Report of an independent review of Westminster City Council's Pandemic response including the local uptake of Covid-19 vaccinations

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Executive summary

This report summarises the findings of an independent review of the council wide Covid-19 pandemic response by Westminster City Council (WCC), conducted by Professor Jill Manthorpe CBE, at the request of WCC. The review was requested to focus on health and care services and the people at the heart of these.

It concludes that there is evidence of systems and processes that worked as well as they could in the unprecedented time of a global pandemic and states that these will be helpful in shaping responses to any future infection outbreaks or disasters through local emergency preparedness.

Key points are highlighted:

- The Council's responses clearly built on many long-standing initiatives and ways of working such as community engagement and effective working practices with its neighbours and local NHS bodies.
- Positive relationships with new NHS structures look set to maintain the focus on improving patient registration data and the Council may wish to seek progress reports on this matter. This might provide greater confidence about decisions on the allocation of resources and priorities to address inequalities.
- WCC played a major role in pan-London activities during the pandemic and benefitted from London's pooled expertise in planning and response. Many of these activities are detailed in this report. These are operational and governance imperatives that may not attract publicity but are crucial to managing high level risks and could contribute to 'stress testing' of systems in the future.
- Continued work on community engagement, communications and deeper analyses disparities experienced in the borough could usefully add to the ambitions and vision of WCC to create and sustain a Fairer Westminster.

Key **recommendations** to inform a future response are embedded throughout the report. A summary of these is as follows:

Effective Cross Functional Working – Relationships with the new NHS bodies, such as North West London (NWL) Integrated Care System (ICS), present opportunities for WCC around risk assessments and management. Early challenges in setting up and delivering vaccination services reflected workforce and other system pressures that need mutual acknowledgement. Similarly, partnership activity on subjects such as preparedness and responses to emergencies will need development with new central government bodies, notably in the public health sphere. Bi-Borough and pan-London working assisted in the pandemic in the sharing of resources, economies of scale and joint initiatives and a shared understanding of these could inform both councils' accounts of their preparedness and response.

Data - Good practice in data recording within local NHS primary care needs developing as a joint priority. This is acknowledged as an important basis for good decision making, sensitive planning and activity around population health and wellbeing, and in particular enabling health disparities to be reduced in areas affecting public health such as screening and immunisations. But the data problems experienced in vaccine reporting appear to go beyond simple data

recording and extend to different resource patterns and other system 'shocks' pre-dating the pandemic. The new ICS will be central to jointly understanding, then resolving, some of these complexities and help promote the obligation to update patient records in practices where this is a particular challenge. The council may wish to ask for progress reports on this matter. This is of course just one part of the wider public health endeavour, since improving trust and healthcare access across different communities should help to improve wider healthy life expectancy and wellbeing. Other data improvements recommended by WCC to national bodies were for the inclusion of ethnicity data on death certification records; this could be followed up.

Communications and Resident Engagement - The local epidemiological picture that WCC in-house expertise provided enabled WCC and partners to tailor pandemic responses to particular communities and residents living in specific geographical locations. Strengthening engagement with voluntary and community sector over time is important learning but care is needed not to duplicate local NHS and other efforts around creating vibrant communities and improving vaccine and other preventive healthcare efforts. WCC should look to reflect on this good practice and evidence such as the shift to online digital communications, the need to see communications as part of strategic thinking and leadership, the development of hub or networked multi-agency working, and the need to ensure best practice in communications that addresses known inequalities.

Workforce and Protection of Vulnerable Groups - The wellbeing of WCC employees and other staff and volunteers responding to the pandemic could be supported further. WCC could address occupational health learning and work with partners on assuring good support for those affected by Long-Covid, bereavements and trauma. WCC brought together the feedback from its 'look back' exercise held after some severe outbreaks in care facilities, such as care homes, to draw together lessons learned for the future. There is also the potential to influence a review of hospital discharge support, ongoing at the time of writing, for people moving into care homes or other settings to inform future hospital discharge planning, including people with experiences of homelessness. There is also commitment to ensure the pandemic experiences shape the future of homelessness services. Effective and respectful approaches to people without recourse to public funds who have housing and other needs remain a continuing challenge for local councils and something which WCC may wish to work with partners to address. I would recommend starting or continuing such activities and also revisiting the support of people who have Direct Payment, care home residents and care providers, and of relatives and friends of care home residents to assess the effectiveness of what was offered in the pandemic context and what can be learned for any future crises.

Work with Global Majority Groups

Threaded through this report are observations on the emergence of high risks affecting Global Majority groups from Covid-19 necessitating partnership work with NHS and the wider community and voluntary sector as well as faith and cultural groups. Some of this had interface with WCC's and others' work on addressing health and other inequalities that have been well documented by the Institute for Health Equity (https://www.instituteofhealthequity.org/home) and others. This report contains evidence that these relationships were further developed during the pandemic leaving the potential for new efforts to increase fairness and wellbeing. The work could be further developed to assess what efforts are particularly effective and acceptable. However, the evidence for this comes from WCC and I would recommend wider views be accessed and considered about how well these relationships are working.

1. Scope of this review

1.1 This is my review of the Covid19 pandemic response by Westminster City Council (WCC) as commissioned on behalf of the Council's administration in line with its manifesto commitments.

1.2 The terms of reference for my review were laid out in an agreed document dated 14 November 2022 (Appendix 1). The scope of this report spans an analysis of the internal review undertaken by WCC as reported in a document dated 26 September 2022, clarification of matters arising by telephone and online communication with relevant officers of WCC and elected members, and other bodies, identification of points of good practice and lessons learned.

1.3 In addition to the documents supplied by WCC, these materials were also contextualised by my access to publicly available documents such as reports, minutes and papers of the Bi-Borough (joint Westminster and Royal Borough of Kensington and Chelsea) Health and Wellbeing Board, wider social media and regional, national and other reports.

1.4 Some of this documentation is accompanied by accounts of engagement with other authorities whereby WCC officers were being informed by peers and contributing to areas of national evaluation (for example, through the vaccinate inequalities programme funded by the Department of Levelling Up, Housing and Communities - DLHUC). There have been suggestions for more peer review activities between councils including by London's Directors of Public Health or via the Association of Directors of Public Health. Such processes often benefit from external scrutiny and some examples of this are reported on below.

1.5 A primary driver for this review came out of concern expressed over Covid-19 vaccination rates for WCC residents. This is a right and proper concern and the learning reported here may impact beyond Covid-19 to positively influence other public health initiatives. While WCC has long-established challenges of resident mobility, such population moves are not uncommon in 'super-city' areas and reflect substantial and increasing global mobility. The relatively high proportions of WCC residents with international and private health care arrangements are challenges to local record keeping systems. As will be seen in this report, WCC has dedicated considerable resources to outreach initiatives and there is emerging evidence about their effectiveness.

2. Independence

2.1 I am independent of WCC and do not regard myself as having any conflict of interest, save that I am a Westminster resident and my primary care provider is a local NHS health centre in the Borough. My most recent Covid-19 vaccination took place in a local community centre staffed in the main by volunteers to whom I extend my thanks. I have previously provided assistance to elected members of WCC Scrutiny Committees in contextualising the annual reports of their Adult Safeguarding Board.

