

Health & Wellbeing Board Agenda

Wednesday 22 July 2020 at 10.00 am
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
Janet Cree - H&F Clinical Commissioning Group
Toby Hyde - Deputy Director of Transformation, Imperial College Healthcare NHS Trust
Inspector Mark Kent – Metropolitan Police
Councillor Larry Culhane - Cabinet Member for Children and Education
Dr Nicola Lang – Acting Director of Public Health
Jacqui McShannon - Director of Children's Services
Lisa Redfern - Strategic Director of Social Care
Glendine Shepherd - Head of Housing Solutions
Sue Spiller - Chief Executive Officer, SOBUS
To Be Confirmed - Healthwatch Representative

Nominated Deputy Member

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

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Date Issued: 14 July 2020

Health & Wellbeing Board

Agenda

<u>Item</u>		<u>Pages</u>
1.	APOLOGIES FOR ABSENCE	
2.	DECLARATIONS OF INTEREST	
	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
3.	MINUTES AND ACTIONS	4 - 12
	<p>(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, 9 September 2019.</p> <p>(b) To note the outstanding actions.</p>	

- 4. LEARNING FROM COUNCIL - NHS JOINT WORKING DURING COVID - UPDATE AND NEXT STEPS**
- The Board to receive a joint verbal update from Lisa Redfern, Strategic Director of Social Care (LBHF) and Toby Hyde, Director of Transformation, Imperial College Healthcare NHS Trust.
- 5. H&F CAN: COMPASSIONATE COMMUNITIES - UPDATE AND NEXT STEPS** To Follow
- The Board is invited to consider an update on the work of local community organisations such as H&F CAN.
- 6. IMPACT OF COVID ON BLACK, ASIAN MINORITY ETHNIC (BAME) COMMUNITIES - UPDATE AND NEXT STEPS** 13 - 14
- The Board to receive a joint update from Dr Nicola Lang, Acting Director of Public Health, Nicola Ashton, Strategic Commissioner and Peter Smith, Head of Policy and Strategy.
- 7. PRIMARY CARE UPDATE** To Follow
- The Board is invited to consider a report from H&F Clinical Commissioning Group which provides an update on Primary Care.
- 8. CONTACT TRACING AND PREVENTION PLAN FOR HAMMERSMITH & FULHAM** 15 - 18
- This information report sets out the Hammersmith & Fulham local Outbreak Control plan which was developed in June and contains seven sections that outlines shared best practice with other Local Authorities.
- 9. TESTING ON DISCHARGE TO PEOPLE RECEIVING COMMUNITY SUPPORT** 19 - 25
- This item is for information on only and provides slides which contains guidance about readmission from hospital of an existing resident for Hammersmith & Fulham care homes.
- 10. WORK PROGRAMME**
- The following items are suggested for the Board's workplan:
- COVID impact on young people's mental health
 - Digital Inclusion - GPs online

11. ANY OTHER BUSINESS

12. DATE OF NEXT MEETING

The Board is asked to note the date of the next meeting on Wednesday, 30 September 2020.

London Borough of Hammersmith & Fulham
Health & Wellbeing Board
Minutes



Monday 9 September 2019

PRESENT

Committee members:

Vanessa Andrae, H&F CCG
Councillors Ben Coleman (Chair)
Janet Cree, H&F CCG
Anita Parkin, Director of Public Health
Lisa Redfern, Strategic Director of Social Care
Sue Spiller, Chief Executive Officer, SOBUS

Nominated Deputies Councillors:

Lucy Richardson

Nominated Representatives:

Melia Simone, Head of Homeless Prevention Assessment
Keith Mallinson, Healthwatch

Officers: Jo Baty, Assistant Director Mental Health LD Provider; Prakash Daryanani, Head of Finance, ASC; Linda Jackson, Assistant Director, ASC; CCGs; Olivia Clymer, Chief Executive Officer, Healthwatch; Dr Robert McLaren, Primary Care Network (Park Medical Centre); John Pullin, H&F CCG; and Sue Roostan, Deputy Managing Director, H&F CCG.

10. MINUTES AND ACTIONS

RESOLVED

That the minutes of the meeting held on 25 June 2019 were agreed as an accurate record.

ACTIONS AND MATTERS ARISING

Janet Cree provided a brief update on the CCG Governing Body consideration of the decision of the CCGs to merge. A paper would be considered by the Council's Health, Inclusion and Social Care Policy and Accountability Committee (HISPAC) at their meeting on 11 September 2019. The recommendation was to defer the merger and aim to work towards implementation in April 2021. The transition year would be used to plan and ensure that the requirements of the NHS LTP were met.

