MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Monday 4 March 2024 at 6.00 pm
Held as a hybrid meeting in the Conference Hall – Brent Civic Centre

PRESENT: Councillor Ketan Sheth (Chair), and Councillors Collymore (Vice-Chair), Begum, Fraser, Long, Lorber, Molloy, Mistry, Rajan-Seelan and Smith, and co-opted members Ms Rachelle Goldberg and Mr Alloysius Frederick

In attendance: Councillor Nerva

1. Apologies for absence and clarification of alternate members

- Councillor Matin, substituted by Councillor Lorber
- Councillor Ethapemi, substituted by Councillor Long
- Councillor Afzal

2. Declarations of interests

Personal interests were declared as follows:

- Councillor Ethapemi – spouse employed by NHS
- Councillor Rajan-Seelan – spouse employed by NHS
- Councillor Collymore – Member of ICP Board
- Councillor Tazi Smith – employed by health provider

3. Deputations (if any)

There were no deputations received.

4. Minutes of the previous meeting

The minutes of the meeting held on 30 January 2024 were approved as an accurate record of the meeting.

5. Matters arising (if any)

The Committee asked whether the issues with access to the Roundwood School experienced by Roundwood Youth Club to the Club been resolved. Chatan Popat (Strategy Lead – Scrutiny, Brent Council) would follow this up with officers and provide an update to the Committee.

6. Substance Misuse Treatment and Recovery in Brent

Councillor Neil Nerva (Cabinet Member for Public Health and Adult Social Care) introduced the report, which outlined the work of the substance misuse treatment and recovery service in Brent. The report highlighted the local needs assessment which had been undertaken and the national policy challenge within which this work was undertaken, including details of funding and commissioning arrangements. He highlighted the work of B3, a recovery

service ran by service users, as a fundamental part of Brent's approach to substance misuse.

In continuing to introduce the report, Andy Brown (Head of Substance Misuse, Brent Council) highlighted the following points:

- The importance of viewing the drug and alcohol misuse service in a wider context was highlighted, as the service contributed to a wide agenda for the Council including the borough plan priority 'healthier Brent', with success defined by increasing numbers of local residents engaged with services, and the borough plan priority 'safe and secure borough', as problematic drug and alcohol use was associated with crime and anti-social behaviour with an effective treatment offer contributing to the reduction of that. As part of that, it was important for the service to work closely with the police and criminal justice system.
- The national drug and alcohol strategy, 'From Harm to Hope', was developed in 2021 in response to Dame Carol Black's independent review of drugs and treatment. The strategy focused local activity on 3 key areas; breaking supply chains; delivering a world class treatment and recovery system; and achieving a generational shift in demand for drugs. The report presented to the Committee focused on the second key area, developing a world class treatment and recovery system.
- Brent required its service provider, VIA New Beginnings, to provide a large amount of data to the National Drug Treatment Monitoring System (NDTMS), and through that, the Office for Health Improvement and Disparities (OHID) provided anonymous reports which enabled the Council to monitor and benchmark performance and review insights into local patterns. The report outlined the estimated figures for Brent in terms of number of users of different substances. The most recent NDTMS data showed that there were 1,369 local residents in Brent engaged in structured treatment services, so although the penetration rate appeared low, the services that Brent commissioned were working to full capacity.
- There were no waiting times to access treatment services in Brent and there was a 24-hour helpline available to anyone worried about their or someone else's substance use. The services also continually reached out to registered clinicians and partners to encourage referrals. Referrals into the service were running at over 100 per month, with an average of 50 new residents coming onto the treatment caseload of VIA New Beginnings per month.
- There were many barriers to treatment, notably an individual's willingness to recognise they have a problem and need help, and part of the role of the service was to minimise those barriers.
- A needs assessment had been undertaken in 2023, showing that the prevalence of alcohol misuse was lower in Brent, at 11%, than the London average of 20% and the national average of 22%. In contrast, the prevalence of drug misuse in Brent was estimated to be higher, at 11%, compared to the national average of 8.9%. This would suggest that more people in Brent had an identified problem with drugs rather than alcohol, and there was estimated to be a higher proportion of crack than opiate users. The rates of alcohol related admissions were higher than the national average, however, for young people, alcohol related admissions were lower than the national average.
- White residents made up the largest proportion of those in treatment which could indicate a greater prevalence of substance misuse within white communities,

however, for young people accessing treatments there was a higher proportion of service users of Black Caribbean heritage.

