London Borough of Hammersmith & Fulham

hammersmith & fulham

Health & Wellbeing Board

Agenda

Wednesday 24 March 2021 at 5.00 pm
Online - Virtual Meeting

MEMBERSHIP

Councillor Ben Coleman - Cabinet Member for Health and Adult Social Care (Chair)
Vanessa Andreae - H&F Clinical Commissioning Group (Vice-Chair)
Dr James Cavanagh - Chair of the Governing Body, H&F Clinical Commissioning Group
Councillor Adam Connell - Cabinet Member for Public Services Reform
Councillor Larry Culhane - Cabinet Member for Children and Education
Dr Nicola Lang - Director of Public Health
Maisie McKenzie – Operational Manager, H&F, Healthwatch Representative
Jacqui McShannon - Director of Children's Services, H&F
Lisa Redfern – Strategic Director of Social Care, H&F
Sue Roostan – Borough Director, H&F Clinical Commissioning Group
Glendine Shepherd – Assistant Director of Housing Management, H&F
Sue Spiller - Chief Executive Officer, SOBUS

Nominated Deputy Member
Councillor Patricia Quigley – Assistant to the Cabinet Member Health and Adult Social Care
Councillor Lucy Richardson, Chair, Health, Inclusion and Social Care Policy and Accountability Committee

This meeting will be held virtually, and a livestream can be viewed at
https://youtu.be/Qbqx9_7bPOQ

CONTACT OFFICER: Bathsheba Mall
Committee Coordinator
Governance and Scrutiny
☎: 020 8753 5758
E-mail: bathsheba.mall@lbhf.gov.uk

Reports on the open agenda are available on the Council's website:
www.lbhf.gov.uk/committees/Health and Wellbeing Board

Date Issued: 16 March 2021

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

Item		**Pages**
1.	**MINUTES AND ACTIONS**	4 - 13

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 2 December 2020; and

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. ROLL CALL AND DECLARATIONS OF INTEREST

To confirm attendance, the Chair will perform a roll call. Members will also have the opportunity to declare any interests.

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4.	**BETTER CARE FUND**	14 - 23
	The Better Care Fund provides financial support for councils and NHS organisations to plan and deliver local services jointly. The Board is being asked formally to approve the borough's BCF agreement for 2020-21.	
5.	**VACCINATION UPDATE**	24 - 36
	The NHS is responsible for vaccination. The Board will discuss the Clinical Commissioning Group's activity and plans for Covid and flu vaccination in the borough and consider what further support the health partners can provide.	
6.	**HEALTH INEQUALITIES**	
	Covid has highlighted long-standing health inequalities. The Board will discuss current and future work by health and other key partners to address this in the borough.	Verbal
7.	**INTEGRATED CARE PARTNERSHIP**	37 - 40
	The Council co-chair the Integrated Care Partnership, which aims to coordinate a variety of health providers, the council and other health and wellbeing services around the whole needs of each person. The Board will discuss the ICP's future draft priorities.	
8.	**WORK PROGRAMME**	
	The Board is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future.	
9.	**DATES OF FUTURE MEETINGS**	
	The Board is asked to note that the dates of the meetings scheduled for the municipal year 2020/ 21 and 2021/22 are as follows: Wednesday, 21 April 2021 Monday, 21 June 2021 Monday, 13 September 2021 Monday, 13 December 2021	

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Wednesday 2 December 2020

Committee members:
Councillor Ben Coleman, Cabinet Member for Health and Social Care (Chair), LBHF
Vanessa Andreae, H&F CCG (Vice-chair)
Dr James Cavanagh, Chair of the Governing Body, H&F CCG
Janet Cree, Managing Director, H&F Clinical Commissioning Group
Toby Hyde, Deputy Director of Transformation, Imperial College Healthcare NHS Trust
Inspector Mark Kent, AW Safeguarding Partnership Hub, Metropolitan Police
Dr Nicola Lang, Director of Public Health, LBHF
Jacqui McShannon, Director of Children's Services, LBHF
Lisa Redfern, Strategic Director of Social Care, LBHF
Maisie McKenzie, Operations Manager at Healthwatch H&F

Nominated Councillors in attendance:
Councillor Patricia Quigley, Assistant to the Cabinet Member for Health and Adult Social Care, LBHF
Councillor Lucy Richardson, Chair of the Health, Inclusion and Social Care Policy and Accountability Committee

Other attendees:

Residents
Peggy Coles, Coordinator, H&F Dementia Action Alliance
Stuart Downey, Chair, H&F Dementia Action Alliance;
Jim Grealy, HAFSON
Merril Hammer, HAFSON
Giles Piercy, H&F Mutual Aid Groups

Third Sector
Kate Sergeant, Local Services Manager H&F, Alzheimer's Society
Nisha Devani, Healthwatch H&F

Health services
Caroline Durack, H&F GP Federation
Philippa Johnson, Director of Operations, Central London Community Healthcare NHS Trust
Wendy Lofthouse, Dementia Commissioner, H&F CCG
Pippa Nightingale, Chief Nursing Officer, Chelsea and Westminster Hospital NHS Foundation Trust

---

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

Council
Jo Baty, Assistant director, mental health, learning disability and provided services social care
Linda Jackson, Director of Covid 19
Joanna McCormick, Assistant director, health and social care

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Larry Culhane and Glendine Shepherd.

2. ROLL CALL AND DECLARATIONS OF INTEREST

The Chair called out a roll call of Board members. There were no declarations of interest.

3. PUBLIC PARTICIPATION

None.

4. MINUTES AND ACTIONS

RESOLVED

That the minutes of the previous meeting held on 30 September 2020 were agreed as an accurate record.

5. COVID-19 UPDATE

Linda Jackson and Dr Nicola Lang provided a joint verbal update. The contact tracing programme had gone very well, with H&F officers successfully contacting 99% of those people whom national contact tracers had been unable to contact. They had used a combination of door knocking and phone calls. Councillor Coleman observed that the rate nationally for contact tracing had fallen as low as 60%. Effective local tracing from the start would have made a significant difference and it was a major government failure not to have introduced it sooner.

Members of the Board commended Linda Jackson and her staff for their achievement, which was a positive example of local expertise and knowledge being applied successfully under difficult and challenging circumstances.

Linda Jackson noted that H&F was one of the first London councils to undertake lateral flow testing (LFT) and had rolled out a targeted testing programme in care homes combining LFT and PCR (polymerase chain reaction) tests, and testing residents and staff, GPs and GP staff. This would be extended to include sheltered housing. There were also plans to train staff as swabbers. The council currently had enough test kits.

As regards to the vaccination programme, it was confirmed that this was led by the NHS both locally and nationally.

