London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

Thursday 10 September 2020 at 6.30 pm
This meeting is being held remotely
You can watch a livestreaming of the meeting on: YouTube

MEMBERSHIP

Administration	**Opposition**
Councillor Lucy Richardson (Chair) Councillor Jonathan Caleb-Landy Councillor Bora Kwon Councillor Mercy Umeh	Councillor Amanda Lloyd-Harris
Co-optees	
Victoria Brignell - Action on Disability, Action On Disability Jim Grealy - H&F Save Our NHS, H&F Save Our NHS Keith Mallinson Roy Margolis	

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Date Issued: 11 September 2020

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

10 September 2020

Item **Pages**

1. APOLOGIES FOR ABSENCE

2. ROLL CALL AND DECLARATION OF INTEREST

A roll call will be carried out to confirm attendance and members will have the opportunity to declare any interests.

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

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

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors 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.

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

3. MINUTES OF THE PREVIOUS MEETING 4 - 14

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on 8 July 2020; and

(b) To note the outstanding actions.

4. PUBLIC PARTICIPATION

This meeting is being held remotely via Microsoft Teams. If you would like to make a comment or ask a question about any of the items on the agenda, either via Teams or in writing, please contact: bathsheba.mall@lbhf.gov.uk

5. COVID-19 UPDATE

This item provides a verbal update from the Director of Public Health on Covid-19. Verbal

6. SUPPORTED EMPLOYMENT

This report considers the support provided to young people with disabilities so that they are able to find suitable employment in a supported setting. It will look at current provision and what has worked successfully. To follow

7. COMMUNITY TRANSFORMATION - MENTAL HEALTH INTEGRATED NETWORK TEAM 15 – 33

This report provides more detailed background as to the development of the Mental Health Integrated Network Teams (MINT) across Hammersmith & Fulham. The report contains the detail held with the staff consultation document “Development of Mental health Integrated Network Teams (MINT)” and follows workshops in each borough that ran before March 2020.

8. WORK PROGRAMME 34 – 37

The Committee is asked to consider its work programme for the remainder of the municipal year.

9. DATES OF NEXT MEETING

Wednesday, 4 November 2020

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London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Wednesday 8 July 2020

PRESENT

Committee members: Councillors Lucy Richardson (Chair), Bora Kwon and Amanda Lloyd-Harris

Co-opted members: Victoria Brignell - Action on Disability (Action On Disability), Jim Grealy - H&F Save Our NHS (H&F Save Our NHS), Roy Margolis and Jen Nightingale

Other Councillors: Ben Coleman

Officers and guests: Mark Jarvis, Head of Governance, H7F CCG, Diane Jones, Chief Nurse and Director of Quality, NHS North West London Collaboration of Clinical Commissioning Groups (NWL CCGs); Dr Nicola Lang, Acting Director of Public Health; Professor Tim Orchard Imperial, CEO, Imperial College Healthcare NHS Trust; Lisa Redfern, Strategic Director of Social Care

Councillor Lucy Richardson began the meeting with a minute's silence to remember those who died of Covid-19. Acknowledging the work of the National Health Service (NHS), Councillor Richardson thanked clinicians, key workers and volunteers, and all those involved in responding to this global issue.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Jonathan Caleb-Landy and Mercy Umeh, and Co-optee Keith Mallinson.

2. DECLARATION OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

RESOLVED

The minutes of the previous meeting held on Wednesday, 4 March 2020 were agreed as an accurate record.

6. ITEM 4 SUMMARY OF ADULT SOCIAL CARE'S RESPONSE TO COVID-19 AND ITEM 6 STAFF AND RESIDENT TESTING IN CARE HOMES

RESOLVED

At the request of the Chair that Items 4 and 6 be considered together.

Item 4: Summary of ASC's Response to Covid-19

Lisa Redfern provided a summary of key work undertaken by Adult Social Care and Public Health, jointly working with the NHS and H&F CAN volunteers. This had been a time of significant challenge, but excellent work had emerged which had saved lives and protected residents. There had been much learning gained by Council staff and volunteers working jointly and effectively at pace on several areas in an agile manner.

The Council had worked hard to provide social care and support for residents. Four months ago, a situation where people could telephone if they were lonely or isolated, seven days per week, could not have been envisaged and this was a remarkable achievement. Lisa Redfern expressed how proud she was that local volunteers had triumphed demonstrating what could be done with the right attitude. This paved the way and offered a blueprint for working collaboratively in the future.

The Council had improved relationships working closely with the NHS which led to a great deal of innovation and improved relationships. There had been many gaps in the provision of PPE (personal protective equipment, and unclear test and tracing protocols, but the successful delivery of local solutions had won the day. There was an urgent need for social care reform and the pandemic had exposed weaknesses in the care system demonstrated by the crises in care homes.

Covid-19 had shown there had been no regard for care home staff and residents or staff. Social care reform was not just a matter of funding; it was about ensuring parity of esteem between health and social care provision. Lisa Redfern was of the view that there had been no "protective ring" around care homes implemented by central government. Testing patients discharged from hospital into care homes had formed part of the H&F, local solution.

Lisa Redfern expressed concern that test and tracing nationally appeared rudderless. Locally, a team had been established by Linda Jackson and Dr Nicola Lang to work with environment colleagues and staff at Imperial College Healthcare NHS Trust. ,

Professor Tim Orchard concurred and felt that to state that there was a "protective ring" around care homes stretched the truth. Work that had been done with care homes and clinicians around infection control based at Charing Cross hospital had been very helpful. He recounted the experience of Lombardy which pre-pandemic had one of the best, acute healthcare systems in Europe but had run out of beds in March 2020. In addition to dealing with PPE shortages there had been a shift in focus, and they were forced to make decisions about which patients could be treated in intensive care units (ICU). In principle, he was of the view that discharging patients was not a concern if they did not have symptoms, but, recognised that the circumstances of patient discharge had not been properly thought through.

Professor Orchard also acknowledged that local action had made a difference. Professor Orchard illustrated the scale of the situation and reported that to date, the Trust had dealt with almost 1300 cases of Covid-19 and that of those, 427 had unfortunately died. At the height of pandemic (before and after Easter) 360 cases had been treated and of these, 132 had been ventilated. Under normal circumstances, there were 68 ventilator beds and 88 high dependency beds so that there had been double the number of ventilator beds in use which had required extensive work to set up.

This had been an intense period and a difficult situation for the ICUs but there had also been very sick patients on the wards. Professor Orchard briefly described "happy hypoxia", a condition where a patient's oxygen level became dangerously low resulting in them unwittingly feeling relatively well because of the lack of carbon dioxide but perilously close to death.

Professor Orchard concluded that It had been a very positive experience to work with Adult Social Care colleagues. Mark Jarvis echoed Professor Orchards comments and reiterated that the CCG had welcomed improved and effective partnership working arrangements which had facilitated more agile decision making and strengthened partnership between the CCG and the Council.

Victoria Brignell commended the Council on its distribution of PPE to the local community responding to requests with same day delivery. In response to her query about payments to care and support staff who had been asked to self-isolate. Lisa Redfern confirmed that the provision of £200 per week had been devised locally without restriction.

Councillor Lloyd-Harris said that she was impressed with the speed and agility of the Council and enquired if PPE could be provided at libraries so that residents could purchase e.g. masks. Linda Jackson confirmed that they had offered partners access to the Council's purchasing channel so PPE could be purchased at the same price.

The Leader of the Council, Councillor Stephen Cowan, was keen to maintain support to those that were currently shielding with plans to distribute 9000 plastic visors and masks so that they would have the confidence to go out and about.

This had been discussed with the CCG and local retailers to establish purchase points and the Council had also raised the issue with Transport for London whom they had arranged to meet with. It was confirmed that the Council had stockpiled PPE provision for a short period.

Councillor Kwon sought further information about access issues to testing, given that there were different processes depending on e.g. whether you were NHS staff, drive through testing or doing home kit tests. She asked if and how the issues had been resolved and what the plans for testing were. Professor Orchard explained that North West London Pathology undertook testing for trusts across NWL and had dramatically increased capacity to 3000 tests per day in addition to 500-1000 anti-body tests. Internally, Covid-19 tests were available to staff on request and about 9000 NHS staff had requested anti-body testing which was on-going.

It was thought that this would be completed within the next two weeks despite an issue with insufficient numbers of phlebotomy staff available to obtain blood samples for testing. For residents who become unwell at home with suspected symptoms, it was suggested that they were tested locally rather than go into a hospital. The Trust was also identifying patient pathways for treatment that were low risk to minimise the risk of infection and maintain control. There was now regular testing of asymptomatic staff in these treatment areas so that this could offer an early warning to exposure.

It was also recognised that there was a significant number of people generally who were asymptomatic. It was found that 0.23% of NHS staff tested were asymptomatic which had reduced from 2-3%. Timings for results Pillar 1 (internal) testing were good in NWL, with swabs being returned within 24 hours. Test results for high risk patients were provided within the hour.

