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Community and Wellbeing Scrutiny Committee

Wednesday 5 July 2023 at 6.00 pm

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

This will be held as an in person physical meeting with all Committee members required to attend in person.

The meeting will be open for the press and public to attend. Alternatively, the link to follow the webcast live will be available HERE.

Membership:

Members	**Substitute Members**
Councillors:	Councillors:
Ketan Sheth (Chair) Collymore (Vice-Chair) Afzal Begum Ethapemi Fraser Molloy Rajan-Seelan Smith Matin Mistry	Aden, Moghaddam, Akram, S Butt, Conneely, Long, Miller, Mitchell and Shah Councillors: Kansagra and Maurice Councillors: Georgiou and Lorber

Co-opted Members
Alloysius Frederick, Roman Catholic Diocese Schools
Sayed Jaffar Milani, Muslim Faith Schools
Rachelle Goldbergh, Jewish Faith Schools
Vacant, Church of England Faith Schools
Jane Noy, Parent Governor
Vacant, Parent Governer Representative

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/democracy**

Notes for Members - Declarations of Interest:

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

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

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

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.

(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.

(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) **Land -** Any beneficial interest in land which is within the council's area.

(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.

(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

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

or

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

- You yourself;

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

Agenda

Introductions, if appropriate.

Item		Page
1	**Apologies for absence and clarification of alternate members**	
2	**Declarations of interests** Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.	
3	**Deputations (if any)** To hear any deputations received from members of the public in accordance with Standing Order 67.	
4	**Minutes of the previous meeting** To approve the minutes of the previous meeting as a correct record.	1 - 14
5	**Matters arising (if any)**	
6	**Tackling Health Inequalities in Brent** To receive an update on the work done to tackle health inequalities in Brent through the Brent Health Matters programme.	15 - 30
7	**Local Healthcare Resources Overview** To receive an overview of local healthcare resource.	31 - 42
8	**Community and Wellbeing Scrutiny Committee Work Programme 2023/24** The report updates Members on the Committee's Work Programme for 2023/24.	43 - 52
9	**2022/23 and 2023/24 Scrutiny Recommendations Tracker** To present the previous year's scrutiny recommendations tracker to the Community and Wellbeing Scrutiny Committee.	53 - 80

10 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: Tuesday 19 September 2023

Please remember to turn your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and a limited number of seats will be provided for members of the public. Alternatively, it will be possible to follow proceedings via the live webcast HERE.

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Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 18 April 2023 at 6.00 pm
Held as a hybrid meeting

PRESENT: Councillor Ketan Sheth (Chair), Councillor Collymore (Vice-Chair) and Councillors Afzal, Ethapemi, Fraser, Rajan-Seelan, Smith, Matin and MistryMistry, Rajan-Seelan and Smith, and observer Rachelle Goldberg

In attendance: Councillors Mili Patel, Krupa Sheth and Neil Nerva

Also in attendance: Councillor Moeen (joining remotely) and co-opted member Mr Alloysius Frederick (joining remotely)

1. Apologies for absence and clarification of alternate members

- Councillor Moeen, joining remotely
- Councillor Begum
- Co-opted member Mr Alloysius Frederick, joining remotely

2. Declarations of interests

Personal interests were declared as follows:

- Councillor Sheth – Lead Governor of Central and North West London NHS Foundation Trust
- Councillor Matin – employed by NHSE, part of the National Programmes Team which includes Diagnostics
- Councillor Ethapemi – spouse employed by NHS
- Councillor Collymore –Member of Palliative Care End of Life Steering Group
- Councillor Rajan-Seelan – spouse employed by NHS
- Councillor Smith – employed at Royal Free Hospital as a Management Consultant for Transformation Partners Healthcare Consultants and previous experience as a Project Manager on the Capital Midwife Programme under NHSE, including a pan-London assessment where Northwick Park Hospital was assessed
- Councillor Fraser – employed with the NHS Transformation Team as a Lived Experience Practitioner

3. Deputations (if any)

There were no deputations received.

4. Minutes of the previous meeting

RESOLVED:-

that the minutes of the previous meeting held on 7 March 2023 be approved as an accurate record of the meeting.

5. Matters arising (if any)

There were no matters arising.

6. Casey Review 1 Years' Update

Chris Whyte (Director of Environment and Leisure, Brent Council) introduced the report, which provided the Committee with a joint presentation explaining the continued response to the Casey Review of the Euro 2020 Final. He reminded the Committee that the Casey Review was a piece of work commissioned in the aftermath of the Euro 2020 Football Tournament Final, where there had been scenes of disorder, much of which were attributed to the consumption of alcohol and other compounding factors at that particular point in time. The review recommended a number of required actions and a fundamental response from all of the partners involved in the planning and preparation of large-scale events at Wembley Stadium.

In continuing the introduction, the Committee heard that, since the Final, the past two years had seen a programme of work to recover the situation, and new regulations had been introduced as well as ways of working, protocols, and the format around enforcement to ensure the type of events that occurred during the Final did not happen again. There were other recommendations around the security of the stadium building itself and arrangements for stewarding that had also been incorporated into the improvement actions undertaken by partners. Chris Whyte highlighted that the Council was only one of a number of partners undertaking this responsibility and there were colleagues present from the Football Association (FA) to present their overall response as well.

In relation to the work the Council had done, Chris Whyte explained that the Council had introduced controls around the sale and consumption of alcohol that contributed to the scenes of the Final. There were now licensing controls in place so that off-licences in the local area were not permitted to sell alcohol for casual street drinking, which was monitored. This was communicated clearly, not just on the day of the event itself but several days before events, through effective liaison and engagement with businesses. The secondary part of that was enforcement of street drinking on the day of the event, with teams of Council officers on the ground undertaking that enforcement with the Metropolitan Police so that individuals who were in the local area and very clearly consuming or in possession of alcohol were asked to hand it in and refrain from that behaviour. Those 2 strands of work had been very effective in harnessing those problems to the extent that there had been no repeat of the issues seen on the day of the Euro 2020 Final. This was also thanks to local businesses' willingness to comply. Within the Council it was felt that those arrangements had transformed event days to create a much more family-friendly and welcoming environment with much less opportunity to create the disorder seen on the day of the Final.

As the Metropolitan Police were unable to be present at the meeting due to staffing a large-scale event at the time of the meeting, they had given Chris Whyte some information to share with the Committee on their behalf regarding their response to the Casey Review. The Police were deploying more officers on event days in much greater numbers of up to 400, which was many more than would have been in place previously. They had also looked at the timings of deployment and were bringing police officers into the local area much earlier on event days to give that reassuring presence and profile, which had been effective. The Police were keen to work in a partnership way, and there were a number of different partnership meetings set up as part of that overall preparation and planning framework around Wembley event days that the Police were part of. Another strong focus had been on Formal Football Banning Orders which allowed for the Police to conduct criminal investigations into disorder and misbehaviour, which held individuals to account to the point where they could be prevented from attending football matches over a long-term

period. Chris Whyte highlighted that he had been reassured as a local authority by the support the Police had been able to offer with enforcement on the ground.

Chris Bryant (Director of Tournaments and Events, Football Association) detailed the response from the FA to the Casey Review. He highlighted that the FA recognised the transformational impact of the measures put in place by all partners over the past 2 years since the Final. The key to the success of that had been the collaboration of all partners, and the FA had worked with teams from the local authority, Metropolitan Police, British Transport Police, Quintain Wembley Park Ltd, Transport for London, and rail operators to put in a much more robust arrangement to ensuring the right type of environment was being provided to audiences, local residents and businesses.

The Committee heard that there was a new 'Zone X Co-ordination Centre', adjacent to the main stadium control room which was where the FA and all other necessary partners were situated on event days. Intelligence could then be passed from the stadium to teams on the ground and vice versa, to enable a co-ordinated response. Brent Enforcement Officers provided a range of support across that footprint, and had confiscated almost 12 tons of alcohol from South Way and Wembley Park Station at the recent Papa John's Trophy Final which helped to 'dry up' the area. This was done alongside off-licences not being permitted to sell alcohol, which was referred to as 'turning off the tap' and enabled the FA to better manage the public and reduce anti-social behaviour in those spaces. A number of Civilian Stewards were then provided on Olympic Way to help set the tone and provide the right welcome experience to those arriving in Wembley while also being clear on the behaviour expected. Quiet zones were now implemented around all residential properties immediately adjacent to the stadium, and the points of access were stewarded with a security provision in place to ensure only residents were given access to those areas. An investment in temporary toilet facilities had been made to reduce public urination, and the FA was in the process of evaluating the capacity of those spaces with a view to providing more facilities. Finally there was now the implementation of Fan Zones, which Baroness Casey had been clear in her review were fundamental parts of event day operations. Given the complexities of the legislation at the time of the Euro 2020 Final, Fan Zones had not been possible, but since then there had been significant investment into the delivery of match day fan zone arrangements. There was now East Village on the concourse with a capacity of £3.5k people and the event pad operation adjacent to the stadium with a capacity of 2.5k people. These zones were taking a significant amount of demand and moving people away from public realm areas into licensed premises where there was sufficient resource to manage those operations.

Councillor Butt (Leader of the Council) added that the change in atmosphere since introducing the restrictions on drinking, extra enforcement and additional police presence had been noticeable. A lot more residents were coming to use the facilities in the area on event days and the atmosphere was much calmer, which he felt was a testament to all the work Council officers, police and the FA had put in, working with the organisers of events.

The Chair thanked Council and FA officers for their updates and invited comments and questions from the Committee, with the following issues raised:

The Committee recorded their disappointment that the Metropolitan Police were not able to attend the meeting virtually or in person. They were advised that the Police were very keen to attend but had a commitment at a large-scale football match which meant senior officers with the most relevant input were needed elsewhere. Partners highlighted that their non-attendance was not a reflection on their commitment and the Police had played an active role in the arrangements now in place to improve the event day experience.

The Committee were pleased to hear about the positive work done around the Wembley Stadium area to address various issues following the Euro Final. They highlighted that they

had received reports of issues in other areas of Brent, such as illegal sales, street drinking, public urination and anti-social behaviour, and asked what awareness partners had of those issues being pushed elsewhere from the event area and what further improvement work needed to be made going forward. Chris Whyte highlighted that he would be keen to understand further details about these issues and the locations of these in order to ensure they were discontinued and enforcement officers intervened in the right way. This was new information to partners so would be something partners would need to come together on to better understand. There were borough wide restrictions on the consumption of alcohol in public places, meaning enforcement officers would be able to prevent this, engaging positively with individuals and seeking co-operation in the first instance. The reassurance that could be offered to the Committee was that if alcohol did appear off the train from those locations and came into Wembley Park then it would be confiscated and not consumed. Tom Legg (Head of External Operations, FA) highlighted that it was certainly not the intention to push the problem away from the stadium footprint and partners had a responsibility regardless of where in the borough the issues were. Councillor Krupa Sheth (Cabinet Member for Environment, Infrastructure and Climate Action) added that the Council worked with several organisations including business associations and resident associations across the event day boundary on those issues in those locations.

The Committee asked for clarity on the number of extra staff needed on Wembley event days and where these would be deployed. Tom Legg explained that, for the upcoming weekend for the Emirates FA Cup Semi-Final matches there were 1,900 stewards employed for the weekend in order to cover the external footprint in comparison to pre-euro finals where it would have been 1,500, and 350 police officers in comparison to pre-euro finals where it would have been around 112. It was recognised that fan behaviour was changing, and fans were arriving at the venue earlier than they ever had before. As such, partners were recognising there was more demand on the stadium concourse which was something they were comfortable managing. The early opening of the stadium by 2 hours before kick-off at the weekend was being trialled as a result of this change in order to analyse the impact of that. With the earlier arrival of fans, there was a need to set the tone and partners were now seeing earlier deployment in those areas in order to own the ground. There was compliance and co-operation from fans as a result of any alcohol confiscation and this was attributed to the large communications campaign that went directly to fans as well as local newspapers such as the Manchester News and Sheffield Star to make people aware that the alcohol consumption in public areas would not be tolerated.

The Committee asked whether a steward would have easy access to the Police if a situation was happening in order to deal with the situation. Liam Boylan (Stadium Director, FA) confirmed that they would have that line of communication. Deployment was done strategically and the first layer would be customer facing stewards, who had no powers and were there to advise and welcome fans but who were very good at pointing out the expected behaviour of fans. The next layer was Brent Enforcement Officers who were able to enforce street drinking bans and the sale of alcohol, and the third layer was the Police. Operationally and strategically, the stewards and enforcement officers were made aware of that hierarchy, and the Police could step in where necessary, with collaboration between the 3 entities that worked very well.

The Committee wanted to feel confident and comfortable going forward with the arrangements in place, and asked whether there was effective communication between fan zones and stadium security. In addition, they asked whether the FA were satisfied with the policing of fans where stadium security perimeters ended. Liam Boylan responded that the FA were satisfied with this aspect of arrangements. Before every event there was a tactical meeting where intelligence was shared between the Police, FA, and Wembley Stadium, where the Police informed the FA what their tactical deployment would be and which the FA would align with. Operations were based on a high, medium and low metric by the

Police, and the FA aligned their own metrics to that as well, based on the intelligence coming in. He highlighted that the key had been owning the ground earlier through earlier deployment which the Police now recognised. It was important to ensure alignment and satisfaction with the arrangements and the operation that was now in place, alongside the Public Space Protection Order (PSPO), allowed for that. He felt what was now seen on event days was a transient movement from transport hub to event which significantly reduced loitering.

In relation to fan behaviour and attempts to bring about a change in the attitudes of football supporters, the Committee asked what was being done by way of campaigns or projects to challenge attitudes, including racism towards players. James McDoogle (Head of Corporate Affairs, Football Association) informed the Committee of the campaign launched earlier in the football season called 'Love Football, Protect the Game' which would be relaunched ahead of the next season working with partners such as the Premier League, English Football League, Match Officials Ltd, and others, so that all parts of the game were working on the campaign. Some work had been done looking at pitch invasions to complement the campaign and improvements had been seen there particularly in relation to pyrotechnics. The campaign had a timeline planned out for the launch and would be a full policy campaign.

In bringing the conversation to a close, the Chair asked whether the reputation of Wembley Stadium had been fully restored following the events of the Euro 2020 Final. Chris Whyte felt the reputation had been fully restored and was proud of the work done to improve the arrangements around event days. It was agreed that the strength of the partnership of key stakeholders involved in the planning and delivery of event days was the key to the success.

The Chair thanked those present for their contributions and drew the item to a close. He invited the Committee to make recommendations, with the following RESOLVED:

i) To recommend that there is consideration of the impact of event days on the wider borough in further updates on the implementation of the Casey Review recommendations.

ii) To recommend that the FA involve local Brent residents and infrastructure within national FA anti-racism campaigns, and for future reports to include a wider view of the campaigns currently underway to change fan behaviour.

iii) To recommend that communications on restrictions of street drinking in surrounding areas, outside of event zones, are developed to encourage good behaviour on event days in these areas.

iv) To explore possibilities to widen police presence further than Wembley Park on event days.

v) To explore the impact of online delivery alcohol vendors on fan behaviour and street drinking.

vi) To recommend that policing continues to be evidence led on match days and that effective communication between branches of the police is continued to ensure event days at Wembley Stadium are safe and can be enjoyed by all, including with British Transport Police.

7. Northwick Park Maternity Improvement Plan Progress Update

Lisa Knight (Chief Nurse, LNWUHT) introduced the report, which updated the Committee on the progress of the Northwick Park Maternity Improvement Plan. She reminded the Committee that Northwick Park Maternity Services had been inspected by the Care Quality Commissioner (CQC) in March 2021 and graded as inadequate. As a result, London North West University Healthcare NHS Trust (LNWUHT) had attended the Scrutiny Committee in August 2021 to provide assurances and present the Maternity Improvement Plan. The CQC had then made a repeat visit in October 2021 where Northwick Park Maternity Services was upgraded from inadequate to requires improvement, which remained the rating at the time of the meeting as there had been no inspection since then. LNWUHT were very pleased with that rating as an outcome after just 6 months and the CQC had said that from a morale perspective and multi-disciplinary team perspective there had been a 'sea change' in the department. The link to that report was included in the agenda pack for the Committee meeting and described what further work was being done to improve, in particular in relation to staffing, training and equipment management.

