London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 14 March 2022 at 6.00 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 Larry Culhane - Cabinet Member for Children and Education
Carleen Duffy – Healthwatch H&F Manager
Philippa Johnson - Central London Community Healthcare NHS Trust
Dr Nicola Lang - Director of Public Health
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
DI Luxan Thurairatnasingam – Metropolitan Police

Nominated deputy members
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
Nadia Taylor – H&F, Healthwatch Representative

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Date Issued: 05 March 2022

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

Item **Pages**

1. APOLOGIES FOR ABSENCE

2. ROLL CALL AND DECLARATIONS OF INTEREST

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.

3. 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 Monday, 13 December 2022; and

(b) To note the outstanding actions.

4. TACKLING HEALTH INEQUALITIES 14 - 17

Vaccine reluctance has shone a stark spotlight on the long-standing problem of lack of trust in our health services by many Black and minority ethnic residents (whether general public or NHS employees) as a result of their lived experience over the years of worse access, treatment and outcomes. An essential component relates to addressing health inequalities and this item is an introduction to the work that the borough is undertaking to address this.

5. PHARMACEUTICAL NEEDS ASSESSMENT 18 - 19

This report presents the program of work required to undertake a Pharmaceutical Needs Assessment (PNA) for the London Borough of Hammersmith & Fulham to ensure that the Health and Wellbeing Board meets its statutory requirement to publish a PNA by October 2022.

6. COVID-19 UPDATE

This verbal report from the Director of Public Health and the Director of Covid-19, provides an update on the council's Covid-19 response.

7. WORK PROGRAMME

The Board is requested to consider the items for future meetings.

8. ANY OTHER BUSINESS

9. DATE OF NEXT MEETING

The Board is asked to note the date of the next meeting on Thursday, 16th March 2022.

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Draft Minutes

Monday 13 December 2021

PRESENT

Board Members:
Councillors Ben Coleman (Chair)
Vanessa Andreae - H&F CCG (Vice-Chair)
Dr Nicola Lang - Director of Public Health, LBHF
Lisa Redfern - Strategic Director of Social Care, LBHF
Sue Roostan - H&F CCG
Glendine Shepherd - AD for Housing Management, H&F
Detective Inspector Luxan Thurairatnasingam - Met Police

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

Officers and guests:
Lucy Allen, CIS, CNWL
Janet Cree, COO, NWL CCGs
Caroline Durack, NWL CGG
Dr Christopher Hilton, West London NHS Trust
Jim Grealy, HAFSON

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr James Cavanagh, Councillor Larry Culhane, Philippa Johnson and Sue Spiller.

2. ROLL CALL AN DECLARATIONS OF INTEREST

None.

3. MINUTES AND ACTIONS

The Chair confirmed that the actions from the previous meeting would be addressed within the order of business.

4. PUBLIC PARTICIPATION

None.

5. COVID UPDATE

5.1 Councillor Ben Coleman welcomed NHW health colleagues who provided a Covid update against the background of the government response on the emergence of the highly transmissible Omicron variant of Covid-19.

5.2 Sue Roostan explained that the timing of the meeting was welcome given the Prime Minster's announcement on 12 December 2021 to offer vaccinations to all by the end of December. Logistically a range of measures would need to be implemented to support the additional requirement. A group of health and local authority officers would work within the borough partnership to deliver the offer and manage the vaccine roll out. The speed of the announcement presented difficulties in mobilising resources to deliver the expected increase in excess of 200k vaccines per week by the end of the year.

5.3 This was a huge task and require considerable resources utilising a mixed local delivery model with four borough hubs, clinics and pop ups, and 10 community pharmacies. It would be supported by focused communication messaging and engagement. Sue Roostan clarified that some clinical and administrative changes were currently being considered by government which would support a rapid delivery of the programme, some of which concerned vaccine supply and the removal of the Pfizer, 15 minute wait time, post vaccination. This would enhance the through flow of people, speed up the process and increase capacity. In terms of capacity, it was reported that pharmacies at this time could offer 8-10 slots per day. It was anticipated that this would be used to capacity soon and lifting the cap on pharmacies was an additional option to consider (it was later confirmed that it was highly unlikely any more pharmacies will be approved).