3. WCC internal review (IR) dated 26 September 2022

3.1 This review (hereafter referred to as the IR) by WCC, entitled Covid-19 Pandemic Review, was comprehensive in terms of the evidence it drew upon and had clarity of purpose. It notes that it has built on several earlier reports, reviews and audits. The focus is council wide, however, several areas of focus are specific to Adult Social Care and Health.

3.2 In several sections this IR concludes that there is evidence of systems and processes that worked as well as they could in the unprecedented time of a global pandemic and states that these will be helpful in shaping consideration of any future infection outbreaks or

disasters through local emergency preparedness. The system working and structures that underpinned this judgement relate to:

- Effective cross-functional working – both within WCC and externally with its partners
- Data-led decision making – drawing on public health and other data
- Already good but also improved communications
- Well-developed investments in community engagement with diverse groups and populations that were sustained during the pandemic
- As an employer, WCC being able to deploy its workforce flexibly and rapidly
- Growing mutual trust between organisations locally and their personnel.

Each of these elements will be reflected on in turn, with section 9 of this review focussing on the challenges identified.

4. Cross-functional working

4.1 Internal to WCC

4.1.1 Preparation for the emergency risks as covered by the Civil Contingencies Act (CCA) 2004, relate to the responsibilities laid on local authorities as Category 1 responders. These statutory duties require assessments and updating of the risks of emergencies which WCC through the Borough Resilience Forum had undertaken on an annual basis long before 2020.

4.1.2 The Borough Resilience Forum provides a means of co-operation but the statutory Local Resilience Forum meets at a London level and oversees planning and preparedness for major incidents and emergencies across the capital. The arrangements that are in place are a combination of local and regional plans and capabilities. Any Category 1 responder can declare a major incident. Within WCC risk factors have been considered on the basis of national and regional risk registers covering individual and social impacts but not specific groups.

4.1.3 The Borough Risk Register, which covered long-standing (5 to 10 years prior to 2020) appreciation of the risks of an influenza-like pandemic, has been published in past years but had not been so recently, similar to its generic Major Incident and Emergency Plan. WCC considers that its generic plans have been flexible and scalable and that there were processes in place for reviews, learning exercise and amendments.

4.1.4 Part of such planning involves assurances about business contingency plans which are maintained by individual Council services and contracted providers (as set out in a document dated 20 December 2020 https://www.westminster.gov.uk/businesses/preparing-your-business-emergencies/creating-business-continuity-plan which also contains a toolkit developed by the Cabinet Office). At WCC corporate level, these are coordinated by the Emergency Planning team. WCC acknowledges that the training around such plans by its contracted service providers is likely to have been inconsistent, with greater focus on larger contracts. Its provision of advice about business continuity to businesses and communities will have also varied, particularly in terms of reach. In terms of health and care providers there may be scope to consult on the effectiveness of such plans either locally in WCC area or regionally.

4.1.5 The structure of WCC's local outbreak management response was detailed in its evolving Local Outbreak Management Plan (https://www.westminster.gov.uk/sites/default/files/wcc_outbreak_control_plan_public_edition_v1.1.pdf and later versions). Its fourth version also set out the weekly assurance

reporting pattern (to the Executive Group and from the Covid-19 Co-ordination Centre to the HPB and Tactical Group, when meeting) as it developed following initial pandemic related initiatives.

4.1.6 There were also prior preparations and responsibilities in WCC that are not often covered in pandemic accounts, such as mortuary responsibility which was held by WCC Chief Executive (https://www.bbc.co.uk/news/uk-england-london-55670469) on behalf of London.

4.1.7 At the start of the pandemic in the UK (reported 18 March 2020), WCC built a temporary body storage facility at Westminster Mortuary to double its capacity (https://www.independent.co.uk/news/health/coronavirus-uk-update-westminster-council-mortuary-tent-a9409586.html). In December 2020 WCC and Camden Council were reported to be taking responsibility for overseeing arrangements for extra mortuary provision if the second wave of the pandemic gave rise to substantial increases in deaths (https://www.mylondon.news/news/west-london-news/london-covid-temporary-london-mortuary-19353207) and, like other boroughs provided extra financial support for mortuary services across London.

4.1.8 In addition to this task, delivery working groups were set up to cover other activities and concerns across the pandemic period, with track & trace and sharing of data as prime examples of early initiatives, then later developments around responses to excess deaths and promotion of vaccine take up. There is substantial evidence of the development of established active management chains of communication for outbreak contingencies, such as local or national trends of possible concern. These were operational round the clock to enable responses to numerous national imperatives or local developments.

4.2 WCC work with other agencies

4.2.1 Systems were in place within WCC to work with other agencies and these were stepped up during the pandemic. Naturally many of these related to local NHS working but others reflect delegation of activities to appropriate agencies within the Voluntary and Community sector (VCS) by agreement that they would be best placed to meet a specific need.

4.2.2 This included, for example, the decision that Citizens Advice Bureau Westminster would be commissioned by WCC to administer a Covid-19 Hardship Fund. Together with WCC's Local Support Payment team, the Citizens Advice Bureau worked with 37 voluntary and statutory agencies to provide 500 households with food vouchers (https://www.westminstercab.org.uk/covid-hf/).

4.2.3 A recent evaluation of local welfare assistance during the pandemic for London Councils and the Greater London Authority such as that provided by WCC concludes that this local provision was effective in meeting the needs of residents in crisis by enabling people to retain their housing and reduce rent arrears. Harmful options that might be considered by people in difficulty were less likely to be taken. Councils were also able to engage with people and offer early help (https://www.londoncouncils.gov.uk/our-key-themes/tracking-welfare-reforms/local-welfare-provision). This detailed evaluation provides good evidence for offering such support in times of further national or local crises.

4.2.4 Offering more to local groups, the extra income from the council's voluntary Community Contribution tax (managed by the City of Westminster Charitable Trust) ran a Covid-19 grant scheme for frontline organisations and charities helping young people, those sleeping rough, or those facing isolation and loneliness during the pandemic (https://www.westminster.gov.uk/westminster-trust?fbclid=IwAR0odaR_1vyyi5HWyu1sTMSuwlSCGRQPw9JTCIanakE3MGJ5RBonzGY6Bik).

4.2.5 Such examples give a richer picture than simple expressions of partnership working and are threaded through accounts of WCC activities during the pandemic. They were visible in the descriptions of joint initiatives such as work on track & tracing.

4.2.6 Work with Global Majority groups, including WWC's own staff, is evidenced by activities reporting on the disproportionate impact of Covid-19 on Black, Asian & Minority communities as in the Staff Forum held early in the pandemic on 28 May 2020 (https://www.kcsc.org.uk/sites/kcsc.org.uk/files/Disproportionate%20Impact%20of%20COVID-19%20on%20Black%20Asian%20%20minority%20communities%20-%2028.05.20.pdf) where connections with communities were discussed as well as the emerging evidence on enhanced risks. The activities listed included discussions with community groups, liaison with the VCS Community Intelligence Forum, recording of community concerns and ideas, and promotion of Community Connects (https://www.westminster.gov.uk/jobs-and-volunteering/volunteering/westminster-connects#:~:text=Westminster%20Connects%20was%20set%20up,to%20those%20who%20are%20vulnerable).