Lisa Knight advised the Committee that there was now a national programme of inspections for all maternity services in the country which had been ongoing for approximately one year. Northwick Park was expecting another inspection fairly soon as business as usual but were not certain whether they were part of the national programme, having been inspected so close to the announcement. As such, preparations were taking place in order to be ready for inspections. As the service had not been inspected for a while, the report included outcomes from the peer assessments undertaken in August 2022 by 14 individuals against the Shrewsbury and Telford report. These assessments found that LNWUHT had maintained compliance on the majority of measures, which was a good outcome, benchmarked against other London areas. The assessment had found 2 areas of non-compliance. One was regarding consultant ward rounds and there had been compliance with that now since November 2022, and one was around workforce planning, particularly around staffing, and whilst that had improved it did remain a challenge. There was still around a 35% vacancy rate in the middle midwifery layer, but there was a solid pipeline of approximately 20 international midwives coming in to Northwick Park Hospital by December as part of the Capital Midwife Programme.

Northwick Park Hospital was on the National Maternity Programme, who were happy with the engagement from Northwick Park Hospital and were helping the Maternity Unit with clinical pathways, triage, governance processes, and preparing for inspection. The Maternity Services Improvement Plan had been moved to a Strategy, and a new National Maternity Improvement Plan had been published the previous week which Northwick Park Hospital was benchmarking against. It had been found that the themes in the Northwick Park Maternity Improvement Strategy aligned with those in the National Programme so there was confidence that LNWUHT was on the right track.

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

Councillor Nerva (Cabinet Member for Public Health & Adult Social Care) highlighted the national news regarding the inequality in care in maternity services and racism within the system. From a local authority perspective, he would expect the local authority and local health service at a borough level to treat that as a priority. The Committee had also seen growing awareness and concern amongst the public regarding the performance and standards of care in maternity services over recent years, with some alarming stories being portrayed at a national news level. Pippa Nightingale advised the Committee that the national news had highlighted some of the failures in maternity services across the country. For example, a woman was 3 times more likely to have a still birth if English was not her first language and she was not white British. The key to addressing that was the publication of The Single Maternity Services Delivery Plan, which LNWUHT very much welcomed.

Prior to the publication of the single delivery plan there had been a variety of recommendations from different national bodies, so seeing that all in one place made a difference. There would also be a user-friendly version of that plan that families could access to see the improvements needing to be made in maternity services and how that would be achieved. A big part of the work would involve co-design and how local maternity services worked with women, families and communities to design services. There was a very active user group in Northwick Park Maternity Services helping that happen and LNWUHT were ahead of the game with that.

The Committee asked what presenting officers would say were the key features to determine maternity safety for patients. Pippa Nightingale highlighted effective multi-disciplinary teamwork as the key to safe care because multiple different professions were involved in the gestation and birth of a baby. There was a very detailed maternity safety dashboard which was overseen by the Quality Committee and Trust Board as well as across the acute collaborative where benchmarking across the four trusts took place. LNWUHT favoured well in maternity safety outcomes, and had both a maternity safety champion and non-executive director at Board level. The Committee would like to see a focus on continuity of care, number of investigations and learning from them, and workforce issues in future reports.

In relation to section 3.2 of the report regarding external assurance and actions 3 and 7 being non-compliant, the Committee asked why those 2 areas had not been compliant. Lisa Knight explained that one area of non-compliance had been around consultant ward rounds and ensuring these happened twice a day because prior to the peer assessment they were only being conducted in the morning. From November 2022, Northwick Park Hospital had subsequently implemented ward rounds in the evenings as well so would be compliant with that action if re-assessed. The second area of non-compliance was regarding the website which had subsequently been updated as well. Lisa Knight had not reported Northwick Park Hospital as compliant against workforce planning because there was not enough staff, not because there was no plan. LNWHUT continued to raise staffing as a genuine risk which was unresolved, but the hospital was not unique in that position. There was a national issue with the recruitment of midwives and an announcement the previous day that there would be an increase in the number of training places for midwives nationally. Locally, Northwick Park were already working with local universities who provided midwifery training and were now training more midwives, and a new course had been introduced for nurses who wanted to convert from nursing to midwifery.

Continuing to discuss staffing, the Committee highlighted the vacancy rate for band 6 midwives of 35%, and asked whether there was anything specific to Northwick Park Hospital that might have contributed to that. Lisa Knight advised the Committee that this had been long term, and partly due to putting additional money into that layer and never recruiting into those vacancies. When the original CQC inspection had taken place, there had been quite a high turnover of staff but that had now significantly settled. Pippa Nightingale (CEO, LNWUHT) did not feel there was anything distinguishing Northwick Park Hospital from other places that contributed to the drop-off following the completion of preceptorship years. She felt there was a need to look at the national challenge and general pattern students followed. Most students qualified, stayed in the Trust they trained in to do their preceptorship years there, and then after a few years returned home with that experience. As such, London was an exporter of expert nurses. In addition, the inner and outer London weighting factored significantly into recruitment, where only a few miles difference meant there was inner London weighting, such as at Imperial. Having said that, the turnover rate at Imperial and Chelsea & Westminster compared to LNWUHT was higher. LNWUHT benefited from the mature nurses at Band 7, and so there was a whole cycle of training and experience into and out of London that needed to be understood in order to work out how to fill the gaps. Band 7 had been overrecruited to in order to fill those gaps and nursing roles within maternity were recruited to wherever possible. Councillor

Nerva added that local authority leads had identified workforce in its widest sense as the biggest issue for the health service in NWL alongside health inequalities and funding. An Integrated Care Board (ICB) meeting taking place that day had recognised the issue and the Brent Borough-based Partnership had made some very clear proposals to the ICB about what could be achieved.

The Committee asked how maternity services could be improved sustainably and the staff in place be retained. Pippa Nightingale felt that making sustainable improvements would be dependent on the culture at Northwick Park Hospital. Individuals worked where they felt they belonged, and so retaining staff within a team would rely on that. She highlighted that culture could not change overnight, but over the past year the culture at Northwick Park Hospital had changed dramatically, and a whole new senior team had been recruited to within maternity services that were really making a difference. She felt that once there was a healthy, inclusive, multi-disciplinary culture then people chose to stay within that unit, so that's what they were working towards.

The Committee highlighted that many women put their trust in professionals completely and assumed they would know if something was wrong and may not raise the alarm themselves, particularly if they had a language barrier. They queried whether this was something Northwick Park Hospital experienced with its patients. Pippa Nightingale informed the Committee that this happened both nationally and locally. The most common factor of a stillbirth, which Northwick Park Hospital was trying to get to a point of avoiding, was language barriers. Northwick Park was aware that women with a language barrier quite often did not contact maternity services when they would like them to when they had reduced foetal movements. She highlighted this was not the fault of the patient and attributed this to the service, as those women had not been helped to understand exactly when to respond to a problem and contact the service. However, Lisa Knight was leading a team locally with an improvement programme focused specifically on women with language barriers delaying contacting maternity services. The programme looked at how to improve the information to women so they contacted the service straight away and came in when the service would want them to, in the same way that someone who was white British with English as their first language would understand.

The Committee asked how the digitisation of patient records would assist the families of Brent. They were advised that this was the first time there had been a digital system across the four hospitals of Imperial, Chelsea & Westminster, Hillingdon and Northwick Park. Northwick Park Hospital was not a high-risk unit so a lot of women were referred to Queen Charlotte's at Imperial and there would now be the ability to share notes across both hospitals for the first time. This would help from a patient safety perspective and the standardisation of notes would help with risk pathways as the original notes could flag where women were vulnerable or where their first language was not English. Pippa Nightingale added that the next part of that digitisation project would be linking it to 'patient knows best', the patient portal into their own record which was translatable into the top 5 languages. LNWUHT had also commissioned the 'Mum and Baby' app which had been designed by midwives and obstetricians in North West London for mothers which was also translatable into the top 5 languages. The app allowed mothers to send questions to their midwives and access other information. Maternity services would also be able to see which women had accessed it.

In relation to community midwives, the Committee heard that there were some vacancies there but a nurse consultant post had been recruited to who specialised in community midwifery. That consultant had been in post for 6 months and was overseeing a remodel of community midwifery. LNWUHT took a lot of women from Queen Charlotte's or Watford for community care, so the number of births delivered by LNUWHT was not actually representative of the care given in the community which was much more. Another piece of

work community midwifery was focused on at the moment was where the best place was for women to have their first visit.

The Committee asked whether there was cause for concern regarding C-Section patients being discharged after 14 hours. They were advised this was not a safety issue and generally most women wanted to be at home within 14 hours, which was a generational culture shift. Women were not forced to leave the unit, but generally preferred to go home as soon as they could.

In drawing the discussion to a close, the Chair asked presenting officers how far away from 'good' they felt they were. In responding, Pippa Nightingale highlighted that the CNST standards for maternity had just changed. She did not think maternity services at Northwick Park Hospital were at 'good' yet but were much closer to 'good' than before. She felt if the service was to be reinspected then it would stay at the same rating whereas some places in the country may drop a rating. In responding, she highlighted that CQC was only one regulator out of money. During the past year the maternity services at Northwick Park Hospital had also been inspected by Health Education England, who had subsequently removed an enforcement notice in place after seeing significant improvement.

The Chair thanked those present for their contributions and drew the item to a close. He invited the Committee to make recommendations, with the following RESOLVED:

i) To recommend that inequalities in maternity care and racism within the system must be tackled as a priority at both system and place levels.

An information request was raised during the discussion, recorded as follows:

i) For the Committee to receive details of the complaints to investigations ratio for midwifery services at Northwick Park Hospital.

ii) For the Committee to receive details on the staffing numbers in Northwick Park Maternity Services broken down by band over the past 5 years.

8. Community Diagnostic Centres in North West London

Pippa Nightingale (CEO, LNWUHT) introduced the report, which provided information on the new Community Diagnostics Centres (CDCs) in NWL. She felt CDCs were an exciting initiative which had received a significant amount of investment (£44m) to decrease waiting times for residents to have diagnostics tests. The report detailed the plan for CDCs and where each centre would go, which was based around deprivation and population need. The methodology for determining the location of CDCs had focused on ensuring patients would not have to travel for more than 45 minutes to a CDC. One important thing to note was that CDCs were an additional service and did not replace the diagnostics already done in hospitals. Instead, the CDCs allowed for an extra 300,000 members of the NWL population to have diagnostics tests in a much quicker way than they were having now. The majority of patients referred for a diagnostics test did not have an illness, so they could be relieved quicker, and those who did have an illness and needed treatment could get faster access to treatment. As a result, the patient pathway was improved as well as survival rates and there was better access to care.

The Chair then invited comments and questions from the Committee, with the following issues raised:

The Committee agreed that CDCs were an exciting initiative. They knew NWL was one of many areas across the country identified as an area of deprivation and who would be opening CDCs, so asked what learning had been taken from other areas that had already launched their CDCs. Pippa Nightingale advised the Committee that the detailed work that

had been done regarding deprivation had also helped other pathways, such as the Elective Orthopaedic Centre, because that data had been collected in a granular way, not just by borough but locality as well. Learning had also been taken from other parts of the country ahead of NWL in the rollout of CDCs, particularly around how those areas decided where the sites would be placed, as well as their implementation and rollout. NWL were working in a detailed and connected way with the CDC NHSE team.

The Committee asked how this related to GP direct access. Pippa Nightingale felt that CDCs were a 'game changer' for GP direct access, as for many years GPs had been frustrated that they had not been able to access basic diagnostics. This gave NWL an opportunity to look at direct access models on a wider scope as well, which was being done by place-based partnerships. Tom Shakespeare (Integrated Care Partnership Director) added that the Integrated Care Partnership (ICP) would be working closely with the GP community as well as acute and NWL colleagues on the development and rollout of CDCs over the coming months.

Members of the Committee advised presenting officers they had heard from residents that they had waited a long time to have tests done and once tests had been done, they had waited a long time to hear the results of those tests. They asked how they could reassure residents that these CDCs would result in better and quicker outcomes. The Committee heard that they could advise residents there would be quicker access to diagnostics with more patients able to be seen within a year, meaning there would be less patients waiting. The IT systems had been upgraded to enable a single system to share test data and a very important part of the initiative was to ensure communication did not fall down when patients were waiting for results.

There were many different staff groups involved in diagnostics, from phlebotomists to radiologists, some of which were hard to recruit to posts and so this had been identified as a risk. However, there was a good track record in NWL through the training academy which was already training staff ready for the CDCs. NWL had learned from the national programme that these were the sort of centres staff wanted to work.

The Committee asked whether there was joined up working to prioritise critical matters such as cancer diagnostics. They were advised that CDCs would help cancer patients because they would get quicker access into the first part of the pathway that all cancer patients started with. GPs and secondary care were able to refer to CDCs directly. Many services who provided care to cancer patients were challenged due to the backlog from Covid, and so CDCs would address that need too.

In response to whether this would free up hospital capacity, Pippa Nightingale confirmed that CDCs did help the acute trust deal with capacity because, currently, most referrals from primary care were because they did not have access to diagnostics so could only refer to an acute trust. Patients who were not ill would be taken out of the pathway so there were more appointments for people that did need the further care, and people were seen at the right time by the right people. Damien Bruty (CDC Senior Programme Manager) agreed that they could provide the overall volume of the activity NWL would envisage to the Committee. A lot of what they had learned from other places that had already gone live with CDCs was their experience of releasing hospitals from some of the high-volume low complexity caseloads. Patients were choosing to go to CDCs instead to have their diagnostics sooner for non-complex diagnostics, which then allowed hospitals to focus on those complex pathways.

The Chair thanked those present for their contributions and brought the discussion to an end. He invited the Committee to make recommendations, with the following RESOLVED:

i) To recommend that groups who are more likely to be impacted by health inequalities are engaged with and will have more opportunities to access these services.

9. GP Access Task Group 1 Year Update

Tom Shakespeare (Integrated Care Partnership Director) introduced the report, which was a one-year response to the scrutiny task group recommendations around primary care access, which the Integrated Care Partnership (ICP) had spent a lot of time and effort implementing. In introducing the item, he highlighted the significant increase in funding coming into primary care, with over £4m coming in and expected recurrently. There had been a significant improvement in the number of appointments available in primary care, including evenings and weekends. Through the Addition Role Reimbursement Scheme (ARRS) there had been a significant increase of additional staff in primary care of 170, and that continued to increase day by day, as well as training in individual practices. He felt that underpinning this was partnership working in a joint, collaborative approach with colleagues in primary care and Primary Care Network (PCN) clinical directors. There was a clear workplan with 5 priority areas that the ICP were working towards, including communications campaigns that gave residents a clear understanding of how to access services.

In continuing to introduce the report, Versha Varsani (Head of Primary Care, ICP) added that the ICP would be working with primary care colleagues and PCNs over the next year to ensure local access plans were done and that primary care was working towards additional access priorities.

The Chair thanked those present for their contributions and invited comments and questions from the Committee, with the following issues raised:

The Committee asked what work was being done to improve access specifically for elderly and vulnerable patients. Versha Varsani acknowledged that demand and capacity were very challenging areas, particularly as the population in Brent was continually growing. An area being worked on was supporting telephony services in GP practices, looking at a cloud-based, smart telephone service that could do call-back opportunities and which gave GP practices data regarding when the biggest demand in the surgery was, so that services could be wrapped around demand. Another approach was for those in ARRS roles to see patients as there were lots of skilled staff in GP surgeries that could see patients aside from doctors. A focus going forward was on both reactive and proactive models. The reactive model would support patients who wanted on the day demand and look how that could be done at scale, such as through the enhanced access hubs. The proactive care model would support more complex patients, including elderly and vulnerable patients. There were many different channels primary care were using to support the work.

The Committee were advised that there had been some technical challenges and the ICP were looking to address some of those challenges, as well as the lack of awareness around the additional out of hours appointments which had been released.

As no further issues were raised, the Committee **RESOLVED:**

i) To note the contents of the report.

10. Community and Wellbeing Scrutiny Committee Recommendations Tracker 2022-23

RESOLVED that the contents of the Update on the Committee's Work Programme 2022-23 report, be noted.

11. **Any other urgent business**

The Chair informed the Committee that this would be Carolyn Down's (Chief Executive, Brent Council) final meeting at the Community and Wellbeing Scrutiny Committee. He thanked her for the support she had given over the years to the Committee and highlighted that some of the work done by the Committee over the past few years would not have been possible without her support.

