Brent

NHS North West London

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a hybrid meeting on Monday 22 January 2024 at 6.00 pm

Members in attendance: Councillor Nerva (Chair), Dr Mohammad Haidar (Vice-Chair), Councillor Shama Tatler (Brent Council), Councillor Grahl (Brent Council), Councillor Donnelly-Jackson (Brent Council), Councillor Kansagra (Brent Council) Patrick Laffey (Deputy Director of Operations, CLCH), Simon Crawford (Deputy Chief Executive, LNWUHT - online), Cleo Chalk (Healthwatch Service Manager), Rachel Crossley (Corporate Director Care, Health and Wellbeing, Brent Council – non-voting), Nigel Chapman (Corporate Director Children and Young People, Brent Council – non-voting), Dr Melanie Smith (Director of Public Health, Brent Council – non-voting), Claudia Brown (Director of Adult Social Care)

In attendance: Tom Shakespeare (Integrated Care Partnership Director), Jonathan Turner (Borough Director – Brent – NWL NHS), Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Josefa Baylon (Head of Integration – Brent, NWL NHS), Versha Varsani (Head of Primary Care - Brent), Shirley Parks (Director of Safeguarding, Performance and Strategy, Brent Council)

1. Apologies for absence and clarification of alternate members

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Jackie Allain – substituted by Patrick Laffey
- Simon Crawford – joined online

2. Declarations of Interest

None declared.

3. Minutes of the previous meeting

RESOLVED: That the minutes of the previous meeting, held on 30 October 2023, be approved as an accurate record of the meeting.

4. Matters arising (if any)

The minutes referenced discussions in relation to health, environment and air quality on page 11, with actions for this to be taken up with LNWUHT and Public Health. Dr Melanie Smith (Director of Public Health, Brent Council) confirmed that a meeting had been arranged to meet with the London North West Lead for Strategy at the Trust to discuss.

5. Health and Wellbeing Strategy - Highlights and Forward Look

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the report, which provided a status update of progress against the commitments made in the Health and Wellbeing Strategy and suggested a way forward. In introducing the report, she highlighted the following key points:

- Members were reminded that the current Health and Wellbeing Strategy had been shaped by extensive community engagement which specifically focused on asking residents about inequalities in health and what they thought could and should be done about inequalities. In response to that engagement, the Board had defined 5 key themes for the strategy: healthy lives, healthy places, staying healthy, healthy ways of working, and understanding, listening and improving.
- Against the 5 key themes, Board members committed to a number of actions that residents had asked of the Board and the paper detailed where progress on each of those commitments were.
- There was a breadth of activity taking place and positive progress had been made on most actions. Officers highlighted that much of the data was qualitative rather than quantitative, this would be addressed when looking at ways forward.
- Officers proposed that the next steps, through each Council department and Integrated Care Partnership (ICP) Executive Group, was to undertake a review of which of the commitments had been met, which had become business as usual, and which may no longer be relevant. Each Council department and ICP Executive Group would be asked to identify 1-2 new commitments, including quantifying those commitments and identifying how the Board would know whether they had been met by providing a set of metrics to measure against. Those commitments should then be incorporated into each service areas' planning processes for the 2024-25 year.

The Chair then invited contributions from those present. The following points were made:

- The Board was pleased to hear about the installation of an accessible changing place facility at Vale Farm Leisure Centre. Dr Melanie Smith highlighted that the future expansion of additional changing places in other locations was dependent on securing additional funding.
- The Board noted that the report detailed improved access to parks and events for people with disabilities, and asked whether the working group set up to progress this work included adults who were disabled and had considered what barriers adults with disabilities using parks and event spaces faced. The Board was advised that the work was currently child focused, but there were plans to expand that to involve adults, which was an area that had not yet been worked on. It was agreed it would be helpful to discuss this work with the Disability Forum to ensure this was done through co-production.
- The Board was pleased to hear about the installation of a wheelchair accessible swing in one of the parks in the borough but noted the comment in the report that it had elicited a mixed response. Officers explained that the facility of the swing was welcomed, however this had highlighted other accessibility issues with access to the surrounding areas that needed to be addressed.
- The Board felt the paper demonstrated some good examples of initiatives aimed at children and young people, such as the oral health bus which was award winning.
- The Board highlighted the importance of ensuring the Council was doing all it could to maximise engagement with hard to reach groups using the institutional knowledge it had gained during the pandemic. For example, embedding public health initiatives in the Brent Hubs was essential as they were the Council's main mechanism for signposting.
- It was felt that the report highlighted the importance of cross-departmental working, such as the need for public health to work closely with the Environment and Leisure Team to prioritise the accessibility of green spaces, active travel and cycling infrastructure. This went beyond the Council, as it was important to work collaboratively with key community partners and NHS stakeholders. Dr Melanie Smith highlighted that the next step would be to engage colleagues across the Council and ICP Executive

