Central Middlesex hospital.

The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people. The trust was last inspected in 2019 and was rated requires improvement overall.

The trust provides, urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children and young people services, end of life care and outpatient services.

The trust provides a range of community services including: dental services, sexual health services, paediatric audiology, musculoskeletal specialist and end of life care.

We inspected one core service at Northwick Park Hospital.

Our inspection was unannounced to enable us to observe routine activity. Before the inspection we reviewed information we had about the trust based on the intelligence we had received.

We carried out an unannounced inspection of the maternity service on 25 and 26 October 2021 at Northwick Park Hospital to follow up the concerns we identified at our previous inspection of the service in April 2021 where we had rated safe and well led as inadequate.

Maternity Services:

Our rating of this maternity services at Northwick Park Hospital improved. We rated this service as Requires Improvement overall at this inspection. We rated safe, responsive and well led as Requires Improvement. We rated effective and caring as Good. We rated it as requires improvement because:

- The service did not always have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Waiting times were longer for women across maternity services when staffing levels were low.
- Mandatory training compliance was still not in line with the trust target of 85%. At 84% compliance, this did not meet the trust target of 85% but was an improvement on previous compliance.

Our findings

- Staff did not always observe control measures to protect women, themselves and others from infection. Some equipment marked as clean had surface dust.
- There was some out of date equipment on resuscitation trolleys and cold cots had been out of operation for two months.
- We saw loose triage log sheets which could become detached from women's notes and meant that information could be misplaced. Records when staff had spent 'Time alone' with women were still not always being recorded at every antenatal appointment.
- We found an open trolley on the delivery suite which contained two drugs vials. There was a risk that unauthorised people could have access to the vials.
- Antenatal classes had been reduced as a result of the logistics of providing classes during the COVID-19 pandemic and staff availability. We were told that videos and online classes had been planned, but these had not been implemented.
- The triage policy was to admit women on their third call in 24 hours to explore any concerns. However, there was no system of recording the time at which women with concerns had previously called.
- Staff on the maternity day assessment unit (DAU) told us there was no clear policy or pathway for women that should go to triage and women that should go to DAU.

However:

- New interim leaders had the skills and abilities to run the service. The new managers understood and managed the priorities and issues the service faced. However the trust needed time to embed this improved leadership and also to forge a period of stability by making permanent appointments to the leadership team.
- In response to external reviews of the service, managers had produced a maternity improvement plan, this was reviewed and updated weekly.
- There had been improvement in doctors, nurses and other healthcare professionals working together as a team to benefit women.
- Work was in progress to ensure staff completed and updated risk assessments for each woman and took action to remove or minimise risks.
- Staff on triage used the modified early obstetric warning score (MEOWS).
- Work was in progress to monitor domestic abuse being assessed at all antenatal appointments.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service had information boards which carried updates for staff on the maternity risk register.
- Policies and clinical guidelines we viewed were up to date and had dates for review.
- The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and development.
- The service had recently employed an audit midwife and a risk midwife to ensure monitoring of patient outcomes and benchmarking of service provision.
- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Our findings

- Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Professor Edward Baker Chief Inspector of Hospitals

How we carried out the inspection:

We visited maternity services at Northwick Park Hospital on 25 to 26 October 2021. During the inspection we visited the labour ward, postnatal and antenatal areas, admission triage area, day assessment unit and theatres. We conducted interviews with staff members on the 25 and 26 October 2021. We spoke to 31 staff including service leads, matrons, midwives, medical staff and maternity care assistants. We also reviewed the trust's performance data and looked at trust policies for the maternity service. You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection>.

Maternity

Requires Improvement  

Our rating of this maternity services at Northwick Park Hospital improved. We rated it as requires improvement because:

- The service did not always have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Waiting times were longer for women across maternity services when staffing levels were low.
- Mandatory training compliance was still not in line with the trust target of 85%. At 84% compliance, this did not meet the trust target of 85% but was an improvement on previous compliance.
- Staff did not always observe control measures to protect women, themselves and others from infection. Some equipment marked as clean had surface dust.
- There was some out of date equipment on resuscitation trolleys and cold cots had been out of operation for two months.
- We saw loose triage log sheets which could become detached from women's notes and meant that information could be misplaced. Records when staff had spent 'Time alone' with women were still not always being recorded at every antenatal appointment.
- We found an open trolley on the delivery suite which contained two drugs vials. There was a risk that unauthorised people could have access to the vials.
- Antenatal classes had been reduced as a result of the logistics of providing classes during the COVID-19 pandemic and staff availability. We were told that videos and online classes had been planned, but these had not been implemented.
- The triage policy was to admit women on their third call in 24 hours to explore any concerns. However, there was no system of recording the time at which women with concerns had previously called.
- Staff on the maternity day assessment unit (DAU) told us there was no clear policy or pathway for women that should go to triage and women that should go to DAU.

However:

- New interim leaders had the skills and abilities to run the service. The new managers understood and managed the priorities and issues the service faced. However the trust needed time to embed this improved leadership and also to forge a period of stability by making permanent appointments to the leadership team.
- In response to external reviews of the service, managers had produced a maternity improvement plan, this was reviewed and updated weekly.
- There had been improvement in doctors, nurses and other healthcare professionals working together as a team to benefit women.
- Work was in progress to ensure staff completed and updated risk assessments for each woman and took action to remove or minimise risks.
- Staff on triage used the modified early obstetric warning score (MEOWS).
- Work was in progress to monitor domestic abuse being assessed at all antenatal appointments.

Maternity

- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service had information boards which carried updates for staff on the maternity risk register.
- Policies and clinical guidelines we viewed were up to date and had dates for review.
- The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and development.
- The service had recently employed an audit midwife and a risk midwife to ensure monitoring of patient outcomes and benchmarking of service provision.
- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Is the service safe?

Requires Improvement  

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with it.

- During our previous inspection in April 2021, we found staff were not compliant with the trust's 85 % mandatory training target. During this inspection we found the overall rate had improved. During this inspection we found that the trust had taken action to improve the overall compliance rate despite the challenges of the COVID-19 pandemic. The trust sent a maternity services dashboard dated 2 November 2021. This showed that overall divisional compliance with mandatory training was 84% which was an improvement from the last inspection but was below the trust target of 85%.
- Mandatory training included fire safety, infection control, safeguarding adults at risk and safeguarding children levels one to four, equality and diversity, health and safety, information governance, and resuscitation basic life support (BLS).
- The overall compliance rate for midwifery staff was 81%. This was below the trust's 85% target. The modules where compliance was below the trust's mandatory training target were: fire safety (72%); manual handling level 2 (76%); resuscitation BLS (63%).
- Medical staff received mandatory training, but some were still not up to date. The overall compliance rate for medical staff was 83%. One module was below the trust's 85% target, this was resuscitation BLS (63%). However, the overall compliance rate was an improvement on medical staff mandatory training rates at the time of our previous inspection in April 2021.
- Mandatory training met the needs of women and staff. Mandatory training and learning updates were provided weekly to staff. Records of attendance were in place and reviewed weekly. Staff non-compliance with mandatory training was dealt with individually.

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- The service had a maternity practice learning team. However, the trust's learning and development team, not the maternity practice learning team, monitored mandatory training compliance. Staff received a notification from the trust's learning and development team when training was due to be updated. Staff told us their line managers also received a notification to inform them when their training was due to be updated.
- Following our inspection, the service informed us that there was a plan to ensure compliance. However, we were not provided with the plan.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Although not all staff were up to date with safeguarding training, staff knew how to recognise, and report abuse and they knew how to apply it.

- The service had a designated team of safeguarding midwives. This team consisted of two named professional team leads and five band 7 midwives including the Female Genital Mutilation (FGM) midwife. All staff received level 2 safeguarding adults and safeguarding children training. Clinical staff received level 3 safeguarding adults and safeguarding children in accordance with intercollegiate guidance 2019 and 2020.
- Staff we spoke with knew how to identify adults and children at risk of abuse and worked with other agencies to protect them. Staff knew how to make safeguarding referrals and who to inform if they had concerns.
- The service's mandatory training spreadsheet dated 2 November 2021 showed that the trust's 85% target for all safeguarding mandatory training was not always met. For example, midwifery staff were not meeting the standard for safeguarding adults' level 2 (80%) and safeguarding children level 3 (70%).
- Healthcare assistants were not meeting the trust target for safeguarding adults' level 2 (70%) and safeguarding children level 3 (56%).
- Medical staff were not meeting the trust target for safeguarding adults' level 2 (80%) and safeguarding children level 3 (70%). This meant the trust could not be assured that all staff had up to date safeguarding training specific for their role.
- All staff could book safeguarding supervision with the maternity safeguarding team. Staff could use these sessions for support if they were working with a woman or baby where safeguarding risks had been identified.
- Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff told us women with safeguarding risks and a language barrier or sensory loss would always be offered face to face interpreting services.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust had a dedicated safeguarding nurse on duty, 24 hours a day, seven days a week. Staff also had access to local safeguarding agencies' contact details on the trust's intranet.
- Staff told us they completed child sexual exploitation training as part of the level 3 safeguarding training.
- The service had two midwives that led on domestic abuse, part of their role was to complete spot checks and record reviews on safeguarding and domestic abuse. At the time of inspection an audit of domestic abuse was in progress.
- During our previous inspection in April 2021 we were not assured domestic abuse was addressed at all antenatal appointments. In response, maternity services completed a spot check audit of antenatal records in May 2021 to review compliance with risks from domestic abuse being recorded at all antenatal appointments. Learning from the audit led to the service highlighting the recording of domestic abuse at team meetings and in risk newsletters. The

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service also scheduled a re-audit of domestic abuse in response, this was completed in September 2021. However, results of this audit were unavailable at the time of inspection. The domestic abuse audit was scheduled to be reviewed at the maternity unit meeting in October 2021 and the maternity clinical governance meeting in November 2021. Domestic abuse recording at every antenatal appointment was on the maternity services' risk register.

- Community midwives received prompts when booking appointments for women. These prompts included whether domestic abuse had been discussed. Community midwives had an electronic risk tool they used with antenatal and breast-feeding women. Staff told us they could not progress appointments unless social issues had been discussed and the electronic record completed.
- Community staff told us they used to have stickers for 'Time Alone'. Community midwives said the stickers indicated on women's records when community midwives had spent one to one time with them, but the stickers had been withdrawn. Community midwives said the stickers were a useful prompt when working in the community, as they were a visual reminder to discuss social issues with women at every appointment.
- The service had a lead midwife for female genital mutilation (FGM). All midwifery and medical staff were trained in recognising and safeguarding women at risk of FGM.
- Staff followed the baby abduction policy and undertook baby abduction drills. There was an up to date baby abduction policy in place. The maternity practice learning team monitored 'skill drills' for baby abduction. Staff we spoke with could describe the procedure in the event of a baby being abducted from the maternity service, including alerting security and closure of exits and entrances to the hospital.

Cleanliness, infection control and hygiene

Staff did not always observe control measures to protect women, themselves and others from infection. Some equipment marked as clean had surface dust.

- Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbows and observed hand hygiene procedures. Staff had access to adequate supplies of PPE. There were appropriate facilities for hand washing and adequate supplies of hand gel available to staff and the public. Guidance on donning and doffing PPE was available to staff across maternity services.
- Equipment we checked throughout the inspection had up to date safety testing, including resuscitaires, defibrillators and blood pressure machines. Curtains were clean and in date.
- Cleaning records were up to date. The service generally performed well for cleanliness. The nominated clinical lead completed regular 'walk arounds' with the cleaning services auditor. The results of these audits were displayed in clinical areas on cleaning information boards. For example, the antenatal unit had 97% compliance with cleanliness audits in September 2021 and October 2021. In the same period the delivery suite compliance was 98% in September 2021 and 99% in October 2021. The postnatal ward (Florence ward) had 99% compliance in September 2021 and October 2021.
- During our inspection we found equipment had been labelled with 'I am clean' stickers on the delivery suite. However, we found the tops of the fetal blood testing trolley and resuscitation trolley were dusty, even though they had stickers applied.
- In the birth centre we found the underside of a cot in pool room 2 was dusty, although the upper-side of the cot was clean. We also found dust on the resuscitation trolley in the antenatal clinic. This meant there was a risk of staff using equipment that was not thoroughly cleaned, due to the equipment having stickers indicating it had recently been cleaned.

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- The service had a member of staff on duty at the main entrance to the maternity unit who conducted temperature checks and provided visitors with masks and hand gel. There were also staff at Northwick Park Hospital's main entrance conducting the same checks.
- We reviewed hand hygiene audit information for maternity services from April to October 2021. We found the lowest rate was on the birth unit (Edith ward) on the 19 September 2021 at 60%. However, there was improvement in subsequent weeks with the rate on 22 October 2021 at 100%. The hand hygiene audit for the postnatal ward (Florence ward) fluctuated between 70% on 29 August 2021 and 22 October 2021 and 100% from 14 May 2021 to 16 June 2021, as well as 16 August 2021 and 13 September 2021. All other weeks in the period were between 80% and 90%. The labour ward had 100% compliance from 31 April 2021 to 29 September 2021. This was an improvement from the previous inspection in April 2021, when compliance rates across maternity services had ranged between 70% and 80%.
- We saw hand hygiene technique posters displayed across wards and clinics.
- Women were required to do a lateral flow test (LFT) for COVID-19 on arrival at the maternity unit. Women testing positive for COVID-19 were isolated. Isolation rooms had clear signage on doors to alert staff of infection control procedures.

Environment and equipment

Overall, the design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, there was out of date equipment on resuscitation trolleys and cold cots were not operational.

- The service had suitable premises and equipment to care for women and babies and keep them safe. Women could reach call bells and staff responded quickly when called. Treatment rooms and clinic rooms were uncluttered, organised and accessible. Sharps bins were signed and dated.
- Staff carried out daily safety checks of specialist equipment. Emergency trolleys were available in every area of the department. Trolleys were checked daily and weekly, and records we viewed were up to date. However, we found out of date items on a trolley in room 8 on the antenatal ward, including blood collection sets and antiseptic solution.
- We found that the two birthing pool rooms in the birth centre had twice daily checks completed on their resuscitation trolleys. We found out of date tracheotomy tubes on trolleys in both birthing pool rooms. On the neonatal unit (NNU) equipment on the resuscitation trolleys was in date, except for two out of date carbon dioxide (CO2) detectors, which were dated July 2021. We drew this to the attention of staff during the inspection and saw that staff removed out of date equipment and replaced the CO2 detectors immediately.
- Maternity services had two surgical theatres. Both theatres were available 24 hours a day, seven days a week. If the theatres were in use, staff told us women could be transferred to the hospital's main theatres.
- Cold cots in the bereavement suite were not operational, due to failure of the cots' cooling systems. This meant bereaved parents might not be able to spend enough time bonding with their babies. (Cold cots slow down the natural changes in the body after death). Staff said the cots had been out of action for two months and they had reported this to the trust. Staff said they had not been informed of a date when the cots would be repaired or replaced.
- We saw tailgating signage on access points to ward areas reminding staff and visitors not to allow people they did not know into wards.
- Staff disposed of clinical waste safely. The hospital had facilities for the management of waste, including procedures for contaminated and hazardous waste, which staff adhered to. We saw noticeboards which displayed information for staff on colour coding for waste disposal bags.

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Assessing and responding to patient risk

Work was in progress to ensure staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

- During our previous inspection we found staff on triage did not use the modified early obstetric warning score (MEOWS). This is a way of formalising measurement of physiological variables. The values of the observations are then translated into a summary score which has a critical threshold, above which medical review and intervention is required. During this inspection we saw that the service had introduced the use of the modified early obstetric warning score (MEOWS) in triage.
- During our inspection we looked at 15 MEOWS records and found these to be complete and correct. Maternity services audited MEOWS in October 2021 and recorded 93% compliance in the use of the tool.
- Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Gaps in risk assessments were a primary feature of perinatal reports about the service, such as Health and Safety Investigation Branch (HSIB), serious incident (SI) investigations and 'Mother and Babies: Reducing Risk Through Audit and Confidential Enquiries' (MBRRACE).
- The service had identified areas where improvements were required in individualised risk assessments and had developed a risk assessment tool in response.
- The risk assessment tool at booking was on the maternity services risk register. The risk register recorded that following the Ockenden report and learning from serious incidents, a new risk assessment tool for booking and follow-up appointments was devised and implemented in March 2021. Information on the use of the tool and requirements for completion during every antenatal contact were widely disseminated to staff, through newsletters and team meetings. The service also ensured all users of the tool had completed training in use of the tool. A progress review in July 2021 of 10 risk assessment documents found 100% compliance with women being allocated to the correct pathway. However, the review found 75% compliance with continuous risk assessments, this was a drop from May 2021 when the compliance rate was 84%. In response, the service decided that risk assessments would remain on the risk register. This demonstrated the service were aware of the risk regarding documented risk assessments and were taking action to monitor risks.
- The service had introduced the 'Saving Babies Lives, version two' care bundle. Staff training on use of the care bundle was on the service's risk register. The service had taken action to mitigate risks in the use of the care bundle, including: guidance and pathways for staff; growth scans for babies identified as measuring small or at risk of growth restriction; pre-term risk assessments; dissemination of information on reduced fetal movement for staff; introduction of a fetal surveillance midwife; weekly cardiotocography (CTG) meetings with shared learning for medical and midwifery staff; the appointment of a consultant lead for the labour ward and CTG; practice development midwives working Monday to Sunday; a dedicated consultant for the pre-term clinic, and the maternity improvement group monitoring the use of the care bundle.
- Staff knew about and dealt with any specific risk issues. The London Maternity Neonatal System (LMNS) is a partnership of organisations, women and families working together to deliver improvements in local maternity services. Northwick Park Hospital used the LMNS dashboard to monitor performance and to benchmark services with other providers in the LMNS.
- The LMNS dashboard recorded the rate of puerperal sepsis as 0.8% in the year to July 2021. This was better than the LMNS network baseline rate of 1.5%. Maternity services had audited the sepsis pathway in 2020, and as a result an action plan was implemented to monitor compliance with the puerperal sepsis pathway. A re-audit was scheduled for January 2022.

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- We reviewed minutes from the maternity unit meeting, dated 27 August 2021. The minutes recorded that new recruits in the neonatal unit (NNU) would be updated on the use of an early onset sepsis calculator.
- The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The service had regular planned psychosocial multidisciplinary meetings to discuss and review the psychosocial needs of women or babies at risk. The meetings facilitated immediate referrals to members of the multidisciplinary team and were a forum to provide feedback regarding interventions.
- Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. The service had twice daily multidisciplinary handovers. We attended the 8am multidisciplinary handover on 25 October 2021. The handover had 14 incoming staff in attendance and was led by a medical registrar. Attendees included the delivery suite manager, director of midwifery, anaesthetist, and neonatal consultant. The handover included a safety briefing for the incoming shift. The service discussed elective caesarean sections for the shift and identified three women that were scheduled for caesarean sections.
- The service audited the induction of labour in April 2021, this involved the review of 21 women that had their labour induced between March 2020 and February 2021. The audit confirmed that induction of labour occurred within 48 hours in 50% of the cases but identified delays in the remaining cases. The audit found this was attributable to the capacity in the antenatal unit and delivery suite at peak times.

Midwife staffing

The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

- During our previous inspection in April 2021, there was a high Band 6 vacancy rate and high use of bank and agency staff. During this inspection we found the service still did not always have enough nursing and midwifery staff to keep women and babies safe. As at August 2021, there was a 28.7% midwifery vacancy rate. All the staff and managers we spoke with identified midwifery staffing as the main challenge for the maternity service. However, most staff we spoke with identified that staffing was improving. The Ockenden Review published in December 2020 detailed a series of immediate recommendations for all NHS hospital trusts in England to meet, with the aim of providing assurance of maternity safety within each NHS trust's maternity services. NHS trusts were asked to undertake a maternity workforce gap analysis, and to have a plan in place to meet the Birthrate Plus standard for 1:1 care for women in labour by the 31st January 2021 and to confirm timescales for implementation. The service had completed a Birthrate Plus assessment in 2019. Based on the planned establishment the ratio was 1 midwife to 23 women, however due to the high number of midwifery vacancies at the time, the ratio was 1:28. However, managers told us that in September 2021 the actual ratio was 1:31. This was worse than the 1:23 Birthrate Plus assessment.
- The red, amber, green (RAG) rated LMNS dashboard in the year up to July 2021 was green rated at a ratio of 1:28 for direct clinical care. This was slightly worse than other trusts in the LMNS network. The green standard for the LMNS dashboard was 1:30 and the red was 1:33.
- At the time of inspection, managers told us there were 53 vacancies across maternity services, this included 40 vacancies at band 6. Data provided by the trust dated September 2021 recorded that the established midwifery whole time equivalent was 229.64. The actual rate in September 2021 was 161.4 whole time equivalent staff. This meant the service had 68.24 midwifery vacancies (30%) in September 2021.

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- We viewed three sets of minutes from divisional governance meetings from July to August 2021. We found recruitment was discussed at every divisional governance meeting. Managers told us there were a number of staffing and workforce initiatives being implemented, but these were work in progress. This included the recruitment of return to practice midwives, the recruitment of general nurses, overseas recruitment, and a support package for newly qualified midwives.
- The service did not fall within the area for the London weighting allowance pay scale. Managers said this had acted as a disincentive to potential new recruits, as they could travel one station further on public transport and receive London weighting allowance. In response the trust had introduced the London weighting allowance pay scale as an incentive to recruit new staff.
- As part of the service's recruitment initiatives, the service was conducting scoping calls with band 2 and band 3 maternity support workers. This meant the service could assess the skills and attributes of potential candidates prior to the candidate making a formal application.
- Staff told us that due to staffing shortages some staff were the named midwives for multiple services. Staff said this meant the named midwives could not spend the required amount of time on the tasks expected of a named midwife.
- The number of midwives and healthcare assistants did not always match the planned numbers. During our inspection, we found the delivery suite safer staffing dashboard recorded the established number of staff for the shift was 11, when the actual number on shift was recorded as nine. The shift also had four maternity care assistants. We also found the safer staffing dashboard displayed the incorrect name of the labour ward coordinator for the shift. Staff corrected this immediately when we drew it to their attention and put the correct coordinator's name on the dashboard.
- Staff told us the birth centre was closed on the night of 24 October 2021 and staff on the birth centre had been redeployed to the delivery suite to supplement staffing on the delivery suite.
- All the midwifery staff on the night shift were agency midwives. However, staff told us they were regular agency staff and worked regularly on the delivery suite, some had worked for the trust previously. Staff on the shift told us they were supported by a band 8 on-call manager. Staff said the shift had been a quiet shift and staffing cover had been adequate.
- The maternity day assessment unit established staffing level was four whole time equivalent (WTE) midwives. However, the actual staffing level was: one full time Band 5 midwife, who was on annual leave on the day of inspection; a Band 6 midwife who worked 15 hours a week, and one full-time WTE Band 7 midwife. Staff said they had been advised by managers that there was a plan in place to recruit a further 1.5 WTE midwives to staff the antenatal unit.
- Community midwives were all permanent or bank staff. Community midwifery did not use agency midwives.
- Managers could not adjust staffing levels daily according to the needs of women. For example, on the 25 October 2021 the maternity day assessment unit (DAU) established number of midwives was two, but there was only one midwife on shift. However, the unit was being supported by two student midwives.
- One member of staff told us the service was regularly short of scrub nurses in theatres. For example, on the 25 October 2021, between 6pm and 8pm, the established number of scrub nurses required was two. The actual number of scrub nurses on shift was one.
- Managers said the recruitment of midwives was a trust priority. Staff told us they were aware of the trust's recruitment initiatives. Work was in progress on recruiting midwives from overseas. Managers said this was to balance the workforce and reflect the trust's demographic.

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- The trust provided the inspection team with dashboards which they used for the monitoring of sickness rates and rates of bank and agency use. However, these had not been completed. Following the inspection, the trust submitted sickness rates for nursing and midwifery staff which was 8.3% as at October 2021.
- The new interim director of midwifery had reviewed agency and bank usage. They found that bank and agency usage correlated with the number of shifts the service needed to cover. The review found that there was no excess use of bank and agency staff. Data from the trust showed on 30 September 2021 maternity services establishment of qualified midwives Bands 5 to 7 was 151.87. The actual number in post was 106.68. Agency staff usage was 22.86, this was 15% of whole time equivalent (WTE) staff.
- All the bank midwives had worked for the trust in a substantive role prior to joining the bank. Agency midwives told us they were on open contracts and most had worked as agency for the trust for a number of years and were familiar with the service.
- Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff we spoke with told us they received the same induction as substantive staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

- The service had enough medical staff to keep women and babies safe. Obstetricians, paediatricians and anaesthetists were available 24 hours a day. Consultant presence was provided seven days a week for 12 hours a day; with a consultant available on call for the remainder of the time.
- Consultant cover for antenatal diabetic clinics was on the maternity risk register. This was due to a lack of consultant cover for the clinics. However, we were told during the inspection that two consultants with maternal medicine and diabetes experience had been recruited and were due to take up their posts in December 2021. To mitigate the risk there was a dedicated specialist diabetic midwifery team with expertise in diabetes. Junior doctors with a specialist interest in diabetes were running clinics. Diabetes consultants and nurses from the main hospital could be remotely consulted for advice.
- The consultant covering the elective caesarean section list also covered the DAU. Staff told us there was a junior doctor on the wards who would be contacted first, but consultant input was provided by the consultant on the caesarean section list.
- The service had three locum consultants at the time of inspection and had recruited another four locums who were taking up their posts between November 2021 and January 2022.
- The dashboards provided to us by the trust had areas for the monitoring of staff turnover, sickness rates and rates of locum use. However, these were not completed for September 2021. Following the inspection, the trust submitted sickness rates for medical staff which was 0% as at October 2021. Data from the trust showed there was a 8.5% vacancy rate for junior doctors, 13.3% for registrars and 25% vacancy rate for consultants which was being covered by six locum consultants.
- The trust sent us a medical staff chart, this recorded in September 2021. The service establishment for obstetrics and gynaecology consultants was 25.10 whole time equivalent. The actual number of consultants employed was 24.75, with 4.45 of these staff being bank staff. This meant substantive consultant staffing was 93% of its establishment.
- Medical staffing identified as 'other' in the same period establishment was 48.6 whole time equivalent. The actual number of medical staff 'other' was 46.91, with 5.09 of these staff being bank staff. This meant substantive medical 'other' was 75% of its establishment.

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- Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a range of skill mixes of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.
- The red, amber, green (RAG) rated LMNS dashboard was rated as green, in the year to July 2021, for the obstetric unit providing seven day a week dedicated consultant presence for 12 hours per day.

Records

Staff kept records of women's care and treatment. There was a risk of triage log sheets becoming detached from women's notes and information on the sheets being misplaced. We found that 'Time alone' records were not always being recorded at every antenatal appointment.

- Staff on triage told us they entered calls from women in a call logbook. However, staff told us the logbooks had been withdrawn and they were using call log sheets. The trust informed us the service was planning to roll out the Birmingham Symptom Specific Obstetric Triage System (BSOTS). In the meantime, the service was using a triage log sheet which allowed an easier but more comprehensive assessment, until BSOTS was introduced and embedded. However, these were loose documents which meant there was a risk of these becoming detached from women's notes and information on the sheets being misplaced, as the information was not recorded on women's electronic patient records.
- The triage assessment had recently been updated to record the time women arrived at the service and the time they were seen. This meant the service would be able to audit and monitor the time women waited in triage before being seen by staff.
- The maternity service had a robust Situation-Background-Assessment-Recommendation (SBAR) tool to ensure appropriate risk assessment when women accessed the triage service. (SBAR is a technique which provides a framework for communication between members of the health care team about a patient's condition). However, staff on triage told us the tool was not being used and said they were not aware of any guidance on how they should use the tool. Triage staff said if a woman was moved more than once, staff in the department women had been transferred to would complete a new form.
- The service had completed an audit of the SBAR tool in October 2021. The audit found 87% were fully completed; 13%, or nine of 69 records reviewed, were not fully completed. In response, learning from the use of the tool had been disseminated to matrons. The service had scheduled a re-audit of the tool in July 2022, to ensure learning was embedded.
- The service had completed an audit of medical records in October 2021, records reviewed dated from June 2021 to October 2021. The audit found mental health risk assessments demonstrated high levels of completion. Records of the antenatal screening programme also had high levels of completion.
- Postnatal assessments were recorded on the trust's electronic record system and had a completion rate of 100%.
- Discharge summaries were sent to health visitors and GPs. The summaries included information about the women's pregnancy, labour and postnatal care, medications they had been prescribed, and any ongoing risks.
- Work was in progress to roll out a fully electronic patient records system in 2022. This was a records system widely used in the NHS and LMNS.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

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- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The maternity service used automated medicines cabinets to store, administer and reorder medicines. This ensured staff had 24-hour access to in date medicines. Staff were accountable for any medicines they used, as this was automatically reported to a central server. The automated system prevented unauthorised access to medicines and provided an audit trail, as well as reducing waste, stock and expiry risks.
- Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. We saw medicines being reviewed at a ward round.
- Staff stored and managed medicines and prescribing documents in line with trust policy. Medicines were stored in secure automated dispensing cabinets in a room allocated for the purpose of storage and dispensing of medicines. Access to the room was via a keycode, this prevented unauthorised access to the medicines room.
- Overall, staff followed current national practice to check women had the correct medicines. We found that maternity services followed best practice and had an automated controlled drug dispensing system. All the drugs we checked were in date. However, we also found the top draw of an open trolley on the delivery suite used for storing hats, contained two drugs vials. We drew this to staff attention, and they removed the vials immediately and placed them in secure storage. However, there was a risk of unauthorised people having access to the drugs on the trolley.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- During a previous inspection in April 2021 we found learning from incidents was not embedded and incidents were not escalated and graded appropriately in accordance with the services serious incident and reporting policy. During this inspection staff knew what incidents to report and how to report them. We saw guidance for staff on incidents displayed in the handover room. For example, a risk noticeboard had a 'trigger list' to guide staff on reporting incidents.
- Maternity services used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately. There was a process of review and monitoring for incidents. The maternity risk team 'walked the floor' daily to identify incidents and ensure they were reported. Incidents were reviewed locally within the maternity team and reviewed by the corporate patient safety team. Incidents were a regular agenda item at clinical governance meetings. Incidents were also reviewed as part of maternity risk update sessions. For example, we viewed a presentation from a risk update session dated 6 July 2021. During the session incident trends were analysed and actions to address risks identified. We also saw incidents being discussed during a morning handover.
- We reviewed data from the *National Reporting and Learning System (NRLS)*, this is a central database of patient safety incident reports. In the period May to September 2021, there had been: 425 'no harm' incidents; there had been 103 'low harm' incidents; 58 'moderate' incidents; two 'severe' incidents; and no deaths. We found most 'moderate' incidents related to 3rd and 4th degree tears. We also found some 'no harm' incidents relating to staffing shortages.
- In accordance with the Serious Incident Framework 2019, maternity services reported five serious incidents (SIs) in obstetrics, which met the reporting criteria set by NHS England, between May and September 2021. We viewed three root cause analysis (RCA) serious incident investigation reports. These documented actions the trust had taken in the investigation of serious incidents. The RCA reports also identified learning from incidents for staff.
- Staff told us incident reporting had been included on the inductions of both new junior doctors and new midwives to promote a culture of incident reporting. Staff told us the service was encouraging a 'no blame' culture in regards to the reporting of incidents.