The meeting closed at 8:00 pm

COUNCILLOR KETAN SHETH
Chair

	Community and Wellbeing Scrutiny Committee 5 July 2023
	Report from the Director of Public Health and the Managing Director, Brent ICP

Tackling Health Inequalities in Brent

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s):	Dr John Licorish Consultant in Public Health John.licorish@brent.gov.uk Nipa Shah Programme Director, Brent Health Matters Nipa.shah@brent.gov.uk

1.0 Purpose of the Report

This report sets out the national and local context to health inequalities; describes the extent of health inequalities in Brent, where data is available; and how Brent Council and health partners are tackling health inequalities, with a focus on how this work is delivered through the ICP (Brent Borough Based Partnership) and the work of the Public Health team and the Brent Health Matters (BHM) programme.

2.0 Recommendation(s)

Members of the Brent Community Wellbeing Scrutiny Committee are asked to note and comment upon the work that the ICP (Brent Borough Based Partnership) is undertaking in partnership with the voluntary sector, faith and community groups and local residents to identify and address health inequalities.

3.0 Detail

3.1 Background / Context (national)

Health Inequalities are unavoidable, unfair, systematic differences in health and health outcomes between different groups of people. These inequalities can involve different aspects of health and health care such as health status; access to, quality and experience of healthcare; behavioural risks to health, and the social determinants of health. As Professor Sir Michael Marmot stated,

"These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad' unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society."[1]

Inequalities can be described between different population groups reflecting:

- socioeconomic factors such as income, education status or deprivation
- characteristics such as ethnicity, age, sex or disability
- social exclusion including homeless people, asylum seekers or refugees, those with substance misuse issues, those without recourse to public funds; and / or
- geography such as ward, local authority or region.

3.2 Within groups who are experiencing health inequalities, the experiences are not homogenous. How inequalities combine to affect specific groups and individuals is referred to as intersectionality. For example, the inequalities experienced by a female resident with substance misuse issues will differ from those of her male compatriots. The inequalities experienced by a homeless individual who has no recourse to public funds and is not proficient in English will differ from those who are proficient in English and have access to public funds.

3.3 Although, arguably, it is only since the Covid-19 pandemic struck that health inequalities have become part of the mainstream media discourse, the fact is inequalities have been known for some time. The World Health Organisation created the Commission on Social Determinants of Health Commission in 2005. The conclusion of the Committee, chaired by Professor Sir Michael Marmot, were that the inequalities in health were preventable by reasonable action and were not just avoidable but unfair.

[1] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

The main recommendations of the Commission's report in 2008 "Closing the Gap in a Generation" were [2]

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action

The then Director General of the World Health Organisation Dr Margaret Chan stated:

> "*This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."*

3.4 The then Secretary of State for Health asked Professor Sir Michael Marmot to review evidence-based strategies for improving health inequalities. Importantly Marmot did not only rely on the academic literature but engaged widely with stakeholders to gain their insights and experiences. The Marmot Report, "Fair Society, Healthy Lives" (2010) outlined five key policy recommendations:

- Give every child the best start in life
- Enable all children, young people, and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health

Marmot was subsequently commissioned to examine progress in the following decade (to 2020). His key findings were that health inequalities had increased in England, while other countries were doing better at reducing health inequalities.

3.5 Following this, the pandemic years ensued and unsurprisingly COVID morbidity and mortality had its greatest impact on those already affected by health inequalities. The pandemic shone a light on existing health inequalities and amplified them.

3.6 The issue of health inequalities in the Black community was examined. The role of racism was acknowledged and is now classified as a public health problem. "Disparities in the Risk and Outcomes of Covid19" was published by Public Health England and highlighted the increased risks of dying of Black and South

[2] https://www.who.int/initiatives/action-on-the-social-determinants-of-health-for-advancing-equity/world-report-on-social-determinants-of-health-equity/commission-on-social-determinants-of-health

Asian minority ethnic groups which was confirmed by later analyses by The Office of National Statistics.

Background / Context (Brent)

3.7 The situation in Brent is a microcosm of the national picture. Long standing structural health inequalities exist both when compared to the national picture but also when examined within the borough.

3.8 Access to primary care, which residents have identified as a longstanding problem, was examined by a GP Access Scrutiny Task Group. Brent CCG as it was configured prior to merger was the 7th most under-doctored in London and had the most patients per nurse.

3.9 Inequalities in mental health and wellbeing were also being described. The Young Brent Foundation report covering the first three months of the Pandemic identified that depression in Black and Minority Ethnic young people increased by 9.2% whereas that in those in their white counterparts decreased by 16.2 %.

3.10 Also mirroring the national picture was the media attention which drew first to the health inequalities in Brent and subsequently to the action taken by communities to address these and the work done by Brent Health Matters and Brent Public Health.

Brent Health Inequalities Picture

3.11 The 2021 census[3] showed Brent has a young population (average age is 35 years of age). However, the number of people in the 50-64 age subgroup rose by 30.7% while the number of residents between 25-34 fell by 8.8%.

Brent is a truly diverse Borough: about 31% of the population identified with a non-UK national identity; less than half of the local population (43%) said they were born in England; 34.6% identified as White ethnic groups, 32.8% as Asian, 17.5% as Black, and 10% as Other ethnic groups.

Brent saw London's joint 3rd largest percentage point rise in the proportion of people who were economically inactive because they were looking after their family or home (from 4.9% to 6%), while 3.4% of Brent residents reported providing up to 19 hours of unpaid care each week.

Brent is ranked the 4th most deprived borough in London, with Stonebridge, Harlesden, Kilburn and Dollis Hill being amongst the most deprived in the borough[4].

[3] How life has changed in Brent: Census 2021 (ons.gov.uk)
[4] Microsoft Power BI Brent ward profiles

3.12 Given the above, ethnicity, potential language barriers for those who were not born in England, deprivation and age are likely to impact on Brent residents' health outcomes and access to services.

3.13 The COVID-19 pandemic starkly exposed how existing inequalities - and the interconnections between them such as race, gender or geography - are associated with increased morbidity and mortality risks[5]. Up until this point however the local health and care service was not systematically reviewing data through the wider determinants of health lenses, traditionally restricting analysis to age and sex only. Since the pandemic, with health inequalities becoming a major priority for the ICP, Brent is committed to a "no more averages" approach to data monitoring and reporting. Averages by their nature may hide where specific groups are underserved.

3.14 We are now committed to analysing data through age, gender, ethnicity, deprivation and disability and we aim to only use overall Brent and North West London averages for reference. This is work in progress. Where the way data is recorded does not support this approach, the ICP is committed to improving this. At the same time, we are designing and implementing tools that identify health inequalities in existing data. Some of the public tools, like the newly launched JSNA interactive toolkit and associated ward profiles continue to use averages to present data in a more accessible way and to provide an overview of the key health and wider determinants of health and well-being needs. Other tools like the Brent Health Matters Dashboard and the Hypertension Dashboard are bespoke tools which allow data analysis by demographic and socio-economic determinants thus providing a more accurate picture on the health inequalities in Brent. Those tools are aimed at service delivery and healthcare stakeholders and provide granular detail which informs targeted interventions.

3.15 Future plans include adding more bespoke dashboards for specific long-term conditions (i.e. cancer) as well as looking at health inequalities for each NHS Neighbourhood / Brent Connect area using the Core 20 Plus 5 framework (more detail in 3.21).

3.16 This approach has meant that, while our understanding of health inequalities can still improve, we have begun to expose major health inequalities in Brent. For example:

1. The proportion of children classified as overweight or very overweight is higher for Year 6 (39.6%) children than for Reception years (18.5%). Whilst these rates are decreasing and are overall lower than other boroughs in North West London, Stonebridge, Harlesden, and Willesden Green have higher prevalence compared to the overall borough. Those wards also have higher levels of income deprivation, income deprivation affecting children and higher levels of long-term unemployment. Furthermore, children of Black and Mixed heritage as well as those identifying as "any other" ethnicity have higher rates of overweight or very overweight compared to other ethnic groups.

[5] A perfect storm - health inequalities and the impact of COVID-19 | Local Government Association

2. Wider determinants of health have a strong impact on long term conditions, chronic diseases, and mental health. Evidence shows that in Stonebridge, the most deprived ward in Brent, 17% of the population is reported to have a long-term condition or disability compared to an overall 14% in Brent.

3. Hospital stays for self-harm, used as an indicator of mental health, show that although the overall Brent standardised admission ratio is 28, the ratio in Welsh Harp is 54, in Barnhill 41, in Harlesden, Kensal Green and Queensbury is 33.

4. The prevalence of diagnosed diabetes in Brent remains higher (8.58%) than that for London (6.75%) and England (7.26%) and the trend is increasing. It is well known that rates of diabetes differ between different ethnic groups, but our local work is also now allowing us to focus on variations in health care received. For example, diabetes reviews for Asian or Asian British population are higher (75%) compared to the Brent average (73%). Conversely diabetes reviews for White and Other ethnic groups are lower (71% each). Certain areas in Alperton have rates of achievement for all 9 Key Care Processes (a marker of good quality care) which are higher than the Brent average while areas in Kilburn have lower rates.

5. Hypertension is known to disproportionately affect Black and Asian communities, but our more recent analysis allows for a more detailed understanding. For example, amongst people with hypertension whose condition is not controlled (and who are therefore at the highest risk of a stroke or heart attack) we see a disproportionate representation of Black Caribbeans. Black Caribbeans make up 15% of uncontrolled hypertensives, in comparison to 7% of the overall population. In addition, this high-risk group is skewed towards more deprived communities: 9% of the group is in the highest deprivation decile, in comparison to 6% of the population overall.

6. Overall, cancer screening remains low in Brent for all cancers. Within this are variations, for example in Asian or Asian British patients eligible for breast cancer screening the uptake is 47% (compared to 41% overall), whereas for the Other ethnic group uptake is 33%. Cervical cancer screening is decreasing in Brent for the whole population being now only 49%. In eligible Black or Black British patients, the rate is 54%, in the Mixed ethnicity group it is 52% whereas for Other ethnic groups it is 45%.

7. Social isolation, loneliness and higher levels of deprivation are all linked with pensioners who live alone. There is a clear link between loneliness and poor mental and physical health. The overall rate in Brent of people who live alone is at 27%. Outliers are Kilburn at 40%, Brondesbury Park and Willesden Green both at 38%, and Stonebridge at 35%.

Tackling Health Inequalities in Brent

3.17 The approach of the Brent Borough Based Partnership (the ICP) to health inequalities is rooted in proportionate universalism, a recognition of the wider determinants of health, co-production with our communities and a systematic approach to holding ourselves to account for examining and addressing inequalities in terms of ethnicity, deprivation, and disability (see the previous section).

3.18 Marmot recommends proportionate universalism, described as "the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need" as a core response to health inequalities. In practice, this means services which are both universal *and* targeted. This approach was exemplified by the local delivery of COVID vaccination. This combined mass vaccination centres, such as the one in Wembley, which operated at maximum efficiency, with more targeted offers, bespoke to local communities, such as the vaccine bus or delivery in faith settings. Appropriate targeting can only be developed and delivered in a dialogue with residents and through co-production.

3.19 Brent ICP's vision for residents is to deliver high quality and best value for all the core health and care services for the people of Brent by:

- Addressing health inequalities by delivering services in a way that responds directly to the needs of our communities
- Improving access to our services by increasing our workforce and appointments available at a time that suits people
- Personalising services by bringing a wide range of services together at neighbourhood level wrapped around the needs of residents
- Supporting people to maximise their independence, and caring for people closer to home

3.20 In order to achieve the above vision, Brent ICP's priority workstreams are:

- Tackling health inequalities
- Strengthening primary care
- Developing community care
- Mental health and wellbeing

3.21 In March 2022, national guidelines were released to focus the work on tackling Health Inequalities, called CORE20PLUS5. This describes the approach based on:

- Most deprived 20 % of the national and local population
- Plus population groups that can be identified at a local level who face Health Inequalities, including

  - ethnic minority communities,
  - people with learning difficulties, long term conditions
  - other groups that share protected characteristics
  - people experiencing homelessness, drug and alcohol dependence
  - vulnerable migrants
  - people in contact with the justice system
- Five clinical areas of focus which include:
  - Maternity
  - Severe mental illness
  - Respiratory diseases
  - Early cancer diagnosis
  - Hypertension

3.22 Within Brent, we had started work on tackling health inequalities with all our stakeholders including the voluntary sector prior to the national guidelines. The approach we have taken in Brent is to engage with our diverse communities to develop priorities and action plans to tackle the issues faced by people at a local level.

3.23 Brent Health Matters (BHM) was created in response to the inequalities highlighted by COVID. The initial focus of BHM was to inform and support communities with Covid restrictions and provide practical help on the ground based on individual community's needs. This progressed to supporting the communities with Covid vaccination, including busting some myths, providing education to ensure people were making informed decisions and, significantly, making vaccinations more accessible.

3.24 Diabetes and Mental Health were identified as priorities by communities in all localities following the pandemic. BHM worked with the communities and GP practices to provide diabetes risk assessments, diabetes reviews, supporting with education and promotion of healthy lifestyles. Mental Health support for communities included increasing awareness of mental health issues, providing bite-size mental health first aid training and bespoke support for some communities e.g. bereavement support for Somali women.

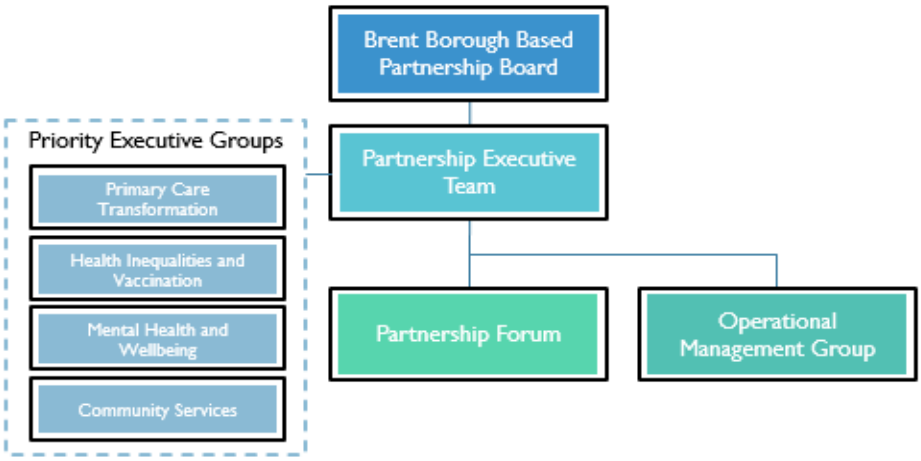
3.25 Recently, BHM has included hypertension as a focus area and are supporting communities with case finding and management of hypertension working closely with the Primary Care Networks (PCNs).

Governance

3.26 The Brent Borough Based Partnership (the ICP) was established in 2022, with an Executive Group for each of the transformation priorities. These Groups meet each month and report to the ICP Executive Group, also meeting monthly.

The ICP Executive reports to the Brent Borough Based Partnership Board (the ICP Board).

3.27 The Executive Groups are co-chaired by senior members from across all partners within the ICP. The co-chairs of the Health Inequalities and Vaccination Executive are Robyn Doran (Brent ICP Director) and Dr Haidar Mohammad (ICP Clinical Lead). The Group includes senior representatives from key partner organisations within the Council, NHS and the voluntary sector. There is also representation from a Community Champion to ensure all stakeholder groups are represented in the decision-making and scrutinising process.



Role and Responsibilities of Brent ICP and Public Health in Tackling Health Inequalities

3.28 Brent Public Health's work on health inequalities, using a social capital approach, predates the new integrated health and care systems. However, the Borough Based Partnership (the ICP) has enabled a step change in the reach and breadth of the work and provided a significant increase in capacity.

3.29 The close working together of the Public Health team and Brent Health Matters is such that partners and the community often do not recognise them as two separate teams. However, the two teams have complementary skills and specialisms.

3.30 The Public Health team provides intelligence products around health inequalities, including qualitative and quantitative understanding of inequalities. The team also provide evidence through the use of surveys, focus groups and the development of evaluation tools to ensure the robustness of the work being undertaken

3.31 Public health leadership, in particular the Public Health Consultant and the Public Health Strategist Health Inequalities, work directly, and through Brent CVS, with large charities, small charities, faith groups, community groups and informal community activists and leaders to build trust with communities and to understand their identification of need.

3.32 The Brent Public Health Inequalities team consists of an agile team that works alongside the BHM team delivering specialist public health intervention such as vaccination or screening. The Public Heath team also have specialised work streams focusing on children, refugees and asylum seekers and emerging communities.

3.33 The BHM Team in collaboration with the Brent Public Health Inequalities Team acts as the delivery arm through which objectives are delivered on the ground.

3.34 BHM and the Public Health team organise themselves around both geographic areas of focus (the Brent Connects areas) and thematic or subject matter lead areas.