5.4 There would a focus on vaccinating those in care homes and who were house bound, and progress on this had been positive. House bound vaccinations had routinely continued, supported by primary care district nurses, although this could be speeded up if the 15 minute time was lifted. Non-essential CCG down would be stepped down from their current roles and redeployed to support vaccination delivery sites and military support would also be mobilised. In the context of military support, Lisa Redfern highlighted the size of the Northwest London Integrated Care System (ICS) footprint supporting 2.3 million people across the region, making it one of the largest ICS programmes nationally.

5.5 Councillor Patricia Quigley received an assurance from Sue Roostan that the decision to remove the requirement for a 15 minute waiting time would be a clinical decision taken by the Chief Medical Officer balanced against the need to locally deliver over 200k vaccine doses weekly. In response to a follow up question from Councillor Coleman, Vanessa Andreae briefly explained that in her clinical experience there was a very low probability of a person having either an anaphylactic or vasovagal (fainting) reaction. The 15 minute wait time would not be removed if it was not safe or in the best interests to do so.

5.6 Jim Grealy referenced the significant figure of 200k people and asked what the current shortfall in numbers were, which Sue Roostan agreed to provide

following the meeting. Clarification about the technical problems with the booking system was sought, most likely prompted by a sharp increase in demand for bookings following the government's announcement. To set the ask in context, in a successful week, 130k doses had been given in one week, and so the requirement was to almost double this over the next two weeks. Definitive plans would be formulated within the coming 24-48 hours to mobilise vaccine sites.

ACTION: Sue Roostan to share figures about the short fall between the number vaccinated and those yet to be vaccinated in the borough

5.7 Councillor Coleman reminded the meeting of previously raised concerns about the closure of pop up sites, capacity and the lack of vaccinators. Sue Roostan explained that in the previous week pharmacy capacity had been 70% utilised and that there had been availability at both 145 King Street and the West12 Shopping Centre sites. However, any spare capacity could become quickly absorbed and other clinical priorities would be reduced in order to increase the capacity to deliver the booster programme. It was clarified that there would be a movement of staff and resources around the system to ensure that the hubs were staffed but that there would be no "new" vaccinators. Janet Cree added that it took time to redistribute and co-ordinate staff resources who were currently engaged in other clinical activities. The NHS had issued a call to trained vaccinators and volunteers and this would ensure staffing for the next three weeks.

5.8 Councillor Coleman recognised the inherent difficulties in responding to a challenging and unpredictable situation and asked how long it would take to mobilise resources to provide booster vaccines within the borough. Sue Roostan confirmed that two hospital sites at Hammersmith and Charing Cross hospitals would shortly go live with extended hours to deliver the booster offer This would be publicised following confirmation.

5.9 DI Luxan Thurairatnasingam commented on the pattern of vaccine take up and with some groups likely to refuse vaccination. Similarly, there were difficulties experienced by those who were unregistered, homeless or asylum seekers in getting vaccinated. Sue Roostan was unable to provide an exact figure as to the unvaccinated proportions within the borough however, there was a local offer to vaccinate non-visible and vulnerable health groups within the population, without the need to be registered. Dr Lang confirmed that there was great provision for schoolchildren and younger people, the homeless and those accommodated in local refugee hotels.

5.10 There had been many conversations about vaccine hesitancy, and it was acknowledged that there would a small percentage that would continue to refuse the offer. Tackling this was an ongoing challenge and would take time to address. It required a hyperlocal approach and the CCG had worked with Dr Nicola Lang's team to support this work. Currently, 61% in the borough had received a first dose, compared to approximately 90% nationally, and 20% had received a second dose compared to 40% nationally. Dr Lang felt that there was a change in attitude, with communities now coming forward. The message provided to a recent faith forum meeting had been that it was

never too late to get vaccinated. The emergence of Omicron had prompted a change of view and it was encouraging to see 70 or 80 people a day receiving their first dose. Sue Roostan reported vaccine uptake data for the week ending 10 December, with 676 receiving a first dose, and 924 receiving a second dose. The offer of the vaccine was “evergreen” meaning that it would be available at any time, for the benefit of those who changed their minds.

5.11 Glendine Shepherd reported that there had been a positive uptake of the vaccine offer those who were homeless, and this was significantly higher than average compared to other local authorities which was a positive and well regarded achievement. Much had been done to mitigate including the provision of self-contained accommodation. At the last rough sleepers count only two individuals had been found and both had declined the offer of accommodation.