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- Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us the service had focused efforts on incident reporting. This included allocating a midwife to assist with the review of incident reports. Managers told us as a result there had been a rise in the number of incidents staff were reporting.
- Never events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The service had one never event. The incident occurred in September 2021 on the delivery suite. The incident was in relation to a retained swab following an induction. The swab count was signed as correct by two signatories.
- We viewed the 72-hour report regarding the never event in September 2021. The 72-hour report identified issues as: suturing documentation not being completed, and maternal postnatal check documentation not fully completed. In response the service took immediate action and emailed all clinicians about the importance of completing and documenting swab and needle counts. A root cause analysis (RCA) investigation was in progress at the time of inspection.
- Managers shared learning about never events with their staff and across the trust. Managers also shared learning with their staff about never events that happened elsewhere. Staff told us they received regular safety bulletins and safety briefings from the risk team. The perinatal team told us they monitored information in the safety briefings. We saw safety information on swab counts displayed in the staff handover room.
- Staff reported serious incidents clearly and in line with trust policy. The London Maternity Neonatal System (LMNS) dashboard dated July 2021 recorded that the service had five serious incidents which met the serious incident (SI) criteria. Any incidents which met the criteria were subject to a 72-hour report, which was completed by the maternity multidisciplinary risk team. Incidents meeting the criteria were reviewed by the lead consultant obstetrician and lead risk midwife. The service had introduced weekly serious incident review meetings to enable learning from serious incidents to be shared across disciplines.
- Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. The duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support. Duty of candour was included in the induction training for new staff. Staff we spoke with told us they had received training in the duty of candour and were aware of their duty of candour responsibilities.
- The perinatal team had responsibility for the duty of candour. Duty of candour was a key performance indicator for the team. The team met with and submitted data monthly to the regional team to discuss the duty of candour.
- Staff received feedback from investigation of incidents, both internal and external to the service. Community midwives told us they always received feedback when they reported incidents. Maternity services had copies of the risk newsletter displayed on a noticeboard in the handover room on the delivery suite. We saw that learning from a never event was included in the risk newsletter in the form of an action plan. All staff received the risk newsletter monthly via email.
- Staff met to discuss the feedback and look at improvements to patient care. We viewed the maternity risk newsletter dated August/September 2021; this reviewed incident reporting trends as learning points for staff. We also saw that learning from incidents was on the agenda at twice daily safety briefings.
- Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We viewed a 72-hour report following a never event in September 2021. The report clearly documented that the woman involved had received verbal duty of candour and had been provided with information on how to contact the patient advice and liaison service (PALS).

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Is the service effective?

Good 

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

- Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. During a previous inspection in April 2021 we found some of the service's clinical guidelines were out of date. During this inspection we reviewed a range of guidelines including antenatal care guideline; induction of labour guideline; and the vaginal birth after caesarean section (VBAC) guideline; recovery and enhanced maternal care guideline; and breast abscess guideline. We found all the guidelines we viewed were in date and had a date for review. The induction of labour guideline had been updated to signpost staff to refer to the VBAC guidelines in cases where women had a previous caesarean section.
- The service had an antenatal care guideline, which was reviewed on 5 August 2021. This gave guidance to staff on the management of antenatal care, including antenatal bookings, risk assessment, screening, referral and follow up care. The guideline contained a flow chart with the midwifery and obstetric pathways. It also had details on how staff could access interpreters, for women where English was not their first language. The guideline had instructions for staff on booking interpreters prior to appointments to ensure they were available to support women.
- The service had 'management of sepsis in maternity guideline', dated April 2021. This was in accordance with NICE guidelines NG51: Sepsis recognition, diagnosis and early management. Managers told us the sepsis pathway was embedded. We saw information on sepsis management was readily available across maternity services. For example, staff information boards carried information on sepsis.
- The service had information boards for staff, these included best practice guidance. For example, we saw guidance for staff on group B streptococcus (GBS), this is a bacterium most women carry during pregnancy and have healthy babies. But there is a small risk that GBS can pass to the baby during childbirth and can cause serious complications. We also saw risk update boards which updated staff on risks on the maternity risk register.
- We saw that staff at handover meetings routinely referred to the psychological and emotional needs of women, their relatives and carers. Maternity services worked in partnership with local perinatal mental health services including community midwifery, health visitors and GPs, improving access to psychological therapies (IAPT), and local social care services to offer specialist care for women with mental health needs. The service offered assessment and treatment to women experiencing mental health difficulties during pregnancy and within the first year after delivery.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

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- Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women were offered a choice of menu options and dietary requirements were taken into consideration with food provision.
- A specialist breast feeding midwife supported women with feeding their babies. All women we spoke to said they had received support to breastfeed soon after birth, and this had continued in the postnatal ward. Women we spoke with gave positive feedback about the care they received with breast feeding.
- The LMNS network dashboard recorded the breastfeeding initiation rate as 91%. This was slightly better than other LMNS trusts. The percentage of babies receiving maternal breastmilk at first feed was 89%, this was amber rated on the dashboard as it was slightly lower than the LMNS baseline rate of 90%. However, the rate was better than other LMNS trusts.
- The national neonatal audit programme (NNAP) showed babies receiving mother's milk (82%) was higher than the national average (58%). However, this was a decrease on the service's rate in 2018.
- The service monitored breast feeding initiation rates on the red, amber, green (RAG) rated maternity dashboard. The service's standard was 90%. The service met the standard from April to July 2021. There was a slight decrease in August to September 2021, when the rate was 89%.
- Patient information on breastfeeding support was available throughout the department. There was a breastfeeding room for women to use with a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available. However, during our inspection we found milk fridges on the delivery suite were not locked and this created a risk that expressed milk could be removed or tampered with. We drew this to staff attention and the fridges were subsequently locked. We also found milk in the medicines room fridge which was not clearly labelled.
- A woman that was post-operative caesarean section told us she had not been offered sips of water or an intravenous drip, she said she had been in the hospital all day and only received fluids following her procedure at 2.30am the following day.
- The service had a Baby Friendly action plan. (The Baby Friendly standards provide services with a roadmap for transforming care for all babies, their mothers and families. It is an accreditation programme that enables services to support families with feeding and help parents build a close and loving relationship with their baby). The action plan identified the staff member responsible for a particular action and date for completion.
- We saw records that women's vitamin D levels were tested at booking and vitamin D was prescribed based on the results. (Vitamin D deficiency is thought to be common among pregnant women, particularly during the winter months, and has been found to be associated with an increased risk of pre-eclampsia, gestational diabetes mellitus, preterm birth, and other tissue-specific conditions).

Pain relief

Staff assessed and monitored women regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff prescribed, administered and recorded pain relief accurately. Most women we spoke with told us they received pain relief soon after requesting it. Women had access to a range of pain relief methods following NICE guidance CG190. This included gas and air and a morphine-based injection for medical pain relief during labour. However, one woman we spoke with told us their pain relief was delayed on the delivery suite for over an hour after requesting it.
- The LMNS dashboard recorded the number of regional analgesia in labour (combined spinal epidural or epidural, excluding caesarean sections) was 268 in the year to July 2021.

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Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

- The service participated in relevant national clinical audits. The service had acted on the perinatal report published by Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries (MBRRACE) in 2020. The report highlighted limited parental engagement. In response the perinatal morbidity review team (PMRT) developed a standard operating procedure for parent engagement (SOP). This SOP outlined the expected practice in communicating and involving parents in reviews.
- The service had named medical and midwifery audit leads. The service had recruited a new audit midwife. The audit midwife said junior doctors were enthusiastic about audit and some of the scheduled audits had been allocated to the junior doctors. Audits in progress at the time of inspection included an audit of agency midwives to ensure they had access to the tools needed to do their jobs and a mattress audit.
- Community midwives told us they were emailed outcomes of audits in safety bulletins.
- Maternity services used the London Maternity Neonatal System (LMNS) dashboard to benchmark their performance with other services. The dashboard enabled the service to benchmarked itself against other NHS maternity units in North West London.
- Most outcomes for women were positive, consistent and met expectations, such as national standards. The red, amber, green (RAG) rated maternity services dashboard recorded between April 2021 and September 2021, 100% of women had received 1:1 care in labour.
- We reviewed the results of an audit into jaundice in new-born babies under 28 days old, October 2021. The audit found 80% of neonatal jaundice was identified on day five or over, this did not correlate with the timing of postnatal face to face visits. Although the service were conducting further analysis into the audit, it was noted that the babies were exclusively breastfed, with half of babies having a weight loss of 9% or more at admission. The audit found that 46% of the babies readmitted were born in other trusts. In response the service had developed a recruitment plan for midwifery support workers to provide face to face breastfeeding support 24 hours after discharge; redesigned 'Baby Friendly' assessment forms, to ensure effective feeding prior to discharge; shared information from the audit in the service's risk letter; and discussed the audit at weekly staff learning sessions and divisional governance meetings. The risk had also been added to the maternity risk register to enable monitoring of the risk.
- The London Maternity Neonatal System (LMNS) dashboard, dated July 2021, was red, amber, green (RAG) rated. The dashboard indicated that there had been four still births in the year to July 2021. This was green rated on the dashboard. The crude stillbirth rate was 3.07, this was better than the 3.12 LMNS baseline rate and better than other trusts in the LMNS network.
- The LMNS dashboard recorded there had been zero neonatal deaths in the year up to July 2021. The dashboard also indicated that there had been one intrapartum brain injury in the same period.
- The babies born before arrival (BBA) rate was amber rated on the dashboard at 1%. This was the same as the lower LMNS threshold. (BBA is a birth that happens away from a hospital or birth centre setting, prior to the arrival of a midwife).
- The induction of labour rate, including premature rupture of membranes, was 32%. This was similar to other services in the LMNS network.
- The spontaneous unassisted vaginal birth rate for all maternities was 36%. This was significantly lower than one trust in the LMNS network and about the same as other trusts.

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- The rate of normal vaginal births including spontaneous and induced labour was green rated on the LMNS dashboard at 63%. This was above the 55% LMNS network recommended rate. However, normal vaginal deliveries were red rated on the trust's maternity services red, amber, green (RAG) rated maternity services dashboard. The trust's standard was 55% or above. Between April 2021 and September 2021, the 55% standard had been achieved in one month in the period, this was July 2021 (55.4%). All other months in the period were below the red RAG rated standard of 50%. In the same period, April 2021 to September 2021, the number of instrumental deliveries were green rated on the RAG rated dashboard. This meant the number of women receiving instrumental deliveries was below the service's 16% trust standard.
- The LMNS dashboard recorded instrumental deliveries, all maternities, as 13%. This was green rated on the RAG rated dashboard. This was lower than the 16.9% LMNS recommended rate. The rate for unsuccessful instrumental births was green RAG rated at 0.6%.
- Post-partum haemorrhage of >1500 ml was green rated on the maternity services dashboard in all months from April 2021 to September 2021. The highest rate in the period was 1.7% in September 2021. The lowest rate was 0.3% in May 2021.
- The rate of full dilatation lower segment caesarean section (LSCS) was RAG rated green at 3.1%. This was better than the 5.9% LMNS recommended rate and better than other trust in the LMNS.
- The total number of caesarean sections was 37%, this was red rated on the LMNS dashboard, indicating it was worse than the LMNS baseline rate of 33%. The rate of prelabour caesarean sections, elective, was 17.1%, this was amber rated on the dashboard. Caesarean section in labour, emergency, was red rated on the dashboard at 20.1%, this was worse than the LMNS baseline rate of 15%
- Emergency caesarean section rates (category 1-3) had been consistently above 20% since August 2020. This was mirrored by the elective rate rise in the same period. However, there was a rise in caesarean section rates across the North West London maternity system. The dashboard target rate was 16% for emergency caesarean section, this not been achieved for the previous 12 months. In September 2021, the emergency caesarean section rate was 23%. The indication for emergency caesarean section was predominantly fetal distress (CTG abnormalities) or failure to progress. The service informed us clinicians may have been more risk averse during this period due to infection prevention and control procedures as a result of the COVID-19 pandemic.
- The maternity services dashboard target rate for elective caesarean section was 13%. This had not been achieved for the previous 12 months. In September 2021 the elective rate was 17%. The service was in the process of a qualitative deep dive to identify factors that may have contributed to the rise in the caesarean section rate.
- Research has found that magnesium sulphate antenatally can reduce the numbers of babies born with cerebral palsy. The service's rate of women receiving magnesium sulphate antenatally was 100%.
- Women experiencing 3rd or 4th degree tears was amber rated on the LMNS dashboard at 4.6% in the year to July 2021. This was worse than other trusts in the LMNS network.
- The post-partum haemorrhage of ≥ 1500 ml was green RAG rated on the LMNS dashboard at 1%.
- The pre-term birth rate was green RAG rated at 5.6%. This was below the LMNS standard rate of 6%.
- The service participated in the national neonatal audit programme (NNAP). We viewed results from the 2020 NNAP. The service met the expected outcomes in most areas. However, the audit also found: A higher proportion of babies, (20.5%), compared to the national average, (12.4%), had temperatures over 37.5 degrees Celsius: Babies born at less than 32 weeks gestational age and surviving up to 48 hours with necrotising enterocolitis (NEC), (this is a serious gastrointestinal problem), decreased from 15.6% in 2018 to 5.6%, this is similar to the national rate of 5.5%;

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- NNAP found the average number of separation days of babies from mother, 34-36 weeks gestation, was worse than the service's performance in 2018 when the rate was 7.6 days; the rate had risen to 8.3 and was worse than the average national rate of 6.5. The service had an action plan to address the outcomes of the NNAP audit.
- Between April 2021 and September 2021 there had been no unexpected admissions to the neonatal unit (NNU). The maternity services dashboard recorded there were no cases of meconium aspiration between April 2021 and September 2021. (Meconium aspiration syndrome occurs when a new-born breathes a mixture of meconium and amniotic fluid into the lungs around the time of delivery).
- The service had no cases of hypoxic ischemic encephalopathy (HIE) between April 2021 and September 2021. (HIE is a type of new-born brain damage caused by oxygen deprivation and limited blood flow).
- Managers and staff used audit and patient outcome results to improve women's care. Following the services induction of labour audit, the scheduling of women requiring induction of labour was changed. The induction of labour pathway was also being supported by the integrated care system (ICS), (ICS are partnerships between organisations that meet health and care needs across an area and plan in a way that improves population health and reduces inequalities between different groups).
- The risk register recorded actions still to be implemented as: the recruitment of specialist breastfeeding midwives; reinstating face to face visits the day following discharge; women being required to attend children centres or the hospital for checks; and liaison with neighbouring trusts to ensure discharge summaries were identifying relevant risk factors relating to babies. The risk was due for review on 30 November 2021 and had an expected date of completion recorded as 31 December 2021.
- The service used the maternity dashboard to monitor maternal non-elective re-admissions up to 42 days after delivery. From August 2020 to August 2021, based on the total number of births of 4323, the maternal re-admission rate was 3.46%.
- The service identified that over the period of October 2020 to October 2021 the neonatal readmission rate from community to the neonatal unit was 0.4%. From October 2020 to October 2021, a total of 44 incidents were reported for babies that were readmitted to either the neonatal or postnatal ward, the readmission rate was 1.1%.
- During our previous inspection in April 2021 we found the service did not have a member of staff in post to oversee the completion of audits in the previous 12 months. During this inspection we found interim managers and staff had carried out a programme of repeat audits to check improvement over time. The service had also recently employed an audit midwife, and work was in progress on a comprehensive audit schedule for maternity services.
- Managers shared and made sure staff understood information from the audits. We saw a range of PowerPoint presentations the service had produced in response to audit outcomes. We also saw information from audits on staff information boards. Audit outcomes were also shared in risk newsletters which were emailed to all staff.
- Improvements were checked and monitored. The service had a maternity improvement plan tracker to monitor improvements in quality and safety over time.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The new interim director of midwifery was in the process of reviewing band 2 to 4 midwifery care assistant competencies. This

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was due to new managers being unable to find evidence of competency assessments for these grades of staff. Managers said the midwifery care assistants had previously been given bandings without evidence of competency. The interim director of midwifery said work was in progress to competency assess all midwifery care assistants' competencies.

- Managers gave all new staff a full induction tailored to their role before they started work. Medical staff said the time spent on induction was protected time. This meant medical staff could concentrate on being introduced to the trust's services and their roles within it.
- New midwives told us they had received an induction and felt well supported by colleagues and managers.
- The service had recently recruited six preceptor midwives. The preceptors told us they received an induction and preceptorship logbook which provided information relating to the preceptorship programme, what was expected of them as a staff member, linked strategies, the training elements of the programme, and final sign off for both induction and preceptorship.
- The service had a schedule of 'skills and drills' simulation training, including baby abduction, water births and major obstetric haemorrhage (MOH).
- Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they received regular annual appraisals. Managers told us the appraisal rate had reduced during the COVID-19 pandemic, but this was being addressed.
- Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers said they needed to further embed a culture of learning and quality improvement. The service had introduced the advocating for education and quality improvement (A-EQUIP) model of midwifery supervision. The service had seven professional midwifery advocates (PMA) to support midwives in their clinical practice and advocate for women. The PMA provided restorative clinical supervision; advocacy; and supported the service's quality improvement activities, including education and leadership for midwives.
- The maternity service had four WTE practice development midwives (PDM) in post. The PDMs had a database of staff training. Staff and their line managers received an email reminder three months prior to training expiring. However, the PDM said it was not part of their role to monitor staff mandatory training, as this was monitored by the trust's learning and development team.
- The maternity service had an integrated care system (ICS) support plan for training doctors which included mentorship and coaching from the local maternity and neonatal network. This included the service's compliance with maternity alliance for structured training (MAST) in October 2021, which provided support with parity of training opportunities across the local network, utilising opportunities for multidisciplinary education and multidisciplinary simulation training.
- Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they received regular supervision. Junior doctors said the supervisions were useful and supervisors were approachable. One junior doctor told us the consultants were good role models.
- Most junior doctors told us they received teaching on Fridays, and this was protected time. However, one junior doctor told us teaching had moved online due to the COVID-19 pandemic and they sometimes found it difficult to attend teaching sessions due to work commitments.
- Junior doctors were positive about ward rounds and said they felt fully supported on the rounds.
- The clinical educators supported the learning and development needs of staff. Maternity had offered six preceptorships to student midwives. These midwives were two weeks into their preceptorships at the time of inspection. Student midwives we spoke with told us they felt well supported in their roles. Managers told us the

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service would provide training to preceptors above that required by the Capital Midwife Programme framework. (The Capital Midwife Programme was developed in response to the growing need to apply London' solutions to the challenges faced by the London midwifery workforce, this included staff support and learning and development). Managers said as a result of the preceptorships the service had student midwives expressing an interest in joining the service once they were fully qualified.

- Practice development and risk midwives ran regular learning from incident sessions. We viewed four email invitations sent to staff. This meant staff had access to shared learning opportunities from incidents.
- Staff had access to 'Learning from' information, this was used to share learning across the service. For example, we saw a noticeboard in the handover room which had information on learning from the management of obstetric haemorrhage.
- The maternity service was in the process of transitioning the online e-learning competency assessment tool for fetal monitoring and maternity crisis management, with a cardiotocography (CTG) training simulator. Maternity had made the decision to change the competency assessments due to evidence of better perinatal outcomes with the new system. The training was being rolled out from October 2021. At the time of inspection 69% of midwifery staff and medical staff had completed the new training and the remaining staff were booked to complete the training by January 2021.
- We reviewed maternity unit meeting minutes dated 27 August 2021. These noted that audit result from the 'Keeping Mother and Baby Together' pathway found improvements were required in the recording of the skin to skin safety checklist and hypo-glycaemia pro-forma. The clinical director was rolling out further training on the use of the pathway to neonatal staff.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend. Community midwives told us they were invited to attend the risk meeting, but this sometimes clashed with their clinical commitments or they were working in the community and could not get remote access to the meeting. Community midwives said minutes from the risk meetings were always emailed to them following the meeting.
- Midwives told us there were monthly staff meetings and any policy updates and learning from incidents was shared at the meetings.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The trust was offering staff short secondments to enhance their skills and knowledge. Managers told us that it could be difficult to offer staff secondment opportunities due to staffing shortages. The shorter secondments gave staff the opportunity to develop their skills and knowledge without taking long periods away from their substantive roles.
- The trust offered the same training opportunities to agency staff as they offered to permanent and bank staff. Managers told us the service had long-term agency midwives that had worked for the service for a number of years. Agency staff were required to complete the same mandatory training as substantive staff.
- Managers made sure staff received specialist training for their role. Medical staff were trained in the use of Practical Obstetric Multi-Professional Training (PROMPT), this covers the management of a range of obstetric emergency situations. Staff told us PROMPT had moved online due to the COVID-19 pandemic.
- The service's continuity of carer (CoC) model had been paused at the time of inspection due to staffing shortages, (CoC is a model of midwifery based on the underpinning philosophy of care being based upon the natural ability of women to experience birth with minimum intervention and giving women increased choice about their place of birth). Managers told us they had discussed this with a professional body responsible for midwives, and they had been understanding due to the service's staffing situation.

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- The service had reviewed consultants job plans and had linked these to activity and the service needs.
- Managers identified poor staff performance promptly and supported staff to improve. The service had commissioned an external organisational development company to deliver a multi professional programme of training and support to the clinical leaders of the service to address behavioural and cultural issues in the staff groups.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Maternity services had a range of multidisciplinary meeting including maternity unit meetings, which involved midwives, doctors, nurses, administrative staff and senior managers from maternity and neonatology.
- There were twice daily multidisciplinary handovers. During our previous inspection in April 2021 we found induction of labour cases, staffing or bed capacity was not discussed at the meetings. During this inspection we found this had been addressed and the meeting included relevant information for staff. We attended a handover during our inspection and saw the meeting was attended by midwifery staff, doctors and senior managers.
- Staff told us the trust had identified key improvement areas. This included the perinatal midwife liaising regularly with the consultant leading perinatal mortality reviews. The perinatal team had moved into a shared office and held regular catch up meetings.
- Staff at the neonatal unit told us they always received handovers from the maternity team when babies were transferred to the unit. Staff said they could ask any questions of the maternity staff.
- Staff worked across health care disciplines and with other agencies when required to care for patients. The service was working with the London Maternity Neonatal System (LMNS). This included reviewing the opportunity for on-site presence of a multidisciplinary team to assist in delivering change. Colleagues from leadership teams at external maternity units in the LMNS had visited the service to support improvements.
- Maternity services were working with another NHS trust in the LMNS by sharing learning and data on perinatal mortality reviews.
- The service had a multiple births team that offered twice weekly twins' clinics. The team included a fetal medicine unit (FMU) midwife, midwifery assistant, and sonographers.
- The service had infant feeding specialist midwives that could support women with breast feeding. The service also had access to a dietician for support with women and babies with dietary needs. The perinatal morbidity review team (PMRT) had asked an independent external reviewer from the child death overview panel (CDOP) to be an external member at PMRT meetings.
- Staff referred women for mental health assessments when they showed signs of mental ill health or depression. The perinatal midwives could offer midwives support when working with women with mental health needs. The perinatal midwives could also offer direct support to women with mental health needs.

Seven-day services

Key services were available seven days a week to support timely care.

- Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on their care pathway.

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- Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.
- The maternity unit was open for emergency obstetric pathways 24 hours a day, seven days a week. This included women in need of emergency obstetric surgery where they had access to a senior obstetric team, including a consultant obstetrician. There was access to two obstetric theatres as well as the main theatre suite. The gynaecology rota provided additional senior level support if required.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

- Staff assessed each woman's health at booking and provided support for any individual needs to live a healthier lifestyle. The LMNS dashboard recorded 67% of all smokers were offered smoking cessation treatment at their first booking. This was worse than the LMNS 90% baseline rate and worse than other trusts in the LMNS network.
- The service had relevant information promoting healthy lifestyles and support on maternity wards and units. We saw information relating to smoking cessation in waiting areas and wards across maternity services, some leaflets were available in a range of languages. We also saw information which signposted women to the local authority stop smoking service where they could get confidential advice and free nicotine replacement products.
- We saw information boards across maternity services which gave women advice on healthy lifestyles and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

We saw examples of records where patients' mental health needs were recorded. Staff were aware of the trusts Mental Capacity Act (MCA) policy and how this could be accessed.

- Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff obtaining consent and procedures being explained to patients. Staff we spoke with understood the importance of shared decision-making with patients.
- Staff clearly recorded consent in women's records we viewed. All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients' notes.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Northwick Park Hospital was a pilot site as part of the implementation of the NHS Long Term Plan. Maternity services were involved in an ICS collaboration that involved providing psychological therapy, maternity support and peer support to women with complex mental health needs relating to their experience of loss or trauma in maternity, neonatal and perinatal contexts.

Is the service caring?

Good   

We rated caring as good.

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Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. The hospital had a bereavement suite and multi-faith prayer room. Bereaved parents could stay overnight in the hospital with their babies. Bereaved parents were provided with memory boxes and photographs.
- Women said staff treated them well and with kindness. A woman who had recently given birth told us the midwives were “very caring” and said all the staff providing care had “gone above and beyond” in providing care and treatment.
- The maternity voices partnership (MVP) told us overall the feedback they received on the care women received was good. However, there were some themes they had identified regarding the postnatal ward, (Florence ward), being busy at times and women not feeling cared for as a result. The MVP said women reported that staff could be abrupt in their communication when they were busy.
- Staff followed the trust’s policies to keep women’s care and treatment confidential. The MVP told us they had not had women raise any concerns regarding women’s privacy but highlighted how comments from staff could have an impact on women’s experiences of care.
- Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. For example, a woman on the postnatal ward told us they wore a hijab and staff had been “very good” in respecting them and providing privacy regarding this.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

- Staff gave women and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The bereavement midwife told us the trust’s chaplains could arrange multi-faith support, such as Imams for people of Muslim faith, at short notice. The trust’s bereavement midwife told us maternity services worked with a funeral director and sometimes helped bereaved families plan funeral services.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

- Staff made sure women and those close to them understood their care and treatment. Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. For example, the service had invested in translation software which could translate information into over 100 languages.
- Women and their families could give feedback on the service and their treatment and staff supported them to do this. A maternity support coordinator spoke to all patients daily about their care and produced a monthly feedback summary for the interim director of midwifery.
- Women gave positive feedback about the service. The friends and family test (FFT), (this is a questionnaire to help providers understand whether patients are happy with the service provided, or where improvements are needed, had been suspended due to the COVID-19 pandemic. The service had reintroduced the FFT in 2021. We viewed the

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service's improvement tracker, this monitored improvements over time in maternity. FFT results demonstrated an increase in women expressing satisfaction with the service over time. For example, in May 2021, 84% of respondents were positive about their care; this had risen every month until August 2021 when the rate of positive responses was 100%. For the question, would you recommend the maternity unit at Northwick Park Hospital to a friend or relative, we found the rate had improved over time. For example, in July 2021 the rate was 29%; this had risen to 56% in September 2021. However, it should be noted that the FFT response rates were low.

- Managers told us the service had a maternity support coordinator, this was midwife who spoke to all patients prior to discharge to gain feedback on their care. Managers told us the maternity support coordinator captured women's views qualitatively, and this was more useful than the FFT. Staff told us as a result of the feedback the maternity support coordinator had gathered, they had been able to identify three areas of improvement: Attitudes and behaviour of staff; transitions from the delivery suite to the postnatal ward; and triage.

Is the service responsive?

Requires Improvement



We rated responsive as requires improvement.

Service delivery to meet the needs of local people

Staffing shortages had an impact on the way the service planned and provided care to local people and the communities it served. The service worked with others in the wider system and local organisations to plan care.

- The service saw a number of women through the antenatal and postnatal periods of their pregnancy. However, staff said they had seen a reduction in the number of deliveries as a result of a proportion of women choosing to deliver their babies at neighbouring units. Staff said they thought this was due to recent adverse publicity, and this putting some women off having their babies at Northwick Park Hospital.
- Staff and the maternity voices partnership (MVP) told us antenatal classes had been reduced as a result of the logistics of providing classes during the COVID-19 pandemic and staff availability. This meant that women had not had access to information that would improve their health and wellbeing during pregnancy. We were told there had been discussions about providing videos and online classes, but these had not been implemented at the time of inspection.
- The Birth Rate Plus midwifery report, dated 31 March 2021, recorded in the year 2019/2020 there were a total of 4708 births at Northwick Park Hospital; 4207 of these were on the delivery suite and in obstetric theatres, 459 were in the birth centre, and 42 were at home.
- The London Maternity Neonatal System (LMNS) dashboard was red, amber, green (RAG) rated and dated July 2021. The dashboard recorded that from July 2020 to July 2021 the service had offered 1694 women (100%) a choice of birth settings and the number of women giving birth in the midwifery led birth unit was 1296.
- Intended home births were red on the RAG rated maternity services dashboard. This meant the service were not meeting the 1.5% standard in any months from April 2021 to September 2021. The highest number of actual home births was six in May 2021, with the lowest rate at zero in June 2021.
- The birth centre had two birthing rooms, two birthing pools and 11 postnatal beds. The delivery suite had 11 birthing rooms. At the time of inspection women were not always given the choice of water births. Staff told us this was due to staffing shortages on the birth centre.

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- The antenatal ward had 15 beds. Clinics were from 8.45am to 2.30pm. At the time of inspection, all on-site antenatal and breast-feeding classes had been cancelled due to the COVID-19 pandemic.
- Community midwifery hours were from 9am to 5pm. Managers told us the services recent improvement efforts had been concentrated on hospital-based staff. Managers said work was in progress for an improvement agenda for community midwifery. Managers said community midwives did not provide on-call services and this was one of the proposed changes in community midwifery, as well as more flexible hours. However, community midwives we spoke with told us there was an on-call rota for community midwifery. Community midwives told us they did not always feel fully included in the maternity change agenda. Home birth services were available for women who lived in the local area. However, staff said there was low demand for home birth.
- Managers told us the service served a diverse population, and maternity services needed to be tailored to the needs of the local population. Managers and staff told us the COVID-19 pandemic had an impact on maternity services and the way they were delivered, as well as on women using the service. Changes the service had to make, in response to the pandemic, meant women had to attend appointments without the support of their loved ones for a period. Maternity services had changed the layout of the unit to allow clinics to continue whilst maintaining social distancing, and community midwives had to change the way they delivered care to women outside the hospital. At the time of inspection women could attend antenatal appointments with their loved ones.
- Managers told us the service had reviewed the service's layout, due to COVID-19 restrictions. Work to upgrade the postnatal ward had been completed. Managers told us they had an agreed capital budget, and part of the budgetary plan was improvements to the flow on the ground floor, which housed the antenatal unit, triage and delivery suite. However, this work was not in progress at the time of inspection.
- The maternity day assessment unit (DAU) was housed in a small area on the ground floor. The DAU had been moved from the sixth floor. The unit was comprised of two small rooms. The rooms did not have windows or ventilation. The unit operated from 8am to 8.30pm. Staff said the unit saw up to 30 women a day. The DAU had consultant cover from 9am to 5pm. Staff said the space was cramped and that the area did not have toilet facilities.
- The DAU shared a waiting area with the antenatal clinics. Staff told us the trust did not audit waiting times for women waiting in the antenatal and DAU waiting area.
- Staff told us there were issues with the fetal medicine unit (FMU) as it was co-located with the antenatal unit. Staff told us women receiving terminations of pregnancy frequently waited 45 minutes for their appointment, in the same waiting area as women attending antenatal and postnatal clinics. Staff said this could be distressing for women.
- The service had a level 2 neonatal unit, this had eight intensive care and high dependency cots.
- The trust had invested in a new transitional care unit, (transitional care is 'in between care' for babies who need a little more nursing care and monitoring than the routine care that all babies receive on the maternity ward) and a new antenatal department.
- Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. Maternity services were a pilot site for Maternal Mental Health Service (MMHS). The MMHS was an innovative joint programme between North West London NHS mental health and maternity services. Staff also told us the community perinatal mental health team were responsive.

Meeting people's individual needs

The service took account of women's individual needs and preferences. The service had made improvements to help women access services. They coordinated care with other services and providers.