Item 6: Staff and Resident Testing in Care Homes

Councillor Richardson welcomed Diane Jones to the discussion, to comment on her work regarding testing in care homes. Diane Jones highlighted the joint approach undertaken with the CCG and GP's working closely with the Council following concerns identified regarding a particular care home supporting residents with specialist, NHS continuing care packages.

These had first been raised by GPs early on who had found that the care home was struggling to implement measures and ensure the safety of staff and residents. A gap analysis identified further risks and solutions were developed to mitigate that risk which included staff training to manage Covid-19, infection control and training to use PPE safely. Measures were also put in place to help support leadership and to develop staff resilience in dealing with Covid-19.

Roy Margolis offered heartfelt thanks to Lisa Redfern, Diane Jones, Professor Tim Orchard and NHS colleagues on their commitment and work in response to the pandemic which he commended. He explained that his background experience and interest lay in digital health and asked about testing and tracing solutions.

Dr Nicola Lang explained that the contact and trace system was set up by Department of Health and lay outside Council control. The advice to anyone with symptoms was to call 119 and, following a call handler assessment, a home test kit would be despatched. The three-tier system was briefly explained. Tier 3 calls would be initially screened and escalated to tier 2, handlers who were retired clinicians, and then to tier 1. Overall there was data developing that offered a good picture as to who was getting tested.

Jim Grealy commended the Borough's efforts to keep residents safe, the way in which resources had been mobilised to support this and how the Council had worked with Imperial and health partners. With reference to page 16, line 4, he sought further clarifications of the definitions used, in terms of care homes and vulnerable "local" residents, and whether this was much broader, across North West London.

Lisa Redfern responded that Council officers had participated in daily, local NHS Gold meetings. This had led to a swift problem - solving approach. Lisa Redfern paid tribute to Dr Lang, who, despite being new to the Borough arriving at the just before the start of the pandemic had demonstrated a "can do attitude", forming strong working partnerships at the outset. Dr Lang was described as a "breath of fresh air" who had created a strong network, who "bucked the trend" and developed a local, innovative response to the crises. Without the partnership with Imperial several weeks would have been lost in developing that response.

Jim Grealy asked if local government funding and the mobilisation of resources would support the expected second wave and how this continue to be delivered going forward. Lisa Redfern confirmed that the H&F Administration was committed to providing whatever it took to combatting the challenges of the pandemic but that all partner organisations and agencies were facing huge financial challenges. Much of this would depend on guidance from central government.

Councillor Coleman added that senior Council officers and health partners had done what was necessary but it was quite concerning that the Secretary of State for Housing, Communities and Local Government, Robert Jenrick, appeared to have backtracked on assurances that local government would be recompensed and supported regarding the expenditure claims that arose from dealing with the pandemic.

The Council would continue to challenge central government to deliver on promised assurances of support. Councillor Coleman stated that the Council, despite strong resistance, had taken a unique decision to close care homes to admissions which had not been replicated elsewhere. Buoyed by the support of colleagues at Imperial, an infection control team had supported a care home in Chiswick. The Council spent approximately £2 million on procuring and distributing PPE and described how the they had worked with volunteers, community groups and mutual aid groups to achieve this. He applauded the work undertaken in bringing this network together, which could be strengthened and maintained.

Jen Nightingale recounted her experience of the pandemic and how she had been redeployed to work in an intensive care unit. Given the significant trauma that could result from dealing daily with Covid-19 related illness and death, she asked what psychological support and counselling was available to staff and community volunteers.

Lisa Redfern explained that the Council's occupational health team had offered open ended counselling to the Council workforce, care home and domiciliary staff. Professor Orchard explained that the Trust had implemented a range of support options. Clinical psychology teams had been deployed to support staff dealing where required, together with staff counselling. However, he cautioned that the response to trauma often materialised later and that enforcing unwelcomed support could worsen the situation. Counselling would continue to be available and accessible at a point at which individuals had been able to process their experiences. The wellbeing offer to staff was critical.

RESOLVED

That the verbal reports were noted.

5. PUBLIC HEALTH UPDATE FOR HISPAC

Dr Lang provided an update on the work carried out by Public Health which covered three main areas: care home testing, testing in schools and Covid-19 BAME issues. Dr Lang expressed her thanks to the support provided by Imperial clinicians that had stepped up to work collaboratively across nine different specialities to help form multi-disciplinary teams which included professors, virologists, senior matrons, paediatricians and epidemiologists. The group had been generous with their time and expertise, for which Dr Lang expressed her thanks.

A rigorous testing regime was established which included repeat testing. The work of the group had solidified and produced considerable guidance in response to a unique situation, with patients being discharged and readmitted to a care home. The generosity of all those involved became an immensely powerful force that had unified around a common purpose to find a solution to an urgent situation.

Describing the work on testing with schools, five H&F primary schools in a national Covid-19 study which Dr Lang regarded as a helpful corollary around increased school attendance. A piece of work to address the concerns around the disproportionate numbers of BAME groups affected by Covid-19. This included work with H&F GPs, smart messaging on YouTube planned on Type 2 diabetes. Dr Lang and colleagues had also met with a local Somalian group and began to engage with faith groups, facilitated with the help of Aysha Esakji (Community Coordinator, Safer Neighbourhood and Registrar services, Housing).

Councillor Lloyd-Harris sought further details about the national school's study that the five H&F primary schools were participating in.

The selection criteria in choosing the schools to participate included the percentage of BAME pupils. Keith Fernandez (Workforce Development Officer, Children's Services) had moved quickly to analyse BAME data to identify suitable schools.

Councillor Coleman stated that the Health and Wellbeing Board had set in train several strands of work that targeted the impact of health inequalities on BAME groups and stated that report from Public Health England and its recommendations would be taken forward by the Council. Local work would be undertaken to consider the evidence that would indicate the positive impact of Mutual Aid Groups, H&F CAN and community groups and how this was harnessed to support residents.

Jim Grealy commended the work undertaken on BAME and Covid-19 related concerns and the remarkable support offered by Imperial. The levels of deprivation and poverty experienced by BAME groups in poorer parts of the Borough had been recognised as contributory factors in the high rates of Covid-19 amongst BAME groups and Jim Grealy asked about the kind of work that could be undertaken to alleviate poverty. He also expressed an interest in any advice offered to shielding groups regarding mental health and wellbeing.

Dr Lang concurred that deprivation was a huge factor, coupled with overcrowded housing. The Office for National Statistics had analysed data indicating a link between the lack of outdoor space (garden) and BAME groups. People who lacked access to an outdoor space were more likely to converge outside in public spaces. The impact of a low income on the wider determinants of health was important as it became harder to self-isolate, if for example you lacked outdoor space. Dr Lang referred to the work of Jan Parnell (Assistant Director, Education) and her team in encouraging children to aspire to high profile occupations through careers guidance at school.

Linda Jackson described the extensive work undertaken to support approximately 9000 people who were shielding within the Borough, who currently received varying levels of support. For those that had accepted that they wanted to be helped, a programme of support had been developed between ASC and Children's Services to help people step back into society. This formed part of an on-going conversation ("Conversation Matters" programme, alluded to earlier by Lisa Redfern) with telephone help, and calls lasting up to 30-40 minutes, email and on-going support which was continuing.

Peer support had been provided by approximately 900 volunteers who had been DBS checked (Disclosure and Barring Service) and accompanied people as they went shopping for the first-time following lockdown restrictions being lifted. Equally, the support can be swiftly reinstated if lockdown restrictions were re-established.

Councillor Coleman reiterated concern about low income or zero hours work and deprivation, and the impact on those who felt forced to use public transport as they returned to work.

Transport for London (TfL) had given assurances that hygiene standards on public transport had been maintained through increased frequency of cleaning and the enforcement of the requirement to wear a mask while travelling on public transport (he acknowledged the inherent difficulties of this) which was essential in protecting vulnerable BAME and low income groups. Mark Jarvis commented that the CCG took the issue of health inequality seriously and the fundamental importance of addressing this, both locally and at NWL level.

Councillor Lloyd-Harris urged the Council to reconsider the need to retain public, open spaces for residents. Councillor Coleman responded that a Parks Commission had recently been established and which would welcome engagement and resident involvement from across the community. A growing misapprehension that a park was available exclusively for one "type" of resident needed to be challenged but it was clear that there was an overlap between good mental health and access to a green space.

ACTION: A letter from the Committee to TfL regarding the enforcement of the requirement to wear a mask when using public transport and to challenge travellers who were not in compliance with the restriction.

RESOLVED

That the report was noted.

7. IMPLEMENTATION OF TEST AND TRACE

Lisa Redfern provided a verbal update on arrangements to implement test and trace protocols.

When the concern around the vulnerability of care homes had become apparent, a programme board had been established about two months ago, which included Dr Lang, Linda Jackson (Chair), colleagues from environmental health teams to collectively address this. A local system had been successfully implemented.