Groups to ensure a joined up approach. It was hoped that when new priorities were presented, the Board would challenge officers to demonstrate that joint working. A multi-agency group had been established in the past 6 months, which met regularly and was made up of colleagues from public health, Brent ICP, and Environment and Leisure. This group aimed to take that partnership working to the next stage.

- The Board highlighted that there was a reluctance from residents to seek out routine health checks, vaccinations and dental check-ups and asked what more was being done to encourage take up of those preventive services. Dr Melanie Smith agreed that the uptake of a range of preventive health services in Brent was poor, but highlighted that the high demand evidenced by the number of parents presenting with their children to the oral health bus was an indication that people did see these services as important. Public Health had been using both quantitative and qualitative intelligence from engagement activities to make the case to the NHS for improved access to services through resourcing.
- The Public Health Team would return to the Health and Wellbeing Board once the Strategy refresh was completed.

RESOLVED: To note the update.

6. Update on Integrated Neighbourhood Teams

The Board received a report from Josefa Baylon (Head of Integration – Brent, NWL NHS) which provided an update on the progress made and the overall strategic approach taken in the continued development of Integrated Neighbour Teams (INTs) in Brent. The approach focused on 3 key enabling pieces of work; workforce and organisational development; estates; and ICT data, digitisation, and connectivity. The Board was asked to approve the next steps and comment on how best INTs could ensure the next phase of work involved meaningful input from communities and best ways to measure and track impact.

In introducing the report, Josefa Baylon reiterated that INTs were a large scale, long term development approach which followed guidance on what integration should look like. It focused on co-production, engagement, and working collaboratively with partners and residents to discover, design, develop, implement, evaluate and sustain models of integrated working. Some of the achievements of the work so far included some neighbourhood deep dives with visioning days, which had fostered an environment of continuous learning and engagement. The Board heard that, collectively, those engagement events had engaged over 200 residents between June – November 2023 on in Willesden, Wembley, and Stonebridge, Harlesden, Kensal Green & Roundwood. Those neighbourhoods were now ready to fulfil their delivery plans within their areas. There was still work to do on the remaining 2 neighbourhoods in Brent, which were Kenton & Kingsbury and Kilburn.

Next steps would include looking at understanding workforce training and development needs across all key delivery partners, and estate optimisation. A local estates strategy had been drafted which was being shared with stakeholders for review. The report provided further details on initiatives which included the opening of a new site for Wembley Medical Practice. As part of the new site, it was hoped it would be possible to integrate it with nearby services, such as Brent Civic Centre, to act as integrated care hubs, meaning residents would not need to repeat their stories more than once. This would look to integrate and connect information, with work was being done with London Care Records, Care Information Exchange, Universal Care Plans, Pharmacy First and Optica to ensure this was done appropriately. The work would look to establish a defined theory of change that would enable INTs to measure and track the impact of delivery.

The Chair then invited contributions from those present, with the following points raised:

- Within the report there was a section on population health needs analysis, which showed a life expectancy and deprivation map outlining that the highest areas of deprivation had less life expectancy. The Board asked, as a result of that information, whether the approach should be more targeted with more resource put behind those areas. Tom Shakespeare (Director of Integrated Care Partnership) felt this was an important point. He stressed that this particular programme was about enabling and did not come with significant additional resource in itself, but looked at aligning existing resources within the system to achieve outcomes. In other areas of work, the ICP was making the case for levelling up, with business cases submitted for additional resource in all parts of the system.
- The Chair queried how each locality would ensure equity operated within their hyperlocal areas where some parts might be more affluent or engaged in processes than others. Officers acknowledged that challenge, and highlighted that they were aware of those areas. For example, there were parts of South Kilburn that might be hard to reach, suggesting it might be easier to work with certain groups in South Kilburn, and that there was a need to ensure all partners in Kilburn were part of the design and development of the Neighbourhood Team. The approach being taken was around co-production with a bottom-up approach and, when delivery plans were designed, officers ensured engagement with those hard to reach communities within a neighbourhood.
- Dr Haidar explained that the purpose of this work was to bring all partners, stakeholders and residents together with a single approach to work towards 'One Brent'. For example, if there was a service in the South of Brent for respiratory services, a person with a similar problem travelling from the North of the borough all the way to the South proved difficult, particularly for people with chronic respiratory conditions who may need to take several buses, so the INTs aimed to provide services as close to home as possible for all Brent residents.
- Board members thought the report could be clearer in helping members and residents to understand what stage the INTs were in their development, as there was some confusion over whether there were any integrated hubs operating already. Josefa Baylon confirmed that no Integrated Care Hubs had been opened yet and officers were still at the scoping and design phase with residents and frontline staff. She highlighted that there was no specific pot of funding for this work, but officers were preparing a strategy that would inform the next phase of options appraisals where it was hoped they would be able to bid for funding. This would prioritise optimising what was already available, so rather than building a new physical space without funding, officers would be looking to maximise community assets with short term, medium term and long-term plans to get to a stage where there were campus style hubs with services within walking distance for residents.
- The Board highlighted that some Council services already operated within a hubs model, such as for debt relief and advice. They queried how linked Integrated Care Hubs would be with existing hub models, highlighting that health was often impacted by other factors in people's lives such as debt and stress. Josefa Baylon explained that the INTs would want to link in with those existing Council ran hubs which was why campus style hubs were proposed to enable health, NHS primary care, social care, and voluntary and community sector care to be located together. For example, the new Wembley Park hub scheduled to open in March 2024 would be made up of the Wembley Park Medical Centre with the Brent Civic Centre located opposite that site, where residents could access health advice and across the road advice and guidance and access to frontline staff regarding housing and Adult Social Care.

- In terms of the approach to the different health needs of different localities, the Board asked how INTs would respond to barriers different groups faced using data such as Census data to better understand that. For example, Census data showed that there were over 100 languages spoken in Brent, with several communities where English was not a first language. The Board wanted to know how INTs would access those communities and how they would link with faith communities who already did outreach work. Josefa Baylon responded that accessibility and language was very important for the INTs, and in order to address health inequalities there was a need to ensure INTs had tools available to break down barriers, such as access to interpreters. Officers had already been using interpreters for co-production and engagement stages of the INT work. There had also been work with the Deaf Parents Forum for Children and Families and work with faith communities. For example, officers were working with Kingsbury Temple who were offering use of their large space to host some of the hubs. Another example highlighted that the vaccination programme was being expanded in the Willesden Central Mosque to target hard to reach communities.
- HealthWatch Brent was excited to see progression with this work and agreed that it aligned with what residents were telling HealthWatch they wanted to see. They hoped that residents would be involved in the process of monitoring and measuring impact to ensure long term transformation and not just short-term outcomes. Josefa Baylon confirmed that the work was committed to the values and principles of co-production and had been agile in first reporting findings to residents before they were reported to the Board and ICP Executive. In Harlesden and Stonebridge, a free venue had been offered for quarterly meetings to ensure residents remained part of the process.

In bringing the discussion to close, the Chair asked the Board to note the report and approve the next steps for development of INTs. For the next presentation to the Board, the following asks were made:

- To include information about the significance of PCN alignment with the geography of Brent localities.
- To include information on the need for health improvement targets for each locality that seek to overcome local health inequalities.
- To include practical examples of the work that has been undertaken so far and an ‘easy read’ report developed for better public accessibility.
- To develop links with the work of Brent’s already established hubs and learn from them.
- To ensure the valued contribution of faith communities is not lost.
- To ensure the Health and Wellbeing Board is made aware of resource issues, including for One Public Estate, and to have a view of the timeline, showing the move from development phase into implementation.

