MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 10 July 2018 at 6.00 pm

PRESENT: Councillors Ketan Sheth (Chair), Afzal, Conneely, Hector, Knight, Shahzad and Thakkar

Co-opted Members Mr Frederick and Ms Askwith

Also Present: Councillors Hirani and McLennan

Absent: Councillor Colwill, Co-opted Members Mr Milani and Ms Yaqub, and Appointed observer Ms Michael

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

The following apologies for absence were received:

- Mr Frederick (Co-opted Member)
- Lesley Gouldbourne (Observer)
- Jean Roberts (Observer)

2. **Declarations of interests**

Councillor Ketan Sheth declared that he was:

- a lead governor at Central and North West London (CNWL) National Health Service (NHS) Foundation Trust;
- a patron of the Silver Star Diabetes charity; and
- an ambassador for the All-Party Parliamentary Group for Diabetes

Ms Askwith deckared that she was a governor at Wembley Primary School.

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

RESOLVED that the minutes of the previous meeting, held on 28 March 2018, be approved as an accurate record.

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

None.

6. **Childhood and School-Age Immunisation Programmes in Brent**

Dr Catherine Heffernan (Principal Advisor for Commissioning Immunisations and Vaccination Services, Public Health England) and Lucy Rumbellow (Immunisation Commissioning Manager for North West London, Public Health England) introduced the report which provided an overview of Section 7a childhood and school age immunisation programmes in the London Borough of Brent for 2017/18. There were 18 publicly funded immunisation programmes under Section 7a which covered the life-course. However, Dr Heffernan said that the focus of the paper was on immunisation programmes provided for 0-5 years under the national Routine Childhood Immunisation Schedule and those programmes provided for children aged 4-18. She spoke about the routine childhood immunisation programme outlined in section 4.1 of the report (page 16 of the Agenda pack) and said that London had been a complicated area to examine and it had performed worse than other parts of the country. Some of the reasons for this could be related to the vast diversity of the population living in the city, the high mobility rates and the high turnover of people. For example, by the age of one, one-third of children would have changed address at least once which this made it difficult to collect and track data.

The Committee heard that in line with other London Boroughs, Brent had not achieved the World Health Organisation recommended 95% uptake coverage for the primaries and Measles, Mumps and Rubella (MMR). Although the Borough's rates were one of the highest in North West London, there was a concern that a cluster could be created in an area where people had not been vaccinated. Therefore, it was important for residents to visit their General Practitioners (GPs) and get their vaccinations done. Dr Heffernan pointed out that Public Health England was working to increase the number of vaccinations available as well as the number of vaccination nurses.

Ms Rumbellow provided an update of specific vaccinations such the ones against MMR and flu. She said that drop prior to the second intake of the MMR vaccine was in line with national trends and that although there had been an increase in the update of flu vaccines (current rate 34%), there were dips in years 2, 3 and 4 which had been addressed with the Local Authority. In relation to risks, Ms Rumbellow noted that there had been a national Measles incident, with young adults who had not had their MMR vaccination being a group of concern. An action plan to respond to an outbreak of Measles had been created and Public Health England was working towards raising awareness of the importance of having the MMR vaccine. Members heard that if a cluster or an outbreak was declared, the initial response would be to vaccinate people in the nearby area.

As far as challenges related to uptake were concerned, it was noted that although Brent had some specific barriers, these were not dissimilar from the ones in other areas of London. As Brent had a very diverse community, it was difficult to ensure that immunisation records were correct – vaccines could have been given without being properly recorded and vice versa. Public Health England had been working with the National Health Service (NHS) Digital to simplify its childcare information centre which was expected to contribute to the removal of double counting. Moreover, in some cases, such as flu vaccines, parents did not see the value of having of one or had declined their child to be immunised due to cultural reasons.

Dr Heffernan explained that it was difficult to point out groups that were more or less likely to take vaccines as uptake varied by practice. Nevertheless, she supported the Committee's view that community engagement was essential for increasing uptake. Work had been undertaken with the British Society for Immunology to establish the best way to communicate information about vaccines to various communities. Dr Heffernan acknowledged that Central and North West London NHS Trust, the provider of the vaccination service, could do more to engage with schools and raise awareness about vaccinations among teachers. A newsletter publication would be issued prior to the flu season as part of the process of improving the relationship between schools and the Trust. In addition, Public Health England, the commissioner of the service, held regular meetings with the Trust to allow issues to be escalated in a timely manner, e.g. letters about future vaccinations not being delivered to parents, and workshops with providers had been organised to take place every six months.