Lisa Redfern queried as a fundamental failure why the UK had not nationally adopted a test and trace app model, as implemented in places such as Germany. There were still cases of people being discharged from hospital (regardless of support needs) without being tested and therefore lacked information as to whether they were infected by Covid-19. She firmly believed that the lack of a functioning app would limit test and trace protocols as tracking one case of Covid-19 took considerable input.

Linda Jackson provided more detail about the work of the programme board which included officers from across the Council. The group was required to formulate detailed local outbreak control plans which would focus on support

for vulnerable groups such as rough sleepers, care home residents, anywhere where there were high numbers of people would congregate.

Working with Imperial colleagues, they had exceeded the brief and had additionally developed plans for e.g. travellers, sheltered housing or residents in homes of multiple occupation. National information had been poor on this and sharing data for safety reasons to inform the plans was not regarded as a breach of data confidentiality and Linda Jackson was confident that this would meet public expectation as the minimum standard required to ensure people were kept safe.

They had tested the outbreak control plans and worked closely with NHS colleagues and GPs to develop them further so that plans could be quickly activated. A communications strategy had been planned which involved the Leader writing to residents of the Borough, language translations and being proactive in advocating the importance of test and trace so that vulnerable communities could be protected. Dr Lang had also proactively engaged with local faith groups to that information about test, trace and prevention was being communicated.

Dr Lang described her work with Public Health England. Each day, data was provided with the anonymised and sparse details of any cases identified within the Borough. The incomplete data on each patient resulted in a fragmented picture of people who had tested positive. Dr Lang briefly outlined Pillar 1 to 4 tiers and the complexities of the testing arrangements, but the difficulties of data sharing meant that it was harder and more time consuming to identify residents.

Bringing together Imperial and Public Health information alleviated data sharing issues, uniting patient details with the post code and building the identity of the Covid-19 positive individual. Pillar 1 testing included those who had tested positive through the NHS, either in a hospital or at a GP site. Pillar 2 were tests conducted through drive through hubs or with a home testing kits. Both pillar 1 and 2 data were provided but anonymised. The advantage of this combined data being provided to the Council meant that in theory, officers could find the person and offer support.

Councillor Richardson submitted a question about digital isolation on behalf of Healthwatch Hammersmith & Fulham: what plans there were to ensure that seldom heard communities and people who did not have access to the digital equipment or internet received information about the test and trace programme. Dr Lang outlined the engagement work undertaken with a local Somali community group. There was a recognised concern about the lack of access to smart phones and devices and being digitally excluded. They had tried to identify who had access to digital and ensure that there is more dialogue facilitated within communications rather than just providing information.

Victoria Brignell commented that as Chair of Action on Disability, she supported the Council and the intention to co-produce. She referenced the

recovery plan, paragraph 10.2 and asked about the Council's commitment to coproduction and to elaborate on the phrase "Covid-19 response mode".

Linda Jackson welcomed the offer of support and outlined how this had been taken forward with input and oversight from Kevin Caulfield and Tara Flood (Strategic Leads, Co-Production) to ensure that the recovery plan was driven by co-production.

Linda Jackson continued, and outlined how the past three months had been the critical response phase of the Covid-19 pandemic where for example, libraries and parks had been closed. A challenge which arose from developing the recovery model was to understand what the new offer would look like. It was also important to understand that the pandemic was not over and that a second wave of cases was expected. Dependent on the different stages of recovery, different levels of alertness were required to ensure a swift re-calibration of resources when needed so that the Council could return to delivering critical frontline services and PPE.

Councillor Richardson observed that it was essential that the Council and health partners engaged with vulnerable members of the community and ensure an inclusive approach allowing all voices to be heard and listened to. Jim Grealy added that further pressure on the government would be necessary to get a working app in place ahead of the winter period where the risk of Covid-19, coupled with the flu season would see rising rates of illness. This would be critical to ensure that all the positive work undertaken so far was not undermined.

Roy Margolis referred to an article about a German app, developed in partnership with Apple and Google, which he agreed to forward to members of the Committee. Councillor Coleman commented that efforts were being made to set up a local test and trace system which could have been progressed during the lockdown. Two sets of data had been provided, from drive by testing and from the hospital but this was limited information. However, despite the piecemeal information there was an expectation that the Council would deliver a local solution.

Councillor Coleman expressed concern that the UK should be able to utilise existing apps available in Ireland, Germany and Gibraltar and questioned why no progress had been made nationally on this issue and the lack of a government response. He stated that this was an issue that he had planned to raise through the West London Alliance and required a local solution. Councillor Kwon pointed out that contract test and tracing in countries such as Vietnam, Singapore and South Korea were not reliant solely on app technology. The downloading of an app did not necessarily indicate success but was corroborated and supported by local, high levels of human tracing with people being contacted by telephone, by call handlers.

ACTION: To raise the issue of the lack of a national, functioning app with other West London scrutiny committee chairs

RESOLVED

That the verbal report be noted and that the action as set out be implemented.

8. WORK PROGRAMME

Councillor Richardson invited members to contribute suggestions for the work programme and offered the option of meeting virtually.

RESOLVED

That the report be noted

9. DATES OF FUTURE MEETINGS

The date of the next meeting of the Committee was noted as 2 September 2020

Meeting started: 4pm
Meeting ended: 6.10pm

Chair .....

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London Borough of Hammersmith & Fulham

Report to: Health and Social Care Policy & Accountability Committee

Date: 10/09/2020

Subject: Supported Employment

Report of: Kamal Motalib, Helen Green and Jo Baty

Responsible Director: Lisa Redfern, Strategic Director of Social Care

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Summary

This report provides an update on the work being undertaken to provide disabled residents with improved access and to training, development and employment opportunities.

Recommendation

For the Committee to note and comment on the power point slides “Closing the Disability Employment Gap”.

Wards Affected: All

H&F Values

Our Values	Summary of how this report aligns to the H&F Priorities
• Building shared prosperity	Engaging with our businesses to support their Covid recovery and ensure that we maximise opportunities for all our residents to secure and sustain work
• Creating a compassionate council	Ensuring that ensure that all our residents receive the support they may require to access the information; advice and work experience they need to get work in our local economy
• Doing things with local residents, not to them	Our work on Inclusive Employment continues has to date been co-produced with residents and particularly parent/carers of young people with Special Educational Needs and/or Disabilities. We need to broaden our co-production to engage our residents with, for example, mental health issues.
• Being ruthlessly financially	Ensuring we streamline our strategic

efficient	engagement with employers to maximise job opportunities for our residents
• Taking pride in H&F	Supporting our residents in securing work locally and re-building our local economy as part of Covid recovery

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1. The enclosed presentation "Closing the Disability Employment Gap[i]" gives an update on the work we have done to date across the Children's Services, Social Care and with our Economy Team, to support the development of more opportunities for our disabled residents to engage in meaningful work experience; training and development; volunteering and paid work and how, against a backdrop of Covid recovery we will co-produce those employment pathways with our residents and with key stakeholders.

2. The council, through Industrial Strategy activity is playing a key part in convening stakeholders to work together to support an inclusive recovery across the borough.

3. The work involves proactively supporting businesses to get help, advice and access grant schemes as well as a major marketing campaign to promote local businesses and activity to help them trade safely.

4. Running parallel to this, the restructure of WorkZone completed January 2020 gives us a new structure to drive inclusive economic outcomes and a greater focus on joint working across the council. External engagement with business will also be focused more on securing inclusive opportunities and will be bolstered by the addition of three new posts (Apprenticeships Lead, S106 Officer and Social Value Officer) which will also focus on increasing supply of inclusive opportunities and more strategic engagement with businesses.

5. Economic Development and People and Talent (HR) are jointly recruiting a new apprenticeship post which will seek to increase apprenticeships including inclusive apprenticeships and the Social Value Policy agreed by cabinet in May 2020 will lead to more inclusive employment related opportunities in the councils supply chain.

List of Appendices:

Appendix 1 - Closing the (Disability) Employment Gap, PowerPoint slides

Health, Inclusion and Social Care Policy and Accountability Committee

Wednesday 10th September 2020

Closing the (Disability) Employment Gap

Our Economy- Impact of COVID-19

Challenges…

- Out of work benefit claimants increased dramatically. In March 2020 4,600 claimants, by the end of July 2020 more than doubled to over 10,390. Once the governments furlough scheme ends there will be another rise in new claims.

- Some groups including young people, BAME, 50+, residents with long term health conditions and disabled residents are likely to be most negatively impacted in the COVID-19 economy.

- In-work poverty and insecure employment also disproportionately impact these groups. H&F is also more exposed to the low-wage and very badly affected hospitality sector than any other West London borough.

- 21% of businesses temporarily shutdown and around 30% of workforce furloughed during lockdown

- The borough has a large retail and wholesale sector providing 18% of jobs, the impact of COVID has been felt strongly in this sector and it is likely face a challenging recovery.