7. Access to Primary Care Implementation Update

Versha Varsani (Head of Primary Care - Brent) introduced the report, which provided an update on access to primary care following the previously presented paper a year ago which had responded to the ‘No One Left Behind’ Scrutiny Task Group Report into access to primary care. In introducing the report, she highlighted that ‘No One Left Behind’ had made a number of recommendations and the report presented an update on progress against those. Some of the key points were highlighted as follows:

- In terms of the patient population, there was a diverse population with the number of patients growing year on year. People were living longer and having lengthier periods of ill health.
- There was a lot of work being done around proactive healthcare and neighbourhood work.
- The demand for GP led appointments surpassed the supply, so primary care was continually seeking different avenues and providing progressively more services to meet this demand.
- There were 51 GP surgeries across Brent, and in a period of one month, GPs collectively provided 210,000 GP led appointments.
- Enhanced access hubs were available which provided delivery of services across the 5 different hubs in the borough and operated outside of GP core hours – in the evenings from 6:30pm–8pm Monday to Friday, and Saturdays 9am–5pm. Those hubs provided an additional 12,500 appointments per month.
- Between GP-led appointments and enhanced access hub appointments, there was an average of 3 appointments per month per patient, or 36 appointments per year per patient. Not every patient registered with a GP would need an appointment, so some patients would have more access than others, but this gave an understanding of the offer.
- NWL was currently piloting a service operating between November 2023 to March 2024 with PCNs to provide more at scale services during core hours and was beginning to analyse the data from that trial.
- There had been additional pressures over winter due to the usual winter pressures, as well as Junior Doctor strikes. PCNs stepped up to provide additional access over the 3 bank holidays during Christmas.
- PCNs and GP practices had active triage models and aimed at signposting patients to the right place at the right time to see the right professional.
- There had been an increase in employees on the Additional Roles Reimbursement Scheme (ARRS), with 206 full-time equivalent additional roles, such as pharmacists, dieticians and social prescribers, compared to 88 two years previously. These additional roles provided specialist skills within GP practices and PCNs.
- A priority of primary care was to help patients chose the right setting to access and there was a range of services to chose from including community pharmacy services, NHS 111 for non-life threatening conditions, and promotion of self-care. Community pharmacists were expanding their offer with the Pharmacy First Scheme in line with the national programme. Pharmacy First would be a walk-in service for access to treatment for minor ailments, initially with 7 pathways. There would be ongoing work to further integrate all these additional services, and pharmacists were currently undertaking training to ensure they could provide the enhanced service.
- Digital technology was advancing with the NHS app. There was awareness that not all communities in Brent were digitally literate, so work was happening to educate residents on how to use the app and enabling residents to use it properly. The technology within the app allowed both GPs and residents to gain access to their patient records.
- There was a vision to align and streamline the access model so that there was one direct phone line for patients to access and work would take place over the coming year towards that.
- Brent Health Matters (BHM) was supporting community engagement to raise awareness with residents about services and NWL continued to update its

communications strategy and engagement plans to ensure residents were aware of what to expect from their primary care.

In considering the report, the following points were raised:

- Members highlighted that many GP surgeries already had an app where patients could book appointments and other actions, and asked how aligned those apps would be with the NHS app to ensure there were not too many applications patients were required to access and look at. They heard that the direction of travel nationally was to move towards using only the NHS app as one application. The NHS app was a highly tested app and had gone through strict governance processes to ensure it was completely safe to use, including in relation to the protection of patient data. The NHS app also allowed two-way messaging between the patient and GP surgery. Data showed that 3 in 4 people had downloaded the NHS app, but that did not necessarily mean they were using it, so the next step was to encourage use of the app.
- Dr Haidar added that digital inclusion work could be presented at a future meeting as there was work being done by NWL NHS around health inequalities and digital exclusion.
- The Board highlighted that a potential barrier for using the app would be accessibility and hoped it had been robustly tested. For example, the Board asked whether the app took account of British Sign Language use. It was agreed that action would be taken to identify whether British Sign Language needs were catered for within the app.
- The Board felt the report missed information relating to women's health needs specifically and Well Woman Clinics. Versha Varsani explained that NWL NHS was currently working with a specialist GP to focus on developing women's health clinics across the borough.
- The Health and Wellbeing Board highlighted that many constituents experienced challenges with the 8am rush in their GP surgeries, for most GPs it was currently necessary for patients to call the surgery at 8am to get a same day appointment, this often coincides with many residents morning commute to their place of work. Tom Shakespeare (Director of Integrated Care Partnership) explained that this challenge was one of the key factors that the ICP wanted to focus on over the next 12 months and there was a triage pilot currently running with 23 of Brent's GP practices. Triaging was being looked at from a borough perspective and considered as part of business modelling, with the intention to manage that demand at 8am by streamlining and filtering demand differently. The pilot was working towards one single access number, where if someone was unable to get a response from their GP surgery, they could use the single access hub and be directed to the right service.
- The Board highlighted that only 55% of the appointments offered were face to face, as outlined in the report. They queried whether there was confidence that this was reflective of the needs and preferences of patients. Officers were of the belief this was reflective of patient preference. If a patient wanted to be seen face to face they would be triaged into being booked in to a face to face appointment. The figure was in line with the average benchmark for NHSE, which was closer to 60%.
- Dr Melanie Smith (Director of Public Health, Brent Council) highlighted the achievement outlined in the report that 100% of GP practices had been accredited as Safe Surgeries. She queried how that was working in practice and suggested that a mystery shopping exercise be carried out, which would be arranged outside of the meeting.
- The Chair asked whether, anecdotally, there had been a reduction in people presenting to A&E which could be linked back to Safe Surgeries, as those without documentation could now register with a GP. Simon Crawford (Deputy CEO, LNWUHT) was not aware that there had been a reduction in attendances for this specific reason, but agreed to undertake further analysis of this. He highlighted that A&E had been extremely busy in