The role of Brent Health Matters in Tackling Health Inequalities

Why the programme was set up

3.35 Between March and June 2020, Brent had the highest age-standardised mortality rate for deaths involving COVID-19. During this first wave of the pandemic, Brent experienced a death rate of 216.6 deaths per 100,000 people. This was significantly higher than the London average of 141.8 deaths per 100,000, and the England average of 88.7 deaths per 100,000.

3.36 COVID-19 had a disproportionate impact on Black and Asian ethnic groups and those living in more deprived areas. This reality highlighted the entrenched structural inequalities that exist in Brent, putting some groups at higher risk of poor health than others. The pandemic also shone a light on the low level of trust and confidence communities had in health and social care services.

3.37 The Council, NHS and VCS (voluntary and community sector) recognised that dedicated staff and resources was required to be able to truly tackle health inequality issues in Brent.

3.38 As a result of this, the Brent Health Matters programme was established in September 2020, to take a whole system partnership approach towards a shared vision of tackling health inequalities in Brent. Importantly, partners agreed that listening to and working with local people, groups and organisations is key to ensuring that the programme addresses the health inequality issues faced by diverse communities.

Who the programme reports into

3.39 The Brent Health Matters programme reports into the Health Inequalities and Vaccination Executive Group, which reports into the Brent ICP executive group.

The key health challenges it seeks to address with Brent's communities

3.40 The Brent Health Matters programme initially focussed on protecting people from Covid-19 and supporting Covid vaccination. Currently, diabetes and mental health are the key challenges being addressed through the programme, as communities voiced their concerns about the high prevalence of both health conditions. The programme is now working on including cardiovascular disease (CVD), including hypertension case finding, into its priorities.

Stakeholders the programme works with

3.41 The core programme team consists of staff from the Council, Central London Community Healthcare NHS Trust (CLCH), Central and Northwest London NHS Foundation Trust (CNWL), Public Health and Brent Carers Centre. CLCH and CNWL are the employers of the clinical team and the Community Connectors. Brent Carers Centre are commissioned to provide the Health Educators service

3.42 The stakeholders include all the above organisations, primary care, the voluntary sector and faith organisations. The programme works in partnership with a wide range of community organisations, including over 400 VCS organisations and community leaders.

How the BHM team works with communities differently

3.43 The Brent Health Matters programme has established five 'locality teams' to work in each of the 5 Brent Connects areas. Each team includes:

- Community Coordinator (Council)
- Public Health Officer (Council)
- Community Connector (CNWL)
- Clinical team (CLCH)
- Health Educator (Brent Carers Centre)
- Strategy and Partnerships Officer (Council).

3.44 Community Coordinators with the locality team focus on community engagement activities in each locality area. This is done by proactive engagement with communities, reaching out to them by face-to-face interactions, virtual meetings, attending their regular events and phone calls.

Through this approach, they have been able to establish and maintain a network of community contacts and Community Champions, to be the voice of the diverse communities in Brent. This enables each locality team to co-produce and co-deliver local action plans in each of the five areas.

3.45 Through this approach, the programme is able to maintain a feedback loop between communities, the council and NHS to ensure that resources address the key challenges that pose a barrier to health equity.

3.46 A number of other boroughs have Community Champions and outreach programmes. A particular feature of the local programme is the combination of roles in the locality teams bringing together in virtual teams a range of staff from the Council, the voluntary sector and (uniquely) clinicians.

3.47 The inclusion of clinicians in the teams enables in reach into communities to include a health intervention, such as health check, and for liaison with other health services including onward referral. It is important that BHM does not only offer advice and information. It takes health services to communities, as described below.

Examples of events held

3.48 One of the priorities of the Brent Borough Based Partnership (the ICP) is to improve access to local services. The programme works towards this priority by taking health and social care services out into the community through community events, which are co-developed and co-delivered with VCS organisations and community leaders.

So far, the programme has held **112** health and wellbeing events in a range of community spaces including community centres, shops, libraries, factories and places of worship.

6,206 people have attended these events and **5,203** people have had health checks.

We have collected structured feedback from 512 attendees since February 2023 which is summarised below:

- 96.1% agreed or completely agreed that staff treated them with respect and dignity
- 95.7% agreed or completely agreed that staff explained everything in a way they could understand
- 96.1% agreed or completely agreed that staff listened to what they had to say

- 95.5% answered or very likely when asked if they would recommend the event they attended to a friend or family member

Factory Work

3.49 A particular example of work by Public Health and BHM is the outreach to a local factory. Five events have been held, including two with night shift workers.

Qualitative learning is that many of these workers have multiple jobs leaving them little time to access health services, let alone attend to their physical and mental wellbeing.

Six hundred and eighteen workers attended the events in the Factory (before their shift or during their breaks) and 606 received a physical health check. There was considerable undiagnosed or unmet health need found:

Number of the 606 workers found to have:

- nondiabetic hyperglycaemia (pre-diabetes) 73
- untreated hypertension 83
- raised heart rate 48
- abnormal heart rhythm (possible atrial fibrillation, a treatable stroke risk) 45
- referred to their GP for follow up 168
- referred urgently to the GP in attendance at the event 34

These findings show not only the value of inreach into communities but the value of combining community engagement with a clinical intervention.

Response to a health protection risk

3.50 UKHSA (the UK Health Security Agency) identified a cluster of TB cases with an apparent link to a particular local community. Routine approaches by UKHSA and TB services to surveillance and screening failed to engage the community.

3.51 Public Health and BHM therefore engaged with the community and worked with UKHSA to bring the NHS mobile Xray unit into the local community. TB screening was offered on a walk-in basis along with blood pressure and blood sugar checks, advice and information with translation by BHM workers. UKHSA described the event as “successful beyond our wildest dreams”: 350 residents attended, 200 residents were x-rayed in a single day and a number of referrals were made to TB services and to GPs.

Progress made so far and how the programme monitors and evaluates its performance

3.52 Diabetes has been a focus of the BHM team. In the last 2 years, the proportion of patients with diabetes who are recorded as having received the 9 key care processes (a marker of good quality diabetic care) has improved significantly as follows:

- March 2021: 8.6%
- March 2022: 44.2%
- Current: 58.5%

3.53 This reflects the work of the whole ICP, but BHM have undoubtedly played a role in raising awareness of and providing education on diabetes in the community as well as actually carrying out some of the key care processes at their events.

3.54 All the *activities* undertaken by BHM are captured in a monthly dashboard. However, it has been challenging to measure *impact* of the work being done. The team is currently working with stakeholders to develop a logic model to underpin the measurement of impact of all the work streams.

3.55 When we started the programme, we were faced with high level of lack of trust and confidence in health and care provision from communities. This was evident when we approached the communities. Having worked with our communities and voluntary sector organisations, the programme has now built a rapport and relationship with a variety of community organisations. This has resulted in the team being inundated by community organisations wanting to run joint initiatives/events with BHM.

3.56 The programme has awarded three rounds of grants (total amount £600k) in the last two years to 59 organisations to support them to develop and run their own health and wellbeing programmes for their community. We are currently working with 17 organisations to support them in monitoring and evaluating the impact of these programmes which will further help them in securing grants from other resources

.

3.57 BHM programme works closely with the public health team to look at locally available data on demographics and health outcomes. This helps the programme identify and prioritise communities that they proactively approach to work with them in addressing the issues. We have recently started collecting detailed demographic details of people attending BHM events and are able to link this to the clinical outcomes at the events. This will inform us further on clinical areas we need to focus on and within specific communities.

Areas of improvement identified so far

3.58 The programme has identified the following areas that we need to focus on in the coming year:

- Working with GP practices, and PCNs to identify cohorts of patients who do not normally engage with GPs
- Working with other health and social care services to ensure tackling Health Inequalities becomes BAU within all services
- Developing an impact outcomes framework for the programme

Funding

3.59 BHM programme is funded through a variety of sources:

- The clinical team (employed by CLCH and CNWL) through recurrent funding from NWL ICB (agreed by NHS CCG in 2020).
- The community team is funded through the Council's public health grant
- The Health Educators programme was initially funded from the public health grant. The current funding is through the section 256 agreement, using underspend in the clinical team last year
- The initial two grant rounds were funded by the public health grant (one round was specific for promoting Covid vaccination). The third grant round, which was distributed in summer 2022, is funded through the section 256 agreement

Next Steps

3.60 BHM and Brent public health have a busy community led intervention programme over the summer months.

3.61 Health inequalities are structured, fixed and, in our communities, intersectional. But while our inequalities are entrenched, our vulnerable populations are in a state of flux. We have the newly arrived communities notably those from Eastern and Southern Europe. We have emerging communities from Latin America and Brazil. The recent census showed our established communities are ageing which will have an impact on our long-term conditions profile. The work to counteract health inequalities therefore needs to continue both in scale and scope.

3.62 Key interventions going forward are:

- Expansion of BHM to focus on addressing inequalities in children and young people
- Expansion of the clinical team within BHM to carry out focussed work on people with long term conditions that do not engage with GPs
- Rationalisation of work around health inequalities in cardiovascular disease long term conditions and the risk assessment process

- Continued work to reduce the substantial health inequalities of emerging and newly arrived communities
- Continued work on reducing health inequalities in our refugee and asylum seeker health populations
- Influencing the NW London agenda through ongoing work on the NW London Race Inequality Steering Group and the NW Core20Plus5 Delivery Group

3.63 We are in process of submitting a business case to NWL ICB for the Brent allocation of ICB Health Inequalities funding. This business case focuses on creating a dedicated team to focus on addressing Health Inequalities in children and young people, with initial focus being on increasing childhood immunisation, supporting patients with Asthma and Mental Health conditions.

4.0 Financial implications

These are contained in the report.

5.0 Legal Implications

There are no legal implications arising from this report.

6.0 Equality Implications

These are contained in the report.

Report sign off:

Dr Melanie Smith
Director of Public Health

Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2023
	Report from Tom Shakespeare (Managing Director, Brent ICP)

Report on Brent healthcare funding, recruitment and retention

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:	None
Background Papers:	Not applicable
Contact Officer(s): (Name, Title, Contact Details)	Tom Shakespeare Managing Director, Brent ICP Tom.shakespeare@brent.gov.uk

1.0 Purpose of the Report

1.1 The purpose of the report is to inform the Board of the current position in relation to health spend and recruitment and retention challenges in the Borough, and to inform Members of work underway and outstanding risks.

2.0 Recommendation(s)

2.1 To comment upon the workforce and funding issues outlined in the report

2.2 To comment upon the proposed actions and next steps in section 3.6

3.0 Detail

3.1 Context

3.1.1 As one of the largest and most diverse Boroughs in NW London, Brent faces many different challenges to other Boroughs. Demand for services is often higher, requiring a workforce to meet that demand and in a way that is more

tailored to meet the needs of our different communities, as well as resources that are commensurate with the need and demand.

3.1.2 Brent ICP has taken local leadership of these issues. For example, undertaking joint programmes of work, looking at innovative new schemes (such as the voluntary sector triaging and seeing people waiting on the CAMHS waiting list). Partnership working has delivered a range of innovative winter schemes, the Brent Health Matters Programme has increased community prevention, and ICP dialogue with the ICB has yielded progress on primary care funding.

3.1.3 However, some issues are cannot be addresses at Borough level alone. That is why Brent's Integrated Care Partnership Board and Health and Wellbeing Board have identified a three key risks to meeting the demand from our residents, and have endorsed three keys asks for joint work between the Brent ICP and NW London ICB, namely:

i. To address health inequalities, ensuring consideration of deprivation, ethnicity and disability in the planning, provision and monitoring of all services
ii. Levelling up funding, ensuring there is a routemap towards equitable funding for core services across NW London
iii. Workforce recruitment and retention, ensuring that terms and conditions for staff in inner and outer London Boroughs are equitable, particularly for hard to recruit professional groups

3.1.4 These risks are compounded by the fact that the system is in a state of transformation – last year the Clinical Commissioning Group was abolished and an ICB created, with 7 borough-based partnerships forming part of the wider integrated care system. The Brent ICP has shifted from a commissioning-based system to a provider-led partnership.[1] Towards the end of 2022, NHS England announced that 30% NHS savings were required to the ICB's running costs by 2025/26, which consists mainly of ICB managerial and administrative staff, including those within the Brent ICP borough team. The required level of savings is £12m across NWL.

3.1.5 The Council also has a significant target to meet with its Medium-Term Financial Strategy. It is acknowledged that there is considerable financial uncertainty in the national economy, owing to factors such as Covid-19, high levels of inflation and the global impact of the Russo-Ukraine war. Together with local changes, this has required the need for substantial savings within the Council's budget. Circa £21 million of savings are required across the council.

[1] In a legal sense, both the local authority and the ICB still commission services since they still procure and hold contracts with providers of services. However, the approach to service improvement has changed, where providers come together to plan changes together with service users, rather than the contracting process being the driver of the change. The new approach avoids service fragmentation and duplication.

3.1.6 Despite this we have worked with colleagues at and across NW London at all levels to try and influence change. For example, through dialogue with our ICB leadership team we have sought greater influence over the Mental Health Programmes through representation on the MH Programme Board. We are also in dialogue with the ICB Executive team about the scope of delegation from ICB to borough level, and we have escalated issues relating to mental health funding to the Chief Executive of the ICB.

3.1.7 The following sections will outline the capacity challenge (both recruitment and retention and finance) in more detail. It should however be noted that work is still underway to gather the relevant information to develop a more detailed picture that will inform further action in these areas.

3.2 Workforce recruitment and retention

3.2.1 As a system Brent health and care system employs an estimated 14,962 people, representing around 9.7% of people employed in the Borough[2].

3.2.2 Recruitment and retention of staff is a major obstacle to delivering on the capacity and demand for services. In large part this is due to the differential in NHS pay of 5% between inner and outer London Boroughs. There are recruitment and retention challenges across the whole of the health and care sector to a greater or lesser extent, but there are 4 professional NHS workforce groups where recruitment and retention are causing significant challenges to the system:

i. Occupational therapists
ii. Health visitors
iii. District nurses
iv. General Practitioners[3]

3.2.3 Brent ICP has identified 5 key priority programmes to support transformation of its workforce. Namely:

- Developing a comprehensive Brent training hub offer to support primary care and integrated neighbourhood teams
- The introduction of ‘SPIN’ GPs (Salaried Portfolio Innovation Scheme)
- Programme of rotation for Occupational Therapy to increase career satisfaction and variety
- The use of recruitment and retention premia such as “golden hellos” to make Brent a more attractive place to come to work.
- Exploring the options around removing the difference in pay between inner and outer London boroughs, which currently means that staff are leaving organisations to work a mile down the road in some cases.

[2] This is an estimate based on national figures employed in health and care, extrapolated to the population size of Brent, and as a percentage of the number of people recorded as employed in the borough.

[3] It should be noted that the recruitment and retention issues are somewhat different for GPs, who are independent contractors and whose earnings are not part of the wider Agenda for Change framework that governs the pay of nurses, allied health professionals and most administrative staff.

3.2.4 The Brent Training Hub is the ‘go to’ place for any information about primary care workforce, education and development. We work to address local needs. The Brent Training Hub and its offerings will be available on the Brent Website and will detail all provision for GPs, Nurses, Practice Managers, HCA, ARRS and Admin. We expect individuals, employers and Primary Care Networks (PCNs) to take the time to find out what’s on offer.

The Training Hub is run by clinical leaders and managers supported by a network of primary care staff with education and training professionals based both in the community and the Brent Civic Centre.

It works closely with Primary Care Networks (PCNs) and the NWL Integrated Care System to support workforce priorities and tackle health inequalities to help meet patient and population demand.

The training hub operates a ‘hub and spoke’ model, with a central resource, and then PCN level resources in addition to that. This ensures that the PCNs have an opportunity to influence the training strategy from the ground level up. We have recently recruited to some of the core clinical and managerial roles in the training hub, but we still have some roles to fill at the PCN level to gain the full complement of roles.

3.2.5 With regard to the SPIN GPs, Brent has at two year supported opportunity for newly qualified GPs to create roots in general practice as a salaried clinician, while simultaneously pursuing their passion in alternative service improvement, leadership or clinical settings.

Currently in Brent there are 7 SPIN fellows focusing on areas such as ENT, CAMHS & Paediatrics. We also have 5 new GPs who have been locally recruited and are currently being supported to start on the SPIN programme.

3.2.6 The workforce programmes have delivered some small successes, which will, to some extent address the recruitment and retention challenges. Specifically this includes the rotation of occupational therapists across settings of care and between local authorities, the introduction of a CLCH “golden hello” scheme, and the enhancement of the Brent training hub.