Our Economy- Impact of COVID-19

Potential positives…

- H&F comparative to other boroughs, has a highly-qualified workforce dominated by managerial, professional and technical occupations (over 70% of residents employed in these groups).

- H&F has a large number of high growth businesses in sectors such as Creative, STEM and the wider Knowledge sector, these sectors may prove to be more resilient during an economic downturn.

- H&F also has a higher than average capacity for home-working which may mean that impact of economic downturn will be less felt then some of its neighbours.

- Compared to neighbouring boroughs H&F has more medium & large businesses who may have more capacity to ‘weather the storm’ and provide opportunities for greater volume of jobs once recovery begins.

- DWP acknowledges that post COVID employment support will be needed- H&F will work with sub regional partners to lobby for programmes which will support our priority groups. It is also likely that eligibility criteria of existing Work and Health programme will be extended.

Our Economy- Impact of COVID-19

What is the council doing?

- The council through Industrial Strategy activity is playing a key part in convening stakeholders to work together to support an inclusive recovery across the borough.

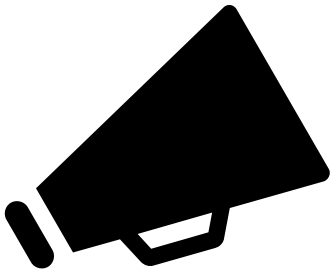
- Proactively supporting businesses to get help, advice and access grant schemes as well as a major marketing campaign to promote local businesses and activity to help them trade safely.

- Restructure of WorkZone completed January 2020- with a new structure to drive inclusive economic outcomes and a greater focus on joint working across the council. External engagement with business will also be focused more on securing inclusive opportunities and will be bolstered by the addition of three new posts (Apprenticeships lead, S106 officer and Social Value Officer) which will also focus on increasing supply of inclusive opportunities and more strategic engagement with businesses.

- Economic Development and People and Talent (HR) are jointly recruiting a new apprenticeship post which will seek to increase apprenticeships including inclusive apprenticeships.

- Social Value Policy agreed by cabinet in May 2020 will lead to more inclusive employment related opportunities in the councils supply chain.

How is coproduction leading to positive change in H&F?



Working together

- Regular sessions with residents, businesses and Parentsactive to share experiences
- Bring together the different voices of young people
- See things from a residents perspective
- Talk through ideas together

Making change happen

- Joint forums to tackle Issues together
- Joint workshops to map out what's working and where improvements needed
- Decide on changes together
- Coproduce pathways, services and comms

Review the impact

- Map out support systems
- Steering groups review progress and outcomes
- Local Offer, People First and WorkZone

Supported Internships Programmes

- Supported Internship programmes are one of the pathways towards sustainable paid work for young people with special educational needs, learning disabilities and/ or autism through learning in the workplace and personalised study programme

- The WLA's Supported Employment Programme was established to develop and commission programmes for young people across the sub-region.

- The programme is funded and supported by West London boroughs, Health Education England and the Department of Education and is led by Hammersmith and Fulham.

- There are over 20 Supported Internship programmes across the local area. Host businesses include Councils, NHS trusts and hospitals as well as retail and hospitality sectors.

- The average employment rate on the programmes to date is over 60% and take up across the 6 boroughs by recorded disability is:

SLD	MLD	ASD	SpLD	LDD	SLCN	PD	Unknown
2	24	9	3	11	1	1	6

- WLA is now working in partnership with Health Education England and the NHS to widen participation into employment within the Health and Care sectors, working across North West London to raise the learning disability employment rate.

The Supported Internship at L'Oréal & Hammersmith & Fulham Council

How the programme sits within the Council and it's partner organisations

The Programme

This is run as a partnership sponsored by Hammersmith & Fulham Council, and L'Oreal and working with a range of local employers.

The Partners:

- LBHF(host LA; & L'Oréal (host business)
- Parentsactive (parent/carer voice)
- West London College (Further Education Partner)
- Action On Disability (Supported Employment Partner, job coaches and follow on support into employment)

Local Employers include:

Nando's; Endemol Shine; Chelsea FC; Schools plus a number of other local employers have indicated they are open to Interns being placed on rotations.

The Supported Internship at L'Oréal & Hammersmith & Fulham Council

Vocational skills opportunities – roles at the host businesses		
At L'Oréal	**At H&F Council**	**At Endemol Shine**
Reception Post room Catering Assisting in the Academy	Business support Housekeeping Library services Site maintenance	Administration Data entry Searching credits in reality TV
In schools	**At Nando's**	**At Chelsea FC**
Learning support assistant	Using the till Serving food Work in the kitchen	Assisting with training courses, hospitality, catering and stewarding.

Employment Outcomes

- 2017-18 – 66.66% in paid employment.
- 2018-19 - 63.63% in paid employment
- 2019-20 - All interns are on AoD extended projects to find employment

Follow on support

- Action On Disability provides focused follow on support for interns to support them into work linking with Children's Services on independence pathway planning.
- This year due to the Coronavirus crisis, Inclusion London has awarded them a grant to extend the period of follow on support through two programmes.

The Supported Internship at L'Oréal & Hammersmith & Fulham Council

The Steering Group meets monthly and is attended by:

- a representative from Parentsactive
- LBHF (People & Talent; Children's Services) West London College
- Action On Disability
- the businesses

The Operational team:

- Meet daily with interns to coproduce plans
- Meet weekly to plan and track progression
- Provide feedback to the steering group

The Steering Group:

- Listens to feedback from young people and representatives
- Monitors progress and outcomes
- Works collaboratively on strategic development and systems
- reviews annual performance and improvement plans
- Informs and shapes development work at the Council across Children's Services, People and Talent, Adults services and The Economy

Summary of wider offer for employment and skills

•**WorkZone** – Employment brokerage, apprenticeships, traineeships, Schools work placements for all adults and young people in H&F.

•**Housing Options** – Employment and skills support for Temporary Accommodation households and Private Rented Sector residents to help move away from Benefit Cap.

• **H&F/WLC Inclusive Apprenticeships** – part-time employment over 24 months with support/ adaptations and a study programme leading to a level 2/3 qualification.

•**WLA supported employment programme** – Internships, apprenticeships, work placements

•**Adult Learning –** wide range of qualifications and skills of adult education courses to adults 19 years of age and above pre-employment, employability skills, health & well-being with some provision specific to inclusive cohort.

•**Youth Offending** - To deliver service to young people involved in the criminal justice system including employment and skills pathways.

• **Partner organisations** – At least 20 other VCS and non-VCS partners including JCP and JCP commissioned providers delivering employment related support across H&F

Next steps - Inclusive Employment

Use new ways of working to expand inclusive employment options for residents:

- Redefined internal offer- a strategic task force will be set up in October to ensure that we maximise inclusive and wider opportunities from the council and its supply chain. This will include an operational sub-group to share knowledge and expertise on a regular basis
- In October Work will begin to co-produce a new employment offer with residents and providers including job carving and work experience and linking in with employment support providers on a joined up local offer.
- Local employment hub – Local Offer, WorkZone, People First, new ‘Front Door’ for the Council.
- Work with education providers on the curriculum for life and the skills all young people need through the 14-25 Strategy and Post-16 networks.
- More pathways to employment opportunities sub-regionally with WLA & Health Education England

London Borough of Hammersmith & Fulham

Report to: Health and Social Care Policy & Accountability Committee

Date: 10/09/2020

Subject: Community Transformation – Mental Health Integrated Network Team".

Report of: Jo Baty, Assistant Director Mental Health, Learning Disability and Provided Services

Responsible Director: Lisa Redfern

Summary

This report provides more detailed background as to the development of the Mental Health Integrated Network Teams (MINT) across Hammersmith & Fulham.

The report contains the detail held with the staff consultation document "Development of Mental health Integrated Network Teams (MINT)" and follows up from workshops in each borough that ran before March 2020.

West London Trust are aware that there has been a gap in engagement events due to the significant disruption that the Covid-19 pandemic has caused. To this end, the joint presentation of the update from West London Trust, the Clinical Commissioning Group and Hammersmith and Fulham Council represents the commitment to collaboration and co-production going forward.

Recommendations

For the Committee to note and comment on the report.

Wards Affected: All

H&F Values

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

Our Values	Summary of how this report aligns to the H&F Priorities
• Creating a compassionate council	Better supporting our residents with a wide range of mental health needs in securing the support they need be it from statutory services or from voluntary and community sector partners

• Doing things with local residents, not to them	Co-producing the pathways of support with our residents – being an accessible and easy to navigate mental health partnership
• Taking pride in H&F	Ensuring that Hammersmith and Fulham have both reputationally and in practice a caring and supportive partnership in mental health service delivery.