terms of winter pressures, although there was good work happening in the community and primary care to support the pressures with alternative pathways.

As no further issues were raised, the Chair drew the discussion to a close, asking the Health and Wellbeing Board to note the work to date to improve access to primary health care and note the proposals in the paper for GP-led services in 2024-25. He requested that the next update included the work which health and the local authority were undertaking in relation to digital inclusion, women's health and the communications strategy, as well as the information regarding Safe Surgeries and any analysis of the impact this has had on A&E attendances and the mystery shopping exercise outcome.

8. Learning from Inspections

9. SEND and Alternative Provision Local Area Inspection

Nigel Chapman (Corporate Director Children and Young People, Brent Council) introduced the report, which detailed the preparedness for the joint inspection of SEND services of both the local authority and health. In introducing the report, he highlighted the following points:

- The inspection was conducted by both CQC and Ofsted as a joint inspection of health and the Council, rather than a solely local authority inspection.
- The SEND inspection would use a new framework which was introduced just over a year ago, the details of which were in the report.
- Brent had been inspected as an area partnership in 2017 and 2019 in relation to SEND.
- Since the new framework had been introduced, approximately 18 inspection reports had been published nationally with a wide variety of outcomes. There had only been three published inspection reports in London, with Haringey's inspection starting the day of the meeting.
- In Brent, it was felt that the local area partnership was in a reasonable place in relation to SEND. The strengths were detailed in the report, and Nigel Chapman highlighted the strong relationship with parents and carers that gave the opportunity to improve services and flow their voice through the work done around SEND.
- Shirley Parks (Director of Safeguarding, Performance and Strategy, Brent Council) added that the appendix provided a good summary of the SEND inspection process and the preparedness for that, which had been shared across the partnership. Where areas of development had been identified, work was already underway to address them, such as CAMHS waiting lists. She highlighted that Brent knew itself quite well, which was important for being inspection ready.
- Jonathan Turner (Borough Lead Director – Brent, NWL NHS) added that the borough-based partnership had been working closely with the local authority to prepare the self-evaluation and the documents that form the required annexes. As a result of the restructure which was currently underway in the Integrated Care Board (ICB), it was likely there would be a full-time Designated Clinical Officer for SEND which was positive news.
- Overall, it was expected that Brent would be inspected during the current year.

The Chair invited comments and questions from those present, with the following points raised:

- The Board felt that the strengths identified under 3.2.5 were not evidenced, for example, where it stated 'SEND provision in Brent schools is strong', there was no

explanation of how that was measured or how that conclusion had been arrived at. Nigel Chapman explained that the purpose of the paper was to explain the readiness and process for the inspection rather than specific details from the self-evaluation. The SEND arrangements had been scrutinised by the Community and Wellbeing Scrutiny Committee during the year where the Committee had scrutinised SEND performance around working with schools, outcomes for children, health provision and working with parents and carers, and the report was available online.