3.2.7 CLCH is implementing is a recruitment and retention premia that falls under the pay enhancements that can be applied under NHS terms and conditions framework, 'Agenda for Change'. This is a 'one off' £2500 bonus paid on starting or for existing band 6 Health visiting staff. This was agreed at trust level to be applied for band 6 Health Visitors on an 'opt in' basis due to the high levels of vacancies in this staff group compared to other staff groups in the organisation. This scheme comes into effect from July 2023.

3.2.8 However, to achieve the scale of change required we are seeking support from the ICB to work together across providers and across Boroughs in NW London to redress the imbalance of London weighting on NHS staff.

3.3 Comparative Borough health spend

3.3.1 Due to the changes in NHS commissioning, and the variety of funding mechanisms, the overall spend across health and care services in Brent is very difficult to understand. The spend areas are as follows:

- Services commissioned by Brent council (including Public Health) for Brent residents;
- Services delivered by Brent council for Brent residents;
- Primary Care services, funded through national contracts, for the Brent GP registered population;
- Local Primary Care, Community Care, VCSE contracts commissioned by North West London (NWL) ICB, specifically for the Brent GP registered population;
- North West London wide Acute Care, Primary Care, Community Care, VCSE services commissioned for the North West London GP registered population, of which includes the Brent population;
- Funding of health related support that takes place outside of Brent for the Brent GP registered population (e.g. hospital admissions outside of NWL).

3.3.2 The vast majority of NHS funding now sits within contracts commissioned at a NWL level for the entire NWL registered GP population. Borough based budgets are therefore managed by NHS providers in many cases, with breakdowns of budgets not held by the NWL ICB.

3.3.3 When compared with other Boroughs, there are a number of spend areas, which differ significantly per head of population, namely:

- Primary Care historically was under-funded in Brent relative to some NWL boroughs. Primary care spend has increased significantly and by 2024/5 will be fully in line with top spending NW Boroughs.
- Adults Mental Health: adult mental health remains significantly underfunded compared with some NWL boroughs, and despite an increase in the proportion of the Mental Health Investment Standard that is applied to Brent, this increase is not sufficient to reach parity levels in the future. Please see the section below on mental health funding.
- Children Mental Health services: Significant service gaps to meet the needs of children (approximately £2m). Including:
    - Supporting medical need in schools
    - Continence (including enuresis)
    - Specialist CAHMS support
    - Neurodiversity assessment and support
    - Non-educational therapy provision
    - Special School Nursing service
    - Audiology for deaf children
    - Global Development Delay pathway for Children over 5
- Brent Integrated Care Equipment Services – significant cost pressures identified to meet demand in Brent (approximately £400,000)

- Discharge to assess rehabilitation services to support people on an independence journey after discharge (approximately £120,000)

3.3.4 Brent health and care services support a broad and diverse population, who face significant inequalities and socio-economic challenges of the borough including high housing costs, and significant low wage employment sectors. Our work through Brent Health Matters has identified significant un-met need, but this is likely to be a small proportion of its totality. This work has also only focussed on Adults, with a need to expand work to Children as proposed in a live business case submitted to the ICB.

3.3.5 The budget for care services in Brent in 23/24 is £117 million. To give an indicative figure for health, if the ICB's budget was split proportionately in accordance with the populations of the 8 North West London boroughs, the Brent expenditure would be £583 million. [4]

3.3.6 There is a case for Brent's relative deprivation and the diversity of its population translating into a need for more resources by reference to the accepted need for universal and targeted interventions as a means to address inequalities. In Brent we have learned that we need a diversity of targeted approaches, as evidenced by our approach to vaccination during the pandemic, involving (for example) PCN- level vaccination clinics, mass vaccination centres, vaccination buses, and events at places of worship and other public areas.

3.3.7 There are considerable socio-economic challenges in the borough – even before the cost of living crisis hit, we had high housing costs and a high number of low-paid employment sectors such as small retail units and food factories.

We know from our experience in Brent Health Matters running outreach clinics that there is considerable unmet need in Brent, and this is only beginning to be discovered. Our logic model is that if we can meet some of the unmet need at an earlier stage, then we can avoid unnecessary hospital admissions and non-elective activity.

3.4 Mental Health Focus

3.4.1 The ICB has conducted a review of expenditure in mental health services across the 8 boroughs.

3.4.2 Variation across services at borough level within provider footprints is *greater* than the difference between provider averages.

3.4.3 Overall, investment is *higher* in inner boroughs on total investment, and on a weighted per-head of population, but a simple inner/outer narrative masks service variation

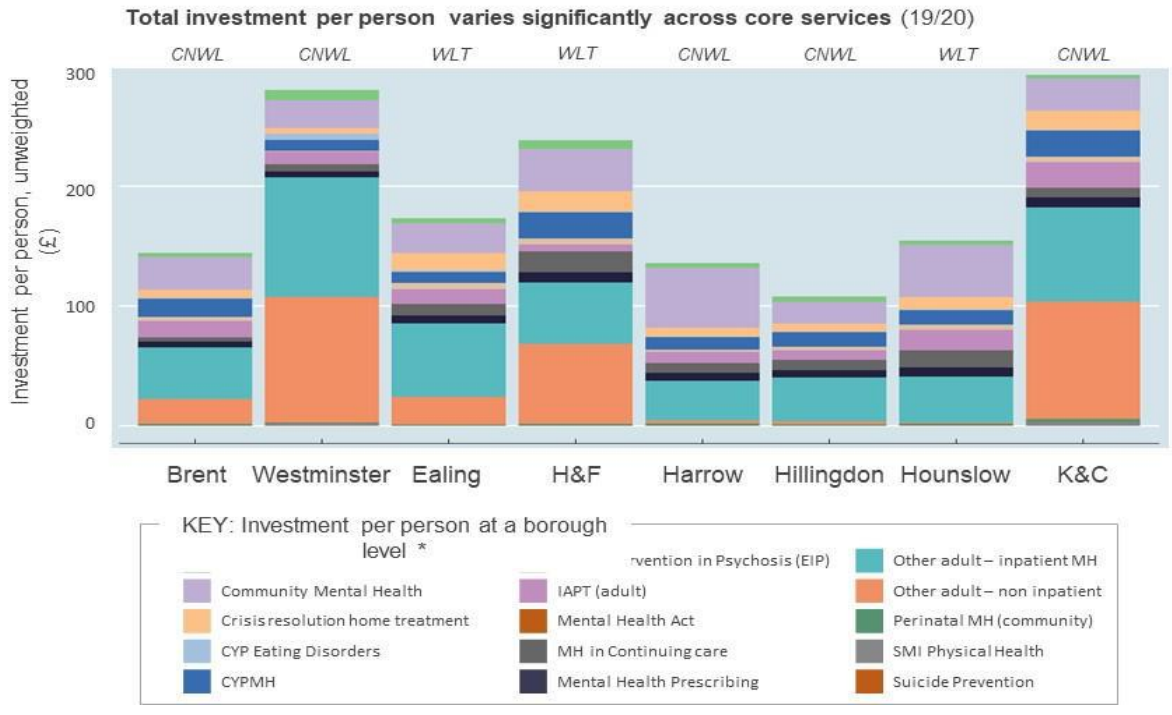
[4] The social care figure is taken from the Council's published budget statements. The health figure is an approximation based on the total NWL ICB budget, which was then apportioned into the Brent portion of the NWL population (16%). This is a notional figure only, and the actual expenditure will be different.

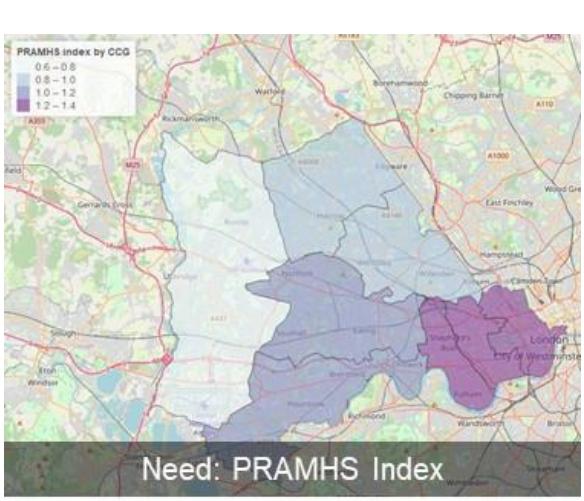
3.4.4 The variation in care provision within and across boroughs in NWL has become increasingly hard to tolerate as strategic partners come together to form an Integrated Care System

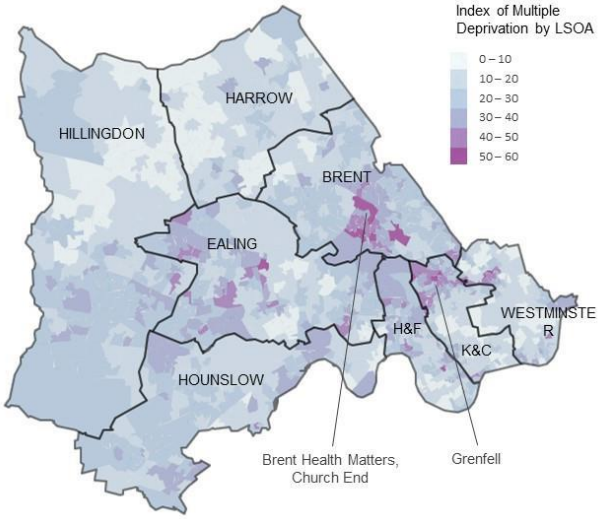
3.4.5 Analysis of variation in investment in isolation is not sufficient to determine whether this funding is right-sized. Need is driven by diverse populations, and activity does not necessarily equate to need.

3.4.6 The diagram below shows the level of investment in Brent's mental health services compared with the other 7 boroughs, broken down into service categories. This originates from financial year 19/20, and whilst the figures will have changed since that year, the pattern of expenditure is unlikely to have changed significantly.

3.4.7 Adults Mental Health: this has been historically under-funded due to the spend calculations being based on 'known' demand, only looking at GP registered lists (PRAHMS). The outputs of these calculations do not correlate with the incidents of serious Mental Health activity seen in Brent. There is also a well evidenced link between areas of deprivation and poor mental health, also not reflected in the calculations.







3.5 Mental Health Survey and Service Improvement Plans

3.5.1 Brent ICP has established a joint clinical and managerial oversight group for mental health, as part of its ICP governance, to further define what the gaps in provision are in access to mental health services and what specific actions should be taken forwards to address them. This was informed by a survey of GPs asking for their experience of need across the Borough. The outline results of this survey were quite stark:

3.5.2 On the whole, across all Primary Care services, respondents rated mental health services as '1, Poor'. The areas of highest concern were in relation to Children and Young People, ADHD and depression, as well as eating disorders.

Overarching themes regarding areas for improvement included:

- Improved responsiveness and communications to GPs
- Improved support for SMI patients in Primary Care
- Quicker response times to referrals
- Improved long-term care and follow-up for SMI/Elderly
- Access to psychiatrists
- GPs to have systematically arranged meetings with Mental Health Teams
- Mental Health Practitioners to be visibly present in Primary Care
- Patients not bounced back to GPs
- Patients to be stabilised before discharging to GPs
- Improved access to Mental Health Support for SMI patients

3.5.3 A detailed set of proposed actions and interventions was developed to respond to this.

Around £5.1 million of Mental Health Investment Standard ("MHIS") funding has recently been allocated to Brent mental health service by NWL ICB. Some of this may be required to absorb existing pressures. Assuming that future 'levelling-up' funding could be forthcoming, the Mental Health and CYP Group has been considering what options it could consider to improve services and

respond to the findings of the survey. The group includes representatives from CNWL as well as clinical input and the ideas formed to date include:

- CAMHS Clinic in primary care using the SPIN GP– to be included in the paediatric hublets. This will include a Child and Family Consultation Service offering help to children and young people who are experiencing emotional, behavioural or mental health difficulties. It will also provide access to an advice and guidance service or to a primary care based CAMHS clinic.
- Designated Primary Care link workers/transition workers/liaison posts – CAMHS to Adult Mental Health services. A collaborative care model with a tiered approach, where young people who have high symptom severity are transitioned to AMHS, and those with low symptom severity but a high risk of recurrence receive follow-up appointments to monitor their symptoms in primary care.
- Mental health professionals in primary care settings to facilitate access to care while reducing the impact of mental health consultations on GP workload
- Specialist community clinics, home visits, school visits using specialist CAMHS nurse practitioner
- Range of psychological, psychiatric and psychosocial interventions. A mixture of expertise available to support CYP in crisis, including intensive community treatment.
- GP-led multi-agency primary care youth clinics with an emphasis on engaging with young people early, early detection and intervention.
- 'Virtual teams', where designated members from separate multidisciplinary teams work together, calling on their range of skills and expertise to help meet the developmental and mental health needs of young people presenting GPs.
- Access to peer support, social support and evidence-based interventions with a focus on a recovery model
- Training - GPs training in adolescent risk-taking behaviours, using a screening tool, and motivational interviewing to improve detection of health risk behaviours in young people
- Increased resources and capacity – Additional CYP CAMHS workforce to level up Specialist CAMHS with sufficient to meet local need.

3.5.4 Further work is needed to understand the mental health data and to define which of these interventions is most likely to improve outcomes. We also need to involve children, young people and their families in the development of the proposals. They are dependent on further work to cost out these proposals and assess their viability within the available funding envelope.

3.5.5 In addition, the concerns have been escalated the MH levelling up funding, and addressed this in the following way:

i. Direct requests from ICP Exec chairs to senior executives at ICB and CNWL
ii. A letter from clinical leads to the ICB chief exec, to which we received a positive response, but which does not yet address the historically lower levels of funding which Brent's mental health services received in the

past (Brent therefore starts from a lower financial baseline). This is an ongoing dialogue and we expect to have further conversations

iii. Agreement for representation of ICP MD at MH Exec and programme board – this has recently begun

3.5.6 It should be noted that in advance of any recurrent and long term solution to these pressures in mental health services, Brent ICP partners are actively maximising all existing and non-recurrent resources available to partners. For example:

i. Winter pressures schemes – for example funding the Adult Mental Health Emergency Centre at Northwick Park Hospital, and the Additional Hospital Discharge Support scheme, which facilitates earlier discharge from A&E.

ii. CNWL services – we have invested non-recurrent resources in addressing the CAMHS backlog, such as commissioning Brent Centre for Young People to triage and see patients who are on the CAMHS waiting list.

3.6 Proposed actions and next steps

3.6.1 The following actions and next steps are proposed:

i. The ICP borough team continue to advance its recruitment and retention and training programmes, drawing on its clinical and managerial resource

ii. That a training needs analysis is commissioned that would ask *"What would make Brent an attractive place for clinicians to move to? What would act as a pull factor?"*

iii. That information from exit interviews (where available) in provider organisations is collated and analysed for information on what might be adding to Brent's recruitment and retention issues.

iv. The issue of the London weighting should be escalated and raised at London-wide level in order to influence change

v. Further scoping should take place with provider organisations to consider what additional schemes we could put in place to further impact upon recruitment and retention

vi. Further work should take place to scope, plan and cost out the proposed ideas to address mental health access and demand, and to continue the dialogue with NWL ICB about how to resource them. There should be appropriate involvement from service users. We would seek a recommendation from the committee that the ICB should commit to a timescale to address the historic underfunding compared with other NWL boroughs and to equalise levels of expenditure.

4.0 Financial Implications

4.1 The conversations with NWL ICB regarding the 'levelling up' agenda are ongoing.

The MHIS requirement in 2023/24 for North West London is £472m, which is in an additional £30.4m. The ICB has confirmed that funding has been allocated

to borough-level services on the basis of population prevalence (i.e. the prevalence of mental health conditions as a percentage of the total NWL mental health prevalence) and this figure is 17%. We are therefore expecting around £5.2 million in additional investment from the MHIS.

The ICB has retained £3.8m of reserves to fund 2023/24 in-year service development which may include expansion of services following the Metropolitan Police Service's plans to implement Right Care, Right Person, further support for implementation of 111 First for Mental Health (due to go live in Q3 2023/24), supporting safe and suitable environments in acute hospitals for mental health patients, further service development as a result of temporary closures, as well as overall co-production activities for the North West London.