4.2.7 Further evidence is contained in the minutes of a meeting of WCC's Adults and Public Health Policy and Scrutiny Committee on 17 February 2021 (https://committees.westminster.gov.uk/ieListDocuments.aspx?CId=479&MId=5642&Ver=4). This reports the unfolding debate about community engagement and the learning of practical and other challenges facing communities. At that time the 'stay at home' message, continuance of symptomatic and asymptomatic testing, and positive vaccine messages were being promulgated but there was increasing awareness of anti-vaccination messages circulating locally. WCC Communications and Community Engagement Teams were described as drawing together more factual information from trusted sources about the vaccine as well as reinforcing national NHS campaigns. The local HealthWatch representative described their own targeted messages to young people and minority groups in this context.

4.3 WCC work with other NHS agencies

4.3.1 Overall, there is a strong feeling among those consulted in this review that the pandemic tested but has now (early 2023) strengthened relationships, particularly with the NHS, which itself reorganised by moving from a Clinical Commissioning Group (CCG) structure to a larger Integrated Care Board (ICB) structure with some new personnel. This potential for stronger relationships seemed to be particularly so at primary care level, complementing than the previous generally good working relationships with local acute hospital Trusts.

4.3.2 Specifically on relationships with local NHS bodies, several of those consulted during this review mentioned how these have generally been positive, however, WCC and others have recognised that, at times during the pandemic, these relationships were strained due to the challenges in achieving what were considered adequate and targeted vaccination levels and resources for Westminster residents. For example, concerns were escalated by WCC to local Members of Parliament (MPs) and the Secretary of State for Health and Social Care. This was not always perceived by NHS partners as undertaken in a spirit of partnership, but more recently relationships appear to have improved and impressions of somewhat adversarial positions seem to have been replaced by commitments to more joint working and reporting.

4.3.3 Weekly meetings were held between WCC Chief Executive Officer (CEO), other WCC Leaders, senior NHS leaders, Executive Directors and the Director of Vaccinations to ensure focus on the NHS vaccination programme locally. The NHS stakeholders consulted

for this review have acknowledged the historic low vaccination/immunisation rates in the WCC area and the variety of explanations for these, with the pandemic providing greater emphasis on population mobility (see section 1.5). They too acknowledge the imperative to address the accuracy of patient lists in primary care so that these are more comprehensive (e.g. in the coding of childhood immunisations) though they also point to the range of their accuracy between practices. For example, some GPs serve people with experiences of homelessness who may stay registered with them despite several moves, while others have sizeable student patients, briefly registered. Overall, however, there is a view from North West London (NWL) Integrated Care Board (ICB), operating mainly from late 2020, and NHS leaders that work with WCC overall and its Adult Social Care and Public Health staff over the pandemic period cemented previously good working relationships. This included the helpful role of WCC in identifying community resources for vaccinations, such as local sports facilities and community centres, which were evidently valued additions to NHS premises.

4.3.4 While community pharmacies are usually independent businesses contracted by the NHS to provide various services for local populations, experience over the pandemic revealed some variety in their ability to offer vaccination services due to eligibility criteria. WCC may wish to work with the local ICB to address barriers to pharmacies taking on roles that are important to local populations and of course may reduce demand on other parts of the NHS. The importance of community pharmacies as local assets could be acknowledged more explicitly.

4.4 Bi-Borough working structures and relationships

4.4.1 WCC and the Royal Borough of Kensington and Chelsea (RBKC) (the Bi-Borough) have a long-established relationship as neighbouring local councils, with an earlier Tri-Borough arrangement (including the London Borough of Hammersmith & Fulham) that was re-engineered as Bi-Borough in 2017 between WCC and RBKC.

4.4.2 Shared services extend to joint inclusion strategies, to shared legal services and a range of other activities such as the shared Early Education and Early Years Consultancy Service. Outbreak management plans in the Covid-19 context were developed in collaboration with RBKC with the Bi-Borough Covid-19 Health Protection Board (HPB) (including partners other than WCC) providing oversight and strategic support. The HPB is convened and chaired by the Bi-Borough's Director of Public Health meaning that there is strong chain of communication with each council's executive leaders.

4.4.3 Further evidence of the robustness of this collaboration is contained in a recent outline of the responsibilities and vision for a new Director of Health Partnerships for Bi-Borough (https://starfishsearch.com/wp-content/uploads/2021/05/Bi-borough-Director-of-Health-Partnerships-JD-May-2021-1.pdf). This made reference to the different strengths and requirements of each council and their values (e.g. the then Westminster Way) but also their substantial complementarity.

4.4.4 Bi-Borough working also extended to supporting NHS vaccination activities, with the development of a Vaccination Task Force covering both councils and its relevant primary care statutory bodies (e.g. the then NHS Clinical Commissioning Groups (CCGs)). A Bi-Borough bus to assist in vaccination delivery was commissioned (communications for this were extensive on social media, see, for example, https://www.facebook.com/mychurchstreet/photos/a.688222051369497/1653488868176139/?type=3&paipv=0&eav=AfZu89AY-FfMFevjEs6-X0a5HXcL6dVx-Ozf7ZhhuO-TqYYb8Yhqub7i9JhWyJdwC3Y&_rdr).

4.5 Pan-London working relationships and structures

4.5.1 As with other London Boroughs, WCC worked regionally across London during the pandemic, building on existing pan-London operations and developing responses to the pandemic. This is evidenced in the scale of its communications with bodies working across London in public services. London, as a region with considerable devolved powers and a strong sense of identity, may, of course, have particular advantages here, aided by senior members of staff across many agencies having experience of working in other parts of London and with each other. As noted above, its major incident planning was focussed on London-wide systems.

4.5.2 A London Covid-19 Response Centre (LCRC) was established in February 2020 (prior to national lockdown) to provide a pan-London Public Health England (PHE) acute response by being able to draw on staff from all three Health Protection Teams (HPTs), other PHE London staff, speciality trainee registrars (doctors) and some volunteers (mainly former staff/registrars). The LCRC managed contact tracing of all Covid-19 cases during the early 'contain' phase, then moved to manage new outbreaks (mainly in care homes) and the surge of enquiries. This was undertaken at local authority level through Incident Management Teams (IMTs). Other early activities at LCRC level included development of shielding and isolation protocols and measures.

4.5.3 For communications a London Coordination Response Cell was established, taking advantage of London's substantial shared if diverse media channels. A London Strategic Coordination Protocol (dated October 2020 - Version 8.7, https://www.london.gov.uk/sites/default/files/strategic_coordination_protocol_v8.7_2020_-_public_version.pdf) indicates the high level of planning of responses to emergencies as illustrated by the existence of the London Resilience Group (LRG) which is jointly funded and governed by the Greater London Authority, London Local Authorities and the London Fire Commissioner.

4.5.4 The work of the LRG and that of the London Resilience Partnership is overseen by the London Resilience Forum (see https://www.londoncouncils.gov.uk/members-area/civil-resilience-handbook-london-councillors/london-resilience). Councils are represented on this by the Chair of the Local Authority panel or other representative. Thus, LRF meetings (held every six months), attendance, delivery of a Community Risk Register and so on are pan-London activities.

