London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee Agenda

Wednesday 15 November 2023 at 7.00 pm

Main Hall (1st Floor) - 3 Shortlands, Hammersmith, W6 8DA

Watch live on YouTube: youtube.com/hammersmithandfulham

MEMBERSHIP

Administration	Opposition
Councillor Natalia Perez (Chair) Councillor Genevieve Nwaogbe Councillor Emma Apthorp Councillor Ann Rosenberg	Councillor Amanda Lloyd-Harris
Co-optees	
Victoria Brignell, Action On Disability Lucia Boddington Jim Grealy, H&F Save Our NHS Keith Mallinson, Healthwatch	

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Members of the public are welcome to attend but spaces are limited, please email David.Abbott@lbhf.gov.uk if you plan to attend. The building has disabled access.

Date Issued: 07 November 2023

Health and Adult Social Care Policy and Accountability Committee
Agenda

If you would like to ask a question about any of the items on the agenda, please email David.Abbott@lbhf.gov.uk by 12pm, 14 November 2023

Item **Pages**

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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 Standards Committee.

3. MINUTES OF THE PREVIOUS MEETING 4 - 11

To approve the minutes of the previous meeting as an accurate record and to note any outstanding actions.

4. SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2022/23 12 - 93

This item presents the Safeguarding Adults Board Annual Report 2022/23 for review and comment.

5. VACCINATION SERVICES IN THE LONDON BOROUGH OF HAMMERSMITH & FULHAM 94 - 142

This paper provides an overview of vaccination programmes in Hammersmith & Fulham. The paper focuses on childhood vaccinations,

but data is included where pertinent on the wider schedule.

Members of the Committee are asked to note and support the work that system partners across London, including NHSE London, the Local Authority, and the Integrated Care Board are doing to increase vaccination uptake.

6. WORK PROGRAMME

The Committee is asked to consider items for inclusion in its work programme.

7. DATES OF FUTURE MEETINGS

To note the following dates of future meetings:

- 31 January 2024
- 27 March 2024

London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee

Minutes

Wednesday 19 July 2023

PRESENT

Committee members: Councillors Natalia Perez (Chair), Genevieve Nwaogbe, and Amanda Lloyd-Harris

Co-opted members: Victoria Brignell (Action On Disability), Jim Grealy (H&F Save Our NHS) and Keith Mallinson (Healthwatch)

Other Councillors
Councillor Ben Coleman (Deputy Leader and Cabinet Member for Health and Social Care)

Guests
Dr Bob Klaber (Imperial College Healthcare NHS Trust)
Jane Wheeler (Director of local care programme, NW London ICB)
Dr Lyndsey Williams (NW London GP clinical lead for end of life and care homes)
Ian Jones (CLCH)
Melissa Mellett (AD, Local Care programme, NW London ICB)
Susan Roostan (NHS North West London)
Merril Hammer (HAFSON)

Officers
Linda Jackson (Strategic Director of Independent Living)
Dr Nicola Lang (Director of Public Health)
David Abbott (Head of Governance)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Emma Apthorp, Councillor Ann Rosenberg, and Lucia Boddington.

Victoria Brignell, Jim Grealy, and Merril Hammer joined the meeting remotely.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 26 April 2023 were agreed as an accurate record.

4. IMPACT OF THE DELAYED REBUILDING OF ST MARY'S HOSPITAL

Dr Bob Klaber (Director of Strategy, Research and Innovation, Imperial College Healthcare NHS Trust) addressed the Committee and provided a verbal update about the delayed rebuilding of Charing Cross, Hammersmith, and St Mary's Hospitals and the healthcare impacts on residents.

A series of photographs showing run-down areas of St Mary's Hospital were distributed in the meeting.

Dr Klaber told the Committee that St Mary's Hospital currently had one ward closed and said there were constant issues across the estate making things difficult for staff and patients. The New Hospital Programme recently announced they were delaying funding for the rebuild beyond 2030, although he noted they had promised funding for a business case for the eventual rebuild.

Dr Klaber said he felt there were opportunities to move further up the list, using a combination of public money and some commercial money from land sales. The Trust calculated they needed around 40% percent of the land for the hospital. He added that Charing Cross and Hammersmith Hospitals could be rebuilt in phases, building on some of the existing good quality infrastructure and replacing the poor infrastructure.

Councillor Amanda Lloyd-Harris noted the refurbishment of Charing Cross was being delayed and asked, if groundwork started in 2024, what the completion date would be. Dr Klaber said he couldn't give an estimate. He noted the business plan was due to be submitted in the autumn. He added that Charing Cross would be a phased rebuild. The business plan would explore how best to deliver that phasing. He said the clear steer from the programme had been that there was potential to have a significant funding envelope brought forward and the trust was doing everything they could to bring it forward. He hoped that could be done in partnership with local authorities.

Councillor Lloyd-Harris said engaging with commercial enterprises was often contentious locally and asked how the Trust planned to deal with that, and what benefits there might be for patients and staff. Dr Klaber said he understood that some people may have anxieties, but by starting with communities and population need, they were much more likely to get to the right answer. He said it was clear that there were ways to do it to create some competition in an open way, to give taxpayers confidence they were getting value for money. He said, things that kicked it into the long grass would make things worse for patients and ultimately cost more money.

Jim Grealy asked if the deteriorating condition of one of the three hospitals could have wider consequences, pushing services to other places. He also asked what the effects of delaying the necessary rebuild would have on care. Dr Klaber said the current state of the buildings was difficult for staff who wanted to deliver the highest quality care, as well as being difficult for patients. He said the impact of estate failure could have knock-on effects in all sorts of spaces. Running services at very high capacities had serious impacts. He said the Trust and its partners needed to work together as a system, to understand patient need – both current and future need – and think about how to run the highest quality systems.

Merril Hammer asked for clarification that Imperial initially understood it would be given money for St Marys, Hammersmith, and Charing Cross Hospitals to complete works before 2030. Dr Klaber said yes, they were part of the initial programme, but there was no specific money attached.

Merril Hammer asked for confirmation that no clear date had yet been given for funding to be given or building works to be completed. Dr Klaber said work and planning around St Mary's hadn't stopped. The Trust was doing everything it could to progress the rebuild. Regarding funding, they had been told it would come after 2030.

Merril Hammer asked for reassurances that Imperial were not considering a Private Finance Initiative (PFI). Dr Klaber said strong financial management was a key part of delivering good care and was important to the Trust. He said the Committee could have confidence that they wouldn't agree to any scheme that would simply defer the financial problem. He said they were trying to be creative and open minded.

Councillor Ben Coleman (Deputy Leader and Cabinet Member for Health and Social Care) asked if the Trust expected to sell enough land on the St Mary's site to get all money needed for the rebuild. Dr Klaber said roughly 40% of the land was needed for a hospital but funding from land sales depended on density, build height etc. He said the relationship with Westminster City Council had been very productive, but it was not a 'done deal'.

Councillor Coleman asked for clarification that if the business plan was completed early, then there was a possibility that Charing Cross and Hammersmith Hospitals might move up the list. Dr Klaber said yes, he believed they could get funding for the refurbishment of certain buildings but it was complex and required the right plans. Councillor Coleman commented that the plans seemed highly contingent.

Councillor Coleman asked what impact the worsening estate at St Mary's would have on Charing Cross and other nearby hospitals. Dr Klaber said the estates team could plan to an extent, but it depended on the services affected. Despite excellent work done to keep services running during recent disruptions, there was a limit because of a lack of spare capacity.

Victoria Brignell suggested the Trust could approach rich philanthropists for contributions to the rebuild. Dr Klaber said they were open-minded, and philanthropy was something they were exploring – particularly in relation to research.

Jim Grealy asked if the state of the buildings at St Mary's and other sites meant innovations and improvements to the patient experience were being postponed. Dr Klaber said it went both ways. The state of the facilities had driven innovation in some areas like 'hospital at home', virtual wards, and a more integrated approach. He noted that in other areas such as research it was not practical to realise their vision of research at every bedside. He added that estate failures meant it was difficult to think in a forward looking way and it was frustrating for the organisation and staff to spend so much time dealing with problems.

The Chair thanked Dr Klaber for attending and providing an update. She highlighted the concerns that residents had over the delays, the importance of hospitals that were fit for purpose and met the needs of patients and the community, and the importance of partnership working.

Councillor Coleman noted that the ICB had commissioned a piece of work looking at the impact on patients and said he looked forward to seeing the report and understanding the impact in more detail.

5. NORTH WEST LONDON ADULT COMMUNITY-BASED SPECIALIST PALLIATIVE AND END-OF-LIFE CARE REVIEW PROGRAMME

Dr Lyndsey Williams (NW London GP clinical lead for end of life and care homes) and Ian Jones (CLCH) presented the update on the progress made by the programme team since their previous presentation on 25 January 2023. She said the programme team welcomed the Committee's feedback on engaging on the new model of care before the engagement process was officially launched.

Councillor Amanda Lloyd-Harris commented that the document was much improved from the version presented in January. She said she was glad to see the service was being extended given how it important it was for residents to be able to contact someone out of hours. Dr Williams said she hoped the new model of care put patients and those around them, and those left behind, at the centre.

Keith Mallinson welcomed the report. He noted that he had been on a panel at Trinity Hospice recently looking at end of life provision for the LGBT community. The takeaway was around how to make it more personalised. Dr Williams said the LGBTQ+ community was one of the cohorts that they had engaged with members on, and undertaken literature reviews looking at cultural sensitivities. She said she could share more of the work they had done in that area. Dr Williams said holistic assessment and being aware of cultural sensitivities was part of the underlying principle for the new model of

care and said perhaps that needed to be clarified in the engagement documents.

Jim Grealy said he welcomed the extension of hours, he felt it needed to be a 24-hour service to be comprehensive. But he said the report lacked the necessary data to make judgements and felt it was too generalised. Dr Williams said the document presented to the Committee was not the complete model of care document with all the detail and data. The item on the agenda was a progress update on that work. She said it was almost finished and was scheduled to go out for engagement at the end of the month. The initial engagement would be on the 'what', not the 'how' – which would come later. The goal was to ensure they were identifying any unmet needs. She said the proposed model of care would be published at the end of the month.

Jim Grealy said he was concerned about an engagement exercise over the summer and felt many people would miss out on their chance to provide feedback. Sue Roostan acknowledged that summer was not an ideal time for the engagement and said they would look at extending the engagement period if the response rate was below expectations. Councillor Lloyd-Harris said she thought it was essential to extend the engagement period to the end of September or early October. Sue Roostan said they would consider it.

Dr Nicola Lang (Director of Public Health) discussed how important it was for the service to operate 24-7. Dr Williams said there was a 24-7 advice line and they intended for that to continue and expand to all patients. There was also a visiting element that would run 8am to 8pm. Dr Lang suggested changing the wording in the engagement document to make that clearer.

Merril Hammer said the document needed to be clearer about how the new model of care differed from the old model. She also raised concerns about access to beds for end-of-life care. She also noted the paper made it seem as though HAFSON had supported the process, but the HAFSON representative on the group had reported reservations about the way the process had been carried out.

Dr Williams said they would look at the language around what was new or enhanced. She said she hoped all of the issues raised would be addressed in the final document. Regarding HAFSON's involvement, she said she would look again at the references in the final document. Dr William's also encouraged Merril's HAFSON colleague to contact her to give them an opportunity to provide feedback.

Linda Jackson (Strategic Director of Independent Living) welcomed the update and said it showed the changes asked for by the communities and this group had been incorporated. She then asked at what point there would be a formal consultation on the changes, given it was a significant service change. Sue Roostan said there would be an engagement process on what was required, then when considering how to deliver the service there would be consideration of whether there needed to be a formal consultation.

Keith Mallinson informed the Committee of his experience of the current service. He said the process around his partner's death had been seamless and he praised the service and the effort the teams put in.

Councillor Coleman asked if the anticipated consultation would be carried out over the Christmas holiday. Sue Roostan said if a consultation was necessary, they would try to avoid another holiday period given the engagement was taking place in summer.

The Chair thanked Dr Williams and colleagues for attending. She noted the Committee's concern about the engagement period and reiterated the request for an extension. She also noted the points made around the engagement document and the importance of using the right language around cultural sensitivities.

6. POST COVID SYNDROME SERVICES UPDATE

Melissa Mellett (AD, Local Care programme, NW London ICB) presented the update on the post-Covid service offer in North West London. She noted that a new service was due to open at Charing Cross Hospital in September. The goal of the new service was to reduce the waiting list to a maximum of 6 weeks for those waiting for the acute service. The recommended approach was to move to a community first model which would mean patients were seen quickly and then referred to the Post-Covid Acute Service if necessary. She also noted the post Covid population statistics and said there was a health inequalities programme focused on ensuring those numbers represented the entire population.

Councillor Amanda Lloyd-Harris asked how they planned to actively increase GP referrals and asked why they did not believe the current figures were reflective of the community. She also asked about the impact of isolation and asked if there had been a concerted effort to see those people face-to-face as it might be better for their mental health. Melissa Mellett said some GP's had been referring at higher rates than others, and population health reviews suggested there were inequalities. Regarding face-to-face assessments – she said triage was done by clinicians and they would try to pick the best solution, while also considering patient need.

Councillor Lloyd-Harris noted the inclusion of digital tools and resources and asked what considerations there were for people who didn't have access to them. Melissa Mellett said it was just one aspect of the service, people could still go to their GP.

Councillor Genevieve Nwaogbe noted that 127 patient referrals were accepted but 125 were returned to their GP. Melissa Mellett said in the beginning there were significant challenges with referrals from primary care settings. The digital record had key information missing so had to be sent back, but each of those cases was carefully managed and followed back into the service.

Councillor Nwaogbe asked if there was a breakdown of those rejected for further support by ethnicity. Melissa Mellett said the figures in the briefing showed both accepted and rejected together.

Keith Mallinson noted it seemed as though older people were not coming forward and asked if the service would be working with organisations like Age Concern to encourage participation. Melissa Mellett said each borough was running different engagement activities to get underrepresented cohorts to come forward.

Jim Grealy asked how the ICS was informing the public of the condition. He had concerns that poorer people were not being referred and there could be a need going unaddressed. Melissa Mellett said they were trying to ensure information about it was made widely available.

Merril Hammer raised concerns that some people had not been taken seriously by GPs at an early stage and would be reluctant to come back now. She asked how the service planned to reach those people. Melissa Mellett said she didn't believe GPs hadn't taken people seriously, but rather the symptoms presented could fit into multiple categories.

Linda Jackson asked if data was being captured about the difference the interventions had made to patients. Melissa Mellett said they had used the standard friends and family questions, but those were too generic. The digital Living with Covid service would provider richer data.

The Chair asked how the service was being funded and how to ensure it was sustainable. Melissa Mellett said it was funded by NHS England in one-off payments. Funding had been secured this year but was not yet secured for next year. She agreed it was important to find a sustainable solution.

The Chair noted Councillor Ann Rosenberg, who had suffered with Long Covid wanted to ask a question but wasn't able to attend – she wanted to know if any research was being done to understand the condition. Melissa Mellett confirmed research was being done and offered to meet with Councillor Rosenberg to discuss it with their clinical lead. Councillor Lloyd-Harris suggested there may be some lessons from the beginnings of ME (chronic fatigue syndrome).

The Chair asked about support for children and young adults. Melissa Mellett said that was part of the second phase of the programme, Janet Cree was leading a workstream on the topic and colleagues could provide feedback at a future meeting.

7. DATES OF FUTURE MEETINGS

The following dates of future meetings were noted:

- 15 November 2023
- 31 January 2024
- 27 March 2024

Meeting started: 7.02 pm
Meeting ended: 9.19 pm

Chair .....

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LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Adult Social Care Policy and Accountability Committee

Date: 15/11/2023

Subject: Safeguarding Adults Board Annual Report 2022/23

Report author: Ceri Gordon, Safeguarding Adults Board Manager

Responsible Director: Linda Jackson, Strategic Director of Independent Living (DASS)

SUMMARY

This item presents the Safeguarding Adults Board Annual Report 2022/23 for review and comment.

RECOMMENDATIONS

1. That the Committee note and comment on the Safeguarding Adults Board Annual Report 2022/23.

Wards Affected: All

Our Values	**Summary of how this report aligns to the H&F Values**
Creating a compassionate council	The annual safeguarding report sets out the work of the Board to protect adult residents, working collaboratively with statutory multi-agency partners to help prevent harm.
Doing things with local residents, not to them	The Safeguarding Adults Board works proactively with residents through our partners to support and protect against those who would seek to take an advantage.

Background Papers Used in Preparing This Report
None.

HAMMERSMITH & FULHAM SAFEGUARDING ADULTS BOARD – SUMMARY OF ANNUAL REPORT 2022 – 2023

Context

Section 43 of the Care Act 2014 states that every local authority must have a Safeguarding Adults Board (SAB). The SAB is a partnership of organisations working together to prevent abuse and neglect of adults in need of care and support. The Care Act 2014 requires each SAB to publish an annual report, which reports on what it has done during that year to achieve its objective and implement its strategy, as well as report on findings of reviews arranged under Section 44 (Safeguarding Adults Reviews).

The SAB also works within the local context of increasing volume of safeguarding adult concerns being referred to the local authority, with 2022-23 seeing a 12% increase in number of concerns received compared to previous year.

Review of 2022-23

Our focus in 2022-34 was on revitalising the work of the SAB, re-establishing our purpose, and ensuring we are evidence-based. This included a review of the SAB's compliance with Care Act statutory guidance to identify gaps, which led to the development of Persons in Positions of Trust guidance.

We have also begun efforts to be more evidence based and strengthen our use of data, supported by the establishment of a new 'Quality in Practice subgroup' who seek to gain a strategic overview of safeguarding adult activity across the partnership and promote best practice and learning.

Learning from Safeguarding Adults Reviews

Two Safeguarding Adult Reviews were commissioned in 2022-23, with the learning from these processes informing a new action plan. This includes focus on the following areas:

- Gaps in understanding of fire risk and our responses.
- Spotlight on the importance of effective multi-agency working.
- Reflection on how we understand fluctuating capacity and executive functioning, with particular focus on assessing mental capacity where person uses drugs/alcohol.
- Reflection on how we work with people who are difficult to engage.

The SAB continues to monitor action plan developed in response to this learning. This work is done with the support of the Safeguarding Adults Case Review Group who have sought to strengthen decision making processes and explored new

methods to capture learning from other cases which may not meet criteria for Safeguarding Adults Review.

