Brent

NHS
Brent Clinical Commissioning Group

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a Hybrid Meeting on Wednesday 16 March 2022 at 6.00 pm

Members in attendance: Dr Mohammad Haidar (Chair), Councillor McLennan (Brent Council), Councillor Nerva (Brent Council), Councillor Kansagra (Brent Council), Fana Hussain (Borough Lead Director – Brent, NWL CCG),Carolyn Downs (Chief Executive, Brent Council – non-voting), Phil Porter (Strategic Director Community Wellbeing, Brent Council – non-voting), Dr Melanie Smith (Director of Public Health, Brent Council – non-voting), Nigel Chapman (Operational Director Integration and Improved Outcomes, Brent Council – non-voting, substituting on behalf of Gail Tolley), James Walters (in remote attendance) (Deputy Chief Operating Officer, London North West University Healthcare NHS Trust – non-voting), Basu Lamichhane (in remote attendance) (Brent Nursing and Residential Care Sector – non-voting).

In attendance: Hannah O'Brien (Governance Officer, Brent Council), James Kinsella (Governance Manager, Brent Council), Janet Lewis (Director of Operations, CLCH)

Carolyn Downs introduced Dr Mohammad Haidar as the new Chair of the CCG, and new member of the Health and Wellbeing Board as Vice Chair. As Councillor Farah, Chair of the Health and Wellbeing Board, had sent apologies, Dr Haidar would Chair the meeting.

Dr Haidar introduced himself as a local GP in Brent and PCN director.

1. Apologies for absence and clarification of alternate members

Apologies for absence were received from the following:

- Gail Tolley (Strategic Director Children and Young People, Brent Council) substituted by Nigel Chapman
- Simon Crawford (Deputy Chief Executive, LNWUHT) substituted by James Walters
- Robyn Doran (Chief Operating Officer, CNWL)
- Dr Ketana Halai (NWL CCG)
- Councillor Farah

2. Declarations of Interest

None declared.

3. Minutes of the previous meeting

RESOLVED: That the minutes of the meeting, held on 13 January 2022, be approved as an accurate record of the meeting, subject to a grammatical amendment to item 6, page 4.

4. Matters arising (if any)

In relation to the action from the previous minutes for the Integrated Care Partnership (ICP) to write to NHSE encouraging them to allow more pharmacists to undertake vaccinations, the Board wanted to know whether the NHS had agreed to make use of local pharmacies. Dr Haidar advised that he was the vaccination lead in Brent and had been involved in the discussions with the Pharmacy Lead, lobbying on behalf of the ICP for community

pharmacists to provide a vaccination service to Brent residents. He highlighted that the process to enable pharmacists to vaccinate was complex and there were particular protocols that needed to be followed including infection control measures, ensuring facilities were safe and residents received the vaccination in an appropriate environment. Dr Haidar had nominated 2 pharmacies and although the space was very small there was a desire to approve and support them to deliver the vaccination programme. The Pharmacy Lead had been in support of piloting first so that was being worked on.

Fana Hussain (Borough Lead Director – Brent, NWL CCG) added that NHSE were looking at all pharmacies in London as a whole, and going forward the assurance process would move to local teams. This was a very rigorous process to ensure protocols, training, adequate space, correct facilities and checks and balances were in place, including for vaccination storage. A number of pharmacies were going through that process and the ICP were supporting pharmacists and working with the Local Pharmaceutical Committee to look at what the requirements were and how they could support pharmacists with adjustments to meet the requirements. Dr Haidar acknowledged that vaccination uptake was low in the South of Brent and the system had continually worked together on ways to reach people, such as introducing a roving team to raise awareness of the vaccination, and would continue to use every opportunity to increase vaccination uptake.

5. HealthWatch Work Plan Update

This item was deferred to a future meeting.

6. Primary Care in Brent

6a. Primary Care update

Fana Hussain (Borough Lead Director – Brent, NWL CCG) introduced the report, which detailed the priorities for primary care going forward, as defined by national, regional, North West London, and local priorities. It was recognised that during the pandemic years, when many services moved to remote, patients may not have come forward for a number of services provided by GP practices, and some services that the GP may have previously provided may not have been accessible. As a result, a priority was reaching those patients who may not have had contact with their GP for some time now that services were fully open. In particular, cervical smear tests and childhood immunisations continued to be a priority. SMI health checks for those with learning disabilities or mental health diagnoses was also a priority going forward. The paper detailed the work being done to recruit to the Additional Role Reimbursement Scheme (ARRS) to support Primary Care Networks (PCNs).

