London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Draft Minutes

Monday 14 March 2022

PRESENT

Board Members:
Councillor Ben Coleman (Chair)
Dr Nicola Lang - Director of Public Health, LBHF
Phillipa Johnson – Director, Integrated Care Partnership, and Director of Operations for Central London Community Health Trust
Lisa Redfern - Strategic Director of Social Care, LBHF
Sue Roostan - Borough Director, H&F, North West London Collaborative CCGs
Sue Spiller - Chief Executive Officer, SOBUS
Detective Inspector Luxan Thurairatnasingam - Met Police

Nominated Deputies Councillors:
Councillor Patricia Quigley - Assistant to the Cabinet Member Health and Adult Social Care, LBHF
Nadia Taylor - Nominated Deputy Healthwatch, H&F

Officers and guests:
Nicola Ashton, Strategic Health Commissioner, H&F
Senal Arkut, Assistant Director for Public Health and Social Care Commissioning, H&F
Charlotte Bailey, Chief People Officer, North West London Collaborative of CCGs
Jazz Browne, Chief Executive, Nubian Life Resource Centre
Dr Naomi Elster, Head of Research and Communications, Prostate Cancer Research
June Farquharson, Assistant Director for Health Inequalities and Population Health, North West London Collaborative of CCGs
Jim Grealy, HAFSON
Rory Hegarty, Director of Communications and Engagement, Integrated Care Partnership
Merrill Hammer, HAFSON
Dr Christopher Hilton, West London NHS Trust
Linda Jackson, Director, Strategy Innovation Community Health and Wellbeing, Social Care, H&F
Ashlee Mulimba, Health Psychologist, Healthy Dialogues Ltd.
Roy Morgan, Head of Prevention and Wellbeing for Adult Social Care and Public Health, H&F
Dr Habib Naqvi, Director of the NHS Race and Health Observatory
Yvonne Okiyo, Strategic Lead for Ethnicity, Diversity and Inclusion, Children's Services
Bevan Powell, Deputy Chair, Nubian Life Resource Centre
Sharon Tomlin, Resident Community Organiser, SOBUS

1. APOLOGIES FOR ABSENCE

Apologies from the following board members: Vanessa Andreae, Councillor Larry Culhane, Dr Nicola Lang, Lisa Redfern, Councillor Lucy Richardson, Sue Roostan and Glendine Shepherd.

2. ROLL CALL AND DECLARATIONS OF INTEREST

None.

3. MINUTES AND ACTIONS

It was noted that Jacqui McShannon had attended the previous meeting. Sue Roostan reported that paragraph 5.4, should state "non-essential CCG work", that in paragraph 5.14, "intuitive" should be replaced by "initial" and that two references to "consultation" in paragraph 6.7 should state "engagement".

RESOLVED

The minutes of the previous meeting held on 13 December 2021 were noted as an accurate record, as amended.

4. TACKLING HEALTH INEQUALITIES

4.1 Councillor Ben Coleman introduced the term "health inequality" within the context of people who receive poorer health treatment because of biased, racist perceptions and behaviours. The recently published report "Ethnic Inequalities in Healthcare: A Rapid Evidence Review" (February 2022) produced by the NHS Race and Health Observatory, and led by its director, Dr Habib Naqvi, evidenced stark and overwhelming racial inequity within the UK's healthcare system. The NHS Race and Health Observatory had engaged nationally which was a positive step. Locally, H&F had recently received a significant funding award to look at the root causes of health inequalities within the borough. Linda Jackson prefaced the discussion by describing the borough's collaborative approach with Dr Bob Klaber, Consultant in Paediatrics, Imperial College Healthcare NHS Trust. A reluctance to come forward for vaccination in some ethnic communities stemmed from a lack of trust. The Council was working with partners including the NHS and police to address this.