- Within the local treatment population, the prevalence of smoking rates in Brent was lower than the national average.
- Services were provided by VIA New Beginnings in Brent which was funded through the Council's Public Health Grant, the Supplementary Substance Misuse Treatment Grant, and the Rough Sleepers Drug and Alcohol Grant. In 2024-25, the Council would spend £6,450,000 on treatment, with 25% of that funding coming from the Supplementary Substance Misuse Treatment Grant and the Rough Sleepers Drug and Alcohol Treatment Grant.
- The VIA New Beginnings Cobbold Road site was in use by B3 on Saturdays and Sundays to run their services. B3 was fully engaged at all levels of commissioning and the operational management of the VIA New Beginnings contract and worked through a range of planning forums, such as the Treatment Sector Conference and Recovery Planning Workshop as well as the Brent Drug and Alcohol Partnership.
- A key achievement of the service had been the micro-elimination of Hepatitis C in the treatment population, one of only 4 London boroughs to do so.
- It was important to focus not only on treatment but also more extraneous factors in recovery, such as employment and housing, and the Independent Placement Service running across NWL saw more residents in Brent accessing referrals to the employment service and gaining full-time employment.

The Chair thanked colleagues for their introduction and invited colleagues present from B3 to talk about their work. B3 representatives delivered a presentation and highlighted the following key points:

- B3 was designed and ran completely by service users and had been created by individuals who had been through treatment services who had wanted to improve services for themselves and others. From the volunteers to the staff to the trustees, B3 was made up of those who had been through treatment and were now stable in their recovery or at the end of their treatment journey.
- B3 wanted to empower people to move forward and supported service users through training such as first aid, fire marshalling, mental health first aid, health and safety awareness, sexual health awareness and food hygiene, and service users could use that training to volunteer with B3 or to as a stepping stone to further their recovery.
- B3 met every Friday and had guest speakers who attended to present information or to get feedback from B3 on what was working well or not within the sector. B3 could then let others know what was going on in the borough which could enhance recovery. B3 was also involved in consultations.
- There were various incentives for B3 members including volunteering opportunities, support for building CVs, training and education, buddying peer to peer, and group trips with families as it was believed families were essential for recovery.
- B3 also delivered the Recovery Champions Programme, was a 5-week course that ran four times a year, teaching individuals about drug and alcohol advice, support and consultancy, presentation and communications skills, confidence building and self-development.
- Of the 32 people who had graduated in the past year, 8 had already found employment, 20 had gone on to volunteer either with B3 or elsewhere, and 19 had gone on to further education and training.

- B3 also ran a weekend drop-in service providing a warm, safe space to be at the weekend and to be surrounded by others in recovery.
- Once a year B3 celebrated its recovery champions, and the Committee was invited to the next celebration event on Friday 15 March 2024 at the Civic Centre, where B3 would be celebrating those who had graduated from the programme within the last year and 16 years of B3.

The Chair thanked B3 for their presentation and invited comments and questions from the Committee, with the following issues raised:

The Committee began by asking what the desired outcome for service users was in terms of recovery and what was meant by recovery. Dr Melanie Smith (Director of Public Health, Brent Council) explained that the summary measure was successful completions of the programme, but the new national strategy, 'From Harm to Hope', had shifted the emphasis onto not only successful completions, i.e. keeping the people in services until they were ready to leave, but also attracting more people into the service. Currently, it was a balancing act between quality and quantity. Max Griffiths (Service Manager, VIA New Beginnings) added that, for them, successful completion would be when someone had left the recovery system positively, so they had become either an occasional user of a substance that is not an opiate or they were fully abstinent from substances. VIA New Beginnings tailored each recovery plan to the individual and all service users had a 1-1 key worker to ensure they met their plan and goals. In concluding the response, he highlighted that this particular service was not trying to manage demand but encourage it, and it was very easy to make a referral. Currently, the service was assessing in under a week and could get someone into treatment very quickly.