The Chair thanked Fana Hussain for her update, adding that they were also using ARRS to support patients with their medication, following 6 years of clinical training. He invited comments and questions, with the following issues raised:

- In relation to face to face services, the Board were advised that access to primary care existed whether virtual or face to face, and if patients wanted face to face that should be made available to them. The Integrated Care Partnership (ICP) had written to all practices and asked them to open their doors while maintaining infection control measures. The ICP had also commissioned Saturday morning clinics from a number of GP practices across all PCNs, with a focus on face to face in particular. Dr Haidar added that there was work to do alongside community services and the Brent Health Matters team to educate patients on which services to attend to best meet their needs, for example to avoid patients going to their GPs when their pharmacist was better equipped to provide a service. Brent Health

Matters had been doing a lot of publicity around winter access including leaflets, social media campaigns and promoting the hours and telephone numbers of primary care services. Specifically in relation to group therapies, the Board were advised that CLCH were offering all their services face to face, or hybrid for families who preferred digital, as well as ensuring home services were offered face to face, with the exception of group sessions. Officers were working with the Medical Officer to understand the guidance and risk assessments to get groups running again.

- In relation to the commissioning of ARRS by PCNs, the Board were advised that the role of ARRS was to help in the reduction of variation across primary care services and standardise care across the patch. They were available to all GP practices in a particular PCN but may be focused on one specific practice. For example, in one PCN there may be 4 GP practices varying between good, middle or poor standards, and so the additional resource from the ARRS may be placed in the practice with poorer standards to level that practice up. It was highlighted that Brent was suffering with recruitment and retention issues for the ARRS. For example, the inner/outer London weighting impacted where staff wanted to work, and a priority for the ICP was to improve that recruitment so that ARRS staff were consistently available to every practice and every person within a PCN. Recruitment was an issue across the whole of the 8 NWL boroughs rather than a Brent specific issue.

- In relation to how those ARRS specialists could be supported with their continued professional development in order to encourage them to work and remain in North West London, the Board were advised there was an Educational Training Hub. They were told no request for training was refused, and nurses were actively encouraged to take on additional training, with an allocation per nurse set aside. The balance that the ICP struggled with was that if a nurse was not working and was on a training course then they were not earning, and the ICP needed to look at encouraging GP practices to release nurses to do education training on a paid basis. This would benefit GP practices as well. Dr Haidar added that across 51 GP practices there were now certain practices which were training practices, including his own.

- A pilot was being trialled at Northwick Park Hospital, where a GP and nurse had been placed in the Urgent Treatment Centre to triage patients turning up there in order to support easy access to medical services. They had been managing over 1,000 patients a month and 3,000 patients had been managed either on site, received self-care advice, been seen by the GP, or had been booked in for an appointment. Other boroughs were now adopting the project due to its success.

RESOLVED: to note the information provided in the paper.

6b. GP Access Scrutiny Task Group

Councillor Mary Daly (Chair of the GP Access Scrutiny Task Group) introduced the report, which included the final findings and recommendations from the GP Access Scrutiny Task Group conducted by the Community and Wellbeing Scrutiny Committee. She highlighted that the report had been very customer focused in relation to access to primary care. One of the key takeaways had been issues experienced by patients around digital literacy and access to remote services, which had led to a recommendation that digital access and literacy was noted on patient records. Another learning point was that face to face was the preference for younger patients as well as older patients, and that parents of infants and young children, and children and young adults, felt neglected by primary care. Some parents who were unable to get a GP appointment for a sick child chose to go to A&E,

spending a lot of time there. The Board were advised that only a handful of patients were dissatisfied with their consultation with a GP, and GPs and community pharmacists were highly valued. It was clear from the interviews conducted that patients did not want to attend A&E, and Councillor Daly highlighted the importance of patients being properly educated and directed to the best services to meet their needs.

The Chair thanked Councillor Daly for the update and invited members to comment, with the following issues raised:

- The Board asked how the recommendations had been received by primary care and how they would be taken forward. The report had been discussed in forums and been looked at from the point of view of primary care. The recommendations had been critically appraised. The Board acknowledged the impact on primary care, particularly over the past two years. The work Councillor Daly and her colleagues had done had been put at the head of all other NWL boroughs, and the Integrated Care System (ICS) was committed to developing standards across the 8 boroughs for access. A number of investments had already been made, for example a cloud based telephone service which allowed a practice to divert calls, see their peak times and increase resource at demand. Digital platforms were also in the process of being re-procured to be more user friendly, such as allowing patients whose first language was not English to translate the website. From October, each PCN would have an access hub open weekdays from 6:30am to 8pm, and Saturdays from 9am to 5pm. It was the intention of the ICS to provide a response to each recommendation, once further details on investment for primary care in the coming year came through.