Contact Officer(s):

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Position: Assistant Director Social Care
Telephone: 07977 469618
Email: jo.baty@lbhf.gov.uk

Background Papers Used in Preparing This Report

Development of Mental health Integrated Network Teams (MINT): An informal consultation August 2020

1. Background

In January 2019, NHS England (NHSE) published the Long-Term Plan (LTP), which highlighted the need to change the way in which community mental health services are delivered. In September 2019, a more formal structure around how to implement this was published. NHS England's Community Mental Health Framework (CMHF) outlined plans to radically transform community mental health services and presented the rationale for these changes as follows:

• Community mental health services have long played a crucial yet under-recognised role in the delivery of mental health care, providing vital support to people with mental health problems closer to their homes and communities since the establishment of generic community mental health teams (CMHTs) for adults 30 years ago. However, the model of care is now in need of fundamental transformation and modernisation.

• This framework provides a historic opportunity to address this gap and achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined-up care and whole population management approaches, and establishing a revitalised purpose and identity for community mental health services. One of the LTP's key objectives is to develop "new and integrated models of primary and community mental health care [which] will support adults and older adults with severe mental illnesses". It supports the development of place based and personalised community mental health services wrapped around the Primary Care Networks (PCNs), and outlines how these developments will help to improving care for people with severe mental illnesses.

• The NHS Mental Health Implementation Plan 2019/20 – 2023/24 describes the ambition as: "a new community-based offer [that] will include access to

psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use… and proactive work to address racial disparities."

- It continues that local areas will be: "supported to redesign and reorganise core community mental health teams to move towards a new place-based, multi-disciplinary service across health and social care aligned with PCNs."

- The CMHF sets out how the vision for a new place-based community mental health model can be realised, and how we can modernise community mental health services to shift to whole person, whole population health approaches. The framework places a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services, but not severe enough to meet secondary care "thresholds", including, for example, eating disorders and complex mental health difficulties associated with a diagnosis of "personality disorder".

- The framework aims to ensure that the provision of NICE-recommended psychological therapies is seen as critical in ensuring that adults and older adults with severe mental illnesses can access evidence-based care in a timely manner within this new community-based mental health offer, to give them the best chance to get better and to stay well – as service users have so often told us they would like

1. The context

The CMHF highlighted that mental health care delivery should focus on supporting the person with the community at the centre of their care. It suggested that the vehicle for service delivery should sit at a place base ideally within their PCNs - a group of GPs typically covering 30,000 to 50,000 patients – with PCNs becoming a key structure for place-based support, care and treatment. The CMHF proposes to achieve this by developing new and integrated models of primary and community mental health care which will support adults and older adults with severe mental illnesses. This means re-modelling services with a renewed focus on working with people with a range of mental health difficulties and ensuring that these services sit at the core of local communities. on how they might transform current mental health services in line with the CMHF.

2. Mental health Integrated Network Teams (MINT) - overview

West London NHS Trust was successful in its bid (via North West London ICS) to become an 'Early Implementer' site, so we have begun working closely with the 18 PCNs that span across Hammersmith & Fulham (and Ealing & Hounslow) boroughs to roll out our model aligned to the CMHF. The proposed model is called Mental health Integrated Network Teams (MINT). The focus on intervention-based support will include an expanded provision of psychology and occupational therapy, together with community link workers and Peer support workers. This service will have an inclusive ethos and support a 'no wrong door'. Working closely with PCNs will enable MINT teams to better address unmet need and support communities to stay well. Previously, services have had different access routes for people with different

problems or with a different level of need, but we hope to make services more accessible by focusing on providing speedy access to a range of interventions. This means that we will be looking at all the community resources available, including health, social care, VCSE (Voluntary, Community and Social Enterprise) organisations and local communities (building on, for instance, the volunteering infrastructure developed during Covid with the Community Aid Network and the Mutual Aid Groups) and considering what resources will support people's wellbeing outside of mental health services, rather than focusing narrowly on only what the NHS provides.

To launch the MINT service, we are proposing to redesign our services so that we can offer integrated mental health care based alongside and working closely with PCNs. This will require a merging of the resources of both secondary and primary care mental health services which, alongside the new resources sought as part of the bid, will then be divided according to weighted population to best serve the population aligned to each of the PCNs.

3. Hammersmith and Fulham MINT Teams

The proposal is to create 3 MINT teams in Hammersmith and Fulham which will wrap around the 3 localities. These locality groupings are based on natural groupings of PCNs (around which other care providers such as community health are also aligning). Each of the 3 MINT teams will have a team manager. The MINT Teams for Hammersmith and Fulham will be focused around North PCN; H&F Central and Partnership PCN and South PCN. It should be noted that note that the majority of patients registered with Babylon or GP@Hand are residents outside of Hammersmith & Fulham and are out of scope for this work as per the discussions with local commissioners.

4. The MINT model

Whilst our first step is to align our staff to place based way of working, it is worth noting that work on developing the MINT model of care is only just beginning and will involve many engagement events, both internally and with a wide range of external stakeholders over several months. Throughout this process staff will be informed and able to contribute to the development of the model. Some of the ideas and opportunities which are likely to feature in the model are:

- An increased front door function with a faster route to treatment
- An increased availability of psychological, occupational, vocational, social and wellbeing interventions, many of which will involve group participation
- Increased development opportunities for staff to develop brief therapy skills and experience
- Work across the spectrum of those referred to services with all staff able to work with those needing a lighter touch and those needing more multi-disciplinary and intensive support
- Increased focus on strengths-based work and goal attainment
- Increased focus on enabling clients to engage with their communities, preventing service dependencies
- Increased working with a wide range of external VCSE organisations and with the CAN and the MAG's – embedding 'compassionate communities'

5. Funding

The NHS Long Term Plan (LTP) recognises that community mental health services across the country have not been invested into for decades. Whilst the transformation funding secured last year allows us to pilot the new MINT model, we are conscious that for us to be able to deliver the LTP ambitions we need sustained investment. It is worth noting that the LTP stipulates further funding coming into community mental health services over next three years to ensure that areas are able to realise the vision set out in the CMHF fully.

List of Appendices:

Appendix 1 - “Stocktake – Community Mental Health Transformation – MINT July 2020”

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STOCKTAKE : Community Mental Health Transformation

(Mental health Integrated Network Teams)

July 2020

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Recap - LTP & New community based offer

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NHS England published a piece of guidance called the Long Term Plan. It stated the need to drastically change the way in which people receive mental health support, care and treatment, with a particular focus on the Community.

Following this, they published another piece of guidance called the Community Mental Health Framework. This explained how and what needs to change.

Context

The NHS Long Term Plan describes a:

"new community-based offer [that] will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use… and proactive work to address racial disparities."

Local areas will be:

"supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks."

MH Trusts to lead transformation of community mental health services (CMHS) **in partnership with Primary Care Networks…**

As well as **local authorities** and the **Voluntary, Community, Social Enterprises**, **service users** and **carers**, to create a new, **flexible, proactive model** of community-based mental health care for people with moderate to **severe mental illnesses** across a range of diagnoses and needs, in line with the imminent new Community MH Framework.
NHSE then sought to give **12 early implementer sites** an opportunity to bid to **pilot new models of care.**

Recap -MINT Community Model

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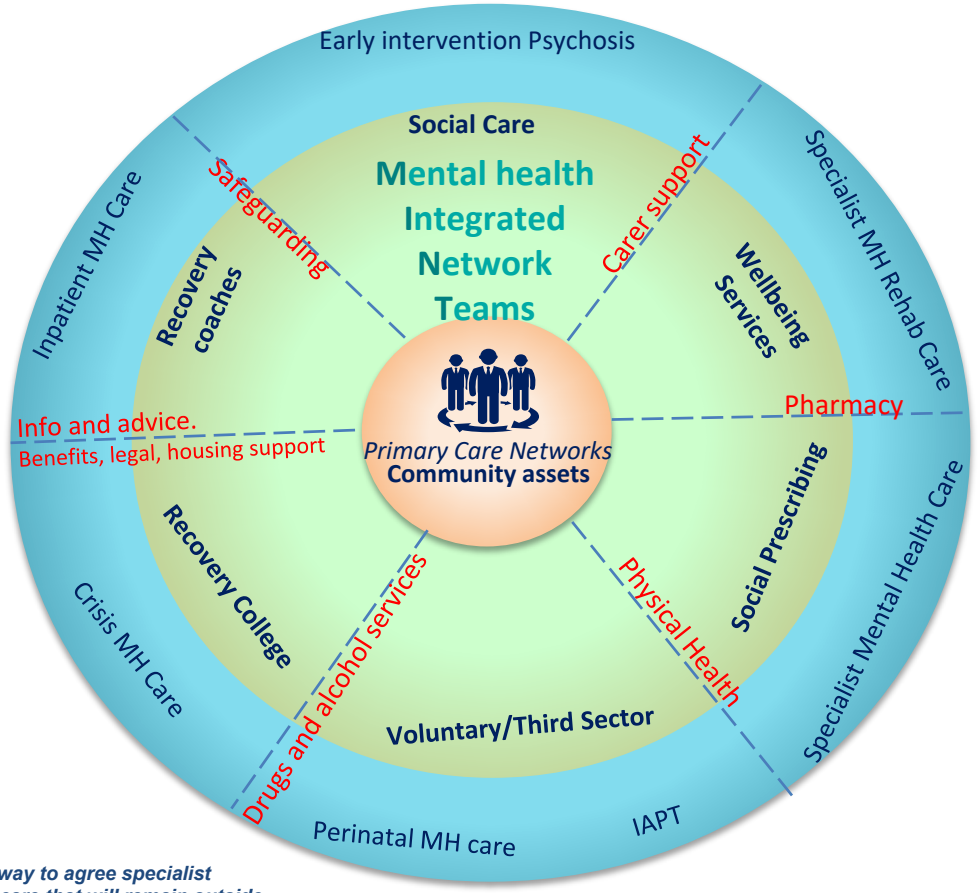
MINT is the conceptualisation of integrated care. MINT will **combine new resource** as per the bid **with existing** resource from **Primary Care Mental Health teams** and Community MH or **Recovery teams**.
The combined workforce will be split into MINT teams which will be wrapped around PCNs (realistically at locality level in each borough)

The Model locates **community mental health services in the centre of the community**, as the central pillar of mental health care, allowing all other services in the mental health care system to function more effectively.