Dr Heffernan spoke of the need for an innovative approach to engaging schools to achieve better results. For example, the lack of return of consent forms had been a major issue as in some areas up to 55% of the forms were missing, hence, an e-consent form had been trialled. In response to a question about the reasons for lack of engagement, she said that refusals were mainly in primary schools which created a paradox because despite the school refusing to let vaccination nurses in, the child had the right to be offered the vaccine. Nevertheless, Dr Heffernan reassured Members that the number of schools refusing vaccinations, which had been religious or independent schools, was small and was declining.

Councillor Hirani (Lead Member for Public Health, Culture and Leisure) noted that there had been difficulties in engaging schools in other projects which were not related to immunisation and suggested that it might be helpful to present issues at the Headteachers Forum which would allow head teachers to discuss the benefits of various initiatives and share experiences.

A Member of the Committee asked a question that related to the monitoring of immunisation uptake and taking measures to ensure that people were informed about the vaccinations they had to have prior to arriving in the United Kingdom. Dr Heffernan said that immunisation records were part of GP records. When registering a new patient, GPs would ask patients what immunisations they had had and would follow guidance issued by Public Health England, which in most cases advised them to give a vaccine if they were not sure whether a patient had had it.

A Co-opted Member referred to figure 16 on page 31 of the Agenda pack and asked for an explanation why the figures for Human papillomavirus (HPV) vaccinations in Brent were declining. Dr Heffernan explained that the course of the vaccine had been changed, with the number of courses being reduced from three to two so in order to compare results accurately, it was necessary to look at the number of completed doses in Year 9. Moreover, as Brent had a considerably bigger eligible cohort, once vaccinations in Year 9 had been completed, the percentage of the population that had been vaccinated would increase. Responding to a question about the factors used to determine eligibility for the HPV vaccine, Dr Heffernan said that although there was no medical risk to offer the vaccination to girls who had had a sexual contact, it was preferable to give it prior to that. Furthermore, being sexually active was not a reason not to offer the vaccine.

The Committee discussed the role of parents in ensuring that their children had been vaccinated. It was noted that parents were the guardians of children's health and it was their decision whether to vaccinate them. However, parents had the right to information and had to be empowered to make rational decisions. Public Health England had drafted the Serving the Underserved Strategy as part of which immunisation champions had been recruited to promote the benefits of vaccines and engage residents, including those whose first language was not English.

The Chair invited Julie Pal (Chief Executive, Healthwatch Brent) to comment on the report. Ms Pal said that she shared the concerns raised by the Committee around the uptake of flu vaccinations. She suggested that Healthwatch could work with Public Health England to encourage uptake and engage with schools to promote the benefits of the HPV vaccine and de-stigmatise some of the areas covered by it.

RESOLVED:

(i) The contents of the Childhood and School-Age Immunisation Programmes in Brent report, be noted;

(ii) Public Health England takes up the opportunity to work with the British Society for Immunology to promote understanding of vaccination and engage the community in Brent, including the recruitment of lay immunisation champions and reaching out to community and religious groups;

(iii) Public Health England works in partnership with Healthwatch Brent to promote the benefits of immunisation;

(iv) The provider Trust, the Council's Public Health service and Public Health England collaborate with education professionals to determine what could be done to support Public Health England's access to schools;

(v) The Council's Public Health service and Public Health England work together to identify available resources and create a structured outreach programme, including training of non-clinical staff to have a basic understanding of childhood immunisation and the benefits of it.