Strategy for 2023-24

Our new strategy for 2023-24 focuses on preventative safeguarding practice and learning from practice, with three priority areas:

- **Effective systems and processes**: We will use an evidence-based approach to develop our responses to potential abuse and neglect and areas of complexity.
- **Creating a culture of learning**: We will promote continuous improvement in safeguarding practice by learning from experience and supporting workforce development.
- **Communication and partnership**: We will work seek to build active partnerships and expand our network.

Self-neglect has also been identified as an important area for us in H&F, accounting for 33% of completed safeguarding concerns in 2022-23.

This has informed a more focused action plan which directs the work of the SAB and its subgroups. Focused pieces of work this year include drafting of multi-agency self-neglect guidance and plans for multi-agency audit, examining understanding of discriminatory abuse, improving SAB communication and multi-agency learning opportunities and review of the High-Risk Panel's scope.

LIST OF APPENDICES

Safeguarding Adults Board Annual Report 2022/23

Safeguarding Adults Board Annual Report 2022-23

NOTE: The original online version of the report can be found at: https://www.lbhf.gov.uk/health-and-care/safeguarding-adults-board/safeguarding-adults-board-annual-report-2022-23

Foreword

Image 1: Mike Howard, Chair of the Hammersmith and Fulham Safeguarding Adults Board

The Care Act 2014 states that every local authority must have a Safeguarding Adults Board (SAB). The SAB is a partnership of organisations working together to prevent abuse and neglect of adults in need of care and support.

If someone experiences such behaviour, they have a duty to respond in a way that supports their choices and aids their wellbeing. The act also requires each SAB to produce an annual report listing its activities, progress, and achievements.

Last year's annual report described the Board's response to the impact of the Covid pandemic. These demands understandably led to the Board being reactive to the extraordinary pressures and demands by placed upon member organisations and their staff.

Last summer, I wanted the board to return to its purpose as outlined by the Care Act. Thanks to the arrival of new members who brought different ways of thinking from their experiences elsewhere, the SAB has embraced change in a relatively short period of time.

The annual report mentions the new Quality in Practice sub-group which has started to evaluate and use local data to better understand the discharge of safeguarding responsibilities by all SAB members.

We have also re-structured the Case Review Group. The group carries out an important function of the SAB; to examine cases involving death or serious injury to adults at risk of harm with a view to 'learn lessons.' This has resulted in the commissioning of two Safeguarding Adult Reviews (SARs). The report goes into detail about the death of 'Alison' and the second SAR will be completed later this summer.

The report also outlines the work of the 'High Risk panel' another area of our work benefitting from a 'new pair of eyes' and a change of approach.

The report does not mention the appointment last autumn, of our first board business manager, Ceri Gordon, who has written this report.

Ceri has brought a dynamism and vitality to the work of the board, providing valuable support to the sub groups and panels as well as being available to all members giving them the benefit of her experience and knowledge. I thank her for her commitment and enthusiasm.

Ceri was the driving force behind the SAB's first development day at the Dawes Road Hub in Fulham in April. It was great to see so many people in person as opposed to through a computer screen.

The day was well attended and one outcome was the development of the SAB strategy for 2023-24 which is both summarised and included in detail in the report.

A key aspect of all safeguarding work is to listen to, and, whenever practical, consider the wishes and experiences of those residents who have been victims of abuse and or neglect: 'Making Safeguarding Personal.'

So, over the next year, I want to work with partners to ensure that the board has a meaningful engagement with the many residents of Hammersmith and Fulham who either have or may have safeguarding needs- commonly known as the 'Voice of the User.' This was, rightly, a key theme from our April get together.

Thank you to all the Board members for their contributions to our work over the past year. I would like to give a special mention to Lisa Redfern, who retired in the spring, from her role as Strategic Director of Social Care and was a founder member of the board. Lisa did so much to launch the board, keep it going during the Covid years and then agreed to the recruitment of a business manager.

I am sure you will join with me in wishing her a long and happy retirement.

Mike Howard

Chair of the Hammersmith and Fulham Safeguarding Adults Board, June 2023

Who we are

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs. **We all have a role to play.**

The Hammersmith and Fulham Safeguarding Adults Board (H&F SAB) is a multi-agency partnership that leads on adult safeguarding work in the borough, and is a statutory body required by the Care Act 2014. Our membership includes a range of organisations:

- H&F Adult Social Care
- North West London NHS (Integrated Care Board)
- Metropolitan Police Service
- H&F Housing
- H&F Public Health
- H&F Community Safety
- West London NHS Trust
- Central London Community Healthcare NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster NHS Trust
- London Fire Brigade
- Carers Network
- Probation services
- Healthwatch Hammersmith & Fulham
- HMPS Wormwood Scrubs
- Department of Work & Pensions
- H&F Trading Standards

Professionals and volunteers across our partnership aim to work collaboratively to prevent and reduce harm to adults at risk in the borough. The SAB seeks to support this work by ensuring that all residents and people who work with adults at risk in H&F are able to recognise potential abuse or neglect, and know how to respond. We also play a role in gathering assurance that adult safeguarding arrangements are effective, and that we work within the principles of Making Safeguarding Personal by putting the person at the centre of everything we do.

The local picture

The SAB seeks to make use of data to ensure that we are making evidence-based decisions and understand how abuse and neglect impact on H&F residents. We have produced a focused report which contains an overview of the demographic of our borough and information about how adults at risk of harm are protected from abuse or neglect through the use of section 42 safeguarding enquiries.

What we've been working on

Our focus in the last year has been on revitalising the work of the SAB, re-establishing our purpose, and ensuring we are evidence-based.

Key to this work has been the creation of our new Quality in Practice subgroup, led by Helena Peros (H&F Designated Professional Safeguarding Adults, North West London NHS ICB) with co-chair Kay Carpenter (Manager of ASC Safeguarding Hub). This group was established to gain a strategic overview of safeguarding adult activity across the partnership and promote best practice and learning. This group has already made an impact by reviewing the SAB's use of local data and developing a survey in order to better understand the views of operational staff in the borough. The group has also reviewed the SAB's compliance with the Care Act statutory guidance, and this has highlighted the need to develop a local framework for responding to allegations against Persons in Positions of Trust. A task and finish group has been established to address this with hopes to conclude this piece of work by September 2023.

Our Safeguarding Adults Case Review Group has also developed over the past year and is now better established and structured, thanks to the leadership of Lisa Redfern (Strategic Director, Adult Social Care) and Parminder Sahota (Director of Safeguarding, West London NHS Trust) who co-chair the group. This has involved a review of our terms of reference and the development of new checklists based on the Safeguarding Adults Review Quality Markers.

Two Safeguarding Adults Reviews were commissioned in 2022-23, the first in the borough (see below) and the group has helped to ensure we take a proactive approach to learning from this process. We have also started to think about how we capture the learning from non-statutory reviews, creating a 7-minute briefing based on learning from a local case that centred on domestic abuse. The group has also developed two new leaflets to support those involved in SARs, with one aimed at family, friends and carers and another aimed at professionals.

NOTE: The leaflets can be found at Appendix 1 and 2

The High-Risk Panel, established in 2018-19, has also continued to operate with leadership from Lloyd Palmer (H&F Borough Commander LFB) and Christopher Nicklin (Assistant Director for Quality, Safety and Performance, Adult Social Care). The panel has seen an increase in the number of referrals and has supported decision making in a range of complex cases. The majority of the cases heard at this panel relate to issues around hoarding and fire risk.

However, there is recognition that this panel may have a role in other types of self-neglect cases which have reached a level of high risk, for instance where a person may be neglecting their health to the extent that it presents a risk to their vital interests. The SAB intends to review the remit of this group in 2023-24, which will include consideration of panel membership to ensure that we have the right people at the table to make informed decisions.

Individual agencies have also been working hard to improve the way we engage with adults at risk in the borough, ensuring we are outcome focused and working in a person-centred way.

Safeguarding Adults Reviews

Under the Care Act 2014, the SAB is responsible for the coordination of Safeguarding Adults Reviews (SARs). These independent reviews are commissioned where there has been an incident of serious harm or death involving an adult at risk, and focus on capturing learning. They set out to establish what may have gone wrong and to identify where agencies or individuals could have acted differently or worked better together.

In 2022-23 the H&F SAB concluded its first SAR and we are now working to implement the recommendations locally.

Alison

Alison was in her late fifties and lived with her civil partner. Alison had a long history of substance misuse, and her drug use was considered as a significant contributory factor in her multiple health issues. Alison was also a smoker and smoked around twenty cigarettes a day.

A SAR was commissioned following Alison's death in December 2021 as a result of a fire in her own home. There were a number of agencies who had regular contact with Alison, whilst others struggled to maintain engagement with Alison, who would decline offers of support. This review sought to understand how professionals are able to balance risk with a person's right to choice and autonomy.

The review also considered the response taken to two previous fatal fires in the borough, which has led to the creation of a local action plan.

What have we learnt?

Importance of multi-agency working
The review has placed a spotlight on the importance of effective multi-agency working. Multi-agency communication is key to reducing the risks for any case and avoiding silo-working. Having an awareness of what other partners can provide to mitigate risks also helps us to plan and share risks.

Improving understanding of fire risk and our responses
This process has also highlighted gaps in understanding of how we assess fire risk, with some training provisions not being sufficient to cover fire risk in the home. In addition, more work is needed to ensure that we have robust risk assessments and that practitioners have an understanding of what they can do to mitigate any identified risk.

Consideration of mental capacity
Whilst Alison was deemed to have the capacity to make decisions in relation to her care and support needs, the review has led to reflection on how we understand fluctuating capacity and executive functioning. This is particularly pertinent when a person is known to be living with addiction.

NOTE: The full review can be found at Appendix 3 – Safeguarding Adults Review: "Alison"

What will we do in response?

Partners within the H&F SAB partnership have taken a proactive approach to learning from this review, with a number of initiatives already put in place.

Multi-agency working
The H&F SAB partnership is committed to strengthening the way in which we work together to protect adults at risk. An example of this work is improved links between the London Fire Brigade and other partner agencies including H&F Adult Social Care and H&F Housing, where there now better relationships in terms of fire safety multi-

agency approaches. The concept of 'Making Every Contact Count' has been introduced as part of this initiative, and this seeks to ensures that all professionals make every possible use of the contact had with vulnerable people in our communities, offering education and advice and, where appropriate, making referrals to partner agencies where wider specific support needs can be offered.

In April 2023, the London Fire Brigade introduced a new system for conducting Home Fire Safety Visits. This will allow them to prioritise the most vulnerable by using new risk categories. Locally, the LFB are seeking to host multi-agency sessions to offer further support and advice around the application of the new process. The LFB are also considering how they can respond to the recommendations that LFB take a new leading role within multi-agency meeting and mental capacity assessments relating to fire risk, with discussions on how this will look in practice.

Risk assessment and response
The care provider involved in Alison's care has done a great deal of work to improve responses to home fire safety, including the creation of a new, more robust risk assessment tool. This work has been supported by the work of LBH&F commissioning services, who have included fire safety as a standing item in monthly contract monitoring. Commissioners have also sought to strengthen communication links with the LFB, with regular updates and training opportunities shared with all known providers registered in the borough.

Adult Social Care has also included a new prompt within their case records database (Mosaic) to complete Person-Centred Fire Risk Assessments with a clearer escalation process. The local authority has also committed to consideration of Personal Protective Equipment to mitigate fire risk, with funds being allocated for this purpose.

These efforts are supported by the London Fire Brigade, who have been delivering multi-agency training to local partners focused person-centred fire risk assessment.

The Central London Community Healthcare NHS Trust has also responded to the learning by dip sampling records of patients who are bedbound or had reduced mobility, to see if a checklist has been completed and LFB home safety visit requested.

Awareness
We have also created an action plan in response to the recommendations within the report in order to monitor partner responses, and with a view to take collective action in areas such as raising awareness of home fire safety and promoting expected best practice in multi-agency working.

An example of this within partner organisations is the work of the Central London Community Healthcare NHS Trust, who has sought to raise awareness of fire safety through the development of posters, sticks and banner pens, and a specific page within internal intranet safeguarding pages to create a specific page with QR code

for staff to easily access resources and information on fire safety. ‘Fire safety in care settings’ awareness has also been added to the CLCH statutory and mandatory training resource, and the team plan to expand on this by hosting lunch and learn webinars and including fire safety as a topic at the CLCH safeguarding conference planned for September 2023.

Other healthcare providers, such as Imperial College London NHS Trust, have also been working with frontline staff to promote the importance of fire prevention, whilst

The West London NHS Trust has also launched a new self-neglect toolkit which provides practitioners with specialist assessment tools and escalation options.

Another important area we need to consider is legal literacy, particularly when working with someone who may have fluctuating capacity. This includes the promotion of different methods and pathways that can be used to manage risk, as well as consideration of case law and inherent jurisdiction. This will be a focus for the SAB as we seek to embed the learning from this SAR.

SARs expected to be concluded in 2023-24

The H&F SAB are now in the final stages of our second SAR. This SAR focuses on the death of a man who lived with a number of physical and mental health issues, and substance misuse. He had also experienced homelessness and had been previously detained in prison.

Initial learning from this SAR centres on:

- the importance of multi-agency working and effective communication
- how we assess the mental capacity of people who use alcohol and, or substances
- how we engage with adults at risk who are difficult to engage.

Some of this learning will overlap with what we have learnt from Alison’s case. We continue to consider how we can take a proactive to this learning.

What’s next

Our new strategy for 2023-24 focuses on preventative safeguarding practice and learning from practice, with three priority areas.

Effective systems and processes
We will use an evidence-based approach to develop our responses to potential abuse and neglect and areas of complexity.

Creating a culture of learning
We will promote continuous improvement in safeguarding practice by learning from experience and supporting workforce development.

Communication and partnership
We will work seek to build active partnerships and expand our network.

This work will consider how we share learning from SARs and other review processes widely across the partnership, with a clear methodology for reviewing the impact on practice. We also want to explore how we expand our reach beyond the immediate SAB membership, by engaging with the local voluntary and community sector and raising awareness in H&F communities on how to spot signs of potential abuse and neglect and seek support.

Self-neglect has also been identified as an important area for us in H&F, and this also links to our plans to review the understanding and application of the Mental Capacity Act by H&F practitioners and promote a deeper understanding of how this legislation can be applied in practice.

We also want to focus on promoting the importance of multi-agency working in safeguarding adults at risk, showcasing best practice in the borough as we do so.

Throughout all of this work, our aim is to keep those we seek to protect at the centre of what we do. We want to do more to capture the voice of service users and understand how abuse and neglect affects our communities.

To find out more about what we aim to achieve next year, please see our strategic plan. H&F SAB Strategic Plan 2023-24.

List of Appendices

Appendix 1 – Safeguarding Adults Reviews: Information for family, friends and carers

Appendix 2 – Safeguarding Adults Reviews: Information for professionals

Appendix 3 – Safeguarding Adults Review: "Alison", March 2023

Safeguarding Adults Reviews:
Information for families, friends and carers

What is Hammersmith and Fulham Safeguarding Adults Board?

The SAB brings together all the main organisations who work to safeguard 'adults at risk'. An 'adult at risk' is someone who has care and support needs, and as a result of those needs may be unable to protect themselves from abuse or neglect. The SAB is a partnership that works together to ensure that there are effective arrangements to keep adults at risk safe from abuse or neglect.

When an adult at risk either dies or suffers serious harm, and when abuse or neglect is thought to have been a factor, Hammersmith and Fulham SAB may need to review what has happened. This is called a Safeguarding Adults Review (SAR).

The main purpose of these reviews is to find out if we can learn anything about the way different organisations worked together to support and protect the person who suffered harm. This could identify barriers, but it could also identify good practice. This learning will help us to make positive changes to the way we work.

We understand this is likely to be a very difficult time for families, friends and carers, but we want to learn as much as possible about how we can do things differently in the future. The SAB wants families, close friends and carers to be involved in the process wherever they can.

We believe the person who suffered harm and those close to them should have the opportunity to discuss any concerns they may have and to share their thoughts and opinions.

What happens during a SAR?

There are different ways in which a SAR can be done, but they all involve gathering information from services who had involvement with the person at the centre of the review. The review team, led by an independent reviewer who had no involvement in the case, can then try to get a better understanding of what happened, and why. They will consider whether things could or should have been done differently and ask how things could be done better in the future.

A SAR will often find there have been lots of agencies involved in the person's life. Sometimes the best way forward is to ask those who were directly involved to share their experience. The lead reviewer will help to facilitate the discussion and lead on identifying recommendations for future practice.

The findings are then summarised in a report which is usually published and made available to the public - however, no individuals are named in the report and no information is included that could lead to the people involved being identified. The lead reviewer may give you the opportunity to review the report and make comment before it is finalised, if you would like to do so.

The SAB will then construct an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. Sometimes an individual organisation involved in the review will also write their own action plan which will work alongside the shared action plan. They will be asked to provide assurance to the SAB that actions are being implemented.

A really important part of undertaking a SAR is to ask you, those close to the person, for your opinion about what happened. Your views should be reflected in the final report.

Your involvement in the SAR process also helps the lead reviewer to get an understanding of who your loved one was as a person.

We will discuss with you how you would like to be involved and to what extent.

Sometimes a SAR can take several months to complete, but we will update you regularly and explain the reasons for any delays.

If you have other questions you would like to ask, you can speak with the lead reviewer or you can contact the Safeguarding Adults Board Manager: Ceri.Gordon@LBHF.gov.uk

Cruse Bereavement Support may also be able to offer additional support.

Safeguarding Adults Reviews:
Information for professionals involved in a review

What is Hammersmith and Fulham Safeguarding Adults Board?

The SAB brings together all the main organisations who work to safeguard 'adults at risk'. An 'adult at risk' is someone who has care and support needs, and as a result of those needs may be unable to protect themselves from abuse or neglect. The SAB is a partnership that works together to ensure that there are effective arrangements to keep adults at risk safe from abuse or neglect.

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The main purpose of these reviews is to find out if we can learn anything about the way different organisations worked together to support and protect the person who suffered harm. This could identify barriers, but it could also identify good practice. This learning will help us to make positive changes to the way we work.

It is important that all relevant staff and volunteers are given an opportunity to share their views on the case as appropriate. This should include your views about what could have made a difference for the adult(s) and their family.

We want you to feel able to "tell it like it is". It is important to note that a SAR is not about apportioning blame and the information you share will be kept in confidence unless there are exceptional circumstances, such as raising concerns about potential risk to adults and children.

We hope that you will feel able to talk openly and reflect on your experiences. This will help us to uncover the real learning and allow improvement to happen.

What happens during a SAR?

There are different ways in which a SAR can be done, but they all involve gathering information from services who had involvement with the person at the centre of the review. The review team, led by an independent reviewer who had no involvement in the case, can then try to get a better understanding of what happened, and why, They will consider whether things could or should have been done differently and ask how things could be done better in the future.