Councillor Coleman welcomed and supported the recommendation but sought further clarification about the specific details. The decision had been deferred and he enquired what the outcome would be if the CCGs were not ready to merge in April 2021. Janet Cree outlined that the deferred merger reflected an aspiration to merge and was optimistic that it would go ahead although she acknowledged that she did not know what would happen if the CCGs decided against a merger. An assurance framework would be established with agreed measures to identify the relevant issues to be considered. Vanessa Andrae added that there were clear governance structures to be put in place and that would need to be agreed by a membership vote throughout the North West London CCGs. It was noted that this would be further discussed at HISPAC.

11. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Patricia Quigley and Larry Culhane; and Dr James Cavanagh, Steve Miley, Glendine Shepherd and Nadia Taylor.

12. DECLARATIONS OF INTEREST

None.

13. BETTER CARE FUND

Linda Jackson and Sue Roostan outlined the background work undertaken on the Better Care Fund (BCF). There were several things that the CCG and the Council were keen to deliver in partnership with primary care preventing people from going into hospital. Paragraph 1.3 was clarified as referring to a “draft” local proposal. Work had commenced on the developing the range of services deliverable by working in partnership. The spend on this would be further monitored and a paper provided to a future Board meeting. A large piece of work on co-production would be undertaken, together with a review of carers, understanding the evaluation of carers in the context of the spend. Winter funding had also been received and Linda Jackson explained that they would be working with colleagues on how this would be applied.

ACTON: Paper on the BCG to be provided to a future Board meeting

Sue Spiller enquired what had been funded and utilised in the past two years. Prakash Daryanani explained that the plan was divided into three sections and supported a range of services. There were CCG delivered services such as the Community Independent Service. The CCG also was the lead commissioner with the local authority, for example, the joint equipment contract (accommodation).

Sue Spiller asked whether a trend in demand for care services could be identified and Lisa Redfern agreed to provide available data. Sue Roostan added that it had been possible to identify co-production outcomes in terms of what could be delivered for residents. Lisa Redfern explained that due to the late provision of guidance in July (it had been expected in May) had

prevented more timely consideration by the Board. Sue Roostan explained that the requirements to be satisfied formed part of four national conditions generated by the Department of Health (the metrics of which were set out in page 6 of the Supplementary Agenda).

Keith Mallinson commented that there was no reference to mental health and enquired if any work on this was planned. It was clarified that there was reference to delayed discharges on mental health which was included within the metrics, together with mental health services as part of the BCF and that the Council was performance measured on this. The next deadline to be aware of was 27 September 2019 and it was noted that some decisions would have to be taken outside the Board. The response template was to be completed by 20 September 2019 and the Chair of the Board and H&F CCG will be invited to sign off.

ACTION: BCF Plan was agreed. Chair of the Board and H&F CCG may sign off final template outside the meeting.

RESOLVED

That the report was noted by the Board

14. PRIMARY CARE NETWORK

Janet Cree, a colleague from H&F CCG and Dr McLaren provided a brief overview of primary care networks (PCN) and how five PCNs would be configured in Hammersmith and Fulham. The concept of PCNs was described as a group of GP practices working together to provide population healthcare. This was not a new concept but offered formalised, structured and developed links within the context of wider changes to GP contracts.

The five-year NHS LTP was issued in January 2019 and the direct enhanced service (DES) timeline extended to March 2019. Considerable work had been undertaken with GP practices to obtain the best provision to meet the needs of residents. The PCN structure had been formally agreed and PCNs practices had signed up to it in addition to their core GP contracts and the DES. This was envisaged as a group of practices delivering a group of services for a portion of the population. The network DES would receive funding to appoint directors and offer extended healthcare access across the population from 1st July.

Details had not yet been provided and in April 2020 there would also be a requirement for each of the PCNs to deliver on the specifications. The PCNs would deliver a range of services provided by health professionals working alongside the GP Federation. The services would be wide ranging with a significant impact and would be mobilised as quickly as possible.

Councillor Coleman enquired about social prescribing and it was explained that work was ongoing to recruit social prescribing link workers for each of the three PCNs. The CCG would also be providing training to Patient and Public Involvement (PPI) groups. Meetings with groups would be held at network

level and working with them was a priority for the CCG. This was a big change in the way in which things were organised but there was a requirement to produce plans in a very short time. It was important to understand what it was that PCNs were required to deliver and the anticipated journey. Some additional investment was to be provided to enable clinical delivery going forward.

