MINUTES

CITY OF WESTMINSTER

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of the virtual joint meeting of Westminster City Council's and the Royal Borough of Kensington & Chelsea's **Health & Wellbeing Board** held on 27 May 2021 at 4pm.

Present:

Councillor Cem Kemahli (RBKC - Lead Member for Adult Social Care and Public Health)
Councillor Tim Mitchell (WCC - Cabinet Member for ASC and Public Health)
Councillor Josh Rendall (RBKC - Lead Member for Family and Children's Services)
Councillor Tim Barnes (WCC - Cabinet Member for Children's Services)
Councillor Lorraine Dean (WCC - Deputy Cabinet Member for Children's Services)
Councillor Nafsika Butler-Thalassis (WCC - Minority Group Representative)
Councillor Christabel Flight (WCC - Deputy Cabinet Member for Adult Social Care and Public Health)
Councillor Marwan Elnaghi (RBKC - Chair of Adult Social Care & Health Select Committee)
Senel Arkut (Bi-Borough - Head of Health Partnerships and Development)
Claire Barry (NWL Cancer Alliance)
James Benson (ICP Chair)
Anna Bokobza (Imperial College Healthcare)
Emma Bikupski (Local Safeguarding Children Partnership Business Manager)
Dr Kathie Binysh (Head of Screening NHSEI London)
Iain Cassidy (OpenAge)
Lena Choudhary-Salter (Westminster Community Network)
Heather Clarke (Housing and Regeneration)
Olivia Clymer (Healthwatch Westminster)
Dominic Conlin (Deputy for Leslie Watts, Chelsea, and Westminster)
Anna Cox (Public Health Business Partner)
Robert Craig (Director of Development & Partnerships, Royal Brompton Hospital)
Sarah Crouch (Deputy Director of Public Health)
Bernie Flaherty (Executive Director for ASC and Health)
Angela Flahive (Head of Safeguarding Review and Quality Assurance)
Jenny Greenfield (Kensington and Chelsea Social Council)
Richard Grocott-Mason (Managing Director, Royal Brompton Hospital)

Simon Hope (Deputy for Joe Nguyen, North West London CCG)
Philippa Johnson (Central London Community Healthcare NHS Trust)
DI Mark Kent (Metropolitan Police)
Tania Kerno (Healthwatch RBKC)
Jeffrey Lake (Deputy Director of Public Health)
Anne Pollock (Principal Policy Officer)
Anna Raleigh (Director of Public Health)
Visva Sathasivam (Director of Social Care)
Ela Sen-Pathak (Deputy for Ade Odunlade, CNWL)
Gemma Stanton (Cabinet Secretariat Manager, WCC)
Susan Sinclair (NWL Cancer Alliance)Dr Andrew Steeden (Chair, West London CCG)
Russell Styles (Deputy Director of Public Health)
Jo Thomas (Director of Communications and Public Affairs, Royal Brompton Hospital)
Dr Mona Vaidya (Central London CCG)

1. WELCOME TO THE MEETING

1.1 Councillor Cem Kemahli welcomed everyone to the meeting. The Board confirmed that as the meeting had been due to be held within RBKC, Councillor Kemahli would chair the meeting in line with the agreed memorandum of understanding.

2. MEMBERSHIP

2.1. Apologies for absence were received from Ade Odunlade (CNWL), Robyn Doran (CNWL), Raj Mistry (Executive Director Environment and City Management), Janet Cree (NWL ICS COO), Jo Ohlson (CNWL CCGs), Aileen Buckton (Chair of Children's Safeguarding Board), and Annabel Saunders (Bi-Borough Children's Services Director of Operations and Programmes).

3. DECLARATIONS OF INTEREST

3.1. There were no declarations of interest.

4. MINUTES

RESOLVED:

4.1. That the minutes of the Kensington & Chelsea and Westminster joint Health & Wellbeing Board meeting held on 23 March 2021 be agreed as a correct record of proceedings.

5. COVID-19 VERBAL EPIDEMIOLOGY UPDATE AND LOCAL VACCINATIONS UPDATE

5.1. Anna Raleigh (Director of Public Health) gave a commentary on her presentation, which had been circulated following the meeting.

5.2. Simon Hope (Borough Director) updated the Board on vaccinations. He noted the approach was to align vaccinations without breaking management of testing. There was work underway to bring forward second doses for patients aged 70 and over from 12 weeks to 8 weeks.

5.3. The local authority, public health, NHS and third sector were working collaboratively as a system to roll out the vaccination programme. Residents aged 30 plus were able to receive vaccinations. There was an increase of vaccination capacity in Westminster of over 20,000 a week. The AstraZeneca vaccine was safe for second doses, but national guidance stated people aged 40 and under should receive Pfizer or Moderna.

5.4. The Bi Borough vaccine bus had launched, it would spend three days a week in both Westminster and RBKC for the next two weeks. There was a push in both boroughs to ensure as many pharmacies as possible were signed up to the national system to book vaccinations. There were also some pharmacy pop-ups under the clinical governance framework of a PCN able to vaccinate patients.