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- Managers told us work was in progress to establish the fundamentals of safe care for women. This was in response to a report on eight perinatal deaths. In response managers had worked with the Healthcare Safety Investigation Branch (HSIB). The service had recruited perinatal and trauma midwives. Managers told us they were assured that risks relating to the report had been addressed.
- The service had information leaflets available in languages spoken by the women and local community. In response Healthcare Safety and Investigation Branch (HSIB) concerns and the Mother and Babies Reducing Risk Through Audit and Confidential Enquiries (MBRRACE) annual report 2020, the service had taken measures to ensure that interpreting services were accessible to staff and patients in all clinical areas.
- Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. The service had access to British Sign Language (BSL) interpreters from an external provider. Staff could access a full range of services for women with sensory loss, this included speech to text services and lip reading.
- The perinatal midwife had developed a perinatal pathway and work was in progress on developing a perinatal mortality review tool (PMRT). Staff told us they were looking at trends in the relationship between perinatal deaths and ethnicity. Staff said the work had identified increased risks between 32 and 36 weeks of pregnancy and this was the period of gestation the service were focusing on.
- The LMNS dashboard recorded that in the previous 12 months 100% of women had been offered a personal care plan. 55% of these women had a personalised care plan and this was slightly above the LMNS recommended baseline rate of 50%. However, this was the second lowest rate of the five trusts in the LMNS network.
- Staff made sure women living with mental health needs and learning disabilities received the necessary care to meet all their needs.
- Maternity services had a specialist mental health midwifery team. Staff could liaise with the team when providing care for women with mental health needs. Women could also have midwifery provision from a member of the mental health team. The team worked closely with the community perinatal mental health team, who could provide more specialist input and care.
- Access to interpreting and translations services was monitored by the service's maternity improvement group.
- Staff had access to communication aids to help women become partners in their care and treatment. The service had introduced an interpreting and translations software product. Staff demonstrated how they could translate information into over 100 languages, including Gujarati, Romanian and Farsi, by using the trust's software. Staff told us accessing any information on the trust's intranet in other languages was simple by using the translate software.
- All labour rooms on the delivery suite had been fitted with handheld telephones. Staff said they could call a telephone interpreting service and women in the labour room could speak directly with an interpreter. Women also had access to face to face interpreting services. However, these needed to be booked in advance. Managers said they were also looking at services that could provide face to face interpreters on request.
- All wards and departments had video screens. The video screens displayed information in a range of languages.
- Managers told us the service were focusing staffing improvement efforts on employing staff from the local area. The service was also planning an initiative to recruit overseas midwives that spoke the most frequently used languages in the locality.
- Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff told us the trust had prioritised improving access to interpreting and signing services. This included women at risk of domestic abuse that did not have English as a first language always having face to face interpreters booked.

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- Community midwives told us they could book interpreters or signers as required. Community midwives said they found face to face interpreters were readily available.
- There were pathways of care for patients with learning disabilities. Women with learning disabilities or autistic spectrum disorder were identified at the booking stage and offered advice and extra support if needed. Women could be referred to the learning disability liaison officer. This was a specialist member of staff that could liaise with women and family members regarding women's needs.
- Women were given a choice of food and drink to meet their cultural and religious preferences. There were a range of menus to suit women's tastes and needs, including: religious and cultural menus, a vegan menu, and allergy aware menu.

Access and flow

People could not always access services when they needed it and receive the right care promptly.

- During the inspection we noted the birth centre was closed. Staff told us the birth centre was closed due to staffing shortages. Birth centre staff were redeployed to support the delivery suite.
- The Birthrate Plus assessment 2019/2020 found annually: 585 antenatal cases were seen on the delivery suite as the women required one to one care and for ongoing observation and monitoring. The birth centre provided intrapartum care to 459 women including postnatal care and new-born and infant physical examination screening (NIPE). There were a further 175 women who started their intrapartum episode in the midwifery led unit (MLU) but required transfer and completed their intrapartum episode on the delivery suite.
- The red, amber, green (RAG) rated maternity dashboard for the number of women delivered was red rated from April to September 2021. This meant the service's standard of 442 per month was not met in any of these months.
- The Day Assessment Unit operated a seven day a week service from 9am to 5pm. Triage was open 24 hours a day, seven days a week. Community midwives' hours of operation were from 9am to 4pm.
- The maternity unit was open for emergency obstetric pathways 24 hours a day, seven days a week. This included women who required emergency obstetric surgery. Women had access to a senior obstetric team which included a consultant obstetrician. A separate gynaecology rota provided additional senior level back up when necessary. There was access to two obstetric theatres and the main theatre suite. We saw guidance on the COVID-19 delivery pathway for women receiving caesarean sections displayed on the delivery suite.
- Staff on the antenatal unit told us things were improving when booking women's antenatal appointments. Staff said there had been issues in the past with women having appointments booked when the consultant was not working. Staff said they had raised this with managers and the rota coordinator, and this had been resolved.
- The LMNS dashboard recorded 80% of bookings were completed by week 10 of pregnancy, in the year to July 2021. This was better than the dashboard standard of 60%. However, women booked at 10 weeks plus six days at 85% was slightly worse than the LMNS dashboard standard of 90%.
- The trust had undertaken a review of the antenatal care pathway focusing on the administrative systems and processes supporting the high-risk pathway. This involved a review dating back 40 weeks to ensure all women were captured and all follow up appointments confirmed. The maternity service was also carrying out daily reviews of electronic care plans to ensure follow up appointments were confirmed. Antenatal care provision was on the agenda for discussion at the maternity clinical governance meeting in November 2021 with a view to adding the antenatal care pathway to the maternity risk register to ensure the pathway was monitored.

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- The red, amber, green (RAG) rated trust's maternity dashboard recorded antenatal bookings (excluding late referrals), as green in all months April 2021 to August 2021, this meant the service's 95% standard had been met. The standard was amber rated in September 2021, when the rate was 94.5%.
- The percentage of women delivered in the birth centre was red rated on the maternity dashboard in all months April 2021 to September 2021. This meant the service's 18% standard had not been met in any month. The highest rate in the period was 12.6% in May 2021 and the lowest rate was 8.9% in September 2021.
- Maternity triage had a flowchart displayed on the unit. This outlined women's journey from check in, assessment to treatment.
- Staff told us the triage policy was to admit women on their third call in 24 hours to explore any concerns. However, there was no system of recording the time at which women with concerns had called.
- We looked at data the service had collated in a triage audit. We found between 8 July 2021 and 6 August 2021, 17 of 71 women triaged were delayed due to staffing capacity: From 1 September 2021 to 21 October 2021, 13 of 108 women triaged were delayed due to staffing capacity.
- Managers told us there were plans to move the triage to the pre-delivery suite, in November 2021, as it would improve the flow of women using the service. An external provider of IT services confirmed that they were reviewing the triage pathway with managers, with the intention of streamlining the triage process.
- Medical staff on the DAU told us there was no clear policy on women who should go to triage and women that should go to DAU. This meant there was no clear assessment pathway for pregnant women who attended hospital with pregnancy related complications or concerns.
- During a previous inspection in April 2021, we had an allegation of poor induction pathway for women. During this inspection we found women attending the service for an induced birth arrived between 3pm and 5pm. The service had audited the induction pathway in April 2021. This identified two areas of concern, these were: a delay in commencing induction of labour: and transferring women to the labour ward. In response staff on the unit recommended changing the time of admission. Subsequent analysis from August 2021 noted that 89% women had induction of labour within two hours of arrival, this was an improvement from the audit in April 2021. The audit also found 82% of women were transferred within 12 hours of informing the labour ward. The service acknowledged that the delay in transfer required further improvement and was being monitored via audits and a daily log. The service had a re-audit of the induction pathway scheduled for December 2021. The service also intended to re-audit the pathway at regular six-monthly intervals.
- As a result of the induction pathway audit the service had added to the induction booklet a record of the time women arrived for their induction of labour. Staff told us as a result they were better able to monitor how long women had waited for their induction. The service had produced an induction pathway flowchart that gave staff a clear visual guide to the flow of women through the pathway.
- There was also a quality initiative in progress to look at improvements to the induction pathway. For example, a 'task and finish' group were in the process of setting up a new electronic induction pathway.
- The service was receiving support for maternal medicine diabetic services and fetal medicine in the form of mutual aid from other trust's in the integrated care system (ICS) with the aim of reducing waiting times on the admitted lists. The trust's theatre teams also helped with full pathway patients and weekend theatre lists.
- Managers told us waiting times for women across maternity services reflected staffing levels. Staff told us they were being encouraged to report delays as incidents.

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- The service used a tracker to monitor improvements over time. We found a sharp increase in delayed induction of labour in August 2021. The rate had risen from 2% in July 2021 to 33% in August 2021, the rate in September 2021 was 6%. The tracker recorded that staffing shortages had contributed to the high rate in August 2021.
- The service performed an average of three caesarean sections a day. Managers told us 40% of these were emergency caesarean sections. Work was in progress at the time of inspection to review the midwifery led pathway for caesarean sections.
- Staff told us there were no issues with capacity on the neonatal unit. However, there was a limited outreach service. The service had one part-time outreach nurse. Staff told us there were currently no plans to expand the service but thought service expansion would enable earlier discharge of low-weight babies and babies on oxygen therapy.
- Community midwives told us staff shortages had an impact on the ability of the service to provide clinics and home visits. Staff said clinics were sometimes cancelled and home visits were sometimes rearranged in the diary due to staffing shortages. However, managers said they were reviewing the model of community midwifery, as services should “wrap around” the women using the service. This included a review of the hours of midwifery cover in community services.
- Managers told us they had asked the trust’s operations team to look at maternity demand and capacity, this was work in progress at the time of inspection.
- The LMNS dashboard recorded that in the year to July 2021 there had been no closures of the maternity unit at Northwick Park Hospital.
- The LMNS dashboard recorded two planned home births and 12 actual homebirths. This equated to 0.9% using National Health Service England (NHSE) measurement. This was slightly less than the LMNS recommended rate of 1%.
- The service had neonatal screening and referral pathways in place, this included a mechanism that meant that babies not screened within 72 hours of birth would be identified. However, staff said the new-born and infant physical examination (NIPE) clinics for low risk babies were occasionally not facilitated due to staffing shortages.
- The national neonatal audit programme, 2020, found: the proportion of parents who had a consultation with a senior member of staff within 24 hours was 98.9%, this was higher than the national rate but slightly lower than the service’s 2018 data (99.1%).
- The LMNS dashboard recorded intrapartum transfer to the labour ward for women labouring on the midwifery led unit as 24% in the year to July 2021. The dashboard recorded intrapartum transfers to the labour ward from home, (labouring at home and intending on a homebirth), as 0%.
- Intrapartum transfers to the delivery suite from the birth centre and midwifery led unit (MLU) was green RAG rated on the maternity services dashboard in all months from May 2021 to September 2021. The service’s standard was less than 26%, the highest rate was 25% in July 2021 and the lowest rate was 6.5% in September 2021.
- The LMNS dashboard recorded there had been no maternal admissions to the intensive therapy unit (ITU) in the year to July 2021. The maternal mortality rate in the same period was zero.
- Most women receiving postnatal care were from other NHS trust hospitals. Managers told us work was in progress to improve planning for postnatal care. Maternity managers had engaged with both midwifery and medical staff with the improvement planning. The plan was scheduled to be launched on 18 November 2021.
- There was guidance for staff on transfers to the neonatal unit, ‘NNU admission criteria V2’ and ‘Neonatal transfer to MRI’. Neonates requiring transfer to other hospitals were transferred using a specialist neonatal transfer service.

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- Managers and staff worked to make sure that they started discharge planning as early as possible. Staff told us discharge planning started on admission. Women being discharged received information outlining medication needs, follow up, and contraception methods. Before departure advice was given on cot death risks including smoking and sleeping positions for their baby.
- Women with mental health needs discharge planning started at 32 weeks. The perinatal mental health team (PMHT) facilitated multi-agency pre-birth meetings to confirm discharge planning.
- The service was in the process of updating the patient electronic record to ensure it captured antenatal information on the postnatal discharge summary. This was scheduled for completion in March 2022.
- Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Women at risk due to domestic abuse, mental health or safeguarding concerns were flagged on the trust's electronic records system. This was a prompt that informed staff to look at the woman's risk assessment. Women received a discharge planning meeting. Staff told us they would not discharge a woman at risk without having planned the discharge and addressed the identified risks.
- Staff supported women and babies when they were referred or transferred between services. Women and babies were discharged from maternity, prior to being transferred to transitional care.
- Managers monitored transfers and followed national standards. We viewed the maternity risk newsletter dated August/September 2021. The newsletter identified jaundice and weight loss as the main causes of readmission. The newsletter had an action plan which detailed actions the service was taking in response, including improving communication between NHS trusts in relation to discharge summaries to identify high risk babies. This was an amber rated risk on the service's risk register. The risk was reviewed on 11 October 2021 and actions to mitigate the risk identified.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

- Women, relatives and carers knew how to complain or raise concerns. The maternity support coordinator undertook daily visits to the ward to identify and respond to areas of concern. The findings from these visits were escalated by the coordinator to matrons daily.
- The service clearly displayed information about how to raise a concern in patient areas. For example, we saw complaints leaflets in patient information racks across the service.
- Staff understood the policy on complaints and knew how to handle them. Staff told us concerns identified from feedback to the maternity support coordinator were dealt with immediately where possible. If women wished to escalate their complaints or concerns, they were provided with the contact details of the patient advice and liaison service (PALS).
- We saw patient information boards which gave details on how to make a complaint to the trust.
- Managers investigated complaints and identified themes. The LMNS dashboard recorded there was an average of six formal complaints per month in the year to July 2021. Complaints were reviewed at monthly divisional governance meetings and analysed for trends. We reviewed the minutes for the August 2021 divisional governance meeting. We found maternity had one complaint in the month, this related to staff attitude.
- The maternity improvement plan identified complaints responses and responses within agreed timescales as an improvement initiative. The improvement plan dated August 2021 recorded that the identified actions had been met.

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Is the service well-led?

Requires Improvement  

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Interim leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. The trust needed time to embed this improved leadership and also to forge a period of stability by making permanent appointments to the leadership team. Leaders of the service needed more time to embed the early signs of improvement and initiatives noted.

- The trust had introduced triumvirate teams at directorate, divisional and service levels. Maternity services sat in the trust's women's and children's division. At the time of inspection, the service had a substantive divisional clinical director and interim divisional general manager. The interim divisional general manager was contracted until March 2022. There was a new interim director of midwifery that had been in post for two months at the time of inspection.
- The service had safety champions from ward to board. The chief nurse was the executive board maternity safety champion and the trust also had a non-executive director who was a maternity patient safety champion.
- Senior managers told us the trust board was engaged with the maternity improvement programme. A senior manager told us the trust board were now aware of the challenges in maternity services and recognised that improvements in maternity must be a priority. Senior managers said the board were committed to supporting sustainable improvements. Senior managers met regularly with the maternity improvement group.
- At our last inspection there were mixed views from staff regarding support from the senior leadership. During this inspection, staff we spoke with were positive about the changes in leadership in maternity. A midwife told us they had previously left the trust and had gone to work for another provider. The midwife said this was due to issues with the management of Northwick Park Hospital maternity services. The midwife said they had seen positive changes in the managerial approach since they returned to work for the trust, with the biggest change being the visibility of senior managers.
- Some staff we spoke with said maternity services needed a period of management stability. All the staff we spoke with told us the new interim director of midwifery was approachable. A senior midwife told us, "Before it felt like them and us." This was echoed by other staff we spoke with, who told us it was a change to see senior managers being visible, wearing uniforms and working on the wards. One midwife told us they were "Impressed" by the change in the leadership approach.
- The service did not have a head of midwifery (HOM) at the time of inspection. The HOM role focuses on the operational delivery of maternity care locally. This is different from the director of midwifery, who leads and advocates for the strategic and operational delivery of maternity services locally. Senior managers said work was in progress on recruiting a HOM, but the service would not fill the vacancy until they found the right candidate. Senior managers said the service wanted to ensure they recruited the right people with the right skills in key roles.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, work was in progress on a vision and strategy focused on sustainability of services and aligned to local plans within the wider local economy.

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- Managers told us a new vision for maternity services was in development at the time of inspection. Managers said they were engaging with staff on the vision for maternity, as they wanted staff to feel included and part of the vision. Managers were also engaging with the Maternity Voices Partnership (MVP), as managers said they wanted the vision to reflect local people's priorities.
- Maternity services had introduced a maternity improvement plan in February 2021. The plan was reviewed weekly at the maternity steering group. Some midwives told us they sometimes struggled to keep up with the rapidity of change in the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- A manager told us historically there had been tensions between a few of the medical staff and midwives. At our last inspection in April 2021 some staff had raised concerns about a blame culture within the service. At this inspection, all the staff we spoke with told us there had been improvements in the culture of maternity services. Although, some staff acknowledged that it would take time for the improvements to become embedded. Staff said the trust had introduced a zero-tolerance policy regarding bullying and inappropriate behaviour from staff. Managers said accountability was on the agenda regarding staff behaviour.
- Staff told us the culture of the service had been highlighted at staff engagement meetings. Most staff we spoke with told us they felt able to escalate inappropriate behaviour from their colleagues without fear of retribution. Staff told us the service was encouraging positive behaviours. For example, the trust had a 'civility' programme to encourage appropriate behaviour towards colleagues. The service had introduced 'back to the floor' days for managers, to address issues relating to the culture in maternity. The service had also introduced 'mindfulness' sessions to provide staff with the opportunity to focus on their wellbeing.
- Midwives were attending consultant meetings to improve relationships between the medical and midwifery staff. Senior managers told us there had been improvements in medical staff engagement. For example, all the medical staff had attended an engagement meeting in October 2021. Midwifery and medical staff had also been engaged in 'task and finish' groups.
- The service had a 'people plan' which was awaiting ratification at the November 2021 divisional management group. This was based on the NHS 'people plan', which included wellbeing support for staff, tackling discrimination, making effective use of staff skills and experience, recruitment and retention of staff.
- 'Freedom to speak up' is an initiative encouraging a positive culture where people feel they can speak up and their voices will be heard. The service had increased the number of 'Freedom to speak up' champions to six staff, these included both midwifery and medical staff.
- The leadership team had fortnightly staff engagement and briefing events co-ordinated by the leadership team. There were also twice weekly executive walk rounds, which were shared by the members of the executive team.
- Cultural issues were on the service's risk register. The service had engaged with the trust's human resources (HR) team to address issues concerning the culture of maternity services. Maternity services had recently appointed two staff members as culture representatives. Managers told us this was to address issues of trust between midwifery and medical staff.
- Managers told us staff retention was a priority. The trust had offered band 2 to band 7 midwifery staff a salary uplift as part of a staff retention initiative.

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- The new management team had conducted staff listening events. Managers told us they had found these events useful in terms of hearing staff feedback and concerns.

Governance

Governance processes needed to be overhauled and time would be needed to embed the changes.

- New managers told us the governance structure of maternity was a challenge. The governance structure was being reviewed at the time of inspection. Managers told us the service was determined to put a governance structure in place that was focused on quality and safety.
- We viewed a flow chart which clearly demonstrated the flow of maternity information from maternity services to the trust board. This demonstrated the processes the trust had in place to ensure the board and senior managers were sighted on the maternity improvement plan. This included fortnightly meetings of the trust executive group, monthly maternity improvement group meetings, as well as board quality and safety sub-committee and trust board meetings.
- The maternity improvement group was the formal governance process for the service. The group was chaired by the chief executive officer and membership included the chief nurse, non-executive director and chief medical officer. The meeting had oversight of maternity audits. Managers told us the group was wide ranging and included a nurse consultant, ultra-sonographer superintendent, as well as staff contributors. Managers said the group was more relaxed than formal board meetings, due to be a working group focused on improvement in maternity services.
- There was a weekly maternity steering group, this was chaired by the executive maternity safety champion. The meetings were not recorded in minutes, as the focus of the group was the action plan, and any actions identified by the group would be recorded on the action plan.
- There were monthly clinical governance meetings which all eligible staff were required to attend.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

- The maternity improvement plan was a 'live' document and updated weekly. The plan was formulated in response to external reviews of the service. In August 2020 the trust noticed a rise in perinatal mortality. The Integrated Care System (ICS) supported an external review. All 28 recommendations from the review were included in the maternity improvement plan.
- Recommendations from the last CQC inspection in April 2021 were also used to inform the maternity improvement plan. The trust's Ockenden self-assessment and recommendations from the Health Service Investigation Branch (HSIB) reports, as well as feedback from the 2020 staff survey, staff engagement events and task and finish groups were integrated into the improvement plan.
- Managers monitored the improvement plan by using a tracking spreadsheet. Managers said they were aware that some actions identified on the plan needed to be sustained and further embedded. However, managers told us there was a different approach in the management culture and a determination to create an infrastructure that was fit for purpose, including governance and human resources (HR).
- The service had dedicated leads to drive the improvement agenda. For example, the service had recently recruited both an audit midwife and a risk midwife. The audit midwife had been in role for two months and the risk midwife was on induction at the time of inspection.

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- The risk register was reviewed at the division's monthly governance meeting and high rated risks were reviewed at the trust's risk and compliance meeting. Maternity was a risk on the board assurance framework (BAF) risk register, this was reviewed at meetings of the trust board.
- The maternity risk register was managed divisionally. The perinatal team also had oversight of the risk register. Any risk for inclusion on the risk register had to be submitted to the trust board.
- We reviewed the maternity services risk register and found it contained 16 risks. The risk register was red, amber, green (RAG) rated. There was one red risk on the register, this related to midwifery staffing. The risk register identified actions in place to mitigate staffing risks, but, recognised that there were still gaps. Actions required included a plan to recruit additional staff, redeployment of specialist midwives to clinical areas, upskilling of maternity assistants, escalation to the executive team regarding condensing services or capping bookings, remodelling of maternity service provision to align community midwives working hours with the service.
- The risk register was reviewed on 2 November 2021 this review recorded the trust was offering band 5 salaries to preceptorship midwives, as well as a training package for band 7 midwives including a study day and competency book. The risk register also recorded there was on-going review of the continuity of care and potentially condensing services, including consideration of five-day services for the day assessment unit.
- The service had an audit plan in place. The service was also planning to introduce an audit tracker, to monitor whether care was being provided in accordance with best practice standards and identify where there could be improvements.
- The service used the maternity dashboard to monitor performance. Senior leaders told us the dashboard had been in use since 2006. However, we found a manager on the delivery suite who said they were not aware there was a performance monitoring dashboard.
- During a previous inspection in April 2021 we found the maternity service's high priority risks were not shared with all staff. During this inspection we found the service had introduced a monthly risk newsletter to highlight and inform staff on risks to the service or women using the service. This was regularly sent to all maternity staff by email. We viewed a newsletter for August/September 2021 and found this disseminated learning from a never event. We also saw risks from the risk register on staff information boards.
- The service had introduced two 'transformation leads' to lead on the 'Maternity Transformation Programme'. The trust had declared compliance with five of the 10 maternity workstreams in the Clinical Negligence Scheme for Trusts (CNST). Managers told us the staffing situation meant they could not declare compliance with all CNST criteria.
- The service had four safety champions. The safety champions reported to the chief nurse, who was the board level safety champion.
- There were joint monthly mortality reviews with senior medical staff and midwifery. The service had regular mortality and morbidity meetings. The medical mortality lead had completed a draft study into mortality documentation and had presented the findings at the maternity improvement group.
- There was regular perinatal mortality review team (PMRT) meetings. We looked at three PMRT meeting agendas and minutes. Post-mortem reports were reviewed at the meetings. The meetings included a grading of the care provision and identified any lessons that could be learnt from perinatal deaths.
- Senior managers highlighted that the service had made significant improvements in a short space of time. But, acknowledged it was an improvement journey and it would take time to embed the changes. The priorities for the

Maternity

service were: midwifery staff recruitment and retention; recruiting a permanent director of midwifery; delivery of the organisational plan, including improvements in the service's culture; coordination of efforts with the London Maternity Neonatal System (LMNS) support team and national maternity safety team; and delivery of the maternity improvement plan.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- The service had a digital improvement programme. Managers told us maternity services were still paper based and digital improvement was a key part of the maternity strategy. Managers were working with IT to improve electronic records systems with the aim of becoming paper light. The service's intention was to move in stages to achieve full digitisation in 2022.
- Staff told us IT access had improved. For example, staff on the fetal medicines unit (FMU) told us they had issues with internet connectivity. However, this was raised with the trust's IT department by managers and the issues were resolved. The service had also implemented a caesarean section pathway tool. Managers told us work was in progress with the trust's IT team to streamline the induction of labour pathway and introduce electronic bookings.
- The service had invested in a new electronic patient record. This used the same platform as other trusts in North West London and had the same electronic patient record system. Managers told us the system would be rolled out in 18 months. The digital improvement team were mapping the systems processes at the time of inspection.
- Maternity had also received digital funds from the trust to improve records that were not on the new electronic patient record, such as a fetal monitoring system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The service was engaged with their local Maternity Voices Partnership, this is a team of women and their families, commissioners, midwives and doctors that work together to review and contribute to the development of local maternity care. Staff told us this had continued weekly through the COVID-19 pandemic. The MVP chair was a member of the maternity improvement group. Work was in progress on engaging community groups to increase the representation of the ethnically diverse population the maternity service served. Managers told us the group needed to be further developed to ensure it was representative of the local population.
- Staff told us there had been numerous staff engagement events since the interim director of midwifery had been employed. This included staff engagement meetings and listening events. A staff member told us, "Management are going all out to support staff."

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

- The service had recently made some key appointments. This included the permanent recruitment of a perinatal midwife in January 2021, an audit midwife in August 2021 and a risk midwife in October 2021.

Maternity

- During the COVID-19 pandemic maternity services provided care for multiple pregnancy patients for the local population of Harrow, Brent, Ealing and surrounding areas. The service developed a model of 'one stop care under one roof'. The model was listed as a finalist in a health journal's patient safety awards in 2021 as maternity and midwifery initiative of the year 2020.
- A consultant had submitted a proposal to research inductions at an earlier date in pregnancy. This was work in progress at the time of inspection.
- The fetal medicine unit (FMU) had applied for innovation funding to get new monitors for women receiving ultrasound scans. This would enable women to see a larger screen image of their scans.
- Maternity services were a pilot site for Maternal Mental Health Service (MMHS). The MMHS was an innovative joint programme between North West London NHS mental health services and maternity services. The programme combined maternity, reproductive health and psychological therapy for women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience.

Areas for improvement

SHOULD

Maternity services:

- The trust should ensure there are enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- The trust should ensure all staff are up to date with all mandatory training, including safeguarding training.
- The trust should ensure staff observe control measures and ensure equipment marked as clean is clean.
- The trust should ensure resuscitation trolleys have out of date equipment removed.
- The trust should ensure cold cots are repaired promptly and operational.
- The trust should ensure triage log sheets cannot become detached from women's notes.
- The trust should ensure 'Time alone' records are fully recorded at every antenatal appointment.
- The trust should ensure drug vials are not inappropriately stored.
- The trust should ensure women have access to antenatal classes.
- The trust should ensure there is a system of triage which records the time at which women with concerns have previously called.
- The trust should ensure they address delays in the induction pathway for transfers of women.
- The trust should ensure there is a clear policy and pathway for women who should go to triage and women that should go to the maternity day assessment unit (DAU).
- The trust should forge a period of leadership stability by making permanent senior leadership appointments to the maternity team
- The trust should develop a strategy for the maternity service beyond the current maternity improvement plan.

Maternity

- The trust should complete its review of its maternity governance structure to incorporate the early improvements noted and to make the structure focus more on safety and quality
- The trust should ensure that early signs of improvement are embedded.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC inspection manager, CQC assistant inspectors and specialist advisors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

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	Community and Wellbeing Scrutiny Committee 22 February 2022
	Report from the Strategic Director, Community and Wellbeing
Fire Safety Standards and Actions in Council Properties – Update Report	

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Hakeem Osiniake Operational Director of Housing Tel: 02089372023 Hakeem.osinaike@brent.gov.uk

1.0 Purpose of the Report

- 1.1 To set out the background and context to Brent Housing Management's programme of works to improve the fire safety standard in the Council's housing stock.
- 1.2 To set out the policy and legislative responsibility of Brent Housing Management to undertake fire safety works in the Council's housing stock, and outline Brent Housing Management's approach to fire safety works since Grenfell.
- 1.3 To set out the programme of fire safety action and works that have been developed and implemented since the last update given to scrutiny in 2019.
- 1.4 To set out the fire safety requirements in the Council's housing stock and the plans to address these going forward. Outlining what Brent Housing Management is doing to ensure the Council's housing stock complies with fire safety legislation, carrying out fire risk assessments and identifying general fire precautions that need to be in place.

2.0 Recommendations

- 2.1 That the Committee note the contents of this report.

3.0 Background, Context and Legislation

- 3.1 Fire Safety has always been high on the agenda of Brent Council. On 10th July 2017 Full Council responded to the Grenfell Tower tragedy by launching the commitment to review fire compliance in the council's high rise stock and identify any measures needed to ensure it reflects best practice, and meet all necessary costs, identify a set of measures to improve fire safety to best practice standards and meet all necessary costs, which were forecasted at £10M. After assessing our stock, we quickly realised that we were in a relatively strong position with regards to fire safety compliance. This is primarily due to a robust system of Fire Risk Assessments (FRA's) but also because we did not have any high-rise buildings with cladding.
- 3.2 However, Grenfell created a new focus on fire safety in its broadest sense and the work since has created new standards and expectations, for example sprinklers, improved fire and smoke alarms systems, emergency lighting, smoke ventilation and resident information communication in the event of a fire.

4.0 Landlord Responsibilities

- 4.1 Landlords and freehold owners of residential buildings have a legal duty to ensure that a fire risk assessment is carried out to identify and remove any fire risks and hazards, or to reduce these as far as possible.
- 4.2 In rented properties, landlords are responsible for ensuring that the properties meet fire safety standards. Landlords also need to keep their tenants informed of what to do in an emergency, including providing evacuation plans.

- 4.3 The Council is required under the Housing Act 2004 to inspect privately owned residential properties (including common areas) under the *Housing Health and Safety Rating System* (HHSRS). The HHSRS is a risk assessment tool used to identify potential hazards to health and safety issues in buildings. Officers use points under the system to calculate the risk and severity of any hazards they identify. Fire is one of the 29 categories of potential hazards under the HHSRS.
- 4.4 In relation to fire hazards, these include inspecting the position of cookers and heaters; the adequacy of space heating facilities, including any defects or disrepair; clothing drying facilities; sockets and other electrical installations; any materials in the property that would allow fire and smoke to spread; facilities to stop fire from spreading, such as fire stops, internal doors, self-closers; any disrepair causing a fire risk; other fire safety equipment such as smoke / heat detectors, fire extinguishers, lightning protection systems; and other fire safety measures like means of escape.
- 4.5 Regional fire and rescue authorities (such as the London Fire Brigade) are responsible for enforcing the '*Fire Safety Order*', which is set out in paragraph 4.7 below, in non-domestic buildings. This includes the communal areas of residential blocks, just not the inside of residential properties. As fire safety authorities, they can enforce landlords' legal fire safety obligations outside the home and within buildings. Some fire safety authorities also make fire safety visits to evaluate the risk of fire inside homes and provide bespoke advice to residents on identifying and addressing fire risks and hazards.
- 4.6 The Council can be contacted by its tenants and leaseholders and they can make a formal complaint directly to the Council. In most cases, this will give an opportunity for Council officers to put things right and explain the Council's position to them. If the customer remains dissatisfied, they may take their complaint to the Ombudsman. Housing officers are available and regularly speak to tenants, offering an opportunity for them to raise any concerns. Should a customer remain concerned or unhappy with how the council is dealing with something they can make a formal complaint.
- 4.7 The Regulatory Reform Order (Fire Safety) 2005 requires building owners to carry out a fire safety risk assessment and keep it up to date. This shares the same approach as health and safety risk assessments and can be carried out either as part of an overall risk assessment or as a separate exercise.
- 4.8 Based on the findings of the assessment, the Council needs to ensure that adequate and appropriate fire safety measures are in place to minimise the risk of injury or loss of life in the event of a fire.
- 4.9 The Fire Safety Act 2021 extends the scope of fire risk assessments to include the building structure and external walls. This includes requiring a Responsible Person to review and update the risk assessment process. The responsible person is the Operational Director of Housing, and their delegates.