The role of clinical directors and their specific role would be key in developing the foundations of PCNs. The five PCNs for Hammersmith and Fulham would include GP At Hand, each covering between 30,000 and 70, 000 patients. With reference to GP At Hand, it was stated that from the CCG perspective, the aim was to respond and support patients that were part of the GP At Hand network (approximately 71,000), even though they did not all meet criteria of placed based commissioning. This would have to be further considered going forward as it involved a significant number of patients of which only 17, 000 were resident within the Borough.

Councillor Richardson enquired what would be different following the introductions of PCNs and the potential impact on the day to day provision of health services. Dr McLaren was unsure if he could explain this fully. There were huge challenges to be addressed with insufficient time or resources. Excellent directors had been appointed and he was hopeful that they could adapt these roles to their professional, clinical commitments. The Federation was to deliver the PCN agenda and would collaborate to ensure that they work efficiently but the PCN was in the early days of implementation. The main area of work was around social prescribing and plans to submit a bit to Macmillan fund were in train.

Councillor Coleman was encouraged by the increased number of social prescribing link workers and was keen to support this working with GPs and the PCNs.

Keith Mallinson welcomed the report and the support being offered to PPI groups referenced on page 66 of the Agenda pack being considered at a network level. Healthwatch also welcomed the opportunity to be involved in the PPI offer and Janet Cree suggested that he contact Bethany Golding who was a key part of this work.

Councillor Richardson welcomed the work on integrated care and enquired if there would be an opportunity to scrutinise the PCNs, given the time and resourcing issue. Janet Cree confirmed that PCNs would be discussed in more detailed at the forthcoming HISPAC meeting. The plans for the PCN were evolving and developing. It was important to identify the measurable aspects, whether they were achieving intended aims and objectives. It was envisaged that this would form part of the scrutiny process but not immediately.

Sue Spiller expressed her interest in the planned engagement and involvement with the third sector. These were small, well placed organisations that were well placed for engaging with local communities and she was keen to understand how SOBUS could support work on social

prescribing and how this could be facilitated, encouraged and supported. Janet Cree responded that there was an opportunity to do this through the integrated care partnership.

Councillor Coleman asked that if the aim was to signpost residents to what was available then the third sector would need to respond. He asked if the CCG would support the third sector through investment or additional resources. Janet Cree responded that from a partnership perspective the CCG also worked with other organisations and that if there was to be a shift in resources this would need to be included in the work programme and be further discussed. There was a lack of clarity currently within primary care as to what could be provided by the third sector and it was hoped that this could be addressed through the work on social prescribing and improving the interface with the third sector.

Sue Spiller concurred that it was not just a matter of funding but that it would take time to make the shift in perspective which will attract better resources. However, understanding how this would work together in practice was complicated. There was a need to balance existing provision and adjust offers accordingly through the PCN. Vanessa Andreae added that this was an excellent opportunity to have the involvement of the third sector. The DES was about widening the scope of the offer and highlighted what else may be on offer in the community. The information and communication about this needed to be correct and a local conversation about the PCNs was essential, for example, the third sector being represented on PCN boards, acknowledging that there were different resident demographic profiles in different geographical parts of the Borough.

Councillor Richardson asked Dr McLaren about his view on the changes given how hard GPs currently worked and the views of his GP colleagues. He explained that the mood was positive with some practices anxious about working more closely together and what this might mean. Generally, there was a sense that practices were going to have to rely on PCN income to survive.

Councillor Coleman enquired whether the aim was to replace contracts. Janet Cree responded that there would be two elements: a core contract, and then in addition, the PCN DES which was growing in scope. Most of the work was to potentially shift resources to becoming more population based. It was confirmed that there would be 72 PCNs across London and that it would be the same process from everyone as they would all be responding to the need to align with the requirements of the integrated care system (ICS) level organisation. These would have a bigger footprint across all the boroughs and there would be 55 ICS across the country.

Councillor Coleman commented on the CCG support for the merger and observed that the intentions outlined by Mark Easton (Accountable Officer, NWL Collaboration of CCGs) were unclear, bringing together many different elements at the same time. Janet Cree replied that the merger of the CCGs was about how commissioning staff were organised within the borough,

finance and office administration, and that part of this was about setting up the PCNs. This was the part that was also affected by the merger but the staff supporting PCNs and GPs remained in place and this would not alter.