5 Data

5.1 The role of WCC's Public Health Intelligence (PHI) team has been to offer monitoring and review of data related to Covid-19 (ranging from vaccine uptake to potential new variants) and of service capacity.

5.2 Several local and national data sources were developed over the course of the acute phase of the pandemic. Some of these were held by NHS and other partners. PHI's epidemiological expertise enabled scrutiny of data by demographic or protected characteristics under the Equality Act 2010 and assists in the understanding of the nuances of such data and the trends within it.

5.3 WCC's local emergency plans and risk assessments that were in place at the start of 2020 considered very many of those groups with potentially high-risk factors for a potential pandemic – notably including those who were clinically vulnerable, living in care homes and homeless or vulnerably housed.

5.4 Perhaps we have also learned during the pandemic of the impact on young people of such a system or social shock. The charity Young Westminster Foundation, for example, was able to undertake research with young people and youth workers across the pandemic (https://www.youngwestminster.com/wp-content/uploads/2021/03/YWF_Our-City-Our-

Future_2020_21.pdf) that will provide a valuable baseline of their views and experiences, for example, high levels of concern about mental health problems.

5.5 During 2022, the former individual outbreak management teams (OMTs) initially responsible for care homes, schools, hostels and other high risk or vulnerable settings were reorganised into a single 'vulnerable settings OMT' to co-ordinate their activities as cases of Covid-19 began to decline. Most OMTs were stood down in May 2022 with WCC's Environmental Health Officers continuing their guidance and liaison with key organisations such as businesses and housing providers.

5.6 The aim of the single OMT is to enable preventative activity in combination with responses to possible new outbreaks. As of May 2022, the process of convening a new OMT can be triggered by a situation of concern expressed by part of WCC or externally.

5.7 Specific data on the pandemic impact locally were provided by the Health Impact Assessment (HIA) 2021 report '*A summary on the direct and indirect impacts of the COVID-19 pandemic in the City of Westminster*'. Prior to publication this had been presented to the Health and Wellbeing Network Meeting on 25 May 2021 for sense checking. This report was an important first pulling together of local statistics.

5.8 In a report to Westminster Scrutiny Commission of 25 November 2020, the Chief Executive noted that WCC in partnership with its then BAME (black and minority ethnic) Staff Network (since re-termed Global Majority) had lobbied central government to include ethnicity data on death certification records so that the impact of Covid-19 and the disparities, could be better established at local and national levels (https://committees.westminster.gov.uk/documents/s39690/4_Item_4_Chief%20Executive%20Scrutiny%20Report%20November%202020.pdf). I would recommend following up this and informing local partners of any developments.

5.9 Previously, in 2020, WCC became the first council to acquire 'mobile footfall data' as a means for evidence-led decision making. This enabled it to look across time and space, to differentiate between the walking activity of residents, workers and visitors (https://www.caci.co.uk/insights/case-studies/westminster-city-council/). For a council that relies substantially on incomers, whether commuters, students, shoppers or tourists, to support its businesses, leisure, cultural and community facilities this data could be potentially helpful.

5.10 As noted by many, there are major workforce implications emerging from the pandemic. WCC may find it helpful to now consider the longer-term effects on its workforce, in combination with other partners. This could include the impacts of Long Covid, bereavements and trauma and how local partners are supporting those affected by physical and mental health changes through occupational health and other interventions. Health promotion work among WCC staff in areas such as immunisation, such as influenza immunisation which is free for all WCC employees, could be part of conversations at strategic and staff engagement groups.

6 Communications and relationships

Within WCC Updates for WCC staff and for its residents, organisations and businesses are posted online, reflecting the general IT literacy of local workforces and many residents. Other communications such as leaflets and posters have been and continue to be circulated to specific audiences by staff or volunteers. WCC also contributed to national thinking here (https://gcs.civilservice.gov.uk/wp-content/uploads/2020/10/COVID-19_Communications_Advisory_Panel_Report.pdf) as noted below.

6.1 Community engagement

6.1.1 There is evidence of system level efforts to step up WCC's engagement with communities but also to directly engage local individuals. On a website entry dated a year after national lockdown was announced, 23 March 2021, WCC reported that in the first lockdown a new Westminster Connects volunteering service was set up with 3,000 volunteers recruited within weeks. A year later this service had helped around 27,000 people and over 500 refurbished laptops had been donated to families in need and to isolated older people during lockdown (https://www.westminster.gov.uk/london-reflects-westminster).

6.1.2 Similarly, early on WCC envisaged that its Community Engagement Plan would need to run alongside a borough-specific Equalities Impact Assessment. Initially this sought to promote public awareness of the 'test & trace' system but also highlighted the need to build and maintain public trust. WCC's Community Engagement Plan was developed in line with PHE's June 2020 report on disparities in the risk and outcomes of COVID-19, '*Beyond the data: Understanding the impact of COVID-19 on BAME groups*'. This identified an association between belonging to some ethnic groups and the likelihood of testing positive and dying from Covid-19. Examples of community engagement around this subject include various initiatives such as an online information event or conference (it is described as both) with leading specialists from diverse communities (see, for example, https://www.westminster.gov.uk/covid-vaccination-discussion).

6.1.3 Such efforts require active communications and WCC reports that this area was staffed by those with the relevant expertise (WCC Local Outbreak Management Plan, v5, 2022).

6.1.4 Three particular developments have been cited by WCC as representing examples of community engagement, first, the existing Community Champions Programme expanded and developed online Community Conversations, second, a new Health Champions Programme (network of over 90 residents initially meeting weekly with public health staff see https://www.westminster.gov.uk/community-support-how-you-can-help/health-champions), and third, community-based summer fairs, and various updates, conversations, small grant programmes, and so on.

6.1.5 These were in addition to developments of relationships with Voluntary, Community Sector (VCS) and faith groups with emphasis on reaching out to different populations, at times augmented by work with national experts. Examples of this work are included in documents such as the Community Champions' End of Year Highlight Report, April 2020 - March 2021 (https://www.westminster.gov.uk/health-and-social-care/your-health/community-champions). Here the addition of Maternity Champions highlights the extended reach of this programme of work. An online conference for Community Champions, the eighth in an annual series, was held in November 2020 and noted 92 active Community and Maternity Champions who had made over 36,000 contacts with individuals.

7 Workforce ability

7.1 Staff wellbeing

7.1.1 In general, WCC documents indicate that its staff were able to be deployed flexibly and new appointments, if necessary, would be considered, subject to resources (WCC Local Management Plan v5, 2022). As with many working in public services, home working was necessary for many. Within a short space of time, most of its workforce had to work from home.

7.1.2 The Chief Executive reported to the WCC Scrutiny Commission in November 2020 that Loop Live sessions had been set up as weekly touchpoints for staff to hear about updates and changes from the Executive Leadership Team first-hand. He added that staff working

from home could have a work chair delivered to them, as well as a personal budget to help with equipment. During the pandemic WCC consulted on its Wellbeing Strategy 2022-24 with the aim of adopting an holistic approach to employee health (https://whatworkswellbeing.org/blog/wellbeing-policy-making-with-westminster-city-council/).