5.12 Vanessa Andreae addressed an earlier comment about providing vaccinations to those that were house bound. She had recently arranged home visits for five of her patients, which included a family group of which three vulnerable members of the same household had non-visible learning disabilities, who lived in poor housing accommodation and were reluctant to venture out of the house. It had taken three consecutive afternoons of her time to arrange for them to receive their first dose of the vaccine. Those with learning disabilities would not usually be included within the definition of house bound however, Vanessa Andreae clarified that in her experience of running pop up clinics for her learning disabled patients, there was a need to continuously review this approach and support identifiable needs as they emerged. This was constrained however, by the 15 minute waiting time. Other hindrances included limited space and one way flows in surgery waiting rooms which made it challenging to deliver vaccination at pace.

5.13 Given the anticipated removal of the 15 minute wait time Nadia Taylor sought further clarification and assurance about safe storage and transportation protocols for Pfizer vaccines and whether their efficacy would remain. She also enquired about the training offered to vaccinators and what it involved. Sue Roostan confirmed that the protocols for storing and transporting Pfizer vaccines was stringent and included the use of cool bags and boxes. Any unused vaccines were discarded and disposed of, and the difficulties in managing this for house bound and care home visits was noted. It was also confirmed that it was not necessary for a vaccinator to be a clinician and that the training involved online, and practical training underpinned by a competency framework. Volunteers were also needed to help with the safe storage and transportation of the vaccine once they had been trained in line with strict pharmaceutical protocols. Councillor Coleman queried the lack of requirement to be a clinician in order to vaccinate, as he had been repeatedly advised that this was necessary. It was confirmed that clinical qualifications were not necessary, provided vaccinator training was successfully completed. Candidates for training were often students or non-clinical CCG staff and the delivery of training sessions required logistical planning.

5.14 Vanessa Andreae’s approach to vaccinating those with non-visible disabilities was welcomed and commended by Councillor Lucy Richardson. She asked if

there was a policy in place to allow the siblings of those with learning disabilities or for families to receive their vaccinations at the same time, or if this relied upon the discretion of the GP. Sue Roostan welcomed this approach and confirmed that it could be possible to arrange for a whole family to be vaccinated at the same time if the individual members fell within the eligibility cohorts. The JCVI (Joint Committee for Vaccination and Immunisation) framework had constrained intuitive delivery due to the need to adhere to the strict eligibility requirements. However, if each family member met the eligibility framework and 3 months had elapsed from their second dose then this would be feasible. Additionally, Vanessa Andreae confirmed that a family member who had not had their first or second dose could also be accommodated at the same time, depending on the circumstances.

5.15 Caroline Durack described what working life was like for GPs, and how this might be affected by the recent announcement. There had been a considerable increase in activity to mobilise delivery plans through the Primary Care Network (PCN) hubs. There were significant concerns about the impact on staff and there were still many surgeries with staff on sick leave and in recovery from long Covid. Concerns about negative tabloid and social media coverage about access to primary care which was anticipated to resume following this current wave of vaccinations were also highlighted. GP practices needed support at this time, particularly as it would be necessary to redeploy staff to mass vaccination sites. Working closely with the CCG to plan and deliver online training, she explained that it was possible for anyone to be supported to undertake training as a vaccinator.

5.16 The issues around support for primary care staff were explored, Councillor Coleman offered support and stated that health staff were currently working under significant pressure without respite and that vitriolic attacks were unhelpful and unfair. Caroline Durack added that there were concerns about staff retention across the borough was a pre-existing issue and which hindered swift mobilisation. England currently had the lowest number of practice nurses per head of population and the GP Federation were currently involved in a piece of work which aimed to address this. It was noted that the NWL ICS was one of the largest nationally serving 2.3 million people. There was support for escalating a request to NWL to increase the number of military support teams allocated to the area from 2 to 3, and a further request for trained vaccinators. It was recognised that the mobilisation of limited resources in a way that was both strategic and agile was the challenge.

ACTION: Sue Roostan to escalate a request for increased military support and additional resources through NWL channels

5.17 DI Luxan Thurairatnasingam observed that there was a need to counteract the misinformation about vaccination, vaccine content and the negative influence of anti-vaxers. Sue Roostan explained that there was a wealth of information available on NHS and UK Health Security Agency (previously known as Public Health England) websites about vaccine content but acknowledged that many people did not trust “official” sources of information.