The Committee asked what the drop-out rate of the service was. Andy Brown highlighted that Brent had one of the highest retention rates in the country, with 97% of opiate users remaining in the service, 94% of crack and opiate users, and 96% of alcohol users. This was significantly higher than the national average.

The Committee highlighted that, from the estimates, 1,141 people were not engaged in the service that were estimated to be in need of treatment, and asked who those people were and why they may not be engaged in terms of the barriers. The Committee specifically wanted to know whether all communities were being reached out to so that the service were aware of any unmet need and could begin to tackle that, and whether those within services were representative of the population requiring treatment. Dr Melanie Smith highlighted that the group that was of particular concern was women and there was a workstream around that. The service aimed as much as possible to minimise barriers to services and there were no waiting times for assessment and a 24-hour helpline available for referrals. There was a lot of targeted outreach and one of the reasons for the focus on referrals was because there was an awareness that a lot of service users had contact with other services before someone signposted them to treatment and recovery. The service had now recruited a BME outreach worker specifically dedicated to working with communities across Brent. As Committee members had highlighted that South Asian communities had experienced barriers to accessing services, the service would ensure the work of the BME outreach worker extended to South Asian communities. The service had been doing a lot of engagement with individuals and organisations in order to raise awareness of the offer, and it was believed the service was now starting to see the benefits of that engagement work with various different organisations such as the Asian Women's Centre. As a result, there was now a good sized portfolio of leaders within the community who knew about the offer. There was also a lot of work being done around breaking the stigma of drug and alcohol misuse within every community to empower people to get treatment and engage in recovery. Representatives from B3 emphasised the importance of breaking down stigma in order to encourage people to use the service. It was important for

those approaching people regarding the service to be aware of that internalised stigma in order for people to trust the person offering help.

In terms of whether the treatment population was representative of the communities in need of treatment, the Committee heard that there was monitoring of the diversity of those in treatment and recovery, but it was difficult to know how representative that was because the data used by OHID was estimated. In relation to VIA New Beginnings, service users were relatively diverse. Max Griffiths added that the service was keen to find those communities that were not represented in treatment services and learn from that engagement. There were local data dashboards that gave further breakdowns into service user demographics that could be shared with the Committee, which helped guide the service as to where to engage. The Committee queried whether there were further breakdowns of wards to know where might need to be targeted for outreach. Max Griffiths responded that there could be breakdowns of service users by postcodes, however, given the sensitive nature of the data, care would need to be taken in providing information at too local a level.

In relation to the data of the treatment population in terms of diversity, the Committee heard that the data was only as good as what was reported and could only capture what was disclosed by the service users. In response to how many people of Indian heritage used the service, the Committee were advised that 7% of the treatment population had described themselves as Indian, but that could be higher. As to how that compared across NWL, Dr Melanie Smith advised that, because the data was sensitive, Brent did not have access to other borough's treatment data, and felt it would be more useful to learn from other boroughs how they had effectively reached out to communities and benchmark in that way rather than looking at raw figures.

The Committee asked what measures were taken to reach crack users in the borough as they were a difficult group to engage. Andy Brown explained that it was believed crack users were a population that needed to be contacted through the criminal justice system or mental health services as those in contact with the criminal justice system and mental health services were often not in contact with treatment services. In the latest plan submitted to central government for the service it included a post-criminal justice team and an in-reach team into mental health services.