5.0 Fire Risk Assessments

- 5.1 The Council carries out risk assessments once a year in all of its high-rise residential buildings and every three years in low rise. The Council also has a process in place for Caretakers and Housing Officers to report on any fire safety concerns when they carry out their regular cleaning and inspections.
- 5.2 Where urgent risks are identified in an FRA, they are logged and sent to the relevant teams. Where the urgent risk can be repaired, it is sent through to the day-to-day responsive team to complete. Where the repair is not urgent and is more specialist we pass to the contractor who undertakes our fire safety planned work. All of these actions are monitored on a weekly basis where a meeting is convened chaired by the Strategic Compliance Manager to discuss progress. An update is then provided to the Head of Housing Property Services. Progress on actions is reported to the Operational Director of Housing and Housing Management Team, on a monthly basis.
- 5.3 In the Council's high-rise blocks the fire risk assessors carried out a Type-4 Fire Risk Assessment, which is an intrusive survey where there is a degree of destructive inspection, in both the common parts and in residents' properties. This will usually require opening up the construction and making good after the inspection. It is essential to ascertain the fire integrity of buildings and in particular compartmentation. A type-4 is the most comprehensive fire risk assessment and was done as a one off exercise we now undertake annual Type-1 FRAs.
- 5.4 Low and medium rise blocks, including converted street properties receive a FRA every 3 years, as they are lower risk buildings.
- 5.5 Within flats, consideration is given to the integrity of compartmentation around openings in walls and floors for services such as gas, water, electricity, telecommunications and drainage. These may be present where such services enter from the common parts or pass between flats. In most cases, the extent of any openings and the extent of fire stopping may require opening up panels in kitchens, bathrooms and other areas.

6.0 Current and Future Fire-Safety Related Works

- 6.1 This programme of work has started to and will continue to address a number of risks identified in the Housing Scrutiny Report dated 25 April 2019 which was submitted to the then Housing Scrutiny Committee.
- 6.2 The Council has continued to undertake fire safety works within its Housing stock. There has been ongoing works throughout all types of properties including high-rise. The low and medium rise programme commenced in 2019 as these properties had not had work undertaken for some time. The high-rise blocks have previously benefitted from targeted works over the last few years. Major works to high-rise blocks will commence from later this year. This is due to the large scale and logistics of the works and the corresponding budget that is required.

- 6.3 The low and medium rise fire safety works programme is now nearing completion. This has been a significant investment and has addressed all of the low and medium rise housing stock.
- 6.4 These properties now have a high standard of fire protection and are able to operate as stay put or evacuation properties as relevant.
- 6.5 The Council has undertaken significant fire-safety related works to its Housing low and medium rise stock. This has included the following:
- 6.5.1 Fire safety and internal communal area refurbishment to low and medium rise properties. The properties include street conversions and purpose built blocks. These works included extensive fire compartmentation, emergency lighting, smoke alarms, and the redecoration of communal areas.
 - 6.5.2 The Council has undertaken this work to 454 blocks and 654 street properties, to bring them up to modern standards and upgrade the fire rating of the properties. 6214 number of households benefited from this programme, and circa £5M has been spent.
- 6.6 The high-rise fire safety works programme. The high-rise fire safety works programme has been driven by the FRA programme, and is ongoing. However, the high-rise blocks will be subject to a higher level of fire safety specification once the high-rise refurbishment programme commences. This will include new sprinkler systems.
- 6.7 These works include fire safety compartmentation, fire doors and smoke alarms to the high-rise blocks, and are ongoing. It is our intention to continue the investment in our high-rise blocks to extend the life of the blocks and improve the fire safety. Over the next five years, the Council plans to invest approximately £33m in refurbishing high-rise blocks. This will include comprehensive refurbishment of all elements in the block but specifically as regards to fire safety, installing sprinkler systems, further fire compartmentation works, and communal fire door replacements.
- 6.8 Electrical upgrades to dwellings. These works are part of an ongoing five year programme of electrical testing and upgrading to dwellings. We will be spending approximately £1.2M each year for the next five years. These works are particularly important with regards to fire safety as faulty electrics rank number 4 in the most common reasons for house fires. Faulty sockets, extension leads and outdated wiring are a few of the reasons why electrical fires start and these will all be identified and remedied as part of the programme.
- 6.9 The current building regulations for new build tower blocks stipulates that buildings over 30m in height are to be fitted with sprinklers in flats. The blocks assessed as part of the type 4 FRA project have each been in excess of 30m in height.
- 6.10 Under the high rise refurbishment programme we intend to install sprinkler systems to the following blocks:

High rise block
WINDMILL COURT
KILBURN SQUARE
WATLING GARDENS – 3 BLOCKS
THE OAKS
MANOR COURT
LODGE COURT

6.11 Taking Kilburn Square as an example.

6.11.1 The various works and estimated costs that would be required to fully modernise this tower block are listed below. The works are significant in terms of specification and scope due to the age of the block, previous lack of investment, and the need to introduce modern systems and functionality for residents. This is a significant investment but it will provide the block with a further 40 to 60 year's serviceable life, and it will be comparable to the new build development that is planned adjacent.

Building Element / Cost Area		Total £	Rational for the Works	Rechargeable to Leaseholders	Value Total	Value Each Leaseholder
Scaffolding		£ 353,025	Access for external fabric works.	Yes	£ 315,195	£ 3,940
Hoists		£ 84,145	Access for external fabric works.	Yes	£ 79,145	£ 989
Roofing		£ 104,940	Roof finish at end of lifecycle.	Yes	£ 35,940	£ 449
Drainage		£ 145,000	Failed drainage pipework throughout the block.	Yes	£ 135,000	£ 1,688
Structure		£ 102,014	Masonry repairs due to concrete spalling.	Yes	£ 97,314	£ 1,216
Balconies/Balustrades		£ 61,200	Necessary repair works.	Yes	£ 27,000	£ 338
External Finishes		£ 19,753	Lifecycle works.	Yes	£ 12,480	£ 156
Decorating Works		£ 90,535	Lifecycle works and fire safety to internal communal areas.	Yes	£ 85,535	£ 1,069
External Wall Insulation		£ 527,272	Insulation is not essential but costs can be partially considered as an option to more thorough masonry repair, redecoration, etc.	Possibly partially; say 30%	£ 148,296	£ 1,854
Windows & Doors		£ 1,645,991	Lifecycle replacement but higher specification	Partially, say 60%	£ 925,870	£ 11,573
Lifts		£ 554,000	Lifecycle replacement	Yes	£ 554,000	£ 6,925
Mechanical & Electrical		£ 304,208	TBA	Say 75%	£ 201,591	£ 2,520
Sprinkler Systems		£ 363,200	Fire safety decision by Cabinet.	No	£ -	£ -
FRA		£ 246,808	Fire safety works	Yes	£ 200,000	£ 2,500
Kitchen & Bathrooms		£ 503,947	Not normally done to leaseholder dwellings. Required due to major upheaval re fabric, services, etc.	Possibly partially; say 30%	£ 136,184	£ 1,702
Asbestos		£ 55,900	To facilitate safe working.	Partially, say 50%	£ 26,000	£ 325
District Heating Installation		£ 960,000	Domestic boilers could be retained, so not chargeable.	No	£ -	£ -
Pressurised Mains		£ 50,000	To suit sprinklers?	No	£ -	£ -
Domestic Extract Ventilation System		£ 115,200	Required for safety reasons. However, higher than necessary specification.	Partially, say 15%	£ 16,200	£ 203
Electrical Lateral Mains		£ 100,000	Lifecycle works.	Yes	£ 67,500	£ 844
Communal Smoke Ventilation System		£ 180,000	Probably higher than necessary specification.	Partially, say 20%	£ 36,000	£ 450
Total £		£ 6,567,137			£ 3,099,250	£ 38,741
Design Team; Consultants;		£ 800,000		15.90%	£ 492,781	£ 6,160
Enablement Works						
Contingency	5%	£ 328,357			£ 154,962	£ 1,937
Prelims		£ 1,379,099			£ 650,842	£ 8,136
OH&P		£ 396,491			£ 187,117	£ 2,339
GRAND TOTAL		£ 9,471,084			£ 4,584,953	£ 57,312

6.11.2 This level of investment does however mean that there will be a significant recharge to leaseholders. The above table also illustrates the works that the Council are likely to be able to recharge, or not depending upon the reasons for the work being specified.

6.12 Officers would expect to complete these installations by 2026.

6.13 The Assessors consider the retrofitting of sprinklers may have been a consideration and subsequent recommended control measure if the building compartmentation had been compromised over the course of alterations and refurbishments since the original build. However, the fire risk assessors have considered this factor throughout the fire risk assessment process and intrusive inspections of the common areas and flats and are satisfied that the retrofit of a sprinkler system is a control measure that is not a statutory requirement.

6.14 The National Fire Chiefs Council note that fires in homes still account for the greatest number of fire deaths and injuries and the installation of sprinklers in domestic premises would have a significant impact in reducing these.

- 6.15 The National Fire Chiefs Council and the National Fire Sprinkler Network have worked together to investigate the “Efficiency and Effectiveness of sprinkler systems”. This report indicates that where installed, sprinkler systems operate on 94% of occasions, demonstrating very high reliability. Furthermore, it is evident that when they do operate, they extinguish or contain the fire on 99% of occasions, which demonstrates that they are very effective. The research also found that in both converted and purpose- built flats, sprinklers are 100% effective in controlling fires.
- 6.16 The installation is backed up by installation of a detection system at each floor that is remotely monitored 24/7. The activation of a sprinkler system is regarded as a ‘fire event’ by the Fire and Rescue Service and they will always attend. Therefore, this enhancement provides direct notification to the Fire Brigade rather than reliance on individual residences
- 6.17 The system will be custom engineered to the requirements of each individual building, and the design parameters ‘signed off’ by the fire and rescue service. A sprinkler system requires multiple fire-rated pumps, which may be also used to deliver the potable domestic boosted supply. Distribution pipework is run throughout the block vertically and laterally through the common parts with junctions into each dwelling. Isolation valves must be provided, the usual model being one per floor.
- 6.18 The Council wish to raise the bar with regard to enhancing fire safety measures for its residents and their homes. Therefore, and considering the above observations such enhancements are recommended to be only introduced on the 8 blocks to be retained as the capital investment can achieve long-term benefits.

7.0 Compartmentation

- 7.1 From the surveys carried out in all blocks, it was apparent the Council has invested in fire safety measures previously with new ‘Gerda’ fire doors being fitted throughout the blocks to flat entrances, cross-corridors and stairs.
- 7.2 In addition to the installation of fire doors, certified fire proofing and stopping works have also been carried out to a large majority of accessible risers to corridors and lobbies within communal areas.
- 7.3 The compartmentation in the Common Areas was to a good standard with no major breaches in compartmentation identified to common areas nor any trends in compartmentation deficiencies in the blocks.
- 7.4 What is common throughout the Flats in all blocks is the high level of fire separation within risers between vertical floor levels. The majority of service penetrations that are in the main cast, steel and copper pipework, between floors have been in-filled by a concrete pour with no major breaches apparent.
- 7.5 However, there is presence of open flues that rise through the height of the building connecting flats below and above, that historically were used to discharge flue gases from former gas fired heating units. A number of the

openings were found to be proofed but the majority inspected were open thus providing passage for smoke and fire. Proofing works are ongoing in this area and Council officers hope to complete these works as part of this year's fire safety programme.

- 7.6 The Council will be installing or upgrading to an enhanced Grade D, Category LD2 or LD1 smoke alarm system in each dwelling as part of our electrical testing programme and will include these as part of our voids specification. These provides additional smoke and fire monitoring within the dwelling and includes the lounge and sometimes the bedrooms in addition to the escape routes and kitchens. This provides early warning to the occupants of the dwelling and means that there is less reliance on higher levels of compartmentation as the occupants would either vacate or raise the alarm as soon as smoke or a fire became apparent.

8.0 People at Risk and Social Factors Impacting Fire Safety

- 8.1 In consideration of people at risk and relating social factors, Council officers are developing a strategy to provide comprehensive fire safety information for all residents in all native or first languages of the residents.
- 8.2 The Council has fitted Gerda 'Premises Information' box in all of our blocks containing a list of residents who require for the use by the London Fire Brigade in the event of a fire. Therefore, the Council is in consultation with the London Fire Brigade and will support with other relevant information and familiarisation visits.
- 8.3 An action plan has been developed by housing officers to identify residents that would benefit from a Person Centred Risk Assessment (PCRA) and/or a Personal Emergency Evacuation Plan (PEEP). They have produced a number of PEEP's and continue to work with Adult and Children social services on the best methods of identifying and implementing PEEPs. These assessments have helped to identify the needs of each vulnerable individual in a block and enabled the Council to put together information the Fire Brigade would need, in the event of a fire. As our surveys confirm compartmentation and as such, a stay put policy, residents are able to remain in their homes, except when they need to be evacuated by the Fire Brigade. In cases where there is not a stay put policy and self-evacuation is necessary, we will discuss a permanent decant to a more suitable home.

9.0 Fire Alarms

- 9.1 Not all Brent Council purpose built blocks require fire alarms to common areas and to the escape routes. The buildings have been designed based on a 'stay put' approach and the occupants in each of the blocks adopt this. Therefore, the focus for purpose built blocks is on providing a comprehensive early warning heat and smoke detection, and alarm system within each dwelling.
- 9.2 The introduction and triggering of a communal fire alarm system would promote a simultaneous evacuation, which is not desirable in a building that is not designed for this. It would inevitably lead to false alarms, unnecessary fire and

rescue service attendance, maintenance costs and a risk to evacuating residents who would be safe to remain in their flats, into areas that may be affected by smoke, or mass confusion and potential injury of residents simultaneously evacuating via the stairs.

- 9.3 All Brent Council converted street properties are designed as “evacuation recommendation” blocks. These have been fitted out to support early warning throughout the property, and the safe evacuation of the properties in the event of a fire alarm being activated.

10.0 Granville New Homes

- 10.1 These blocks have been managed by BHM on behalf of First Wave Housing since 2017. It was identified that the blocks have suffered from a number of defects. However, there are two main issues with the properties, water ingress at various locations in the blocks and uncertainty about the fire rating of the external and internal walls and floors. In addition to the above, the Fire Bridge served First Wave Housing with Enforcement Notices, which led to a waking watch to be introduced in the blocks. Recent consultation will see the properties coming into the HRA in April 2022.
- 10.2 The fire risk assessment for the blocks and the subsequent intrusive investigations have identified that the construction is poor. The blocks have two distinct methods of cladding. One is formed of cementitious panels, and the other is of brick effect panels. Both of these appear to have a variety of insulation materials including expanded polystyrene, mineral wool and void spaces.
- 10.3 A comprehensive communal and dwelling interlinked fire alarm system has now been installed into the properties. Alarm monitoring arrangements will be in place over the next couple of weeks. A joint inspection was held with the London Fire Brigade to assess the block following the previous enforcement notice. The actions identified in the Enforcement Notices have now been signed off. It is expected that the alarm system will be commissioned within the next few weeks.
- 10.4 In addition, combustible material has been removed from communal areas, and additional fire stopping has been installed. The panels and insulation will require to be removed and replaced with A1 or A2 rated materials to comply with building regulations. The waking watch will be removed in stages once the alarm monitoring is mobilised. A procurement exercise is required to procure the new cladding and other repairs to the blocks. This project is expected to take three years.

11.0 Building Safety Bill

- 11.1 Going forward, the Council will be focussing on the new Building Safety Bill. This will focus on the following.

- 11.1.1 A more stringent regime for higher-risk buildings and drive improvements in building safety and performance standards in all buildings.
- 11.1.2 Ensure residents have a stronger voice in the system, and establish additional protections for leaseholders in relation to financing remediation works.
- 11.1.3 Additional obligations under The Regulatory Reform (Fire Safety) Order 2005:
 - 11.1.3.1 Participate in a new, more stringent regulatory regime for high-risk residential buildings.
 - 11.1.3.2 Increased competence among industry professionals and regulators to raise standards in the design, construction and management of buildings;
 - 11.1.3.3 Oversee performance systems of all buildings, with guidance on building performance as well as building safety, ensuring that factors like countering climate change are factored into regulatory decisions.
 - 11.1.3.4 Establishing a 'golden thread of information' which is a live digital document with accurate and up-to-date information of the building data around fire safety matters.
 - 11.1.3.5 Evidencing that the relevant standards have been satisfied.
 - 11.1.3.6 Developing a Building Assurance Certificate from the Building Safety Regulator in respect of all high-risk buildings in occupation.
 - 11.1.3.7 Developing the role of 'Accountable Person' who will be legally responsible for building safety on occupation.
- 11.2 The Council is in the process of recruiting a building safety team to put a plan together and deliver the requirements of the Building Safety Bill when it comes into effect as the Building Safety Act.

12.0 Financial Implications

- 12.1 Fire safety related works on council homes are funded from the Housing Revenue Accounts (HRA), predominantly through rental income, along with recovery of cost through major work billing to leaseholders. Budgetary requirements over the next five years are informed through the Asset Management Strategy.
- 12.2 Statutory work elements in relation to fire safety works are incorporated within baseline assumptions in the 30 year HRA Business Plan. This consists of £33m investment over the next five years to refurbish high-rise blocks and address

fire safety requirements, such as sprinkler systems, compartmentation works, and communal fire door replacements.

- 12.3 In addition to the above, further £6m over the next five years have been profiled to undertake electrical upgrades as a preventative measure of fire risk.
- 12.4 Annual revenue budgets have been set at £0.3m per annum towards cyclical maintenance and day-to-day responsive repairs in relation to fire safety monitoring devices.

Additional new roles required to form the building safety team have been integrated within Property Services staffing establishment, through restructuring of vacant positions, without any further growth in 2022/23 salary budgets.

13.0 Legal Implications

- 13.1 Owners and landlords of residential buildings have to comply with various legal duties to ensure the safety of others, including occupiers, and to discharge the duties they owe. There are further legal duties, which landlords of residential properties owe to their tenants, some of which are covered in section 11 of the Landlord and Tenant Act 1985 in relation to keeping properties in repair. Local authorities also have specified statutory duties and powers to take action against those, including owners of properties of residential accommodation, who expose others to hazardous or dangerous living conditions due to safety risks which include fire safety, most of which are covered in the Housing Act 2004. Local housing authorities as landlords also need to give comply with other statutory requirements that are set out in the Gas safety (Installation and Use) Regulations 1998, the Electrical Equipment (Safety) Regulations 1994 and the Furniture and Furnishings Act 1988. In most cases, it is the responsibility of the Fire and Rescue Authority (i.e. the London Fire Brigade) for the area to enforce the obligations of The Regulatory Reform (Fire Safety) Order 2005.
- 13.2 The remaining legal implications, including details of recent and forthcoming legislation, are set out in the main body of the report.

14.0 Equality Implications

- 14.1 There are no equality implications associated with the content of this report.

Report sign off:

Phil Porter

Strategic Director, Community Wellbeing

 Brent	Community and Wellbeing Scrutiny Committee 22 February 2022
	Report from the GP Access Task Group
GP Access Task Group Final Report	

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	Appendix 1 – GP Access Scrutiny Task Group Final Report
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Craig Player Scrutiny Officer Strategy and Partnerships craig.player@brent.gov.uk Meenara Islam Strategic Partnership Manager Strategy and Partnerships meenara.islam@brent.gov.uk Lorna Hughes Head of Strategy and Partnerships Strategy and Partnerships lorna.hughes@brent.gov.uk

1.0 Purpose of the Report

- 1.1 To present the findings and recommendations of the GP Access Task Group to the Community and Wellbeing Scrutiny Committee.

2.0 Recommendation(s)

- 2.1 To discuss and agree the contents of the report, with particular regard to the recommendations for Brent Council's Cabinet and local NHS organisations.

3.0 Detail

- 3.1 The Community and Wellbeing Scrutiny Committee can commission evidence based reviews of a policy area or function of the local authority, which are led by non-executive members. The GP Access Task Group was established to review the accessibility of general practice in Brent since the end of lockdown in March 2021.
- 3.2 It was considered timely in terms of the pressures on primary care and the transformations underway in general practice and the wider health economy, some of which have been accelerated in response to the Covid-19 pandemic. Importantly, the Task Group was set up in response to residents' concern about the ease with which they are able to access their local GP practice.
- 3.3 The Task Group was asked to produce a written report with recommendations to Brent Council's Cabinet and/or local NHS organisations. The Task Group's interim report was presented to the Community and Wellbeing Scrutiny Committee on 15 November 2021 which included early feedback on their findings. It has now concluded its work and its findings and recommendations are set out in the full report attached as Appendix 1.

4.0 Financial Implications

- 4.1 It is possible that if a recommendation was accepted and implemented that it may have financial implications for the local authority and/or local NHS organisations. Any financial implications will be reviewed by officers and reported to Cabinet for their consideration and approval.

5.0 Legal Implications

- 5.1 Section 9F, Part 2 of the Local Government Act 2000, *overview and scrutiny committees: functions*, requires that Executive Arrangements by a local authority must ensure that its overview and scrutiny committees have the power to make reports or recommendations to the authority or the executive with respect to the discharge of any functions which are or are not the responsibility of the executive, or on matters which affect the authority's area or the inhabitants of that area.
- 5.2 Section 9Fe, *duty of authority or executive to respond to overview and scrutiny committee*, requires that the authority or executive;-
- (a) consider the report or recommendations,
 - (b) respond to the overview and scrutiny committee indicating what (if any) action the authority, or the executive, proposes to take,
 - (c) if the overview and scrutiny committee has published the report or recommendations, publish the response, within two months beginning with the date on which the authority or executive received the report or recommendations.

6.0 Equality Implications

- 6.1 The scrutiny review has been driven by the Task Group's desire to ensure that each resident in Brent has equal access to GP services. The consideration of health inequalities and the ways in which these can be addressed has been at the heart of the scrutiny review.
- 6.2 The scrutiny review should also consider equalities duties as part of the general duty set out in the 2010 Equality Act.
- 6.3 Under Section 149 of the Equality Act 2010, the Council has a duty when exercising their functions to have 'due regard' to the need to:
- a) eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act;
 - b) advance equality of opportunity; and
 - c) foster good relations between those who share a "protected characteristic" and those who do not.
- 6.4 This is the Public Sector Equality Duty (PSED). The 'protected characteristics' are: age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex, and sexual orientation.

7.0 Consultation with Ward Members and Stakeholders

- 7.1 The report has been drawn up in consultation with Task Group members.

Report sign off:

SHAZIA HUSSAIN
Assistant Chief Executive

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‘No One Left Behind’

GP Access in Brent

A Scrutiny Task Group Report

Chair, Councillor Mary Daly

**Brent Community and Wellbeing
Scrutiny Committee**

Members of the Task Group

Councillor Mary Daly (Chair)

Councillor Abdi Aden

Councillor Tony Ethapemi

Councillor Claudia Hector

Councillor Gaynor Lloyd

Councillor Ahmed Shahzad OBE

The task group was set up by members of Brent Council's Community and Wellbeing Scrutiny Committee on 24 March 2021.

Contact:

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Chair's Foreword



Good access to GP services in Brent is central to ensuring that all residents receive the right healthcare, in the right setting, at the right time. Many residents will be aware of the impact that the Covid-19 pandemic has had on general practice, and in particular on the ways in which residents are able to access services.

We recognise the significant pressures the pandemic has placed on general practice, already impacted by rising and ageing populations, an increase in long-term conditions and changing patient expectations. To reduce transmission of Covid-19, general practice implemented predominantly remote consulting via telephone, video or online consultation platforms during the pandemic. This move was largely backed by the public, who understood its necessity in order to protect the health of staff, patients and the public.

Following the end of lockdown in March 2021, a national debate has emerged about whether general practice should return to its pre-pandemic face-to-face model. Some doctors and patients have voiced concern that the system adopted during the pandemic may be preventing some patients from accessing the care they need, and that the pandemic has exacerbated long-term issues and made them more apparent. It was therefore felt that a scrutiny task group would be timely in light of the pressures on general practice during the pandemic, and the various changes that it has brought about.

It is recognised that people will have different views and experiences of general practice, and the Task Group has endeavoured to capture a range of these in its findings and recommendations. The tireless work of GP staff to ensure general practice remained open during the pandemic is acknowledged and, for many patients, their experiences of the care they receive from their GP has continued to be positive. However, the Task Group has come away with a sense that, even in these challenging circumstances, there are things that can be done across Brent's health economy to improve the accessibility of GP services. Our ambition is for Brent to be a borough where no one is left behind – in which all residents live well, with access to high quality appropriate healthcare whenever it is needed.

Our work was conducted in the spirit of cooperation and partnership, and we were encouraged by the willingness of all of those who participated in our work to contribute to a shared vision of GP access across Brent. On behalf of my Task Group colleagues, I would like to thank everyone who participated in our work, including officers, local commissioners and service providers. In particular, I wish to thank Dr Madhuker C Patel, Brent Borough Lead at North West London CCG for his wisdom, knowledge and contribution to the Task Group's work, and to all the residents who gave their time to complete the GP access survey.

I would like to thank Councillor Ketan Sheth, Chair of the Community and Wellbeing Scrutiny Committee for inviting me to Chair the Task Group, as well as my fellow Task Group colleagues for volunteering to be part of this important work and for their vital contributions. I would also like to express my gratitude to those Cabinet Members that offered up their expertise in their respective portfolios during our research, and to the support received from officers at Brent Council, in particular those within the Scrutiny Team.

Councillor Mary Daly
Chair, GP Access Scrutiny Task Group

Recommendations

Recommendations

In light of its findings, the Task Group makes the following recommendations. The recommendations will be shared across the key partners including: Brent Council's Cabinet, Brent Integrated Care Partnership (ICP), North West London Clinical Commissioning Group (NWL CCG), North West London Integrated Care System (NWL ICS) and local primary care networks (PCNs).

The Task Group recognises that these recommendations will need to be implemented in partnership across agencies and with the support of patients and the public.

1) Brent Council's Cabinet works with NWL ICS to ensure fair funding for local health services.

The Task Group recognises the high levels of need and demand in Brent. It is recommended that Brent Council's Cabinet works with NWL ICS to ensure fair funding for local health services to meet this need.

2) Brent PCNs demonstrate a clear career development pathway for health care professionals in order to make best use of professional practice staff that enables greater capacity and more appropriate use of GPs. Brent PCNs should report progress against the development pathway to Brent ICP.

The Task Group has found that many GP appointments, such as for minor illnesses and injury, could be dealt with by a health professional. It is recommended that Brent PCNs ensure each GP practice has a clear development pathway in place for health care professionals with a view to utilising their full expertise, allowing them to deal with more routine appointments and increase the capacity of GPs. PCNs should ensure that the increased role of health care professionals in delivering GP services is communicated to patients.

3) Brent PCNs adopt a GP access and treatment standard that all GP practices sign up to and are accountable to. The standard should describe what services are available and what patients can expect from them. All patient participation groups (PPGs) should be involved in setting this standard, and PPGs should be regularly updated on the performance of the standard.

The Task Group has found that the ease with which patients access GP services varies across practices, and their experience of services varies too. An access and treatment standard will ensure that Brent residents experience consistently high levels of service in access and treatment when they need them, and in a way that suits their needs. The Brent standard should build on best practice of other local areas, and Brent Council should promote the standard across the West London Alliance.

The Task Group has identified the following access and treatment standards based on the experience of patients, which should be used a minimum:

- i. Reception and telephone access for all patient needs during opening hours
- ii. Agreed arrangements for evening and weekend access communicated to patients
- iii. Reception telephone answered within a maximum time frame or call back facility available (subject to the move to cloud based telephony systems)
- iv. Appointment and prescription requests addressed within a maximum time frame – regardless of whether request is made via telephone, online or in person

- v. Patients make one call only to make an appointment during core hours (subject to the move to cloud based telephony systems)
- vi. Appropriately trained clinicians should be involved in all stages of the triage process
- vii. Patients updated on all further action taken in respect of requests, appointments and/or treatments where these are carried out by the practice
- viii. Referrals to secondary care are clinically appropriate and in accordance with any agreed clinical pathways and referral protocols – patients are updated at each stage of the referral
- ix. For rapid access - conversation with registered clinician within fixed period in advance; emergency and urgent needs triaged within four hours. Practices clearly set out the process for routine, rapid and emergency access by agreement with NHS 111 and PPGs – this should be made clear on practice websites
- x. Flexible appointment types should be offered and booked in line with clinical need and patient's preference, including face-to-face, telephone, remote/digital and home visits – the range of appointment types should be made clear on practice websites
- xi. Bookings available to patients up to four weeks in advance for routine care and patients are made aware of process for cancelling and rebooking routine care appointments
- xii. Registration at any GP practice, where this is possible with no requirement for address, immigration status, identification or NHS number – with digital and face-to-face registration options for new patients
- xiii. Patients have their digital literacy and access to digital devices recorded on their patient file and taken into account when treatment is given
- xiv. Consent for digital communication and services and recorded in patient file
- xv. Guidance on online consultation service and digital communication communicated on practice website in easy to use language
- xvi. Patients to be able to communicate with GP practice via online consultation system and secure online messaging
- xvii. Each practice works towards developing consultant nurse practitioner and prescriber skills
- xviii. Non-clinical staff should be available at each GP practice e.g. social prescribers – availability made clear on practice websites
- xix. Treatment plans for all patient care agreed with and shared with patients
- xx. Prescription medicines issued where clinically effective and cost-effective, ensuring patients are engaged in the process at each stage by their clinical team
- xxi. Newly registered patients should receive information on GP practice and NHS England complaints procedures, as well as local complaints and advocacy services

4) Brent PCNs widely communicate the GP access and treatment standard and information on patients' rights to access and treatment including registration, appointments and prescriptions.

The Task Group has found that some patients were unaware of their rights to access GP services, the various GP services available to them, the clinical and social teams at a practice and the ways in which they are delivered. It is recommended that Brent PCNs communicate the GP access and treatment standard, as well as information on patients' rights concerning access and treatment including registration, appointments and prescriptions to ensure they have a clear understanding of what to expect from general practice. Brent PCNs should also measure and communicate the delivery of the standard, for example through the annual GP patient survey, practice websites and PPG meetings.

5) Brent PCNs develop an action plan to ensure that patient participation groups (PPGs) are supported to be actively involved in improving GP services. Brent PCNs

should report progress against the action plan to Brent ICP and Brent Community and Wellbeing Scrutiny Committee.

The Task Group is keen to ensure that practice PPGs are well resourced, representative of the practice population, have input from relevant health and voluntary professionals and are actively involved in service improvement. Brent PCNs should also set up PCN-wide PPGs that are representative of the geographical area they cover and actively involve patients in designing future service delivery. Brent ICS and Brent Community and Wellbeing Scrutiny Committee should ensure that the action plan is delivered by monitoring the effectiveness of PPGs, and Brent ICS should report to Brent Health and Wellbeing Board on PPG performance. Where appropriate, PPG representatives should be co-opted onto the Community and Wellbeing Scrutiny Committee and/or its Task Groups and consideration should be given to formalising links with Healthwatch Brent.

6) Brent PCNs demonstrate that the configuration of their services does not disadvantage patients based on where they live.

The Task Group is concerned that the current arrangement of GP services in local areas may disadvantage some patients based on where they live. It is recommended that Brent PCNs consider ensuring that their configuration recognises pre-existing localities such as the five Brent Connects footprints. This should facilitate more geographically accessible services for patients and more effective integrated working between PCNs and statutory health and care partners. PCNs should consult statutory health and care partners on any proposal to change the configuration of a PCN, and if a change is made the rationale for doing so should be communicated to registered practice patients.

7) Brent PCNs implement a SMART action plan to reduce the barriers experienced by patients when accessing GP services, with a focus on deprivation, ethnicity, disability and other protected characteristics. Brent PCNs should report progress against the action plan to Brent ICP and Brent Community and Wellbeing Scrutiny Committee.

The Task Group has repeatedly found that some groups of patients experience significant barriers and unequal access to GP services, including patients on persistent low incomes, those with a disability, some older patients, patients whose first language is not English, some children and young people, refugees and asylum seekers and those who cannot access digital technology. It is recommended that a SMART action plan is developed to advance equality of access between people who share a protected characteristic and those who do not (with consideration for the Equality Act 2010), and that the actions identified are incorporated into the access treatment standard.