It was confirmed that the PCNs were evolving and that further development would be undertaken once the specification had been provided and that this would have a long-term impact. There would be seven specifications in total, five of which would be in place by April 2019 and two further ones to follow by 2021. Janet Cree added that the CCG was also commissioning services across the Borough and was that this already included in part of the work being undertaken. It was noted that setting up the PCNs in themselves was not enough which was why there was a need for the NWL merger to be in place to provide an overarching infrastructure in the form of an ICS. The LTP commissioned an eight-borough delivery model and the merger was happening because of the expectation that the CCGs would align with the ICS for logistical reasons. The merger therefore, was the delivery vehicle for commissioning intentions.

Lisa Redfern commented that it was difficult to understand the whole system, particularly given the variation in terminology and the way this had evolved. Janet Cree confirmed that there was a plan about how this would be delivered and acknowledged that there had been a mixture and overlap of terminology, both old and new. The STP no longer existed and the ICS was current. The five parts of the STP also no longer existed.

One of the items expected to be discussed at HISPAC would articulate how the local authority could influence and shape outputs required to facilitate delivery of the LTP. Dr McLaren (as a clinical director) reported that practices were generally positive about the change and saw potential improvements in the way primary healthcare was offered in terms of the support they might receive.

RESOLVED

That the Board noted the report.

15. DRAFT CHILDREN AND YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) REPORT

Jo Baty presented the report on behalf of Mandy Lawson, Assistant Director of SEND. The JNSA (Joint Strategic Needs Assessment) was formulated and published in 2017, just as the Council left the shared services arrangement. It was reported that the outline data was broadly the same with 16% of the population with special educational needs (SEN).

It was difficult to capture data due to missing information and difficulties in drawing comparisons due to the differences in cohorts.

In terms of speech, language and communication needs it was important to note that the way in which schools captured SEN data was based on

presented need. For example, a child with SEN may be autistic, with mental health issues and physical disabilities, so the data was one-dimensional. 62%* of EHC (educational health care plans) were conducted in 2018, with only 8 not carried out. The data was significant and one that the service was very proud of. This was highlighted in the inspection report and indicated a huge improvement.

ACTION: *Exact data about ECH plans to be circulated.

It was explained that the relationship with the CCG was not as well embedded as it could have been at the time, but the inspection report identified a strong working relationship with the CCG and parents, so this was also welcome news. There was also an improved local offer accessible on the Council website for 0-25-years SEND. A young person had just been appointed to lead work on co-production to co-produce a SEND pathway. There was a large transition team in place, appointed in line with the transition report recommendations. This had been in place for one year but there was considerable progress to be made. In terms of post 16 pathways, it was reported that they were working with West London College to develop these in more detail.

There was a focus on early intervention and prevention, mental health wellbeing and joint working with CCG colleagues. They were also considering how to fund mental health pathways and how this work could properly support young people at risk. The speech and language SEND team was well established and further information about this was available. There were some excellent special schools in the Borough, and it would be interesting to identify if SEND arose within the local cohort or was imported, with many those with SEND moving into the area attracted by the local offer. On transitioning to a sovereign service, Jo Baty highlighted the need for more data and research, and they were fortunate to now have in place a team that offered a high standard of business intelligence.

Keith Mallinson asked how it would be possible to identify those with SEND in main stream schools as it was difficult to do this. Jo Baty explained that they worked with teachers and the wider education service. It was anticipated that a child may not meet the EHC threshold but may still have SEND requirements. It was confirmed that they were working to develop this further and welcomed the fact that experienced and committed staff had been attracted to working in the borough because of the innovative transitions and SEND collective approach to services.

It was noted that continuity of care for a child with SEN was essential. Some parents did not see the value of coming to a GP practice with provision was made in a special school (if the child was enrolled in one).

It was important that the child was able to see the same GP or medical professional at the same practice so that they are familiar with both professionals and the surrounding environment.

Jo Baty reported that a transitions conference was being organised by Parents Active. Alison Markwell had made a huge impact both pre and post

inspection and this had helped refine the way the service worked. Vanessa Andreae acknowledged that there remained difficulties in ensuring continuity of care, for example, ensuring long enough appointment time slots that could accommodate unintended late attendance.

The CCG had undertaken many workshops on how to deliver care to vulnerable patients and had worked with SEND colleagues to refine this. Councillor Richardson highlighted that training should be made available to GP to help them communicate with vulnerable patients as this would help encourage take up at surgeries. Vanessa Andreae confirmed that this was not generally monitored but there had been a trajectory of improvement which she had noted through her work with five strong practices.

With reference to data on page 5 of the report, clarification was sought about the number of those seeking an EHC plan and how many in the Borough already had one in place, highlighting the concern that parents may not be aware that their child might require an EHC plan. Lisa Redfern assured the Board that take up within the Borough was high. The Council worked closely with organisations such as Parents Active, undertook advocacy and support work and had received significant, positive feedback as a result.