7.1.3 Overall, WCC reported that it had been able to maintain good working relationships among its staff (IR September 2022) and that multi-disciplinary teams had consistently worked well and effectively. Within the NHS there were reports however of the workforce being stretched, which necessitated some adjustments to planned activities.

7.1.4 Despite the pressures of the pandemic, the Chief Executive's report of November 2020 notes that staff survey findings since 2017 had improved compared to previously. Engagement scores had increased by 12 per cent. The number of staff describing WCC as "a great place to work" had increased from 53 per cent to 76 per cent from 2017-2020.

7.1.5 WCC may now find it helpful to address longer-term workforce wellbeing, and to consider the support of those affected by Long Covid, bereavements and enduring physical and/or mental health problems. This could include scrutiny of the offer and take up of occupational health support by its own staff and its partners to address adequacy and any inequalities.

7.2 Workforce ability to respond to vulnerable groups

7.2.1 A key initiative here relates to WCC recommendations issued 9 March 2020 (https://committees.westminster.gov.uk/documents/s39690/4_Item_4_Chief%20Executive%20Scrutiny%20Report%20November%202020.pdf) and adopted by local care homes as from 16 March 2020, prior to UK national lockdown. Expectations for rapid discharge of patients from hospital to care homes at the start of the pandemic were recognised to present a significant infection control risk with the potential to introduce infection into premises with vulnerable residents and with far more limited infection, prevention, and control capacity in the care homes than in hospital Trusts. WCC's commitment to protecting local care homes, most of which it does not own, was clearly established from the start of the pandemic with senior NHS leaders and managers.

7.2.2 These social restrictions took the form of 'cocooning' residents. 'Cocooning' means suspending all non-essential visiting (IR September 2022; https://www.bbc.co.uk/news/uk-51828000). To minimise exposure to Covid-19, WCC asked local care homes to cocoon from 9 March 2020, 12 days before 'cocooning' became national guidance. Care providers were required by WCC to complete risk assessments and business continuity plans, and daily contacts with care homes and other registered providers were instigated.

7.2.3 While the IR notes these WCC activities, it is not clear from this report how this support was interpreted and what were the views of care providers although providers were invited to participate in 'look back exercises' held by WCC to inform the refresh of the Local Outbreak Management Plan. WCC supported some prevention measures such as in purchase of air purification units for all local care homes, as reported to Council members in a briefing dated 26 August 2021 (https://safeairquality.com/cutting-edge-technology-to-reduce-covid-risk-in-london-care-homes/). The effectiveness of this in the short and long-term could be evaluated. The level of demand for out of hours support by providers could also be usefully established now infection levels have declined, to see if continuing such on call systems would be welcome.

7.2.4 In my experience few councils have been able to describe the nature of their contacts with adults who use Direct Payments to fund their own care and support. WCC's practice of setting up welfare calls for these individuals appears commendable and confirmation of

how this had been helpful or otherwise might be useful for future learning and perhaps reporting to oversight groups such as the Health and Wellbeing Board. I would recommend auditing this work.

7.2.5 As the IR (Sept 2022) notes, such individuals were likely to have been shielding or otherwise at risk. This process of reviews may explain why WCC, as with other London councils, did not feel it necessary to apply for Easements of its duties under the Care Act 2014, as permitted by the Coronavirus Act 2020, to suspend some of its mandatory obligations in relation to people with care and support needs (see https://doi.org/10.1093/bjsw/bcac165). A report to the Audit and Performance Committee in February 2022; (https://committees.westminster.gov.uk/documents/g5639/Public%20reports%20pack%2016th-Feb-2022%2018.30%20Audit%20and%20Performance%20Committee.pdf?T=10) on Direct Payments' use in Children's Services also covers some of the Bi-Borough administrative details of these payments (made to 136 families at the time of the audit) to ensure that the greater flexibility permitted under such arrangements during the pandemic was sustained where beneficial; follow up here might also be appropriate.

7.2.6 The extent and quality of hospital discharge support for people then moving to care homes or other settings have been concerns for many and are likely to feature in the national Covid-19 Inquiry. The local situation may warrant further data collection and reflection by the individuals and teams involved. There may be lessons for future Discharge to Assess developments and discharge planning, as well as the possible development of Essential Care Giver status for relatives or friends. A report to WCC's Audit and Performance Committee in February 2022 (https://committees.westminster.gov.uk/documents/g5639/Public%20reports%20pack%2016th-Feb-2022%2018.30%20Audit%20and%20Performance%20Committee.pdf?T=10) provides some detail of a substantial increase in care home expenditure, albeit less so than on homecare services. Part of this was laid at the door of changes to patient discharge regulations, and more, if temporary, NHS funding for post-discharge support for greater numbers of patients. WCC notes that swift moves to care homes from hospital may not enable the individual to return to their own home. This may need exploring to avoid intended brief rehabilitative stays becoming permanent moves. Such NHS funding has continued to be temporary and therefore a financial risk for WCC if it is obligated to meet the care home fees.

7.2.7 Other initiatives reported by WCC Chief Executive to Westminster Scrutiny Commission on 25 November 2020 (https://committees.westminster.gov.uk/documents/s39690/4_Item_4_Chief%20Executive%20Scrutiny%20Report%20November%202020.pdf) were ensuring care homes had adequate testing and personal protective equipment (PPE), providing mental health and wellbeing support for residents and staff, and the funding of testing for all residents and staff in July 2020, when testing was difficult to access through the national portal. WCC also funded and sourced iPads for care homes to enable video calling for residents' benefit.

7.2.8 I have been told by WCC that work has been undertaken with care homes and other providers on the acceptability and accessibility of digital solutions which may be useful for the future. There are national initiatives on technology enabled care such as electronic care records ongoing in this subject area at the time of writing.

8 Vulnerable groups – homeless people

8.1 As happened across the UK, the risks facing homeless people during the pandemic became quickly evident and the initiative 'Everyone In' prompted some major developments of help and long-term support.

8.2 WCC has a much larger homeless population than many other areas meaning that work here involved several hundreds of people and multiple agencies. It has reported that 266 rough sleepers moved into emergency accommodation during lockdown, where medical, mental health and employment support were offered.

8.3 Working with Housing Services and partners, including St. Mungo's, The Connection at St Martin's, The Passage and West London Mission, the Rough Sleeping team subsequently moved over 430 people into long-term housing (https://www.westminster.gov.uk/rough-sleeping-support-during-and-after-coronavirus).

8.4 Early reflections on these developments were assembled by Westminster Homelessness Partnership in a facilitated exploration of pandemic learning (see https://whpartnership.org.uk/general/learning-from-the-covid-19-response-in-westminster/).

8.5 WCC has made a commitment to learn from the lessons of this experience during the pandemic to shape future services. This is intended to bring together the experiences of all partners and public sector colleagues to explore if it may be possible to phase out shared accommodation, such as hostels, to help people move to permanent independent accommodation. This will no doubt draw on other early overviews of 'Everyone In' initiatives and future planning (see the 2021 Shelter report, https://assets.ctfassets.net/6sxvmndnpn0s/7BtKmhvyB8Xygax9A2hhHP/2fde1c08424fe9f482792d22ed5469a0/Shelter_Everyone_In_Where_Are_They_Now.pdf).