In terms of flu vaccination, Dr Nicola Lang said the rate of uptake had not been as high as was hoped. Corrective action was in progress through improved communications utilising social media. Public Health were engaged in work with local faith communities.

The need for closer monitoring was accepted and following discussion it was agreed that the issue would be considered at the next Health, Inclusion and Social Care Policy and Accountability Committee meeting on 26 January 2021. Janet Cree concurred and pointed that rates of uptake were low across all cohorts but particularly low in the under 65 age group who were at risk.

Vanessa Andreae said the rate of uptake had surpassed figures for the previous year, which represented huge progress given the need for social distancing. Councillor Coleman said the borough had one of the lowest uptake rates in London and that other councils had largely managed to maintain better uptake rates.

Councillor Quigley recounted her experience of trying to arrange for a flu vaccination given that she was currently shielding. She asked if it was possible for volunteers to be used in helping to deliver the vaccine to those who were shielding at home. Philippa Johnson said this could not be considered a viable approach as qualified health professionals and district nurses were required to ensure the safety of both staff and residents. There were also complexities around storing and administering doses effectively that needed to be considered

Merril Hammer acknowledged that although there had been improvement, the uptake remained shockingly low, not just amongst the under-65s. There were also low rates for the over-65s in H&F, with overall figures across all cohorts disturbing. The rate for primary care staff was at 50%.

Merril Hammer enquired what action other CCGs had taken to get better uptake rates. Janet Cree agreed that the rates for health staff was disappointing and responded that the CCG had consistently shared best practice and learning with other CCGs. They had worked consistently over the past five years to improve rates, working with the Board, Primary Care Networks and the wider North West London system. Whilst she recognised the seriousness of the issue there was no easy solution.

Dr James Cavanagh cautioned that there was a struggle to understand individual choices around vaccination and testing and the right to make such choices. These could be inexplicable, but it was important to take the time to empathise with where these beliefs were coming from. This might also be a big challenge when it came to the Covid vaccine.

Vanessa Andreae added that she had anticipated a bigger, national campaign but this had not been evidenced to date so there might be a need for localised communications using, for example, patient feedback groups. However, she

did not think this was a question of access (unless shielding) and there was little anecdotal evidence to support this.

Merril Hammer said Imperial were actively engaged in trying to address low uptake amongst Trust staff, given the need to protect patients. Imperial might build this into terms and conditions for newly appointed staff, suggesting a more proactive approach. Dr Cavanagh said this would make it harder to attract and recruit staff and that it was an individual right to refuse a vaccine.

In response to a question from Sue Spiller, it was confirmed that there needed to be a seven-day gap between following the flu vaccine with the Covid vaccine, although this might change with advances in epidemiology.

Councillor Coleman asked if more research-based approaches could be taken. Linda Jackson confirmed that they had considered behavioural sciences and that this had been discussed with the CCG, who were keen to explore this further.

Jim Grealy observed that H&F was not distinct from most of the other West London boroughs and asked if it was possible to commission some comparative research to understand and identify factors for low uptake locally and what other boroughs were doing with greater success.

Councillor Coleman summarised that there appeared to be a collective commitment to improve uptake but that this was not reflected in the results and that there was a need to address the feedback from under 65's indicating a lack of trust in vaccines.

Councillor Coleman asked whether GPs had local flexibility to vary the Covid vaccine priority lists decided by the Joint Committee for Vaccination and Immunisations (JCVI). Pippa Nightingale said there was a national team supporting clinicians in the delivery of the vaccine as determined by the JCVI according to a health and age driven criteria. Within NWL there had been pragmatic agreement to allow greater freedom to be exercised by clinicians at a local level.

Dr Lang had previously reported on the work of the newly re-established H&F Immunisation Working Group, where the themes of reluctance around childhood immunisations were similar to adult vaccinations. Dr Lang said this work could be considered more fully at the HISPAC meeting in January. Some progress had already been made in engaging with the local Somali community and agreeing to use more effective channels of communication such as WhatsApp rather than letters. Dr Lang was determined things should improve.

Councillor Coleman said it was important for vaccine prioritisation being determined inclusively. The engagement work initiated by Dr Lang should be developed, working with opinion formers within each community to build trust in the vaccine. Jim Grealy commented that whilst most residents would take a positive view of the Covid vaccine, others might need encouragement and he

suggested that the council considered using email signatures/banners that had been successful in communicating key information across the borough.

ACTION: That flu vaccination be an item at the next HISPAC.

RESOLVED

That the verbal report and actions be noted.

6. INTEGRATION

The Board received a verbal report from Lisa Redfern and Janet Cree regarding national NHS changes and the introduction of integration systems which included the H&F Integrated Care Partnership (ICP). Janet Cree updated the Board on new governance arrangements following consultation with CCG governing bodies and conditional approval of the decision to move to a merged, single CCG body covering North West London in November 2020. GPs would vote on whether to accept a revised constitution this week, with the results to be notified the following week. The deadline to submit any outstanding plans was 31 December and this was currently on track, subject to the vote. GPs were expected to vote further in January on the new governance arrangements. A new shadow governing body would be established at the end of February, local CCGs closed down in March and the newly formed single CCG would go live in April.

Janet Cree outlined the role of the eight-borough Integrated Care System (ICS) in leading the planning and commissioning of care for its population, and providing systems leadership for NHS providers, commissioners and local authorities working together to improve health and care provision.

The ICS would be a non-decision making, strategic group independently chaired by Penny Dash and all provider organisations would be represented including the London Ambulance Service. There was local government representation through Councillor Graham Henson, Harrow Council's Leader and City of Westminster Council Deputy Leader and Councillor Tim Mitchell, Cabinet Member for Adult Social Care and Public Health.

An initial conversation would be held about the strategic priorities for North West London. There would need to be effective engagement with stakeholders. The anticipated vision was about improving life expectancy and health outcomes and to establish initial priorities such as mental health.

Janet Cree outlined three key functions: strategic planning, delivery of care and assurance of delivery. They would look at inequality hotspots through gap analysis. The clinical strategy would be evidenced by basing it on interventions and by identifying models of care suitable for NWL. This would be supported and driven by compliance with governance standards to ensure that the right leadership was in place in each of the organisations.

The intention was to provide the very best, equitable and simple local care, with services consolidated to achieve the best outcomes, and to ensure that this was also the case for specialist care, making effective use of resources.

Having chaired her first H&F ICP meeting on 23 November, Lisa Redfern said the ICP was an alliance of NHS providers that would work together to deliver care through collaboration rather than competition and that it included hospitals, GP practices and third sector providers. The ICP fed into the ICS and although it was established it would undergo a refresh together with a review of governance structures and a workshop planned for the new year.