A SAR will often find there have been lots of agencies involved in the person's life. Sometimes the best way forward is to ask those who were directly involved to share their experience, and you may be invited to take part in either a group discussion or to support with a written report. The lead reviewer will help to facilitate any discussion in a confidential space and lead on identifying recommendations for future practice.

The findings are then summarised in a report which is usually published and made available to the public – however, no individuals are named in the report and no information that could to the people involved being identified.

The SAB will then construct an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. Sometimes an individual organisation involved in the review will also write their own action plan which will sit alongside the shared action plan. They will be asked to provide assurance to the SAB that actions are being implemented.

We recognise that the death or serious injury of an adult at risk will have an impact on staff and volunteers, and this impact may be felt beyond the individual staff and volunteers directly involved.

All SAB partner organisations are expected to ensure that staff and volunteers are provided with a safe environment to discuss their feelings and offered support where needed. If you have been involved in a SAR and need more support, please make contact with the SAB Member for your organisation.

If you have other questions you would like to ask, you can speak with the lead reviewer or you can contact the Safeguarding Adults Board Manager: Ceri.Gordon@LBHF.gov.uk

Cruse Bereavement Support may also be able to offer additional support.

Safeguarding Adults Review

“Alison”

Martin Corbett

MIFireE GInSTR DipHMO

Independent Review Report Writer

March 2023

Table of Contents

1 Executive Summary

Since 2019 Hammersmith and Fulham has experienced three fatal fires. A fire involving “Brian” (a pseudonym for confidentiality) on the 31st December 2019, one involving “Claire” (a pseudonym) on the 31st January 2021 and the most recent, involving “Alison” (again a pseudonym), on the 10th December 2021.

When looking at Brian and Claire, the Hammersmith and Fulham Safeguarding Adults Board (HFSAB) identified common factors in the circumstances of their deaths, one being smoking, therefore undertook a review to establish if any multi agency learning can be established from these cases. This review found a number of findings and established an action plan to address these findings.

However, on the 10th December 2021, H&F experienced another fatal fire involving Alison, the circumstances again being similar to Brian and Claire. Following this incident HFSAB had a number of concerns about whether the learning from the Claire action plan had been implemented and whether partner agencies could have worked better in Alison’s case and agreed that it met the criteria for a formal Safeguarding Adults Review (SAR), undertaken by an independent reviewer, according to the Care Act 2014 (Section 44).

The review identified that much has been done since Alison’s death:

- The care agency has introduced better risk assessments
- Adult Social Care (ASC) have updated the MOSIAC system to include additional triggers for a Person-Centred Fire Risk Assessment (PCFRA) and a clearer escalation process
- A better MDT network approach involving more partners
- An improved escalation of complex cases to the High Risk Panel
- There are better relationships between the Fire Brigade, ASC and housing as part of a fire safety assurance Multi-Disciplinary Team (MDT) approach.
- Changes to the way the London Fire Brigade (LFB) prioritise Home Fire Safety Visits (HFSV) and,
- The use of Personal Protective Systems to better mitigate fires in the most complex cases.

All these things will reduce the chance of a similar incident occurring again.

However, multi-agency communication is the most important element in reducing the risks for any case, but in particular, high-risk, complex cases and especially in cases involving drug dependency which was a significant issue in Alison’s case. Having an awareness of what other partners can provide to mitigate risks places more significance on joint working (for instance in assessing mental capacity) and

MDT meetings. Having formalised ones as is proposed with the new network will aid this communication.

Alison's disengagement with the Drug and Alcohol Wellbeing Service (DAWS) after 2018 meant she did not receive specialist help and support to address her drug habit and better MDT coordination could have instigated a different, more effective, client centred approach used by the DAWS.

Housing providers can play a huge part in identifying vulnerable people who may be at a greater risk of fire in their home considering their responsibility to a large proportion of tenants within H&F. The checks as part of tenant home visits should identify these people to allow for earlier intervention. Similarly, a hospital discharge process that identifies vulnerable people who are more at risk of fire in their home, will aid intervention when they most need it.

The Fire Safety Act 2021[1] and Building safety Act 2022[2] introduced since Grenfell Tower also places more importance of multi-agency communication. Building risk assessments should now consider fire risks in demised areas[3] and information about these risks should be available to residents and the fire service (for use in the event of a fire). Including housing providers in these multi-agency discussions is therefore essential.

Training is a key issue in the identification of fire risks, especially knowing the criteria for a vulnerable person where extra consideration will be required in terms of fire risks and what to do to reduce them.

Better awareness of fire risk mitigation solutions will allow issues to be addressed at a more local level so only the most complex, high-risk cases that require more creative ways to resolve and additional resources that MDTs cannot provide, are escalated to the High-Risk Panel.

Fires will happen, but it is important to show what was done to avoid them. These multi agency processes must record what has been done to manage complex cases, so should the worst happen again it can be shown that due diligence was undertaken.

[1] https://www.gov.uk/government/publications/fire-safety-act-2021

[2] https://www.gov.uk/guidance/the-building-safety-act

[3] The phrase "demised area" describes the space that is occupied by a tenant under a lease or rental agreement

2 Purpose of the review

Within the Care Act 2014 section 44 there is a statutory requirement to undertake Safeguarding Adult Review (SAR) if:

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

or if:

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

It is not about apportioning blame, but to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

This SAR is about learning lessons for the future, making sure that Safeguarding Adults Boards get the full picture of what went wrong and improving the practice of all organisations involved.

3 Wider context

Tragically there have been numerous SARs into fire deaths nationally[4]. London Fire Brigade data report that in 2021 there were 50 fatal fires in London. The factors that influence the chances of a fire casualty becoming a fire fatality are complex. Some of the main contributors include:

- how able the person was to respond to the fire (i.e., were they mobile; were they awake; were they impaired by drugs or alcohol).
- how early the fire is discovered.
- how quickly the brigade is called.
- the materials involved in the fire.

[4] The National SAB Chairs repository identifies 40 Safeguarding Adults reviews undertaken between 2019-22 where fire contributed to the harm suffered. Some of these will be thematic reviews, including multiple fire deaths.

- the size and construction of the room/building.
- the proximity of the victim to the fire.
- the arrival time and response of the brigade.

Over the last five years, 10 percent of those who died in fires were aged between 0 to 15 years, 49 percent of fire fatalities were people within the 16 to 64 age range, 39 percent of fatalities were of those aged 65 and over and two percent were unknown. Men are slightly more likely to die in fires than women. Around 74% of fires (based on the average over the ten years to 2021) were of accidental motive. Whilst most fires start in a kitchen, these fires are less likely to be fatal. Most dwelling fires with fatalities happen in a living room, followed by the bedroom. However, in some of these incidents, the living room was also being used as a bedroom. Over the last five years to 2021, bedrooms and living rooms resulted in 32 and 39 percent respectively for all fatal fires in dwellings.

The predominant source of ignition at fires where there is a fire-related casualty is smoking-related. This source of ignition accounts for 27 percent of all fatal fires, with a further 16 percent involving matches and candles. The proportions for dwelling fires are similar at 28 percent, and 16 percent respectively. The next highest identified source of ignition was naked flame (11 percent of all fatal fires and 9 percent of fatal dwelling fires). Heating and cooking equipment accounted for less than ten per cent each as the source of ignition for fires where there are fire related fatalities (including in dwelling fires).

Chart 12: Fires with fire related deaths in dwelling fires by location of fire start, five year average to 2021

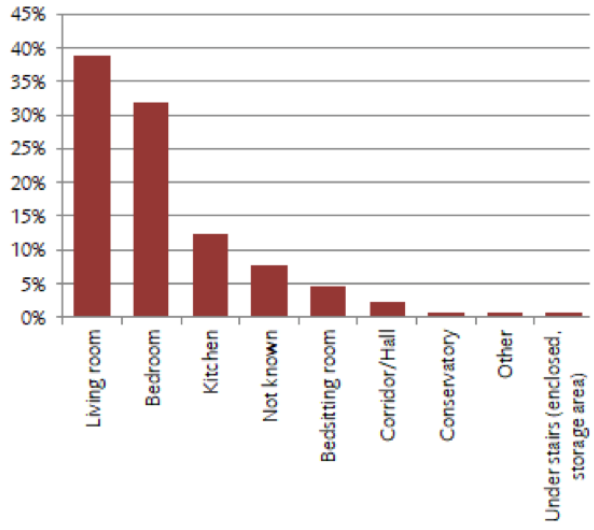
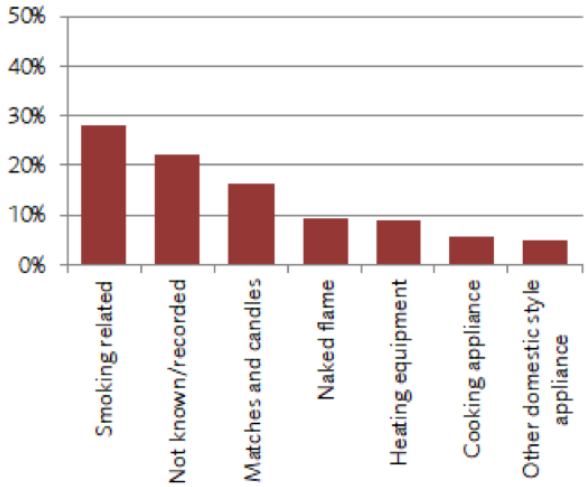


Chart 13: Top seven source of ignition for fires in dwellings with fire related fatalities, five years to 2021



The proportion of older people who die in fires is higher than the proportion of that age group within the population for London. Around only 12 percent of Londoner's are aged 65 and over.[5]

FIRE STATISTICS TABLE 0503a: Fatalities[1] by age, gender and type of location, England

Select a year and gender from the drop-down lists in the orange boxes below:

2021/22

All genders

	Fire-related fatalities[1]									
Age of victim	**Total**	Dwellings - Total	Dwellings - Single occupancy[2]	Dwellings - Multiple occupancy[3]	Dwellings - Other / unspecified[4]	Other Buildings	Road Vehicles	Other Outdoors	Age of victim	Fatality rate[5] per million population
Total	**272**	**208**	**199**	**1**	**8**	**11**	**35**	**18**	**Total**	**4.8**
Under 1	**2**	0	0	0	0	1	1	0	Under 1	3.2
1 - 5	**7**	6	6	0	0	1	0	0	1 - 5	2.2
6 - 10	**0**	0	0	0	0	0	0	0	6 - 10	NA
11 - 16	**1**	0	0	0	0	0	1	0	11 - 16	0.2
17 - 24	**6**	1	1	0	0	0	4	1	17 - 24	1.1
25 - 39	**26**	18	17	0	1	1	5	2	25 - 39	2.3
40 - 54	**39**	31	29	1	1	1	7	0	40 - 54	3.5
55 - 64	**31**	24	22	0	2	1	2	4	55 - 64	4.4
65 - 79	**79**	70	67	0	3	2	4	3	65 - 79	10.4
80 and over	**55**	48	47	0	1	3	0	4	80 and over	19.7
Unspecified	**26**	10	10	0	0	1	11	4	Unspecified	..

1 Includes fatalities marked as "fire-related" but excludes fatalities marked as "not fire-related".
Those where the role of fire in the fatality was "not known" are included in "fire-related". Fire-related fatalities are those that would not have otherwise occurred had there not been a fire.

2 Single occupancy includes: Bungalow, Flat/Maisonette (Purpose Built and Converted), House and Self-contained Sheltered Housing.

3 Multiple occupancy includes: HMOs (licensed, unlicensed and unknown if licensed) and Tenement buildings.

4 Other / unspecified includes: Caravan/Mobile home, Houseboat and Other dwelling.

5 Based on the Mid-year population estimates from the Office for National Statistics, although figures from 2021 were incomplete at the time of publication, and so estimation was involved for five age bands (between 0 and 24):
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

4 Demographic of Hammersmith and Fulham[6]

In Hammersmith and Fulham, the population size has increased slightly (0.4%), from around 182,500 in 2011 to 183,200 in 2021. At 0.4%, Hammersmith and Fulham's population increase is lower than the increase for London (7.7%).

As of 2021, Hammersmith and Fulham is the sixth most densely populated of London's 33 local authority areas, with around 80 people living on each football pitch-sized area of land.

Hammersmith and Fulham has seen an increase of 15.2% in people aged 65 years and over, a decrease of 0.5% in people aged 15 to 64 years, and a decrease of 4.2% in children aged under 15 years. This is significant considering the statistics above of someone aged 65 or over dying in fire.

[5] https://data.london.gov.uk/dataset/fire-facts--fire-deaths-in-greater-london

[6] https://www.ons.gov.uk/visualisations/censuspopulationchange/E09000013/

Approximately 500 adults are receiving care in a care home and approx. 2000 receiving care at home (care provision in H&F is free)[7].

5 Terms of reference

5.1 Lessons learnt from previous fatal fires and the implementation of the action plan

- What lessons learnt from previous fatal fires, and the subsequent action plan, were/are embedded within the borough?
- Who was involved in the dissemination and implementation of the plan and what monitoring processes were put in place?

5.2 Safeguarding risks and Making Safeguarding Personal

- How did Alison's heroin addiction and approach to risk influence the attitude of service providers and in their interactions with her?
- How is independence, choice and risk managed in high-risk cases like Alison?
- What is the level of understanding of the multi-agency risk management processes in H&F and how effective are they in reducing safeguarding risks from fire?
- How do these processes identify opportunities for intervention and include the learning from cases like Alison prior to escalation to the SAB?
- How are/ were practitioners supported to ensure decisions regarding Alison's 'ability to understand' risk was actioned (specifically Alison's mental capacity in to understand fire risk)?
- What other options are considered if the adult at risk refuses help or support and the risk of serious harm or fire remains?
- How well are all these decisions or assessments documented?

5.3 COVID

- What impact did the COVID pandemic have on implementing lessons from previous fires or on the management of care for Alison prior to the fire?

6 Methodology

- Review the action plan and recommendations developed in response to previous fatal fires, and if required interview leading players in its creation

[7] Approximate data from H&F Adult Social Care team

- Review Alison's Individual Management Review (IMR) and accounts by leading representatives from organisations involved in Alison's care
- Review the chronology of events leading to the fire involving Alison
- Interviewing leading representatives from organisations involved in Alison's case and organisation that commission care services (or any other agency or partner deemed appropriate at the time)
- Review their processes or documentation such as risk assessments and service provider contracts
- Review practitioner training systems, specifically in the context of adult safeguarding and fire risks in the home
- A question set will be provided prior to the interviews and used as a basis for discussion.
- Carry out two "practitioner learning workshops" where multi agency practitioners complete a questionnaire and have the opportunity to take part in a fire risk Q&A session.

7 Agencies involved in IMR and interview process

Alison's interaction with the following partner agencies was reviewed by the independent reviewer to identify learning.

- Local Authority Housing team
- Care provider
- Two Acute NHS Trusts
- Local Community NHS Trust
- Adult Social Care (ASC)
- GP Practice
- Drug and alcohol Welfare service
- Fire Service

8 Membership of the Review Panel

The role of this group is to provide project oversight, by contributing to and scrutinising information submitted. Wider engagement with this project will be required across partnership agencies.

9 Involvement of the family

Unfortunately, Alison's long-term partner "Debbie" (again a pseudonym) passed away before the commencement of the review and records indicate that Alison did

not have any other close family. However, there was a neighbour who helped Alison and visited her on a regular basis. The neighbour was contacted by the reviewer to seek their views and to feedback the recommendations from this report. They felt very strongly about what happened and as such they use Alison's story to promote change in their role working for an organisation that provides housing for their staff.

10 Legal Considerations

There are ongoing parallel coronial processes. Therefore, this report has used pseudonyms to anonymise personal information so as not to impact on the integrity of ongoing coronial process.

11 Alison's Background

Alison was in her late fifties and was living with her civil partner (Debbie) in a leasehold flat within a block of Local Authority owned flats.

Alison had a history of substance (heroin) misuse dating back to 1986 and would use wound sites to inject heroin and continued to do so until her tragic death. Her drug use is considered as a significant contributory factor in her multiple health issues. She was known historically to commissioned Drug and Alcohol Welfare Service (DAWS) but at the time of her death was not receiving support from them. She was also a smoker and smoked around twenty cigarettes a day.

Alison also had multiple health issues including brittle bone disease, history of infection in right arm resulting in no functional use, braces and metal work in right hand, history of broken right leg, infection on right thigh scars on both legs, low body weight, Grade 2 pressure sore, paraplegic post brain tumour, and Chronic Obstructive Pulmonary Disease (COPD).

Her partner Debbie, whom she had known for over thirty-five years, has been described as caring greatly for Alison. Debbie had her own health issues including a leg amputation (she used a wheelchair) resulting in her also being in receipt of a package of care. Alison was in receipt of homecare from the care provider from 14 March 2019 until 10 December 2021, when she died.

The couple are described as being very private people who have family in the UK but do not maintain contact with them. They had a supportive neighbour who visited twice a week.

District nurses visited twice a week to provide care for a pressure sore and wounds on her thigh which repeatedly became infected due to Alison using the wound sites as drug injection points.

The Care Agency provided care to Alison from 14 March 2019 until the time of her death on 10 December 2021. They report that at the time of the fire there were two flame retardant blankets in use as well as a fire-resistant ash tray. They also report that the fire alarm was in good working order.

Alison was reliant on carers to support her with all aspects of her daily living tasks. Debbie supported with prompting of medication and meals. Equipment was in place to support with this. Alison was in receipt of a package of care consisting of three calls a day seven days a week:

- Morning - 9am: 45 minutes, 2 x Carers, 7 x days a week. Carers to provide full bed care. Change pads, prompt medication, encourage nutrition, change bed linen if required, dress in the mornings and undress at night; reposition in bed
- Lunchtime - 1pm: 45 minutes, 2 x Carers to support with changing pads, prompt meds, encourage nutrition and hydration, change bed linen if required and lunch preparation.
- Evening - 6.30pm: 45 mins, 2 x Carers to change pads and get undressed for the night, change pads, prompt meds, encourage nutrition and hydration, change bed linen if required.
- Wednesday: Domestic Call, once a week for one hour. Carer to assist and support to complete weekly housework; to sweep and mop the kitchen and bathroom floors

12 Circumstances of Alison's death

At approximately 00:25 hours on 10th December 2021, Alison's partner was in her wheelchair in the kitchen when she heard a smoke alarm. Thinking it was a false alarm she made her way out to the hallway and attempted to reset the alarm using a broomstick. At this point she noticed an orange light coming from the bedroom.