8.6 Nationally, but relevant to WCC, is the position of people without recourse to public funds who have housing needs. A Local Government Association (LGA) report of November 2020 (https://www.local.gov.uk/publications/lessons-learnt-councils-response-rough-sleeping-during-covid-19-pandemic#conclusions) considered this group of people presented a continuing dilemma for local councils as their positions were so uncertain at many levels. The LGA describes this as an 'outstanding issue' for many councils and WCC may wish to work with partners to continue developments here.

8.7 Other important evidence of the health impacts of the pandemic are contained in WCC's Covid-19 Health Impact Assessment (HIA) of the first wave of the pandemic (https://www.westminster.gov.uk/health-and-social-care/public-health-strategy-policies-and-reports/public-health-vision-policies-and-reports). This detailed report published in January 2021 expresses the commitment of WCC's Public Health team to focus attention on areas and communities with the greatest needs; to ask residents about their health and wellbeing; to co-designing campaigns and actions; to invest £3 million into local Covid-19 recovery programmes to address health inequalities. It is apparent that the inequalities amplified by the pandemic were already being understood and addressed by WCC following its first stage.

9 Challenges

Vaccinations

9.1 Vaccine data

9.1.1 An overview of many of WCC's public health-related responsibilities for and activities around immunisation is contained in a report to WCC's Audit and Performance Committee (https://committees.westminster.gov.uk/documents/g5639/Public%20reports%20pack%2016th-Feb-2022%2018.30%20Audit%20and%20Performance%20Committee.pdf?T=10). This sets the local context in a national picture, for example, WCC's historically low but varied take up of childhood immunisations (also occurring across London) which the council had been raising with the local NHS systems and NHS England for some time. It

notes that the co-ordinating Bi-Borough Immunisations Partnership Board, established in 2019, meets quarterly.

9.1.2 The role of this Board is to bring together the wider health and care system in line with WCC's health protection oversight function under the Health & Social Care Act 2012. Problems cited as accounting for low levels of immunisations relate to demand and supply; they include high population mobility, population increases, increasing cost pressures and demands on the NHS, and a shrinking vaccinating workforce. Others are related to complexities in data collection and inconsistent contact systems. This background helps to set Covid-19 vaccination delivery and up-take in context.

9.1.3 In relation to Covid-19 vaccination data, WCC has acknowledged that vaccine take-up appears low compared to national figures but has also pointed to substantial uncertainty about the accuracy of these figures. This relates to the mobility and diversity of the local population (within the UK and internationally), second home availability, use of private healthcare, and accuracy of GP data on NHS registered patients. Once this problem was identified, as noted above in section 9.1.2, weekly meetings were instigated by WCC whose attendees included WCC's Chief Executive Officer, Members of Parliament, and NHS leaders. One example of the impact of uncertainty arising from such records was given at a meeting of the Adult and Public Health Policy and Scrutiny Committee of 24 January 2002, where WCC considered there was likely to have been over-estimates of older populations and under-estimates of the young (https://committees.westminster.gov.uk/documents/g5680/Public%20reports%20pack%24th-Jan-2022%2019.00%20Adults%20and%20Public%20Health%20Policy%20and%20Scrutiny%20Committee.pdf?T=10).

9.1.4 A useful exercise was conducted during the pandemic by both RBKC and WCC to investigate vaccine take up. Figures relating to both boroughs pointed to difficulty in contacting all registered patients and so establishing vaccine rates. As noted in section 9.1.2, this may have arisen from movements related to the pandemic or reflect out-of-date NHS information, despite WCC deploying senior staff to assist GP practices in improving their data quality (data cleaning).

9.1.5 WCC conveyed these data problems to regional and national bodies, acknowledging that while vaccine hesitancy and refusal may be important to address, NHS primary care 'list inflation' and coding problems were key factors to consider when looking at data and to resolve missing data or duplications. WCC's IR (September 2022) highlights how emerging census data suggests that the local population in March 2021 was 'markedly smaller' than assumed, by nearly a quarter (24%). Clearly census data also have problems of completeness, but they do suggest lack of confidence in vaccine statistics.

9.1.6 Problems with data reliability are also acknowledged nationally, for example, in a data set presented by the Greater London Authority (https://data.london.gov.uk/dataset/coronavirus--covid-19--vaccine-roll-out). On the face of it, there are differences in vaccine take up between London and 'rest of England' in respect of almost all priority groups. However, the data are presented with the caveat that '*There is considerable uncertainty in the population denominators used to calculate the percentage vaccinated'.* In London data by ethnicity is complicated by two long-standing problems:

1) *'Ethnicity information for recipients is unavailable for a very large number of the vaccinations that have been delivered. As a result, estimates of vaccine uptake by ethnic group are highly sensitive to the assumptions about and treatment of the Unknown group in calculations of rates'.*

As a simple example of this – *'For vaccinations given to people aged 50 and over in London nearly 10% do not have ethnicity information available',*

2) This reason relates to data collection on a broader scale and the length of time between the last census and the pandemic period. *'The accuracy of available population denominators by ethnic group is limited. Because ethnicity information is not captured in official estimates of births, deaths, and migration, the available population denominators typically rely on projecting forward patterns captured in the 2011 Census. Subsequent changes to these patterns, particularly with respect to international migration, leads to increasing uncertainty in the accuracy of denominators sources as we move further away from 2011'.*

9.1.7 Such information does not mean that efforts to increase vaccinations are not needed or were not undertaken but substantial improvements must be made to have confidence in the robustness and trustworthiness of collection, management and maintenance of healthcare record systems.

9.2 Vaccine initiatives

9.2.1 There is substantial evidence that both vaccine hesitancy and refusal have been and are being addressed by WCC in partnership with other organisations.

9.2.2 At local level, as mentioned in other sections of this report, this included the deployment of a mobile vaccine bus and 'pop-up' clinics, targeting low up-take geographies, with the attendant publicity of such initiatives. There is now some evidence of the relative success, in terms of Covid-19 vaccine take up in 2021, of these initiatives. For example, a pan-London report, to which WCC and another 26 of the 32 London authorities contributed (Bulmer et al 2021, https://uclpartners.com/wp-content/uploads/Delivering-the-COVID-19-Vaccine-Across-London-Report-July-2021-FINAL.pdf), provides some data about which initiatives appeared to attract whom, and their effectiveness. From this report what stands out for me is that WCC experiences appear to resemble those of their (statistical and other) neighbours who encountered some limited demand for the vaccine and found residents were experiencing some access problems.

9.2.3 The London-wide problems of access appeared to reflect pre-existing inequalities some of which were compounded by the pandemic, various problems with infrastructure and workforce availability and skills, some difficulties with partnerships and community engagement. These are not solely WCC's responsibilities since local government's role is to provide oversight and challenge to NHS and wider system on vaccination performance. It is interesting that Bulmer and colleagues' recommendations to local authorities are focussed on them needing to create, sustain or enhance two-way dialogue with their community, '*to both listen and respond, rather than just share messages'*, to develop deeper understandings of their views (https://uclpartners.com/wp-content/uploads/Delivering-the-COVID-19-Vaccine-Across-London-Report-July-2021-FINAL.pdf).