5.0 Legal Implications

5.1 There are no legal implications

6.0 Equality Implications

6.1 There are equality implications for the more deprived sections of the population, which suffers from a greater degree of illness and mental health issue compared with wealthier groups. There is therefore a need to invest more in these areas of the population in line with the principle of "proportionate universalism"

7.0 Consultation with Ward Members and Stakeholders

7.1 The report has no consultation implications for ward members. There has been engagement with provider organisations about their needs and solutions to their recruitment problems.

8.0 Human Resources/Property Implications (if appropriate)

8.1 The Human Resources implications are outlined in the main body of the report i.e. in some cases recruitment and retention premia may be paid to particular groups of staff and further work is due to take place relating to the London weighting.

Report sign off:

Tom Shakespeare
Managing Director of Brent Integrated Care Partnership

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Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2023
	Report from the Corporate Director of Communities and Regeneration

Scrutiny Committee Work Programme 2023-2024

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:Draft Community and Wellbeing Scrutiny Committee Work Programme 2023/24
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	George Kockelbergh Strategy Lead – Scrutiny, Strategy and Partnerships George.Kockelbergh@brent.gov.uk Tom Pickup, Policy Partnerships and Scrutiny Manager, Strategy and Partnerships Tom.Pickup@brent.gov.uk Janet Latinwo Head of Strategy and Partnerships, Strategy and Partnerships Janet.Latinwo@brent.gov.uk

1.0 Purpose of the Report

1.1 To update the committee on the Community and Wellbeing Scrutiny Committee's Work Programme for 2023/24.

2.0 Recommendation(s)

2.1 That:

The committee discuss and agree the contents of the report and the 2023/24 Community and Wellbeing Scrutiny Committee's Work Programme, set out in Appendix 1.

3.0 Detail

3.1 The Community and Wellbeing Scrutiny Committee's work programme outlines the policy areas and council decisions that the committee plans to review during the 2023/24 municipal year according to its remit. The remit of the Community and Wellbeing Scrutiny Committee is set out in the Council Constitution under the Terms of Reference for Scrutiny Committees which includes:

Adult social care; Safeguarding; Children's services; Cultural services; Education; Health; Housing; Public Health and Wellbeing.

3.2 Reports presented to this committee are based on Cabinet decisions, annual safeguarding board reports, and strategies and policies from the council and its partners.

3.3 To ensure that scrutiny is effective, members of the committee prioritised items for inclusion in its work programme at its annual work planning meeting. This process ensured that items included in the committee's work programme were a strategic priority as set out in the council's 2023-27 Borough Plan; of concern for a significant number of the borough's residents; a significant cabinet decision or part of a forthcoming policy review or a new strategy being developed by the Cabinet. This method of prioritisation is considered best practice by the Centre for Governance and Scrutiny (CfGS) and enables a scrutiny committee to develop a work plan that is coherent and flexible.[1]

3.4 There is scope for the committee's work programme to change during the municipal year. This is so that the committee can be flexible and review emerging issues as they arise and as the Cabinet's Forward Plan is updated. The committee's work programme should be viewed as a living document that will adapt according to the committee's needs. Sometimes it may also be necessary to move items from a particular committee date for practical reasons, in these cases the work programme will be updated accordingly and will be presented to the committee at its next meeting.

3.5 As set out under Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Community and Wellbeing Scrutiny Committee is also responsible for scrutinising relevant NHS bodies or health service providers. This role gives the committee power to review the provision and operation of health services in Brent and can make recommendations to NHS bodies or other relevant health service providers.

4.0 Financial Implications

[1] *The Good Scrutiny Guide* (Centre for Public Scrutiny, June 2019), p26

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

6.1 There are no equality implications arising from this report.

7.0 Consultation with Ward Members and Stakeholders

7.1 Non-executive members were involved in developing the work programme as part of their membership of the committee..

Report sign off:

Zahur Khan,
Corporate Director of Communities and Regeneration

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Appendix 1: Draft 2023/24 Community and Wellbeing Scrutiny Committee Work Programme

5 July 2023

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive / Corporate Directors	External Organisations	External Participants
Health Inequalities, focusing on the work of Brent Health Matters (60 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing	Brent Integrated Care Partnership	Robyn Doran, Director, Brent Integrated Care Partnership
Funding and Recruitment: Impact of challenges on Brent's healthcare provision (60 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing	Brent Integrated Care Partnership	Robyn Doran, Director, Brent Integrated Care Partnership

19 September 2023

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive / Corporate Directors	External Organisations	External Participants

Outcome of 2023 Ofsted ILACS and current children's social care improvement activity (including current workforce challenges) (40 minutes)	Councillor Gwen Grahl, Lead Member, Children, Young People & Schools	Nigel Chapman, Corporate Director Children and Young People	TBC	TBC
SEND strategy implementation and readiness for a joint Ofsted/CQC inspection (40 minutes)	Councillor Gwen Grahl, Lead Member, Children, Young People & Schools	Nigel Chapman, Corporate Director Children and Young People	TBC	TBC
Adult Social Care CQC assurance (40 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing Claudia Brown, Director of Adult Social Services	TBC	TBC

22 November 2023

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive / Corporate Directors	External Organisations	External Participants
Brent's Multi-Agency Safeguarding Arrangements for Children (Considered annually) (40 minutes)	Councillor Gwen Grahl, Lead Member, Children, Young People & Schools	Nigel Chapman, Corporate Director Children and Young People	Metropolitan Police NHS	Independent Chair / Scrutineer, Brent Safeguarding Children Board Jennifer Roye, Director of Quality, North West London Integrated Care Board Detective Superintendent Tony Bellis, Public Protection, North West London Basic Command Unit, Metropolitan Police

Brent Safeguarding Adults Board Annual Report 2022-2023 (Considered annually) (40 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing Claudia Brown, Director of Adult Social Services	Metropolitan Police NHS	Fran Pearson, Independent Chair, Safeguarding Adults Board Jennifer Roye, Deputy Chief Nursing Officer, North West London Integrated Care Board Detective Superintendent Tony Bellis, Public Protection, North West London Basic Command Unit, Metropolitan Police
Brent Youth Strategy and provision (40 minutes)	Councillor Gwen Grahl, Lead Member, Children, Young People & Schools	Nigel Chapman, Corporate Director Children and Young People	Brent Community and Voluntary Sector Organisations	TBC

30 January 2024

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive / Corporate Directors	External Organisations	External Participants
Brent Housing Management: including readiness for tenancy satisfaction measures and responsive repairs performance (50 minutes)	Councillor Promise Knight, Lead Member, Housing, Homelessness & Renters Security	Peter Gadsdon, Corporate Director, Resident Services Hakeem Osinaike, Director, Housing		
New single homelessness service (50 minutes)	Councillor Promise Knight, Lead Member, Housing, Homelessness & Renters Security	Peter Gadsdon, Corporate Director, Resident Services Hakeem Osinaike, Director, Housing		

Selective Licensing (20 minutes)	Councillor Promise Knight, Lead Member, Housing, Homelessness & Renters Security	Peter Gadsdon, Corporate Director, Resident Services Hakeem Osinaike, Director, Housing		

4 March 2024

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive / Corporate Directors	External Organisations	External Participants
Substance Misuse (50 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing Melanie Smith, Director of Public Health	TBC	TBC
Brent Health and Wellbeing Strategy implementation (50 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing Melanie Smith, Director of Public Health	Brent Integrated Care Partnership	TBC
Social Prescribing Task Group 1 Year Update (20 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing	Brent Integrated Care Partnership	Robyn Doran, Director, Brent Integrated Care Partnership

16 April 2024

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive / Corporate Directors	External Organisations	External Participants
Annual school standards and achievement report (50 minutes)	Councillor Gwen Grahl, Lead Member, Children, Young People & Schools	Nigel Chapman, Corporate Director Children and Young People	Headteachers from Brent schools	TBC

Implementation of the carer's strategy (50 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing Claudia Brown, Director of Adult Social Services	Representatives from Carers forum	TBC
Brent's new reablement service (20 minutes)	Cllr Neil Nerva, Lead Member Adult Social Care and Public Health	Helen Coombes, Interim Corporate Director, Care, Health and Wellbeing Claudia Brown, Director of Adult Social Services	TBC	TBC

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Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2023
	Report from Communities & Regeneration

2022/23 and 2023/24 Scrutiny Recommendations Trackers

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:	Appendix 1: Community and Wellbeing Scrutiny Committee Recommendations Tracker 2022/23 Appendix 2: Community and Wellbeing Scrutiny Committee Recommendations Tracker 2023/24
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	George Kockelbergh Strategy Lead – Scrutiny, Strategy and Partnerships George.Kockelbergh@brent.gov.uk Tom Pickup, Policy Partnerships and Scrutiny Manager, Strategy and Partnerships Tom.Pickup@brent.gov.uk Janet Latinwo Head of Strategy and Partnerships, Strategy and Partnerships Janet.Latinwo@brent.gov.uk

1.0 Purpose of the Report

1.1 To present the previous municipal year's scrutiny recommendations tracker to the Community and Wellbeing Scrutiny Committee, and to set out a blank scrutiny recommendations tracker to be used by the committee during the 2023/24 municipal year.

2.0 Recommendation

2.1 That:

The previous recommendations, suggestions, and information requests of the committee in the 2022/23 municipal year be noted in Appendix 1.

The committee note the blank recommendations tracker for use in the 2023/24 municipal year in Appendix 2.

3.0 Detail

3.1 The Recommendations Tracker tabled in Appendix 1 at the 5 July 2023 meeting relates to the 2022/23 municipal year.

3.2 In accordance with Part 4 of the Brent Council Constitution (Standing Orders of Committees), Brent Council scrutiny committees may make recommendations to the Full Council or the Cabinet with respect to any functions which are the responsibility of the Executive, or of any functions which are not the responsibility of the Executive, or on matters which affect the borough or its inhabitants.

3.3 The Community and Wellbeing Scrutiny Committee may not make executive decisions. Scrutiny recommendations therefore require consideration and decision by the appropriate decision maker; the Cabinet or Full Council for policy and budgetary decisions.

3.4 The 2022/23 scrutiny recommendations tracker, outlined in Appendix 1 provides a summary of the scrutiny recommendations made during the municipal year, in order to track executive decisions and any implementation progress. It also includes suggestions of improvement and information requests, as captured in the minutes of the committee meetings.

3.5 The 2023/24 scrutiny recommendations tracker set out in Appendix 2 is currently blank and will be populated as the municipal year progresses.

4.0 Procedure for Recommendations from Scrutiny Committees

4.1 Where scrutiny committees make recommendations to the Cabinet, these will be referred to the Cabinet requesting an Executive Response and the issue will be published on the Council's Forward Plan. This will instigate the preparation of a report to Cabinet and the necessary consideration of the response.

4.2 Where scrutiny committees develop reports or recommendations to Full Council (e.g. in the case of policy and budgetary decisions), the same process will be followed, with a report to Cabinet to agree an Executive Response, and thereafter, a report to Full Council for consideration of the scrutiny report and recommendations along with the Cabinet's response.

4.3 Where scrutiny committees have powers under their terms of reference to make reports or recommendations to external decision makers (e.g. NHS bodies), the

relevant external decision maker shall be notified in writing, providing them with a copy of the Committee's report and recommendations, and requesting a response.

4.4 Once the Executive Response has been agreed, the scrutiny committee shall receive a report to receive the response and the Committee may review implementation of the Executive's decisions after such a period as these may reasonably be implemented (review date).

5.0 Financial Implications

5.1 There are no financial implications for the purposes of this report.

6.0 Legal Implications

6.1 Section 9F, Part 1A 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.

6.2 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.

7.0 Equality Implications

7.1 There are no equality implications for the purposes of this report.

8.0 Consultation with Ward Members and Stakeholders

8.1 None for the purposes of this report.

Report sign off:

Lorna Hughes
Director of Communities

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Appendix 1

Community and Wellbeing Scrutiny Committee
Scrutiny Recommendations and Information Request Tracker 2022-23

These tables are to track the progress of scrutiny recommendations and suggestions for improvement made by the Community and Wellbeing Scrutiny Committee, with details provided by the relevant lead departments. It is a standing item on the Committee's agendas, so that the Committee can keep track of the recommendations, suggestions and requests it has made, and the related the decisions made and implementation status. The tracker lists the recommendations, suggestions and information requests made by the committee throughout a municipal year and any recommendations not fully implemented from previous years.

The tracker documents the scrutiny recommendations to Cabinet made, the dates when they were made, the decision maker who can make each decision in respect of the recommendations, the date the decision was made and the actual decision taken. The executive decision taken may be the same as the scrutiny recommendation (e.g. the recommendation was "agreed") or it may be a different decision, which should be clarified here. The tracker also asks if the respective executive decisions have been implemented and this should be updated accordingly throughout the year.

Scrutiny Task Group report recommendations should be included here but referenced collectively (e.g. the name of the scrutiny inquiry and date of the agreement of the scrutiny report and recommendations by the scrutiny committee, along with the respective dates when the decision maker(s) considered and responded to the report and recommendations. The Committee should generally review the implementation of scrutiny task group report recommendations separately with stand-alone agenda items at relevant junctures – e.g. the Executive Response to a scrutiny report and after six months or a year, or upon expected implementation of the agreed recommendation of report. The "Expected Implementation Date" should provide an indication of a suitable time for review.

Key:

Date of scrutiny committee meeting - For each table, the date of scrutiny committee meeting when the recommendation was made is provided in the subtitle header.
Subject – this is the item title on the committee's agenda; the subject being considered.
Scrutiny Recommendation – This is the text of the scrutiny recommendation as it appears on the minutes – **in bold**.
Decision Maker – the decision maker for the recommendation, (**in bold**), e.g. the Cabinet (for Council executive decisions), full Council (for Council policy and budgetary decisions), or an NHS executive body for recommendations to the NHS. In brackets, (date), the date on which the Executive Response was made.
Executive Response – The response of the decision maker (e.g. Cabinet decision) for the recommendation. This should be the executive decision as recorded in the minutes. The Executive Response should provide details of what, if anything, the executive will do in response to the scrutiny recommendation. Ideally, the Executive Response will include a decision to either agree/reject/or amend the scrutiny recommendation and where the scrutiny recommendation is rejected, provide an explanation of why. In brackets, provide the date of Cabinet/executive meeting that considered the scrutiny recommendation and made the decision.
Department – the Council directorate (and/or external agencies) that are responsible for implementation of the agreed executive decision/response. Also provided, for reference only, the relevant Cabinet Member and strategic director.

Implementation Status – This is the progress of any implementation of the agreed Executive Response against key milestones. This may cross reference to any specific actions and deadlines that may be provided in the Executive Response. This should be as specific and quantifiable as possible. This should also provide, as far as possible, any evidenced outcomes or improvements resulting from implementation.
Review Date - This is the expected date when the agreed Executive Response should be fully implemented and when the scrutiny committee may usefully review the implementation and any evidenced outcomes (e.g. service improvements). (Note: this is the implementation of the agreed Executive Response, which may not be the same as the scrutiny recommendation).

Recorded Recommendations to Cabinet from CWBSC

Meeting date and agenda item	Scrutiny Recommendation	Cabinet Member, Lead Officer, and Department	Executive Response	Implementation Status	Review date

Recorded suggestions for improvement from to Council departments/partners

Meeting date and agenda item	Suggestions for improvement	Council Department/External Partner	Response	Status
5 July 2022 – Adult Care Services	To recommend that Adult Social Care embeds a pathway for carers within the Carers Strategy when it was relaunched.	**Adult Social Care & Health – Adult Social Care**	Adult Social Care is currently in the process of redesigning the customer pathway in partnership with colleagues from the transformation service. A revised customer journey map will be available later this year. **March 2023 Update:** A "soft launch" of the Carers Strategy will commence during April 2023. This will include a carer's pathway/journey to ASC services. As part of this work, Adult Social Care colleagues have attended a number of carers engagement sessions over the last three months. This is part of our commitment to co-production/design of carers services in Brent and to support the council to understand the needs of unpaid carers in our community. All contributions will be considered as we work together with the Carers project group to craft the final strategy. The face-to-face engagement sessions have really supported the development of a fuller carers offer.	