It was noted that CCG would eventually become redundant. Councillor Coleman added that there might be a periodic rotation of local authority representation on the ICS.

Merril Hammer cautioned that the ICS was amorphous and lacked a clear structure and legal identity. Concerns about the move to a merged single CCG entity remained, despite the Long-Term NHS plan reference to maintaining local bodies. A key concern was that the public would have no clear understanding of the ICS structure and what the new system would look like. There had been a CCG commitment to delivering co-produced services, but it was important to understand how this would work at ICS level and whether there would be a follow through commitment to work with the borough.

Dr Cavanagh agreed and accepted that there were issues with the ICS structure. The CCGs would eventually be abolished as part of a move away from an internal market model. Providers would work together, and improved co-operation would place patients around the health care system to access the right provision, which would be an enormous benefit. Improved co-operation and a strong emphasis on effective, place-based partnership would be critical.

Councillor Coleman welcomed this in light of the council's commitment to doing things with residents and not to them.

RESOLVED

That the verbal report be noted.

7. DEMENTIA

The Board received three presentations about dementia and how the council provided support for residents and visitors living with dementia. Jo Baty said that a draft strategy and action plan would be co-produced with input from the Dementia Action Alliance and the Alzheimer Society before final agreement.

Stuart Downey said his work in private practice as a solicitor supporting individuals and their families in dealing with mental health and capacity issues and his own personal experience of dementia had afforded him significant insight. As Chair of the Dementia Action Alliance (DAA) he explained the key

aim of the organisation was to encourage Hammersmith and Fulham to be a dementia friendly borough.

The scale of dementia was a huge issue affecting many people personally and professionally and H&F was unique in that it paid for home care provision for residents, including those living with dementia. There was significant statistical evidence to indicate that by 2030 the cost of health and social care within the Borough could amount to £105 million, twice the expected rate of inflation. The number of residents currently in the borough diagnosed with dementia was 889 and this was expected to increase to 1800.

He said that an integrated, more holistic and innovative approach with wider community and voluntary support was needed. This summer, a strategic group had brought together representatives from across the borough to actively develop a network of support. The group had looked for both quantitative and qualitative data to help identify a platform and direction of travel and to gain an understanding of existing providers within the borough, working with organisations such as Sobus. Identifying existing strategies had not been straightforward and data had been unavailable as information had not been recorded. A different approach to dealing with dementia was needed to bring together people and services and deliver a more cohesive framework of support services. A dementia friendly community would be a friendly community for all.

Kate Sergeant said this had been a collaborative process and although clinical input was required, much of the support would result from the social care community to address cross-cutting issues. Dementia was a long-term illness spanning years, a serious diagnosis without a cure or effective medical treatment. A person with a dementia diagnosis was normally sent straight back out into the community to deal with the consequences of their diagnosis with little support. Similarly, for the primary carer of a person with dementia there were significant and challenging issues and an important part of the strategy would be to ensure support was provided for carers.

Peggy Coles said that working with people with dementia had inspired workshops at Hammersmith Town Hall in 2016 which provided activities and advice. Improving a local dementia offer required a dedicated and collaborative vision. She commended the borough for building on its mission to be a compassionate borough. A challenge offered to the Board was for all member organisations to become Dementia Friends, and to consider how partners could collaborate and how GP practices could be made dementia friendly. The goal was to apply to be a dementia friendly borough by 2022.

Councillor Coleman thanked the presenters for their unyielding and tenacious commitment. He asked members to choose one aspect that they would like to see improved by 2022:

- Raise awareness about dementia and services available for excluded communities, and make these more accessible to minority groups;
- Have earlier diagnosis and improve the low rate of diagnosis through education and awareness of the signs to look out for;

- Destigmatise the dementia diagnosis and prevent discrimination – have a more intergenerational approach that involved younger people in the borough;
- Recognise that dementia was a mental health issue;
- Ensure that those with dementia could access and receive palliative care support (Appendix 1, page 22 of the report);
- Expand carers' support, including young carers and recognise hat the Carers Allowance was insufficient;
- Recognise that there were increasing numbers of single people in the borough who live in isolation and a dementia diagnosis would have significant consequences for those lacking a support network;
- Tailor support in terms of need;
- Understand how the hospital environment feels for people with dementia and how this can be improved;
- Explore the role of assistive technology in supporting people with dementia;
- Develop a "wellbeing environment" suitable for those with dementia; and
- Providers should improve communication and information-sharing protocols to facilitate contact with carers and people with dementia.

RESOLVED

1. That the Health and Wellbeing Board support the development and delivery of an integrated Hammersmith and Fulham Dementia Strategy between the local Council, the local NHS, the voluntary sector, residents and businesses; and
2. That the Health and Wellbeing Board support its members and constituent groups to become Dementia Friends.

8. GP ACCESS TO DIGITAL SERVICES - DRAFT CHARTER OF STANDARDS

Councillor Coleman welcomed Healthwatch Your Voice H&F, who had been commissioned to inform a draft charter of inclusive standards to provide guidance to GP practices and the wider NHS shaping access to digital services. Maisie McKenzie said the draft standards were iterative, inclusive and had been co-produced with input from the Healthwatch H&F shadow executive committee, the local authority, CCG and HAFSON. Nisha Devani confirmed that draft standards were derived from the response to the survey questions, which had also been carefully calibrated to ensure accessible and inclusive engagement.

Councillor Coleman welcomed the draft charter of standards. He asked how a GP practice might commit to this, how the charter might be adapted for use in hospitals, and what the next steps might be. Nisha said it was essential to engage with clinicians in order to maintain a balanced view. Following the engagement work with residents it was now important to obtain input from GPs.

Following a question from Merril Hammer it was also clarified that although the draft charter had come out of the survey work, this information would be

presented at a separate meeting of the Board. This would include the headline findings from the survey and data from the focus groups. This would allow an opportunity to understand the core issues for patients, which could vary demographically.

Councillor Richardson said the draft charter needed to be contextualised and simplified, with greater clarity to understand who it was for. If aimed at patients then a "less is more" approach was suggested, written in a clear and accessible way.

RESOLVED

1. That the draft charter of standards would be further refined with input from Primary Care Networks and the GP Federation; and
2. That the Board would consider a further iteration of the draft charter at a future meeting.

9. FOOD ACTION PLAN

Jo McCormick briefly outlined progress on the Food Action Plan (FAP). This set out a number of different projects and programmes that were currently ongoing. It was clarified that that this would also capture NHS work around the borough.