Alison's partner got to the bedroom door, where she could see her sat up in bed with flames on the bedding. Alison's partner attempted to remove the bed covers before going to the kitchen to get a fire blanket. Returning, she threw the fire blanket over Alison in an attempt to extinguish the fire, which momentarily died down but quickly flared up again. Alison's partner opened the front door and shouted for help before going back inside.

Neighbours heard a smoke alarm. The alarm wasn't very loud and after approximately five minutes it was still sounding. One neighbour went to investigate and found that the sound was coming from the neighbours flat and saw smoke

coming from around the top of the front door. They also heard someone call for help from inside.

They then made the first of two 999 calls to the London Fire Brigade (LFB). Whilst on the line they informed the Fire Brigade Control Operator that two people were in the property, one was in a wheelchair and the other was bedbound within the bedroom where the fire was located. They then kicked at the door which opened straight away and once opened, black smoke came billowing out. He could see Alison's partner in the hallway in her wheelchair, her sleeve appeared to be on fire and was asking for help. She told him that Alison was trapped in her bedroom. The neighbour then brought Alison's partner out of the flat.

On arrival the Fire Brigade, breathing apparatus crews quickly entered the property and made their way to the bedroom. They extinguished a fire involving the bed and whilst searching located Alison on the bed. Due to the restricted visibility, they could not assess her injuries and so they started to rescue her from the property. However, it became apparent that her injuries were incompatible with life and was declared deceased by London Ambulance Service (LAS) Paramedics.

Alison's partner, Debbie, was taken to hospital suffering from smoke inhalation and burns. She spent three to four days in hospital. She was allocated to a Social Worker from the hospital who was supporting her before being discharged into temporary accommodation provided by the Local Authority (LA).

There were two possible causes for this fire. Firstly, the halogen heater, which was reported to be in use at the time of the fire and was close enough to come in contact with the bed and ignite the bedding. Secondly, it is also possible that Alison had dropped a cigarette onto the bedding which burnt through to the air mattress.

Both of these scenarios could be consistent with the observations that were made by Alison's partner. She described the smoke alarm sounding, located just outside the bedroom and when she went to reset, she saw an orange glow. On investigation she described seeing Alison sat up in bed with flames on the bed. She has then tried to remove the bedding and it is likely that some of the bedding fell to the left side of the bed which accounts for the fire developing in that area.

For these reasons, the LFB were not able to state if the fire was the result of combustible items coming into contact with the halogen heater, or the unsafe disposal of smoking materials[8].

[8] London Fire Brigade Fire Investigation Report

12.1 Multi-agency interaction

12.1.1 Hospital care

Alison was admitted or seen at hospital five times since 2017.

1. On 12th June 2017 she was brought in by ambulance to the Emergency Department after falling from the commode when transferring back to bed. Debbie could not help her back so called an ambulance. Alison was admitted due to possible end stage COPD and sepsis. It was suspected that the sepsis was from a wound on her right hip where she had been injecting Diamorphine (Heroin).

Alison was admitted for two days where she received pain relief and IV antibiotics. A safeguarding concern was raised as the pharmacist contacted her GP who denied prescribing or administering Diamorphine. Alison had stated her partner collects her prescription and administers. This was resolved and it was found that her partner collects the Diamorphine from DAWS.

2. On 23rd February 2019 she was taken by ambulance to an Emergency Department after a fall at home. She was found to have two grade 2 pressure ulcers, one to sacrum and one to her bottom. She also had multiple lesions on her right thigh. A Safeguarding concern was raised. A Computed Tomography (CT) scan was undertaken for a suspected head injury where no acute haemorrhage or infarct (dead tissue) was detected and endoscopy for gastritis. A review was also undertaken by a psychiatric nurse which included her anti-depression medication. A discharge plan was made with Adult Social Care with a package of care for Alison and Debbie, and deep clean of their home.

3. On 10th July 2019, Alison was admitted to hospital after attending the Emergency department, having been referred by the District Nurse (DN) due to an infected ulcer on her right thigh. She was kept in overnight and discharged the next day with the DN arranging follow up on discharge.

4. On the 7th September 2019 Alison was taken to an Emergency Department via ambulance with chest pain, and discharged following investigations. Record of her transport home in liaison with Debbie shows Debbie was noted as her friend rather than her partner.

5. On the 3rd November 2021, Alison was visited by a podiatrist who noticed swelling of her right leg. A GP phone consultation resulted in a 999 call and admission to an Emergency Department. It was noted that there was a new swelling to her right foot radiating to her shin. There were no associated symptoms, no pain and no swelling

to thigh, no chest pain, no signs of infection or deep vein thrombosis (DVT) so she was discharged and referred back to her GP in regard pitting oedema[9].

Alison's care whilst in hospital, in terms of her medical treatment, appears very thorough. However, considering Alison died in a fire, this review looked into whether anything further could have been done to reduce the fire risk as it is noted that fire risks were not considered as part of discharge plans.

The reviewer spoke to the safeguarding leads from the two hospitals involved in Alison's care, specifically in regard to the identification of vulnerable patients who may need extra consideration to reduce the risk of fire in their homes and how this can be part of devising discharge plans.

Both have very robust and comprehensive safeguarding processes but no trigger to raise lower-level concerns such as patients who may be at a risk of fire at home.

Identification of such patients is the start and should part of the either the admission and discharge process. The reviewer had long discussions with the safeguarding leads about how this can be done, as combining this with other hospital processes and systems is complex. A variety of options were discussed including involvement discharge teams in referral processes (who are normally only involved in complex cases where someone may not necessarily be discharged to their home), discussing with patients within discharge lounges[10], or using Occupational Therapists who may be better placed to identify patients at high risk of fire in their home. Ultimately the hospitals are best placed to devise how to identify those who may be at a higher risk of fire in their home.

The LFB's guidance on people who need extra consideration can be used to identify those who may need referral to the LFB[11]. This guidance recommends referral is made for:

- Anyone that may not be able respond to a fire as quickly.
- Anyone that may not be able to escape a fire.
- Anyone who may be at more at risk due to lifestyle factors (such as smoking or drug use, whether prescribed or not)

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[9] Excess fluid build-up in the body, causing swelling, when pressure is applied to the swollen area, a "pit", or indentation, will remain.

[10] Discharge lounge is an area where patients move to before discharge to free up beds. They deal with practicality or going home, transport, keys, relatives, care etc.

[11] https://www.london-fire.gov.uk/safety/carers-and-support-workers/

- Anyone that uses healthcare equipment such as oxygen or emollient creams that are flammable.

This mainly covers older people, people with disabilities, those who may be immobile, people with visual and hearing impairments, and people who are vulnerable for other reasons as they all need careful consideration when it comes to fire safety in their home.

How the LFB is informed is key as one hospital will cover a number of local authorities, each having their own referral systems. What is needed is a consistent process so any hospital can refer in the same way.

ASC have legal powers and duties to assess care and support needs under section 9 of the Care Act 2014. When discharging from hospital, this should involve contacting any relevant agency that can help in addressing aspects of the patient's needs and wellbeing. In regards to the risk of fire this will be the LFB. In cases where a significant fire risk has been identified or a patient is considered needing extra consideration as per the criteria above, a direct referral to the LFB and the Local Authority ASC would be better as it will quicken the process of getting a HFSV either before the patient returns home or as soon after. To help facilitate this as hospitals serve many Local Authorities, a standard referral method of contacting the LFB is needed.

Training is also key. If staff know which patients are more at risk to a fire in their home, they will be better placed to identify them. Therefore, learning outcomes such as what behavioural issues, medical conditions or factors that constitute someone as needing extra consideration or a referral to the LFB, should be included in their training.

It was noted by the safeguarding leads that staff workloads are high, but the positive sell to this is if there is a simple referral process.

Recommendation 1

That hospitals establish a process to identify those more vulnerable to the risks of fire in their home and refer to LFB as part of discharge plans.

Recommendation 2

The London Fire Brigade establish a standard process whereby any hospital can refer vulnerable patients directly for a Home Fire Safety visit.

12.1.2 Alison's domiciliary care

As already described, Alison had a comprehensive daily care package delivered by the domiciliary care provider which was seen to be appropriate and addressed Alison's care needs.

In terms of identifying risk, the care provider's risk assessment at the time of Alison's death (dated 18/5/2021) was person-centred and highlighted her risks associated with choking, health, pressure sores, mental health, immobility, smoking and manual handling. There was also a section on *"internal risk assessment of home"* which included other areas within the home but not any other fire risks. So other than smoking no other fire risks were included in the risk assessment.

There is also a contradiction in terms in regard to emollient creams. The care provider's care plan states moisturisers are used three times a day but the risk assessment says "flammable creams" are not used. Any emollient cream is flammable whether paraffin based or not. During the interview with the care provider the ways to reduce the risk of emollient creams was not fully understood (i.e., regular washing of clothes and bed linen). It was not known that the fire risk from moisturisers is much the same as emollient creams[12], something that all practitioners should also be made more aware of.

In general terms it is the reviewers experience that care providers undertake generic risk assessments, but a person-centred approach to fire risk was not routinely considered. Care plans are vague in terms of who is at risk as they appear to be more of a risk assessment for the care worker rather than identifying the risks and mitigation methods for the service user.

Standard health and safety risk assessment formats identify the hazard (something that has the potential to cause harm), the risk (the likelihood of it occurring), who is at risk, the risk rating before control measures are applied (using a risk rating five point scale), control measures that will reduce or eliminate the risk, and then the risk rating after control measure have been applied. If this process is applied by care

[12] https://www.nationalfirechiefs.org.uk/News/nfcc-warns-of-fire-risk-when-using-emollients

providers, then who is at risk (i.e., the service user or practitioners etc.) and the control measures can be more clearly explained.

Another option could be to have two separate risk assessments, one tailored for the carer and the other a specific, person-centred care plan which includes a risk assessment for the service user.

Since Alison's incident the care provider have been very proactive in identifying lessons and have created a new and very comprehensive risk assessment which could be used as best practice for other care providers. The care provider has also taken on board the risk of emollient creams and are devising leaflets for their clients.

Recommendation 3

That commissioning services, in conjunction with other agencies, lead a review of care provider risk assessments to ensure they are person-centred and include all potential fire risks in the home.

In terms of training, the care providers training does not cover fire risks in the home in detail. The new risk assessment will partly address identification of risks, but training is an essential part. When asked the question if fire risk awareness in the home is part of mandatory training the care provider said it was part of a fire module within the Health and Safety day training. When discussed further in the interview it was established that there were no specific objectives within the training for identification of fire risks in the home but rather the responsibilities as an employer under the Regulatory Reform (Fire Safety) Order 2005 (known as the RRO). The care provider was also not aware of the Personal Protective Systems (PPS)[13] that can be used to mitigate very high-risk service users.

Again, the care provider was very responsive to feedback by the reviewer and will be changing their training objectives to include fire risks in the home.

In terms of communication with other partners the care agency highlighted risks to the Local Authority and had a process of requesting HFSV by the LFB via the Local Authority. However, their view was that these were not always actioned, or feedback provided to say that it has been forwarded to the Fire Brigade. As a consequence, the care agency now refers directly to the LFB with the Local Authority

[13] https://www.surefire.co.uk/suppression/portable-sprinkler-mist-systems/

ASC copied. This now allows the LFB to provide feedback to the care agency which they say is done on a regular basis.

12.1.3 Drug and Alcohol Welfare Service (DAWS)

As part of a new contract for Drug and Alcohol Wellbeing Service (DAWS), Alison was transferred to a new drug rehabilitation service in April 2016, from a previous provider. They work with people who need support with their drug or alcohol use, mental health, offending behaviour, unemployment issues and people with a learning disability.

Keyworker sessions started in January 2017 and regular sessions continued until September 2018, during which time Alison's medication was reviewed and she was prescribed Diamorphine (200mg) and changed to oral Methadone (90mg daily) in August 2017 due to possible sourcing difficulties and issue with injecting. The keyworker also discussed safeguarding risks with Alison as well as her financial situation and determined that no additional support was needed at that time.

A further review was held by the keyworker and clinical lead in June 2018, where Alison was reported as being stable on her prescription, abstinent on illicit substances, and stable in her psychological wellbeing and physical health despite mobility issues. Her medication reduction, detox and rehabilitation were discussed but declined.

In July 2018 support from ASC was discussed and Alison said she will self-refer and make contact to have a reassessment. However, in September 2018 Debbie delivered a letter to the service informing them of Alison's disengagement. A home visit was carried out to discuss the issue; Debbie answered the door but declined entry to workers and access to Alison for discussion. A letter was sent by the DAWS hub manager informing them of their concerns and that self-discharge is against clinical advice, but no response was received. After two months, in November 2018, Alison was discharged from the service.

Two further independent referrals were made to DAWS, one from the care agency in August 2019 (which ASC followed up in November 2019) and another by the GP in February 2021 but despite these referrals Alison remained disengaged with the service. The DAWS state that they where not invited to any multi agency discussion during this time even though there were concerns about Alison's drug use. If they had been then their DAWS Plus service (see appendix 2), an approach use for clients who are not open to treatment or who are resistant to change, could have been used.

As part of the review the reviewer investigated the role of the DAWS in identifying risks in the home as keyworkers visit clients in their home so are ideally placed to identify any risks. It is clear from their account and risk assessment template that safeguarding, mental health, drug and health risks are part of their review process. Housing is also included in terms of poor accommodation or living conditions but fire risks are not specifically referenced. It is noted that in Alison's case, the DAWS were unable to access Alison's home making it impossible for them to assess these risks.

In regard to future cases, including fire risks on the risk assessment template should improve identification of client's fire risks and trigger a referral to the Fire Service.

In regard to whether keyworkers are able to identify risks associated with fire in the home, fire risks in the home in not covered within DAWS training and it is expected that the risks from their fire safety in the workplace training are transferred and applied in the home.

Fire risks in the workplace are very different from those in the home. Fire safety in workplaces is very well regulated and because of this workplaces are generally well managed and safety maintained. The same cannot be said for people's homes, so expecting that the risks from the training in the workplace are transferred and applied in the home by keyworkers, is not sufficient. Dedicated objectives for fire risks in the home should be included in the training.

The DAWS have a datix incident management system[14] that records fire safety incidents and is used to identify lessons learnt. They have an excellent escalation process; any concern is raised with line managers who would instigate an internal complex case meeting within the DAWS service then a Multi-Disciplinary Team (MDT) meeting, and if required a further escalation to the Community MARAC. It was noted that the DAWS were not aware of the role of the High-Risk Panel as part of the escalation process.

Incidents or near misses relating to fire are referred to ASC and it is expected that ASC forward to LFB for a home fire safety visit. However, it is not always known that this has been done (which is a similar concern raised by the care provider and hospitals). As part of this review ASC questioned why it is considered their role to forward referrals to the LFB. Referring should be the responsibility of all agencies and consideration should be made to referring to ASC and LFB at the same time to provide a quicker Fire Brigade response, particularly in high-risk cases.

[14] The same as used by NHS providers (the acute trusts, the community trust and General Practice) for all incident reporting which enables management review or escalation processes and policies.

Recommendation 4

That all agencies and partners have a process of referring cases involving fire risks directly to the LFB and inform ASC at the same time so they can maintain an overview of the case.

12.1.4 Community nursing

Alison was referred to the district nurse (DN) service in March 2019 following discharge from hospital, for wound care relating to delayed healing of abscesses (formed when drugs injected under the skin). She was visited twice a week to dress Alison's leg wounds, with regular visits for continued treatment of these wounds and pressure ulcers until she was last seen on the 7th December 2021.

It is positive that DN's communicated with other partners regarding the risk of fire, for example they referred to the LFB in January 2020 as they noted cigarette burns on her bedclothes and bedding and referred to the care agency in February 2020 to ensure use of the flame-retardant bedding issued by the LFB. They also had a conversation with the LFB about the use of non-paraffin based emollient creams.

In December 2020 they noted that Alison was using scissors to cut off parts of the duvet that had cigarette burns as Alison said they were sharp on her skin. Both these instances show the risk of fire remained.

The DN service have a clear process of escalation hoarding cases but DN's may be less certain of how to escalate other high-risk cases which involve, immobility, smoking, air mattresses, emollients etc. Alison's DN did inform others involved in her care but it was not coordinated in a formal way so that all the risks were considered, and all people and agencies involved in Alison's care were aware of the risk factors in order to allow a consistent approach to treatment and risk mitigation. Issue of fire was considered but maybe not fully appreciated in terms of risk to Alison who was bedbound, smoked, used emollient creams and what can be done to mitigate such risks. This is also where greater awareness of the High-Risk Panel's remit and how to refer is needed (as per section 13.4)

12.1.5 GP service

Alison was registered with her GP service in January 2020 after previously being with another local Surgery.

Between March 2020 and February 2021, the Surgery tried to contact her on seventeen occasions where there was no answer on her landline phone.

There were communications from ASC regarding a HFSV referral to the Fire Brigade which was completed on 16th February 2020.

The GP advised there are fortnightly patient MDT meetings which is an opportunity to discuss risks for registered patients. He explained these meetings are coordinated by the Community Nursing Service (Matron) who identifies which patients need to be brought for discussion based on presenting risks. Normally the GP, district nurse, OT or ASC (sometimes) attend these Integrated Domiciliary Hub meetings together with the GP care navigator. There is a record in her patient notes that Alison was discussed at this meeting in February 2021 following ASC contacting the GP in relation to the risk of needles in her home to care workers and the wounds on arms.

The GP patient record evidences that a referral was made to the drug abuse counsellor, however no minutes of this meeting has been shared with the reviewer from any of the agencies in attendance. It is unknown whether ASC (the referrer) was in attendance at this specific meeting, or how, or if, they received feedback. The DAWS confirmed they received this referral from the GP, but Alison declined assessment and treatment. Neither the GP or ASC received any feedback from the DAWS on this referral outcome and were not notified that risk therefore remained unmitigated.

In terms of being able to identify fire risks, fire safety at work training is used which, according to the GP, does not include specific fire risks in the home as an objective. Considering that in the reviewer meeting it was admitted that some GPs don't know what the Clutter Image Rating (CIR)[15] scale is, suggests a lack of sufficient fire risk awareness. The GP also stated that immobility was the main reason for Alison dying in the fire and it was a higher risk factor than her drug use, which is true as she was unable to escape due to this immobility (it must be noted that it is not known whether she was under the influence of drugs at the time). However, this shows a lack of understanding of the risks associated with fire in the home in that if the fire had not started Alison would not have died.