5.18 Given the recent emergence of Omicron it was becoming clear that it would take longer than three weeks to manage the roll out of boosters as well as first and second doses. Jim Grealy asked what messaging, support and advice was being offered to local businesses about prevention measures. Dr Lang acknowledged that ensuring compliance with safety protocols such as mask wearing and social distancing was difficult, however businesses were being reminded and supported by H&F Environmental health officers to undertake checks, monitor and provide advice and support. Posters had been commissioned with messaging provided in key languages: English, Polish, Arabic, Somali and Farsi. These would be located at strategic points around the borough. Dr Lang observed that there had been a change in behaviour since the pandemic began and that this was reflected in a lower level of compliance with preventative measures such as mask wearing.

5.19 Councillor Coleman sought further information about flu vaccine uptake. Sue Roostan confirmed that figures for flu vaccine uptake were not as strong as for Covid vaccination and significant efforts were being made to address this. The co-administration of flu and Covid vaccination had been previously discussed by the Board and it was confirmed that refreshed data about this was expected. It was noted that the CCG had queried whether the borough's pharmacy data had been included in the Whole Integrated System Care (WISC) dashboards. Data for 2021 showed an uptake of 22%, lower than the previous year's take up which was 36% so there was much work to be done. By contrast, the take up in care homes was at 80%, and GP at Hand was at 28%. There was an opportunity to co-administer the flu vaccine, to offer or promote it at the same time as the booster programme.

5.20 Councillor Coleman shared his experience of receiving a booster jab and suggested that he should have been asked the question as to whether he would like a flu jab at the same time. There was also anecdotal evidence to indicate that requests for co-administering the flu and booster jab were being declined and that it was important to ensure that it was being offered. Sue Roostan acknowledged that further work was necessary to understand systemic vaccine hesitancy. Lisa Redfern cautioned that it should not be assumed that people have an awareness about vaccine booking systems as even some staff within the NHS lacked awareness.

ACTIONS: Vanessa Andreae to follow up about how those who were vaccinating could explore having a flu jab with the person receiving the booster jab; Jo Ohlson to follow up within the ICS on the issue of NHS staff awareness about flu jabs.

RESOLVED

That the verbal update and arising actions were noted.

6. PROGRESS UPDATE ON TRANSITION TO THE INTEGRATED CARE SYSTEM

6.1 Councillor Coleman provided a brief overview of the move towards a health administrative system which would see the decommissioning of clinical

commissioning groups (CCGs) and the creation of a new integrated care partnership board to support an integrated care system (ICS). The ICS would co-ordinate the delivery of local health services to 8 north west London boroughs and represented the coming together of different parts of the NHS.

6.2 Jo Ohlson explained that the current system of CCGs would be disbanded in February 2022 subject to parliamentary approval of the legislation and any delay would see the CCGs continue as a statutory body. The terminology was also in the process of being agreed but it was anticipated that there would be two statutory bodies established. Robert Hurd had been appointed as the chief executive officer of the ICS and would replace the interim CEO, Lesley Watts, and he had already begun to meet with colleagues ahead of his start date on 6 January 2022. The ICS anticipated the appointment of a chief nurse and a draft constitution had been prepared which specified a constitutional membership governance mandate, as specified by NHS England. In terms of ICS priorities, it was reported that delivering the areas Covid response was key. Numbers of Covid cases were increasing exponentially and this coincided with winter pressures, exacerbating concerns about increased susceptibility to flu caused by low immunity.

6.3 Councillor Coleman observed that the ICP had made successful progress, beginning slowly at a senior level and had gathered momentum with signs of improved communication on multiple levels. At the same time the disproportionate impact of health inequalities minority ethnic communities, had been recognised. The NHS, and NWL in particular had acknowledged that structural racism existed and was endeavouring to working directly with black communities, a bold decision which was commended. Exploring the configuration of the ICP board, Jo Ohlson confirmed that there would be improved local authority representation on the board and recognised that the integration of partners and the integration of component parts of the NHS were both equally challenging.