The draft aims for the plan were that no one should go hungry or be malnourished, that everyone can eat healthily and that no one should have to eat alone unless they chose to. A further aim that was also being considered was eating without causing harm to the environment. The Board was invited to endorse further work being undertaken on the plan to bring together different strands of work and track the various activities.

Vanessa Andreae commented on the frailty work undertaken by consultants at Imperial and it was noted that the need for regular meal support for people was identified through patients presenting with weight loss. The often-overlooked benefit of frozen of tinned food over fresh food was acknowledged and the Board noted the ongoing work of community groups such as the Smile Brigade, which was working with the Council to prepare and deliver 600 Christmas lunches by e-bike.

Jim Grealy asked if the quality of hospital food could be reviewed at, for example, Imperial. Toby Hyde commented that the issue of food was complex and that there was currently work ongoing to look at the provision of cafes on Trust sites and work with local organisations to improve the quality of food for both patients and staff.

Councillor Coleman emphasised that the aims were work in progress and would be subject to further and more nuanced refinement to reframe the aims. A suggestion to amend one of the aims to "that everyone in the borough has an opportunity to eat with others" was agreed.

ACTION: Further reports to be provided to the Board and to be included in the updated work programme.

RESOLVED

1. That the Board endorsed the development of the Food Action Plan with Board partners with a slightly amended third aim, and a recommendation that the fourth aim be considered further; and
2. That the Board continued to steer and monitor the Food Action Plan work.

10. WORK PROGRAMME

RESOLVED

That the Board's work programme be noted.

11. DATES OF NEXT MEETINGS

Monday, 8 February 2020.

Meeting started: 6.30pm
Meeting ended: 9:23pm

Chair ....

Contact officer: Bathsheba Mall
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 5758 / 07776672816
E-mail: bathsheba.mall@lbhf.gov.uk

London Borough of Hammersmith & Fulham

Report to: Health and Wellbeing Board

Date: 24/03/2021

Subject: Better Care Fund

Report of: Lisa Redfern

Responsible Director: Strategic Director for Social Care

Summary

The Better Care Fund paper setting out the proposal for the London Borough of Hammersmith & Fulham (H&F) and the H&F Clinical Commissioning Group (CCG). This will form part of the submission to NHSE in April 2021.

Wards Affected: All

---

1 EXECUTIVE SUMMARY

1.1 In accordance with the statutory duties and powers given to the Health and Wellbeing Board (HWB) by the Health and Social Care Act 2012, the Board's Terms of Reference in Hammersmith & Fulham Council's constitution include overseeing the development and use of the Better Care Fund by the Council and the H&F Clinical Commissioning Group (CCG).

1.2 For clarity, the Better Care Fund supports community health and social care resources to reduce the number of people who need to be admitted to hospital. Residents that do require admission to hospital are supported to get home as soon as they are well.

1.3 The Board is asked to review, comment on and endorse the draft Better Care Fund guidance and local proposal.[1]

1.4 This paper supports the development of the submission to NHS England on how we plan to pool our monies to support joint working over the forthcoming year. The submission is a template submission that has mandated fields for completion by both the CCG and Council. The paper below sets out our

[1] BCF Grant Guidance can be found at https://www.gov.uk/government/publications/better-care-fund-policy-statement-2020-to2021

approach, areas where we will work jointly, and the governance arrangements to monitor the delivery of the plan in year.

1.5 Both H&F Council and H&F CCG have committed to completing the template in accordance with the Better Care Fund planning guidance.

2 RECOMENDATIONS

2.1 That Cllr Coleman, on behalf of the Health & Wellbeing Board, agrees the planned total expenditure and the proposed schemes for 2020-21.

2.2 That the HWB receive an end of year report outlining the outcomes of each scheme and the difference it has made for residents of H&F.

Sign-off template which will be used for NHSE submission

Local Authority	**London Borough of Hammersmith & Fulham**
Clinical Commissioning Groups	**Hammersmith and Fulham Clinical Commissioning Group**
Date to be agreed at Councillors Members Board:	**9th February 2021**
Date submitted:	**February 2021**
Minimum required value of CCG contribution to BCF pooled budget: 2020/21	***£14,657,325***
Agreed value of CCG contribution to BCF pooled budget 2020/21	**£31,135,151**
Agreed value of LA contribution to BCF pooled budget 2020/21	**£17,875,111**
Total proposed value of pooled budget 2020/21	**£49,010,262**

a) **Authorisation and signoff**

Signed on behalf of the Clinical Commissioning Group	
By	Dr James Cavanagh
Position	Chair
Date	February 2021
Signed on behalf of the Council	
By	Lisa Redfern
Position	Strategic Director for Social Care
Date	9th February 2021
By Chair of Health and Wellbeing Board	Councillor Ben Coleman Cabinet Member for Health and Adult Social

	Care
Date	9th February 2021

Appendix 1

Better Care Fund proposal - Hammersmith & Fulham

1. Introduction

1.1 This is the third-year plan for the Better Care Fund as a sovereign council and CCG. A sovereign plan will provide greater clarity for residents of the borough as to what they can expect from the pooling of our resources.

1.2 The following programmes of work are partially in place and are undergoing further development and focus to March 2021 to support delivery of the requirements as set out in the BCF guidance.

1.3 The four national conditions set by government in the Policy Statement are:

- Plans covering all mandatory funding contributions have been agreed by HWB areas as are minimum contributions.
- The contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation.
- Spend on CCG commissioned out of hospital services meets or exceeds the minimum ringfence.
- CCGs and local authorities confirm compliance with the above conditions to their Health and Wellbeing Boards.

1.4 In previous years, the system has been monitored using the following metrics:

- Non elective admissions (specifically acute)
- Admissions to residential and care homes
- Effectiveness of reablement.

However, for 20/21 the national BCF team have confirmed that systems will not be monitored on metrics and therefore are not required to report on these.

1.5 The joint working described in this report is reflected in the allocation of spend within the BCF and will be reflected in a new Better Care Fund Section 75 Agreement which records the formal commitments of partners. Areas of funding that are currently joint but in transition back to commissioning organisations will continue to form part of the section 75 but will clearly set out commissioning responsibilities and timelines to repatriate services where appropriate and agreed.

2. Our Aims and approach

2.1 The aims of the BCF programme for this coming year is to build on existing work and continue to focus on system benefits for the medium and long term. Our aim through all work streams is to deliver:

- Learning from waves 1 and 2 of the Covid pandemic, working together
- Patient-centred care improving outcomes for patients
- Integrated work for social care and mental health services locally
- Efficient use of resources across the system
- Reduced duplication of effort and contacts of residents
- Continued working together to support clinically extremely vulnerable residents
- A programme approach to supporting residents who find themselves in need of financial support and subsequently additional mental health support.