[15] https://hoardingdisordersuk.org/research-and-resources/clutter-image-ratings/

12.1.6 Adult Social Care

In February 2019 a formal protection plan was created following a safeguarding concern raised by the LAS. This resulted in a review of Alison's care and support needs with a several things done to aid her including an increase to care, a key safe number put on front of a file, a pendant alarm in place, access to a telephone, and updating information / action plan for front door staff. At that time Alison was assessed as having capacity to make decisions in relation to her care and support needs.

In August 2019 a concern was raised by the care agency. Their care workers reported that Alison's house contained multiple used needles and posed a risk to care workers. Also, Debbie had been admitted to hospital due to an ischaemic foot (inadequate blood flow to the foot) and there were concerns that Alison's care would be affected considering Debbie was in hospital. Their review established that she was coping with three visits a day by the care agency, but sharps remained which they picked up and disposed of in the sharps box provided. Alison was also referred to the DAWS, but she declined their support.

In September 2019 a safeguarding concern was raised by the DN and carer who reported that Alison had reported that on the 19th August 2019 a man came into her room early in the morning raped her. This was reported to the Police who investigated (and submitted a Merlin report[16]) but no evidence was found to corroborate the allegation. Alison made no allegation to the Police and there is no way of anyone gaining access unless they have a key or key safe number.

In February 2021 a review of Alison's care was undertaken and it was decided to increase in care provision to four daily calls, seven days weekly to meet identified health and social care needs. In March 2021 another safeguarding concern was raised in relation to a man and dog having moved into her property alleged to be providing both Debbie and Alison with drugs. The safeguarding concern was closed as the decision was taken that neither Alison nor Debbie were at risk of abuse as both had capacity to make unwise decisions in relation to their wellbeing. They consented to this man residing in the property so that they could continue their drug use, but it was unclear as to the arrangement that the two parties had. However, there were concerns that drug taking in her property could pose safety risks to

[16] The Merlin system allows police officers to record and share concerns about vulnerable members of the public with partners to effectively safeguard them. A Metropolitan Police Service employee records their findings in a Merlin which is then processed according to the type of report written.

carers. The care agency responded that they have their own Risk Assessment in place.

In April 2021 a home visit was undertaken to review Alison's package of care and check the concerns raised regarding cuckooing. As part of the review of care fire risk and staying safe were discussed. Alison stated that she smoked about 20 cigarettes per day, with the holes in the bed because of this, and that the LFB had done a fire safety check. The social worker advised on the benefits from wearing a fire-retardant apron, which she should wear whilst smoking. Alison described the ash falling down her back and it was determined that the LFB would be able to advise, so referral needed for another fire safety check. Debbie stated that fire alarms and sensors were already put in the flat.

In summary, ASC records show it is clear that Alison was a complex case and there were multiple risks to her health and wellbeing which were reviewed with the care providers. These involved her general health, drug use, smoking and cuckooing. Each issue was reviewed and investigated when practitioners raised concerns. There is no evidence to show if an MDT meeting was held to coordinate all the concerns in a multi-agency way or when the LFB referral recommended in April 2021 was made. It is assumed that this instigated the calls made by the LFB (see section 12.1.8) and the attempted visit on the 8th November 2021.

12.1.7 Occupational Therapy

In August 2020, after numerous contacts were attempted by the Occupational Therapy team, they managed to complete a home visit (it is unclear whether one or several visits were made during August) and a number of recommendations were made with various items of equipment ordered for Alison.

At these visits, a discussion was had regarding fire risks. The Occupational Therapist (OT) mentioned the need for smoke detectors in the rooms, heat detector and carbon monoxide detector - Debbie said that the LFB visited the property around February, and they provided flame-retardant bedding which would help to limit the extent of damage caused by a fire in the bed. The OT was not aware of the LFB visit and was unsure whether she noticed the flame-retardant bedding on the bed. Regarding a smoke detector, the LFB decided that all that was required was for a smoke detector to be placed in the hallway because smoking could repeatedly set them off if placed in the bedroom, and they appear to have not felt that more were required.

The OT also raised the use of Careline with Debbie again. Debbie was very concerned that Alison will not use it appropriately and there was also concern about the cost

(despite there being no costs for those in receipt of benefits). Alison had in the past called out the ambulance three times to take her to hospital. OT also referred to LFB for a carbon monoxide detector even though they are not something that the LFB will supply, and should normally be provided by the housing provider, or if the property is owned, the resident themselves.

During another visit the OT noticed Alison was in bed with her fire-retardant duvet which had lots of holes in it through her smoking in bed and dropping the cigarette. Alison admitted that she would fall asleep with the cigarette alight. Alison said that some of the other fire-retardant bedding was in the wash. Alison was advised again that smoking in bed was unsafe.

12.1.8 London Fire Brigade

From records provided by the LFB a number of HFSV's were completed for Alison.

On the 16th September 2019 and 1st November 2020, visits were completed as part of a Group Risk Visit (GRV). These are visits where crews target a specific area or postcode that are deemed higher priority based on the location (P1 postcode). The P1 postcode is a targeted approach and uses a combination of MOSAIC[17] lifestyle data, fire data, demographic profiling and a range of risk factors such as smoking, drinking and mobility impairment. The intention of GRVs according to P1 postcodes, is to focus on those homes where the risk of fire is thought to be higher; given the size of London, the LFB will only ever reach a very small percentage of households, so targeting based on risk is critical.

Another HFSV was completed on 20th February 2020 (the review could not identify who referred Alison for the visit). During the visit it was recommended that Alison receive flame retardant bedding and this was provided at that time. Discussions were also had with the district nurse about using non-paraffin based emollient creams.

In May 2021 a request for a second set of flame-retardant bedding was made by the care provider via the local authority.

Six attempts to contact Alison by landline phone were made to book an appointment and as contact could not be made a visit to Alison's address by local fire crews was allocated for 8th November 2021. Unfortunately, as the LFB record, Alison was not available. Whether this was because she was immobile and not able to answer the door or that she was out when the LFB visited, is not known. The crew waited at the

[17] Mosaic is a system for geodemographic classification of households. It applies the principles of geodemography to consumer household and individual data collated from censuses and other sources.

address for a time as they believed this was arranged as a joint visit with care workers, but no care worker arrived.

No cancellation of the case took place and LFB records do not reflect a rescheduled visit having been arranged after the attempted visit on the 8th November. The HFSV team leader reports that the process does include notification to the referral agency when scheduled visits are not completed and they believe this took place, but it cannot be proven.

Effective communication and liaison with other partners to ensure the outcome of HFSV's is known and documented in case notes or risk assessments is an essential part of multi-agency communication. The fact that a number of HFSV's were completed and flame-retardant bedding provided is positive and shows that partners were thinking of the risks associated with Alison's lifestyle and referred them to the LFB.

It is understood that the LFB Home Fire Safety Visit strategy is changing from a quantitative one to a qualitive one, and that the emphasis will be on prioritising HFSV's for those that need them most rather than the number completed. The process of referring and producing feedback to partners is also changing. The precise process has not yet been confirmed but the reviewer understands that a new referral process, including an out of hours system, is planned from April 2023 which will prioritise low, medium, high and very high cases. Low priority cases will be asked to complete the online home fire safety checker. Other cases will be visited depending on their risk, for instance, medium risk within 30 days, high risk the next working day and very high risk within 4 hours. An individual as being classed as very high risk if they have all of these six characteristics:

- Smoker
- living alone
- over 60 years old
- in receipt of care (informal, formal or both)
- no working smoke alarms in their home
- user of mobility aids, or chair/bed bound

There will also be additional guidance on communicating with referrers before and after visits or where visits cannot be completed so that all partners are aware of what has been achieved.

The change to the HFSV process is a very positive step forward, however what is essential is communication between local partners rather than central teams. Local Fire Brigade management (preferably the watch-based staff, who undertake the

visits) are best placed to liaise with other partners about actions or recommendations from a HFSV.

12.1.9 Housing provider

The challenge for housing providers or managing agents is that they are somewhat restricted in what they can enforce within peoples homes. The Regulatory Reform Order requires that they manage the fire safety of communal areas, but they don't have jurisdiction past the front door. What made it even more challenging with Alison was her leaseholder status, which meant that the Housing team had little opportunity to maintain regular contact with her.

The housing team were contacted by the care agency in February 2021 as they were concerned about Alison's smoking and the lack of flame-retardant bedding. Considering it was the third COVID lockdown the Housing Fire Safety Team contacted Alison by phone in March 2021, offered flame retardant bedding and a Person-Centred Fire Risk Assessment (PCFRA), however Alison refused saying she had already been seen by the LFB.

The introduction of the Building Safety Act 2022 (BSA), Fire Safety Act 2021 (FSA), and Fire Safety (England) Regulations 2022 has highlighted the roles and responsibilities of accountable persons, owners, and managers of residential properties. This now means that housing managers and agents must extend the coverage of their assessments into the demised areas and implement new, more stringent fire safety management controls and practices. Regarding demised areas, housing managers will need to consider both tenants and leaseholders in this assessment so any vulnerable person known to them can be included in plans given to the Fire Brigade in the event of a fire so they can prioritise their rescue.

Since Alison's incident, the housing team have established better communication with the LFB and have introduced a check as part of tenant home visits. The question asked is "are you or anyone in your family unable to self-evacuate in the event of a fire in your home?". If the answer is yes, they are referred to the Fire Safety Team so they can undertake a PCFRA and Personal Emergency Evacuation Plan (PEEP). This is more difficult for leaseholders and housing teams are reliant on vulnerable people being referred to them by ASC, one more reason for housing teams to be involved in MDT meetings.

This question could also be used by other practitioners to assess whether further consideration is needed to prevent fires in service users' homes and could be used as a trigger to refer to the LFB for a HFSV.

12.2 Personal Protective Systems

Another significant change since Alison, discussed with the housing team, is the introduction of supplying Personal Protective System (PPS)[18] for complex cases.

This was also highlighted as part of the practitioner questionnaire, in that a significant number of practitioners either did not know what PPS was or confused it with personal alarm systems.

PPS is a self-contained water mist system that can be used in one room of a building. These systems are designed for people who spend most of their time confined to a specific area of their home, for instance, high risk cases where someone is chair or bedbound. Water mist systems use a spray of fine water droplets that can suppress a fire by cooling, wetting and displacing oxygen. It can also connect to existing autodialer or telecare systems to alert monitoring or emergency services that the system has activated. They can be quickly installed to protect a vulnerable person and can be moved or re-used as required.

PPS is a method of reducing the effects of a fire and can save lives in cases where there is a significant fire risk. They are expensive to purchase initially and require people to be trained in their installation and maintenance. However, once purchased and maintained correctly they have the potential to save lives.

It is understood that PPS was not considered an option in Alison's case. However as part of the research for this review, members of the High-Risk Panel were made aware of PPS and have implemented a referral process to the panel. As a result, a number of cases have since been referred to it and PPS has been recommended and used as a solution to mitigate fire risk.

Another point of discussion is the risk assessment recording process. PPS is probably the last option to consider when trying to reduce fire risks in very high-risk cases and the process of recording whether one should or can be provided is very important, even if one is not recommended. PPS may not be appropriate in all cases, but recording will show that a process has been followed, all the options considered, and the reasons for recommending one or not. It should also include all agencies involved in the case so all views can be expressed and a collective decision made. This means that should the worst happen there is a record that a full and thorough risk assessment process was followed and outcome that can be provided to any subsequent investigations or review.

[18] https://www.surefire.co.uk/suppression/portable-sprinkler-mist-systems/

Recommendation 5

That the High-Risk Panel and Local Authority housing teams continue to consider Personal Protective Systems to be available, and appropriate people within the borough be trained to install and maintain them, for use by all partners.

13 Questions posed within terms of reference

13.1 Impact of Alison's heroin addiction and risk appetite

Alison's drug use was at the heart of or root cause of her health and wellbeing. One theory is that addiction may not really be classed as a 'lifestyle choice' but a maladaptive coping mechanism to escape problems.

Both the care provider and Community Health district nurses felt that Alison's drug use did impact on her care. Skin wounds were used as a site to inject drugs which meant they did not heal and extended the treatment of these wounds. However, whilst practitioners were frustrated with this, there is no evidence that it affected the level of care that was provided to Alison.

It was felt that the regular visitors that both Alison and Debbie had overnight supplied them with drugs and that there was potential cuckooing, but there was not much the practitioners could do to stop this other than refer to the appropriate agency, which they did. The care provider suggested that Alison and her partner's risk appetite increased due to her drug taking and as already mentioned Alison's drug use may have changed her mental capacity. An example of this being the constant use of wounds to inject and furniture moved around by Alison's partner and visitors which included the heaters.

This is backed up by other practitioners who took part in the questionnaire. 43% said they had a client with drug dependency and that it hindered or affected how their case was managed. The reasons being:

- The client would not listen or take heed of advice to address risks in their home or how to improve their health (35%)
- The service users drug dependency took priority over other more important parts of their care (31%)
- Supporting the client was pointless until their drug dependency was addressed (4%)
- The practitioner felt they had done all they could to help the service user (17%)

As mentioned, Alison's drug use was at the heart of or root cause of her health wellbeing. NICE clinical guidelines [CG52][19] provide guidance on opioid detoxification; however her disengagement created a barrier to her receiving this help and support.

Engagement is a big issue with someone with drug or alcohol dependency and something that was available at the time of Alison's death is "The Blue Light Project"[20] which seeks to address by developing alternative approaches and care pathways for people who drink and who are not in contact with treatment services. Whilst this project is aimed at those who drink, the principles it promotes could equally be applied to substance misuse. For instance, treating people in a different, client or person-centred way rather than just drug users and identifying potential barriers to change.

Similarly, the 2021 publication "How to use legal powers to safeguard highly vulnerable dependent drinkers"[21] by Professor Michael Preston-Shoot and Mike Ward, challenges common myths or misconceptions that have grown up around the care of and support for this group of people. It also discusses many of the issues raised in this report, the knowledge of which would be of use to all practitioners who have clients with complex needs and those with a history or substance misuse.

The DAWS Plus service as described in appendix 2, applies the principles of the Blue Light Project and work as a dedicated outreach team, working alongside partner agencies, with the overall aims to support more reach of clients, raise insight into a client's own use, provide harm reduction support to ensure clients are able to make informed decisions about whether or not to engage in treatment and support. It uses the assets of the client and local community to reinforce permanent change and support sustained recovery.

Recommendation 6

That the DAWS Plus service is considered for clients with known substance misuse and who have disengaged, or are at risk of disengaging, with support services.

[19] https://www.nice.org.uk/guidance/cg52/chapter/1-Guidance#opioid-detoxification-in-communityresidential-inpatient-and-prison-settings

[20] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-lightproject

[21] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-finalAugust-2021.pdf

13.2 Independence, choice and risk management

Independence and choice is a primary element of social care. However, a balance has to be made between the right to a private life[22], the risks to the individual, and duty of care by practitioners.

When does the risk of death or injury outweigh the choice of the individual? What can be done if practitioners have done all they can, and the risk remains? For example, in cases where someone smokes, is chair or bedbound and is known to take drugs or drinks alcohol, as was the case with Alison, the combination of these risks means the likelihood of a fire occurring is very high.

Alison could be considered as having fluctuating mental capacity when she was under the influence of drugs and she may not have had capacity to understand the risks associated with fire (this is discussed in more detail in section 14.2). If she had been formally assessed as not having capacity, a best interests meeting could have been held to address the risks.

It appears that each practitioner dealt with the risk in their own way according to their own processes, for instance referring to the appropriate agency. Outcome focussed and person-centred care with mitigation of risks as much as possible can be challenging if a service user is considered to be making unwise decisions or chooses to refuse support. The OT, DN, care provider and housing team all spoke to Alison and her partner about fire risks, but Alison and her partner chose to refuse further intervention saying the LFB had already visited. Careline services were also recommended but refused by Alison which meant the risk was not fully addressed.

There was a lack of a coordinated, multi-agency approach, so that all agencies involved in Alison's case were aware of the risks and a common plan established to address them. Joint mental capacity assessments, formal MDT meetings, best interest meetings and the High-Risk Panel will help to support the assertive approach and not allow the service user to "play one practitioner off with another". They will also help to ensure the trauma informed[23] principles of safety, trust, choice, collaboration, empowerment, and culture are considered.

The General Data Protection Regulation, Data Protection Act 2018 (GDPR) and the Crime and Disorder Act 1998 permit the disclosure of information to organisations

[22] Human Rights Act 1998, article 8. The right to respect for your family and private life

[23] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/workingdefinition-of-trauma-informed-practice

such as the police, local authorities and social services. A disclosure in the public interest is likely to be justified where it is essential to prevent a serious and imminent risk to public health, national security, to protect other people from risks of serious harm or death, or to prevent or detect serious crime[24]. The Caldicott Principles[25] also to help inform decision making on whether to override consent.

In terms of the risk of harm due to a fire, the LFB are best placed to advise on how to address any fire risks, even if the client refuses a face-to-face visit to their home. In these cases, it is therefore essential that they are still referred to the LFB or, as recommended above, a multi-agency meeting (which should include the LFB) should be held to discuss the how risks can be managed.

In cases where the LFB are not able to access the service user's property, one option is for them to provide advice, support or training to any appropriate person or agency that is able to interact with the client and complete a HFSV on the LFB's behalf. This may require some further discussion to agree how this will be done, for instance, a form or disclaimer, indemnity, or in the longer-term a Memorandum of Understanding.

Recommendation 7

That within the ASC/LFB review meetings or the High-Risk panel a process is established whereby, for those people that refuse or decline a HFSV or where the LFB are unable to access the service users property, the LFB provide relevant feedback, advice, support or training so the HFSV is completed by the appropriate agency on the LFB's behalf.

Annual reviews, escalation, recording and risk assessment processes are really important in all cases where the service user is uncooperative, fiercely independent or continually refuses help and support, but particularly important where addiction or dependency issues affect the persons ability to change.

One thing that could outweigh the choice of the service user is if there is a risk to others. If a fire should start in the service users' premises and it could endanger other occupants within the building or restrict their escape, then this could be used as

[24] https://www.bma.org.uk/advice-and-support/ethics/safeguarding/adults-at-risk-confidentiality-anddisclosure-of-information

[25] https://www.gov.uk/government/publications/the-caldicott-principles

evidence to justify more assertive action. This could involve using tenancy agreements, or in the case of Alison, terms of a leasehold agreement, to comply with recommended support. In extreme cases this could involve legal processes to secure a move to more appropriate accommodation.

Article 8 of the Human Rights Act (HRA) may also apply in this situation. Article 8, the right to respect your private and family life, is a qualified right. This means a public authority can sometimes interfere with your right to respect for private and family life if it is in the interest of the wider community or to protect other people's rights, for instance Article 2, the absolute right to life. It must also show that it has a specific reason set out in the Human Rights Act for interfering with your rights. The HRA calls these reasons a legitimate aim.