8) Brent ICP should work alongside Brent Children's Trust to conduct further research into the experience of children and young people in accessing GP services and take any action as identified.

The Task Group has concern that some parents with young children and children and young people themselves are having difficulty accessing GP services, especially in accessing mental health support and rapid access to primary care for infants and young children with childhood illness. As such, there is an urgent need to quantify the service offer for children and young people. It is recommended that Brent ICP works alongside Brent Children's Trust to commission necessary expertise to conduct further research on this matter, and that the findings inform an update of the actions identified in the SMART action plan to address the barriers to access and deliver the GP access and treatment standard.

Introduction

The last in-depth review by scrutiny of primary care in Brent was in 2015. It was therefore felt both timely and necessary for the Community and Wellbeing Scrutiny Committee to undertake a review of GP access in Brent. The previous scrutiny task group looked at the ability of primary care to meet demand and provide fair and equitable access, and recommended investment in access, development of innovative ways to meet and arrange demand, and encouraged residents to support themselves where possible in terms of improving their own health and wellbeing.

The GP Access Task Group was established to review the accessibility of general practice in Brent following the end of lockdown in March 2021. It was considered timely in terms of the pressures on primary care and the transformations underway in general practice and the wider health economy, some of which have been accelerated in response to the Covid-19 pandemic. Importantly, the Task Group was set up in response to residents' concern about the ease with which they are able to access their local GP practice.

General practice plays a key role in promoting health, preventing illness, and helping patients to manage long-term conditions. A GP practice provides the first point of contact in the healthcare system, and is the main point of access to other parts of NHS care such as acute and community services.

The significance of the role of general practice and the right of patients with regard to GP services are set out in the NHS Constitution:

- You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.
- You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.
- You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.
- You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices.

The NHS also pledges to:

- Inform you about the healthcare services available to you, locally and nationally
- Offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it.¹

Task Group Membership

The Task Group was comprised of the following six elected members:

- Councillor Mary Daly (Chair)
- Councillor Abdi Aden
- Councillor Tony Ethapemi
- Councillor Claudia Hector
- Councillor Gaynor Lloyd
- Councillor Ahmed Shahzad OBE

¹ NHS England, (2021), NHS Constitution

Terms of Reference

The following Terms of Reference were agreed for the Task Group:

- 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 Covid19 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.

Methodology

The Task Group gathered qualitative and quantitative evidence to complete its report and develop its recommendations. In particular, the Task Group carried out a number of discussions with those involved in providing GP services. A full list of those who took part is detailed in Appendix A.

Members of the Task Group took part in seven themed evidence sessions in which they discussed issues relating to GP accessibility and demand, health inequalities, primary care workforce and capacity, GP digital services and digital exclusion, mental health services, GP contingency planning and the vision for primary care in Brent.

As well as carrying out evidence sessions, the Task Group requested data and quantitative information from a range of stakeholders. The Task Group also developed and carried out a survey on patients' experience of accessing GP services since March 2021, which comprised of a questionnaire with scalable answers provided by anonymised residents. Task Group members worked alongside Healthwatch Brent as volunteer data collectors to conduct the survey in various communities in Stonebridge, Preston, Wembley and Willesden.

Recommendations were developed according to existing legislation for local authority scrutiny. The Task Group notes that an external body or local authority executive is not compelled to act on a recommendation; however, a local authority executive must respond within two months, and NHS organisations are expected to give a meaningful response within 28 days of recommendations being agreed by a scrutiny committee.²

During the review, the Task Group had the opportunity to speak with a range of key stakeholders who shared their opinions and experiences of services. The Task Group recognises that people have different experiences of general practice and, through the analysis of information gathered, has tried to present a balanced view of the opinions given.

² Department of Health (2014), Local Authority Health Scrutiny

Background

The local health profile

Brent is home to around 327,800 people, making it the ninth largest borough in London. The Brent population has been growing strongly over the last few decades, with the population growing by 27% from 1998-2018 – an increase of 70,900 residents. The population is expected to grow by another 17% between 2020 and 2041 - an increase of 56,700 residents. The wards of Tokyngton and Alperton are expected to see the fastest growth: considered together, they are projected to accommodate an additional 33,200 residents by 2041.³

In Brent, life expectancy has been growing steadily. Life expectancy for men in Brent was 81.3 between 2017 and 2019, and 85.5 for women. This is slightly higher than the London average – which is 80.9 for males and 84.7 for women. Healthy life expectancy (the number of years of full health rather than with a disability or in poor health) for men in Brent was 61.6 between 2017 and 2019 – lower than the London average of 63.5. For women, it was 71.3 – second highest behind Richmond upon Thames.⁴ Healthy life expectancy is fundamental to a person's quality of life and reducing pressures on primary care.

The premature mortality (dying under the age of 75) rate from all causes in Brent is 288 per 100,000, compared to 326 nationally and 299 across London between 2019 and 2020. Brent has a high rate of premature mortality from cardiovascular disease at 76.2 per 100,000 people, compared to 70.4 nationally 69.1 across London 2019 and 2020. Brent ranks comparatively well nationally in regards to premature mortality caused by cancer with 108.9 per 100,000 compared to 129.2 nationally and 117.4 in London 2019 and 2020.⁵ The number of older people with higher dependency is predicted to rise by 62% between 2015 and 2035, which is likely to increase demand on primary care.⁶

In 2018, the proportion of adults aged 18 and over in Brent who are overweight or obese was 55.4%, compared to the national average of 63%. While this is significantly better than the national average, it still represents a present and future burden on primary care. Although rates have improved slightly in recent years, fewer residents in Brent are active (for more than 150 minutes a week) than London and Brent is the fourth most inactive borough in London. Just over half of adults (55.5%) in Brent are estimated to achieve the recommended minimum five portions of fruit and vegetables per day – similar to the national average of 54.8%.⁷

³ Brent Council (2021), Population Change in Brent

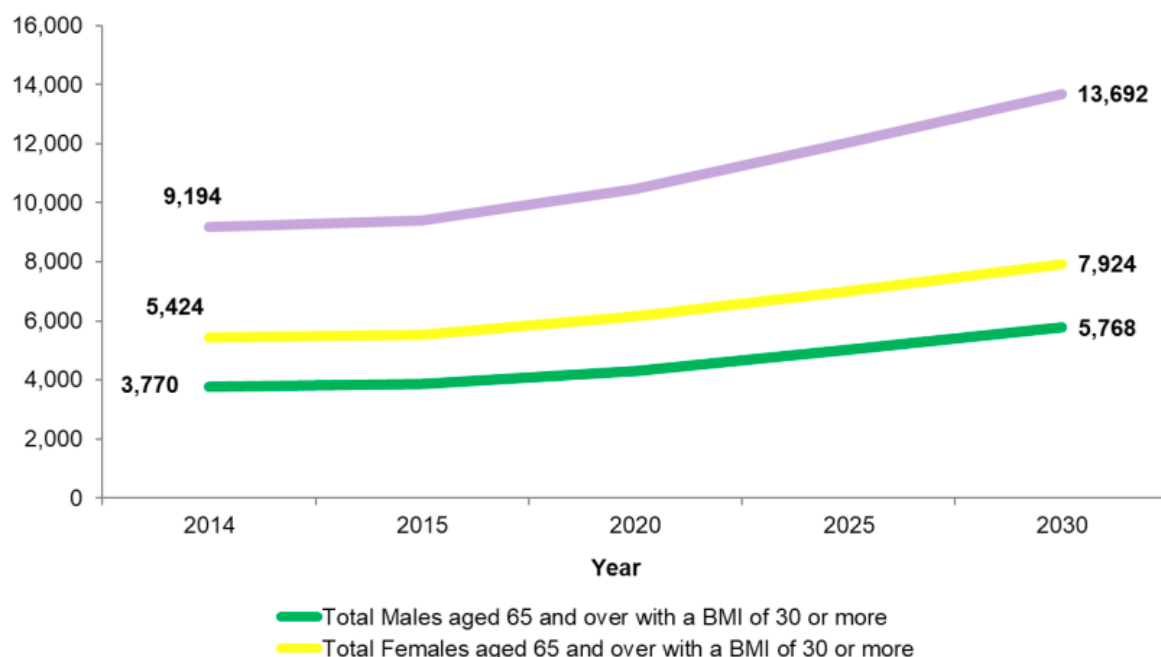
⁴ Office for National Statistic (2021), Health and life expectancies

⁵ Public Health England (2019), Local Authority Health Profiles

⁶ Brent Council (2019), Inclusive Growth Strategy: Health

⁷ Brent Council and Brent Clinical Commissioning Group (2019), Joint Strategic Needs Assessment: Health and Lifestyle

Figure 1: People aged 65 and over who are obese or morbidly obese in Brent projected to 2030⁸



Childhood obesity in Brent is especially high – this is problematic because childhood obesity can affect an individual’s health and wellbeing for the long-term, as it is also a predictor of adult obesity. In Brent, 1 in 3 children are obese by the time they leave primary school. In 2019, Brent had a higher prevalence of obese school children leaving primary school compared to the national and London average – in 2019, 26% of children in Brent were obese at Year 6, compared to 23% across London and 20% across England. By 2023, it is estimated that 70% of adults in Brent will be overweight or obese.⁹

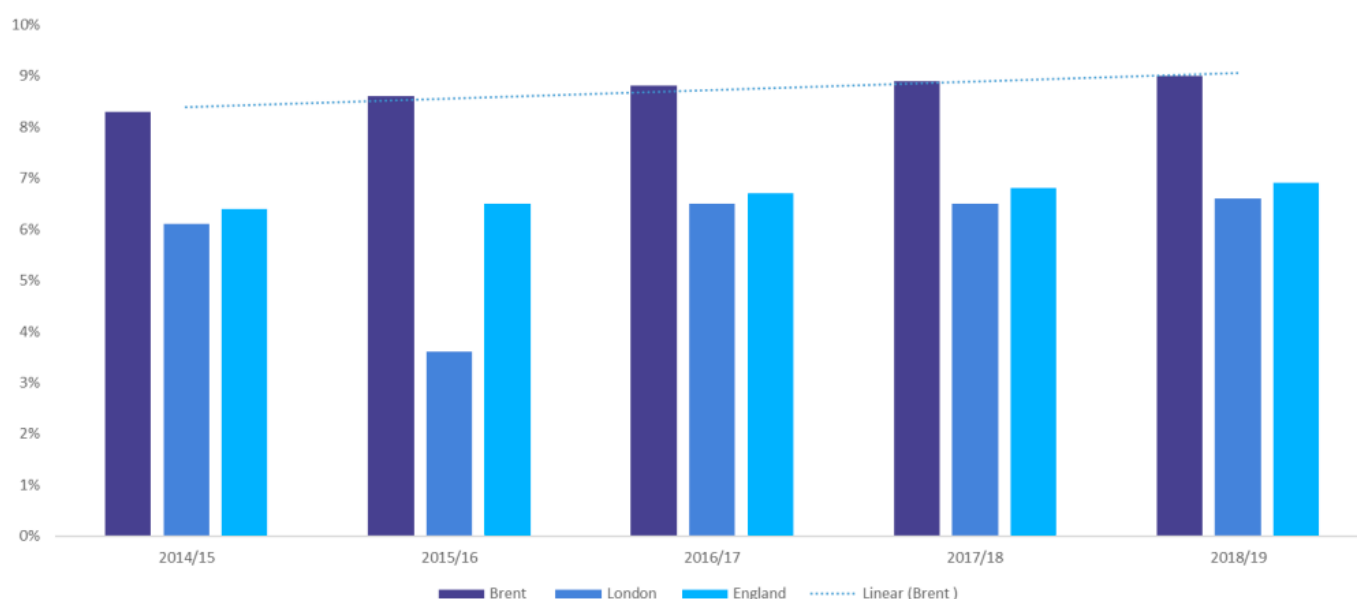
In Brent, 17% of all deaths are attributable to diabetes - by 2030, it is estimated that nearly 15% of people aged 16 and over in Brent will have diabetes. In 2019, 9% of adults in Brent had diabetes, compared with 6% across London and 7% nationally. Research shows that people of South African, African, African Caribbean and Middle Eastern descent have a higher than average risk of Type 2 diabetes. Demographic changes and the high obesity rate mean that, if the costs of treating a patient with diabetes stays the same, the overall costs of diabetes are set to grow in England over the next 20 years, when it is projected to account for 17% of the entire NHS budget. This is mainly because of its complications, such as amputation, kidney failure and strokes.¹⁰

⁸ Ibid

⁹ Brent Council and Brent Clinical Commissioning Group (2019), Joint Strategic Needs Assessment: Childhood Obesity

¹⁰ Brent Council and Brent Clinical Commissioning Group (2019), Joint Strategic Needs Assessment: Diabetes

Figure 2: Prevalence of adults (17+) with diabetes in Brent, London and England



It is estimated that 16% of the adult population in Brent has a common mental health disorder – slightly higher than the national average of 15.1%.¹¹ Data suggests that a high proportion of people in Brent feel low levels of worthwhileness, happiness and satisfaction – 17% feel low levels of satisfaction and 16.7% feel high levels of anxiety. Mental health issues often begin in childhood, with 50% of mental health problems being established by age 14 and 75% by age 24. The Covid-19 pandemic has served to exacerbate these – studies show that almost half of all 16-24 year olds nationally showed new symptoms of psychological distress during the pandemic.¹² As of 2017, Brent had approximately 7,000 residents with a learning disability when applied to census population estimates and, between 2014 and 2030, the number of people in Brent with a learning disability is expected to rise by 8%.¹³ We know that people with a learning disability have worse physical and mental health outcomes than people without a learning disability – in fact, the life expectancy of women with a learning disability is 17 years shorter than women in the general population, and 14 years shorter for men with a learning disability compared to men in the general population.¹⁴

There is a strong correlation between deprivation and health in Brent. In Brent, the life expectancy gap between the most and least deprived areas is 4.7 years for men and 4.4 years for women. In the ten year period between 2011 and the 2011 Census, overcrowding increased substantially – in Brent, there was an increase of 8,745 overcrowded units. In 2010, 12.1% of households in Brent were overcrowded, which was the third highest level amongst London boroughs, and was much higher than the London-wide overcrowding level which was 7.5%.¹⁵ Within Brent, around half of households in the private rented sector claim Housing Benefit and 45% of people claiming Housing Benefit are in the PRS. Such data suggests that a significant number of people in poverty in Brent are in the private rented sector, where rents are higher and there is less security.¹⁶ In 2015, Brent had the highest number of households in temporary accommodation. However, it has managed to reduce the overall number of

¹¹ Brent Council, (2018), Public Mental Wellbeing Strategy and Action Plan

¹² Mental Health Foundation (2020), Mental Health Statistics: Children and Young People

¹³ Brent Council & Brent Clinical Commissioning Group (2017), Joint Learning Disability Strategy 2017-2020

¹⁴ NHS Digital (2020), Health and Care of People with Learning Disabilities

¹⁵ Brent Council (2013), Brent 2011 Census Profile

¹⁶ Brent Council (2020), A Fairer Future: Ending Poverty in Brent

households in temporary accommodation by 10% year on year between 2015 and 2020, leaving it as the 7th highest.¹⁷ The effects of poor housing on physical and mental health are well documented, especially in relation to overcrowding and substandard housing conditions. Poor housing can lead to a number of health issues, including people seeking medical help or taking medication for mental health issues, not getting enough sleep, people experiencing depression or stress, as well as those falling physically ill or catching Covid-19.

Fuel poverty (the inability to adequately heat a home) is caused by low income and poor housing standards. Data shows that 17,000 households in Brent are in fuel poverty – 15% of all households in the borough. Brent has the second highest rate of fuel poverty of any London borough, and 14th highest of all 326 local authorities across England.¹⁸ The health impacts of fuel poverty for children include weight gain, high hospital admission rates, lower developmental status, and the severity and frequency of asthmatic symptoms. For older people it is associated with higher mortality rates and has a negative impact on physical health. Hospital stays for alcohol-related harm were highest in the two most deprived areas of Brent – Stonebridge and Harlesden – suggesting that poverty is closely linked to people's ability to make healthy lifestyle choices.¹⁹

Brent workers are relatively low paid: almost one third of residents (31%) earned less than the London Living Wage – the second highest percentage in London, after Newham. The local economic consequences of the Covid-19 pandemic are set to be significant – Brent had the second highest proportion of its working age population furloughed in London. Most jobs in Brent are in less well paid occupations (such as wholesale/retail, health and care, hospitality, transportation and food industries). As such, a high proportion of the workforce – 29% earned less than the living wage as of 2019.²⁰ Unemployment and insecure or low-paid employment has consistently been found to have a negative impact on health, such as the increased prevalence of mental health issues.

The local health economy

Brent has 51 GP practices, with practice list sizes ranging from 533 patients to 22,685. A full list of practice sizes is shown below.

¹⁷ Brent Council (2020), Homelessness and Rough Sleeping Strategy

¹⁸ Ibid

¹⁹ Brent Council (2020), A Fairer Future: Ending Poverty in Brent

²⁰ Brent Council and Brent Clinical Commissioning Group (2019), Joint Strategic Needs Assessment: Economy and Employment

Figure 3: List of PCNs and practice sizes in Brent²¹

PRACTICE	PCN AREA	Practice List Size 01/01/2021
Brentfield Medical Centre	Harness South	9075
Church End Med Centre	Harness South	7986
Stonebridge Medical Centre	Harness South	7284
Aksyr Medical Centre	Harness South	4624
Hilltop Medical Practce	Harness South	4196
Oxgate Gardens Surgery	Harness South	6727
Roundwood Park Medical Centre	Harness South	4775
Walm Lane Surgery	Harness South	7841
Park Royal Medical Centre	Harness South	7895
Freuchen Medical Centre	Harness South	8929
Total Harness South		69332
The Surgery	Harness North	5680
Pearl Medical Practice	Harness North	4838
Wembley Park Drive Medical Centre	Harness North	12448
SMS Medical Practice	Harness North	5355
Lanfranc	Harness North	6045
Sunflower Practice	Harness North	3202
Church Lane Surgery	Harness North	9201
Willow Tree Family Doctors	Harness North	15917
Preston Road Surgery	Harness North	4359
Sudbury & Alperton Practice	Harness North	8694
Total Harness North		75739
Kilburn Park Medical	Kilburn Partnership	8492
Chichele Road Surgery	Kilburn Partnership	5656
Staverton Medical Centre	Kilburn Partnership	8925
Mapesbury Medical Centre	Kilburn Partnership	8906
Peel Precinct Surgery	Kilburn Partnership	533
Willesden Green Surgery	Kilburn Partnership	6197
The Law Medical Centre	Kilburn Partnership	17899
Total Kilburn		56608
Gladstone Medical Centre	K&W South	9326
Willesden Medical Centre	South	13678
St George's Medical centre	South	2245
Burnley Practice	South	9431
St Andrews Medical Centre	South	1839
The Lonsdale	South	22685
Total K&W South		59204
Neasden Medical Centre & Greenhill Park	North	9678
Uxendon	North	5469
Jai Medical Centre	North	6369
The Fryent Way	North	8273
Kingsbury Health & Wellbeing	North	4572
Brampton	North	5347
Kings Edge Medical Centre	North	3637
Total K&W North		43345

²¹ NHS Digital (2021), Patients Registered at a GP Practice

Forty Willows Surgery	Central	6905
Tudor House Medical Centre	Central	3897
Chalkhill Practice	Central	7119
Ellis Practice	Central	8876
Preston Road Medical	Central	6875
Sudbury Surgery	Central	8684
Total K&W Central		42356
Premier Medical Centre	West	9293
The Wembley Practice	West	14312
Hazeldene	West	24569
Alpertown	West	5855
Lancelot	West	7017
Stanley Corner	West	6008
Total K&W West		67054

The total number of each type of NHS GP contract held by GP practices in Brent is shown below, and further information on the NHS GP contract is provided in Appendix E. 75% of GP practices in Brent operate under the GMS contract – much like nationally, where 70% of GP practices operate under it.²²

Figure 4: Total numbers of GP practices in Brent by contract type²³

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

In a report presented to the Community and Wellbeing Scrutiny Committee in July 2017, Brent CCG outlined its ambition to increase the capacity and effectiveness of primary care in the borough. Brent CCG stated that it would focus on extended access and improved access to GP services, provider development and resilience at both individual practice level and at scale, online consultations and the use of technology, developing the local primary care workforce and the delegation of commissioned GP services.²⁴ The report also highlighted the significant pressures facing primary care in Brent, including an increasingly ageing population, increasing demand on services, variation in care quality and outcomes, financial pressures, ageing infrastructure and recruitment and retention issues.

In 2019, the organisation of GPs in Brent changed with the establishment of PCNs. A PCN 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 local populations. PCNs are expected to be consistent in their sizes and geography, and with local ICP and CCG/ICS footprints. Initially in Brent, the GPs established ten PCNs, but later decided to reduce the number to seven in order to work at scale. There are now 51 practices affiliated with the seven PCNs, as detailed in Figure 3. All seven PCNs are led by GP Clinical Directors.

PCNs are expected to be the mechanism by which primary care representation is made

²² NHS Digital (2020), NHS Payments to General Practice

²³ North West London CCG, Evidence received at Evidence Session 1

²⁴ Report to the Community and Wellbeing Scrutiny Committee (July 2017), Brent CCG: Primary Care Transformation

stronger in integrated care partnerships (ICPs) and integrated care systems (ICSs), with the accountable clinical directors from each network being the link between general practice and the wider system. ICSs seek to bring together all NHS organisations and local authorities to redesign care and improve the health of local populations, and will take the lead on planning, commissioning care and providing system leadership. All NHS organisations and local authorities in North West London have been working as an informal ICS, led by an Independent Chair and a Chief Executive. The Health and Care Bill was published in July 2021, with ICSs due to become legally recognised bodies in July 2022.

ICSs will also have a key role in working with local authorities, hospitals, community services, mental health services and GPs at local levels at 'place' level through integrated care partnerships (ICPs). 'Place' has a smaller footprint than the ICS, and in many cases will be that of the local authority. The Brent Integrated Care Partnership Executive Committee (ICPEC) is the place-based ICP in Brent within the ICS.

Demand on GP services

Registered patients

The number of registered patients across GP practices in Brent has risen since 2015 and is continuing to rise. As of April 2021, there were 422,377 registered patients across Brent's 51 GP practices, compared to 365,165 across 67 GP practices in April 2015. Of those patients 220,609 were men, and 201,768 were women.²⁵ A breakdown of the number of registered patients by age groups can be seen below.

Figure 5: Number of registered patients in Brent by age group²⁶

0-4 22,067	5-14 46,600	15-44 211,968	45-64 98,972
65-74 24,268	75-84 13,156	85+ 5,346	

The picture is similar across North West London CCG. Between November 2020 and November 2021, registered patients grew by over 100,000.²⁷ Population projections for Brent suggest an ongoing increase in the number of residents in the borough, and a further increase in patients registered to a GP practice in Brent. It is important to note that the population is not projected to increase in all wards. Tokyington (+85%), Alperton (+84%) and Dollis Hill (+47%) are projected to increase most between 2020-41, whereas Queens Park (-9%), Sudbury (-7%) and Kensal Green (-7%) are projected to decline most.²⁸

These projections also show likely changes to the age profile of residents with an increase in older people. The number of registered patients is largest in the 15-44 age group, and as these patients get older they are likely to place additional pressure on GP services. This correlates with increased prevalence of long-term health conditions such as diabetes. For example, Kingsbury and Willesden North PCN has one of the highest prevalence for diabetes, which may be due to the PCN having a greater population of 64+ years.²⁹

GP practice workforce

Before merging into a single CCG as North West London CCG, Brent was ranked the 7th most under doctored CCG in London with a decreasing and older GP workforce. It was identified as having the most patients per nurse in London as well as the greatest proportion of nurses over 55.³⁰ As of December 2020, Brent had 177 GPs, 58 nurses, 77 direct patient care staff (such as pharmacists and physician associates) and 351 administration/non-clerical staff (such as practice managers and receptionists).³¹

²⁵ NHS Digital (2020 & 2021), Patients Registered at a GP Practice

²⁶ Ibid

²⁷ Ibid

²⁸ Brent Council (2021), Population Change in Brent

²⁹ North West London CCG, Evidence received at Evidence Session 1

³⁰ Ibid

³¹ NHS Digital, (2020), General Practice Workforce

Figure 6: Total number of GPs and other healthcare professionals in all Brent practices³²

GP Partners	GP Salaried	Practice Managers	Nurses	Pharmacists	Physician Associates	Receptionists
94	53	56	58	12	5	225

It is important to note that the general practice workforce has seen little growth nationally since 2015, with the number of GP partners significantly declining over that time. As of September 2021, there were 1,704 fewer fully qualified full-time GPs nationally compared to 2015.³³ The picture is much the same in Brent – the number of fully qualified full-time GPs in Brent has decreased from 200 in 2015 to 177 in December 2020. Similarly, the number of nurses in the borough has decreased from 105 in 2015 to 58 in December 2020.³⁴

However, the level of cover of GPs varies across England – in 2019, North West London had the lowest number of GPs per 100,000 population (54). Some differences are justifiable because the need for healthcare varies due to factors like age, poverty, and rurality in different areas. However, there is concern that there are significantly less GPs per head in North West London than other regions across London.³⁵ It should be noted that the cover of the GP workforce varies across North West London, too – while Brent had 177 fully qualified full-time GPs in December 2020, Ealing had 221. Similarly, while Brent had 58 nurses in December 2020, Ealing had 82.³⁶

Recruitment and retention programmes are being introduced in Brent to reverse the decline in the GP and general practice nurse workforce with fellowships for newly qualified and experienced GPs and general practice nurses, continuing professional development training opportunities, clinical skills development, staff education forums and mentorship and supervision. The introduction of the Additional Role Reimbursement Scheme in 2020, which provides funding for PCNs to recruit to new roles to expand their healthcare teams, has also sought to increase the direct patient workforce with the introduction of new roles such as nursing associates, pharmacy technicians, mental health therapists and physiotherapists.

It is important to recognise that GPs, nurses, direct patient care staff and administrative/non-clerical staff work together in practices as part of multidisciplinary teams, with other healthcare professionals within PCNs called upon when necessary. Practice nurses have become significantly more skilled over recent years and are now providing some services to patients that were previously delivered by GPs, leading to the creation of roles such as nurse practitioners (a nurse who has additional education and training in a speciality area, such as family practice or paediatrics) and independent nurse prescribers (nurses that are able to prescribe any medicine for any medical condition). Some practices may implement nurse-led triage services, meaning that only patients who need to see a doctor are seen by a GP and the remaining patients have their needs met by other healthcare professionals or services, releasing GP time for essential cases.

³² Ibid

³³ NHS Digital, (2015, 2020 & 2021), General Practice Workforce (comparison of 2015, 2020 and 2021 data)

³⁴ Ibid

³⁵ Nuffield Trust (2019), Level of GP staffing in 2018

³⁶ NHS Digital, (2015, 2020 & 2021), General Practice Workforce (comparison of 2015, 2020 and 2021 data)

The Task Group has concerns regarding the issue of recruitment and retention and the impact this may have on the ability of patients to access GP services. It is clear that there are fewer GPs and other primary healthcare professionals in Brent, despite the number of registered patients rising since 2015. More registered patients does not just mean greater demand for appointments, but also more paperwork, test results and administrative work too. This, mixed with rising patient need, places additional pressure on GP practices.

Covid-19 pandemic

Since the start of the pandemic, the impact of Covid-19 on primary care, and those working within it, has been significant. Staff have been under considerable pressure to maintain services despite social distancing measures, adjusting to virtual consultations and helping to roll out the Covid-19 vaccine. In March 2020 the UK government instructed GP practices to conduct consultations remotely unless there was urgent need for a face-to-face appointment. As a result, most GP practices stopped using face-to-face appointments and introduced remote or digital consultation (via telephone, online message or video) to reduce footfall, and protect patients and staff from risk of infection. Many of these types of consultations continue to be delivered to patients today.

Despite the end of lockdown in March 2021, there remains practical challenges to delivering routine care while Covid-19 remains a risk. Infection control measures are likely to slow the pace at which patients can be treated, having an impact on waiting times and people's outcomes and experiences of care. GP practices also face the challenge of delivering routine care at the same time as continuing to deliver a mass vaccination campaign. GP services will also need to deal with the ongoing health effects of Covid-19, including rehabilitation needs stemming from the virus, and support for those whose health has deteriorated as a result of delayed presentations or gaps in routine care.

Recommendation 1

Brent Council's Cabinet works with NWL ICS to ensure fair funding for local health services.

The Task Group recognises the high levels of need and demand in Brent. It is recommended that Brent Council's Cabinet works with NWL ICS to ensure fair funding for local health services to meet this need.

Recommendation 2

Brent PCNs demonstrate a clear career development pathway for health care professionals in order to make best use of professional practice staff that enables greater capacity and more appropriate use of GPs. Brent PCNs should report progress against the development pathway to Brent ICP.

The Task Group has found that many GP appointments, such as for minor illnesses and injury, could be dealt with by a health professional. It is recommended that Brent PCNs ensure each GP practice has a clear development pathway in place for health care professionals with a view to utilising their full expertise, allowing them to deal with more routine appointments and increase the capacity of GPs. PCNs should ensure that the increased role of health care professionals in delivering GP services is communicated to patients.

Access to GP services

Registering with a GP practice

The number of unregistered patients is not routinely monitored by most CCGs in England – including North West London CCG. The trend of patients registered at GP practices has been in excess of population estimates since recording began in 2013 – though this is thought to be because patients who should have been de-registered are still recorded (for example, because patients move away and do not de-register when they leave).³⁷

Anecdotal evidence heard by the Task Group suggests that a significant portion of Brent residents are not registered with a GP practice. Not registering with a GP may be a personal choice (for example, short or medium-term economic immigrants or people who have relocated who are younger and healthier may defer registration until they need to see a GP) or due to systematic barriers (for example, homeless patients or refugees have difficulty accessing NHS services because they have no permanent address). It is also important to note that some residents may be registered with a GP practice outside of Brent.

“I was recommended a GP practice to register with on e-consult. However, that practice refused to register me. I tried another and they refused to register me too. I finally managed to register with a third practice, but this was outside of Brent.”

Patient from Park Royal

NHS England guidance makes it clear that you do not need to have proof of address, immigration status, identification or NHS number when registering with a GP. This also applies if you are an asylum seeker, refugee, homeless patient or an overseas visitor – whether lawfully in the UK or not. However, a GP practice does have the right to refuse registration if the practice cannot take on new patients, if the practice is not accepting patients that do not live within its practice boundary or if it may not be appropriate for a patient to register with a practice because it is a long way from where they live.

Booking an appointment

Nationally, 21 million fewer primary care appointments were booked between April 2020 and March 2021 compared to the previous 12 months – a fall from 310 million to 279 million. The picture was similar in Brent - in total, GPs across Brent delivered 1.7 million appointments from March 2019 to February 2020, yet delivered just 1.56 million appointments between March 2020 and February 2021.³⁸ However, appointments have largely returned to pre-pandemic levels since March 2021. In September 2021, 1.9 million GP appointments were delivered in North West London compared to 777,737 in September 2020. It should be noted that this may in part be due to the number of Covid-19 vaccinations delivered by practices.