2.2 The health and social care system, which consists of Social Care, community Health, mental Health trusts, Clinical commissioning groups, primary care networks and Acute hospital trusts. They are working through the Integrated Care partnership and Accident and Emergency Delivery Board to identify areas that will impact on non-elective admissions, reducing length of stay. The work streams are currently focused on:

- Extended Length of Stay – supporting the Trust to reduce the length of stay of patients to below 21 days, where possible
- Discharge to Assess pathways for all patients (more detail below)
- NHS Continuing Health Care (CHC) assessments – completing and updating CHC assessments and decision for residents who have been discharged during the peaks of infection rates to care homes.

2.3 Our focus on the Discharge to Assess pathways continues to ensure patients are discharged in a timely way and supported by the appropriate packages of support in their own home.

2.4 To reduce delayed transfers of care and achieve the Extended Length of Stay trajectory, work has continued and pathways have been tested and amended as appropriate. The aim of the programme continues to be to ensure that:

- Patients are involved in planning for their discharge
- Where possible patients are supported to be discharged home to have assessments for ongoing care in their own home.
- The expectation is a reduction in care home placements.

2.5 The principles for commissioning discharge to assess pathways are as follows:

- Patients need to be registered with a GP and live within the agreed borough area
- Integrated health and social care pathway - effective and efficient use of resources, where home is the default
- Single pathway and single referral process for all patients going home, regardless of complexity
- Assessments for long-term care are not completed in hospital
- Support independent living with the resident and co-produced care plans
- Aligned budget – health and social care contributions
- Care and settings for provision of need will be determined based on them being both clinically appropriate and proportionate to clinical need
- Need oversight of patients through the pathway to ensure assessments and decisions are made in a timely way – especially re: on-going requirement for overnight care. Close co-ordination with primary care to facilitate discharge
- Assessment process is time limited and decisions made re: on-going needs within 14 days
- Access to rehabilitation and an enabling approach to care, including access to technology
- Timely handover between teams, to avoid delay.

2.6 H&F is also focused on being a compassionate community. Throughout the pandemic, we have worked alongside the Primary Care Networks (PCN) as a multi-disciplinary team, supporting vulnerable people in our communities. We will continue to build on this, making specific reference to:

- BAME communities and engagement in relation to immunisations and vaccinations
- Working age families who are now unable to maintain financial independence through worklessness and subsequent impacts on health and well-being
- Residents who are clinically vulnerable - promoting health and wellbeing programmes to encourage people to get back to ordinary life.

3. Grant funding and pooling arrangements in the BCF plans

3.1 The guidance sets out clearly that the Disability Facilities Grant (DFG), Improved Better Care Fund (iBCF) and Winter Pressures grant monies continue to be included in the BCF pooled fund this year. This is under Section 31 of the Local Government Act 2003. The conditions of these grants are set out in the guidance and in the H&F submission there will need to be clear reference as to how these funds are committed and agreed with health partners.

3.2 **iBCF**

3.2.1 The Grant Determination issued in April 2020 sets out that the purposes will replicate those from 17-19 and therefore the funding is used for:

- Meeting adult social care needs
- Reducing pressure on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring local social care provider market is supported.

3.2.2 The grant conditions for the iBCF also require the local authority to pool the grant funding into the local BCF and report as required.

3.2.3 iBCF funding can be allocated across any or all of the three purposes of the grant in a way that local authorities, working with the CCG, determine best meet local needs and pressures. No fixed proportion needs to be allocated across each of the three purposes. The funding does not need to be directed to funding the changes in the High Impact Change Model (HICM). This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

3.2.4 Since April 2018, reporting on the iBCF has been incorporated into the main BCF reports and this will continue for 202021.

3.3 Winter Pressures Funding

3.3.1 The grant determination for Winter Pressures was issued in April 2020. In 2021, the Grant Determination sets a condition that this funding must be pooled into BCF plans. The grant conditions also require that the grant is used to support the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures. This includes interventions that support people to be discharged from hospital who would otherwise be delayed, with the appropriate social care support in place, and which helps promote people’s independence. This funding does not replace, and must not be offset against, the minimum contribution to adult social care.

3.3.2 Each BCF plan should set out the agreed approach to use of winter pressures grant, including how the funding will be utilised to ensure capacity is available in the winter to support safe discharge and admissions avoidance. The BCF process will ensure the use of this money has been agreed by plan signatories and the HWB, confirmed in the planning template.

3.4 Disabled Facilities Grant (DFG)

3.4.1 The DFG continues to be allocated through BCF. There should be consideration given to the use of home adaptations, the use of technologies to support people living independently in their own homes for longer and taking a joined up approach to improving outcomes across health, housing and social care.

3.4.2 Expenditure details will be set out in the planning template showing the level of resource that will be dedicated to the delivery of these activities. Reablement and other support to help people stay in their own homes or return home from hospital with support remain important outcomes for integrations and match priorities set out in the NHS Long Term Plan.

4. Governance arrangements for BCF

4.1 H&F Council and CCG will need to agree an appropriate level of governance to manage the operational day-to-day delivery against the BCF.

4.2 The organisations will require an operational officer group including Finance that meets monthly to look at the metrics and performance against these and conditions of the BCF. For 2020-21, due to Covid-19 and the consequent delay in the publication of the planning template, the BCF submission will be made to NHSE&I at year end and the outturn will be reported formally at the first scheduled meeting of the HWB following the closure of the 2021 accounts.

5. Financial and Resources Management

5.1 The Better Care Fund joint budget for 2020/21 is proposed as £49,010,262. This is an increase in investment from 2019-20 of £1,772,343 or 3.75%.

Analysis of 2020-21 BCF & S75 Joint Budgets

Lead Commissioner	Budget Description	Amount £	Total £
CCG	Community Services & Learning Disabilities Care	18,661,871	
CCG	CCG Investment to Protect ASC	6,785,011	
CCG	Lead Commissioning S75 Services	5,688,269	
Sub total			**31,135,151**
LA	Improved Better Care Fund	8,814,025	
LA	Winter Pressures	918,381	
LA	Disabled Facilities Grant	1,495,597	
LA	Community Independence Service	631,000	
LA	S75 Commissioned Services	6,016,108	
Sub Total			17,875,111
Grand Total			**49,010,262**

Within the above resources is the amount of £6,785,011, which is transferred to adult social care to protect front line social care services to meet a condition of the BCF guidance. The minimum amount that the CCG is required to contribute to Adult Social Care in 20/21 is £6,358,445. The main difference between these two figures relates largely to the System Resilience programme which in previous years was classified within the H&F CCG minimum contribution.