6.4 Part of the change process would involve the development of provider collaboratives and this would be considered both in acute mental health services and community collaboratives to ensure a greater convergence in service standards and delivery. This would not necessarily dilute services and Jo Ohlson described a detailed piece of work in community nursing and the delivery of intravenous fluids where small refinements had allowed people to remain in their homes whilst being treated. Other refinements included improved rapid response times to urgent care cases which had helped to alleviate pressure on the London Ambulance Service.

6.5 Jacqui McShannon confirmed that despite challenges in Children's Service, there had been improved partnership collaboration at a local, placed based borough level. There had been a greater inclusion of local authorities and this would continue to evolve despite some false starts and challenges to overcome. There had been a welcome commitment from health colleagues which indicated a positive direction of travel. Children's Services could not be an isolated voice and greater advocacy was required throughout the collaborative and newly integrated system. Jacqui McShannon welcomed the establishment of a dedicated team on children and mental health, together with the implementation of a new board that would report to the ICS and

HWB. Greater clarity was anticipated as the terminology and systems links between the new and evolving statutory bodies still caused confusion. Sue Roostan recognised that there were challenges and a decision had been taken within the ICP to have an all age framework throughout the different campaigns, including for example, frailty campaign. She assured the Board that the ICP had taken a decision to identify four campaigns to allow greater focus and prioritisation but it would continue to monitor and review the possibility of having a children and young peoples' specific campaign in the future.

6.6 Janet Cree echoed comments about the ICP perspective regarding the children and young people's programme. The ICP was drawing upon existing learning and experience to work increasingly more closely with children's services in the local authority. Communication channels would continue to be monitored to ensure greater clarity and sharing of information at a local level and which would feed into the NWL ICP programme. She acknowledged the challenges articulated by Jacqui McShannon to ensure that there was clarity about care being delivered and that this covered all ages but that this could also be specifically children focused where required. There had been a sense of change within the ICP as it reorientated towards working across the whole ICS system and a small example of this was a weekly meeting within the gold meeting system regarding paediatrics to report the challenges that might be experienced.

6.7 Councillor Coleman referenced the current NWL palliative care consultation, which was expected to conclude on 23 February 2022, and highlighted the different approach required for children's palliative care compared to adults. He enquired if this would be acknowledged within the consultation framework. Janet Cree confirmed that the consultation was focused on specialist adult palliative care and acknowledged that there was a different approach to how children's end of life care was managed and supported. However, this would not preclude an all age approach as benchmarking work would be undertaken to ensure that the service aligned to national standards.

6.8 Lisa Redfern asked which healthcare priorities and services would be scaled back or paused while the booster delivery programme was prioritised. Jo Ohlson confirmed that this was a rapidly moving situation and that further communication about primary care priorities about this was expected imminently. Some guidance had just been issued about clinical priorities but these would need to be followed up. The guidance letter had confirmed that a level four incident had been declared and that the booster vaccination programme would be prioritised for the next three weeks. In addition, resources would be used to support emergency care pathways and there was currently a review underway to identify the most urgent priority cases for elective surgeries. Whilst that they would try to keep many services going as possible, what this translated to in real terms was that there would a reduction in non-urgent outpatient services with staff redeployed to deliver the booster campaign. Primary care GPs had been contacted and requested to support a doubling up of the booster campaign and additionally, to continue to support urgent and emergency care pathways. The expectation was that practices would continue to be accessible but that they would also identify the most

vulnerable patients, including for example, asthmatic children. Further information about priorities was expected and these would be reviewed again in January.

6.9 Exploring the logistics around supporting the delivery of the booster programme, Councillor Coleman focused on the need to have more people trained to vaccinate, which would release GPs to continue to deliver primary care. Jo Ohlson stressed that delivering the booster programme presented a huge logistical challenge to scale up the programme to deliver the expected increase of 250k vaccines per week and this extended beyond the provision of GPs. It also required a significant increase in the number of vaccinators and vaccine supplies. Councillor Coleman asked if a request for vaccinators was made, would there be sufficient resources available to train them. He indicated that council staff within the borough would be willing to respond and support such a request. Janet Cree confirmed that there was limited capacity to train more vaccinators to vaccinate within the next three weeks and that they were currently trying to deploy trained staff as efficiently as possible. There would be a period of mobilisation to meet the surge in demand, followed by inactivity so it was important to maintain consistent and clear messaging. Vanessa Andreae commented that GPs had oversight of lay and clinical vaccinators which comprised of nurses, students and non-clinical health staff and she expressed her concern that routine primary care services would be in hiatus during this time. There would be further delays to non-life threatening conditions and treatments which would be difficult and frustrating for those having to self-manage their conditions.