Examples of legitimate aims include:

- the protection of other people's rights
- national security
- public safety
- the prevention of crime
- the protection of health

In cases where there is a significant increased risk of fire, especially in blocks of flats, should a fire occur the health risk to neighbours in the building due to smoke inhalation is likely. In Alison's case there was a potential risk to others in the building and the fire did have a significant impact on them during and afterwards.

It is not known if there is any case law that has tested this element of the HRA. Therefore, in regard to future cases, any decisions would need to be made on a case-by-case basis and legal advice about how the HRA applies, gained at the time.

13.3 Understanding and effectiveness of multi-agency risk management processes

Practitioners did not fully understand how risk assessments are applied and in terms of fire risks they do not fully understand risks within the home. Practitioners are aware of the PCFRA but not necessarily how to apply it and what can be done to mitigate fire risks, especially in complex, high risk cases and how to escalate. In terms of escalation, the change to the MDT network approach (see section 14.1) and changes to the ASC Mosaic system[26] will help practitioners to understand the risk

[26] The Mosaic System is a social care case management system, not to be confused with the MOSAIC geodemographic classification of households.

management processes but including fire risks in the home and fluctuating and executive mental capacity in regular mandatory training will also help.

Commissioning team audits that include fire risk processes, as per the Claire action plan (below), will also help ensure service providers include fire risks in their management of their clients.

13.4 Escalation process

H&F has two Multi Agency Risk Assessment Conferences (MARAC), one for domestic abuse (DAMARAC) and one for anti-social behaviour (community or CMARAC). The DAWS mentioned that they refer cases to the CMARAC but as fire risks are not part of either group terms of reference, it is not the most appropriate escalation pathway. This highlights a gap in how to escalate cases that involve fire risks. Rather than create another forum for dealing with cases involving fire risks, the current escalation process of joint mental capacity assessments/ MDT/ best interests meetings seem to be the most appropriate means to discuss cases before escalation to the High-Risk Panel if the case is complex or they cannot address the issues. At the time of writing, it is understood that MDT's do not have formal terms of reference but there is best practice. As mentioned before, it is essential that full and accurate records kept.

The High-Risk Panel, which has become more established since Alison, has clear terms of reference, that includes significant fire risks, and will greatly contribute towards addressing future complex cases:

The panel will consider case presentations for situations which have already been considered within partner agencies risk assessment processes and there remains a significant risk arising from

1. *Hoarding that has reach level 5 or above in the Clutter Index[27] shown in appendix 2, <u>for at least one room</u>*
2. *A significant fire risks. This might include*
    a. *evidence of cigarette burns to clothes or bedding*
    b. *residence displays evidence of small burns or fires*
    c. *unsafe storage of inappropriate flammable liquids or gases*
    d. *where the person's ability to identify and manage a fire risk is impaired by a lack of decision-making capacity or substance misuse*

[27] International OCD Foundation, Hoarding Centre, Clutter Image Rating 7 Naik, Lai, Kunick & Dyer 2006

3. *Self-neglect which is having a significant effect on the individual's ability to manage their:*
    a. *personal care and hygiene*
    b. *home environment*
    c. *activities of daily living such as shopping*
    d. *health conditions*
    e. *finances*
4. *Complex homelessness.*

These terms of reference are very clear and if practitioners are more aware of them, more appropriate referrals will be made.

Recommendation 8

That, in relation to fire risks, the SAB seeks assurance that MDT meetings, decision making and escalation processes to the High-Risk Panel, are formally documented.
Also, that the SAB promote best practice MDT working and expectations, and increase awareness of the High-Risk panel and its purpose as part of the Fire Safety Assurance MDT approach briefings.

13.5 Opportunities for intervention and learning from other cases

Prior to Alison, there were two similar cases in the previous two years where an adult died in a fire in H&F:

Brian - 31st December 2019

A male, HIV positive, who smoked and drank. His wife also smoked and had a brain injury and found multi-tasking difficult and her memory recall was poor. A care package was in place, possible domestic abuse accusation that his wife hit him. Cause of the fire was a discarded cigarette whilst sitting in his chair.

Claire - 31st January 2021

An Black-Caribbean female, aged 69, who lived with her daughters in a Victorian terrace house which was adapted to her needs. She smoked cannabis and cigarettes, was immobile, had a four times daily care package and Careline. She had cognitive impairment due to a stroke and took anti-depressants. In regard to fire prevention, she had five smoke alarms, all of which worked, and did not like the flame-retardant blanket given to her by the LFB.

She died in a fire after her carers had left her in the morning in her recliner. The probable cause of the fire was a dropped cigarette which ignited the duvet she was using and burnt through Careline cable wire.

There was not much previous interaction with her (three calls previously: once when she was locked in, the other to assist within the property and one to fit in smoke alarm). At that time house was found in good condition and no safeguarding concerns or fire risks noted or raised.

13.5.1 Claire Action plan

As a result of Claire, the H&F SAB SAR case review group met on 7th April 2021, mainly to discuss Claire, but Brian was mentioned. The minutes of the meeting mainly focus on the events of the incidents, interaction and intervention agencies had with Claire, and there are not specific outcome or action from the meeting. The group concluded that it did not meet the criteria for a SAR and that, according to the minutes *"'Claire' seemed to have been thoroughly assessed by Cognitive Impairment and Dementia Service (CIDS), GP, ASC and that she was receiving appropriate level of support and care; was capable of communicating if she was in a distress situation by being able to press the alarm on the pendant, demonstrated that she understood the risk of fire but chose to continue smoking, had fire retardant bedding in place."*

It was mentioned by the LFB Borough Commander at the meeting that the *"critical point is that everybody should be aware of the risks… and that one point to consider is that professionals who visit the same person for a long time can become 'property blind'".* He also said he would be meeting with the H&F Chief Executive Officer soon to brief her about the recommendations for future as there is some learning, such as providers flagging up when somebody is a heavy smoker and what risk assessment were being done. This was not however, recorded as an action of the meeting.

On the 5th July 2021 the SAR Review group held a meeting to discuss Brian who was referred to the group by the LFB.

The meeting concluded that there were issues regarding a mental capacity assessment or possible lack of professional curiosity, such as perhaps not asking enough questions. The Chair considered it could be a discretionary SAR but was satisfied that the learnings from this case can be carried forward as part of the ongoing work on fire risk prevention. This is presumed as a result of the Claire case.

Following the Claire case, an Individual Management Review (IMR) took place which highlighted several findings and made thirteen recommendations. To

implement the findings an action plan was devised, owned by the LA Chief executive. Monthly meetings to review the action plan were planned for twelve months after the incident. The last action plan (v12) was dated 2nd July 2021 (although some actions have been updated in August 2021), eight months after the Claire incident.

There are a number of queries which imply that the action plan was not fully completed:

- The action plan timeline was for twelve months but updates stop after August 2021, eight months after Claire incident.
- RAG ratings for six of the recommendations are green, implying they have been completed, the remainder are amber implying they are still in progress.
- There are various comments suggesting work was still in progress. Examples being repeated (and the same) commissioning comments throughout the action plan about identifying gaps, internal processes and awaiting final drafts of their internal risk assessment; the audit quality visiting form template contained within the action plan does not include the fire risk assessment and action taken by provider included Q 5.12.
- It is not known whether the multi-agency learning meetings were held to agree governance so that all agencies are held to account from delivering on the action plan.

This review into Alison has highlighted several issues similar to those found in the Claire review, which indicate that the lessons learnt from Claire have not been implemented.

- Fire Safety training for practitioners who visit people's homes is still an issue. The previous action plan does not specifically include risks in the home and solutions to mitigate risks for high-risk patients. The questionnaire also highlighted several things that a proper training package can address, for instance, the PCFRA process, clutter image rating scale, emollient creams, use of PPS etc.
- Risk assessments considered smoking but did not include other fire risks such as emollient creams, air mattresses and other risks in the home such as heaters or unsafe electrics. This was evident from the care providers risk assessment (which, since Alison, has been updated and is now much more thorough).

Identifying people who are more vulnerable to the risk of fire is the key and establishing opportunities for intervention and the learning from Alison will help to do this.

The trigger mechanisms within the ASC Mosaic system will better identify opportunities for intervention and referring to other agencies. It will also ensure better MDT engagement and widening the invites to the Fire LFB, Housing teams, or any other agency involved in a case such as the DAWS, will ensure better management.

13.5.2 Change of leadership

It is understood that a couple of significant stakeholders left their relevant organisations during the time of implementing the Claire action plan. This included the owner of the action plan, the LA Chief Executive and the LFB Borough Commander. A handover of leadership will no doubt have an initial effect on the delivery of any action plan. New leadership will have differing views and opinions which shape strategic priorities. It does appear that this change did impact on completing the Claire action plan but the review cannot establish the exact reasons.

Considering that the overarching purpose of the SAB is to gather assurance that effective adult safeguarding arrangements are in place, governance of such an action plan would more appropriately sit with them. It would also mean the collective responsibility of the SAB would not be affected by any strategic leadership change.

Recommendation 9

That the SAB govern and manage any action plan devised as a result of this review.

13.6 Recording of decisions and assessments

Practitioner notes are the first step in the recording of decisions from practitioner appointments or visits and are an essential part of professional standards and best practice. The recording of notes that the reviewer had sight on were generally good, however some statements and decisions made were ambiguous and needed clarification. Workloads do impact on note taking, which is discussed later in the report, but clear and concise notes are important to protect the practitioner and ensure a more accurate account is available in the event of subsequent reviews or investigations.

As already mentioned, in Alison's case it is unclear if MDT meetings are formally recorded. Risk assessments covered health risks but did not include all the risks associated with fire, the care plan only included smoking and there is no evidence of MDT or ASC risk assessments.

Annual reviews by care providers and ASC must accurately record the risks, including previous risks to identify whether they remain or have changed. MDT meetings

convened should include ALL relevant partners, with discussions and decisions properly minuted. This is particularly important in cases where service users refuse help and support. The change to the MDT network approach established since Alison will better address this.

Similarly, recording escalation processes right through to the High-Risk Panel must be done. Appropriate and proper recording of risk management plans is essential, as if done properly any plan or decision is defensible in court should a serious incident occur.

13.7 Support for practitioners

ASC have a process where social workers should discuss all high-risk cases within supervision with line managers and use a very comprehensive one-to-one supervision record. It would also be expected that immediate risks are flagged as part of daily interactions with their line manager and guidance is that they should not wait for formal supervision to have these conversations.

From the questionnaire, 78% of practitioners from across the partnership that took part said that where they had a client with long term care needs and/or significant fire risks, they were given sufficient support to manage them. However, 22% said that they had not been given sufficient support which is worrying. The reviewer clarified why this was and number of participants blamed the pressure that some organisations and consequently practitioners are under, and increased workloads meant they could not be as thorough or conscientious as they would like. It was also mentioned that workloads had an impact on the accurate recording of notes as less time is available to write them.

Human, financial and physical resources also have an impact on the management and support of high-risk long term complex cases. H&F has seen a 40% rise in the number of people eligible for care in their own homes due to its commitment to free home case (in place since 2015). H&F is a small London Borough with a population of 180,000+ and leads the way in London and nationally regarding the amount of care in the community it provides. It also provides free day services and short-stay care and a subsidised daily hot meal of £2.00.

During the COVID pandemic, a system called Discharge to Assess[28] was introduced to help reduce the time they spend in hospital and avoid unnecessary delays in discharging patients. Where a patient does not require an acute hospital bed, but

[28] https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-toaccess.pdf

may still require care services in the short term, they are discharged to their own home with funded help and support, or to another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the patient.

The impact of this is that more higher risk people are living at home. Whilst this is positive, as independence for those people is maintained, increased resources are needed to reduce practitioner workloads and enable effective management of these cases.

The social care workforce is not a regulated profession (not to be confused with Social Work which is a regulated profession) and much needs to be done to raise carer standards especially in regard to the identification and management of fire risks. Including how to identify and mitigate fire risks in the home in mandatory training should address this.

In terms of mental capacity, as has been highlighted earlier, Alison was considered as having capacity but there is no evidence that capacity in a "issue specific" area of fire risks was considered. The review could not highlight whether this was due to a lack of training, managerial support or peer supervision. However, clarifying this area of mental capacity with all practitioners will help with the management of future complex, high risk cases.

13.8 Other options if adult at risk refuses help or support

This is a theme throughout the review and has been discussed in a number of previous sections; mental capacity section 14.2; choice and risk section 13.1 in regard to completing HFSV on behalf of the Fire Brigade; Claire action plan section 13.5.1 regarding the ASC Mosaic system "red flag" triggers for MDT meetings.

The theme is that practitioners should be more assertive in their approach and use their professional curiosity to explore and understand the reason for refusing, rather than accepting the refusal at face value. There are times, especially when the risk to the service user is high, when challenging or trying to persuade them further by explaining the consequences, even in more graphic terms, would be appropriate. In terms of fire risk, understanding fire risks in the home is key to this which then places the importance of training, joint mental capacity assessments, multi-agency working and recording of these discussions. If then the service user continues to refuse, it can be escalated as described in section 13.4.

As discussed under the mental capacity section, if the service user has capacity and the risk remains, care provision continues and all mitigating options for support or

help have been refused, then a signed document that they accept the risks may be an option to explore as a last resort and with the consent of the adult.

13.9 Impact of the COVID pandemic

There were three national COVID lockdowns, the first from 23rd March 2020, with various indoor and outdoor restrictions continuing until October when the second national lockdown came into force from 31st October for four weeks and the third from 5th January 2021. Various restrictions remained until the 19th July 2021 when legal limits on social contact were removed.

During this time, public organisations had to react to reduction in staff and prioritise their response to the pandemic over their normal functions with some staff redeployed to other duties and then later on, the delivery of the vaccine programme.

During this time Alison continued to receive face-to-face visits from the care provider to provide domiciliary care and the DN to redress her leg wounds. However, records show that from April to July 2020 numerous unsuccessful attempts were made to contact Alison by the OT. It cannot be determined whether this was due to the lockdown, but the dates do coincide. They managed to speak with Debbie in July 2020 as she was in hospital and then complete a home visit in August 2020.

The housing fire safety team contacted Alison by phone rather than making a visit in March 2021. LFB home fire safety visits were reduced during the pandemic however one was completed for Alison a month before the first national lockdown began and attempts were made to make a further after restrictions were eased in July 2021.

This shows that not all agencies were visiting the home during the pandemic, but essential care service from the care provider and DN were still being maintained. This may, to some extent, have left Alison and her partner more isolated to undertake risk taking behaviours.

One question the review has not answered is why it took eighteen months for the Safeguarding Adults Case Review Group (SACRG) to formally review the Brian case. Brian was formally referred to the group by the LFB in July 2021 and should have been done much earlier. The Brian incident occurred just before the first COVID lockdown, however the SACRG met three times in 2020, but no record of Brian being discussed apart from a recent fatal fire being mentioned but not identified as Brian. 2020 was a difficult time for everyone, reacting to the uncertainty of the pandemic, regular changes in government guidance and significantly reduced staff numbers, whilst trying to maintain essential services put enormous strain on all public services. It can therefore only be assumed that the response and impact of the pandemic delayed the LFB referring the Brian case.

14 Issues raised from Alison's case

14.1 Multi agency communication

MDT meetings are key to ensuring all risks to a client or patient are known by everyone involved. The review highlights that some agencies did communicate with each other, for instance the DN, GP and ASC and care agency but there was not a coordinated approach. The GP did hold one for Alison but this was to address the specific risk of Alison's drug use and needles in her property being a risk to care workers. The reviewer has not seen a record of the meeting so the review cannot determine whether other risks were discussed.

From accounts it was found that practitioners tended to be task focused rather than looking at the wider risks. It is clear that the DN, OT and the care agency were aware of the fire risk posed by Alison's smoking and made the appropriate referrals, however when the risk remained and further evidence was found of burn marks on her duvet and blanket (August 2020 and December 2020), these look to be independent reports and it appears no further action was taken until the care agency requested a second set of flame-retardant bedding in February 2021.

Alison's situation and presentation was a complex one, she was immobile, and bed bound, smoked, used drugs, used emollient creams and an air mattress. These characteristics were all the triggers for treating as someone who needs extra consideration of their risk due to fire and should have instigated a better MDT response.

The issues with Alison, in addition to her general care and wellbeing, that required a further discussion were:

- Use of Careline (which the LA will provide at no cost)
- Her continued smoking, drug use and the risk of needles and sharps
- Additional carbon monoxide and smoke alarms (for instance the use of a heat detector in the bedroom instead of a smoke detector)
- Maintenance and use of flame-retardant bedding
- Increased fire risk due to having an air mattress
- Use of emollient creams
- Risks to others within the building

In Alison's case, in addition to the GP, ASC, OT, care agency and DN, the LFB, Housing teams and DAWS should have been involved in a formal MDT meeting, led by one agency, to address these risks and record the outcome:

- The LFB to provide more specific fire prevention advice,

- Housing to complete a PCFRA, PEEP and determine the potential risk to others in the building, and
- DAWS to provide alternative approaches to reduce her drug use.

Following Alison's case, ASC have reviewed their attendance at the Integrated Domiciliary Hub meetings as social work attendance was a bit 'hit and miss'. Workloads meant that representatives from non-health partners didn't always attend as their organisational structures did not mirror the primary care networks. Each GP practice in the Borough is part of a primary care network (PCN), of which there are five in H&F.

Virtual MDT meetings in each of the PCN areas consist of the community matron, DN, GP and practice link worker, a senior social worker, a dementia link worker and a representation from the geriatric service. Other services such as community neurorehabilitation or respiratory team, are invited as required. These meetings discuss several cases and are therefore short and focus on complex clinical assessment needs and management (because of the case list, this is is not the place for a longer case specific MDT review). Any issues raised would result in actions for discussions outside of that meeting. For instance fire may be raised but the action may be outside of that meeting to review assessment and need for referral. The meeting is recorded and the community matrons will normally make a note of the outcomes.