7. Diabetes: Diagnosis, Treatment and Prevention in Brent

Dr Shazia Siddiqi (Clinical Director, Brent Clinical Commissioning Group (CCG) introduced the paper which provided an update on diabetes services in Brent, focusing on high-risk factors, prevention, diagnosis and treatment initiatives. Dr Siddiqi said that it was estimated that the total number of adults with both Type 1 and Type 2 diabetes in England was 3.8 million people, 90% of whom had Type 2 diabetes, costing the National Health Service (NHS) approximately £10 billion a year. She directed Members' attention to table 7 on page 55 of the Agenda pack which showed how Brent compared to other boroughs. Prevalence of diabetes in Brent was higher than the national average and Public Health England had estimated that there were approximately 7,500 undiagnosed patients so engaging them should be a key priority for Brent Council and Brent CCG. Dr Siddiqi spoke of the Public Health England Diabetes Prevalence Model which had found that diabetes was more common in men, people from South Asian and Black ethnic groups and older members of society.

Dr Melanie Smith (Brent Council's Director of Public Health) spoke about the need for a whole population approach to be adopted to prevent diabetes and she noted that intervention should be underpinned by three objectives – encouraging physical activity, reducing weight and eating a healthy diet. She referred to heath checks that had been commissioned from patients' General Practitioners (GPs) (section 5.2 of the report on page 43 of the Agenda pack) and said that the Brent Integrated Diabetes Service had been launched in October 2014. Its main focus had been to strengthen and increase the overall management of the condition, improve health and reduce health inequalities among the Borough's population and deliver high quality services that were easily accessible. Dr Smith explained that more information about the services available at different tiers could be found in Table 5 on page 47 of the Agenda pack.

Introducing diabetes.co.uk Charlotte Summers (Chief Operating Officer, diabetes.co.uk) said that it was the world's largest diabetes community, providing a platform to facilitate conversation between people affected by the condition. The organisation had developed a low carb programme and had been working on weight loss, among other initiatives aimed at empowering people to achieve remission of Type 2 diabetes. Members heard that information could be tailored according to individual needs and it could be accessed online and on mobile devices to increase flexibility.

The Chair invited the Diabetes Community Champions present at the meeting to share their experiences. Tony Hennessey spoke about his experience of engaging people at various events ranging from health fairs, though visiting community groups to holding stalls at Brent Civic Centre. He emphasised the importance of getting the right message to residents and educating them about diabetes. Dee Sime shared her personal experience of being diagnosed with borderline Type 2 diabetes and the measures she had taken to try and reverse the condition. Ms Sime explained how she had decided to become a Diabetes Community Champion in February 2015 and said that her goal as a Champion was to share her knowledge and encourage people to be physically active. Responding to a question about engaging young people, Mrs Sime said that she had noticed that a large number of people thought that diabetes affected older people. She added that as a significant proportion of young people she had met at events did not think diabetes could affect them, it might be helpful to consider ways of raising awareness in schools and colleges. Dr Smith confirmed that engagement efforts had been focused on older age groups with the exception of some work that had been done with primary schools such as the Slash Sugar Campaign (a campaign about hidden sugar in food).

One of the reasons for high prevalence of diabetes in Brent was the ethnic composition of the Borough which was different from some of the other areas mentioned in the report. Dr Siddiqi emphasised the importance of promoting self-care, targeting vulnerable groups, including people with disabilities, and engaging communities to prevent the condition. Moreover, the Committee heard about a range of strategies and programmes related to tackling diabetes such as the Diabetes Action Group and the National Diabetes Prevention Programme, delivered by Public Health England, NHS England and Diabetes UK.

The Committee questioned the effectiveness of prevention programmes and enquired about the barriers to improvement. Dr Siddiqi responded that Brent

Council and Brent CCG were optimistic about the National Diabetes Prevention Programme as it offered a combination of approaches to tackling the condition. In her view, any initiatives aimed at tackling diabetes had to look at a wide range of factors such as sugar in foods, eating patterns, diets and physical exercise, which had an impact not only on diabetes, but on conditions such as cardiovascular diseases and obesity. It was noted that if someone was in a pre-diabetic condition, it might be possible to prevent diabetes from developing, but this would be much easier of engagement and intervention had taken place earlier.