	To recommend utilising Community Champions to help with the engagement of different communities within Brent.	**Adult Social Care & Health – Adult Social Care**	Adult Social Care is always looking at ways to utilise community and operational carers champions in engagement and via the carers board and forums. This will be done through adult social care operational carers champions who will strengthen communication, seek to enhance our understanding of the user experience and representation at the carers board, especially for residents and carers of people with mental health support needs and learning disabilities.	
22 September 2022 – Implementation of SEND review	To recommend that an event takes place at the Civic centre showcasing the work on SEND within the council.	**Children and Young People**	There is to be a celebration event of children and young people with SEND in early Spring. This will be coproduced with parents/carers and young people. Along with a celebration of young people the event will offer the opportunity to share the work undertaken to date and establish our priorities based on the expectation of a government White Paper being produced in the coming months. Details on the event will be shared once a date is confirmed.	
	That the SEND green paper is circulated to all relevant stakeholders included all school staff.	**Children and Young People**	The green paper was circulated to settings and schools via the Headteachers' Bulletin and SENCO Forum; to health staff and the parent/carer forum via the strategic partnership board. Links to the green paper are also on the Local Offer which is hosted on the Council's website.	
	That that there is a framework for more joined up working with the ICP / ICS on SEND	**Children and Young People**	The ICP has established the priorities for children and young people for which meeting the needs of children with SEND is a key theme.	
22 September 2022 – Early Help	To recommend that a representative from the parent's forum or steering group attends a relevant scrutiny committee meeting.	**Children and Young People**	Members of the parent forum and members of the FWC local steering groups have been spoken to and they have indicated their willingness to attend scrutiny as and when required.	

	To recommend that the council continues to work in partnership with the community and voluntary sector on early help.	**Children and Young People**	All service areas will continue to work in partnership with the community and voluntary sector on early help. The Early Help network includes professionals from all the universal and targeted VCS services for families in Brent.	
22 November 2022 – Transitional Safeguarding Task Group 12 Month Update	To recommend that the Black Community Action Plan team are consulted on within the traditional safeguarding approach. To ensure that the voices of young black people are reflected in the council's approach.	**Adult Social Care & Health – Adult Social Care**	Agreed. As part of the development of the council's transitional safeguarding approach. The council is working in partnership with the Young Brent Foundation to ensure that all communities in Brent are represented in the engagement.	
22 November 2022 – Brent Safeguarding Adults Board Annual Report	To recommend that a narrative is further developed to compliment safeguarding data within future Safeguarding Adults Board annual reports.	**Brent Safeguarding Adults Board**	Additional narrative was added to the current annual report in order to provide clarity on the data contained within it. Greater attention will be paid to the narrative to better explain the data within future annual reports. The link to the amended annual report can be found here: https://brentsafeguardingpartnerships.uk/adults/article.php?id=974&menu=1&sub_menu=9	
	To recommend that additional equalities statistics are include as part of future Safeguarding Adults Board annual reports.	**Brent Safeguarding Adults Board**	Appropriate additional equalities statistics will be included within next year's annual report.	
	To recommend that there is extensive training on adult safeguarding issues amongst partner organisations to drive up standards.	**Brent Safeguarding Adults Board**	The Safeguarding Adults Board has a statutory role in ensuring that lessons are learned. This includes having a learning and development programme. Elected members should note that the SAB has been busy agreeing and scoping its new strategic priorities for the coming years and that the learning and development programme will grow from these priorities. Therefore, the main progress in relation to this area will come after the priorities have been agreed and scoped which will fall just outside the next annual report. However, members can be given an update in relation to this on request.	

	To recommend that there be an outline of what successful partnership working looks like and details on how partners are working to improve safeguarding processes in individual agencies in future Safeguarding Adults Board annual reports.	**Brent Safeguarding Adults Board**	This will be evidenced within future annual reports by highlighting the work of the SAB and its sub-groups and also in relation to Safeguarding Adult Reviews.	
	To recommend that information is shared on areas of improvement for the Brent Safeguarding Adults Board and the action plans to address them.	**Brent Safeguarding Adults Board**	The current period is a time of change for Brent SAB. The new Independent Chair is working collaboratively with partners to continue developing the SAB and its sub-groups. Any changes to the SAB, its constitution and its structures will be reported on within the next annual report.	
22 November 2022 -Brent Safeguarding Children Partnership Annual Report	To recommend that more information on the partnerships key achievements is included within future Brent Safeguarding Children Partnership Annual Reports.	**Brent Safeguarding Children's Partnership**	Agreed. The annual report covering the period 1 October 2022 – 30 September 2023 will include more information on the safeguarding children partnership's key achievements and learning from local partnership reviews of serious safeguarding incidents, where appropriate, giving due consideration to sensitivity and confidentiality.	
	To recommend that more information and details on how learnings from rapid reviews are incorporated into future working of the partnership.	**Brent Safeguarding Children's Partnership**	Agreed. The annual report covering the period 1 October 2022 – 30 September 2023 will include more information on the safeguarding children partnership's key achievements and learning from local partnership reviews of serious safeguarding incidents, where appropriate, giving due consideration to sensitivity and confidentiality.	
25 January 2023 – Mental Health and Wellbeing Subgroup	To recommend that more detailed statistics on demographics of residents accessing mental health and wellbeing support are included in future reports, and to ensure these statistics are accessible and easy to understand.	**Brent Borough Based Partnership (Brent Integrated Care Partnership)**	Representatives from the ICP have confirmed that this can be included in future reports.	
25 January 2023 – Mental Health and Wellbeing Subgroup	To recommend that a report on the work of Brent Health Matters is brought to the committee at a future date.	**Brent Borough Based Partnership (Brent Integrated Care Partnership)**	Representatives from the ICP have agreed to bring a report on the work of Brent Health Matters to a future committee meeting.	

25 January 2023 – Brent Housing Management	To recommend that future reports include a more detailed breakdown of the nature of repairs to understand what types of repairs are being completed on time and those that aren't.	**Resident Services – Housing**	Brent Housing Management will ensure that future reports include a more detailed breakdown of the nature of repairs, so that the committee can better understand what types of repairs are being completed on time	
25 January 2023 – Brent Housing Management	To recommend that council policies are signposted to or included in future reports when they are referenced.	**Governance**	Agreed. The report writing style guide will be updated to include to include a heading 'Council Policies Referenced' where officers will be advised to add a link to referenced polices (if applicable).	
7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To recommend that future reports to this committee about the attainment of Black Caribbean Boys to be structured around the journey of the child. In practice this will consist of outlining their educational experiences and outcomes from early years to the end of secondary school.	**Children and Young People**	The Children and Young People's department accepts this recommendation which will be taken forward in future reports.	
7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To recommend that a future report highlights the specific challenges that are addressed at Early Years stages in relation to school attainment.	**Children and Young People**	The Children and Young People's department accepts this recommendation which will be taken forward in future reports.	
7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To recommend that future reports on this issue include a wider narrative on reasons for historically lower attainment for Black British boys of Caribbean heritage, to give the committee a sense of the bigger picture.	**Children and Young People**	The Children and Young People's department accepts this recommendation which will be taken forward in future reports.	

7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To include more information on the underlying issues that contribute to poor school attainment for this cohort in future reports.	**Children and Young People**	The Children and Young People's department accepts this recommendation which will be taken forward in future reports.	
7 March – Mental Health and Wellbeing for Children and Young People including CAMHS	To receive data on which mental health conditions are most prevalent in children and young people in Brent, and for this to be included in future reports to this committee	**Children and Young People**	Provided within a confidential briefing to the committee due to sensitivity.	
7 March 2023 - Immunisations	To recommend that targeted engagement and work with communities in Brent is accelerated to improve health outcomes of vaccine hesitant groups of residents	**Adult Social Care & Health - Health**	Recommendation accepted (and welcomed). The work of Brent Health Matters and Public Health in outreaching to communities has shown impact in reducing inequalities in COVID vaccination. The ICP has agreed to extent this approach to inequalities to children and young people's health issues with immunisation as a priority within this. A business case to expand the BHM model to include children is under development.	
7 March 2023 - Immunisations	To recommend that NHSE works in partnership with local authorities to ensure that targeted and community specific council communications compliment national messaging.	**Adult Social Care & Health - Health**	Recommendation accepted (and welcomed). Council communications colleagues and public health have made contact with NHS communication leads to develop a local plan.	
7 March 2023 - Immunisations	To recommend that a collaborative approach and joint working between public health and Brent Health Matters is developed to increase vaccination uptake, including for HPV.	**NHS England**	Agreed to be provided W/C 17 April.	
18 April 2023 – Casey Review 1 Year Update	To recommend that there is consideration of the impact of event days on the wider borough in further updates on the implementation of the Casey Review recommendations.	**Brent Council**	All areas beyond the Zone Ex area (i.e. the area immediately surrounding Wembley Stadium) are being taken into consideration during routine event day planning and event activities delivered on the day. This includes areas such as Wembley Park, Wembley Central and even Kilburn where we officers have been made aware that there may be a high number of visitors and therefore potential fan related ASB issues. The council's PSPO, CCTV	

			Control Room and relationship with our partners such as the Metropolitan Police now extends across the whole borough in order to address the wider event day impact on the area by assisting us in monitoring and managing event related ASB as it occurs in the outlying areas as well.	
18 April 2023 – Casey Review 1 Year Update	To recommend that the FA involve local Brent residents and infrastructure within national FA anti-racism campaigns, and for future reports to include a wider view of the campaigns currently underway to change fan behaviour.	**The Football Association**	Love Football Protect the Game will be activated around matches towards the end of the 2023/24 season and the campaign then relaunched for the 2024/25 season. The FA will look into ways of engaging Brent communities in the relaunch for the new season or any activations around the stadium.	
18 April 2023 – Casey Review 1 Year Update	To recommend that communications on restrictions on street drinking in surrounding areas of Wembley, outside of event zones are developed to encourage good behaviour on event days in these areas.	**Brent Council**	The council has put in place a boroughwide PSPO which amongst other things, prohibits street drinking. The communication for the PSPO includes signage placed on the public highway and in parks. The council is also currently in communication with all premises responsible for the supply of alcohol and works closely with them to ensure that at high risk events, alcohol is not supplied. This communication also includes the risk rating of each event, giving businesses the opportunity to put measures in place where necessary and meetings with the relevant football clubs prior to each event, who in turn advise their fans of what is expected of them when they attend Wembley. Officers are also in the process of developing a program of education and engagement across the borough, specifically around PSPO awareness.	
18 April 2023 – Casey Review 1 Year Update	To explore possibilities to widen police presence further than Wembley Park on event days.	**Metropolitan Police**	For each fixture, the police review the deployments and the resourcing numbers. They are constantly looking to review the police numbers on football and ensuring they perform core policing roles. Within each operation there is always mobile asset that will respond to intelligence on where fans will gather and respond proportionately. Examples beyond Wembley Park include the focus around The Torch Public House when Man Utd are playing and the Kilburn areas.	

18 April 2023 – Casey Review 1 Year Update	To explore the impact of online delivery alcohol vendors on fan behaviour and street drinking.	**Brent Council**	Evidence has shown that alcohol being surrendered at Wembley Stadium events predominantly comes from fans who bring it into the area via public transport or private coaches or at times, from local businesses outside of the Wembley Park area. Officers involved in event working are not currently aware of and have not seen evidence of online delivery alcohol vendors supplying alcohol to fans in the area, but recognise this as a potential future risk as officers continue to enforce the PSPO. Officers will therefore monitor closely, raise awareness with partners and consider in advance options to tackle the issue should it arise.	
18 April 2023 – Casey Review 1 Year Update	To recommend that policing continues to be evidence led on match days and that effective communication between branches of the police is continued to ensure event days at Wembley Stadium are safe and can be enjoyed by all, including with British Transport Police.	**Metropolitan Police**	The MPS planning for Wembley events starts many weeks and often months (when teams are known) in advance. Crucial to this is the intelligence picture. MPS intel staff link in with the dedicated football officer for the clubs playing at Wembley. Sharing of information and intelligence happens early and plans are set based upon the threat, harm and risk for each fixture. Information from many stakeholders helps build the picture for the event. Consistency in command teams is also key to planning and successful delivery. BTP are part of the planning meetings early on. On match day they work with our Vulcan Units to ensure the early 'heads up' on groups travelling towards the footprint or in central London. Handing over risk groups from BTP to the MPS at transport hubs is a smooth process and we constantly review our tactics.	
18 April 2023 – Northwick Park Maternity Improvement Plan Progress Update	To recommend that inequalities in maternity care and racism within the system must be tackled as a priority at both system and place levels.	**London North West University Healthcare NHS Trust**	To follow.	
18 April 2023 – Community Diagnostic Centres	To recommend that groups who are more likely to be impacted by health inequalities will be engaged with and will have more opportunities to access these services.	**London North West University Healthcare NHS Trust**	The committee will be aware that the new Community Diagnostic Centres (CDCs) in Wembley and Willesden will be strategically located in relation to clusters of deprivation and disadvantaged communities in north west London. The triple aim of these CDCs is to increase diagnostic capacity, reduce health inequalities, and improve the health of the entire population of north west London.	

			The two centres will be fully integrated into the existing network of diagnostic services across north west London, and referral to a CDC will result from a GP or hospital doctor requesting one or more diagnostic tests in the usual way. A range of explanatory information and advice for patients, GPs and other stakeholders is in preparation. As these additional diagnostic services bed-in, we will engage with patient groups to ensure all information and advice on CDCs remains clear and accessible, with alternative languages provided as required. There will be additional ongoing engagement with diverse communities through the Integrated Care Board engagement teams.	

Information requests from CWBSC to Council departments/partners

Meeting date and agenda item	Information requests	Council Department/External Partner	Response
5 July 2022 End of Life Care	How many people attended the 15 June engagement event?	**Northwest London Integrated Care System**	There were 24 attendees at the Brent engagement event on June 15th, 2022.
5 July 2022 End of Life Care	How does the NHS work to engage with people with disabilities and what are the plans moving forward?	**Northwest London Integrated Care System**	In order to develop our proposals NHS North West London has taken the opportunity to look at the best ways to gather different perspectives and the widest range of feedback and evidence we can to influence discussions on the future model of care. Remembering that palliative care is usually provided when needs of a patient becomes more complex and goes beyond the expertise and knowledge of a patient's generalist and usual care team (e.g. GP and district nurse). This means the patient may have a range of health conditions including many that may fall amongst common definitions of disability which would include a range of learning, mental health and physical disabilities. We have looked at obtaining feedback direct from Brent and North West London residents who have direct experience of community-based specialist palliative care services as well as the wider population. We have also looked to gather views of experts – colleagues working in commissioning and provider organisations as well voluntary, community and faith sectors. We have done so by a range of methodologies, for example: • Webinars involving service users, carers, voluntary, community and faith organisations, and staff • Surveys • Attending meetings of different groups to obtain feedback • 1:1 interviews with individuals and expert representatives

			• Developing case studies that show the in-depth experiences of people who have used services • Using existing research to provide evidence (literature reviews) With regards to people who live with a disability, we have sought to seek people's views and address this using all these methodologies. Further work needs to take place to seek feedback from certain groups including vision and hearing. We welcome further feedback and suggestions from Brent Council on how we can further engage with people living with a disability. Please let us know by emailing nhsnwlicb.endoflife@nhs.net **Literature reviews** We started discussing with experts (commissioners and colleagues in provider organisations who provide care and support) to agree the best approach to gaining feedback. In the case of people with learning disabilities, they advised that that a lot of research had already been carried out which we would be repeating. The decision was therefore made to carry out a literature review using existing research as this would be the best approach in terms of understanding what we need to improve on in terms of community based specialist palliative care for people from a number of different groups and demographics. Once the review was carried out we tested it back with our experts to ensure we had analysed it correctly and made changes according to their advice. The purpose of the reviews was to identify the reasons why people who live with a learning disabilities do not have fair and equitable access to community based palliative care. As part of this we specifically looked at barriers to accessing and improving care, challenges for those working within the healthcare system and how to make improvements. The review outlines a number of recommendations to be taken forward with potential improvements grouped under four headings – education, communication, collaboration and health and social care delivery. A further literature review was carried out for people who are experiencing homelessness. Both reviews can be found at https://www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/literature-reviews **Case studies** We want to use case studies to illustrate the good experiences and the challenges that people face when using community-based specialist palliative care services so that we can learn from their experiences. The case stories are drawn from people who contacted us via our engagement activity who wanted to tell us about their experiences of services when caring for a loved one. The people covered by the case studies cover a range of health conditions including Creutzfeldt–Jakob disease, cancer, Alzheimer's disease and other health conditions. The model of care working group have fed back that they find the case studies particularly useful in illustrating issues that need to be addressed by the review. The case studies can be found here: https://www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/case-studies **Interviews** We have used 1:1 interviews as a way of obtaining information from experts and representatives of particular groups including people living with dementia, BAME groups and a group providing a range of services to marginalised groups, including trans, non-binary and gender diverse people. More interviews are planned including experts representing people living with a mental health illness. The interviews can be found within our wider engagement activity report which can be found here: https://www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved **Surveys**