Jo Baty confirmed that the data on page 5 referred to children aged 3 and 4, and acknowledged that this was low, but the Borough had a significantly high number of children with EHC plans. The statutory time frame in which an EHC was required to be completed was a critical element, as was the number of children who were eligible. This could potentially be cross referenced with the data held by GP practices.

Sue Spiller recounted how a vulnerable Somalian child within the criminal justice system had been targeted by gangs. The children were initially befriended ("mate" crime) and the family had struggled with trying to persuade police that the child had been a victim and not the perpetrator.

Lisa Redfern commented that in terms of renegotiating the new CLCH contract, it was important that performance on Learning disability Health checks was improved to above 90% completed.

It was confirmed by Anita Parkin that the next expected update for the JNSA was within five years. It would be helpful to consider specific pieces of work and plan priorities so that they corresponded to expected outcomes. It was also necessary to demonstrate how this would inform policy and it would be helpful for the Board to understand how this was done. A six-month update would be provided to the Board and it was agreed that CLCH would be invited to contribute to further discussions about this and learning-disabled health checks.

Vanessa Andreae pointed out that learning disabled health checks were primarily conducted by primary care so there was an issue around access to patient records because of the lack of integration between information technology systems.

In welcoming this encouraging report and drawing the discussion to a close, Councillor Coleman supported Councillor Richardson's view that it was often difficult for a young person to access GP care and that it was important that barriers to accessing care be carefully explored and identified. There was a similar point about the difficulties for children with SEN in accessing main stream schools. Councillor Coleman recognised that this required further work to understand how the Council could be more effective and asked that this also be explored in the six-month report.

ACTION: JNSA update report to be provided in six months (May/June 2020), to include input from CLCH who would be invited to participate.

ACTION: Details about the conference on autism to be circulated to Board members

16. WORK PROGRAMME

Councillor Coleman referred Board members to a piece reported in the Guardian newspaper regarding the CCG merger and how this had been postponed and delayed to April 2021. He expressed concern that the recommendation to merge would be rushed without full consideration and more information was required in order to understand the changes being sought.

Vanessa Andreae commented that this was within the remit of the JHOSC (Joint Health Overview and Scrutiny Committee) and that it was reasonable for the NWL Collaboration of CCGs to be called to account so that the output can then be locally driven. She also suggested that it would be helpful to identify how the social inclusion and loneliness (SIL) strategy linked in with the evolution of PCNs. Councillor Coleman welcomed this and asked that officers identify how SIL could be addressed in all future reports, to be included at the beginning of each report.

ACTION: Vanessa Andreae to seek further details about the merger recommendation

17. DATE OF NEXT MEETING

The date of the next meeting was noted as Wednesday, 11 November 2019.

Meeting started: 6.15pm

Meeting ended: 8.40pm

Chair

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Agenda Item 6

Impact of COVID on Black, Asian and Minority Ethnic (BAME) Communities – Update and next steps

PHE Report

PHE in their report *Beyond the data: Understanding the impact of COVID-19 on BAME groups*¹ made the following recommendations

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users....
4. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
5. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma
6. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.¹

Next Steps

H&F to work with local communities and stakeholders to develop Hammersmith and Fulham's response to the PHE recommendations across all council services.

1

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf pg. 50-51

Report to Health & Wellbeing Board – For information
22 July 2020

Contact Tracing and prevention plan for Hammersmith & Fulham

1 Executive Summary

Public Health England (PHE) are the lead for contact tracing, the role of Local Government has been unclear for several months. We now know that the local Authority is responsible for monitoring the number of positive residents within the community and managing outbreak plans and subsequent local lockdown plans.

2 The Local Outbreak Control Plan

2.1 Hammersmith & Fulham local Outbreak Control plan was developed in June which contains seven sections and will share best practice with other Local Authorities.

2.2 The Local Outbreak Control Plan has been developed to the existing pandemic in response to COVID-19. Implementation of the plan is using existing Governance structures (for example, the Senior Leadership Team and Recovery Board).

3 The Local Outbreak implementation plan

H&F Local Outbreak Implementation plan includes the following:

- 1 Planning for local outbreaks in care homes and schools
- 2 Planning for local outbreaks in other high-risk places, locations and communities
- 3 Identifying methods for local testing to ensure response that is accessible to residents in the borough
- 4 Assessing local and regional contact tracing and infection control capability in complex settings and the need for mutual aid
- 5 Integrating national and local data and scenario planning through the Joint Biosecurity Centre
- 6 Supporting vulnerable local people, including to get help to self-isolate
- 7 Establishing governance structures

In addition, we have developed the following:

- 8 Local risk register

The risk register tracks local needs assessment to identify priorities for contact tracing in Hammersmith & Fulham including numbers required to self-isolate, communities and individuals at greater risk through isolation or lack of engagement with contact tracing.