4.2 Dr Naqvi's provided an overview of the work of the Observatory, which was set up to be a semi-independent unit scrutinising the NHS and UK Healthcare system. Details were provided on the Observatory's form and function. Observatory's work focused on 5 main areas. These were: maternal and foetal mortality in ethnic communities; disproportionate mental health illness in ethnic communities and access to mental healthcare; empowering vulnerable communities; and digital health. Councillor Ben Coleman commended Dr Naqvi for his work and an insightful, that to achieve meaningful and sustained progress it was necessary to get "comfortable with the uncomfortable in order meet the needs of diverse communities".

A Zoom recording of Dr Naqvi's complete presentation from can be accessed at H&F Health & Wellbeing Board | 14 March 2022 - YouTube, 13:42.

4.3 Bevin Powell referenced historic reports which highlighted the impact of health inequalities and cultural misrepresentation in the NHS which impeded building trust and confidence. He asked how improved cultural competencies could help address institutional and structural racism. Assistive technology and digital innovations were helpful, but this would not necessarily avoid cultural bias due to an absence of systemic planning. Ensuring cultural competency at every level from commissioning to service delivery required that the right questions be asked throughout.

4.4 Dr Naqvi agreed and outlined a piece of work that the Observatory was currently engaged in that identified new innovations in the NHS to ensure that an equalities impact assessment was factored in at the start. The review of racial bias in pulse oximeters illustrated that the design of the device did not recognise differences in skin pigmentation and needed to be addressed. This led to a decision to have a wider review of medical devices. Dr Naqvi focused on leadership and how dealing with this challenge should not be a burden for those most affected by it. There should be an equal burden of commitment for everyone and if it worked for the most vulnerable in the community then it would work for the majority. Councillor Coleman endorsed the response and recognised the importance and challenge of joint working.

4.5 Sue Spiller asked if there were any examples that Dr Naqvi could offer of where there was trust, observing that decades of mistrust could not be resolved overnight. Dr Naqvi described his experience of being vaccinated at the Malcom X centre in Bristol which had been led and hosted by the local community and was a good example of building trust through partnership, community working with the local authority. However, building trust was a complex issue and he agreed that this kind of movement from entrenched values would be slow. Many people who experienced racism saw little value in numerous reports without real change, so this required persistence and patience.

4.6 Dr Naomi Elster agreed and commented that there was a sense that patients were tired of initiatives being directed at them and questioning. She cited several examples including: Muslim women and their reluctance to accept hormone therapy for breast cancer and who repeatedly reported lower levels of empathy from NHS staff than white women with the same reservations; how the pain threshold for Black women was perceived by NHS staff, and the reason why they fared much worse in childbirth; and also, Black men, who had a greater likelihood of being diagnosed with prostate cancer at a younger age, however, confused messaging from GPs advised waiting. Dr Naqvi felt that this was not simply a moral issue but that there were cost and efficiency benefits, as well as critically, the potential for saving lives if there was a greater focus on education. He agreed with Dr Elster's point regarding pain management, illustrating this with the example of endometriosis and skewed preconceptions about a person's threshold for pain.

4.7 June Farquharson highlighted a perspective from the North West London Integrated Care System (ICS). Issues such as the death of George Floyd offered a platform to explore the mistrust felt by Black communities. There was a commitment to start a different conversation and to rebuild trust, beginning with health inequalities, identifying barriers to care and to improve outcomes. The ICS was currently leading on two initiatives that built on the work of the Observatory, with a commitment to coproduce a five-year inequalities' framework that would identify health inequalities by collaborating strategically with communities. Health inequalities had been identified across the North West London area and there was a need to change the narrative about how the issue of mistrust could be addressed, reaching beyond the data. The ICS aimed to be responsive to messages from the Black community and planned to develop a steering group, jointly co-chaired by a local authority representative and a senior member of the health service. The group would have a remit to contextualise local conversations within a strategic framework so Black communities would be listened to, and to include this within the group's terms of reference.