Of the respondents to the Task Group survey who had booked one or more GP appointments since March 2021, 83% booked via telephone, 21% booked via their GP's app or website and 12% booked by visiting their GP practice. It appears that many GP surgeries are still using

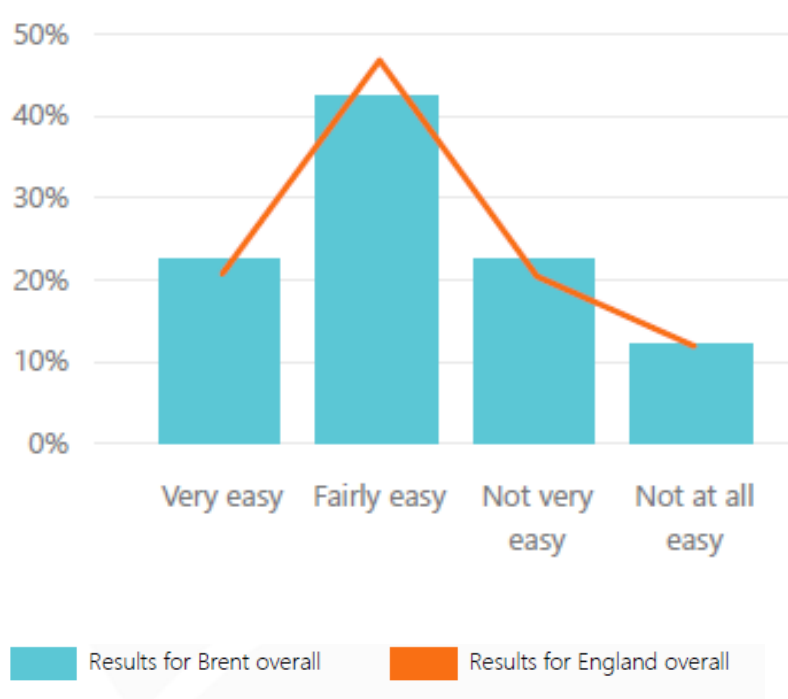
³⁷ NHS Digital (2021), Patients Registered at a GP Practice

³⁸ NHS Digital (2020 & 2021), Appointments in General Practice

online triage systems such as eConsult, or telephone triage via a receptionist or practice nurse to determine which type of appointment to provide. This often means that patients are offered telephone or video consultations first and face-to-face appointments if the initial appointment(s) indicates it would be appropriate. The Task Group is concerned that this may mean that some people have three interactions with their GP practice before they get the care they need.

Local health commissioners have said that the scale and configuration of telephony systems across Brent varies. The Covid-19 pandemic has placed primary care telephony in Brent under the spotlight, which has highlighted some of the limitations with older traditional telephony systems. People would often not be able to get through to GP practices or, if they did, found that appointments were fully booked. In fact, 29% of people in Brent found it difficult to get through to their GP practice on the phone in 2021, compared to 25% nationally.³⁹

Figure 7: Ease of getting through to someone at GP practice on the phone in 2021⁴⁰



Some patients have expressed their frustration about telephone appointments and not knowing exactly when a doctor will call within a wide time slot. Some patients were discouraged by the short slots given to appointment bookings on each morning, and spoke of unsuccessful waits to get through to a receptionist to book an appointment. Other patients have been told that a GP will call any time in the morning or afternoon, or any time during opening hours without checking if this is convenient. People who work full-time may find this particularly difficult. For many people this challenge is also exacerbated by needing an interpreter, carer or family member to help with the appointment.

³⁹ NHS England (2021), GP Patient Survey: Brent results

⁴⁰ Ibid

"I had difficulty getting through to my GP practice on the phone and, once I did get through, I waited a long time to be called back by a doctor."

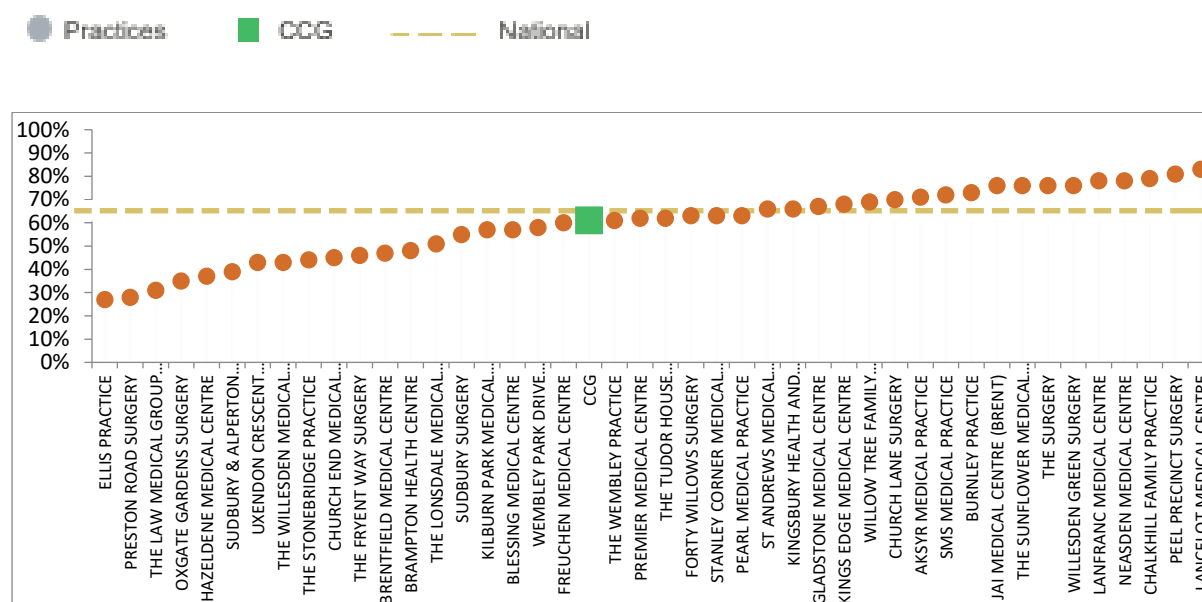
Patient from Wembley

"Booking an appointment on the telephone is stressful. It feels like pot luck whether I get through or not."

Patient from Stonebridge

As in Figure 8, there is significant variation in the percentage of patients saying it is 'easy' to get through to someone on the phone at practice level. Currently, practices are responsible for providing their own telephony systems paid for using funding allocated to them by NHS England, and some practices are locked into expensive contracts with telephony systems which may not be capable of effectively supporting new ways of working. The Task Group has heard that practices are looking at proposals to share back office functions at PCN level, including telephony systems. While such integration is encouraged and the benefits of a shared front-door experience is recognised, such a system would need to be adequately funded and ensure that patients' access to the care that they need is not adversely impacted.

Figure 8: Percentage of patients saying it is 'easy' to get through to someone on the phone⁴¹



⁴¹ NHS England (2020), GP Patient Survey: Brent results



It was frequently heard that some patients experience difficulties when trying to use GP websites or apps to book appointments. 28% of patients in Brent found it difficult to use their GP practice's website to look for information or access services in 2021.⁴² Different online platforms were used at different GP practices, although the most of common of those was eConsult (33% of respondents to the Task Group survey had used eConsult since March 2021). eConsult is an online platform that patients access via their GP practice website. Patients who want help for a specific condition are given options to access self-help information, learn about pharmacy treatments or contact NHS 111. Patients can also submit their symptoms to a GP electronically through their practice website, creating an online consultation. Any urgent symptoms identified during this process will immediately signpost the patient to their practice, emergency services or NHS 111. Some respondents felt that their GP practice did not have clear information on how to book appointments through their website, and others said that the format of some GP websites made it difficult to read or navigate to information on how to make an appointment.

⁴² NHS England (2021), GP Patient Survey: Brent results

Figure 9: Ease of using GP practice websites to look for information or access services⁴³



It has been found that some people were unsure if their online requests were successful, as people did not always receive notification, leading to people having to chase their GP practice to ensure requests had gone through. Others experienced missing information in online communications, such as a missing link to upload requested information. Such difficulties in using online platforms such as eConsult has created issues for GP practices too, with some reporting that unnecessary requests had been made around minor conditions manageable at home and that the time required to process requests created staff capacity issues. There is concern that patients at some practices are finding it easier to use digital or remote services than others – suggesting that there is variation in the online consultation service offered across practices. While the Task Group recognises the benefits of online consultation platforms, especially in relation to simple and routine medical enquiries and repeat prescriptions, it is keen to ensure that it does not replace investment in the GP workforce.

“I found e-consult confusing and difficult to use. I ended up calling NHS 111 instead.”

Patient from Preston

“I found it unhelpful for acute problems such as abdominal pain, headaches or rashes. It cannot judge the severity of your physical symptoms like a GP can.”

Patient from Alperton

The Task Group has heard that North West London CCG are currently looking at proposals to recommission its service provider for online consultations, with eConsult’s contract due to expire shortly. The Task Group welcomes the offer to meet with North West London CCG and

⁴³ Ibid

share its views on the current service, which it hopes will support the procurement exercise and help to deliver an improved online consultation service for patients in Brent.

Some respondents to the Task Group survey felt that the receptionist at their GP practice was unhelpful, or made it difficult to book an appointment. Receptionists in GP practices are generally the first point of contact for people seeking medical help, acting as gatekeepers to the service. In fact, 16% patients in Brent did not find their receptionist helpful in 2021, compared to 11.3% nationally.⁴⁴ However, it is important to note that the role of a receptionist has been more challenging than ever throughout the Covid-19 pandemic, with receptionists receiving a high volume of telephone and online requests with patients being asked to avoid trips to the practice.

“The receptionist at my GP practice wanted to know my medical issues before they would book me an appointment with a doctor. I found this quite intrusive.”

Patient from Wembley

Overall, 60% of people in Brent described their experience of making an appointment in Brent in 2020 as good, compared to 65% nationally. Of those, 19% described it as poor, compared to 17% nationally.⁴⁵ Of those who responded to the Task Group survey and had contacted their GP since March 2021, 43% had found it either more difficult, much more difficult or were unable to contact the GP at all.

Some residents said that they were giving up before they are offered an appropriate GP appointment, and even presenting at A&E as an alternative.. Of the respondents to the Task Group survey who had used healthcare services other than their GP practice since March 2021, 27% had used NHS 111 and 26% had used A&E after making contact with their GP – suggesting that patients did not always access the necessary care at the first time of asking. As demonstrated in Indeed, 19% of patients went to A&E after declining an appointment with their GP in 2020, compared with 13% nationally.⁴⁶ This may put additional pressure on A&E units – with some patients presenting with issues that could be resolved at general practice.

It is important to note that the majority of respondents to the Task Group survey were happy with the treatment they received from their GP since March 2021. Of those who had sought care and treatment from their GP practice since March 2021, 52% felt that their GP had been good or very good at giving them enough time, and 60% felt that their GP had been good or very good at listening to them. This suggests that the main issue for many patients is accessing GP services, rather than the care they receive from GPs themselves.

Type of appointment

Unlike the overall number of appointments delivered by GP practices, the number of face-to-face appointments offered has failed to return to pre-pandemic levels. Following the easing of social distancing rules in May 2021, NHS England issued updated guidance for GP practices which stated that all practices must ensure they are offering face-to-face appointments alongside the use of video, online and telephone consultations.⁴⁷ Nationally, only 58% of

⁴⁴ NHS England (2021), GP Patient Survey: Brent results

⁴⁵ NHS England (2020), GP Patient Survey: Brent results

⁴⁶ Ibid

⁴⁷ NHS England (2021), Updated Standard Operating Procedure to Support the Restoration of General Practice Services

appointments in August 2021 were face-to-face, compared with 54% in January 2021 and 80% before the pandemic.⁴⁸ The picture is the same across North West London – 62% of appointments in August 2021 were face-to-face, compared with 64% in January 2021.⁴⁹ Of those respondents to the Task Group survey who had been offered a consultation with their GP since March 2021, 68% were via telephone, 8% were via video and 28% were face-to-face.

Many residents said that they were not given a choice of appointment when making contact with a GP practice. NHS England issued updated guidance on patients' choice of consultation type in May 2021, stating that practices should respect preferences for face-to-face care unless there were good clinical reasons to the contrary.⁵⁰ The benefits of using online or telephone triage is well documented and recognised. However, there is concern that patients are becoming increasingly dissatisfied with the type of appointment offered, as well as the lack of choice in the appointment offered. Last year in Brent, 36% of patients were unsatisfied with the type of appointment they were offered, compared with 27% nationally.⁵¹

Moreover, some respondents to the Task Group survey stated their dissatisfaction with the type of appointment given by their GP practice since March 2021. Some people preferred the option of face-to-face appointments, whereas others believed that a lack of face-to-face appointments hindered an effective diagnosis. It was felt that, in some cases, GP practices may overlook individual support requirements, and that there may be insufficient systems in place to anticipate these. Whilst the demand on GP services and current infection measures in place are recognised, it is clear that face-to-face appointments do not work for every patient.

"I asked for a face-to-face appointment but was told to make my appointment online. I was given treatment following my online consultation but that did not work. I think if the doctor had seen me face-to-face they would have found it easier to diagnose me. I ended up getting private treatment."

Patient from Preston

Extended services and urgent care

Currently, there are two types of service which provide GP extended access services in Brent – the extra GP and nurse appointments provided in the evenings and weekends. There are currently five GP Access Hubs in Brent which operate by appointment only (booked through a patient's GP practice) or when a patient phones NHS 111. The service is only available to people who are registered with a GP in Brent. There is also one GP Access Centre located in Wembley, which is accessed by walk-in only and will see any patient whether they are registered in Brent or not. Referral to these services is largely dependent on the person who makes your appointment, for example, staff who are less tolerant of uncertainty or who perceive serious disease to be a more frequent event may refer more patients. In fact, 51% of Brent residents felt that it took too long to access care or receive advice when their GP practice was closed in 2020.⁵² There is also concern that patients are not aware that GP Access Hub

⁴⁸ NHS Digital (2019 & 2021), Appointments in General Practice

⁴⁹ Ibid

⁵⁰ NHS England (2021), Updated Standard Operating Procedure to Support the Restoration of General Practice Services

⁵¹ NHS England (2020), GP Patient Survey: Brent results

⁵² Ibid

are available outside of GP practice hours. This has been heard by respondents to the Task Group survey and, in January 2020, 26% of respondents to a Healthwatch Brent survey stated that they were unaware that their out-of-hours appointment was provided by a GP Access Hub.⁵³ Patients not knowing what out-of-hours services are available to them could negatively impact the care they receive, and could put pressure on A&E as well as other healthcare staff who may have to spend considerable time redirecting patients to appropriate health and social care services.

Brent Urgent Care Centre (UCC), based at Central Middlesex Hospital, is open 24 hours a day, seven days a week, and every week of the year. Its GP-led team offers urgent and immediate medical care when patients are unable to see their own GP and as an alternative to A&E without having to book an appointment. It is recognised that access to this service will vary, as what is deemed urgent may differ between individuals and clinicians. It has been heard that in recent months, the number of patients presenting to UCCs with a 'primary condition' has been high, and has largely returned to its pre-pandemic level. This may be as a result of difficulty in accessing GP appointments in some areas. There may also be other factors, such as a patient's proximity to a UCC or the deprivation of an area (with patients in high deprivation areas with limited access to resources to access self-care services such as pharmacies or the NHS App more likely to attend this setting). Indeed, the Task Group has heard that Brent UCC was utilised more in Stonebridge and Harlesden than any other area in Brent – the two highest areas of deprivation in the borough, and two areas of close proximity to Brent UCC.

Local commissioners explained that primary care is available through GP practices for general mental health needs, such as anxiety, depression, or post-traumatic stress disorders. A GP can then advise the patient with general self-help materials, refer them to counselling and prescribe medication. According to a Mind survey, two in five (40%) of all GP appointments in 2018 involved mental health issues.⁵⁴ While the situation is often complex, there is also an established pathway for referral to secondary care should a patient present to a GP practice in mental health crisis. Brent's Single Point of Access (SPA) provides a referral point, 24/7, to secondary mental health services for emergency, urgent and routine referrals. If deemed an emergency situation, an emergency response team would arrive to assess the patient and decide whether the patient is transferred to an acute bed or given treatment at home. Inconsistent decision-making can result in delays to access and the individual's care and treatment. It has been heard that these delays can result in the patient becoming more distressed and unwell, as well as increasing the potential risk to GP staff and other patients. However, it is important to consider the difficult considerations a GP may have in dealing with a patient in crisis, such as patient and staff safety, infection control measures, the different ways that patients may present and the time it takes for an emergency response team to arrive.

⁵³ Healthwatch Brent (2020), GP access hub appointments in Brent

⁵⁴ Mind (2018), 40 per cent of all GP appointments about mental health

Recommendation 3

Brent PCNs adopt a GP access and treatment standard that all GP practices sign up to and are accountable to. The standard should describe what services are available and what patients can expect from them. All patient participation groups (PPGs) should be involved in setting this standard, and PPGs should be regularly updated on the performance of the standard.

The Task Group has found that the ease with which patients access GP services varies across practices, and their experience of services varies too. An access and treatment standard will ensure that Brent residents experience consistently high levels of service in access and treatment when they need them, and in a way that suits their needs. The Brent standard should build on best practice of other local areas, and Brent Council should promote the standard across the West London Alliance.

The Task Group has identified the following access and treatment standards based on the experience of patients, which should be used a minimum:

- i. Reception and telephone access for all patient needs during opening hours
- ii. Agreed arrangements for evening and weekend access communicated to patients
- iii. Reception telephone answered within a maximum time frame or call back facility available (subject to the move to cloud based telephony systems)
- iv. Appointment and prescription requests addressed within a maximum time frame – regardless of whether request is made via telephone, online or in person
- v. Patients make one call only to make an appointment during core hours (subject to the move to cloud based telephony systems)
- vi. Appropriately trained clinicians should be involved in all stages of the triage process
- vii. Patients updated on all further action taken in respect of requests, appointments and/or treatments where these are carried out by the practice
- viii. Referrals to secondary care are clinically appropriate and in accordance with any agreed clinical pathways and referral protocols – patients are updated at each stage of the referral
- ix. For rapid access - conversation with registered clinician within fixed period in advance; emergency and urgent needs triaged within four hours. Practices clearly set out the process for routine, rapid and emergency access by agreement with NHS 111 and PPGs – this should be made clear on practice websites
- x. Flexible appointment types should be offered and booked in line with clinical need and patient's preference, including face-to-face, telephone, remote/digital and home visits – the range of appointment types should be made clear on practice websites
- xi. Bookings available to patients up to four weeks in advance for routine care and patients are made aware of process for cancelling and rebooking routine care appointments
- xii. Registration at any GP practice, where this is possible with no requirement for address, immigration status, identification or NHS number – with digital and face-to-face registration options for new patients
- xiii. Patients have their digital literacy and access to digital devices recorded on their patient file and taken into account when treatment is given
- xiv. Consent for digital communication and services and recorded in patient file
- xv. Guidance on online consultation service and digital communication communicated on practice website in easy to use language
- xvi. Patients to be able to communicate with GP practice via online consultation system and secure online messaging
- xvii. Each practice works towards developing consultant nurse practitioner and prescriber skills
- xviii. Non-clinical staff should be available at each GP practice e.g. social prescribers – availability made clear on practice websites
- xix. Treatment plans for all patient care agreed with and shared with patients
- xx. Prescription medicines issued where clinically effective and cost-effective, ensuring patients are engaged in the process at each stage by their clinical team
- xxi. Newly registered patients should receive information on GP practice and NHS England complaints procedures, as well as local complaints and advocacy services

Recommendation 4

Brent PCNs widely communicate the GP access and treatment standard and information on patients' rights to access and treatment including registration, appointments and prescriptions.

The Task Group has found that some patients were unaware of their rights to access GP services, the various GP services available to them, the clinical and social teams at a practice and the ways in which they are delivered. It is recommended that Brent PCNs communicate the GP access and treatment standard, as well as information on patients' rights concerning access and treatment including registration, appointments and prescriptions to ensure they have a clear understanding of what to expect from general practice. Brent PCNs should also measure and communicate the delivery of the standard, for example through the annual GP patient survey, practice websites and PPG meetings.

Recommendation 5

Brent PCNs develop an action plan to ensure that patient participation groups (PPGs) are supported to be actively involved in improving GP services. Brent PCNs should report progress against the action plan to Brent ICP and Brent Community and Wellbeing Scrutiny Committee.

The Task Group is keen to ensure that practice PPGs are well resourced, representative of the practice population, have input from relevant health and voluntary professionals and are actively involved in service improvement. Brent PCNs should also set up PCN-wide PPGs that are representative of the geographical area they cover and actively involve patients in designing future service delivery. Brent ICS and Brent Community and Wellbeing Scrutiny Committee should ensure that the action plan is delivered by monitoring the effectiveness of PPGs, and Brent ICS should report to Brent Health and Wellbeing Board on PPG performance. Where appropriate, PPG representatives should be co-opted onto the Community and Wellbeing Scrutiny Committee and/or its Task Groups and consideration should be given to formalising links with Healthwatch Brent.

Recommendation 6

Brent PCNs demonstrate that the configuration of their services does not disadvantage patients based on where they live.

The Task Group is concerned that the current arrangement of GP services in local areas may disadvantage some patients based on where they live. It is recommended that Brent PCNs consider ensuring that their configuration recognises pre-existing localities such as the five Brent Connects footprints. This should facilitate more geographically accessible services for patients and more effective integrated working between PCNs and statutory health and care partners. PCNs should consult statutory health and care partners on any proposal to change the configuration of a PCN, and if a change is made the rationale for doing so should be communicated to registered practice patients.

Barriers to accessing GP services

Language

Brent is one of the most linguistically diverse areas in the country, with around 150 different languages used. In 2011, 37% of the Brent population used a main language other than English, which is the second highest in England after Newham (41%). While the majority using other languages are also highly proficient in English, around 9% of adults in Brent could not speak English well, or at all. Proficiency in English was related to both age and gender: older women typically had poorer levels of proficiency in English.⁵⁵

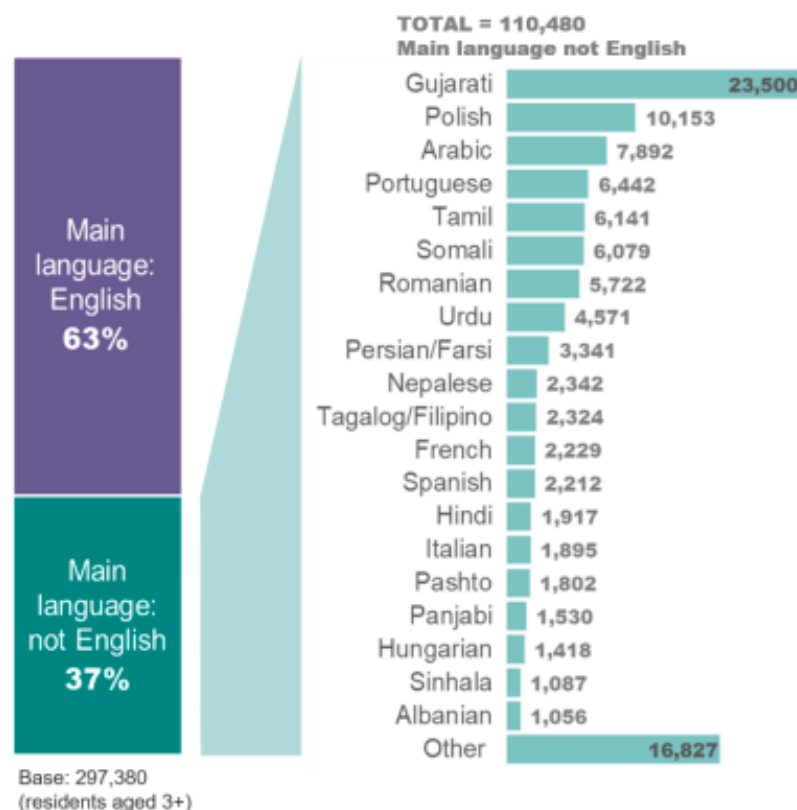


Figure 10: Residents by main language, Brent 2011⁵⁶

Deaf patients are specifically entitled to British Sign Language (BSL) interpreters to ensure they can receive and understand information about their care and communicate with practitioners. While patients who do not speak English or have English as a second language and require extra support are not legally obliged to receive it, NHS England guidance states that patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others.⁵⁷

⁵⁵ Brent Council and Brent Clinical Commissioning Group (2019), Joint Strategic Needs Assessment: Migrants and Refugees

⁵⁶ Ibid

⁵⁷ NHS England (2018), Interpreting and Translation Services in Primary Care

Residents who do not speak English as their first language expressed concern that language barriers can lead to miscommunication between clinicians and patients, which can decrease the quality of care given. Whereas interpreters can usually be present during a face-to-face appointment, remote booking systems and telephone consultations present a more significant challenge for those that do not speak English. People with limited English proficiency, especially the elderly, tend to rely on body language and facial expressions to communicate with their doctors during face-to-face appointments, making remote appointments difficult. People with language barriers often depend on family to translate their issues during consultations, which can be an issue when sharing private medical information and can put people off contacting their GP practice. As most online information is in English, people with language barriers, including those who use British Sign Language, find it hard to understand. For example, trying to book or confirm an appointment on an English-based online consultation platform, such as eConsult, can be a problem and can prevent patients from accessing care.

“We can’t express our medical issues over the phone because English isn’t our first language. We can’t demonstrate our concern in the same way.”

Patient from Wembley

“I have to use e-consult for my grandparents because they do not speak English. Once an appointment I made I need to make sure I’m around for most of that day because the appointment slots are so wide.”

Patient from Harlesden

Disability and long-term conditions

Around one in seven Brent residents (14%) have a long-term health problem or disability that limits their day-to-day activities – either a little (7%) or a lot (7%). Those who regularly use GP services are more likely to have a disability or long-term condition - of those who responded to the Task Group survey, 33% had a disability. The prevalence of disability and poor health rises sharply with age: 83% of residents aged 85 or over had a long-term health problem or disability compared with 3% of children. Of all those aged 65 and over, more than half (54%) had a long-term health problem or disability. The prevalence of disability in Brent and London is lower than nationally (20%), reflecting the fact that the population in London has a younger age profile.⁵⁸

Nationally, 2.2% of the population have a learning disability. In Brent, this equates to approximately 7,000 people when applied to census population estimates. As of 2017 approximately 3,300 adults were registered as diagnosed with a learning disability with Brent CCG and 640 are known to Brent Council as users of statutory funded services to meet their Care Act eligible needs.⁵⁹ The number of children and young people with Special Educational Needs and Disabilities (SEND) is relatively high and continuing to rise, with 3.9% of children

⁵⁸ Brent Council (2020), Equality Profile of Brent

⁵⁹ Brent Council and Brent Clinical Commissioning Group (2017), Brent Joint Learning Disability Strategy 2017-20

who attend school having an education, health and care plan (EHC), compared to 3.7% nationally.⁶⁰

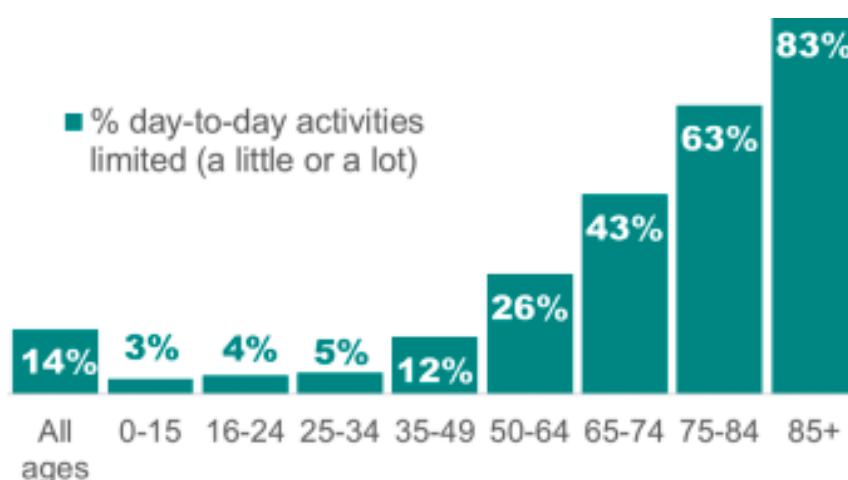


Figure 11: Long-term disability or health problem by age, Brent 2011⁶¹

It is estimated that 4,300 disabled residents in Brent are offline. Disabled internet users are less likely to access public services online than non-disabled internet users – 37% vs 43% nationally. This gap varies among people with different impairments: it is largest for visually impaired people (27% vs 43%), while hearing-impaired people are as likely as non-disabled people to use the internet to access public services (44% vs 43%).⁶² The Task Group has heard that some people with a learning disability did not have digital access or were unable to use technology without support or a carer present. Some people with sight impairments were unable to read instructions unless they were in Braille, and those with hearing impairments may struggle to make or attend appointments via telephone. There is concern that this can make some people reluctant to contact their GP practice via telephone or online, and as a result they may not access the care that they need.

Physical disabilities can also be a barrier to accessing digital or remote healthcare. For example, people with disabilities affecting their arms may not be able to use a computer or telephone screen. Holding the telephone for a long time to get through to a GP practice can also be difficult. Some people who responded to the Task Group survey were unaware that their GP practice may offer home visits – suggesting that some disabled patients and their carers did not have access to home visits either due to a lack of communication or because their GP practice were not offering them at the time. There is concern that for many disabled people the alternatives are not always appropriate.

Some disabled residents have said that prior to the Covid-19 pandemic they found it difficult to book same-day appointments if their GP practice required them to physically attend the surgery and queue in the morning. Similarly, people with paid carers were only able to attend appointments at certain times of the day, but this did not always match with the times available for same-day appointments. Therefore, some disabled people, especially those with mobility issues, have found that remote or digital healthcare has made it easier for them to access GP services and to avoid difficult trips to their practice.

⁶⁰ Office for National Statistics (2021), 'Special educational needs in England: January 2021'

⁶¹ Brent Council (2020), Equality Profile of Brent

⁶² Citizens Online (2020), Digital Inclusion in Brent

"I can't get an appointment. I struggle with technology and making an appointment via telephone is difficult for me – I have a hearing impairment and have to wear a hearing aid."

Patient from Wembley

"My surgery is not accessible for disabled people like myself. Due to my disability, I also find it difficult to make appointments online and the wait to get through on the telephone is just too long. I find it difficult to contact my GP practice."

Patient from Willesden Green

Deprivation

Brent has high levels of poverty and deprivation. One in three households in Brent live in poverty - compared to one in five in England. This is the sixth highest rate in London and the highest in outer London. Of Brent's 34 neighbourhoods, 15 are in the top 10% nationally for poverty rates. There are particular concentrations of poverty in areas such as Harlesden and Stonebridge. Poverty rates are particularly high for young people in Brent - one study has found that for every five children in Brent, two will be in poverty.⁶³ The local economic consequences of the pandemic are set to be significant too - Brent had the second highest proportion of its working age population on furlough during the pandemic.⁶⁴

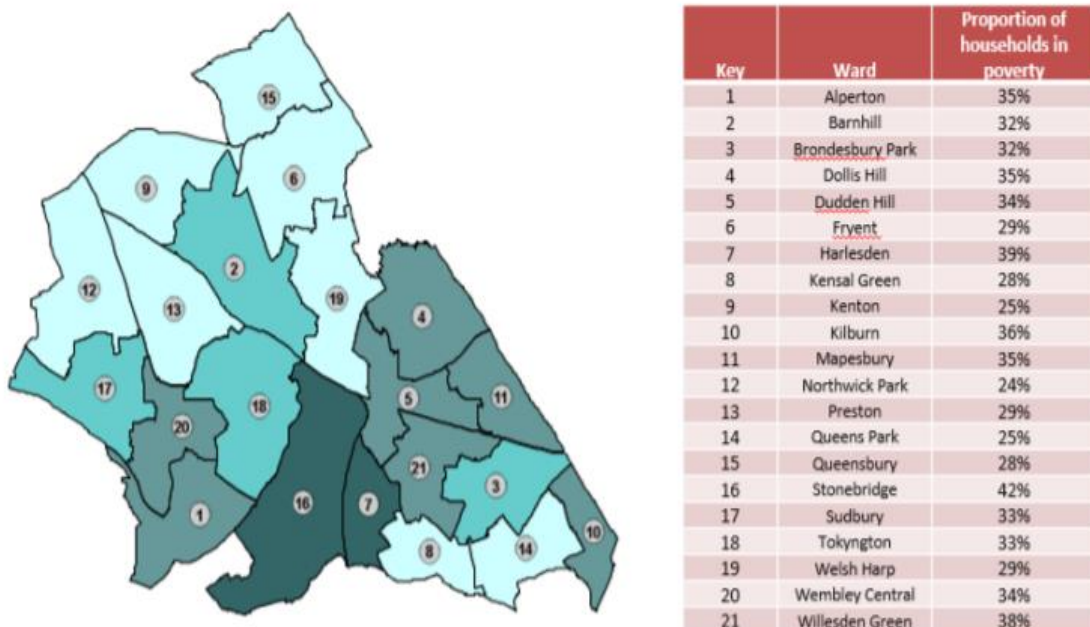


Figure 12: Brent households in poverty by middle layer super output areas⁶⁵

⁶³ Brent Council (2020), A Fairer Future: Ending Poverty in Brent

⁶⁴ Ibid

⁶⁵ Ibid

Residents on lower incomes have said that they are less likely to have digital skills and therefore may struggle to access digital or remote GP services. Nationally, only 25% of people earning under £11,499 per year have skills in each of the five essential digital skills groups (communicating, handling information and content, transacting, problem solving and being safe and legal online), compared to 61% of people earning over £25,000. Furthermore, people on lower incomes are less likely to be able to afford digital devices, and are therefore more likely to be digitally excluded - between 34,000 and 98,000 adults in Brent lack access to one or more digital devices (between 13% and 37% of the adult population).⁶⁶ In fact, Harlesden, Stonebridge and Dollis Hill were all included in the 10% of wards nationwide most at risk to digital exclusion – three of the most deprived wards in Brent.⁶⁷

Some people on lower incomes may be unable to afford the extra charge of a broadband contract, or some may opt for devices with more basic features which may prevent them from using certain healthcare applications. Access to the internet is not the only barrier – it can also be difficult for people to afford to call their GPs using a telephone if they are on a pay-as-you-go contract or a contract with limited call allowances, and people may be put off by the cost of long waiting times to get through to their GP practice. It has also been heard that people on cheaper internet deals may have poor connection and slow internet speed, making remote or digital consultation difficult. This becomes more challenging for those with language barriers and in need of interpreter services when communicating with their GP online.