The Committee noted the report detailed other boroughs placing vulnerable people in Brent and asked whether that had been a problem. Dr Melanie Smith highlighted that there was an issue when someone was placed in Brent by another borough's housing teams and the Council was not told. Andy Brown provided further details, explaining that there had been 4 deaths in hostels over the past 3-4 months involving vulnerable people from other boroughs and those host boroughs were still trying to understand why that had happened with their treatment providers. Brent had targeted hostels by asking VIA New Beginnings to send their outreach workers to ensure those hostels had links to and knew where the local treatment services were, and to get staff in hotels and hostels to check on everybody every day. Brent had also spoken with Hammersmith and Fulham and Hackney and requested that those boroughs let them know if they placed people within Brent and whether those people had treatment needs. Officers added that, in Brent, there was co-location of services with the substance misuse service and the single homelessness service which had a very robust screening process for the drug and alcohol service, so when a Brent resident was placed in a setting like a hostel and had a drug and alcohol problem the Council would know and the relevant referrals would be made.

The Committee highlighted that some people could have multiple addictions, or addictions outside the realm of substances such as gambling, gaming and sex addictions, and asked how the service would deal with someone who had multiple addictions. Max Griffiths responded that VIA New Beginning's speciality was substance misuse, but knew that

behaviour within addiction could extend itself to other areas and this was being seen more in services. He explained that the service would support someone as much as needed to reach their care plan goals, and a lot of the behaviours taught for tackling substance misuse could be mimicked using the advice and professionalism of the key workers supporting service users, but there were growing and improving treatment systems for gambling issues and other addictions not related to substance misuse, for example the CNWL Central Gambling Clinic. VIA New Beginnings would make the referrals to those systems but would not let go of those people until they knew they had the right support from the right service. He highlighted that VIA New Beginnings would always work with professionals working with the service user effectively so that there was no overlap between treatments and clear communications with that individual. It was added that B3 played an important role in the wellbeing of people who were in recovery.

The Committee asked whether the service would treat someone if there was dual diagnosis, such as a mental health condition, and were informed that the service would always treat someone with mental health issues if they had substance misuse issues as well and had a dual diagnosis team working alongside Central Middlesex Hospital in order to support that.

The Committee noted that paragraph 3.25 stated there were many barriers to substance misuse, with a key issue being an individual's willingness to recognise they had a problem. Committee members highlighted evidence that people were most likely compelled to recognise they had a problem when they were in A & E or respiratory inpatients where they were shown the impact substances had on the body, and asked how the service linked with the NHS to support the service. Dr Melanie Smith highlighted that officers had continued to put pressure on the NHS to deliver on its commitment to fund Alcohol Care Teams locally. Max Griffiths assured members that, operationally, VIA New Beginnings were working with all the big hospitals and had an effective outreach worker who completed assessments in Central Middlesex Hospital and Park Royal Hospital, working with A & E departments almost daily. Officers had good relationships with staff in those hospitals so that they could make referrals to the service and they were one of the highest referrers.

VIA New Beginnings confirmed that they did not do testing on behalf of the criminal justice system, as all testing by VIA was for treatment purposes.

The Committee asked what preventative work was done in schools and youth centres to mitigate the increase of drug misuse. Dr Melanie Smith highlighted the specific young people service, Elevate, which was a holistic offer for young people.

The Chair thanked those present for their contributions and drew the item to a close.

Information requests were also made throughout the discussion as noted below:

i) For a further breakdown of demographics to include which communities were not being reached but identified as needing treatment, and where in the borough those were identified.

7. Brent Joint Health and Wellbeing Strategy Update

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the report, which provided an update on the Brent Health and Wellbeing Strategy. In introducing the report, she highlighted that the Health and Wellbeing Strategy belonged to the Health and Wellbeing Board which brought together the Council with the NHS and Healthwatch. It was a requirement to have a Health and Wellbeing Strategy, and Brent's earlier strategies were very focused on health and care, but the current strategy reflected a far greater process of

community engagement resulting in a much broader strategy not just covering the work of the Council and NHS but a much wider perspective of action. There were 5 themes within the strategy, and the report updated against those. Brent Health and Wellbeing Board had recently reaffirmed their endorsement of the 5 themes and were now engaged in the process of refreshing the commitments.