4.8 Councillor Coleman welcomed the commitment from the ICS. It was clear that structural racism was a barrier and required greater prominence. Rory Hegarty endorsed the comments and added that the launch of the inequality's framework would ensure that ongoing dialogue with communities was encouraged and supported. There was a strong agreement that there should be partisan working across health and social care, and an understanding of how to collaborate with communities and grass roots organisations that was both inclusive and foster challenging conversations. Charlotte Bailey referenced the issue of leadership and culture within organisations, and discrimination which hindered workforce career progression. There was a recognition that the workforce interfaced with patients, but it was leadership that made decisions about resources. Across NWL the intention was to use workforce ratio quality standard data to inform leadership career programs and inclusive recruitment, using ethnically diverse staff voices and experiences to create movement and change through positive action interventions.

4.9 Linda Jackson volunteered the NWL ICS to work with the Observatory and outlined specific interests in mental health and young people. Dr Naqvi welcomed the offer to be a potential pilot site and although there was no specific work on these areas a maternal health group was exploring mental health and young people. There was potential work that the Observatory might lead on around the ethnicity pay gap.

4.10 Phillipa Johnson welcomed the discussion and focused on the borough-based partnership as a new way of working to deliver local integrated care. The CCG aimed to build a deeper understanding of population and community needs, with a commitment to coproduction. Councillor Coleman added that there had been discussions as to the structural question and areas of responsibility at either ICS or borough levels. Sharing best practice was a positive but a top-down policy setting could be one directional. The potential of achieving improved equalities outcomes across all communities could be

realised if there was capacity for the ICS to work with councils. Engagement had to be community led as people perceived themselves by locality rather than regionally.

4.11 DI Thurairatnasingam commented on how the police engaged with local communities by trying to build trust. One barrier to address was unconscious bias and procedural fairness in technology. There were ethnically diverse health professionals within the NHS holding prominent positions but there was a lack of cohesion with doctors not rooted within the communities. Their experience within the health service would be invaluable in helping to re-engage with communities. Public confidence in public services had dropped significantly despite equitable policies and procedural fairness.

4.12 Jim Grealy found it shocking that issue of structural racism, when he first entered the teaching profession fifty years previously, remained. The NHS had been slow to recognise that structural racism was a barrier and that the approach would be better framed as “earning” rather than “building” trust. Many communities had stepped back from the NHS because of their negative experiences. He stated NWL had been poor at listening to local people and involving their voices and views in local decision-making and queried whether communities would be listened to as an outcome of the five-year strategy and that for this to happen communities would need to be involved at the outset. June Farquharson responded that the plan was a framework and offered a starting point to facilitate dialogue with communities.

4.13 Councillor Coleman thanked Dr Naqvi for his attendance and contribution and commended the use of the phrase “trust is truth told consistently over time” and how this manifested over time was part of the challenge.

4.14 Roy Morgan introduced local plans and outlined that health inequalities had been highlighted by the disproportionate number Black minority ethnic residents who had been reluctant to accept vaccination, because of a lack of trust and confidence in the healthcare system based on their lived experiences. The salient parts of the report were highlighted. It was noted The Building Trust program was aimed at sceptical communities and involved local community organisations which had begun to explore how to best engage with local communities. A separate workstream would also explore the removal of barriers to vaccine take up within black ethnic groups. Linda Jackson expanded on the role of the steering group which would recruit local, H&F community champions who could share their lived experiences of health care provision, working closely with the ICS as experiences differed between boroughs. Merril Hammer welcomed the comments and observed that the work done by Sir Michael Marmot on the social dynamics of health inequalities had not been referenced.

4.15 Dr Elster felt encouraged by the references to workforce issues as this was regarded as integral to the problem, as highlighted during Dr Naqvi’s presentation. Prostate Cancer Research UK funded 3% of prostate cancer research in 2017, which had increased under her leadership to 14%. In terms of workforce there was a focus on recruiting school age role models but nothing to address the fact that many women and those from ethnic

minorities, were leaving the workforce. This linked to the issue of mistrust and how this fostered misrepresentation which often apportions blame to the patient for raising the initial concern with a health professional. She asked the rhetorical question 'how could mistrust could be dealt with in a way that was constructive without creating a cycle of blame'.