9.2.4 This is perhaps in recognition that local councils know their communities well and are best placed to inform the NHS on targeting and accessibility. Throughout the pandemic WCC has worked with communications teams and vaccination services to enable a better understanding of community sentiments and enhance the offer which has resulted in a better uptake rate.

9.2.5 Bulmer and colleagues (page 39) recommend sustaining the community champions model (a strong feature of WCC prior to the pandemic and stepped up during it), to ensure residents can access '*people who they trust, who have a similar cultural and/or social background*, as well as using '*multiple communications channels to relay messages'*. Of

the interventions to increase access to vaccines, Bulmer and colleagues note that flexible booking of appointments, walk in services, out-reach and pop-up initiatives may attract people but 'surge events' may not improve equalities but simply (and valuably) make it easier for the general population to receive their vaccines conveniently. Interestingly, the main recommendations of this report are directed at London regional bodies and this underlines the need to often view WCC activities in the wider city context.

9.2.6 In confirmation of the extension of the championing work, I found evidence of how WCC was still undertaking this activity in 2022. From January 2022 WCC's Public Health Department secured £485,000 funding from the Department for Levelling Up, Housing and Communities (DLUHC) for a 'Community Vaccine Champions' scheme to work alongside other ongoing community engagement initiatives to promote vaccine uptake amongst underserved and hesitant communities in areas with low uptake rates. Earlier, online conversations were being held with Heath and Community Champions, and online events are available as recordings (see https://www.westminster.gov.uk/covid-vaccination-discussion of 3 February 2021), with diverse groups of experts.

9.2.7 More broadly, with a pan-London perspective, there is ambition in new national public health administrative systems (such as the creation of the Office for Health Improvement and Disparities), to tackle health inequalities, among which are health service access and behaviours. Prof Kevin Fenton has called for these to be based on deep understandings of the complexity of London's populations (see https://www.local.gov.uk/sites/default/files/documents/Professor%20Kevin%20Fenton%2C%20Regional%20Director%20for%20London%2C%20OHID.pdf). He notes how the pandemic has shone '*an unrelenting light on persistent, emergent and pervasive social and health inequalities'* but has also highlighted the importance of place-based approaches for addressing current public health challenges in an equitable and sustainable way as well as the importance of community-centred and culturally competent public health programmes. His call for the engagement of communities in every aspect of the design, delivery, scale up and evaluation to help address the disparities of health outcomes would seem to resonate with the WCC approach but, of course, also needs to be reflected in the NHS at primary care network levels, the integrated care systems (ICS) and NHS hospital services.

10 Good practice

10.1 Building a base

10.1.1 This report has identified the presence of good practice within WCC although this is largely based on its own descriptions of its activities and those activities that are currently reported online, in council documentation and stakeholder interviews with WCC and NHS officers and the lead Cabinet Member for this period.

10.1.2 The coming years may offer considerable resources related to the pandemic from multiple perspectives to offer further examples of good practice, with the lessons more easily observable with the benefit of hindsight.

10.1.3 The City of Westminster Archives have a strong tradition of curating its work to engage young people (see '*Why Archives, Why Now?'* published by the London Archives Partnership). It may wish to offer facilities to curate personal and organisational accounts or narratives to enrich its understandings of the pandemic and to identify where gaps in the evidence may lie. A Pandemic Archive, for example, (https://libguides.stir.ac.uk/c.php?g=530467&p=4844635) was an early development by the University of Stirling in Scotland.

10.1.4 Other initiatives relevant to WCC work on inclusion are, for example, Queer Pandemic - a video-based oral history project aimed at collecting stories about the experiences of LGBTQ+ people living across the UK during Covid-19 being run locally (see https://www.westminster.ac.uk/current-students/events/preserving-lgbtq-experiences-of-covid-19) and thought pieces on the impact of the pandemic on urban tourism (see for example a comparison of London and Paris (https://westminsterresearch.westminster.ac.uk/download/e468d9410d82a6d302e6e87b117ff5d8ac6e230c1df200c91b22e824a8ee042d/457206/Pappalepore%20Gravari-Barbas%20%282022%29%20COVID19%20and%20the%20localisation%20of%20tourism-%20author%27s%20final%20draft.pdf).

10.1.5 As learning from the pandemic developed, WCC extended and developed its community engagement activities in partnership with the voluntary sector to reach Global Majority Groups and work alongside community leaders to spread messages on vaccination and keeping safe.

10.1.6 WCC appeared able to build on its long-standing work to accelerate its in-depth community engagement programmes described above, such as, for example, its Community Champions work to launch COVID Champions and DLUHC Programme - these largely focused on Global Majority groups. These approaches may have contributed to the relatively good uptake of Covid-19 vaccinations by area of deprivation, bucking the London and national trends.

10.1.7 While not so central to adult social care and health, the council's overview of its pandemic response, notes that WCC's work with schools was extensive including regular meetings with headteachers and staff to support schools to stay open and information about vaccinations was also delivered to the head teachers' forum, and other educational channels. WCC was able to support all schools to remain open throughout the course of the pandemic; such work is not just important for the children and young people but also to parents and carers working in frontline services.

11 Lessons learned

11.1 Pandemic preparedness

11.1.1 New emergencies, such as Extreme Heat, Mpox, and polio outbreaks, have been identified (IR September 2022) as potentially informed by the Covid-19 pandemic experiences under a revised WCC All Hazards Outbreak Management Plan. One lesson evidently being well taken on board by WCC and its partners is that action on vaccinations (not just for Covid-19) and immunisations, will continue to be necessary and enhanced by using inclusive language, sustained champion engagement, more accurate data and promotion of trust. Councillors may wish to hear further of this work over the coming years.

11.2 Changing relationships and trust

11.2.1 Relationships with the new North West London (NWL) Integrated Care System (ICS) are presenting challenges and opportunities for WCC around risk assessments and management. These are likely to emerge over the coming years and have already been alluded to in pandemic reporting in general terms. It is hoped that there will be continuity of relationships.

11.2.2 Similarly, partnership activity on subjects such as preparedness and responses to emergencies will need development with new central government bodies, notably in the public health sphere. As WCC's IR report (September 2022) observes, there is a plan to expand the role of the Health Protection Board to include immunisations and cancer screening, making this a more prominent and wider WCC inter-agency commitment.

Considerations have been given to the implications for governance and operations following a review of the HPB.

11.2.3 The government's report on lessons learned about communications with the public would seem of substantial relevance to WCC and its partners (https://gcs.civilservice.gov.uk/publications/covid-19-communications-advisory-panel-report/#Lessons-learnt). It was interesting to see that WCC activity was cited in this report (evidence from July 2020) and WCC doubtless has reflected on this compilation of good practice and evidence such as the shift to online digital communications, the need to see communications as part of strategic thinking and leadership, the development of hub or networked multi-agency working, and the need to ensure communication best practice equality.