ACTION: Sue Roostan to circulate details about vaccinator training

6.10 Jim Grealy sought clarification about the frequency of ICP and ICS governance meetings and the differences of this. In the context of 'power of place' he also noted the lack of reference to H&F patient group meetings. There had been a proud history of coproduced bottom up health engagement in the borough but there continued to be a lack of trust from patients who were concerned about the vaccine. In the current situation, social distancing may increase and so it was important to include a local aspect. Jo Ohlson recognised the borough as the place for local service delivery and that NWL priorities would be structured to reflect to ensure a locally strategic allocation of resources and decision making. The development of local standards for community services such as primary care, mental health and access to care homes reflected place based delivery so that residents would know what to expect to receive either in a care home or from a GP consultation. It was important to understand the variation in local conditions and coproduction was key, particularly in terms of supporting minority ethnic groups and disabled people.

6.11 Councillor Quigley commented on the prime minister's announcement at short notice to deliver the booster programme by the end of December. There was a collective responsibility to provide clearer, strategic guidance to ensure that expectations could be properly managed. She shared her fears and anxieties as person who had been advised to shield and had received her booster, however, there were many who were unsure of what to expect over next few

weeks. Sue Roostan assured Councillor Quigley that she and her colleagues had a strong awareness of the collective responsibility around vaccine delivery and planning and that they were committed to implementing a plan of action for H&F. While it was recognised that the discussion had circulated back to the issue of Covid dealt with earlier, Councillor Coleman welcomed the commitment of health colleagues who had advocated so strongly on behalf of the borough and the needs of its residents. He reiterated his view that the number of hubs and vaccinators available in the borough need to be urgently revisited.

RESOLVED

That the report and actions were noted.

7. WORK PROGRAMME

Councillor Coleman reminded members to review the Better Care Fund report for 2022 (circulated). This had been agreed in principle but would require collective formal approval from the Board at an in person or hybrid meeting on 14 March 2022 (subject to any further temporary Covid regulations to facilitate statutory decision making at virtual meetings). It was noted that the palliative care response would be considered and prepared by the Health, Inclusion and Social Care Policy and Accountability Committee. The following items were agreed:

- Long covid support
- GP surgeries
- Better Care Fund (approval)

8. ANY OTHER BUSINESS

Vanessa Andreae reported on a piece of work on improving access to primary care and how positive and helpful it had been to have input from a social worker to support the work of the frailty multi-disciplinary team. This was welcomed as an approach and it was hoped that it could be replicated with other areas of work within the PCN.

9. DATES OF NEXT MEETING

Monday, 14 March 2022.

Meeting started: 6pm
Meeting ended: 8pm

Chair .....

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London Borough of Hammersmith & Fulham

Report to: Health and Wellbeing Board

Date: 14 March 2022

Subject: **TACKLING HEALTH INEQUALITIES**

Report author: Roy Morgan, Head of Wellbeing and Transformation

Responsible director: Linda Jackson, Director of Covid 19

Wards Affected: All

H&F Priorities	**How this report aligns to H&F Priorities**
Creating a compassionate council	Working with communities to address needs and concerns
Doing things with local residents, not to them	Engaging and co-producing with local residents and community groups
Being ruthlessly financially efficient	Using existing council services and resources to assist with delivery plan
Taking pride in H&F	Ensuring that all H&F residents get equal access, treatment and outcomes from local health services, regardless of their background.
Rising to the challenge of the climate and ecological emergency	All events and activities will aim to maximise energy efficiency.

1. Summary

The Covid-19 pandemic has both increased health inequality and shone a spotlight on it. The proportion of our Black and minority ethnic residents who are reluctant to take the Covid vaccine has exposed a long-standing lack of trust and confidence in the healthcare system as a result of lived experience.

If we want to tackle differential health outcomes, we need to build confidence and trust with our communities. To do that, we need to work with and truly understand our communities, their different views and cultures and their experience of our services. We need to work together to come up with co-produced solutions that influence long-term change and start to tackle our differential outcomes.