4.16 Bevan Powel focused on the importance of engaging and listening to the community and translating this into policy and action. He asked if there was any work being undertaken in evaluating technical competencies of health practitioners to make these more robust. Rory Hegarty responded that local authorities were working collectively with the NHS in north east London to address competency standards for practitioners. The key point was that this was the beginning of a conversation highlighting inequalities and what this meant for delivering health care services, but this was not autonomous and needed to be undertaken in partnership with other organisations and communities.

4.17 Sue Roostan felt that the work could be linked intrinsically with the borough based partnership. In terms of vaccination, it was important to not replicate the same set of difficulties that led to mistrust. This was an opportunity to place equalities at the heart of policy and decision-making around coproduction. Councillor Coleman suggested that councils, the NHS and the third sector could find a way to work collaboratively together on structural racism, in genuinely constructive way. Charlotte Bailey commented that a unifying factor was to identify and articulate jointly values and principles such as being inclusive, kind, safe and compassionate, underpinned by an assurance about what this would mean.

4.18 Jim Grealy welcomed the insights offered by NHS colleagues but felt that there was a need to mitigate against a "top down" approach when working at speed, and at a local level within the Integrated Care Partnership. There was a danger that those patients who have experienced racial bias, would be invited to share their experiences to drive future policy change but that this would not necessarily affect immediate change for them. Racist behaviour could not be addressed without having a means to change practice. He suggested the formation of a standing committee which could offer a platform for asking question and getting answers with great frequency. Sue Spiller concurred with an earlier point about having a set of standards that all organisations could sign up to, but it was the behaviour of some individual practitioners that needed to be addressed. External and independent scrutiny of these practices and processes offered a way of holding organisations to account and challenge practitioners who might be dismissive.

4.19 Dr Elster recounted her experience of working on maternal mortality in Guatemala, in 2019 where most women who died during pregnancy were from the indigenous population. One successful initiative was to employ trained Mayan midwives whose practice was rooted in spirituality and inherited knowledge who were also given training in western midwifery. In another, UK example an initiative that increased the uptake of cervical screening in Muslim women was an education program delivered jointly by female medics and female religious scholars who provided an Islamic faith

perspective on cancer screening. Both were good examples of respectful partnership working. Dr Elster welcomed news that the council would be working with community champions but cautioned that they should be fully supported to avoid any potential community backlash.

4.20 Yvonne Okiyo commented that an adversarial approach would not be helpful as a starting point. A level playing field was being sought but while this should acknowledge that structural racism exists, the response to undo this collaboratively should be humble, doing things with communities rather than too them. Communities would need to be supported to engage, with safe spaces to so that they can share experiences and be listened to. This was a message to those who were yet to be converted to listen, act and feedback. There were many organisations that had been doing this work, building trust but the conversation needed to be community led. Rory Hegarty agreed that this should be led by "trusted community organisations" informed by the council or NHS but not led by them.

4.21 Councillor Coleman referenced the vaccine equity workshops (organised by Imperial College Healthcare NHS Foundation Trust) and focused on the delivery of services which extended beyond the implementation of policies to address bias. This approach embodied a collaborative approach that pooled the best ideas and concepts to deliver something that could be uniquely inclusive without being prescriptive. He suggested that this could be done by for example, quarterly meetings between the north west London.

4.22 Sharon Tomlin supported the need to create a safe space for residents and stakeholder organisations to nurture conversations, supported within a structured framework by local councils. The phrase "poorly reached" resonated as they were already disadvantaged but that did not mean that they could not offer rich insights, which could inform policy change at a higher level. She also endorsed the advice from Dr Elster regarding support for community champions and Bevan Powell's comments on unconscious bias in relation to practitioner competency. She also cautioned that facilitating dialogue without leading to change would be a significant disappointment.

4.23 On a final note, June Farquharson agreed with previous speakers she would like the community to invite the NHS to have a conversation at when they were ready and to have this in a safe space. Trust would be possible when the community could see their voices reflected in policy and practical changes to create equitable healthcare. Councillor Coleman endorsed this point and added that irrespective of whether it was at a local or regional level, change should be resident led, supported by the NHS, administratively and clinically.