5.2 Both organisations continue to face cost pressures which have been risk managed and reviewed through governance processes in year. Respective mitigating actions have been taken to manage these pressures. With respect to the S75 Lead Commissioned Budgets, the CCG have confirmed that if they over perform, they will reimburse the Council for the over-performance.

Agenda Item 5

London Borough of Hammersmith & Fulham

Report to: Health & Wellbeing board

Date: 24/03/2021

Subject: **Joint Vaccination Plan**

Report of: Susan Rooston- Borough Director H&F CCG
Linda Jackson- Director Covid H&F Council

Responsible Director: Janet Cree- COO NWL CCG
Lisa Redfern – Strategic Director Social Care

Summary

The attached plan has been developed jointly between the CCG and the Council and submitted to NWL CCG.
The plan is a live document and is intended to develop over the next four months as the roll out of the vaccination programme continues. It also describes what activities are happening with community groups to support people in making decisions about having the vaccine.

There are risks as there are with most plans, mitigating actions are described. However, one of the greatest risk is any potential reduction of the volume of vaccine made available to the borough.

Recommendations

1. That the HWBB considers the plan and the proposed planning numbers to reach the community within the JVCI priority group.
2. That the HWBB considers and comments on the community engagement plan to support individual and communities who have concerns about the vaccine
3. The Board receives update at the next meeting on the progress

---

Wards Affected: All

H&F Priorities

Our Priorities	Summary of how this report aligns to the H&F Priorities
• Doing things with residents not to them	Through the pandemic we have our residents have remained the central focus to ensure we have services available, that are flexible and responsive to meet their needs. With that in mind the plan creates a range of opportunities available for people to access vaccines and seek information and advice.

• Creating a compassionate Council	We continue to make our voices heard in order to ensure we gain the commitment to the vaccine capacity, to protect our residents.
• Taking pride in Hammersmith and Fulham	We have led the way on several fronts through out the pandemic, we are proud to be able to offer high quality services, through such a devastating time.

Contact Officer(s):

Name: Sue Rooston
Position: Borough Director
Telephone: 07393 865332
Email : Susan.rooston@nhs.co.uk

Name: Linda Jackson
Position: Director of Covid
Telephone: 07776 673085
Email: Linda.jackson@lbhf.gov.uk

Background Papers Used in Preparing This Report

Not Applicable

NHS

h&f
hammersmith & fulham

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Borough Level Vaccination Plan

12/03/21

NHS England and NHS Improvement

Contents

Contents Current performance and changes in the last 4 weeks for cohorts 1-4

1. A description of our in-borough delivery model built on population need and community preference
2. Current plans to complete vaccinations in cohorts – a breakdown of remaining populations to be vaccinated and our specific plans to address these should be included.
3. A description of how we have addressed this in borough and what adaptations we have made to ensure access
4. Use of additional budget
5. A description of how are we managing and maximising the use of slots (across all cohorts)

1. Current performance

Please could you add in a summary table for the cohorts, the change in the last 4 weeks and comments on what has driven this change over this period

The table below indicates the current vaccination figures based on the NWL WSIC data until 14/03/21 with a comparison of the same data to 14/02/21 for the 80+, 75-79, 70-74 and CEV cohorts. The higher cohorts have seen incremental gains where time has been invested to tackle those who had initially expressed hesitation in receiving the vaccine. This has been complemented by increasing numbers of vaccinations in the CEV and below cohorts as vaccine supplies have increased. This increase in lower cohorts is recognised as an important step in increasing vaccination in the priority groups as family and community leaders increasingly receive vaccines and build confidence in the vaccination programme.

JCVI	Category	Eligible Pts	1st Vaccine	% vaccinated (to 15/03/21)	% vaccinated (to 15/02/21)
1	Care Home Resident	517	403	77.9% (coding issue – actual figure closer to 92%)	
2	Age 80+	5094	4052	79.5%	74.5%
3	Age 75-79	3975	3135	78.9%	77.7%
	Age 70-74	5709	4428	77.6%	76.9%
4	CEV	5568	3953	71.0%	54.2%
5	Age 65-69	5897	4077	69.1%	
6	Age 16-64 with underlying conditions	15732	6031	38.3%	
7	Age 60-64	6219	3541	56.9%	
8	Age 55-59	9505	3890	40.9%	
9	Age 50-54	12476	2148	17.2%	

2. Description of in-borough delivery model 1/2

Query	Data points	Approach
How have you built up your delivery model from your assessment of your population's and individual community's needs and preferences	**E.g. how the cohorts were segmented** Practices have worked collectively to work through the JCVI priority cohorts and where possible identified those at higher clinical risk. We have been data driven and used the intelligence from Wisic and power BI to track the take up and understand at ward level the variances and the socio economic factors that are affecting take up. With the mobilisation of a mass vaccination site within the borough and a pending request for additional pharmacy sites to be designated the delivery model has been adapted. The revised model continues to provide geographical coverage including the addition of sites in areas with lower vaccination rates but releases capacity at PCN sites to allow them to focus on engaging more hesitant individuals. Data is monitored on a bi weekly basis at the local Gold meeting, likewise the vaccination programme is subject to CEO, MD and political oversight every fortnight.	**E.g. how you went about focusing on different groups** The delivery model has been iterated to reflect the balance between the scale and pace of vaccination alongside effective prioritisation of the population and community groups. Progress through the cohorts has therefore been based on inviting those at highest clinical risk followed by periods of on-going engagement with more 'planned' invitations to provide the time to give information and support to those with additional needs. Subsequently additional delivery models have been organised to address specific individual and community needs through roving and pop-up clinic models to access those areas with lower vaccination rates. This revised approach will see an overall increase in vaccination capacity but see a shift to 75%+ of vaccinations being undertaken through the mass site rather than PCNs. The remaining vaccinations based at PCN sites will be continue to make use of roving, 'pop-up' or satellite models as preferences and engagement activities dictate to meet the current needs.