5.5. In response to questions, the following points were made

(i) There were hopes to ensure the Pfizer vaccine would become available on vaccination buses. This involved working to ensure it could be safely transported
(ii) While clinics were available to all, advertising too widely could lead to large numbers of people which would be difficult to manage.
(iii) Individuals who were over 30 could choose to receive the AstraZeneca vaccine but most were only available for second doses.
(iv) While mass vaccine centres were listed as walk-in centres, they were just about managing capacity.

6. ROYAL BROMPTON UPDATE

6.1. Dr Richard Grocott-Mason (Managing Director) and Rob Craig (Director of Development and Partnerships) presented an update on the Royal Brompton Hospital, a copy of their presentation was circulated.

6.2. The hospital treated patients of all ages that required specialist heart and lung care. Patients were concentrated in London and South-east England but there were patients from all over England.

6.3. During the peak of the pandemic the hospital more than doubled capacity for critical care. The hospital cared for patients with Covid-19 from other intensive care united in NWL to relieve capacity.

6.4. The hospital was also a national provider for ECMO which was a machine to support patients whose lungs were damaged and needed oxygen via an

artificial lung. During the peak of the pandemic, 28 patients were on ECMO and outcomes were good with a survival rate of 70%.

6.5. Both hospitals continued to treat patients with non-Covid-19 heart and lung disease, as well as treating patients with heart surgery, transplantation, and lung cancer surgery.

6.6. As an organisation, the hospital made a significant investment in staff health and wellbeing during the year, this included staff psychological support.

6.7. Children's services were a particular focus over the past year, work was done throughout the pandemic to ensure treatment and surgery for children with congenital heart disease was able to continue unaffected. This led to some longer-term advantages, as there was now a permanent joint multidisciplinary team for specialist cardiac treatment between Evelina Children's Hospital and the Royal Brompton. As a long-term commitment, the Brompton service would also remain a part of the West London Children Alliance.

6.8. There were several developments at Royal Brompton hospital, including a new imaging centre that would open at the beginning of 2022. As well as further collaboration between Royal Brompton and Royal Marsden, including a long-term partnership for a joint thoracic oncology service which focused on cancers of the lung and chest.

6.4 In response to questions, the following points were made:

(i) Any plans that would involve moving would be long-term and services were not moving for at least a decade. The reference to 5-7 years in the report referred to children's inpatient services that would move from the Brompton site depending on new facilities being built.
(ii) There were no changes in relation to other hospitals in NWL, during the pandemic the working arrangements were as positive.
(iii) The hospital was evaluating the right option for services, the pandemic provided an opportunity for learning that would factor into the evaluation of services.
(iv) The Board welcomed ongoing discussions and further details on plans going forward.

7. HEALTH AND WELLBEING STRATEGY REFRESH, POSITION STATEMENT AND HWBB ROLE

7.1. Senel Arkut (Bi-Borough Director of Health Partnerships) updated the board on the health and wellbeing strategy. As part of its statutory duties, that Board had a requirement to oversee each borough's health and wellbeing strategy.

7.2. RBKC's strategy would expire this year and WCC's strategy was due to expire in 2022. While there was work underway on the new strategy, there had been an increased demand on services and resources due to the pandemic. There was also a significant restructuring of the NHS, and as a statutory body, the role of the Board was also changing.

7.3. The role of the Board was expected to oversee the local ICP (Integrated Care Partnership) work of health and care delivery while also taking an active role in shaping the future of services and service delivery in a more strategic partnership and integrated approach.

7.4. The aim was to incorporate the changes and learning because of the pandemic into the new joint health and wellbeing strategy. The Board generally agreed to the proposed continuation of the current strategy for RBKC pending the launch the joint Kensington & Chelsea and Westminster strategy, as well as the new role of the HWBB. Papers on both would be presented to the Board in due course.

7.5. The Board was the only statutory Board that remained locally. As a result, the board had a responsibility to ensure a platform was provided for collaboration and that the work was conducted in an integrated way through the delivery of integrated patient-focused services. This fit in with the aims and purposes of the ICP, and it was an aim that the Board had an oversight of the ICP activities and priorities, as well as regular updates from the ICP on the development of work locally.

8. ICP STRUCTURE, PRIORITIES AND RELATIONSHIP WITH THE JOINT HWBB

8.1. James Benson (ICP Chair) presented an update on the ICP structure, priorities, and relationship with the HWBB, a copy of the presentation was circulated.

8.2. There was rich data in terms of public health indicators, and it was recognised that some of the big challenges in communities were obesity, diabetes, hypertension etc.

8.3. There were key principles set for NWL as a priority. This included managing public health, developing the primary care networks, reviewing, and improving diabetes care etc.

8.4. On local priorities, there was a focus on strategy and learning from the pandemic, as well as methods of working collaboratively to maximise health and care delivery and reducing duplication of effort. In addition to supporting residents to stay at home and being discharged in a safe and timely manner when in hospital.

8.5. Work has begun on project plans that look at key areas, measures for consideration and key performance indicators. There were plans to take this to the first partnership board meeting. A variety of partners were invited to join the partnership board, which was scheduled once a month for both RBKC and WCC individually.