- The Board was aware that the inspectors would choose some cases to review during their visit, and asked how that process would work. Shirley Parks explained that the Council would be asked to provide a list of datasets of individual children from which the inspectors would select a number of cases to look at in detail. The inspectors would then expect the Brent partnership to do its own internal audit of those cases to see how well Brent understood what good practice looked like. The inspectors would talk to the families and practitioners linked to those cases as appropriate. In addition to this, the Brent partnership would be asked to send out a survey to all parents with children with SEND to garner the views of families and children. This would be done both via schools and the Parent Carer Forum. The inspectors would then triangulate that information alongside other data.
- The Board highlighted the need for the Integrated Care Board (ICB) to be cognisant of the fact that the new inspection regime would mean that they may face several inspections due to its wider footprint covering several London boroughs. Jonathan Turner confirmed this was being considered at an ICB level and there was now a specific CYP Lead who was aware of the upcoming inspections and had already made arrangements identifying who would be responsible at ICB level should the call come for an inspection.

RESOLVED:

i) To note the report and welcome the Designated Clinical Officer for SEND post for Brent.

9.1 CQC Inspection of Adults Social Care Services

Rachel Crossley (Corporate Director Care, Health and Wellbeing, Brent Council) introduced the report which detailed the process for the CQC Inspection of Adult Social Care Services. The new inspection process was focused on a single assessment framework, meaning that from a local authority perspective it would be focused on Adult Social Care. The slides included in the agenda pack aimed to ensure an understanding of the framework and would be used for briefings to get the message out about what the inspection was. Claudia Brown (Director of Adult Social Care, Brent Council) added the following points:

- The inspection would look at 4 main areas;
    - How Adult Social Care (ASC) worked with people and provided support to market providers, including the monitoring of contracts and ensuring services were equitable for users. As part of evidence gathering there would be interviews with service users.
    - Leadership of ASC including directors of the Council. Principle social workers would be spending some time looking at quality and standards as part of preparing for inspection.
    - Safety, particularly safeguarding vulnerable adults.
    - Feedback from partners, including councillors and health colleagues. The inspectors would be looking to see how ASC worked with other partners,

and ASC could demonstrate that social workers were very much involved in Integrated Neighbourhood Teams and worked closely with GP surgeries.

- The inspectors would collect data through interviews with people who have lived experience of ASC services. The inspectors would also be using documentation from case file audits, chosen from a list of 50 cases selected by ASC, and the inspectors would then audit those cases and provide feedback on them.
- The inspectors would look at outcomes for service users and what service users had to say about their outcomes.
- Brent's ASC had not been inspected for over ten years, so the department was being supported by colleagues in the children and young people's department who were more accustomed to being inspected regularly.
- Work around engagement had begun, particularly with the multi-disciplinary team, staff, health and other organisations including providers. The information gathered from engagement would help to inform the ASC self-assessment, and ASC was now at a stage where there was a working self-assessment document that continued to be developed.
- Dr Haidar (Vice Chair) added that the CQC would focus on safety, care, responsiveness, effectiveness and leadership. He felt that responsiveness was key, and the borough team had been very responsive and engaged in the process. Brent was in a good position with a regular monthly meeting involving ASC, voluntary and community sector partners and health to address challenges. The CQC would be looking at the borough-based partnership to see if there was dialogue between ASC and health, and how the partners responded to each other and supported each other.
- It was likely that ASC would be inspected every two years, so there was a need to have a process in place that ensured preparedness at all times for inspection.

The Chair thanked colleagues for their introduction and invited the Board to contribute, with the following points raised:

- The Board asked whether the self-assessment had identified any strengths or weaknesses that might be expected to be picked up during inspection. Claudia Brown explained that one of the strengths identified through the self-assessment, as well as the peer-review that took place the previous year, was that the client voice was heard throughout case recordings, and the peer reviewer felt the service was responsive and leadership was good. One of the areas for development identified from the self-assessment was around service user participation, and ASC was developing a project to ensure service user participation ran throughout services as a 'golden thread'.
- The Board highlighted that ASC worked with external providers, and asked how accountability could be sought if there were failures or weaknesses identified at inspection in relation to external provision. Claudia Brown explained that if there was a service failure then the inspectors would be looking at how ASC's systems and processes put corrective action in place and how that was managed with providers. There was a regular Provider Forum and the Commissioning Team worked closely with providers to improve their offer and monitor contracts to ensure issues were addressed.
- The Board acknowledged that the SEND inspection, discussed in the item above, was a joint review of both the Council and local health service. The CQC ASC inspection was more focused on the local authority, but the Board highlighted that ASC was impacted by a range of other parts of the whole system, for example through the hospital discharge process where there would need to be a common approach. Claudia Brown responded that ASC had been meeting with NHS