The Chair thanked Dr Melanie Smith for her introduction and invited comments and questions from those present, with the following issues raised:

The Committee felt the report was missing information about outreach work in schools which they saw as central to the strategy. An example was given in Kilburn, where Camden's air quality initiative was being introduced in school. Dr Melanie Smith agreed that the approach would fit well with Brent Council's existing air quality strategy and was something that could be explored with the air quality team. She explained that any particular aspect that was felt to be missing could be addressed when officers engaged Brent Children's Trust to reaffirm their commitments and strengthen the input from CYP.

The Committee highlighted that the report gave a raw figure for rates of smoking in the borough and asked whether there was any further breakdown by community, so that the Council could target communities with heavier smokers. Dr Melanie Smith explained that there was not robust data in relation to smoking communities but there was a qualitative understanding of which communities were smoking, with a higher prevalence of smoking in Eastern European communities and Latin American communities as well as mental health service users and B3. In response to that organisational knowledge, engagement was happening with those communities.

The Committee also asked what the strategy would do to support residents chewing tobacco to stop. They were advised that there was a stop chewing service as well as a stop smoking service which had been publicised and officers had tried to education people in conjunction with an oral surgeon about the dangers of chewing tobacco. Unfortunately, the uptake of the stop chewing service had been disappointing, and members were asked to let officers know of any support they could offer to encourage people to stop chewing.

The Committee was pleased to see the efforts to improve access to toilet provision in the borough and asked what more could be done to improve that. Dr Melanie Smith expressed disappointment that this was a part of the strategy that had not been able to progress due to availability of resource. The Council had explicitly approached the Office for Health Improvement and Disparities (OHID) about whether public health grant funding could be used for the purpose of improving toilet provision and been told it could not, so the Council was looking at alternative ways to move that forward. Councillor Nerva (Cabinet Member for Public Health and Adult Social Care) expanded, informing the Committee that One Kilburn had got a successful community toilet scheme running along the High Road with various outlets signed up to allow access to toilets, and this had been highlighted for potential roll-out in other parts of the local authority.

In relation to Council estates and food growing, the Committee highlighted that many estates in the borough were not Council owned but were owned by Housing Associations, and asked what work was being done with Registered Social Landlords (RSLs) to advance food growing on estates. Dr Melanie Smith advised the Committee that officers would look to explore this through the Food Strategy. Progress with the Council's own estates had been disappointing, and there was a need for the Council to lead by example on this, which it was hoping to progress on St Raphael's Estate. The Council was working with Sufra on the Food Strategy, specifically on growing on estates, and would hesitate to approach RSLs until the Council was in a position of having delivered something akin to what Sufra had done to ensure credibility. Sufra was leading in that space currently and were partners in the Food Strategy. One thing that had been heard clearly from the community was that the Council should be facilitating the work and not driving it, so while it was hoped there

would be progress on this work by summer, it was dependent on the community signing up to that timetable. The Committee added that one way to encourage residents to get involved would be for the Council to publicise the sites and locations that had been identified for the project.

Continuing to discuss food, the Committee asked how the Council would work to increase the sign up of healthy catering considering the high number of fast food outlets on high streets in Brent. Dr Melanie Smith advised that, rather than going out randomly to engage fast food outlets, officers were focusing on particular areas. In Harlesden, there was a fear amongst retailers that if they were the only outlet in a row of fast food outlets offering a healthy option that it would make them less competitive, but evidence and case studies showed it did not harm the bottom line and in some cases could be beneficial, so officers were building relationships and persuading outlets in a geographical approach. The commitment from outlets was variable, and providers who had been supportive could be listed outside of the Committee.

The Committee asked how this work aligned with work around diabetes which Brent Health Matters (BHM) were leading on and were advised that the healthy catering commitment and allied work focused on the supply side, whereas BHM looked at managing demand and consumer education.