8.6. In response to questions the following points were made:

(i) The pandemic revealed inequalities across both boroughs. There was a need for further work on population health management, but it was

important to first identify key areas that require further work and then look at how population health management would be embedded in that work.

(ii) With regards to the timeline for the new arrangements, initial meetings would begin over the next two months for each borough.

(iii) It was important to look across both boroughs on health inequalities, obesity was an area that needed particular focus, and it was important to work collaboratively to make a difference.

(iv) Ensuring residents understood systems and felt actively involved was a topic that required further discussion. Work would explore ways of ensuring that patients were practically heard and engaged with.

(v) As the ICP develop, the focus would not be solely on health. The CCG has been asked to write to partners in RBKC and WCC to build an understanding.

(vi) There were several priorities that overlap among partners, and work could be done to bring these together and change ways of working.

(vii) On the possibility of a Bi-Borough ICP, it was important to first work as individual ICPs and delivering improvements for citizens. There was optimism that in time, the 2 ICPs will evolve organically into 1 Bi Borough ICP.

(viii) There were discussions on developing work to understand and work towards addressing the health inequalities in both boroughs.

(ix) Over the next year there were additional roles opening in primary care such as mental health practitioners.

(x) There were conversations on improving the use of data, but there was an existing understanding of the health and care of the population.

8.7. The Chair noted it was important to ensure local priorities matched with wider ones and suggested this was kept as an ongoing agenda item for the Board.

9. CANCER SCREENINGS AND RECOVERY UPDATE

9.1. Anna Raleigh (Director of Public Health) introduced the item. NHS England was responsible for commissioning the NHS cancer screening programme and the local authority public health maintained an oversight role.

9.2. This included reviewing trends and highlighting concerns to ensure adequate delivery of the screening services to the local population. The Board was invited to consider the reports, to comment on the recovery plans, and consider a timeframe for discussion to come back to the HWBB.

9.3. Dr Kathie Binysh presented an update on cancer screenings. Services were paused during the first lockdown; work was done to screen those that were particularly high risk. Recovery was currently underway; bowl and cervical screening programmes were either recovered or close to being recovered. The breast screening programme was more challenging, but it was anticipated that the programme would be recovered by March 2022.

9.4. In response to questions the following points were made:

(i) There were concerns about the increasing inequalities as part of the recovery programme. Officers assured the board that reducing inequalities was at the heart of interventions that would be supported over the next number of years.

(ii) Smear testing remained a challenge, there appeared to be a decline in women taking up cervical screenings over time both locally and nationally. This may have been related to confusion as to whether it was required if they had been vaccinated, but it was still required.

(iii) There were conversations ongoing with colleagues in the CCG on understanding and validating data.

9.5. The situation would be monitored given the significant impact on morbidity and mortality of late cancer diagnosis. The Chair welcomed an update and the Board noted to invite screening colleagues to a future meeting once updated data was available.

10. CHILDREN'S ANNUAL SAFEGUARDING REPORT

10.1. Angela Flahive (Head of Safeguarding Review and Quality Assurance – Children's Services) and Emma Biskupski (Local Safeguarding Children Partnership Business Manager) presented the Children's Annual Safeguarding Report to the Board.

10.2. The report covered three boroughs, RBKC, WCC and H&F. All partnerships were required by the Department of Education to review their working arrangements in the first year. An independent reviewer had been commissioned and this contributed to the formation of decisions around the Bi-Borough partnership.

10.3. On safeguarding figures, 2593 referrals were made to children's social care in RBKC and 2012 in WCC. RBKC figures reflected all contacts while WCC counted the formal referrals.

10.4. The police were major contributors in terms of referrals, followed by education and health colleagues. The most common age group referred were children aged 10-15 years, as they were they most common cohort supported through child protection plans.

10.5. A new safeguarding partnership had been created that was Bi-Borough, with the introduction of a new independent chair Aillen Buckton.

10.6. Three safeguarding partners were involved in new arrangements: the CCG, police, and the local authority. Partners were consulted but the partnership took lead in identifying key areas and priorities.

10.7. Three subgroups were also developed for partnership which included: case review, better practice and development and engagement and accountability.

10.8. Local children and adolescent mental health services were run by CNWL and systemic clinician services within children services. There were also several mental health services that were promoted.

10.9. There continued to be challenges to meet the needs of the most vulnerable children and young people, there were joint packages of care, but it was a complex and challenging issue.

11. ANY OTHER BUSINESS

11.1. Senel Arkut (Bi-Borough Director of Health Partnerships) spoke of the 2020-2021 CCG assessment review request, as part of the Health and Social Care Act 2012, NHS England has a duty to consult with the Board on the contribution to the delivery and any joint HWB strategies. To fulfil this statutory responsibility NHS England circulated a consultation questionnaire designed to assess the effectiveness of the CCG's working relationship with statutory bodies within the local system. The questionnaire would be shared with the Board in due course.

The Meeting ended at 5.53pm.

CHAIR: _____ **DATE** _____