colleagues and provided a briefing on the inspection process where colleagues had been asked how best the Council could support them to prepare for CQC, as the inspectors would be talking to health partners and reviewing discharge data. Further briefings would also be disseminated, including to councillors, as the inspectors would look at anywhere that ASC had a role to play. Simon Crawford (Deputy CEO, LNWUHT) added that the Trust had been engaged as part of the process and had a strong story to tell in terms of the working relationship between ASC and discharge teams and the support the Trust received from ASC. Brent ASC had been flexible and responsive to support the Trust in a challenging environment during winter pressures and the junior doctor strikes.

- The Board highlighted there were cross-cutting themes between ASC and housing, such as Disabled Facilities Grants (DFG), and asked whether housing would be involved in the process. Whilst officers could not guarantee that the inspectors would go in that direction, it was recognised that if they came across a case involving DFG then they could investigate that in more detail, so ASC was trying to be as broad as possible with the briefings they were offering and were also holding comprehensive focus groups, talking to colleagues across the whole Council. There was a communications plan in place so that everyone within the Council was aware that the inspection was happening.
- If the inspectors found that ASC was underperforming, the inspectors would have the authority to introduce support for the organisation to improve standards, which would mean reputational damage, so it was imperative that ASC was judged as good.

As no further issues were raised, the Board **RESOLVED** to note the report and recognise the significance of the local system adopting a whole system approach towards the upcoming CQC ASC inspection.

10. Any other urgent business

9a. ***Follow up on Winter Pressures – Risk Management of System Pressures***

Simon Crawford (Deputy CEO, LNWUHT) provided an update on the winter pressures at the local acute trust – London North West University NHS Healthcare Trust. He highlighted that the Trust had been exceptionally busy over the winter period which had been exacerbated by the challenges of the 7-day Junior Doctor Strike, which had meant cancelling elective appointments and procedures. Across the Trust, safe rotas were maintained during that time but there were a number of days ambulatory services were diverting staff into A&E departments to support the emergency pathway. On a daily basis, Northwick Park Hospital continued to receive the highest number of ambulances across London at an average of 170 a day from 23 December 2023 to 10 January 2024. During the bank holiday weekend following Christmas, there had been 70 empty beds made available in preparation, but this had been followed by a busy two weeks which put the Trust under a large amount of pressure. There had been an unprecedented number of patients waiting in corridors to be assessed and patients were being sent to wards before a bed was ready so they were waiting in ward corridors for other patients to be discharged. Northwick Park operated daily on the Full Capacity Protocol on Opal Level 4, with senior staff supporting A&E departments. Ealing was under similar pressure. Staff were redistributed across sites to support safer staffing ratios within emergency departments and in-patient wards. The Transfer Teams had been mobilised within emergency departments to support the move of patients and ensure they were monitored and kept safe. Additional Discharge Support Teams were available over the weekends who were well supported by Brent Council through an additional social worker to support packages of care and placements. The Trust had been able to open some temporary beds in emergency department units to maintain the balance of safety, and support same day emergency care

as much as possible as well as alternative pathways which prioritised patients who could be assessed quickly.

Dr Haidar provided an update on the support primary care had provided during the pressurised period. He acknowledged the challenging period and highlighted that all partners had aimed to work as one system and have strategies in place for hospitals to manage demand with the support of primary care and the community team. The Primary Care Team had opened PCN hubs on three Sundays throughout the Christmas period to take some pressure away from acute settings, and with Adult Social Care supporting discharges, it had showed how working as one team together as a borough-based partnership could make a positive difference to residents. There were learnings from the period, such as for the primary care team to work better in terms of communications to inform colleagues in the acute sector of plans such as opening hours over the holiday period. The London Ambulance Service had asked GPs to not request ambulances or refer patients to emergency departments where it was possible for the GP to see and treat the patient, instead asking for an increase in the capacity for GPs to visit patients where possible rather than requiring an ambulance.