4 Data

4.1 Regional and National Data

Comparison of first 4 weeks of T&T regional and national data

T&T data	London	England
Cases registered	1,372	27,125
Cases completed	968 (71%)	20,039 (74%)
Contacts identified (all Levels)	7,897	153,442
Contacts completed (all Levels)	6,826 (86%)	132,525 (86%)

[Source: London data from contact tracing daily reports; England data from weekly T&T experimental statistics]

4.2 Data Issues

Problem with data	What we have learned so far	Solution for H&F
Incomplete postcode data possibly due to use of mobile testing units	We chase with PHE London however no solution yet	None yet
No workplace on our data on cases	Will be added slowly, we understand from DH	None yet
No school information on child cases	We have raised with DH data team	Further call to be arranged between Duncan Smith and DH colleagues
No data on positive cases that contact tracers cannot reach	We have asked PHE twice to share the data. They cannot as it sits with Tier 2 and 3 call handlers (PHE is Tier 1)	Once we have the Imperial data sharing with WSICC, PHE may re-consider?
No data on why contact tracers haven't reached someone or why not follow	Is it ethnicity, is it lack of mobiles in vulnerable persons	Once we have the Imperial data sharing with WSICC, PHE may re-consider?
We only have postcode and age in years	No patient identifiable data to help us locate people even those living together in a house	Data sharing with WSICC? (Imperial)

5 Risk assessments and outbreak plans

Outbreak plans that have been written and tested over the last three weeks. These are evolving and the outcomes of the learning from the testing are being shared across the Council to learn lessons and ensure continual improvement. Outbreak plans tested to date include:

- Care settings Inc. extra care
- Special schools
- Mainstream schools
- Early years
- HMO
- Sheltered housing
- Workplaces
- Places of worship
- Homeless hostels

6 Key Stakeholders

- Public Health England (PHE)
- Local providers including drug and alcohol services (Turning Point)
- Sexual health provider (Chelwest)
- Local GP practice (Brook Green/North End/Richford Gate)
- Imperial Healthcare NHS Trust
- Imperial Health Partners and College
- Whole System Integrated Care NWL
- Department of Health
- Community groups/faith groups