RESOLVED

That the comments and discussion generated was noted.

5. PHARMACEUTICAL NEEDS ASSESSMENT

5.1 Nicola Ashton outlined the requirements of the Pharmaceutical Needs Assessment (PNA) and how the Board would have to deliver this. Required

every three years, an extended grace period of 6 months had been permitted and the PNA would be required by October 2022. Health Dialogues Limited was the appointed provider that would help support and deliver the PNA process. With reference to the slide deck Ashlee Mulimba explained that the PNA captured local views and assessed the current pharmacy provision to see if this met existing local needs. This was achieved through a process of engagement, communication using tools such as social print mediums to channel the views of seldom heard voices. This ensured that the views of those furthest from decision making such as addicts, the homeless, sex workers, Black and Asian Minority Ethnic groups were included. The intention was to complete stakeholder engagement by the end of March 2022, using a broad approach with multiple channels to generate wide ranging perspectives. Dr Lang clarified that consultation, and a survey would be conducted over the summer period. The suggestion to include organisations such as Nubian Life as part of the engagement was welcomed.

5.2 Councillor Coleman commented that given the earlier discussions around minority ethnic groups that were “poorly reached”, pharmacies had a critical role to engage and meet the needs of these communities. Nicola Ashton reported that previous surveys had indicated that there had been minor variation in the level of use except in the timing of access. Bevan Powell enquired about what collective measures were being taken to work with grass roots communities. Dr Lang confirmed that engagement would be undertaken through local faith forums in the borough. She was keen to ensure that those without a voice should be included, together with data and feedback obtained from other co-produced sessions. Yvonne Okiyo recommended that an equalities impact assessment be undertaken to ensure that there was range of suitable methods to facilitate consultation with different communities of interest. It would also assist consultation with groups with protected characteristics or those most likely to be impacted.

RESOLVED

That Health and Wellbeing Board commented on and noted the statutory requirement to develop and publish an updated Pharmaceutical Needs Assessment (PNA) by October 2022.

6. COVID-19 UPDATE

6.1 Dr Niki Lang reported that Covid rates were rising and that the Secretary of State for Health had mentioned that our local rate was 550 per 100,000 population, and that in H&F there had been 40 cases reported in the previous 7 days. There had been a London level discussion about what could have caused this, but it was likely to be because of increased social interaction and low false testing rates, given that people had begun testing again. The BA2 variant of Omicron was found to be more easily spread compared to the original Omicron variant, wanning vaccine immunity and reduced mitigation measures with fewer people distancing or wearing face masks.

6.2 Dr Lang also reported that they were supporting local service providers with advice regarding the most recently implemented changes issued on 24

February 2022. Sue Roostan confirmed that a spring booster vaccination plan was about to be implemented and delivered through community pharmacies with some pop up. It was unlikely that large, primary care network hubs would be used although this might change depending on the view of the Joint Committee for Vaccination and Immunisation. Given the 40% increase in the number of cases Sue Roostan confirmed that hospitalisations were low in number, both in terms of intake and the intensive care units.

6.3 Jacqui Mc Shannon reported that schools continued to implement the advice of the Director of Public Health in terms of testing provision for children and staff in vulnerable settings, including the guidance on self-isolation. Dr Lang confirmed that refreshed guidance had been issued to schools and the requirement for schools to test twice weekly had been removed. The BA2 variant was a concern and schools had been supported in continuing to follow the advice. Commenting on the possibility that lateral flow test kits would be charged for in future, Dr Lang acknowledged that this was a concern as it might inhibit testing. There was a consensus that contrary to the government view, Covid was very much present.

RESOLVED

That the verbal report was noted.

7. WORK PROGRAMME

To be followed up.

8. ANY OTHER BUSINESS

None.

9. DATE OF NEXT MEETING

Wednesday, 29 June 2022.

Meeting started: 6pm
Meeting ended: 8.31pm

Chair .....

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