Social determinants, availability of services, **assets and other resources** have a direct bearing on the level of mental health problems in a community. A key aspect of **effective mental health care** is ensuring that all **communities can maximise the support they provide to people who need it** and therefore address local population needs. The model places the community offer as central.



** Work is underway to agree specialist community MH care that will remain outside MINT*

Underpinning principles

- Physical health with mental health
- Minimise bureaucracy, Increase parity of esteem
- Working as one Team and whole system
- Joint prioritisation for patients and resource
- Optimises use of community based resources
- Active intervention based on needs with clear outcome
- Preparing for end of intervention and transition of care

Recap – MINT timelines prior to Covid

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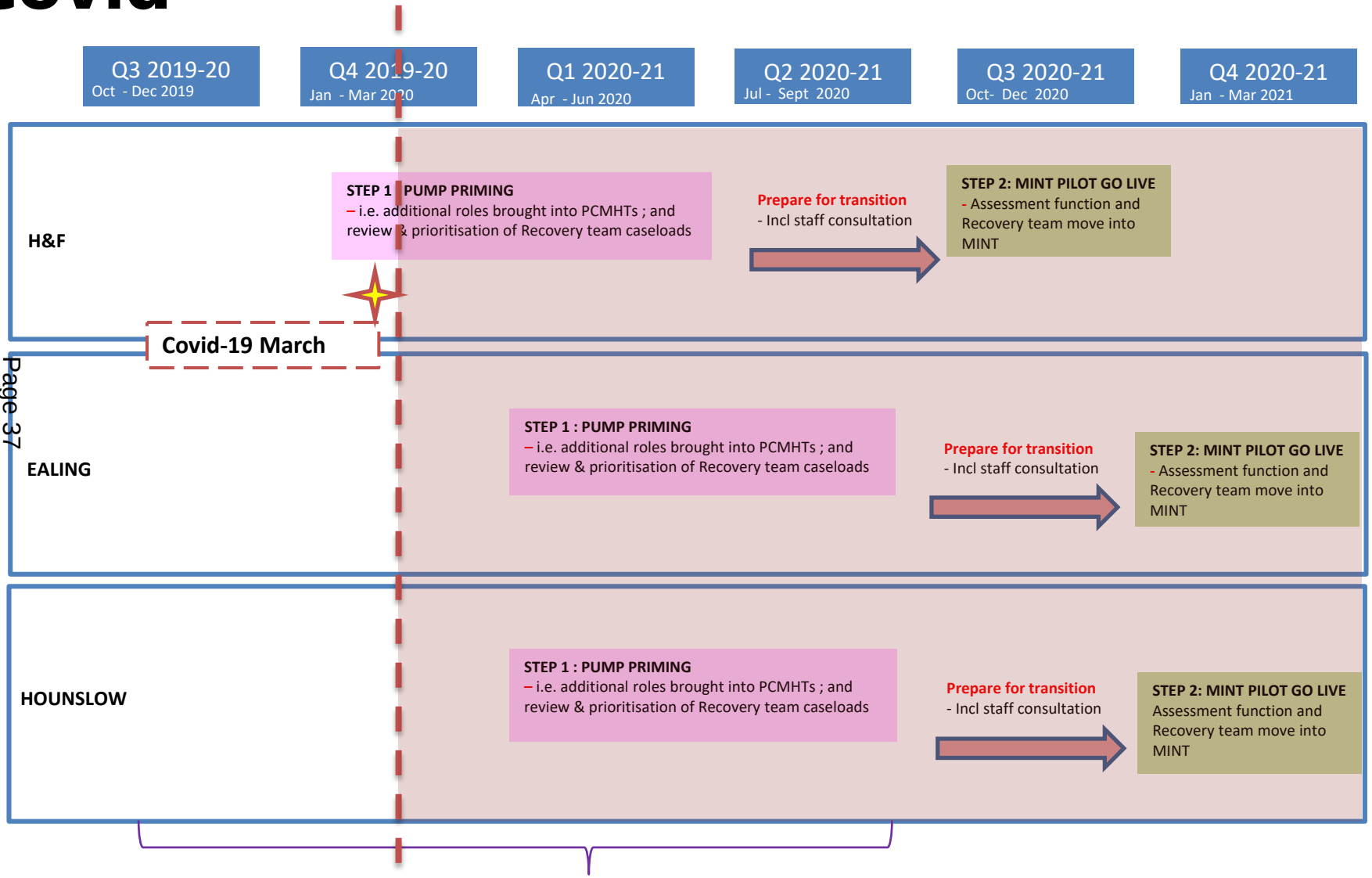

Simultaneous work to develop Clinical Model of Care , Operating Model and Patient, Public and wider stakeholder engagement, participation & involvement will be done in this timeframe

Recap of delivery work prior to Covid

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Prior to Covid-19 we were in Step 1: Pump Priming & Model Design

1. Expanding existing primary care mental health workforce and establishing flow, working with PCNs; with local partners, VCSE leads and experts by experience: Work commenced on recruitment of new roles as well as model design with Niche and clinicians on developing a menu of interventions and clinical offer within the model for patients with low/ moderate/ high SMI needs inline with NICE guidelines
2. MINT Implementation Working groups were set up in each to work towards genuine co-design of the model between professionals, experts by experience, social care and community service providers in each borough
3. Digital aspects; work commenced on design and review of data needs, migration of data and EPR use (SystemOne/RiO), how will the systems collect and input data relevant for all clinical groups and how will data flow into MHSDS

During Covid - impact on teams

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Work undertaken

- **PCMHTs and Recovery teams were combined** to **enable a safe service** due to limited staff within teams.
- Focus on **maintaining business continuity**
- Caseloads were RAG rated, according to need and risk status to ensure that critical functions were maintained
- Tasks were refined to focus on **work regarded as 'essential', e.g. preventing relapse** and **reducing** the use of the **acute** ward
- Local borough **shifted structures to enable rapid acute discharges**. (approx. 187 or more discharges from inpatient services).
- Teams **focused on the client's** with the **highest risk** and those who required face to face contact.

Therapeutic intervention

- **Red and Amber clients; provided therapeutic input** on containment and support to minimise the risk of relapse.
  - **Psychology focused on contacting** Amber/Green that are on **CPA high risk.**
- **A proportion of non-CPA were contacted without active intervention**
  - all **cases currently** being **contacted by 'check and Chat' staff** to ensure that needs are being picked up and reprioritized changing picture out of RAG rated duality in risk and care.
  - **Active therapeutic contacts were paused** to enable a **focus on stabilisation for clients in need.**
- **Some additional focus was given to unplanned contacts** and rapid discharges coming in
- Some patient **discharges** were **completed where appropriate**

MINT implementation work since Covid

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- Some of the recruitment for MINT roles had to pause while in the initial phase more focus was on essential staffing ; emphasise was put back on recruitment of the MINT roles in May.
- Had to pause F2F training and meetings – organisational development element
- Delayed estates sourcing development work
- Had to paused communication on Transformation with all stakeholders and staff, to focus on compassionate comms/ wellbeing during Covid
- Reduced ability for wider stakeholder engagement due to Covid impact on clinical capacity to undertake the work, however some Coproduction elements continue such as model design (using Covid learning and virtual aspects to review new normal).
- System alignment, communication and engagement with wider stakeholder in relation to transformation paused (LA, DN's, PCN's, GP, MAC).
- Model design work with the map of interventions and workforce demand and capacity was continued.