- The Board drew a parallel between the GP Access paper and the Health and Wellbeing Strategy due to be presented during the meeting, in terms of the focus on health inequalities, specifically the recommendations that access should be looked at through a lens of deprivation, ethnicity and disability.

- The Board noted that the Community and Wellbeing Scrutiny Committee would expect a report on the progression of the recommendations in a years' time, which should be overseen by the Health and Wellbeing Board as opposed to the Cabinet.

RESOLVED: To note the content of the report, with particular regard to the recommendations to Brent Cabinet and local NHS organisations.

6c. HealthWatch GP Survey

This item was deferred to a future meeting.

6d. Integrated Care Partnership update - Organisational Development Plan

Tom Shakespeare (Director of Brent Integrated Care Partnership) introduced the update on the development of the Integrated Care Partnership (ICP). He highlighted that the ICP was an opportunity to put weight behind primary care as the frontline of the health service, and the paper explored how to embed primary care as leaders in the system. The recommendations in the paper had been produced following engagement with the ICP executive and PCN directors in the initial phase, which formed the first stage of the work. Those recommendations were; putting patients and citizens at the heart of joint working and re-establishing a joint vision driven by primary care; reaffirming shared delivery commitments and looking at the work streams that had been developed with the ICP, primary care, and community; championing a person-centred approach; exploring the support and wraparound services community health and social care could provide within

primary care; focusing on ARRS roles; addressing health inequalities; and improving recruitment and retention. The ICP were also looking at how to hold itself to account and develop a shared culture, building awareness in the community across all service areas such as how to access services, what services were available, and addressing the GP access scrutiny recommendations.

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

- The Chair invited Councillor Daly to contribute to the meeting. She asked what the relationship was with Health Education England in introducing pharmacists, nurses and paramedics into primary care as part of their training during their student period. The Chair advised that there were programmes working with secondary care for training, which GPs helped with, similarly with pharmacists and physicians, supported by Health Education England. The ICP had a Training Hub Lead working hard to encourage GPs to take on student nurses and train them, although there was a workforce issue whereby there were not enough GPs to be released to become educators. The ICP were aware of this and were taking on the challenge as a system. There were also challenges with taking on paramedics in primary care, where the ICP had been asked not to recruit paramedics due to demand in acute and ambulance services. Going forward, the aim was for paramedics to take on a dual role working with the acute trust and GP practices, which was being planned with Health Education England. Basu Lamichaane (Brent Nursing and Residential Care Sector) advised that there were care homes in Brent providing nursing placements with the University of West London and 200 nurses had been supported through that scheme with very good feedback. It was agreed Basu could be put in touch with the Training Hub Manager to look into how this scheme could be further utilised. Dr Melanie Smith (Director of Public Health, Brent Council) highlighted that Health Education England worked to national levels which was less flexible than it could be, but hoped that the work the Integrated Care System (ICS) were doing, with its larger influence, would be a way to increase the responsiveness of Health Education England to enable more training opportunities. Other challenges were the difficulties recruiting nurses due to the withdrawal of the nursing bursary and the difficulty for aspiring GPs getting placements. The ICP had been able to secure additional funding for areas it wanted to develop.

RESOLVED:

i) To note the update.

7. Vaccinations

Dr Melanie Smith (Director of Public Health, Brent Council) first updated the Board in relation to Covid-19, as at the time of the meeting. She advised that the rates of Covid-19 infection were increasing locally, across London, and nationally, although it was becoming more difficult to interpret the rates as measured by testing as it became less accepted and people prepared for testing to be unavailable from the following month. The Public Health Team had been paying attention to the ONS survey figures, which were reliable but only gave London figures rather than Brent figures. Both the testing figures and ONS figures showed approximately 4.4% of the population in London had Covid-19 at the time of the meeting which the Board were advised was very high, with increases across all age groups. Locally, the NHS was not being significantly impacted, because the vaccination had broken the link between infection and severe disease. Dr Melanie Smith advised that Public Health experts would have predicted this increase as society opened up and people

began to mix. It was critical to monitor the impact on hospitalisation in terms of how sick people were from Covid-19 in hospital.