“I haven’t looked into using e-consult. I don’t have the money to afford a device to use it, nor the digital skills or confidence to navigate it.”

Patient from Stonebridge

Age

Like other boroughs in London, Brent has a relatively young population. The median age of the population is 36, four years lower than the national average. Brent has proportionately fewer over 50s than England (30% vs. 38%), and more adults aged 25-44 (31% vs. 26%). Brent also has a higher proportion of children aged under ten compared with England (14% vs. 12%).⁶⁸ Between 2020-41, the number of residents aged 65 and over is projected to increase by 78% – an additional 33,000 older residents by 2041. In contrast, the child population is expected to see little change over the same period, increasing only marginally by 1%.⁶⁹

⁶⁶ Citizens Online (2020), Digital Inclusion in Brent

⁶⁷ Ibid

⁶⁸ Brent Council (2021), Population Change in Brent

⁶⁹ Ibid

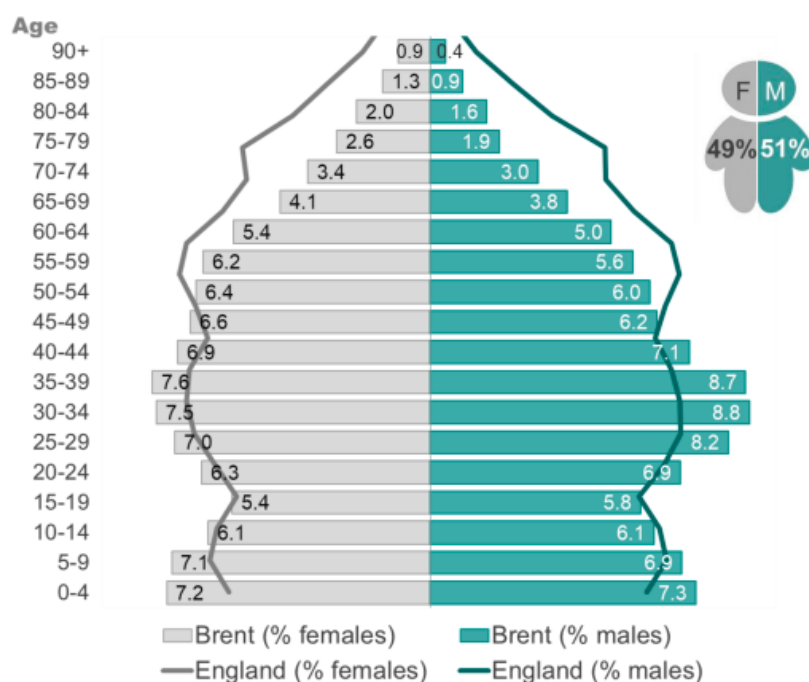


Figure 13: Population by age and gender, Brent and England 2020⁷⁰

Older people are more likely to be digitally excluded – to be offline, to lack digital skills and to be less likely to have access to digital devices. Nationally, 33% of people aged over 65 have not been online in the last three months. The majority of these (86%, or 29% of all people aged over 65) have never been online.⁷¹ Of those who responded to the Task Group survey and had not used eConsult, 18% were over the age of 64. There may be number of reasons for this, including a lack of knowledge, cost and security concerns. It has been heard that some elderly patients are more comfortable depending on family to help them access digital or remote healthcare services, but this has not been possible for some who may be isolating due to the Covid-19 pandemic and cannot meet their family. There is concern that a lack of alternatives to remote or online consultations may mean that they do not receive vital healthcare. However, it should be noted that some elderly patients do feel comfortable using digital devices. The Task Group has heard that some elderly patients find online platforms such as eConsult useful in managing long-term conditions – especially in accessing routine care, medical reviews and prescriptions.

“My elderly mother struggled to get through to her GP practice on the telephone. She had to wait a long time and wasn’t called back within the time frame given to her. She doesn’t have access to any technology and doesn’t have the digital skills to use online services so her options are limited.”

Patient from Tokyngton

⁷⁰ Ibid

⁷¹ Citizens Online (2020), Digital Inclusion in Brent

Some young people have said that they find it difficult to make appointments with their GP. Once children reach the age of 16, they can agree to examination and treatment just like adults, and GP practices do not need to seek parental consent to see them. However, Brent Youth Parliament has told the Task Group that contacting a GP practice was daunting for some young people. Some felt that GP staff were not always empathetic towards the issues that young people present with, such as mental health concerns, and others felt altogether unimportant to their GP. Generally, it was felt that GP practices were unwelcoming for young people and that staff sometimes failed to ease any concerns that they may have prior to attending an appointment. Anecdotal evidence has also been heard from some parents with young children that they are being turned away from GP practices, and are instead reverting to NHS 111 or even presenting at A&E. There is concern that practices are refusing to see children with flu-like symptoms such as a cough, runny nose and fever, even if they are Covid-19 negative. It is important to note that some children and young people (especially those with long-term conditions) are regular users of GP services. Asthma is the most common long-term condition in childhood nationally – in Brent, there were 168 emergency admissions of children (under 10 years) due to asthma in 2019/20. Indeed, this is higher than the average rate for England, which lied at 161.⁷²

“My GP practice refused to see my infant child because she had a cough and a fever. We were told to present at A&E instead.”

Patient from Wembley

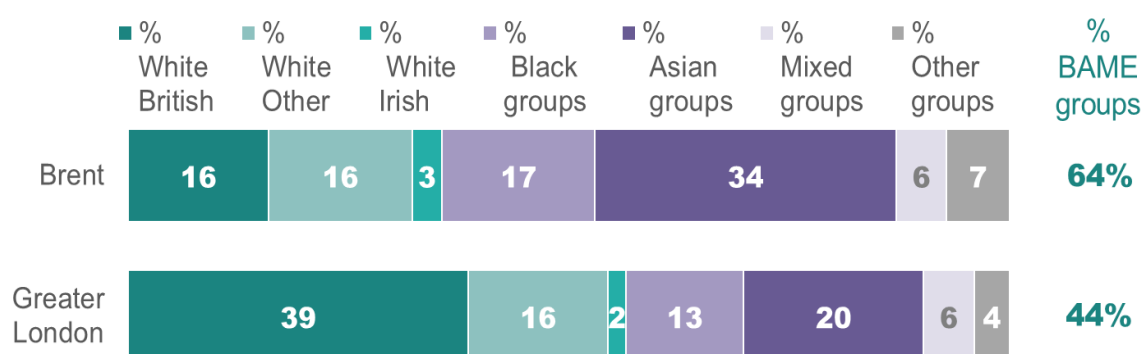
Ethnicity and country of birth

Brent is one of the most diverse boroughs in London. In Brent, almost two thirds of the population are from minority ethnic groups, the third highest in London behind Newham and Redbridge. A further 19% of residents are from White minority groups, and the remaining 16% are White British, the second lowest rate in London after Newham. It has a large Asian population: one third of its residents are from Asian groups compared to 20% across London. Around 18% of residents are from Black ethnic groups, higher than the London average (13%). It is estimated that around 16% of the Brent population are from ‘White Other’ groups – up from 14% in 2011. Around three quarters of this ethnic group were from countries in Eastern and Western Europe in 2011.⁷³

⁷² Public Health England (2021), Child Health Profiles

⁷³ Brent Council (2021), Community Profiling: Diversity in Brent

Figure 14: Population by ethnicity, Brent and London 2020⁷⁴



Brent attracts residents from all over the world. In 2011, over half (55%) of the Brent population were born outside the UK – the highest percentage in England and Wales. The 2011 Census identified Brent residents born in 215 different countries. The top countries of origin included: India, Poland, Ireland, Sri Lanka, Kenya, Jamaica, Somali, Pakistan, Romania and Iraq. In 2011.⁷⁵

While there is little data on the levels of asylum seekers and refugees in Brent, the number is thought to be considerable. Brent Council offered to home 52 Syrian refugees under the Vulnerable Person Resettlement Scheme between March 2017 and June 2019, including 25 children. 306 unaccompanied asylum-seeking children came to Brent between 2017 and 2019. More than half of Brent's unaccompanied asylum seeking children came from two countries: Afghanistan and Albania.⁷⁶

Some residents have said that GP practices in Brent are not providing undocumented migrants, refugees and asylum seekers with the necessary support to register with a GP practice, or are not allowing them to register altogether. An investigation by the Bureau of Investigative Journalism (BIJ) in 2021 found that undocumented migrants without proof of address or ID were being refused registration with GP surgeries in Brent. It contacted 19 surgeries posing as a migrant's friend – four would not respond to the enquiry at all, and a further 12 refused to register an undocumented prospective patient.⁷⁷ The Task Group has also heard about the difficulties refugees and asylum seekers have found in registering with a GP practice - some were unaware of their right to register with a GP practice, which led to delayed access to free NHS prescriptions and dental care. It also affects the effectiveness of

⁷⁴ Ibid

⁷⁵ Ibid

⁷⁶ Brent Council and Brent Clinical Commissioning Group (2019), Joint Strategic Needs Assessment: Migrants and Refugees

⁷⁷ Kilburn Times (2021), Undocumented migrants in Brent denied access to GPs

the Covid-19 vaccination programme, as people will only be contacted to arrange a vaccination appointment if they are registered with a GP practice.

“Many of the asylum seekers and refugees I work with are unaware of their rights to access primary care. This makes receiving any treatment a lengthy process, as we have to support them to navigate the registration process and to book an appointment. Only then can they get the treatment they need.”

Refugee Resettlement Officer based in Stonebridge

Recommendation 7

Brent PCNs implement a SMART action plan to reduce the barriers experienced by patients when accessing GP services, with a focus on deprivation, ethnicity, disability and other protected characteristics. Brent PCNs should report progress against the action plan to Brent ICP and Brent Community and Wellbeing Scrutiny Committee.

The Task Group has repeatedly found that some groups of patients experience significant barriers and unequal access to GP services, including patients on persistent low incomes, those with a disability, some older patients, patients whose first language is not English, some children and young people, refugees and asylum seekers and those who cannot access digital technology. It is recommended that a SMART action plan is developed to advance equality of access between people who share a protected characteristic and those who do not (with consideration for the Equality Act 2010), and that the actions identified are incorporated into the access treatment standard.

Recommendation 8

Brent ICP should work alongside Brent Children’s Trust to conduct further research into the experience of children and young people in accessing GP services and take any action as identified.

The Task Group has concern that some parents with young children and children and young people themselves are having difficulty accessing GP services, especially in accessing mental health support and rapid access to primary care for infants and young children with childhood illness. As such, there is an urgent need to quantify the service offer for children and young people. It is recommended that Brent ICP works alongside Brent Children’s Trust to commission necessary expertise to conduct further research on this matter, and that the findings inform an update of the actions identified in the SMART action plan to address the barriers to access and deliver the GP access and treatment standard.

Appendices

Appendix A Participants

The task group would like to thank the following participants who contributed to the report and/or took part in evidence sessions held between 26 May 2021 and 11 November 2021:

- Fana Hussain, Interim Brent Borough Director, North West London Clinical Commissioning Group
- Dr Madhuker C Patel, Brent Borough Lead, North West London Clinical Commissioning Group
- Jonathan Turner, Brent Borough Director, North West London Clinical Commissioning Group
- Councillor Harbi Farah, Lead Member for Adult Social Care, Brent Council
- John Licorish, Public Health Consultant, Brent Council
- Sheik Auladin, Managing Director, North West London Clinical Commissioning Group
- Councillor Neil Nerva, Lead Member for Public Health, Culture and Leisure, Brent Council
- Dr Sachin Patel, Clinical Lead, North West London Clinical Commissioning Group
- Jon Baker, Deputy Medical Director, London North West Healthcare NHS Trust
- Norrita Labastide, Divisional Manager, London North West Healthcare NHS Trust
- Patrick Brooke, Director of Totally Urgent Care, London North West Healthcare NHS Trust
- Jo Kay, Manager, Healthwatch Brent
- Isha Coombes, Programme Director, Brent Integrated Care and Community Services
- Dr Jahan Mahmoodi, General Practitioner, Hazeldene Medical Centre
- Behtenie Woolfson, Area Inspection Manager, Care Quality Commission
- Dr Ishani Patel, Clinical Lead, North West London Digital Accelerator
- Rehena Ramesh, Digital Lead, Brent Council
- Madeleine Leathley, Digital Workstream Lead, Brent Council
- Kemi Akanle, Clinical Director for Brent Mental Health Services, Central and North West London NHS Foundation Trust
- Michelle Reilly, Practice Manager, Lonsdale Surgery
- Dr Sana Rabbani, General Practitioner, Freuchen Practice
- Karen McCartney, Practice Nurse, The Surgery
- Dr Mohammed Haidar, General Practitioner, The Wembley Practice
- Sarah Nyandoro, Head of Joint Commissioning for Mental Health, Learning Disability and Autism, North West London Clinical Commissioning Group
- Philippa Galligan, Borough Director for Brent Mental Health Services, Central and North West London NHS Foundation Trust
- Zena Kazeme, Refugee Resettlement Officer, Sufra North West London
- Kenechi Ezeajughi, Chair of Brent Youth Parliament

The Task Group would also like to thank all residents who took part in the survey on their experiences of access to GP services in Brent since March 2021. It has been valuable to hear directly from patients with experience of accessing general practice in Brent.

The Task Group has been impressed by the knowledge and insight of all stakeholders and expert witnesses involved, and thanks them for their contribution to a shared vision of GP access across Brent in which no patient is left behind.

Appendix B

Evidence Sessions

	Themes and Areas for Discussion
Evidence Session 1 26 May 2021	Demand and Access for Primary Care GP Services GP and Out of Hours Provision in Brent Health Inequalities Primary Care Workforce and Capacity
Evidence Session 2 9 June 2021	Quality Standards GP Access and Deprivation, Deprivation GP Primary Care and Health Inequalities Cultural Communities GP Primary Care and Health
Evidence Session 3 24 June 2021	Understanding Digital Exclusion in Brent Digital GP Access and Health Inequalities Digital Local Offer for GP Primary Care
Evidence Session 4 15 July 2021	General Practice Teams and Primary Care Services Supporting Patients to Access GP Primary Care General Practice Workforce and the Digital Offer
Evidence Session 5 20 October 2021	Vision for Primary Care in Brent Pathways from GP Services to Mental Health Services GP Practice Contingency Planning
Evidence Session 5a 27 October 2021	Vision for Primary Care in Brent
Evidence Session 6 11 November 2021	Accessibility of GP Mental Health Services Pathways from GP Services to Mental Health Services

Appendix C

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Appendix D

Glossary of Terms

- A&E: Accident and Emergency
- CCG: Clinical Commissioning Group
- GP: General Practitioner
- GP Access Hub: GP practice offering evening and weekend appointments for patients registered with other practices in the area, providing access to primary care out of normal GP practice opening times.
- NHS: National Health Service
- NHSE: NHS England
- ICS: Integrated Care System
- ICP: Integrated Care Partnership
- NWL: North West London
- Primary Care: Primary care is the day-to-day healthcare given by a health care provider. Typically, this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need. Patients can access primary care services through their local general practice, community pharmacy, optometrist, dental surgery and community hearing care providers.
- PCN: Primary Care Network
- PPG: Patient Participant Group
- UCC: Urgent Care Centre

Appendix E

NHS GP contract explained

Every individual or partnership of GPs must hold an NHS GP contract to run an NHS-commissioned general practice. These set out mandatory requirements and services for all general practices, as well making provisions for several types of other services that practices may also provide. There are three different types of GP contract arrangements used by NHS

commissioners in England – General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS). All types of contract are managed by the NHS commissioner (either NHS England or a local CCG).

The GMS contract is the national standard GP contract. This contract is negotiated nationally every year between NHS England and the General Practice Committee of the British Medical Association, the trade union representative of GPs in England. It is then used by either NHS England and/or CCGs (depending on delegated powers) to contract local general practices in an area. The PMS contract is another form of core contract but unlike the GMS contract, is negotiated and agreed locally by CCGs or NHS England with a general practice or practices. This contract offers commissioners an alternative route with more flexibility to tailor requirements to local need while also keeping within national guidelines and legislation. The APMS contract offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services. APMS contracts can also be used to commission other types of primary care service, beyond that of ‘core’ general practice.

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 Brent	Community and Wellbeing Scrutiny Committee 22 February 2022
	Report from the Transitional Safeguarding Task Group
Transitional Safeguarding Task Group Final Report	

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	Appendix 1 – Transitional Safeguarding Scrutiny Task Group Final Report
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Craig Player Scrutiny Officer Strategy and Partnerships craig.player@brent.gov.uk Meenara Islam Strategic Partnership Manager Strategy and Partnerships meenara.islam@brent.gov.uk Lorna Hughes Head of Strategy and Partnerships Strategy and Partnerships lorna.hughes@brent.gov.uk

1.0 Purpose of the Report

- 1.1 To present the findings and recommendations of the Transitional Safeguarding Task Group to the Community and Wellbeing Scrutiny Committee.

2.0 Recommendation(s)

- 2.1 To discuss and agree the contents of the report, with particular regard to the recommendations for Brent Council's Cabinet.

3.0 Detail

- 3.1 The Community and Wellbeing Scrutiny Committee can commission evidence based reviews of a policy area or function of the local authority, which are led by non-executive members. The Transitional Safeguarding Task Group was established to review the development of transitional safeguarding in Brent.
- 3.2 The evolution of transitional safeguarding practice nationally and the development of transitional safeguarding arrangements in Brent made the creation of the scrutiny task group timely, and has enabled members to review these arrangements at an early stage.
- 3.3 The Task Group was asked to produce a written report with recommendations to Brent Council's Cabinet and/or local NHS organisations. The Task Group's interim report was presented to the Community and Wellbeing Scrutiny Committee on 24 January 2022 which included early feedback on their findings. It has now concluded its work and its findings and recommendations are set out in the full report attached as Appendix 1.

4.0 Financial Implications

- 4.1 It is possible that if a recommendation was accepted and implemented that it may have financial implications for the local authority and/or local NHS organisations. Any financial implications will be reviewed by officers and reported to Cabinet for their consideration and approval.

5.0 Legal Implications

- 5.1 Section 9F, Part 2 of the Local Government Act 2000, *overview and scrutiny committees: functions*, requires that Executive Arrangements by a local authority must ensure that its overview and scrutiny committees have the power to make reports or recommendations to the authority or the executive with respect to the discharge of any functions which are or are not the responsibility of the executive, or on matters which affect the authority's area or the inhabitants of that area.
- 5.2 Section 9Fe, *duty of authority or executive to respond to overview and scrutiny committee*, requires that the authority or executive;-
- (a) consider the report or recommendations,
 - (b) respond to the overview and scrutiny committee indicating what (if any) action the authority, or the executive, proposes to take,
 - (c) if the overview and scrutiny committee has published the report or recommendations, publish the response, within two months beginning with the date on which the authority or executive received the report or recommendations.

6.0 Equality Implications

- 6.1 The scrutiny review should consider equalities duties as part of the general duty set out in the 2010 Equality Act.
- 6.2 Under Section 149 of the Equality Act 2010, the Council has a duty when exercising their functions to have 'due regard' to the need to:
- a) eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act;
 - b) advance equality of opportunity; and
 - c) foster good relations between those who share a "protected characteristic" and those who do not.
- 6.3 This is the Public Sector Equality Duty (PSED). The 'protected characteristics' are: age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex, and sexual orientation.

7.0 Consultation with Ward Members and Stakeholders

- 7.1 The report has been drawn up in consultation with Task Group members.

Report sign off:

SHAZIA HUSSAIN

Assistant Chief Executive

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Transitional Safeguarding in Brent

A Scrutiny Task Group Report

Chair, Councillor Ketan Sheth

**Brent Community and Wellbeing
Scrutiny Committee**

Members of the Task Group

Councillor Ketan Sheth (Chair)

Councillor Anita Thakkar (Vice-Chair)

Councillor Claudia Hector

Reverend Helen Askwith

The task group was set up by members of Brent Council's Community and Wellbeing Scrutiny Committee on 15 November 2021.

Contact:

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Chair's Foreword



In recent years, safeguarding children and adults has become increasingly complex, with risks such as sexual exploitation, gang and group offending and violent crime challenging the children's and adults' safeguarding workforce to identify opportunities for innovation. The notion of transitional safeguarding is an emerging one, not currently widely applied in policy or practice. Its implementation requires changes in policy and practice and across systems involving all agencies. Many local authority areas are already innovating and creating opportunities for more flexible and bespoke support, providing valuable experiences for young people at a key point in their lives.

Supporting young people's safety and wellbeing during the transition to adulthood is not only morally and ethically important, but it is also important for the future health of society and future generations. Young people may experience a range of risks and harms which may require a distinct multi-agency safeguarding response, and safeguarding support should not end simply because a young person reaches the age of 18. Investing in support to address harm and its impacts at this life stage can help to reduce the need for specialist and statutory intervention and criminal justice involvement later on in life.

The Task Group has been encouraged by the progress Brent has made so far in developing transitional safeguarding. It has come away with optimism that this good work will continue, and hopes that its findings and recommendations help Brent Council to provide leadership in this area through expanded partnership working, meaningful engagement with communities and active knowledge and skills exchange. The Task Group looks forward to seeing how Brent's approach to transitional safeguarding evolves.

Everybody has a valuable contribution to make to the transitional safeguarding agenda. I would like to thank all stakeholders and expert witnesses who gave up their time to meet with the Task Group; I have been impressed with their knowledge, insight and commitment to Brent's young people. I would also like to say a special thank you to Dez Homes, Director at Research in Practice, who kindly gave up her time to share her detailed understanding of the practice of transitional safeguarding and its evolution nationally. Finally, I would like to say a thank you my fellow Task Group members – Councillor Anita Thakkar, Councillor Claudia Hector and Reverend Helen Askwith.

Councillor Ketan Sheth

Chair, Transitional Safeguarding Scrutiny Task Group

Recommendations

The Transitional Safeguarding Task Group makes the following recommendations to Brent Council's Cabinet:

Recommendation 1: It is recommended that Brent Council identifies transitional safeguarding as a whole council priority.

Increased pressure on local authorities and partners to respond to complex risks and harms point to the need to consider a new way of working to safeguard young people more effectively. The Task Group believes that providing more effective and fluid support for young people as they enter adulthood not only supports their safety and wellbeing, but may also reduce the need for specialist and statutory services and criminal justice involvement.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that the development of transitional safeguarding is considered an organisational priority.

Recommendation 2: It is recommended that Brent Council considers developing a council-wide approach to transitional safeguarding which is evidence-informed, participative and considers equality, culture, diversity and inclusivity.

It is clear that some young people may fall through the gap between children's and adults' services as thresholds for support are not aligned or they fall out of contact with services. The Task Group believes that opportunities for developing multi-agency and integrated models that can better enable a transitional approach to safeguarding should continue to be explored, recognising that the interconnectedness of harms and adversities requires a highly integrated and consistent system of support.

The council-wide approach to transitional safeguarding should be informed by recommendations 3-5. Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that work plans across Brent actively consider and address transitional safeguarding.

Recommendation 3: It is recommended that Brent Council ensures that young people are active partners in the development of its transitional safeguarding approach.

The Task Group believes that transitional safeguarding should be a participative, user-led approach. This means adopting a collaborative approach; respecting young people's expertise and enabling them to coproduce solutions and support rather than

being treated as a passive recipient of support. Services should be responsive to the specific needs of the individual young person and as such should be flexible, integrated and multi-agency. This user involvement will support the development of effective safeguarding practice, informed by young people whose self-confidence, self-esteem and resilience can be developed through that involvement.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that young people are active partners in the development of transitional safeguarding.

Recommendation 4: It is recommended that Brent Council considers how it can enhance its support to young people within the transitional safeguarding cohort with needs in education, training and employment (ETE), financial literacy and housing.

The risks young people face are often inter-connected, and a range of risk factors, such as financial difficulties, housing problems, and not being in education, training or employment can co-exist. Strict service criteria or thresholds can generate confusion for young people as the system is complex and it can be difficult for them to work out what support they are able to access. The Task Group believes that some young people therefore need multi-agency support at a more intensive level in order to navigate the complexities of housing, education, training and employment (ETE), finances and further agency support. Brent Council's SMART team offers an example of good practice within adult social care which can be learned from across services to support young people transitioning to adulthood.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that there are measures in place to demonstrate practice change.

Recommendation 5: It is recommended that Brent Council promotes transitional safeguarding across safeguarding agencies and services working directly with young people by:

- a. Ensuring that Brent's strategic partnerships for children's and adults' safeguarding and Safer Brent Partnership offer multi-agency training for officers, local commissioners and service providers to raise awareness of transitional safeguarding.**
- b. Commissioning specialist training for elected and co-opted members to raise awareness of transitional safeguarding and empower them to identify gaps and areas for improvement in local safeguarding practice.**

The Task Group believes that the development of transitional safeguarding requires strong, collaborative leadership to enable creative and coherent practice and services for local residents. It is important that officers, local commissioners and service providers develop their knowledge and understanding of transitional safeguarding issues within the local area, share their expertise and support other professionals to develop their practice. The Task Group also sees elected and co-opted members as well placed to lead across boundaries with their experience of working across services, organisations and sectors, as well as their unique knowledge of the communities they represent.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that training is well attended and informs the development of transitional safeguarding across agencies.

Introduction

The Transitional Safeguarding Task Group was set up to review the development of transitional safeguarding in Brent. The evolution of practice nationally and the development of transitional safeguarding arrangements in Brent made the creation of the scrutiny task group timely, and has enabled members to review these arrangements at an early stage.

In recent years, safeguarding children and adults has become increasingly complex. Sexual exploitation, gang and group offending and violent crime - including domestic violence and abuse, modern slavery and trafficking - are challenging those involved in safeguarding children and adults to reflect on established models of safeguarding. Safeguarding is a field where binary notions of childhood and adulthood have prevailed and, as such, the notion of transitional safeguarding is an emerging one. Emerging evidence indicates that more effectively meeting the needs of young people as they transition to adulthood may help to avoid later interventions.

Task Group Membership

The Task Group was comprised of the following elected and co-opted members:

- Councillor Ketan Sheth (Chair)
- Councillor Anita Thakkar (Vice-Chair)
- Councillor Claudia Hector
- Reverend Helen Askwith

Terms of Reference

The following Terms of Reference were agreed for the Task Group:

- i) Understand the practice of transitional safeguarding, its evolution nationally and the applicability of its implementation in Brent
- ii) Consider how Brent is developing transitional safeguarding practice as part of an improvement to children and young people's services, and what the current offer is
- iii) Understand Brent's particular social demographics and the scale of the risks for adolescents in Brent
- iv) Explore the next steps and potential further development of transitional safeguarding by the local authority and its partners

Methodology

The Task Group gathered qualitative and quantitative evidence to complete its report and develop its recommendations. In particular, the Task Group carried out a number of evidence sessions with Brent Council officers, Brent Council Cabinet Members, local health commissioners, the police, voluntary and community service sector providers and academics. A full list of those who took part is detailed in Appendix A.

Members of the Task Group took part in three evidence sessions between December 2021 and January 2022. The first evidence session focused on the practice of transitional safeguarding, its evolution nationally and how it is being implemented in Brent. The second evidence session focused on the transitional safeguarding development work being undertaken in Brent and the experiences of transitional safeguarding for frontline staff, young people and families. The third evidence session focused on the next steps for developing transitional safeguarding in Brent, and the lessons that have been learned from other local areas, other services and wider parts of the system.

Recommendations were developed with reference to existing legislation for local authority scrutiny. The Task Group notes that an external body or local authority executive is not compelled to act on a recommendation; however, a local authority executive must respond within two months, and NHS organisations are expected to give a meaningful response within 28 days of recommendations being agreed by a scrutiny committee.¹

Background

Definitions

Definitions of adolescence and young adulthood are a source of some debate. For the purposes of this report, 'adolescence' is used to mean 10-18 years and 'late

¹ Department of Health (2014), Local Authority Health Scrutiny

adolescence' is from 16 years to the early twenties. 'Early adulthood' is understood as overlapping with late adolescence and 'young adults' refers to 18 years to mid-late twenties.² The term 'young people' is used in the report to bring these definitions together and refers to people aged 16-25 years.

The report uses the terms 'risk' and 'harm' to refer to abuse, neglect and the experience of adversity that would trigger a safeguarding response from services, for example a child 'is suffering, or is likely to suffer, significant harm' or 'an adult is experiencing, or at risk of, abuse or neglect'. It also uses the term 'risk' to denote the likelihood of experiencing harm or significant adversity.

'Extra-familial' harm refers to harm that occurs to young people outside of their family system, often during the adolescent years because at this age their social networks widen. The term 'contextual' when used in a safeguarding context refers to environment in which young people grow and develop and the different relationships that they form in their neighbourhoods, schools and online.

The term 'transitional safeguarding' describes the need for "an approach to safeguarding adolescents and young adults fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives".³ It focuses on safeguarding young people, from adolescence to adulthood, recognising this period of transition will be experienced differently by young people at different times.

Transitional safeguarding is not simply transition planning for people who are moving from children's social care to adult social care services. It refers to activity that has often fallen outside of the traditional notions of both 'transitions' and 'safeguarding', recognising that support to young people experiencing transition to adulthood can be fragmented, with differing age thresholds for service access and service eligibility and with differing services available for young adults.

Underpinning frameworks and legislation

The Task Group has heard that children's and adults' safeguarding services share a common aim of protecting people from harm, but that these two systems have evolved differently over time and are governed by distinct practice, policy and statutory frameworks. Practice, policy and statutory frameworks underpin multi-agency roles and define safeguarding responsibilities.

² Holmes, D. and Smale, E. (2018) 'Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood.'