<table>
<tr><td></td><td></td><td></td><td>We used a number of surveys to ask detailed question that could be analysed and fed into the review. In the equality and diversity monitoring form we included a question asking respondents if they had a diversity and giving them an option to indicate their disability if they wished.
Out of a total of 53 responses 20% advised their day to day activity was either limited a lot or limited a little because of a health problem or disability that has lasted or is expected to last at least 12 months.
A survey aimed at community and voluntary sector found that out of a total of 47 respondents advised that 36 % advised their day to day activity was either limited a lot or limited a little because of a health problem or disability that has lasted or is expected to last at least 12 months.
The analysis of the survey can be found online here: https://www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/surveys</td></tr>
<tr><td rowspan="2">5 July 2022 Update on Day Opportunities</td><td>Adult Social Care to provide a detailed breakdown of the numbers of residents using day opportunities who have mental health issues, disabilities or both.</td><td>Adult Social Care & Health – Adult Social Care</td><td>Some residents receiving support from Brent Adult Social care have a dual diagnosis. We have extracted data from the Brent Adult Social Care electronic Mosaic system where resident's needs are recorded based on their primary support needs.
<table>
<tr><th>Primary Service User Support Need</th><th>Number of people using Day Opportunities</th></tr>
<tr><td>Support with memory & cognition</td><td>12</td></tr>
<tr><td>Sensory Support</td><td>1</td></tr>
<tr><td>Physical Disability</td><td>103</td></tr>
<tr><td>Mental Health</td><td>2</td></tr>
<tr><td>Learning Disability</td><td>204</td></tr>
<tr><td>Total</td><td>322</td></tr>
</table></td></tr>
<tr><td>Adult Social Care to provide data on the effectiveness on different engagement methods in regard to promoting day opportunities.</td><td>Adult Social Care & Health – Adult Social Care</td><td>To date, Adult Social Care Commissioners have organised three information sessions. These sessions are primarily aimed at social care practitioners. This is to ensure that practitioners are aware of the local offer post-pandemic.
These events have taken place both virtually and in-person as detailed below and were well attended by Health & Social care staff.
Day Opportunity providers shared timetables and information packs with attendees. Future events are planned to promote Day Opportunities for residents who are eligible for this offer.
4th August 2021 – Virtual (Learning Disabilities)
2nd February 2022 – Virtual
24th May 2022 – In Person at Brent Civic Centre
With regards to the impact of the work we’re doing to get the number of people using day opportunities to increase, to date we haven’t seen an increase but it’s early days. We will hold another event in September with day opportunities providers and social workers to promote day opportunities and for providers to speak directly to our staff.</td></tr>
</table>

<table>
<tr>
<td>5 July 2022 – Adult Care Services</td>
<td>To provide a demographic breakdown of carers in Brent by age, ethnicity, gender etc.</td>
<td>Adult Social Care & Health – Adult Social Care</td>
<td>A breakdown is provided below: please note that for Gender, the response prefer not to say was excluded from the figures. This means that the gender figures do not fully equate to 100% of Brent carers, but are representative of those willing to state their gender.

<table>
<tr><th>Age
(unknown excluded)</th><th>% of Brent Carers</th></tr>
<tr><td>18 – 24</td><td>1%</td></tr>
<tr><td>25 – 34</td><td>3%</td></tr>
<tr><td>35 – 44</td><td>4%</td></tr>
<tr><td>45 – 54</td><td>17%</td></tr>
<tr><td>55 – 64</td><td>29%</td></tr>
<tr><td>65 – 74</td><td>22%</td></tr>
<tr><td>75 – 84</td><td>18%</td></tr>
<tr><td>85+</td><td>7%</td></tr>
<tr><th>Gender</th><th>% of Brent Carers</th></tr>
<tr><td>Female</td><td>75%</td></tr>
<tr><td>Male</td><td>25%</td></tr>
<tr><th>Ethnicity</th><th>% of Brent Carers</th></tr>
<tr><td>Asian or Asian British</td><td>39%</td></tr>
<tr><td>Black or Black British</td><td>29%</td></tr>
<tr><td>White</td><td>21%</td></tr>
<tr><td>Other Ethnic Groups</td><td>4%</td></tr>
<tr><td>Mixed / Multiple</td><td>1%</td></tr>
<tr><td>Not Stated / Undeclared</td><td>7%</td></tr>
</table>
</td>
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</table>

<table>
<tr>
<td>5 July 2022 – Adult Care Services</td>
<td>To provide a breakdown of the number of carers that provide care for each need, i.e. mental health, learning disability, older people/dementia, physical disability</td>
<td>Adult Social Care & Health – Adult Social Care</td>
<td>
<table>
<tr><th>Service User Primary Need Group</th><th>% Of Brent Carers</th></tr>
<tr><td>Physical Support</td><td>57.7%</td></tr>
<tr><td>Learning Disability</td><td>32.2%</td></tr>
<tr><td>Support with Memory & Cognition</td><td>5.7%</td></tr>
<tr><td>Mental Health</td><td>0.9%</td></tr>
<tr><td>Family in Acute Stress</td><td>0.1%</td></tr>
<tr><td>Disability</td><td>1.4%</td></tr>
<tr><td>Sensory Support</td><td>1.0%</td></tr>
<tr><td>Social Support</td><td>0.9%</td></tr>
</table>
</td>
</tr>
<tr>
<td rowspan="2">22 September 2022 – Implementation of SEND review</td>
<td>The committee to receive the training programme for staff who work with children with autism in additional needs settings</td>
<td>Children and Young People</td>
<td>SEND in schools training offer is attached:
SEND in schools
Training offer 22-23 c</td>
</tr>
<tr>
<td>The committee to receive data on the diversity in the level of need within those who have EHCP’s</td>
<td>Children and Young People</td>
<td>
<table>
<tr><th>Category of Need</th><th>Count</th></tr>
<tr><td>Cognition And Learning Needs</td><td>861</td></tr>
<tr><td>Communication And Interaction Needs</td><td>1543</td></tr>
<tr><td>Other Needs</td><td>13</td></tr>
<tr><td>Sensory And/or Physical Needs</td><td>225</td></tr>
<tr><td>Social, Emotional And Mental Health</td><td>294</td></tr>
<tr><td>(blank)</td><td>2</td></tr>
<tr><td>Grand Total</td><td>2938</td></tr>
</table>

<table>
<tr><th>Special Educational Need Description</th><th>Count</th></tr>
<tr><td>ASD - Autistic Spectrum Disorder</td><td>1097</td></tr>
<tr><td>HI - Hearing Impairment</td><td>68</td></tr>
<tr><td>MLD - Moderate Learning Difficulties</td><td>506</td></tr>
</table>
</td>
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</table>

<table>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>MSI - Multi-Sensory Impairment</td><td>7</td></tr>
<tr><td>OTH - Other Difficulty/disability</td><td>13</td></tr>
<tr><td>PD - Physical Disability</td><td>115</td></tr>
<tr><td>PMLD - Profound & Multiple Learning Difficult</td><td>88</td></tr>
<tr><td>SEMH - Social, Emotional And Mental Health</td><td>294</td></tr>
<tr><td>SLCN - Speech, Language And Communication Needs</td><td>446</td></tr>
<tr><td>SLD - Severe Learning Difficulties</td><td>219</td></tr>
<tr><td>SPLD - Specific Learning Difficulty</td><td>48</td></tr>
<tr><td>VI - Visual Impairment</td><td>35</td></tr>
<tr><td>(blank)</td><td>2</td></tr>
<tr><td>Grand Total</td><td>2938</td></tr>
</table>
</td></tr>
<tr><td></td><td>The committee receive information on how the recommendations of the transitional safeguarding task group feed into the SEND strategy.</td><td>Children and Young People</td><td>Support for young people with SEND must be provided until they reach the age of 25 where this is agreed within their Education, Health and Care plan (EHCP). These plans will include, as part of the ‘care’ element consideration as to how young people will be encouraged to become more independent, balancing this against how potential risks within the community are to be managed. There are well established links between CYP and Adult Social Care to ensure the transition point for young people with SEND is well managed leading up to their 25th birthday. Learning from good practice in this transition work is being shared more broadly across services to enable new ways of working to be created, consistent with the task group recommendations</td></tr>
<tr><td>25 January 2023 – Brent Housing Management</td><td>To receive results of the latest tenant perception surveys and transactional surveys.</td><td>Resident Services - Housing</td><td>Tenant Satisfaction Measures – Results PowerPoint has been shared with the committee.</td></tr>
<tr><td></td><td>To receive more information on the nature of outstanding, out of target complex repairs (P3, P4) that have taken a year or longer to resolve.</td><td>Resident Services - Housing</td><td>Below are the contractual repairs priorities including timeframe to complete works

• P1 = 4 Hour Emergencies only
• P2 = 24 hours and complete in 3 days
• P3 = 21 Days
• P4 = 60 Days

There are some orders that take longer that these to be delivered. Having delved into these, they are predominantly large complex works orders, relating to structural works, legal disrepair claims and works of</td></tr>
</table>

			multiple trades. There are also a few repairs where materials have been limited in supply such as fence panels for replacement fences. There is also a mixture of non- urgent repairs, which include paving and drainage issues requiring CCTV equipment, but these are in the minority. Following discussions with Wates last year, they have taken the following actions: • increased direct labour operatives from 15 - 20 to 40 directly employed operative and their daily job completion has improved from 1.2 jobs per day to 2.4. • increased their available multi-trade supply chain (subcontractors) who can deliver the larger more complex works such as disrepair, structural and damp and mould works. • completing more repairs weekly than they are receiving, the current overall WIP sits at 2884 down from 3613 in Jan 2023 WIP Reduction Plan (Work in progress), Property Services and Wates meet weekly to discuss progress and WIP recovery profile (this profiles direction based on average number of jobs Wates operatives and supply chain complete per day/week), Wates are currently completing an average of 128 jobs more than they receive. We are exploring other routes to ensuring outstanding repair works are dealt with.
	To receive a breakdown of Brent Housing Management's complaints to help the committee understand which type of residents are making complaints.	**Resident Services - Housing**	We do not hold any personal data on the demographics of the resident's making complaints, so are unable to give additional information about the types of residents making complaints. However, we can detail a breakdown of the complaints received, by how we log them. An excel sheet has been shared, which demonstrates the nature and number of complaints received. We meet quarterly with all Managers, Service Managers and Corporate Complaints Managers to look at trends and identify themes which inform how we should target interventions to reduce issues residents face and make improvements. Senior management also meet with Complaints Managers monthly to discuss any areas which are a risk and look at how we are handling our complaints service in line with the Ombudsman and their recommendations. For example, our response time for complaints will shortly be reducing from 20 days to 10 in line with the Ombudsman's recommendation for best practice, and we are improving the accessibility of the complaints process.
	To receive details of the Q4 performance report when available.	**Communities and Regeneration**	To be shared once published for Cabinet, likely to be June 2023 meeting.

25 January 2023 – Mental Health and Wellbeing Subgroup	To receive information on how we are managing demand for mental health services, and how we are performing in comparison to other NW London boroughs.	**Brent Borough Based Partnership (Brent Integrated Care Partnership)**	To Follow.
	To receive an infographic/ schematic example of a typical person's recovery pathway.	**Brent Borough Based Partnership (Brent Integrated Care Partnership)**	The Brent Integrated Care Partnership have advised this will take longer to create, so will be included at a later date.
7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To provide a breakdown of children diagnosed with neurodiversity by ethnicity in Brent	**Children and Young People**	This information has been shared with a committee as part of a confidential briefing, owing to sensitivity.
7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To provide the breakdown on attainment data for Black British boys of Caribbean heritage, including how this has changed since 2019.	**Children and Young People**	This information has been shared with a committee as part of a confidential briefing, owing to sensitivity.

7 March 2023 - Update on school attainment, including for Black British boys of Caribbean heritage	To receive information on how the Children and Young People's directorate is prioritising this issue and how it works with other departments to tackle underlying issues that contribute to lower attainment for Black British boys of Caribbean heritage	**Children and Young People**	This information has been shared with a committee as part of a confidential briefing, owing to sensitivity.
7 March 2023 – Immunisations	To receive a breakdown of the number of childhood vaccinations by GP practice, to provide a more localised understanding of vaccination uptake across Brent's primary care system to inform the NHS' approach to improve vaccination uptake.	**ASC & Health - Health**	This information has been provided to the committee separately.
18 April 2023 – Northwick Park Maternity Improvement Plan Progress Update	To receive details on the complaints to investigations ratio for midwifery services at Northwick Park	**London North West University Healthcare NHS Trust**	To follow

18 April 2023 – Northwick Park Maternity Improvement Plan Progress Update	To receive details on the staffing numbers in Northwick Park Maternity Services broken down by band over the past 5 years.	**London North West University Healthcare NHS Trust**	To follow

Appendix 2

Community and Wellbeing Scrutiny Committee
Scrutiny Recommendations and Information Request Tracker 2023-24

These tables are to track the progress of scrutiny recommendations and suggestions for improvement made by the Community and Wellbeing Scrutiny Committee, with details provided by the relevant lead departments. It is a standing item on the Committee's agendas, so that the Committee can keep track of the recommendations, suggestions and requests it has made, and the related the decisions made and implementation status. The tracker lists the recommendations, suggestions and information requests made by the committee throughout a municipal year and any recommendations not fully implemented from previous years.

The tracker documents the scrutiny recommendations to Cabinet made, the dates when they were made, the decision maker who can make each decision in respect of the recommendations, the date the decision was made and the actual decision taken. The executive decision taken may be the same as the scrutiny recommendation (e.g. the recommendation was "agreed") or it may be a different decision, which should be clarified here. The tracker also asks if the respective executive decisions have been implemented and this should be updated accordingly throughout the year.

Scrutiny Task Group report recommendations should be included here but referenced collectively (e.g. the name of the scrutiny inquiry and date of the agreement of the scrutiny report and recommendations by the scrutiny committee, along with the respective dates when the decision maker(s) considered and responded to the report and recommendations. The Committee should generally review the implementation of scrutiny task group report recommendations separately with stand-alone agenda items at relevant junctures – e.g. the Executive Response to a scrutiny report and after six months or a year, or upon expected implementation of the agreed recommendation of report. The "Expected Implementation Date" should provide an indication of a suitable time for review.

Key:

Date of scrutiny committee meeting - For each table, the date of scrutiny committee meeting when the recommendation was made is provided in the subtitle header.
Subject – this is the item title on the committee's agenda; the subject being considered.
Scrutiny Recommendation – This is the text of the scrutiny recommendation as it appears on the minutes – **in bold**.
Decision Maker – the decision maker for the recommendation, (**in bold**), e.g. the Cabinet (for Council executive decisions), full Council (for Council policy and budgetary decisions), or an NHS executive body for recommendations to the NHS. In brackets, (date), the date on which the Executive Response was made.
Executive Response – The response of the decision maker (e.g. Cabinet decision) for the recommendation. This should be the executive decision as recorded in the minutes. The Executive Response should provide details of what, if anything, the executive will do in response to the scrutiny recommendation. Ideally, the Executive Response will include a decision to either agree/reject/or amend the scrutiny recommendation and where the scrutiny recommendation is rejected, provide an explanation of why. In brackets, provide the date of Cabinet/executive meeting that considered the scrutiny recommendation and made the decision.
Department – the Council directorate (and/or external agencies) that are responsible for implementation of the agreed executive decision/response. Also provided, for reference only, the relevant Cabinet Member and strategic director.

Implementation Status – This is the progress of any implementation of the agreed Executive Response against key milestones. This may cross reference to any specific actions and deadlines that may be provided in the Executive Response. This should be as specific and quantifiable as possible. This should also provide, as far as possible, any evidenced outcomes or improvements resulting from implementation.
Review Date - This is the expected date when the agreed Executive Response should be fully implemented and when the scrutiny committee may usefully review the implementation and any evidenced outcomes (e.g. service improvements). (Note: this is the implementation of the agreed Executive Response, which may not be the same as the scrutiny recommendation).

Recorded Recommendations to Cabinet from CWBSC

Meeting date and agenda item	Scrutiny Recommendation	Cabinet Member, Lead Officer, and Department	Executive Response	Implementation Status	Review date

Recorded suggestions for improvement from to Council departments/partners

Meeting date and agenda item	Suggestions for improvement	Council Department/External Partner	Response	Status

Information requests from CWBSC to Council departments/partners

Meeting date and agenda item	Information requests	Council Department/External Partner	Response