This report sets out the national, regional and borough context and proposes a way forward.

2. Covid spotlight on ethnic health inequalities

The Covid-19 pandemic has both increased ethnic health inequality and shone a spotlight on it.

At the height of the Covid-19 pandemic, H&F Council and Imperial College Healthcare NHS Trust (Imperial) ran a 90-day series of rapid improvement events with community health providers and residents to understand why Black and minority ethnic residents were disproportionately (in terms of their share of the population) reluctant to have a Covid vaccine. These events were well attended and provided a safe space for sharing experiences.

From these conversations and others during the pandemic, it is apparent that an important element of vaccine reluctance stems from the long-standing lack of trust which many Black and minority ethnic residents feel in the NHS and local and central government as a result of what they and their family and friends experience on a daily basis.

Numerous studies support this view. It is now generally recognised that if you come from a Black, Asian or other ethnic minority background, you can find it harder to access healthcare, receive a high quality service and get a good health outcome.

Vaccine reluctance cannot be addressed without addressing this root cause.

3. National imperative

A report from the **NHS Race and Health Observatory (RHO)** published on 14 February 2022 found *"widespread ethnic inequalities… as well as ethnic inequalities present for the NHS workforce."* [1]

In his introduction to the report, RHO Director Dr Habib Naqvi stated:

> *"By drawing together the evidence, and plugging the gaps where we find them, we intend to make clear the overwhelming case for radical action on race inequity in our health service. Put another way, we exist to remove excuses. This report represents a foundational step in our development."*
>
> *"This report is the first of its kind to analyse the overwhelming evidence of ethnic health inequality through the lens of racism. A process that, until recently, our leaders have shied away from…. There is no excuse for inaction."*

[1] The RHO is supported by NHS England and hosted by the NHS Confederation. Its report *Ethnic Inequalities in Healthcare: A Rapid Evidence Review* presents the findings and recommendations of a rapid review of ethnic inequalities in healthcare and within the NHS workforce, conducted for the RHO by academics at The University of Manchester, The University of Sheffield and The University of Sussex. The review looked at mental healthcare, maternal and neonatal healthcare, digital access to healthcare, genetic testing and genomic medicine and the NHS workforce. See https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf.

On 1 October 2021, a new **Office for Health Improvement and Disparities (OHID)** was launched within the Department of Health and Social Care (DHSC). This has the aim of *"levelling up health disparities to break the link between background and prospects for a healthy life."*

The OHID intends to focus *"on those groups and areas where health inequalities have greatest effect"* and to work across the DHSC, the rest of government, the healthcare system, local government, communities and industry.

As they develop across the country, Integrated Care Systems are being encouraged by NHS England and NHS Improvement (NHSEI) to reduce health inequalities by taking a **Core20PLUS5** approach.[2] NHSEI describe this as *"the NHS contribution to a wider system effort by Local Authorities, communities and the Voluntary, Community and Social Enterprise sector to tackling healthcare inequalities – [it] aims to complement and enhance existing work in this area".*

4. North-West London commitment

H&F Council is supporting the North-West London Integrated Care System (NWL ICS) as it plans to transform care over the next five years to ensure greater equality of access, experience and outcomes.

The work will include acknowledgment of structural racism as one of the key causes of current health inequalities. There will be a commitment to listen to and work with Black and minority ethnic communities to develop solutions that influence long term change and tackle differential outcomes and experience.

5. Hammersmith & Fulham action

Achieving genuine change on the ground will require a new approach towards how services are shaped and provided. This will depend on residents, community groups, the NHS and the council being able to work together in a new way in authentic co-production.

H&F Council aims to play a full, constructive role here with residents and health partners. In January 2022, the council was successful in bidding for new funding from the Department of Levelling Up, Housing and Communities (DLUHC) and NHS England for projects to tackle vaccine reluctance and address the inequality barriers facing target communities around NHS access, treatment and outcomes.

Under the working title of *"Building Trust Within Sceptical Communities"*, a steering group made up of local community organisations and the council has been exploring how best to end health inequalities and address vaccine reluctance.

[2] See https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Its view is that at the heart of our activity should be bringing together (in workshops, focus groups, etc.) Black and minority ethnic residents who use health services with those who provide the services. These events will explore people's lived experience of unequal treatment and outcomes and enable service providers to hear at first hand where the system is failing.