11.2.4 Dealing with disinformation and misinformation was further noted as being a more prominent part of communication activities by governments and their partners. The role of WCC trading standards officers is pertinent here and may be more formally integrated into WCC pandemic discussions since activities such as scams and exploitation undermine trust and cause harm (see https://www.westminster.gov.uk/businesses/trading-standards/scams-during-coronavirus).

11.2.5 Further plans for improving community engagement could be developed in the coming months through consultative, creative and engaging approaches. As noted above, it will be important for NHS work on similar activities, such as promotion of its funding for community groups to help with addressing vaccine hesitancy (https://www.nwlondonics.nhs.uk/news/news/community-organisations-we-want-your-support), not to duplicate activities but to be collaborative.

11.2.6 From documents such as the Bulmer and colleagues' (2021) report mentioned in section 3.1.2 very similar approaches seem to have been taken by London councils to community engagement, probably because they were all working under pre-existing and pandemic specific pan-London systems. WCC will no doubt benefit from their wider reflections.

11.3 With the benefit of hindsight

11.3.1 Exercise Winter Willow (a Department of Health/Health Protection Authority test of the UK National Framework for Responding to an Influenza Pandemic) was held in 2007 but with limited local council engagement. This may have been a missed opportunity for central government to have considered local systems.

11.3.2 The report of this Exercise (http://data.parliament.uk/DepositedPapers/Files/DEP2007-0334/DEP2007-0334.pdf) and the government's response to the House of Lords' Science and Technology Committee Report on Pandemic Influenza – 3rd Report of Session 2008–09 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/238527/7722.pdf) make interesting reading with the benefit of hindsight. It is evident from this, the largest peacetime exercise on how to prepare for an influenza pandemic, that NHS planning was being informed and strengthened by the process of completing self-assessments of their pandemic plans in Decembers 2007 and 2008 and that NHS organisations were later encouraged to test their plans by the 2009/10 NHS Operating Framework. Lack of reference to this planning may not mean that WCC was not influenced by this learning but highlights how the learning from Winter Willow was more NHS focussed.

11.3.3 The much smaller planning activity, Exercise Cygnus (Public Health England 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment

_data/file/927770/exercise-cygnus-report.pdf), also focused on a possible pandemic. WCC may wish to ensure that learning from any future such exercises assumes greater prominence in its deliberations and engagement with residents.

11.3.4 With the benefit of hindsight, good practice in data recording within local NHS primary care needs developing as joint priority, as noted in section 2.1.2. This is acknowledged as an important basis for shared understandings, good decision making, sensitive planning and activity around population health and wellbeing, and in particular enabling health disparities to be reduced. The ICS will be central to resolving some of these complexities, including those of interpretation of the data, and help promote the obligation to clean and update patient records in practices where this is a particular challenge. Other recording could be improved or its requirements amended (see section 3.1.1).

12 Summary and conclusions

12.1 This review has its limitations of course; it was not a research study but is an opportunity for reflection and learning after the major system shock of the pandemic.

12.2 I saw evidence and confirmed in conversations with stakeholders of systems and processes that worked as well as they could in an unprecedented time and consistent as well as significant efforts to respond to disparities with some clear examples of innovation such as provision of air purification systems to all local care homes. WCC has already undertaken many steps to review the lessons learned from the pandemic including undertaking a review by the Health Protection Board and collating reflections from the Outbreak Management Teams to gather examples of positive and negative working.

12.3 I would recommend attention to occupational health for WCC staff and wider partners to address the pandemic's legacy.

12.4 WCC's response clearly built on many long-standing initiatives and ways of working such as community engagement and effective working practices with its neighbours and local NHS bodies. The views of other parties in the community and voluntary sectors would help confirm this impression. There would seem room to seek out the views of local care providers and people with care and support needs to ascertain what was useful and what might be improved.

12.5 Positive relationships with new NHS structures look set to maintain the focus on improving patient registration data and the council may wish to ask for progress reports on this matter. This might provide greater confidence about decisions on the allocation of resources and priorities to address inequalities.

12.6 WCC also played a major role in pan-London activities and benefitted from its pooled expertise in planning and response, despite the limited opportunities to engage in risk planning exercises to the same extent as the NHS. Many of these activities have been detailed in the above sections of this report while specific Standard Operating Procedures, 'how to guides' and other documents have also been revised. These are operational and governance imperatives that may not attract publicity but are crucial to managing high level risks and could contribute to 'stress testing' of systems in the future.

12.7 Continued work on the effectiveness of community engagement, communications and deeper analyses of the impact of the pandemic could usefully add to the ambitions and vision of WWC to create and sustain a Fairer Westminster.

Appendix 1 - Terms of reference

City of Westminster

Title	Scoping an independent review of Westminster City Council's Pandemic response including the local uptake of Covid-19 vaccinations
Author	Anna Raleigh, Director of Public Health
Date	14th November 2022

1. **Purpose**

1.1. An independent review of Westminster City Council's pandemic response is required to ensure system wide learning is identified which will shape future outbreak management and emergency preparedness.

1.2. The review will ensure the delivery of the two related manifesto commitments

- Urgently review the root causes of Westminster having one of the lowest vaccination rates in the country and put in a place a plan to make sure everyone in our community has the information they need to get protected from Covid-19.
- Order an independent review of the Council and other local providers' pandemic response, and identify lessons learned to inform future planning.

2. **Findings of the Internal Review**

2.1. A comprehensive internal review has concluded to ensure lessons learned from the response to the pandemic are identified to shape future outbreak management and emergency preparedness.

2.2. The review concluded there was effective cross-functional working, data led decision-making, high quality and innovative use of communication and community engagement. The internal review noted that Covid measures implemented across settings were highly effective in preventing the further spread of Covid-19 in the borough.

2.3. Challenges centred on the speed of decision making, clarity of multi-agency roles and responsibility, funding uncertainty and communications including appropriate response to false messaging.

2.4. The flexibility of the organisation was recognised including the ability to identify experienced workforce able to response at pace to guideline changes and overcome data sharing barriers.

2.5. As with national trends, deprived areas experienced higher diagnosis rates and mortality rates. In addition, people from Black ethnic groups were most likely to be diagnosed and experienced significantly higher mortality than White groups. An interconnected range of factors were recognised as contributing to this observation including socioeconomic deprivation, involvement in high contact or high-risk occupations, geography, household size and composition, and comorbidities.

2.6. Vaccination uptake was seen to be subject to similar disparities with the lowest rates amongst Black and Mixed ethnicities although in Westminster rates did not appear to vary by deprivation.

2.7. Partnership working across the council, with voluntary sector partners and with the NHS, and community engagement was core to ensuring that areas of concern were recognised, challenged and addressed. Targeted communications, welfare support and vaccine promotion was undertaken.

2.8. Regular meetings with NHS and Council senior leaders were convened throughout the pandemic to maintain focus and oversight. When necessary, extra support was provided to NHS in order to protect residents' health.

3. Scope of the independent review

3.1. An independent reviewer is requested to:

- Interrogate the findings of the internal review undertaken by Westminster City Council;
- seek clarification if needed from identified people, and
- identify good practice and further lessons to be learnt.