Patrick Laffey (Deputy Director of Operations, CLCH) provided an update on how Community Services had supported the Acute Trust during winter pressures. He highlighted there had been a focus on supporting the acute flow and discharge, with local beds in Brent accessible for the whole NWL system. There were strong relationships with Brent Council to enable that to happen with a strong and mature relationship to facilitate discharges from Brent and Harrow. The Community Healthcare Trust had demonstrated flexibility, where possible, to take patients into community rehabilitation beds where they might normally not fulfil the criteria and had put in new pathways including stepping up colleagues from the community services to provide care to patients who might otherwise go into hospital. Now the focus was on how those new ways of working could be converted to business as usual, as demand was increasing year on year.

Tom Shakespeare (Director of Integrated Care Partnership) informed the Board that the next steps would be to reflect on the schemes that had been put in place and how they could be embedded into the system. Joint work was happening with LNWUHT and Harrow to evaluate discharge and what was driving the pressures.

The Chair thanked colleagues for their updates and offered appreciation on behalf of the Board for the staff working across the health and social care sector for their work over the winter period.

9b. Measles Update

Dr Melanie Smith (Director of Public Health, Brent Council) provided an update on measles. She explained that there had been national coverage on measles recently, prompted by the fact that, nationally, MMR immunisations rates were the lowest they had been for ten years and there had been significant outbreaks of measles in the West Midlands. Locally, MMR immunisation rates were increasing, but were still well below the 95% level needed for herd immunity. The UK Health Security Agency had modelled that London was at risk of a significant outbreak of a size that would have an impact on the NHS.

The local response had been to amplify and communicate national messages which included;

- measles remains a serious disease, particularly for babies, during pregnancy, and for people who were immunocompromised
- measles was very infectious with contacts of an infected case that were not vaccinated having a 90% chance of developing measles and,

- vaccination was safe and effective.

The local response also focused on messaging that there was a free Porcine Gel vaccination alternative available at request and with no shortage of supply. This message had not been disseminated nationally but would be locally. Messages had already been translated into Somalian and a Romanian language, with a video was in production, as those were the communities where it was known vaccination rates were particularly low, although Dr Melanie Smith highlighted they were not the communities most at risk of catching measles as that was everybody.

The Public Health team was lobbying the NHS to introduce MMR immunisation alongside Covid and Flu immunisations with the roving team at community catch-ups. The immunisation was usually administered by primary care and so GPs had been asked to step up their efforts to vaccinate the community. Dr Haidar added that there would be a meeting the following week to discuss operations and strategies for delivery.

The following points were made in response to the update:

- The Board noted that this was the second outbreak of measles following the outbreak around ten years previously. They asked whether councillors could lobby, through London Councils, for the government to introduce a national campaign around the importance of vaccinations, dispelling the myths around various different vaccinations that made people hesitant to receive vaccination. Dr Melanie Smith confirmed that there would be a national communications campaign commencing, which the Council would disseminate messages from whilst ensuring they were presented in a way that resonated with Brent's communities.
- The Board asked whether the MMR immunisation could be administered through schools in the same way that flu and HPV vaccines were. Dr Melanie Smith agreed that it was possible to do MMR catch-ups in schools, but the issue was with capacity within the school aged immunisations service. Consent was also an issue, so the immunisations team had tried to target catch-ups in schools to those with particularly low vaccination rates or where there were measles cases.
- The Board asked how refugees and asylum seekers were being supported to ensure they have vaccinations. Dr Melanie Smith explained that Brent was doing particularly well and thanked primary care colleagues for the outreach work they did with refugees and asylum seekers, with a reasonable response from those communities.
- In terms of the primary care plans for outreach, Dr Haidar advised that he would work with the immunisations co-ordinators from primary care as well as public health colleagues and borough leads to support outreach. A schedule was being created to provide capacity to deliver this work as urgent. Community leads and community organisations were also helping with outreach to those with health inequalities, and he hoped to utilise the vaccination bus to supplement the work.
- In response to how local pharmacies could play a role in MMR vaccination, Dr Melanie Smith explained that there was a local willingness for pharmacies to vaccinate within a nationally inflexible system and Public Health teams continued to lobby for that. The Chair highlighted that this could be picked up at member level to support lobbying.
- Locations where the community could access MMR vaccinations would be communicated in due course.

The Board agreed to note the need for a national vaccination campaign and for NHSE to initiate a catch-up campaign. Councillor Nerva and Dr Melanie Smith would write a joint letter to request this at a national level.

The meeting was declared closed at 8.00 pm

COUNCILLOR NEIL NERVA
Chair