The ultimate outcome will be a co-produced improvement plan which identifies what needs to change and recommends how best to effect change so as to ensure a truly equal health care system.

It will be essential that conversations are meaningful in that they are perceived as leading to positive change, which will in turn build trust and confidence. If they prove to be only another talking shop, participants are likely to have their trust further undermined and their scepticism deepened.

It will also be important to structure this work in the right way from the beginning, with the NHS, council and community partners all making a commitment to work in a co-produced way.

A wide range of residents will need to be involved, including those who may have been poorly reached in the past.[3] Priority target groups will include Black Caribbean, Somali and other Black African communities. We will also wish to work in close collaboration with NHS-led initiatives, such as that being planned by Imperial.

Initial engagement will involve existing third sector organisations, five new Community Health Champions (to be recruited) and existing council outreach work, supplemented by new communication activity. Opportunities provided by existing programmes, such as scheduled sessions run by the council's sports development team, will be explored.

6. Next steps

We look forward to the Health and Wellbeing Board's views on the approach set out here and how we can most effectively work together to achieve the shared aim of ending local ethnic health inequalities.

[3] Note: the term *"hard to reach"* is often wrongly used to describe people who do not engage with services. We dislike this term as it places the blame on them. We prefer the term *"poorly reached"* as this recognises the responsibility of those providing services to engage proactively with the people who most need them.

LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Well Being Board

Date: 14 March 2022

Subject: Hammersmith and Fulham Pharmaceutical Needs Assessment

Report author: Nicola Ashton, Strategic Commissioner

Responsible Director: Lisa Redfern, Strategic Director Social Care

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SUMMARY

This report notes the requirement for the Health and Wellbeing Board to develop and publish a Pharmaceutical Needs Assessment (PNA) for Hammersmith and Fulham by October 2022 and sets out the process for developing and delivering the PNA.

RECOMMENDATIONS

1. For the Health and Wellbeing Board to comment and note the statutory requirement to develop and publish an updated Pharmaceutical Needs Assessment (PNA) by October 2022.

Wards Affected: All

DETAILED ANALYSIS

1. Health and Wellbeing Boards are required to publish and maintain a Pharmaceutical Needs Assessment by virtue of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012.

2. PNAs are a statement of the need for pharmaceutical services of the population in a defined geographical area (i.e. the area covered by the Health and Wellbeing Board).
3. PNAs are an important market entry tool. Anyone who wishes to provide NHS pharmaceutical services in a given area must apply to NHS England (NHSE) to be included on the local Pharmaceutical List and prove that they are able to

meet a pharmaceutical service need. The local PNA is used by NHSE to make such decisions in response to any applications.

4. PNAs are also used by commissioners to make decisions on which funded services need to be provided by local community pharmacies.
5. All Health and Wellbeing Boards were required to publish their first PNA by 1st April 2015, and then to publish a new PNA every 3 years. The current PNA for Hammersmith and Fulham was published in 2018.
6. Under the existing NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the "2013 Regulations"), the next PNA was due to be published by April 2021. However, this was extended to October 2022 due to the Covid19 pandemic
7. When producing a PNA, Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once (and for a minimum period of 60 days). These bodies are:
    - Local Pharmaceutical Committee;
    - Local Medical Committee;
    - Any persons on pharmaceutical lists and any dispensing doctors;
    - Any Local Pharmaceutical Services chemist in the area with whom NHS
    - England has made arrangements for the provision of any local pharmaceutical services;
    - Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest;
    - Any NHS trust or Foundation Trust;
    - NHS England
    - Any neighbouring Health and Wellbeing Boards.
8. To deliver the PNA for 2022 a specialist provider has been appointed in accordance with Contract Standing Order 9 (CSO 9). The advertising and competition process was followed and three quotes were sought from the market through the e-tendering service. Healthy Dialogues have been appointed to support the production of the PNA.
9. Delivery will be monitored closely by an established PNA Steering Group which will include representation from key stakeholders including the Local Pharmaceutical Committee, NWL Clinical Commissioning Group, and Healthwatch.

LIST OF APPENDICES

Appendix 1 – Production of the Hammersmith and Fulham Needs Assessment