In response to how GPs were supported to contribute to the strategy, the Committee were advised that BHM was developing connections with GPs, and the Integrated Care Partnership (ICP) had recently appointed a local GP as the Clinical Lead for BHM, which had resulted in a step-change in the engagement of GPs within the BHM programme.

The Committee asked how officers would measure the impact and outcomes of the strategy and the 5 themes going forward. Dr Melanie Smith highlighted that the first set of commitments of the current strategy had been a narrative which had been right at the time and mostly delivered, but there was currently no quantitative measure of that impact. Going forward, when the commitments were refreshed, officers would be talking to Council departments, Integrated Care Board (ICB) colleagues, other partners, and Brent Youth Parliament about making those commitments measurable, which would be one of the big changes in the refreshed strategy. In response to whether Healthwatch would be engaged in that process, Dr Melanie Smith confirmed they would be, highlighting that the initial engagement for the strategy had been largely delivered by Healthwatch and officers were grateful to them for the work they had done.

Members flagged an issue in Chalkhill Park that had been raised by park users regarding beer cans littering park benches which impacted the commitment to improve usable green spaces in Brent. They also advised of a small allotment in the area which might be a good location for food growing projects. Presenting officers thanked members for the intelligence.

The Chair thanked those present for their contributions and drew the item to a close.

8. Social Prescribing Task Group Year 1 Update

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the report, which was an update on progress on the recommendations made by the Committee a year ago in the Social Prescribing Task Group report. She highlighted that the report was themed around governance arrangements, where she felt a lot of progress had been made, access to social prescribing, where she felt some progress had been made, and the social prescribing offer, where she felt least progress had been made.

The Chair thanked Dr Melanie Smith for her introduction and invited comments and questions from those present. The following points were raised:

The Committee highlighted examples of patients waiting a long time, sometimes between 8 weeks to 3 months, before they were contacted by a social prescriber, and asked how that issue could be progressed. Dr Melanie Smith advised members that the existing Primary Care Network of Social Prescribers was delivered and directed through the Primary Care Network, and Public Health felt there was the potential for the system to work more efficiently in that space. Social Prescribers within primary care had been largely set up in response to pressures on GPs to alleviate demand, meaning social prescribers were now being asked to do things they had not necessarily set up to do, so Social Prescribers may not necessarily have all of the context and skills needed in order to do that. In response to that, a community of practice was being developed to share good practice, and Public Health was seeking to work across the system to increase efficiency and ensure there were better links between different parts of the system.

In relation to the information in the report, the Committee asked how that was obtained. They were advised that officers were getting data directly from GP staff after approaching Primary Care Networks (PCNs) for the data.

The Committee asked where the main challenges were in progressing social prescribing and how that was being mitigated, as well as how Brent Council was facilitating the process to make better health outcomes. Dr Melanie Smith advised that the current provision of social prescribing was an NHS service, and the task group report had recommended that the social prescribing service should be more widely available. The Council had no direct jurisdiction over PCNs but was seeking to work with them and influence them to improve social prescribing in the borough, particularly around how social prescribers related to Council services. For example, there had been a lot of work done to improve referral routes between social prescribers and Adult Social Care and social prescribers and housing which social prescribers had recognised as beneficial. The Council was also piloting social prescribing principles within Adult Social Care using holistic assessments, signposting and directing to other services. The Council was quite advanced with its implementation of social prescribing principles in Adult Social Care and had an agreed role that was currently going through the HR recruitment process. There were prospects for significant progress in this area over the next 12 months, but Public Health did not foresee an offer where residents would receive the exact same offer in Adult Social Care as they would in primary care because there would always be slight differences between the Council and NHS.

As no further points were raised, the Chair drew the item to a close.

9. Scrutiny Recommendations Tracker

The Committee noted the recommendations tracker.

10. Any other urgent business

The Committee heard that this would be Janet Latinwo's final meeting as the Statutory Scrutiny Officer. The Committee thanked her for the work on the Committee and wished her well for the future.

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