7 Community Outreach Insights

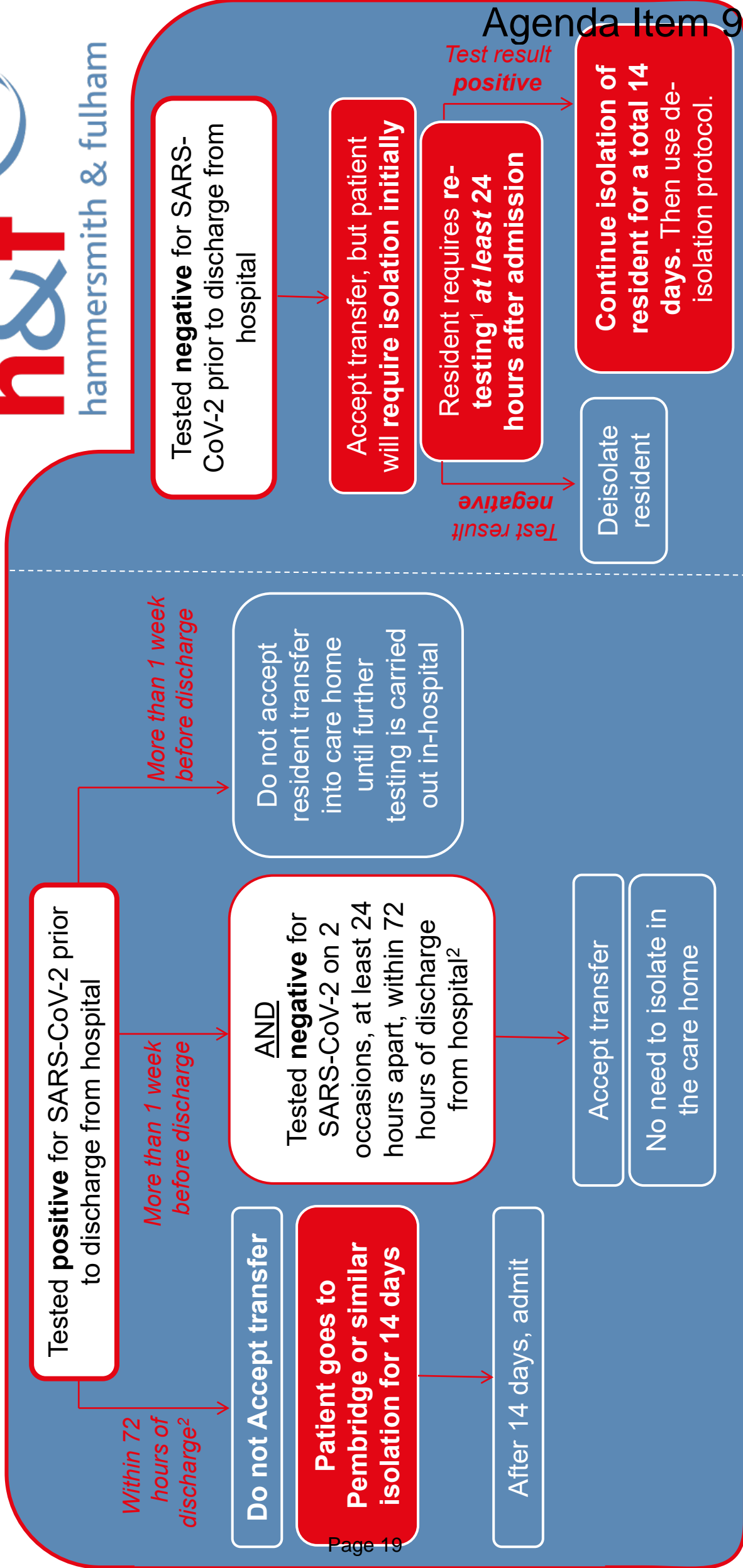
- Focus groups held so far by Aysha Esakji and Niki Lang (28 June to now)
- Mother and Child Welfare Organisation and Prevent Action Group (Faith Leaders)
- People worried about their children's safety in school
- Well informed about issue of higher mortality in BAME groups and also their own levels of diabetes
- Concerned that attending NHS settings means they are ignored or will catch COVID or be tested unnecessarily
- Worried about distancing in market stalls and small businesses
- Worried about mosques re-opening and how community will be perceived

8 Prevention

A range of prevention and Early Intervention opportunities have been taken as they have arisen

- Advice provided to care nursing homes re cleaning and laundry practices.
- Engagement throughout lockdown with businesses. Letters sent with link to guidance to licensed premises, takeaways, approved food premises. Proactive monitoring business closures. Prohibition Notices served on businesses that were not permitted to open/prohibit consumption of food or drink on premises. Reactive work in respect of complaints received.
- Letter/poster sent to over 400 mandatory licensed HMOs.
- Daily liaison meetings with Licensing MPS team, Licensing and Food & safety team to feedback intelligence and determine course of actions.
- Football players tweets ahead of Super Saturday (after complaints re ASBO and street parties).
- Visit made by GM and RS to SB Mosque. To implement a one-way system (entry/exit), single use prayer mats, shoe bag provided, worshippers to bring own prayer book, duration of service limited to 30 mins am and pm, cleaned in between, 2 m distance between worshippers. The trustees informed us that they are looking to provide security marshals to manage the queues outside the mosque.
- Ongoing conversations with the Somali Community and the Director of Public Health

READMISSION FROM HOSPITAL OF AN EXISTING RESIDENT: GUIDANCE FOR HAMMERSMITH & FULHAM CARE HOMES



Agenda Item 9

1. FOR ALL RESIDENTS, THE GP WILL ARRANGE FOR SWABBING. 2. FOR DISCHARGE FROM HOSPITAL, RESIDENTS REQUIRE EITHER 1x NEGATIVE SWAB WITHIN 72 HOURS OF DISCHARGE OR, IF THEY HAVE PREVIOUSLY TESTED POSITIVE FOR COVID-19, 2 NEGATIVE SWABS (AT LEAST 24 HOURS APART) WITHIN 72 HOURS OF DISCHARGE

Admission criteria (new admissions)

- No symptoms in 2 weeks before admission (fever, cough, shortness of breath, anosmia, loss of taste, anorexia, gastroenteritis or other)
- Referral form filled in (Dr Wright & Dr Cavanaugh's new form with medical referral details)
- Not a contact of a known case i.e. was not self isolating as a contact at home