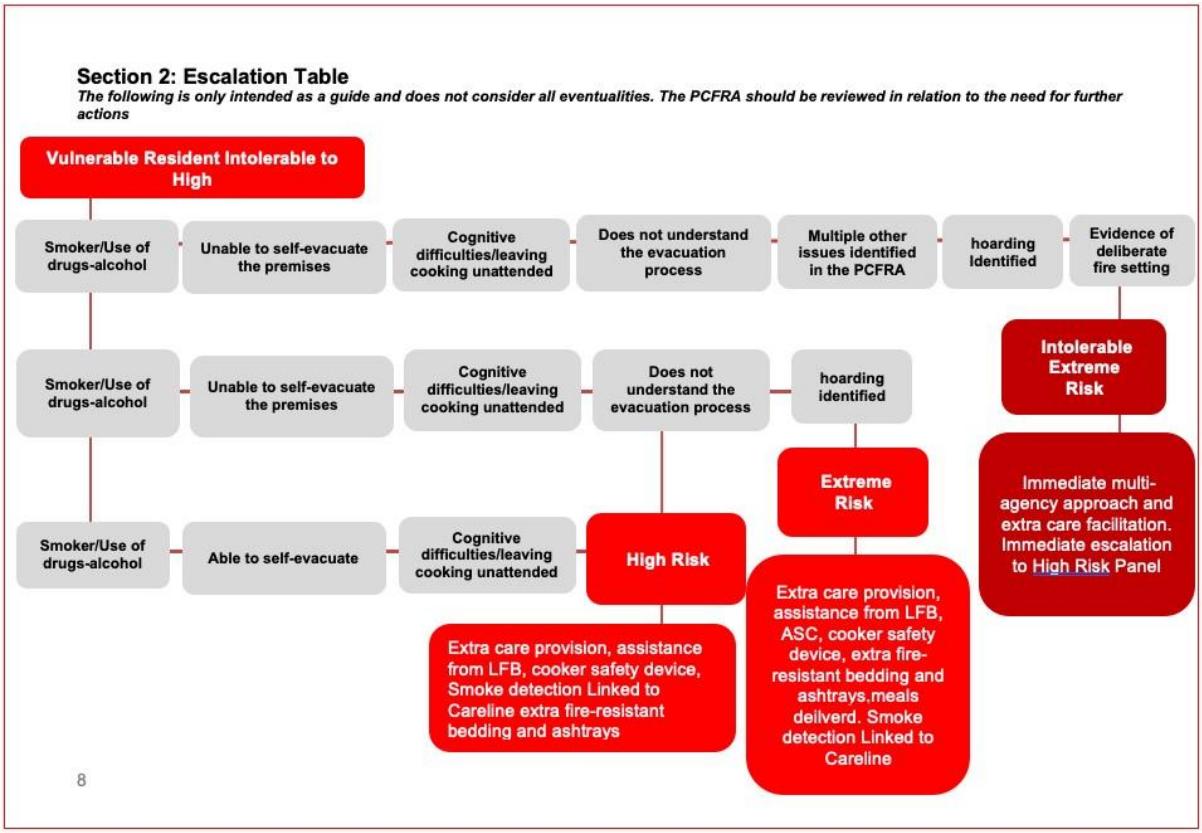
A six month pilot is currently underway of funding two additional social worker posts from health winter monies. These 2 additional posts are aligned to the five PCNs to provide additional capacity to support these MDTs. This pilot was in response to ASC being unable to configure to PCN geographies and being unable to regularly commit to attend MDTs. The Hammersmith and Fulham Health and Social Care Partnership will need to evaluate the pilot in May and identify recurrent funding as required.

This approach ensures that if a practitioner raises an issue, initial discussions are held with relevant agencies. However, it is important that if this process doesn't or can't resolve the issue then a more formal case specific MDT meeting is held with all involved partners. **In short, getting the right people round the table at the right time.** If need be further multi agency discussions are had and if there is still no resolution to the risk, the case is referred to the High-Risk panel. The most importance thing is that at each stage minutes are taken and care notes record outcomes and decisions.

In addition to this, strategic managers from Community nursing, ASC, Housing and the Fire Service now meet regularly to discuss cases and support the network to ensure appropriate escalation.

As part of the Claire action plan in 2021, which unfortunately was not completed prior to Alison's incident but has been since, the electronic Mosaic system used by ASC now triggers a "red flag" for completion of PCFRA for cases where a service user smokes, refuses consent or access and it is known that the risk remains. As part of this there is a very clear escalation flowchart (see below). This also triggers an annual review within care reviews or when health of service user changes.

It is essential that in these cases that there is a clear recording of these cases on a PCFRA or case notes trigger MDT discussions or escalation to High-Risk Panel. For instance, where smoke detectors are refused in bedrooms as was the case in Alison and her partner refused access to Alison. Practitioners should be more assertive in these cases and clients persuaded to comply with fire precautions. For instance, if they do not and carers are put at risk, withdrawal of care could be used to persuade them to comply. If there is a risk to others within the building should a fire occur, housing officers can use conditions within tenancy agreements.



14.2 Mental Capacity

The Mental Capacity Act states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. In Alison's case, in August 2019 ASC state that the GP said she had capacity and again in March 2021 as part of a safeguarding review. The decision was taken that neither Alison or Debbie were at risk of abuse as both had capacity to make unwise decisions in relation to their wellbeing.

Some social workers believe wrongly that the Mental Capacity Act provides a right to make unwise decisions, creating risks for service users[29]. Practitioners often mistakenly believe adults have a 'right to make unwise decisions' re smoking in their home and believe they cannot take any further action if a person is making unwise decisions, or that they do not consider repeated unwise decisions as possible sign that person lacks capacity and requires assessment.

Section 1 of the Mental Capacity Act 2005 states that a 'person should not be treated as unable to make a decision merely because they make an unwise decision'[30]. This principle requires consideration of the person's capacity in a time and issue specific manner, so their ability to realise and weigh up the risks smoking posed must be explored.

Assessing mental capacity, in particular executive mental capacity in relation to fire risks, is often very difficult. Executive Capacity is about the ability to use or weigh information. The Code of Practice (para 4.21)[31] notes: '*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information, but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given*'. In other words, a person may appear to be able to weigh facts while in

[29] How misinterpretation of 'unwise decisions' principle illustrates value of legal literacy for social workers. By Angela Jenkinson and John Chamberlain.
https://www.communitycare.co.uk/2019/06/28/misinterpretationunwise-decisions-principle-illustrates-value-legal-literacy-social-workers/

[30] The concept of 'unwise decisions' is contained within the principles set out in the Mental Capacity Act 2005, which states (section 1) that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".

[31]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

an interview or practitioner meeting but if they do not transfer those facts to everyday life (execute the plan) they may lack mental capacity.

The care provider, DN and OT all discussed Alison's smoking with her on several occasions. However, it is likely that her drug use changed her mental capacity and that her drug use changed her ability to make informed decision about smoking. One time she could be coherent and understand the risks but once she had taken drugs, she could be unaware of them. It is also likely that her drug use increased her risk appetite and became the priority over her care. Considering repeated discussions were made about the risks of her smoking and she made, what the Mental Capacity Act 2005 calls 'unwise decisions'[32], this should have triggered further investigation via MDT meeting or a robust joint mental capacity assessment to determine her capacity to understand the risks and consequences associated with her drug taking and smoking.

The LFB, as part of a HFSV can provide an opinion in this "issue specific" area, in other words, whether a person understands the fire risks associated with smoking or other fire risks and the consequences should a fire start. If they don't then they could be considered as not having capacity in that issue specific area and this should be communicated to ASC either via local communications or a formal safeguarding concern. The next most appropriate step prior to an MDT meeting would be to complete a joint assessment with the LFB and Clinician (social worker or District Nurse). The LFB being the subject matter expert in fire prevention and the clinician in mental capacity and jointly they would be able to assess the mental capacity of the service user in this issue specific area. The LFB or the Clinician should instigate and lead the MDT with the specific aim of finding ways to mitigating the risks considering the outcome of the mental capacity assessment.

Neither the fire service nor local authorities have any general power to regulate or prevent smoking or drug use within individual private homes, whether they are owner occupied or rented, or whether they are houses or flats (including flats in sheltered units). Cases where there is a high risk of fire due to the person's smoking (or other risks) and where the person may lack mental capacity should then next be

[29] Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice. London: DCA. Para 2.11 "There may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character. These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices."

discussed within an MDT or Best Interests meeting, with the LFB being a key contributor, to determine the best way forward to address the risks.

Recommendation 10

That cases where there is doubt as to the capacity of a service user to understand fire risks in their home:

a) a joint LFB mental capacity assessment is completed with other relevant professionals and,
b) that the LFB are invited to future MDT or best interests meetings.

Recommendation 11

In cases that involve significant fire risks, the LFB lead MDT meetings

The most problematic issue is if, in these high-risk cases involving someone who smokes or takes drugs, it is determined that they have mental capacity and therefore the right to make unwise decisions. If all mitigating options for support or help have been fully discussed and refused or ignored, then this must be fully recorded. In addition, a signed document that the person accepts the risks may be an option to explore.

14.3 Training

There was a common theme that appeared throughout the review in terms of training. Some partners referred to completing their initial “fire safety” training in respect to what they do in the event of a fire as an employee in the workplace, according to their responsibilities as an employer under the Regulatory Reform (Fire Safety) Order 2005 (known as the RRO), rather than applying it to the risk within the homes of the service user, clients or tenants. This led to the conclusion that “home fire safety” or more applicable in this report’s context, the term “home fire risk awareness” by practitioners was often confused with “fire safety”.

This misunderstanding of the term Fire Safety is having the effect of not applying the person-centred approach to risk assessment, especially with respect to fire risks in people’s homes.

The questionnaire also highlighted the majority of the practitioners (76%) that took part correctly understood the term Person-Centred Fire Risk Assessment but 24%

answered incorrectly. Only 26% knew the first element of the PCFRA. Whilst these results are encouraging, there is still work to be done to raise awareness of how to identify and assess fire risks in the home and how to apply a PCFRA.

The audits also highlighted that a number of agencies do not use a PCFRA, examples of which are freely available on the LFB website[30] and from H&F ASC. The PCFRA can be used for an initial quick and easy assessment of elderly or vulnerable residents in their own private home. It will provide specific and relevant information to aid in the completion of a full PCFRA where one is required and signpost to the LFB or ASC for further advice.

Recommendation 12

That the SAB seek reassurance from all multi-agency partners that fire risks in the home and ways to mitigate them are included in practitioner or staff training.

15 Recommendations

1. That hospitals establish a process to identify those more vulnerable to the risks of fire in their home and refer to LFB as part of discharge plans.
2. The LFB establish a standard process whereby any hospital can refer vulnerable patients directly for a Home Fire Safety visit.
3. That commissioning services, in conjunction with other agencies, lead a review of care provider risk assessments to ensure they are person-centred and include all potential fire risks in the home.
4. That all agencies and partners have a process of referring cases involving fire risks directly to the LFB and inform ASC at the same time so they can maintain an overview of the case.
5. That the High-Risk Panel and Local Authority housing teams continue to consider Personal Protective Systems to be available and appropriate people within the borough be trained to install and maintain them, for use by all partners.
6. That the DAWS Plus service is considered for clients with known substance misuse and who have disengaged, or are at risk of disengaging, with support services.

[30] https://www.london-fire.gov.uk/media/4844/pcra_v2-april-2020-final.pdf

7. That within the ASC/LFB review meetings or the High-Risk panel a process is established whereby, for those people that refuse or decline a HFSV or where the LFB are unable to access the service users property, the LFB provide relevant feedback, advice, support or training so the HFSV is completed by the appropriate agency on the LFB's behalf.
8. That, in relation to fire risks, the SAB seeks assurance that MDT meetings, decision making and escalation processes to the High-Risk Panel, are formally documented. Also, that the SAB promote best practice MDT working and expectations, and increase awareness of the High-Risk panel and its purpose as part of the Fire Safety Assurance MDT approach briefings.
9. That the SAB govern and manage any action plan devised as a result of this review.
10. That cases where it is identified that a person may not have capacity to understand fire risks in their home:
    a. a joint LFB mental capacity assessment is completed with other relevant professionals and,
    b. that the LFB are invited to future MDT or best interests meetings.
11. In cases that involve significant fire risks, the LFB lead MDT meetings.
12. That the SAB seek reassurance from all multi agency partners that fire risks in the home and ways to mitigate them are included in practitioner or staff training.

Martin Corbett
MIFireE GInSTR DipHMO

16 Glossary

ASC	Adult Social Care
CIRS	Clutter Image Rating Scale
COPD	Chronic obstructive pulmonary disease
EPA	Environmental Protection Act 1990
EDT	ASC Emergency Duty Team
DAWS	Drug Abuse and Welfare Service
DN	District Nurse
DVT	Deep Vein Thrombosis
FRS	Fire and Rescue Service
HFSAB	Hammersmith & Fulham Safeguarding Adults Board
HFSV	Home Fire Safety Visit (completed by the Fire Brigade)
HMO	House of Multiple Occupation
ICB	Integrated Care Board (formerly the Clinical Commissioning Group)
IMR	Individual Management Review
LA	Local Authority
LAS	London Ambulance Service
LFB	London Fire Brigade
MARAC	Multi-Agency Risk Assessment Conference
MDT	Multi-Disciplinary Team
NHS	National Health Service
OT	Occupational Therapist
PCFRA	Person-centred fire risk assessment
PEEP	Personal Emergency Evacuation Plan
PHA	Public Health Act 1936
PPS	Personal (or portable) protective system (which is an automatic mist system that activates in the event of a fire)
RRO	Regulatory Reform (Fire Safety) Order 2005
SACR Group	Safeguarding Adults Case Review Group
SAR	Safeguarding Adults Review

17 Appendix 1 - Results from questionnaire and analysis

As mentioned in the methodology, two practitioner sessions were held. These sessions targeted anyone who visited people's homes and involved completing a questionnaire and were an open session where participants had the opportunity to ask the reviewer any fire safety related questions. The session was split into three parts, the first asked 10 questions and the answers followed by a small break, the second the last 10 questions and answers and the third the open session.

38 participants took part, 25 participants attended the first session and 13 the second (which was moved to attract more participants as the first was within school half term holidays). It was noted that more registered for the events than actually attended on the day.

Not all responded to every question, all 38 answered the first 10 questions but after the small break 6 participants left so only 32 answered the last 10 questions.

The percentages below are based on the actual number of respondents to each question.

Of the 38 who started the session, the majority (44%) were from Adult Social Care, 22% from Housing, 16% from Health care, 7% each from the voluntary sector and Care Provision, 2% each from Mental Health Services and others not specified.

The majority (76%) knew what a Person-Centred Fire Risk Assessment (PCFRA) was however only 26% correctly identified the first element. Also, only 27% said they have used a PCFRA to address fire risk for a client. This indicates awareness of the PCFRA but not a working knowledge of using or applying it.

It was encouraging that the majority (74%) knew what PEEP stands for (Personal Emergency Evacuation Plan) and 98% knew when it should be completed.

All participants knew a way to refer an adult safeguarding concern.

53% correctly identified that lack of Mental Capacity is not a distinct characteristic of self-neglect.

31% did not know what a Clutter image rating scale is but 23% new that above 4 of the CIR scale is considered a significant risk and 90% correctly identified the circumstances where action can be taken to address hoarding.

In regard to smoking cessation the majority of respondents (92%) knew the methods that are available on the NHS and all knew how to contact a stop smoking advisor.

71% knew what an Assistive Technology Catalogue was (which is a catalogue that lists products and services which can help support independence)

35% of participants knew what a Personal Protective System (PPS) was (which is an automatic mist system that activates in the event of a fire), with 46% confusing it with an alarm service for the elderly. This is of concern considering a PPS is a very effective control measure for very high-risk cases. Only 7% of participants said they had recommended a PPS for a client.

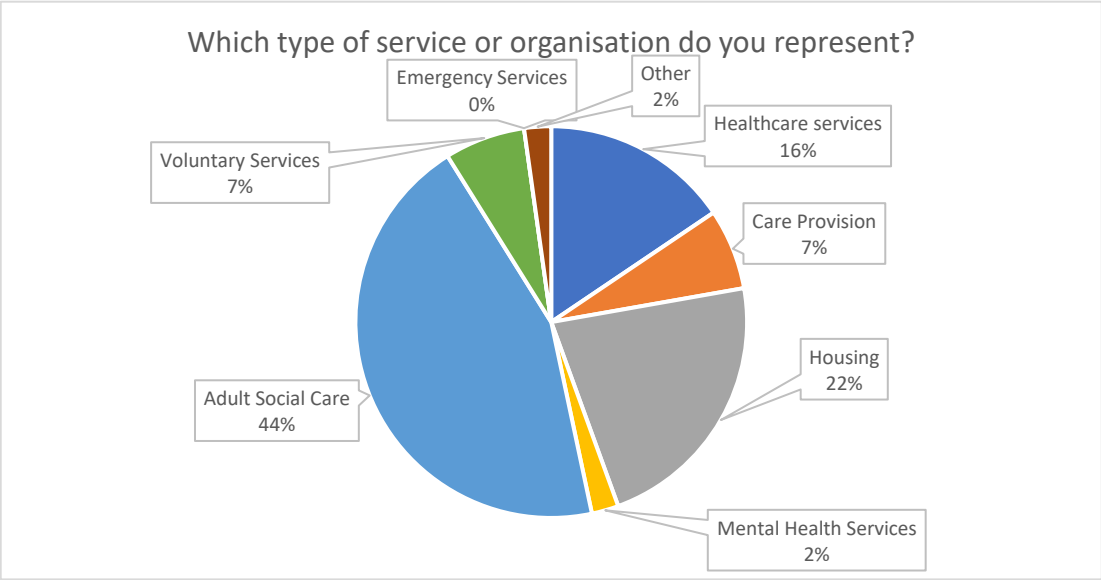
43% said they had a client with drug dependency and that it hindered or affected how their case was managed. The reasons being:

- The client would not listen or take heed of advice to address risks in their home or how to improve their health (35%)
- The service users drug dependency took priority over other more important parts of their care practitioners felt you had done all you can to help the client (31%)
- Supporting the client was pointless until their drug dependency was addressed (4%)
- The practitioner felt they had done all they could to help the service user (17%)
- Other 13%

It is good that the 62% said they had a client who had an increased risk of fire, 78% said they had been offered fire prevention support

78% said where they had a client with long term care needs and/or significant fire risks, they were given sufficient support to manage their care and fire risks. 22% said that they had not been given sufficient support which is worrying. The reviewer asked to clarify why this was and a number or participants blamed the pressure that some organisations are under and increased practitioner workloads.

1.