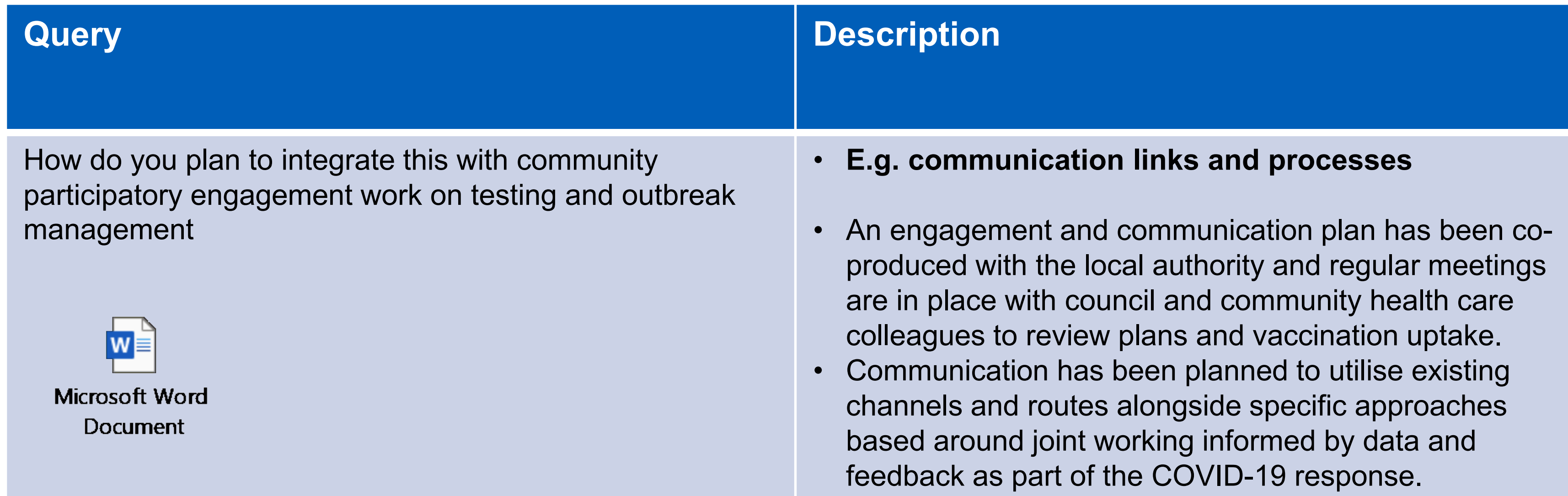
2. Description of in-borough delivery model 2/2

Query	Data points	Approach
Who are you “targeting” for delivery at each site and how is uptake in each community being tracked	**E.g. expected numbers at each site type versus actual** To date the vaccinations in H&F have all be planned through PCN sites due to the lack of a mass vaccination site within the borough. Moving forwards the majority of vaccinations are planned to take place through the mass vaccination setting as the cohorts become increasingly mobile. Additional models of delivery have been organised to make effective use of the workforce across the system ‘targeting’ vaccination based on individual and community needs including roving models and pop-up clinics in different wards within the borough or utilising community settings.	**E.g. communications used to encourage vaccination at a certain site type** **E.g. systems / meetings used to capture data and work out solutions** Vaccination invitations have been organised through practices to utilise the trusted relationships that exist within their local communities. This has been complimented by text invites to ensure that practice capacity is retained to support those who need additional information and those parts of the community where vaccination rates remain lower. PCN grouping and borough level meetings have been used to review take up across different groups and settings and identify different delivery approaches appropriate to those areas with lower vaccination rates.

3. Current plans to vaccinate remaining cohort

Cohort	Completed	Remaining	Specific plans for reaching the remainder
1 – Care Homes	403 (77.9%) WSIC coding issue – other data indicates this is closer to 92%	114 (22.1%)	• **E.g. how are you adapting your model of delivery depending on updates/learnings?** • **E.g. how are we engaging with these communities using a combination of hyper-local approaches?** • **E.g. how are you working with local government, VCSE and employers?** • Practices are continuing to engage with those who have yet to take up the vaccination recognising that a significant number of those who have yet to be vaccinated have indicated that they wished to wait rather than not wishing to be vaccinated. • LBHF are also undertaking welfare checks for a large number of local residents and as part of this process are discussing vaccination to tackle any hesitancy and provide additional information. Lists of those wanting vaccinations following these discussions are then shared with PCN sites to offer a vaccination slot • LBHF also started calls on behalf of PCN to encourage take up ahead of JVCI categories • Both borough and hyper-local discussions with local community groups and community settings to both provide education and information and look at opportunities for pop-up clinics where take up is low.
2 – 80+	4036 (79.4%)	1049 (20.6%)	
3 – 75+	3135 (78.7%)	847 (21.3%)	
4 – 70+	4416 (77.2%)	1301 (22.8%)	

4. A description of changes made locally for the future 1/2



Query	Description
How do you plan to integrate this with community participatory engagement work on testing and outbreak management Microsoft Word Document	• **E.g. communication links and processes** • An engagement and communication plan has been co-produced with the local authority and regular meetings are in place with council and community health care colleagues to review plans and vaccination uptake. • Communication has been planned to utilise existing channels and routes alongside specific approaches based around joint working informed by data and feedback as part of the COVID-19 response.

4. A description of changes made locally for the future 2/2

Query	Description
Have you got plans to build on this work to tackle other determinants of health inequity both medical (e.g. LTC management) and social **Key priorities arising out of Covid and what we've learned** •Greater focus on earlier intervention and reduction of impact on statutory services •Sustainable community engagement, building on vaccine equality conversations •We need to build on co-operative partnerships within Covid e.g. across primary care, secondary care, and social care and housing (no boundaries-person focussed) •Cause and effect approaches to strategic delivery •To be data driven in planning and decision making e.g. the work we have done using business intelligence to plan use of mobile testing and mass testing centres	• **E.g. longer term planning** • The vaccination programme and wider COVID-19 response has resulted in a strengthening of existing relationships along with the establishment of several forums at operational and strategic leadership across the borough. • The learning from the COVID-19 response has also resulted in a renewed focus on primary care at the centre of the ICP in H&F which will be used a building block to help address unwarranted variation across the borough through a supportive approach to PCNs.

5. Use of improvement support money

Please could you explain how you have already invested local funding to improve uptake and how you be how you plan to allocate this money to improve uptake for example incentivising GPs to have a clinical conversation with each of their patients who hasn't taken up the offer of the vaccine

	Description of investment	Total £	Date start	Date end	Targeted improvement
Already invested	Financial investment has not been committed other than income protection to release capacity in primary care to focus on vaccination and engage individual patients				
	In addition system resource has been used flexibly to provide support and enable an increase in the roving models of vaccination for those unable or unwilling to attend the PCN sites.				
	Similarly significant time has been invested across all partners to promote and carry out community engagement including a financial investment in a social media campaign.	£8k			
Additional funding	NWL Improvement Support Funding	£50k	15/03/21		• Developing plans with LBHF colleagues but will focus on tackling inequalities based on take up within different borough wards and demographics within the local population. • A task and finish group is being established to drive this work and continue to review the progress through a continuous improvement approach linking in with the NWL Vaccine Equity Group through LBHF colleagues.