James Walters (Deputy Chief Operating Officer, London North West University Healthcare NHS Trust) explained that in LWNUHT the number of Covid-19 inpatients had increased, but the number of incidental findings was around 40%. These were patients whose primary presenting health complaint was not Covid-19, so would have otherwise been in hospital but happened to have Covid-19. A & E was exceptionally busy across the whole of NWL, putting pressure on each of those services, for example how patients' urgent and emergency care needs were managed while maintaining infection control and prevention. Those in hospital who happened to have Covid-19 were not making their way to the High Dependency Unit or Critical Care in the way patients with Covid-19 were previously.

Regarding the vaccination programme, Dr Melanie Smith highlighted that achieving vaccine equity in Brent was a challenge, but the vaccination programme had shown how the system could work together, be innovative and develop solutions with communities. There was no desire to continue doing things the way they had been done in the past, and the paper asked the Board to take the lessons learnt from Covid-19 specifically in relation to inequalities. The new approach would involve working with communities to co-produce solutions, and take that learning and apply it to other programmes such as the childhood immunisation programme. There would be a need to develop new KPIs in order for the system to hold itself to account on performance for inequalities and the Board was asked to assist with that. The Board strongly supported Dr Melanie Smith's suggestions and hoped those conversations would take place at an ICP and ICS level, with any proposals brought back to the Health and Wellbeing Board.

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

- The Board noted the increase in Covid-19 infections in Brent, with the figures showing around a 40% increase in cases compared to the previous week, and some London boroughs showing nearly 100% increase. The Board queried at what point the government or NHS would consider another booster vaccination. Dr Melanie Smith advised that the JCVI were meeting on a regular basis to discuss this, and she predicted more boosters.

- In relation to how comfortable Dr Melanie Smith was, as the Director of Public Health in Brent, with the full easing of restrictions and testing, she advised that she would always be cautious from a public health perspective, but that must be balanced against the fact the public had been living against unprecedented levels of restriction for two years. At this time, she was not uncomfortable with the lifting of restrictions, but thought it was critical that the ability to scale back up the restrictions was retained, should the UK be faced with a variant which evaded the vaccination. She highlighted that surveillance needed to be maintained so that any new variant was discovered.

- The Board noted that free Lateral Flow Tests which had been available to the public for testing would cease to be available by the NHS in 2 weeks' time, which would mean fewer tests were available and there may be a charge for them. They queried the implications for both infection management and control, and for local, regional and national data. Dr Melanie Smith advised that at the time of the meeting there was not complete clarity about the testing arrangements going forward. There were some helpful commitments from the UK Health Security Agency (UKHSA) about the principles in which testing would be made available, and while it would be important to see how those principles translated into practice, as principles they were sound. The ONS survey would continue, which gave reliable data, although it was not Brent specific.

There had also been assurance from the UKHSA that, with the current levels of Covid-19, the intention was to maintain testing in residential and social care settings, although there was less clarity on other health and social care settings and SEND settings. Locally, the Public Health Team were looking at contingency arrangements should the national testing regime not continue to provide tests to those groups which were considered high risk.

- Public Health predicted that, over the summer, infection levels would decline to such a level that routine testing could be switched off even in high-risk non-clinical settings, but there would be a need to be prepared to switch that back on during Autumn, and standard testing would remain for clinical purposes.

- In relation to the 3 major cities in China currently in lockdown due to new variants, Dr Melanie Smith advised that it was not known whether those variants were likely to spread to the UK. She highlighted it was inevitable there would be variants as the virus mutates, but it was very difficult to extrapolate the experience of populations with differing levels of past infection, natural immunity, and different approaches to vaccination. To date, it had been seen that the UK vaccination programme protected against all variants that had spread in the UK, but the risk was that it could fail in the future. This was why surveillance systems were important in order to spot new variants, assess how transmissible they were, look at whether they caused more severe disease, and find out whether they evaded the vaccination.

RESOLVED:

i) To commit to a continued and consistent “evergreen” offer of Covid-19 vaccinations which is delivered in community settings in partnership with community and faith groups.

ii) To make childhood and maternal immunisation a priority for the ICP, and to invite NHSE&I (as commissioners of immunisations) to join the ICP in developing plans as outlined in section 2.2 of the report.

8. Joint Health and Wellbeing Strategy

The Board were presented with the final Health and Wellbeing Strategy following the consultation process and asked to approve the final draft. The Board thanked all those involved in devoting their time to the engagement process and thanked Anne Kittappa (Senior Policy Officer, Brent Council) and HealthWatch in pulling the work together.

RESOLVED: to approve the Joint Health and Wellbeing Strategy (JHWS).

9. Any other urgent business

None.

The meeting was declared closed at 19:45
DR MOHAMMAD HAIDAR, Chair