- **If admitted from home**

- Needs isolation for 14 days after admission to the home

<https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes#annex-c>

Patients who go home on a weekend visit

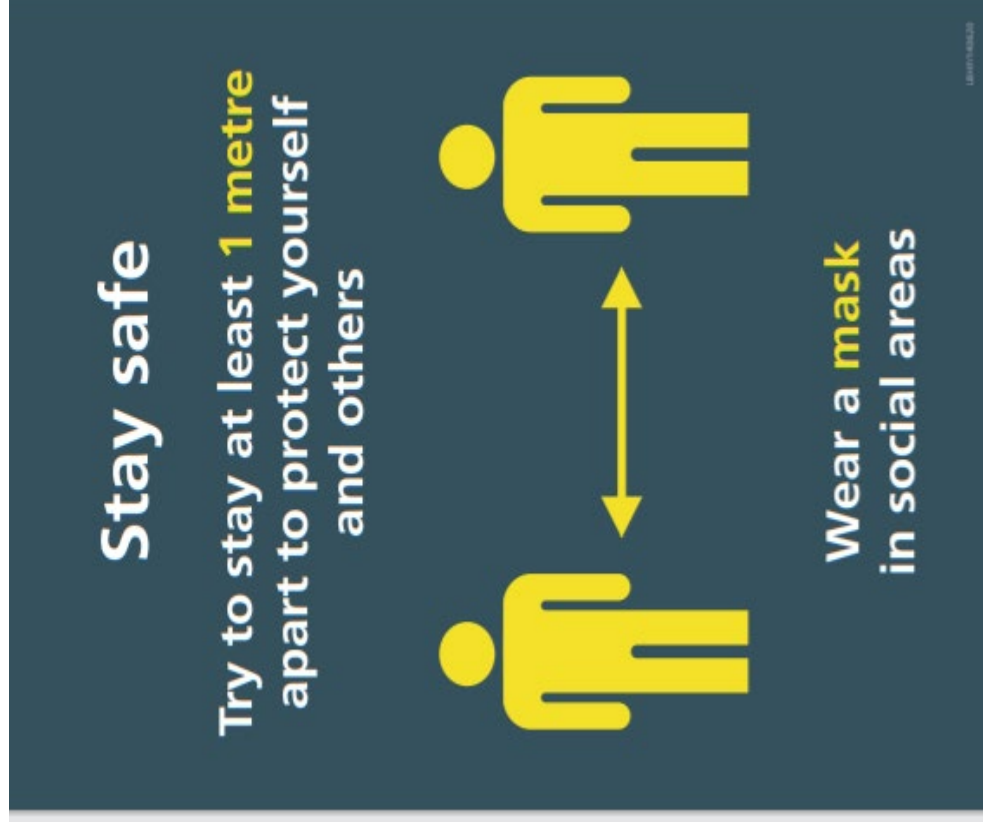
- Have to isolate on return to the NH for one week then
- Need a virus swab on day 7, then another >24 hours later
- Only de-isolate if both tests negative

Visitor protocol

- Only one visitor allowed per visit
- Visitors need to have been asymptomatic in the past week (no fever cough, shortness of breath, loss of taste or smell)
- Cannot visit if they are a contact of a case (i.e. during their 14 day isolation)
- Visits to take place outside
- With social distancing of at least one metre
- Visitors advised to wear a face covering
- <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19>

Staff socialising and resilience

- Don't overcrowd communal or office areas
- If staff working in same room, **wear a mask if possible**
- Keep at least 1 meter apart
- Only 2 people max in a coffee break area if possible
- Don't prepare food together
- Wash hands frequently
- Don't share lifts/cars to work
- Don't share snacks
- Use the posters (ask LBHF comms to print off)
- Try to meet or eat outside
- Providers please think of what you would do if 50%/100% staff are a contact and must isolate. **Have plans in place eg mutual aid/ living on site**



Discharges into sheltered housing or homecare after admission to hospital

- All patients to be swabbed before d/c
- need a swab result within 72 hrs of returning home
- Then share result with carers and cleaners and sheltered housing manager as soon as available
- If no result, do not discharge

- All carers and cleaners to wear full PPE and take all IPC precautions regardless of positive/negative status of client

People who are not admitted and just visit A&E (in and out) from care homes or homecare

- A swab result reflects what happened in the community rather than acquisition in hospital
- **If they have symptoms of COVID** – fever, cough, loss taste or smell (include atypical symps in older ppl eg loss of appetite) – then swab when in A&E

All carers and cleaners to wear full PPE and take all IPC precautions regardless of positive/negative status of client

- **No need to wait for result before leaving A&E**
- **share result ASAP with the GP as soon as it comes out**
- **If no COVID symptoms then no need to swab**