6. How are you maximising the use of slots (all cohorts) 1/2

Query	Description
How are you managing the use of slots across all delivery types?	• **E.g. targeted approach** • To date local vaccination has been predominantly through the PCN sites with the mass vaccination site within the borough opening in mid-March. • With the opening of the mass vaccination centre the PCN sites have been prioritising the remaining individuals who have not yet received a vaccination within the priority cohorts 1-6. • Where additional vaccine supplies have been confirmed the PCN sites have then moved into the additional priority cohorts in order to avoid stockpiling vaccine. • Pharmacy sites and mass vaccination sites will compliment this approach by providing access to those who are able to travel and allow the PCN sites to work with those who are more hesitant or less able to travel.

6. How are you maximising the use of slots (all cohorts) 2/2

Query	Description
How do you optimise the use of the slots where they become available without going in to other cohorts	• **E.g. Using last minute availability** • PCN sites have generated lists of individuals that are able and willing to attend at short notice to ensure that wherever possible slots are optimised to ensure that vaccination is prioritised for the current target cohorts. • LBHF colleagues have further been supporting this work by a list of Social Care employees still to be vaccinated and undertaking welfare checks for residents and using this as an opportunity to identify individuals who have not received the vaccine and addressing any concerns that they may have preventing them taking this up. These lists are then shared with the GPs to undertake the clinical screening and offer a vaccination slot.

Agenda Item 7

London Borough of Hammersmith & Fulham

Report to: Health and Wellbeing Board

Date: 24/03/2021

Subject: Hammersmith & Fulham Integrated Care Partnership Draft Priorities

Report of: Margot Williams, H&F ICP Programme Manager

Responsible Director: Lisa Redfern, Strategic Director of Social Care and H&F ICP Board Co-chair

---

Summary

The Hammersmith & Fulham Integrated Care Partnership (H&F ICP) has now agreed five priorities, which aren't set in stone, to address through its work that meet the identified needs of residents across the life course, with a central aim of preventing and reducing health inequalities that have been exacerbated by the Covid-19 pandemic, building on the learning from the increased collaborative working between health, social care and community & voluntary sector partners during the last year. The priorities are:

- **Staying well** — We support people of all ages to live well and support communities and voluntary organisations to develop & mobilise support/community assets.
- **Living with illness** — Keep people of all ages well at home, avoid admissions unless necessary and ensure good transitions between care sectors.
- **All age mental health** — Partners unite to rapidly tackle the impact of Covid-19 on mental wellbeing across the lifecourse with a long-term focus on the development and delivery of holistic mental wellbeing support.
- **Recovery** — Restoration of health and care services based on learning from Covid-19 and most pressing needs.
- **ICP and PCN development** — Develop the ICP to be delivery focussed with PCNs at the heart of local communities.

Within the above priorities, the following have been identified as the immediate areas of focus:

- Diabetes
- Frailty
- Implementation of the mental health integrated network teams (MINT) model
- Health and wellbeing

The purpose of this paper is to present the draft priorities and areas of focus to the Health and Wellbeing Board for discussion and feedback to the H&F ICP.

Recommendations

1. The Board are asked to note the report and comment on the draft priorities and areas of focus.

Wards Affected: All

H&F Values

Please state how the subject of the report relates to our values – delete those values which are not appropriate

Our Values	Summary of how this report aligns to the H&F Priorities
• Building shared prosperity	*Brief details of any impact of the proposals in the report on businesses in the Borough*
• Creating a compassionate council	
• Doing things with local residents, not to them	
• Being ruthlessly financially efficient	
• Taking pride in H&F	
• Rising to the challenge of the climate and ecological emergency	

Contact Officer(s):

Name: Lisa Redfern

Position: Strategic Director of Social Care
Telephone: 020 8753 5218
Email: Lisa.redfern@lbhf.gov.uk

Background Papers Used in Preparing This Report

None.

1. Background

1.1 During the first peak of the Covid-19 pandemic in 2020, the H&F ICP paused its formal business to support partners in prioritising their operational responses. An alternative governance structure was put in place to facilitate the increased collaboration required between health and social care during this time.

1.2 The ICP resumed its formal business in September 2020 at a 'reset' meeting of its board, at which the Council was agreed as part of a new co-chairing arrangement, signalling a renewed commitment to working together with health, community, and voluntary sector partners to improve the health and wellbeing of H&F residents through the delivery of integrated care.

1.3 Since this time, the ICP has been engaged in 'resetting' its priorities to ensure it continues to address the health and wellbeing challenges in the borough and tackle the health inequalities highlighted by Covid-19.

1.4 To support a 'grass roots' approach the ICP has facilitated virtual workshops within three H&F primary care networks (South Fulham, Babylon GP at Hand and Hammersmith & Fulham Partnership) through their patient participation groups to understand the patient and resident perspective on integrated care and inform the renewed areas of focus. Workshops for the remaining two PCNs, Central and North, were, at the time, unable to progress due to Covid and plans are in development to support their engagement through alternative forums.

1.5 Alongside these developments, the North West London Integrated Care System (NWL ICS) implemented a leadership framework for borough partnerships across the North West London sector, known as ICP Leadership 'quartet' teams. These teams are comprised of a lead from social care, community services, primary care and mental health, supported by the local CCG Borough Director and one of the 'quartet' members assuming an overall Borough Lead position, responsible for the development of integrated care on behalf of the ICP.

1.6 Signalling a further commitment to partnership working and driving local integration, the new Leadership 'quartet' Team has agreed to facilitate a key development for the ICP that places the ICP Board as central to the

arrangements for the delivery of integrated care, with a greater focus on preventing and reducing health inequalities in the borough. It is also intended that through the evolution of the current ICP governance arrangements, the ICP Board will have a clear link to the Health and Wellbeing Board.

1.7 In March 2021, the ICP facilitated a board development session, led by its co-chairs, at which all partners were asked to participate in discussions about the development of future priorities based on the outputs of the PCN workshops, board conversations, individual organisational aspirations for integrated care and learning from the Covid-19 response.

1.8 The ICP recognises the value of the learning gained from the Covid-19 response and the importance of building on collaborative programme such as the vaccine hesitancy work between health, social care and the community & voluntary sector, as an example.

1.9 The draft priorities and areas of focus are intended to reflect the new ways of working outlined above, with a shared committment to embed the learning from recent months and build on the increased collaboration between sectors to develop partnership approaches to tackling health inequalities.

2. Next steps

2.1 To maintain the momentum built in recent months, the intention is to evolve the current ICP governance arrangements to facilitate rapid work-up of the areas of focus and continue to develop the ICP as the forum in which plans are agreed to further integration across the borough, with a clear link to the Health and Wellbeing Board.