³ Ibid

The current duty to promote the welfare of children has been established in law since the Children Act 1989 and 2004. This framework places a general duty on a range of agencies, including local authorities, the police and health services, to promote and safeguard the welfare of children in need in their area by providing a range of services appropriate to those children's needs.⁴ The statutory guidance, Working Together to Safeguard Children 2018, sets out how individuals and organisations should work together to safeguard and promote the welfare of children and young people in accordance with the relevant legislation.⁵ The Task Group has heard that, as of December 2021, there were 2878 children open to statutory services in Brent. Of these children, 353 were on a Child Protection Plan and 352 were Looked After Children.⁶

The current duties and responsibilities regarding care and support for adults has been established in law since the Care Act 2014. It places a general duty on local authorities and health services to provide a system of support to maintain and promote the independence and wellbeing of adults, and a statutory framework to protect adults from neglect and abuse. Making Safeguarding Personal, as set out in the Care Act 2014, aims to identify what action needs to be taken to stop or prevent abuse and neglect in the context of an individual's wellbeing.⁷ The Mental Capacity Act 2005 provides the framework by which an adult's capacity to make specific decisions at a particular point in time is assessed.⁸ The Task Group has heard that, as of September 2021, there were 4015 people in receipt of funded adult social care services in Brent. These are adults who have needs that arise from a physical or mental impairment or illness. There were almost 2,000 reports of abuse or neglect involving adults at risk in 2020/21, and Brent Council's statutory duty to intervene was met in 35% of these cases.⁹

Brent's young people

There are estimated to be around 42,500 young people aged 16-25 in Brent – this group makes up around 13% of the Brent population.¹⁰ It is estimated that 63% of Brent young people aged 16-25 are from Black, Asian and other ethnically diverse groups including 35% from Asian groups and 19% from Black ethnic groups.¹¹ Over two thirds of Brent's pupils (68%) have a first language other than English and, in total, Brent pupils use around 150 different languages.¹²

⁴ Children Act (1989) & Children Act (2004)

⁵ Department for Education (2020), 'Working Together to Safeguarding Children'

⁶ Brent Council, Evidence received at Evidence Session 1

⁷ Care Act (2014)

⁸ Mental Capacity Act (2005)

⁹ Brent Council, Evidence received at Evidence Session 1

¹⁰ Office for National Statistics, (2020), '2019 based mid-year population projections'

¹¹ Office for National Statistics, (2017), '2016 based ethnic group projections'

¹² Brent Council (2021), 'Brent Youth Strategy 2021-2023'

The poverty rate in the borough is significantly higher compared to the overall poverty rate in London. One in three households in Brent live in poverty – compared to one in five in the country as a whole. This is the sixth highest rate in London and the highest in outer London. Poverty rates are particularly high for children and young people in Brent – around 22% of children live in poverty, and this rises to 43% where housing costs are considered.¹³

Despite this relative deprivation, Brent's adolescent children perform well at secondary school. The proportion of 16/17 year olds not in education, employment or training is 1.4%. For London the proportion is 1.8% and nationally it is 2.6%.¹⁴ The number of children and young people with Special Educational Needs and Disabilities (SEND) is relatively high and continuing to rise, with 3.9% of children who attend school having an education, health and care plan (EHC), compared to 3.7% nationally.¹⁵

As of March 2021 Brent had 288 looked after children and young people. This represents 37 out of every 10,000 children and young people in Brent, compared to a rate of 62 out of 10,000 for England. 38.4% of the care population in Brent were aged between 16-18 years old and, as of March 2021, Brent Council was responsible for 415 care leavers (307 of which were aged 18-21 and 108 aged 22-25).¹⁶

A small minority of young people are vulnerable to extra-familial harm such as criminal and sexual exploitation. County lines is one area where criminal exploitation of young people can occur – as of April 2021, 133 individuals in Brent were identified who evidence a link to county lines activity and, of those individuals, the highest proportion were aged 17 to 19 years (35%) and 58% were aged 18 to 25. Moreover, 21.5% of knife crime victims (excluding domestic abuse) are aged 18-25, and 29.5% of knife crime suspects (excluding domestic abuse) are aged 18-25.¹⁷

The case for change

It is important to note upfront both the financial realities facing providers of safeguarding services and the financial case for innovation. The financial constraints placed upon local areas like Brent make it difficult to undertake any work considered non-statutory, and embedding transitional safeguarding would indeed require local services to provide support to young people that are currently not receiving a statutory safeguarding response. However, investing in preventative and recovery-

¹³ Brent Council (2020), 'A Fairer Future: Ending Poverty in Brent'

¹⁴ Brent Council (2021), 'Brent Youth Strategy 2021-2023'

¹⁵ Office for National Statistics (2021), 'Special educational needs in England: January 2021'

¹⁶ Report to the Corporate Parenting Committee (July 2021), 'Annual Corporate Parenting Report April 2020 - March 2021'

¹⁷ Brent Council, Evidence received at Evidence Session 1

oriented work to promote people's safety and wellbeing can play an important role in avoiding the need for specialist and statutory services and criminal justice involvement.

It is noted that extensive research has been undertaken by academics to illustrate why a more fluid and transitional safeguarding approach is needed for young people entering adulthood. The most widely accepted reasons are summarised in the following paragraphs.

Complex safeguarding needs of adolescents

Adolescents may have distinct safeguarding needs, harms and routes to protection. These are often 'contextual', extra-familial and are underpinned by complex social and biological drivers. The Task Group has heard that the risks adolescents face in Brent are often interconnected, and can include sexual abuse, physical and/or emotional abuse, neglect, homelessness, criminal exploitation and substance misuse. A range of risk factors, such as emotional and mental health difficulties, accommodation problems, and not being in education, training or employment can co-exist, and exposure to adversities such as bereavement and strained family relationships can make some more vulnerable to abuse. It is recognised that adolescents who have experienced harm may often require ongoing support beyond the age of 18, either because the harm continues into adulthood or because they need help to recover from the impact of harm.

The Task Group has heard that research on wider social determinants, such as poverty, show a link between deprivation – where families live and their resources – and safety and wellbeing needs. Childhood poverty is argued by some as the biggest factor increasing risk of homelessness, and poverty has been shown to have a strong effect on both physical and mental health. Poverty is also linked to sexual exploitation of adults, and some research suggests a connection between modern slavery (including forced labour, sexual exploitation and trafficking) and homelessness. Multiple studies find that poverty and associated structural factors are consistently linked to multiple crime-related outcomes, and poverty and inequality is also highlighted as a key factor in understanding gang-related crime and disorder. Some groups might face structural disadvantage, as a result of systemic racism, ableism, classism or sexism, and these persist into adulthood and may mean a person is targeted by those seeking to exploit them.¹⁸

Adolescence is also a time of considerable change with physical development and the effects of puberty having emotional and behavioural impacts. The Task Group has heard that some studies into brain development and its effects on behaviour show that

¹⁸ Holmes, D. and Smale, E. (2018) 'Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood.'

some elements of brain growth – such as the development to emotional regulation, social relationships and executive functioning - continue into the 20s. It is argued that the transitional nature of maturation after 18 may therefore require a more nuanced approach to ‘maturity’ and account for young adults’ individual experiences and circumstances in understanding their capacity to take particular decisions.¹⁹

The Task Group is of the view that the interconnectedness of these harms and adversities means that enabling young adults in Brent to be safe may require an integrated system of support that pays attention to childhood and adolescent experiences. It is recognised that there are a variety of ways in which a young person might need help to be safe, including housing support, therapeutic support, financial advice, employment support, legal support, and practical support.

Divergence between children’s and adults’ safeguarding systems and ‘silo working’

Safeguarding systems have developed in accordance with different legislative and policy frameworks and arguably divergent conceptual frameworks. The Task Group has heard that neither system is specifically designed with adolescents’ developmental needs or behaviours in mind, nor do existing approaches to safeguarding take into account evidence that the transition period for adopting adult social roles and responsibilities extends into the twenties. This can lead to what is termed as ‘silo working’ – where services work in close vicinity but independently from each other.

In relation to children, safeguarding duties aim to promote children’s upbringing and their welfare (rather than wellbeing). The Task Group recognises that the role of parents and the familial context arguably frames children’s safeguarding practice, because children are broadly viewed as lacking the full capacity to make decisions for themselves. A primary driver in children’s safeguarding is considered to be protection from harm and removing or mitigating risk - children fall within the scope of safeguarding duties if the local authority has ‘reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm’.²⁰

In relation to safeguarding adults, the Making Safeguarding Personal agenda aims to identify what action needs to be taken to stop or prevent abuse and neglect in the context of an individual’s wellbeing. The Task Group has heard that this approach is based on an understanding of ‘maturity’, associated with adult roles and responsibilities and capacity to make decisions. The Mental Capacity Act 2005 provides the framework by which an adult’s capacity to make specific decisions at a particular point in time is assessed. In terms of eligibility, the safeguarding duties apply to an adult who ‘has needs for care and support (whether or not the local authority is

¹⁹ Ibid

²⁰ Children Act (1989) & Children Act (2004)

meeting any of those needs) and; is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect'.²¹

The Task Group recognises that this divergence presents some challenges in terms of providing a fluid transitional response to safeguarding as young people enter adulthood in Brent, as the criteria by which someone is deemed to require a safeguarding response can change significantly upon reaching their 18th birthday. Consent provides another area of complexity; a child's consent is not required to initiate a safeguarding intervention, whereas consent is broadly considered essential before making a safeguarding referral should an adult be deemed to have capacity.

Differing legal and statutory thresholds

The Task Group has heard that young people in Brent transitioning from childhood to adulthood can find it difficult to access services. Older adolescents and young adults can fall through the gaps between children's and adults' services, often because they do not meet eligibility criteria for care and support from adult services (nor therefore for adult safeguarding), or they fall out of contact with services. This may exacerbate harm in adulthood, potentially leading to poorer outcomes across their lifespan and increasing the likelihood of specialist and statutory interventions in later life.

Whilst children in care in Brent are now entitled to support until the age of 25, those adolescents who have experienced high levels of trauma and harm but are not in care do not automatically have the same entitlements. Young people entering adulthood can fall out of contact with services or disengage with them for a range of reasons – often because services are not as flexible or responsive to adolescents' needs as they could be.

Importantly, the Task Group recognises that young people in Brent can experience a 'cliff-edge' due to different thresholds for access to services. For example, adolescents entering adulthood often do not meet adult mental health criteria, and young people with moderate special educational needs who received support while at school do not necessarily meet eligibility criteria for care and support from adults' services. The criteria by which a person is eligible for safeguarding support can therefore be very different for older adolescents and young adults.

²¹ Care Act (2014)

Recommendation 1: It is recommended that Brent Council identifies transitional safeguarding as a whole council priority.

Increased pressure on local authorities and partners to respond to complex risks and harms point to the need to consider a new way of working to safeguard young people more effectively. The Task Group believes that providing more effective and fluid support for young people as they enter adulthood not only supports their safety and wellbeing, but may also reduce the need for specialist and statutory services and criminal justice involvement.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that the development of transitional safeguarding is considered an organisational priority.

Recommendation 2: It is recommended that Brent Council considers developing a council-wide approach to transitional safeguarding which is evidence-informed, participative and considers equality, culture, diversity and inclusivity.

It is clear that some young people may fall through the gap between children's and adults' services as thresholds for support are not aligned or they fall out of contact with services. The Task Group believes that opportunities for developing multi-agency and integrated models that can better enable a transitional approach to safeguarding should continue to be explored, recognising that the interconnectedness of harms and adversities requires a highly integrated and consistent system of support.

The council-wide approach to transitional safeguarding should be informed by recommendations 3-5. Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that work plans across Brent actively consider and address transitional safeguarding.

Good practice

The Task Group believes that the evidence therefore points to a need to consider a new way of working in Brent in which existing safeguarding systems and services for children and adults become more aligned, more fluid and more responsive to the needs of young people. Working this way includes seeking to prevent harm for this cohort of young people, protecting them where harm is occurring and also recognising and responding in ways that can help them recover from the impact of harm. As such,

it is a multi-agency issue dependent on collaboration and connection between agencies, services and with communities.

Transitional safeguarding is not a prescribed model. It is a joined-up approach to policy and practice that is being developed and applied in different ways according to local circumstances. There are a number of areas that localities, including Brent, are exploring when considering how to strengthen their local safeguarding response to adolescents and young adults, as detailed in the following paragraphs.

Good practice within adults' safeguarding

The Task Group believes that there are many positive elements to safeguarding adults that might be usefully drawn into adolescent safeguarding practice. It is felt that doing so may not only create smoother transition to adulthood for young people in Brent who will continue to require support to be safe once they are adults, but might also ensure that young people's emerging independence and autonomy is more effectively promoted.

For example, the Care Act 2014 sets out the following six key principles that underpin all adult safeguarding work. The Task Group feels that these principles are arguably equally applicable to the safeguarding of adolescents, particularly older adolescents:

- Empowerment: People being supported and encouraged to make their own decisions and informed consent.
- Prevention: It is better to take action before harm occurs.
- Proportionality: The least intrusive response appropriate to the risk presented.
- Protection: Support and representation for those in greatest need.
- Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability: Accountability and transparency in safeguarding practice.

Making Safeguarding Personal is a person-centred and rights-based approach to adult safeguarding, which became part of the formal guidance under the Care Act 2014. It is an approach to safeguarding that aims to ensure that adults at risk are fully engaged and consulted throughout an intervention and that their wishes and views are central to the final outcomes.²² The Task Group feels that understanding participative approaches within adults' safeguarding and applying this understanding to transitional safeguarding practice could go some way to improving young people's experience of services in Brent.

²² Ibid

Good practice within children's safeguarding

The Task Group feels that, in turn, there are elements of children and adolescent safeguarding that might prove useful to those seeking to ensure young adults in Brent facing risk are supported most effectively. For example, the Contextual Safeguarding framework and learning from those local areas, like Brent, which have embedded it into policy and practice offers key messages and practical tools for safeguarding young people more effectively beyond the age of 18 years.

Contextual safeguarding may provide a framework for Brent to develop a transitional safeguarding approach that engages with extra-familial risks in adolescence. It may be useful as it recognises that many young people's needs cannot necessarily be addressed by traditional social work interventions, and focusing on the need to assess and intervene with extra-familial contexts and relationships in order to safeguard young people during adolescence. It also encourages an expansive understanding of who constitutes a safeguarding partner – with local businesses, stewards of public spaces and communities playing a key role alongside statutory and voluntary sector agencies.²³

Examples of innovation

The Task Group recognises that transitional safeguarding is being developed and applied in different ways according to local circumstances, and elements of a transitional safeguarding approach can be seen across agencies and services working with young people. For example, in some local areas the focus is on extending the support available to young people experiencing harm in their communities, for others there is a drive to develop services for young adults to prevent them developing longer-term care and support needs.

Newcastle - Sexual Exploitation Hub

This is a multi-agency service that supports both child and adult victims of sexual exploitation and modern day slavery. The service was initially commissioned by the police in partnership with the local authority, in recognition of the way perpetrators were targeting individuals regardless of age. The service works with people where there are identified risks and ongoing concerns around grooming, coercion and control.

Key features of the service include:

²³ Firmin C, Horan J, Holmes D & Hopper G (2019), 'Safeguarding during adolescence – the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding'

- Enables young adults to make sound choices and negotiate risks safely, with the team routinely using the Mental Capacity Act 2005 to assess adolescents' capacity to make safe decisions
- Outcomes-focused and with no upper age limit for the young people being supported
- Work is not time limited and practitioners are able to develop an in-depth understanding of the nature of the risks and needs experienced by adolescents
- Referrals into the service are made via a transition protocol across different services²⁴

Metropolitan Police – DIVERT programme

DIVERT was created to address a gap in statutory provision for young adults who go into police custody. It is a Metropolitan Police Service diversion programme designed to use police custody as a teachable moment to prevent young people aged 18-25 from reoffending, and leading them away from crime into employment, education or training.

Key features of the service include:

- Coaches tailor their approach to the individual's needs, assisting them in a variety of ways; from facilitating access to training, education or employment opportunities to assisting with housing issues or arranging support for mental health or addiction problems
- Coaches continue to work with the young person outside of custody, drawing on a network of partners and agencies for support
- Process continues completely independent of the criminal justice process, and coaches often maintain contact with young people who have received custodial sentences and continue working with them on release²⁵

Brent Council – Supportive Multi-Agency Response Team (SMART)

Brent Council's SMART service supports adults who experience multiple and intersecting vulnerabilities but who do not meet statutory criteria for social care interventions. The SMART service works with people within Brent who often have a cycle of homelessness, mental health admissions, drug and alcohol dependencies and contact with criminal justice and probation services. It is multi-disciplinary, involving social workers with mental health and social care backgrounds, an occupational

²⁴ Department of Health and Social Care (2021), 'Bridging the Gap: transitional safeguarding and the role of social work with adults'

²⁵ Ibid

therapist, drug and alcohol misuse professionals, a housing officer and supportive outreach officers.

Key features of the service include:

- Engages with service users who are difficult to reach and do not meet eligibility for social care interventions
- Enables a collaborative approach in which the person being supported and those providing support work together to determine an outcome that draws on the adult's strengths and goals
- Attention is given to developing and strengthening the person's support network
- Partnership working with a range of agencies and services working with vulnerable adults to ensure integrated and tailored support

The Task Group is of the view that lessons and learning can be taken from local areas that are adopting a more fluid transitional safeguarding approach and from other services and parts of the wider system where transitional approaches are more embedded. The progress of these local areas and other services and parts of the wider system can be drawn upon when considering how to strengthen Brent's transitional safeguarding approach.

Recommendation 3: It is recommended that Brent Council ensures that young people are active partners in the development of its transitional safeguarding approach.

The Task Group believes that transitional safeguarding should be a participative, user-led approach. This means adopting a collaborative approach; respecting young people's expertise and enabling them to coproduce solutions and support rather than being treated as a passive recipient of support. Services should be responsive to the specific needs of the individual young person and as such should to be flexible, integrated and multi-agency. This user involvement will support the development of effective safeguarding practice, informed by young people whose self-confidence, self-esteem and resilience can be developed through that involvement.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that young people are active partners in the development of transitional safeguarding.

Development of transitional safeguarding in Brent

The Task Group notes that change must be considered within the context of each local authority's setting. For some local authorities, there may be a number of blocks and barriers to developing transitional safeguarding. For example, the financial constraints facing local areas like Brent make it difficult to undertake any work considered non-statutory. It is also recognised that the impact of the Covid-19 pandemic may have slowed progress in this area as emergency and recovery responses were rightly prioritised. The development of Brent's approach to transitional safeguarding should therefore be explored in this context. Whilst its development is at an early stage, there are a number of key forums where transitional safeguarding work is being undertaken.

Brent's Multi-Agency Risk Assessment Conferences (MARAC) is a structure where professionals from agencies share information on cases of vulnerable and high-risk individuals whose personal safety is a concern. The meeting creates a risk management plan to offer immediate support. The aim of the process is to address the safety and protection of an individual and to review and coordinate the case and case management plan. Examples of vulnerable individuals that can be referred to the panel are those who are victims of domestic abuse, victims of hate crimes, at risk of fire related incidents, at risk of financial abuse/fraud and at risk of homelessness/or have difficulties maintaining their property. The MARAC evidences information sharing between a range of agencies and includes representatives from the local police, health, child protection, housing practitioners, domestic violence advisors and other specialists. Young people are considered who are under the age of 18, as well young adults aged 18 and over.

The Exploitation, Violence and Vulnerability Panel (EVVP) is another forum in which transitional safeguarding is being developed. Alongside overseeing interventions for children, young people and adults at risk of exploitation, the panel provides a coordinated, visible and accountable partnership response for managing those in the Violence and Vulnerability Programme cohort. The Violence and Vulnerability Programme focuses on supporting vulnerable young people and reducing reoffending and serious youth violence through a coordinated, multi-agency and intelligence led approach. As of May 2021, the programme was supporting 130 clients aged between 17-25. This includes gang members, persistent offenders, habitual weapons (knife/gun) carriers, domestic abuse perpetrators and those at the cusp of offending behaviour.²⁶

The Contextual Safeguarding Strategic Group progresses the contextual safeguarding agenda in Brent. It works to ensure that policy and practice responds more effectively to harms faced by children and young people outside the family of home. The main extra-familial risks to children and young people in Brent are recognised to include

²⁶ Brent Council, Evidence received at Evidence Session 1

youth violence, gang involvement, and child exploitation, including sexual exploitation and criminal exploitation such as county lines. The Task Group is encouraged to learn that the Transitional Safeguarding sub-group of the Contextual Safeguarding Strategic Group brings together representatives from Brent Council's Children and Young People, Community Wellbeing and Regeneration and Environment services to look at the ways in which the local authority can develop its transitional safeguarding approach.

The Transitional Safeguarding sub-group's current work is focused on transitions for children leaving care. As a result of joint-working, a more collaborative approach was recently piloted between the Leaving Care and Adult Safeguarding teams which sought to explore the ways that vulnerable young people who are leaving care are supported where non-statutory interventions are needed. The majority of the cases identified did not meet eligibility criteria for an adult safeguarding intervention, where there is no statutory duty to support these young people. The Task Group is encouraged by the support received across services for the pilot and the expectation that those involved learn from one another and work together to consider what transitional safeguarding may look like in Brent. A learning event took place in February 2021 to discuss the challenges and opportunities emerging from the pilot, as well as the opportunities to reimagine systems to support for this cohort.

Case Study: Piloting transitional safeguarding approaches for young people at risk of sexual exploitation in Brent

Freya is an 18 year old care leaver who is at high risk of sexual exploitation and is very vulnerable with a history of abuse and neglect in her life. Freya has a history of going missing and it has been reported that she both sends and receives messages from men she has met online, meets with them and is offered drugs and alcohol. Freya is frequently reported missing together with other young people known to CYP.

Concerns escalated around Freya's eighteenth birthday and these were reported through the Integrated Risk Management Meeting, leading to a complex strategy meeting to ensure that all the professionals involved, including the Adult Safeguarding Team and Police representatives, share information and intelligence from partner police services in the various locations Freya is known to have visited.

Following this, Adult Safeguarding and the Leaving Care Personal Advisor carried out a joint Mental Capacity Act assessment. As this assessment concluded that she does have capacity, professional focus is currently on developing an adult safeguarding risk management plan, drawing on Adult Safeguarding expertise in this area.

Four sessions of multi-agency training on transitional safeguarding were conducted in 2021 in partnership with Research in Practice. The objectives of the training were to raise awareness of transitional safeguarding, communicate messages from Safeguarding Adult Reviews and to understand the tensions, blocks and barriers to developing a transitional safeguarding approach. The Task Group is pleased that attendees included practitioners from the Council's Community Wellbeing and Children and Young People services alongside health partners, commissioned services, schools and local charities. In addition, Research in Practice were invited to speak to the Council's Adult Social Care team about its research and encourage attendees to share their expertise and explore the ways in which they could develop their safeguarding practice.

The Task Group is encouraged to hear that Brent Council commissions a range of interventions available to children and young people in Brent to the age of 25. St Giles Trust have been commissioned to provide a Gangs Intervention Programme (which falls under the EVVP) to challenge and work with those involved with or on the periphery of gangs to change their behaviour and take responsibility for their actions. There is a dedicated Gangs Mentor based within Brent Council's Youth Offending Service Team to provide support and interventions for young people working with the Youth Offending Service, Early Help, and Social Care teams. AIR Network have been commissioned to deliver a mentoring, sports, and wellbeing programme and have provided support to offenders on the Violence and Vulnerability Programme. AIR Network engages with offenders prior and during release from prison and provides support in areas such as housing, education, training, employment, mental health and drug and alcohol abuse.

Another example of a commissioned intervention available to children and young people in Brent to the age of 25 is the Embedded Youth Violence Hospital Project delivered by St Giles Trust. This project aims to improve the identification and engagement of young people who present at Northwick Park Hospital as a victim of serious youth violence. They also deliver training and professional development programmes to professionals who have contact with young people. Westminster Drug Project (WDP) is commissioned through Brent Council's Public Health service to provide support services to young people and adults in Brent. For example, the Mental Health Outreach Project provides support for those with either diagnosed and non-diagnosed mental health conditions to reduce re-offending rates. It also works to focus on cohorts not yet known to statutory services, increasing earlier intervention and identification.

Global Thinking's Young Women's Diversionary Project delivers a bespoke service for young women affected by gangs, criminal exploitation and county lines. It aims to ensure that young women are able to access help and are free from harm, abuse and exploitation. The project also delivers training days for professionals to help increase

the awareness of how young women can be affected by threats and to help professionals better identify risk indicators for early intervention. Brent Council also commissions Advance Minerva Wrap Around which provides specialist support to women and girls over 15, with complex multiple needs who have committed crime and are at risk of re-offending. The service is designed to be a multi-agency response to women in contact with the criminal justice system and is offered in women only hubs and two regional women's centres.

Brent's Probation Services is involved in the transition of young people from the Youth Offending Service to Probation Services and is a member of key safeguarding forums such as EVVP and Brent MARAC. Young people are usually transferred from the Youth Offending Service to Probation Services at the age of 18. The Task Group heard that the Transitions to Adulthood programme provides a community-based holistic service for 17 year olds transitioning from the Youth Offending Service to adult probation, informed by an understanding of maturity rather than age in order to reduce reoffending, improve mental health and support young adults to make positive life choices. Pilots are also underway in Brent to provide trauma-informed training for staff to assess a young person's capacity to make informed decisions and to identify care leavers and care experienced offenders to ensure risk assessments and sentence plans take this experience into account.

Case Study: Transitional support from the Youth Offending Service in Brent

A Crown Court provided positive feedback about interventions for two young people age 19. Their Youth Offending Service worker continued to work with them post-18, funded by Brent Council Covid-19 pressures funding. due to the progress made, on returning to Court to seek a variation the Judge decided to revoke both orders. The young people were asked what made the biggest difference. They responded:

"Receiving support in applying for courses, preventing me from re-offending and doing stupid stuff."

"Engaging in sessions addressing my offence and the impact it had on victims."

"Discussions that made me think hard about my actions and the consequences."

Brent's schools also undertake considerable work to support young people moving into adulthood. In particular, schools play an important role in identifying young people that may experience risks and harm. The Task Group heard that many schools have close working relationships with a range of agencies and services that work with young people, such as the local police, mental health services, statutory children's and adults'

safeguarding services and commissioned services, and work alongside these organisations to ensure safeguarding support is in place. This provides a platform by which young people transitioning into adulthood can be supported regardless of whether they fit into adult safeguarding statutory criteria.

Local health commissioners such as North West London Clinical Commissioning Group and Central and North West London NHS Foundation Trust play an important role in supporting young people as they transition into adulthood, and provide another area in which transitional safeguarding practice is being developed. Local health commissioners are seeking to ensure that commissioned services are afforded flexibility in order to support people across this stage of development, and to incorporate co-productive principles within local commissioning approaches to ensure those young people that receive care are involved in the planning, development and delivery of the care they receive. They are also uniquely placed to ensure robust local needs analysis, so that young people's needs are understood and incorporated into service planning and reflected in the market.

The Task Group is encouraged to learn that the need to improve transitions from Children and Adolescent Mental Health (CAMHS) to Adult Mental Health (AMHs) services was recognised in the NHS Long Term Plan. In response, Central and North West London NHS Foundation Trust has introduced a new model of mental healthcare designed for young adults aged 16-25 years. Specific features of the model include dedicated support for young adults moving from CAMHS to AMHs, continued support for young adults who have experienced adversities such as youth violence and in-reach services where young people are based, for example universities, colleges or local hubs for those not in employment or higher education. It also includes Multi-agency Young Adult Triage and Partnership meetings with clinical assistance for referrers to develop management plans and young adult focused therapies and service adaptations.²⁷

Whilst recognising that the development of transitional safeguarding in Brent is at an early stage, the Task Group is encouraged by the progress made so far. The Task Group feels that the transitional safeguarding agenda must continue to be progressed with clear, credible and explicitly owned local leadership, an expanded definition of partnership working, meaningful engagement with communities and active knowledge and skills exchange.

²⁷ Central and North West London NHS Foundation Trust (2021), 'Improving Young Adult Mental Health in North West London – A new model of care is ready for local implementation'

Recommendation 4: It is recommended that Brent Council considers how it can enhance its support to young people within the transitional safeguarding cohort with needs in education, training and employment (ETE), financial literacy and housing.

The risks young people face are often inter-connected, and a range of risk factors, such as financial difficulties, housing problems, and not being in education, training or employment can co-exist. Strict service criteria or thresholds can generate confusion for young people as the system is complex and it can be difficult for them to work out what support they are able to access. The Task Group believes that some young people therefore need multi-agency support at a more intensive level in order to navigate the complexities of housing, education, training and employment (ETE), finances and further agency support. Brent Council's SMART team offers an example of good practice within adult social care which can be learned from across services to support young people transitioning to adulthood.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that there are measures in place to demonstrate practice change.

Recommendation 5: It is recommended that Brent Council promotes transitional safeguarding across safeguarding agencies and services working directly with young people by:

- a. Ensuring that Brent’s strategic partnerships for children’s and adults’ safeguarding and Safer Brent Partnership offer multi-agency training for officers, local commissioners and service providers to raise awareness of transitional safeguarding.**
- b. Commissioning specialist training for elected and co-opted members to raise awareness of transitional safeguarding and empower them to identify gaps and areas for improvement in local safeguarding practice.**

The Task Group believes that the development of transitional safeguarding requires strong, collaborative leadership to enable creative and coherent practice and services for local residents. It is important that officers, local commissioners and service providers develop their knowledge and understanding of transitional safeguarding issues within the local area, share their expertise and support other professionals to develop their practice. The Task Group also sees elected members as well placed to lead across boundaries with their experience of working across services, organisations and sectors, as well as their unique knowledge of the communities they represent.

Brent Community and Wellbeing Scrutiny Committee should be updated on the progress of this recommendation and seek assurance that training is well attended and informs the development of transitional safeguarding across agencies.

Appendices

Appendix A Participants

The Task Group would like to thank the following participants who contributed to the report and/or took part in evidence sessions held between December 2021 and January 2022:

- Dez Holmes – Director, Research in Practice
- Georgina Diba - Head of Adult Safeguarding , Brent Council

- Sonya Kalyniak - Head of Safeguarding and Quality Assurance, Children and Young People, Brent Council
- Natasha Langleben - Team Manager (LAC and Permanency), Children and Young People, Brent Council
- Jyoti Morar - Deputy Team Manager (Integration and Improved Outcomes), Children and Young People, Brent Council
- Rebecca Byrne - Head of Learning Disability and Mental Health, Brent Council
- Colin Wilderspin – Head of Community Protection, Brent Council
- Andy Brown – Head of Substance Misuse, Brent Council
- Marcus Hanvey - Acting Inspector, Gangs and Project Horizon, North West London Basic Command Unit
- Kathryn Hunt - Head of Service, Brent Prison and Probation Service
- Hermann Farrington - Headteacher, The Village School
- Trish Davies - CAHMS Manager, Central and North West London NHS Foundation Trust
- Claudia Brown – Operational Director Adult Social Care, Brent Council
- Nadeem Janjua - Hospital Embedded Team Manager, St Giles Trust
- Lance Findlater - St Giles SOS Project Caseworker, St Giles Trust
- Sam Amiryan - Coordinator, Air Network
- Dr Arlene Boroda - Designated Doctor for Safeguarding Children, Child Death and Children Looked After, North West London Clinical Commissioning Group
- Gail Tolley – Strategic Director Children and Young People, Brent Council
- Phil Porter – Strategic Director Community and Wellbeing, Brent Council
- Philippa Galligan – Borough Director, Central and North West London NHS Foundation Trust
- Tiffany Adonis-French – Head of Adult Services (Complex Care), Brent Council
- Councillor Harbi Farah - Lead Member for Adult Social Care, Brent Council
- Councillor Margaret McLennan – Deputy Leader and Lead Member for Children's Safeguarding, Early Help and Social Care

The Task Group has been impressed by the knowledge and insight of all stakeholders and expert witnesses involved, and thanks them for their contribution.

Appendix B

Evidence Sessions

	Themes and Areas for Discussion
Evidence Session 1 9 December 2021	Understanding transitional safeguarding Practice of transitional safeguarding Evolution of transitional safeguarding practice nationally Examples of good practice and learning from other boroughs and/or nationally
Evidence Session 2 14 December 2021	Transitional safeguarding development work undertaken in Brent Role of multi-agency working in developing transitional safeguarding practice Experience of young people and families who may require transitional support
Evidence Session 3 11 January 2022	Development of transitional safeguarding practice going forward Lessons learned from both good practice and where things could be improved and from other services/wider parts of the system

Appendix C

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