NHS Covid 'New Normal' ways of working and developing MINT

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- **Virtual where possible and safe** (this means that we need to consider social distancing to keep people physically well, and where this is not seen as the best method, an assessment of the patient's ability to disclose information freely whilst at home will also be discussed).
- Systematic deliberate **public engagement**
- Existing patients known to mental health services need to be **contacted proactively** and **supported** (particular focus on those who have been discharged from inpatient services and those who are shielding)
- Prepare for a **possible longer term increase in demand** ,as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan
- Take account of **inequalities in access to mental health services**, and in particular the needs of BAME and other dis-advantaged communities
- Separation of Covid and non-Covid patients in the urgent care and inpatient settings; triage/ control at the front end of the pathways through 'talk before you walk' access to keep people safe and best cared for and with **best in class infection prevention and control practices**
- Further **alignment and joining together of services** within integrated care systems
- New approaches to **minimise hospital stay** to that which is required to meet needs

MINT implementation areas of focus:

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- To **re-engage with key stakeholders** and finalise the MINT clinical model of care that has been developed based on feedback and input from clinicians, service managers, commissioners and other wider partners and is rooted in the long term plan.
- **Recruit** to additional clinical roles in the **MINT model,** this will support the greater needs of the community
- **Build relationships with you** our community and hear about what you know to be great assets that take place locally.
- **Reach out to the community** to hear what the harder to reach groups think about change and what is needed, particularly our minority communities to understand more of the unmet need that exist, we will be **working with We Coproduce** and others.
- Continue with your involvement throughout development of the new model of care with **more dedicated groups** in each area of the pilot and to **continue learning and sharing throughout** the journey.
- **Share information and updates** on some of the great work that has been taking place despite Covid, but also **keep you up to date with progress** being made and how to stay involved.
- **Align all staff locality MINT teams**. This includes all the workforce and building teams to your local neighborhood.**Align** the **caseloads by locality MINT teams,** this means ensuring that care happens closer to home with named people.
- **Build relationships** with GPs/PCN within the **locality teams** so that GPs know who their Mental health teams are.
- Build **clear lines of communication**; close working relationships with GP MH leads and consultants in teams but also ensuring that we have plenty of ways to share what's happening with the wider public.

The MINT 9 locality teams according to population based needs

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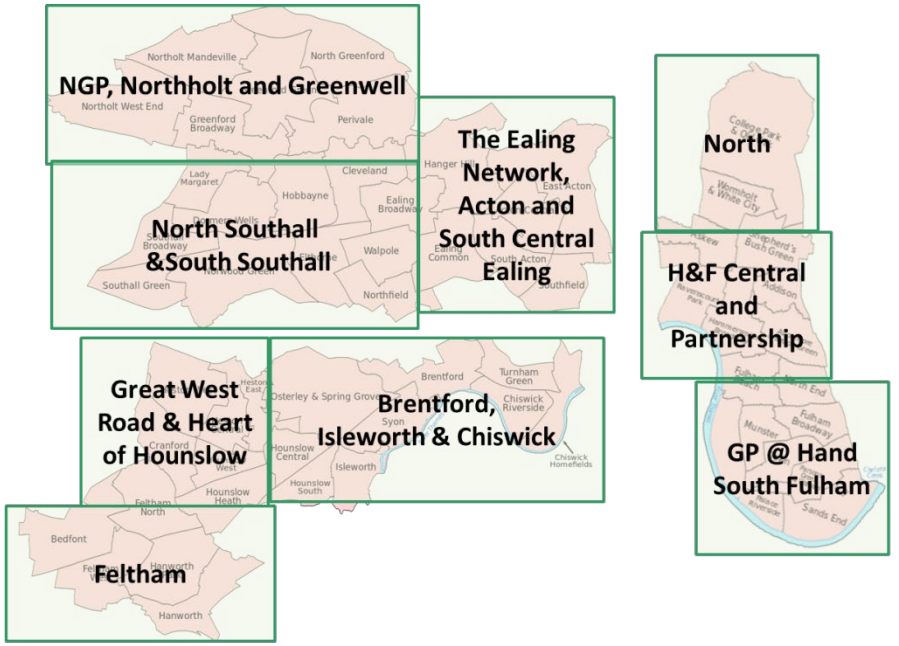
In the long term plan for mental health, we were asked as a pilot site, to ensure that the new service is based on needs of the neighbourhood. The new teams are also building relationships with services that are already set up this way within the borough to strengthen the support and connection at neighbourhood level.



Borough	PCN Grouping	Proposed staff allocation within borough (Niche Method)	GP List Population Proportion within borough	GP List Population Proportion within borough (discounting Babylon)
Ealing	NGP, Northolt, Greenwell	35.1%	32.3%	32.3%
	North Southall, South Southall	26.8%	25.3%	25.3%
	Acton, The Ealing Network, South Central Ealing	38.2%	42.4%	42.4%
H&F	North H&F	24.9%	15.5%	20.5%
	H&F Central, H&F Partnership	48.0%	41.6%	54.9%
	Babylon GP at Hand, South Fulham	27.0%	42.9%	24.6%
Hounslow	Feltham	21.4%	12.6%	12.6%
	Great West Road, Heart of Hounslow	46.5%	42.6%	42.6%
	Brentford & Isleworth, Chiswick	32.1%	44.7%	44.7%

Critical areas of work to make MINT happen

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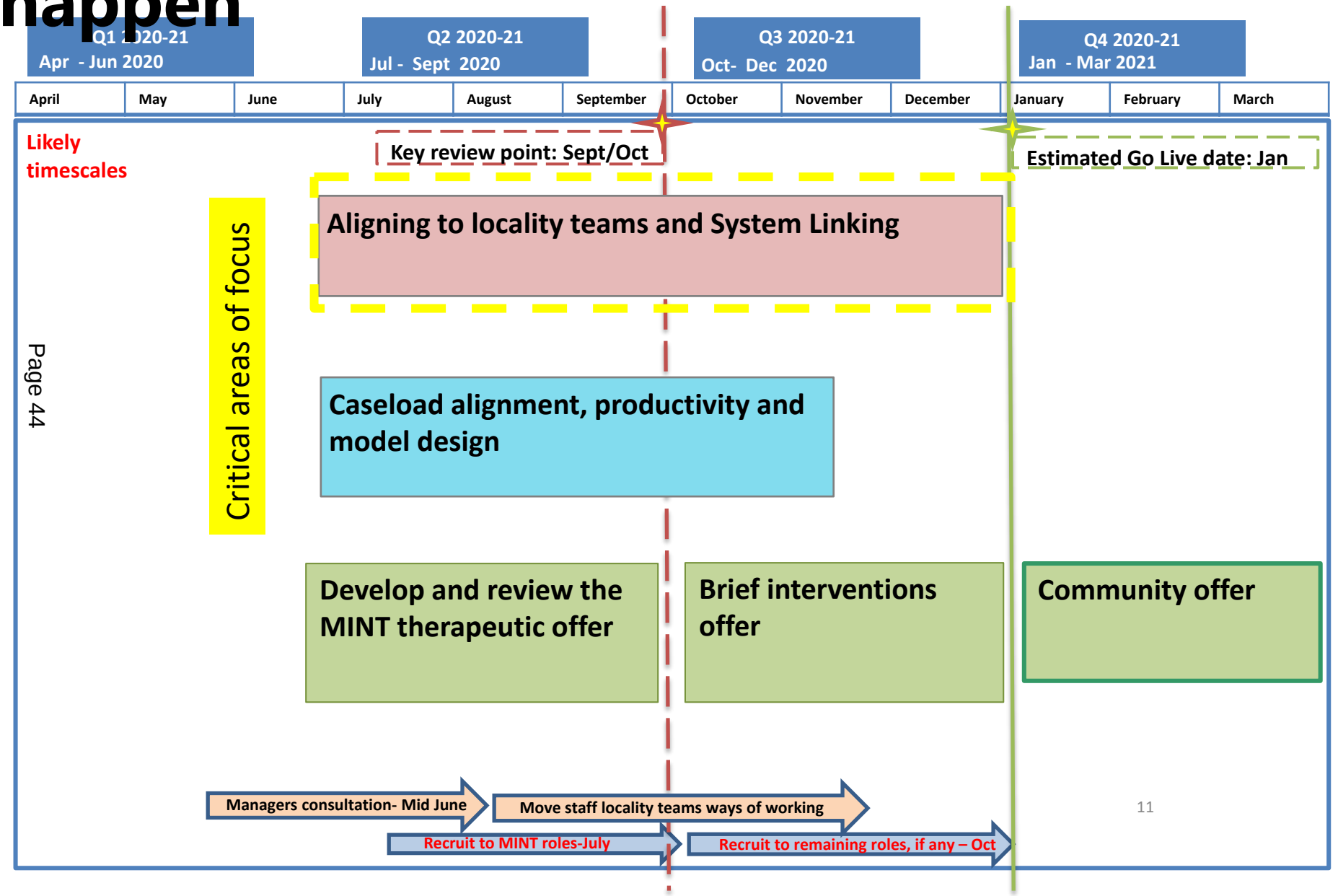