Dr Siddiqi spoke of the perception of food in some cultures as mealtimes were seen as an opportunity for the whole family to spend time together. People who had diabetes were often isolated at events as they could not eat the food on offer or required members of the family to prepare special dishes for them. Public Health England had developed structured learning sessions for GPs to engage families and look at how they cooked and how they viewed food. She also acknowledged that children had to be engaged and educated about the importance of eating a healthy diet, but this could take time and results would not be imminent. Dr Ajit Shah (Co-Clinical Director, Brent CCG) pointed out that preventing diabetes in Brent was a cultural issue and noted that activity levels of families in the Borough were not as good as in other areas of the country, despite the efforts of the Local Authority. In his view, the diabetes epidemic in the Borough could be reversed, but this required Public Health, the Diabetes Community Champions, GPs and residents to work together for the common benefit.

Ms Summers added that diabetes.co.uk had developed a targeted programme for South Asian communities living in Slough, focusing on specific aspects of their culture. However, a similar approach had not been taken in Brent, although work had been done on specific diets and individual programmes had been delivered in multiple languages, among which Hindi and Tamil. An additional barrier to tackling the conditions was that individuals often did not feel ill and either refused to visit their GP for a check-up or, if they had already been diagnosed, underestimated the risk to their wellbeing. Members expressed concern that the current arrangements did not allow clinicians to screen patients who were working as often services were not available outside working hours. Dr Smith noted that Brent was fortunate because GP surgeries were extending their hours and pointed out that preventing diabetes should be a result of striking balance between raising awareness and providing clinical assessments.

In response to a question that related to the recruitment and retention of Diabetes Community Champions, Councillor Hirani (Lead Member for Public Health, Culture and Leisure) reassured Members that the 40 Diabetes Community Champions that had been recruited so far came from a wide range of backgrounds and were representative of Brent's community. They had been trained using the train the trainer model so when they attended events, they could spread their knowledge to a large number of people. Dr Smith added that the work Public Health had delivered in collaboration with the Champions provided the foundation of grassroots movement as they were local people who had given up their time and who delivered results as people often listed to them in a way they may not have always listened to professionals. Furthermore, Diabetes UK had provided ongoing support to the Champions and the Council had supplied the tools, such as leaflets and stalls, necessary to deliver engagement sessions, some of which had been culturally specific, i.e. focused on Diwalli.

As far as the recruitment of more Champions was concerned, Dr Smith explained that the decision whether to expand the programme or whether to replicate it in other areas would depend on capacity and funding. Councillor Hirani explained that the programme had been funded through a Public Health grant, which would not be available after 2020 when it was expected that retention of business rates would fund Public Health initiatives. The Council remained keen to recruit more Champions as long as it could offer them a decent level of support.

The Committee heard that as far as prevalence was concerned, the CCG was confident in the data presented in the report. However, attendance at the DESMOND one-day self-care management course had been an area of concern, because data had not been recorded accurately due to practices not coding patients correctly. In addition, figures for the undiagnosed population had been estimated on the basis of list sizes at GP practices, residents' weight, age, and background, weight, and other risk factors. In a number of cases, people had been diagnosed with diabetes because they had visited their GP for other reason. In relation to pre- and post-natal prevention, tests results were kept on file and specialists followed up mothers with diabetes and their children.

In terms of expectations for the future, Dr Shah said that it would be a positive outcome if long-term complications of diabetes were prevented so patients could have meaningful lives. He stressed the importance of engaging patients soon after they had been diagnosed with the condition as early intervention maximased the chances to prevent complications and achieve remission which reduced the risk for individuals' health.

RESOLVED:

(i) The contents of the Diabetes: Diagnosis, Treatment and Prevention in Brent report, be noted;

(ii) The Committee's appreciation of the constraints on the Public Health budget be placed on record;

(iii) Brent Council considers increasing the number of Diabetes Community Champions and continues to provide support to them;

(iv) The work carried out by the Diabetes Community Champions be extended to include organising focused community engagement sessions; and

(v) A briefing for Ward Councillors on Brent Council's Healthy Catering Commitment and Planning policies regarding fast food outlets near schools be organised

(vi) The Committee supports the Healthy Catering Commitment and the work with takeaway owners around food preparation and cooking.

8. **Overview and Scrutiny Annual Report 2017/18**

RESOLVED that the contents of the 2017-18 Annual Scrutiny report be noted.

9. **Any other urgent business**

None.

The meeting closed at 8:33 pm

COUNCILLOR KETAN SHETH
Chair