Engagement led draft MINT therapeutic model on a page

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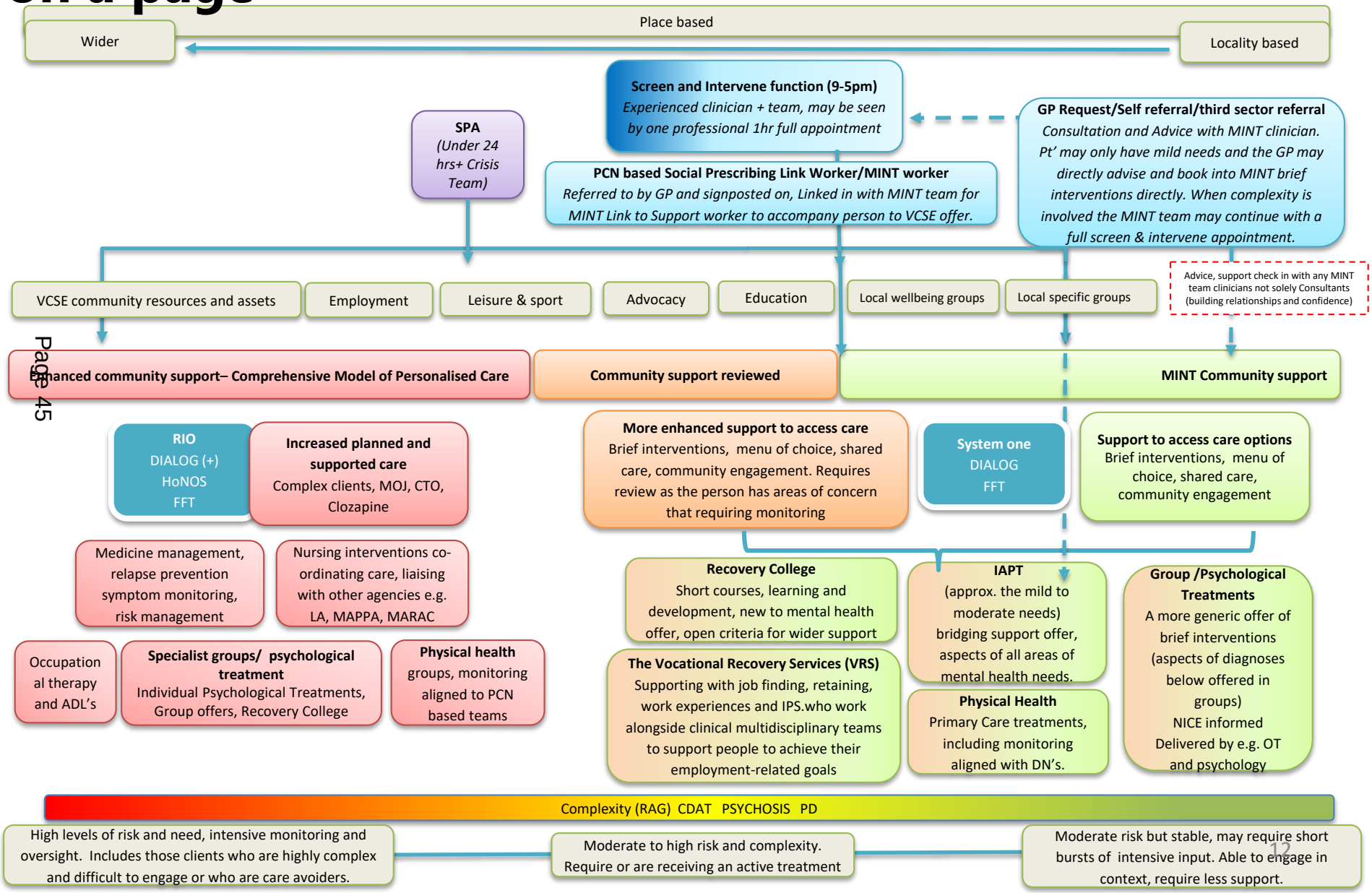

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APPENDIX

Promoting hope
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How we had planned MINT development into following three categories

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Must Do's (based on direction set in the NHS Long Term Plan and Community Framework)	What needs to be designed centrally at three borough level (this is the current phase of work)	What needs to be designed locally at each borough level (this is the current phase of work)
1. The new model of care must be **population based** to **address the needs of a defined population** through improving access to therapeutic interventions for mental and physical health problems and a wider community based offer to advance MH equality in the communities. 2. The new model of care must **advance mental health equality in the communities** 3. The new model of care must **integrate primary and secondary community MH services** 4. The new model of care must be **place based** , ideally working at neighborhood or PCN level with a defined MH resource that the local population can access 5. The new model of care must **minimise thresholds or barriers for accessing care** 6. The new model must **measure how many new people are accessing** it	1. Build momentum through **local 'case for change' and vision** for model work with patients, wider public and staff 2. **Menu of therapeutic interventions** that will be delivered in the MINT model for a) Enabling effective Screen and intervene b) People with low/ moderate/ high Personality Disorder c) People with low/ moderate/ high Psychosis d) People with low/ moderate/ high CDATT e) Supporting transition for 18-25 age group f) Supporting low/ moderate needs of older people g) Adults with Eating Disorders 3. **Workforce and skill mix** to deliver the menu of therapeutic interventions 4. Approach to **improve generic CPA offer and uni-disciplinary working** 5. **Outcomes** and activity to measure , reporting arrangements and evaluation approach for the pilots 6. **Shared care principles** between MINT teams and Primary Care 7. Infrastructure requirements to enable the MINT model succeed – IT systems, methods of communication	1. **Community based offer** within MINT to advance MH equality in the communities; covering: a) employment, education and training services b) help and advice with benefits, housing and social care c) Advocacy d) leisure, sport and social activities e) community and faith groups f) specific support groups – for example, mother and baby groups, older adult groups, hearing voices groups or problem-specific support groups (such as for diabetes or depression). 2. **Workforce and skill mix** and **staffing configuration** for the MINT teams 3. **Place base for MINT teams** – what is provided in local (PCN) or wider communities (neighborhoods/localities or borough level) 4. Way of **promoting joint working between MINT teams and GPs** 5. **Alignment to local integrated systems** and ways of bringing physical and mental community care together

Agenda Item 8

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: Thursday, 10 September 2020

Subject: Work Programme

Report of: Bathsheba Mall

Summary

The Committee is asked to consider its work programme for the municipal year 2020/21

Recommendations

The Committee is asked to consider the proposed draft work programme (attached as Appendix 1) and suggest further items for consideration

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Wards Affected: All

H&F Priorities

Our Priorities	Summary of how this report aligns to the H&F Priorities
• Building shared prosperity	*In accordance with its constitutional terms of reference the work of the Committee will support the Council's priorities by helping to develop, shape and deliver health and social care services for the benefit of all borough residents.* *The Work Programme comprises of health and social care topics, ensuring an inclusive agenda of emerging and strategic policy areas.*
• Creating a compassionate council	
• Doing things with local residents, not to them	
• Being ruthlessly financially efficient	
• Taking pride in H&F	

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Background Papers Used in Preparing This Report

None.

List of Appendices:

Committee Work Programme 2020/21

Appendix 1

Health, Inclusion and Social Care Policy and Accountability Committee
Work Programme Development Plan 2020/21

Item / working title	Overview / Development	Report Author / service
10 September 2020		
Covid-19 Update	Brief update from the Director of Public Health	PH
Supported Employment	To look at the opportunities for improving the provision of supported employment placements within the Borough and that development of guidance for this.	ASC / Economy (LBHF) / Providers
Community Transformation – Mental Health Integrated Network Team	This item provides detailed background information as to the development of the Mental Health Integrated Network Teams (MINT) across Hammersmith & Fulham.	CCG / WLT
4 November 2020		
Suggested items (TBC)*		
Engage with and review work being done by PCNs on the effectiveness of their work on Long Term conditions		
Dentistry – most services have been suspended for COVID (an issue that disproportionately effect the more deprived areas)		
Brompton Hospital - Update		

Appendix 1

Suggested items – included for information (2020/21)

Mental Health	**Children's**
• Analysis of Mental Health data and how this informs key performance indicators • West London NHS Trust update • Health Based Places of Safety • The impact of Covid-19 on mental health and wellbeing • Impact of Covid-19 on older people	• Immunisations • Supported Employment
Community / Public Health	**Health Partners and Providers**
• Community Champions - to consider current provision and support, following disaggregation of the service and what this means for LBHF residents; to consider the further development and support of the service. • Health and Public Transport for older residents • The Digital Development of Primary Health Services – GP at Hand • Brompton hospital – impact of the transfer of services*	• CAMHS update • Track and track review issues generated by the Imperial Quality Audit. • Engage with and review work being done by PCNs on the effectiveness of their work on Long Term conditions* • Dentistry – most services have been suspended for COVID (an issue that disproportionately effect the more deprived areas)*