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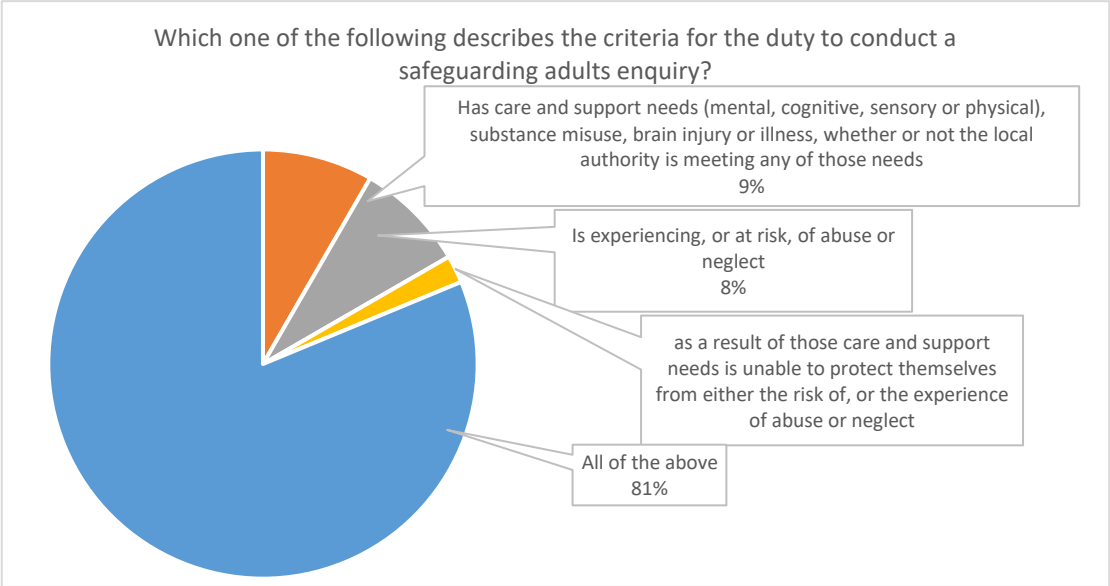
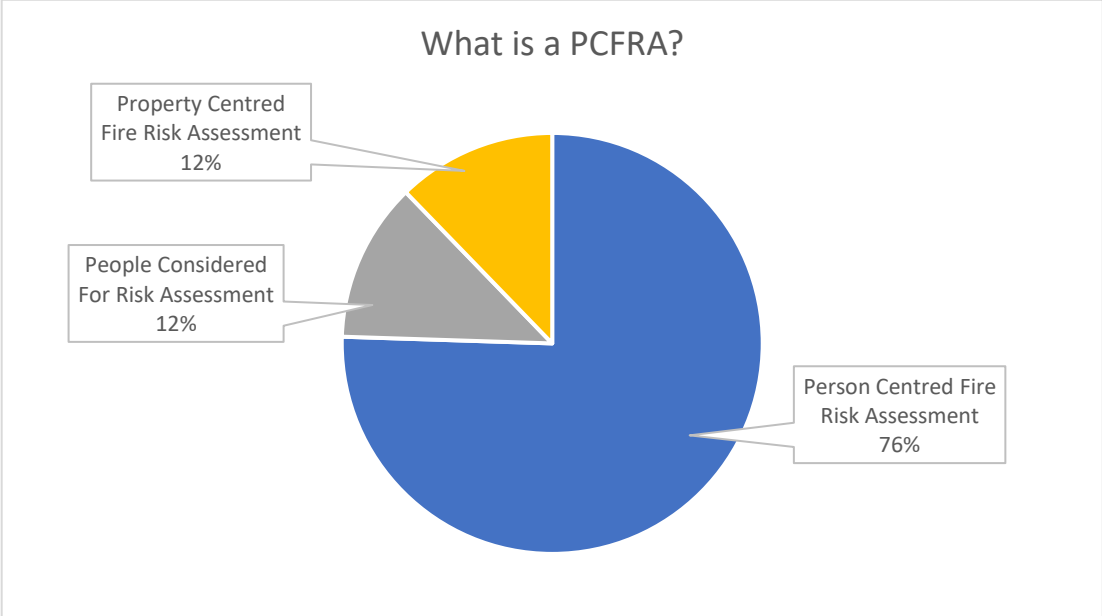
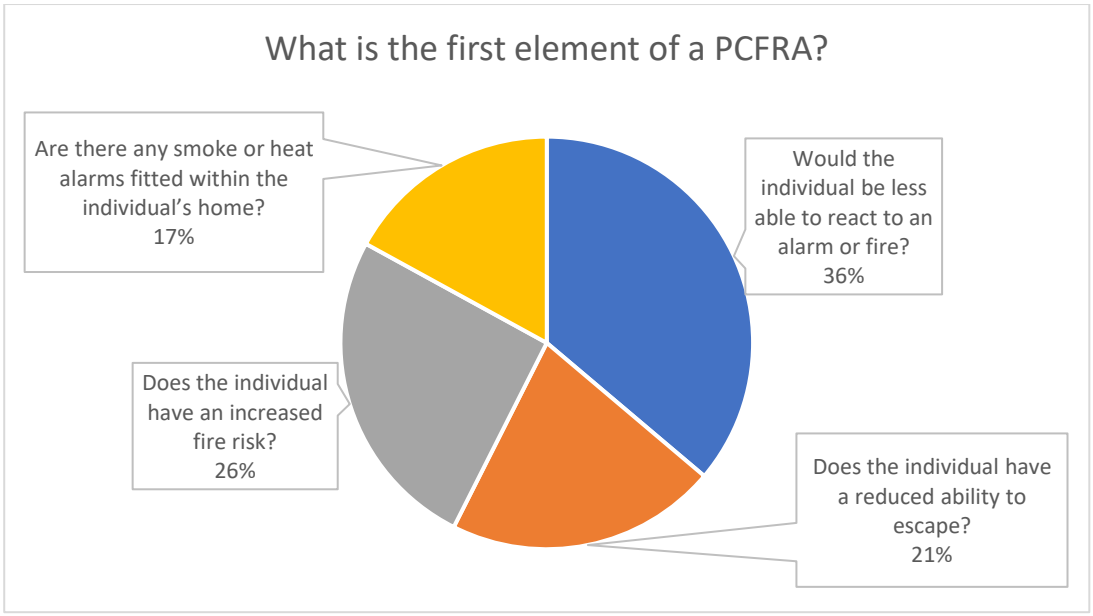

Which one of the following describes the criteria for the duty to conduct a safeguarding adults enquiry?
Has care and support needs (mental, cognitive, sensory or physical), substance misuse, brain injury or illness, whether or not the local authority is meeting any of those needs
9%
Is experiencing, or at risk, of abuse or neglect
8%
as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect
All of the above
81%

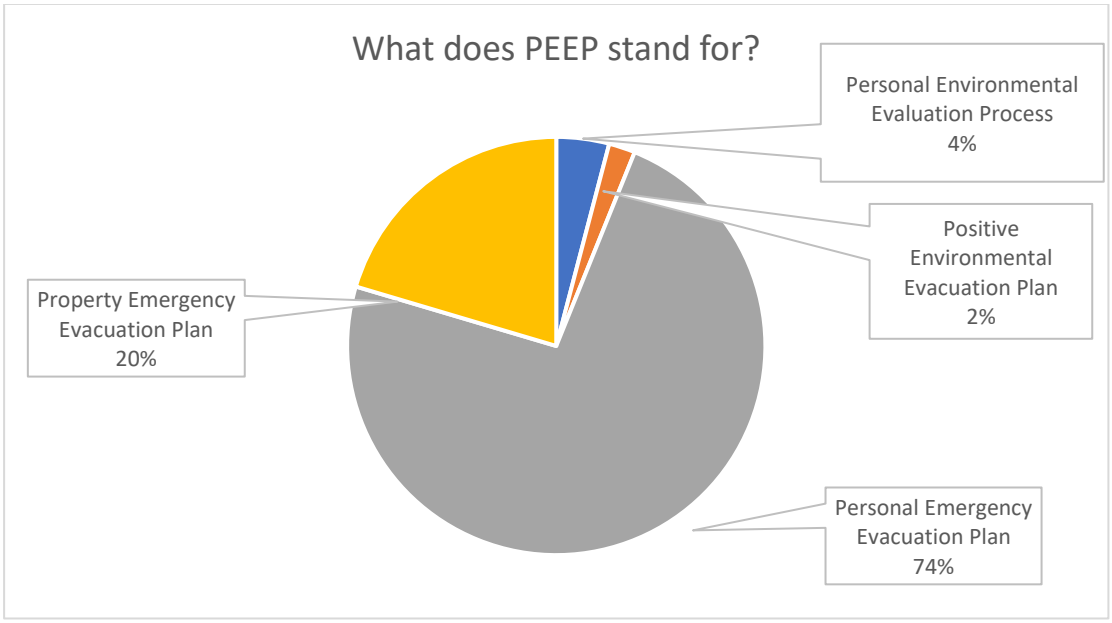
3.


What is a PCFRA?
Property Centred Fire Risk Assessment
12%
People Considered For Risk Assessment
12%
Person Centred Fire Risk Assessment
76%

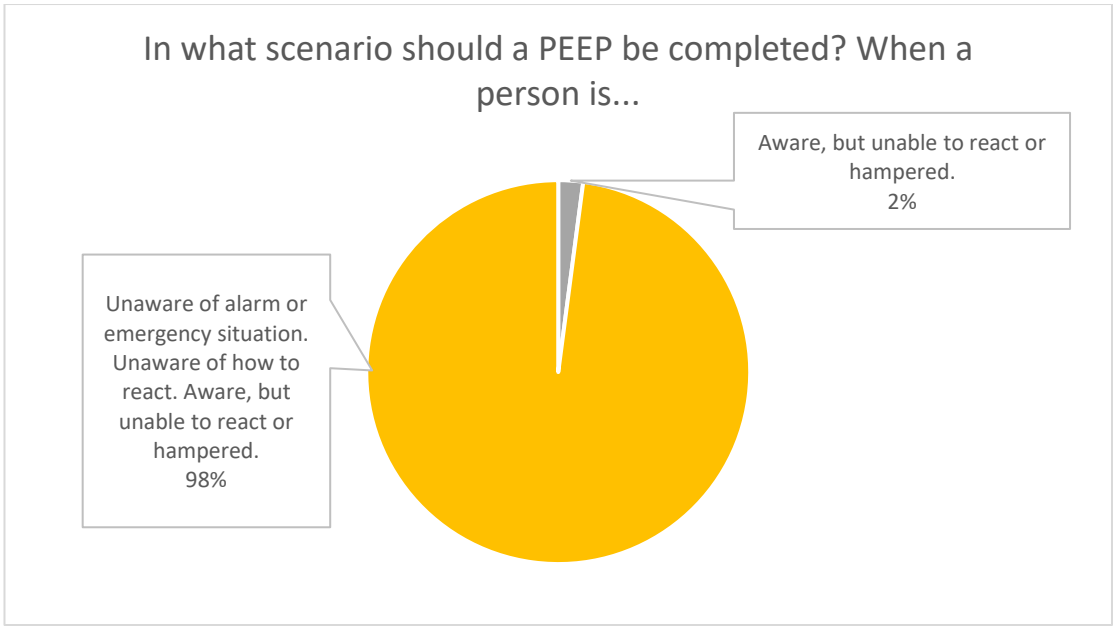
4.


What is the first element of a PCFRA?
Are there any smoke or heat alarms fitted within the individual's home? 17%
Would the individual be less able to react to an alarm or fire? 36%
Does the individual have an increased fire risk? 26%
Does the individual have a reduced ability to escape? 21%

5.


What does PEEP stand for?
Personal Environmental Evaluation Process 4%
Positive Environmental Evacuation Plan 2%
Property Emergency Evacuation Plan 20%
Personal Emergency Evacuation Plan 74%

6.



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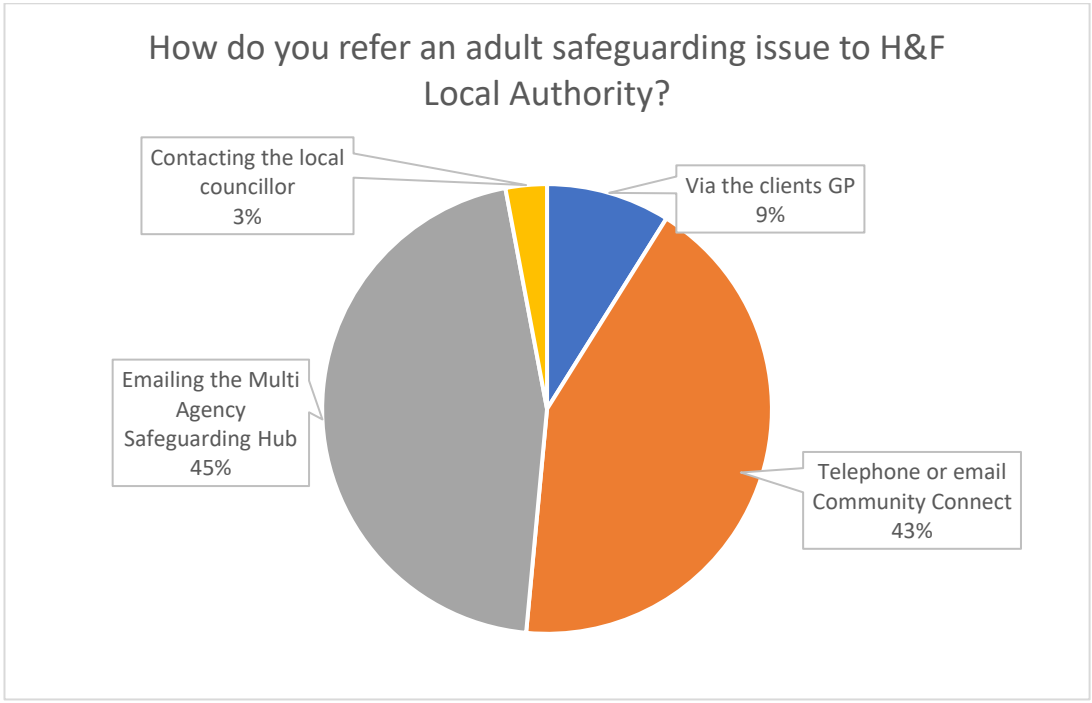
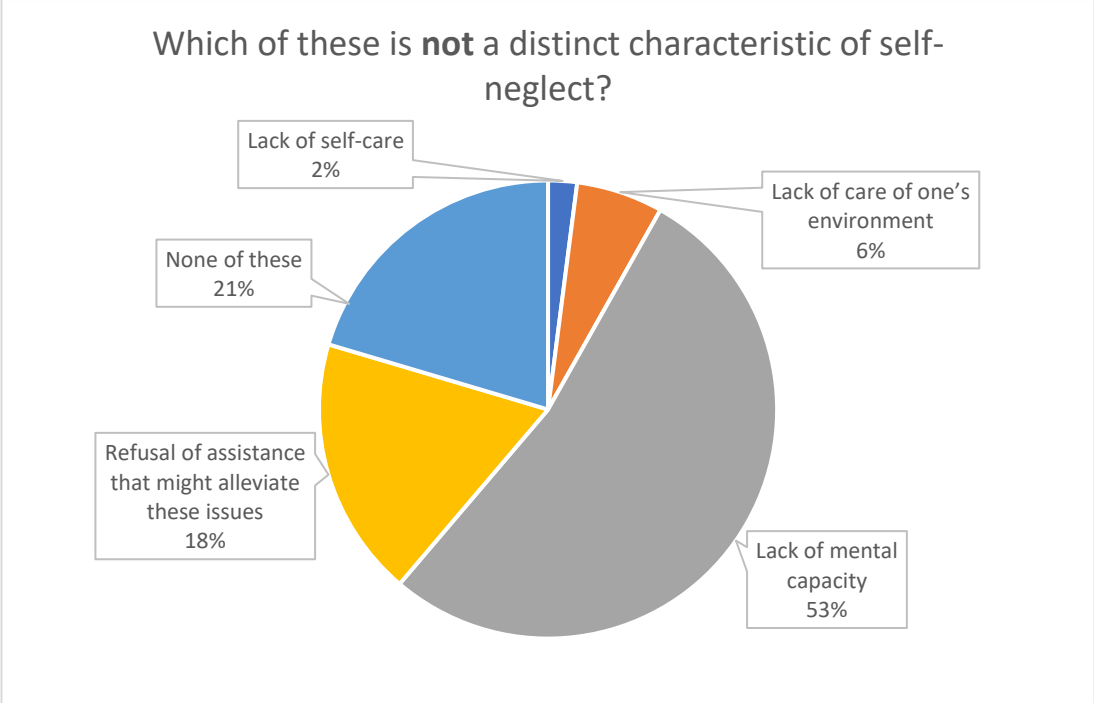
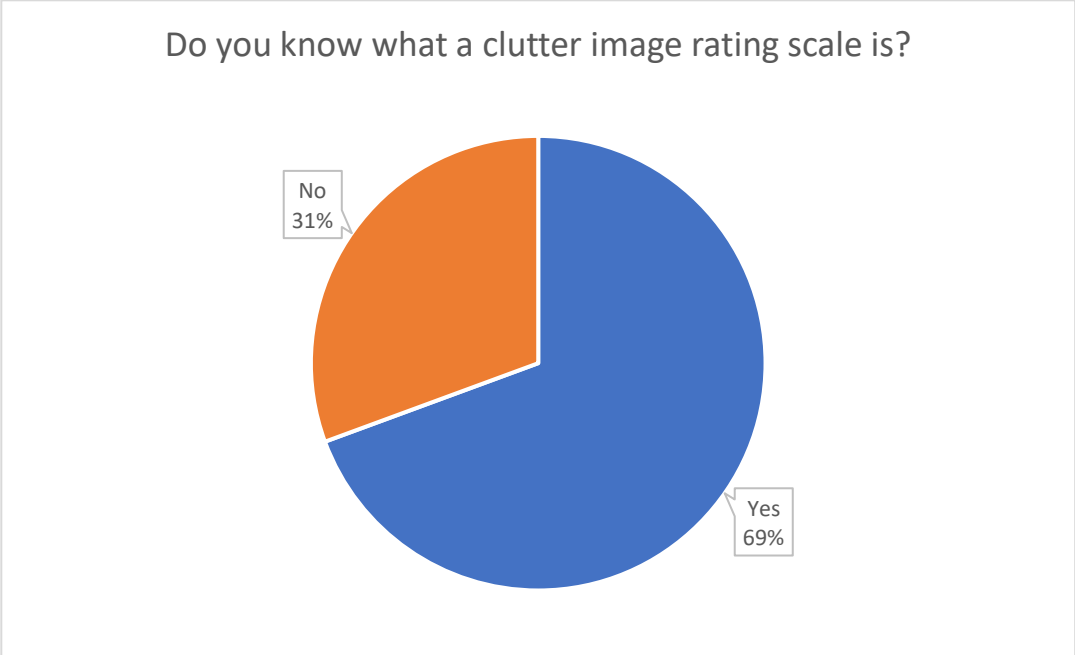


*To note: those that chose GP/local councillor also selected at least one of the correct choices

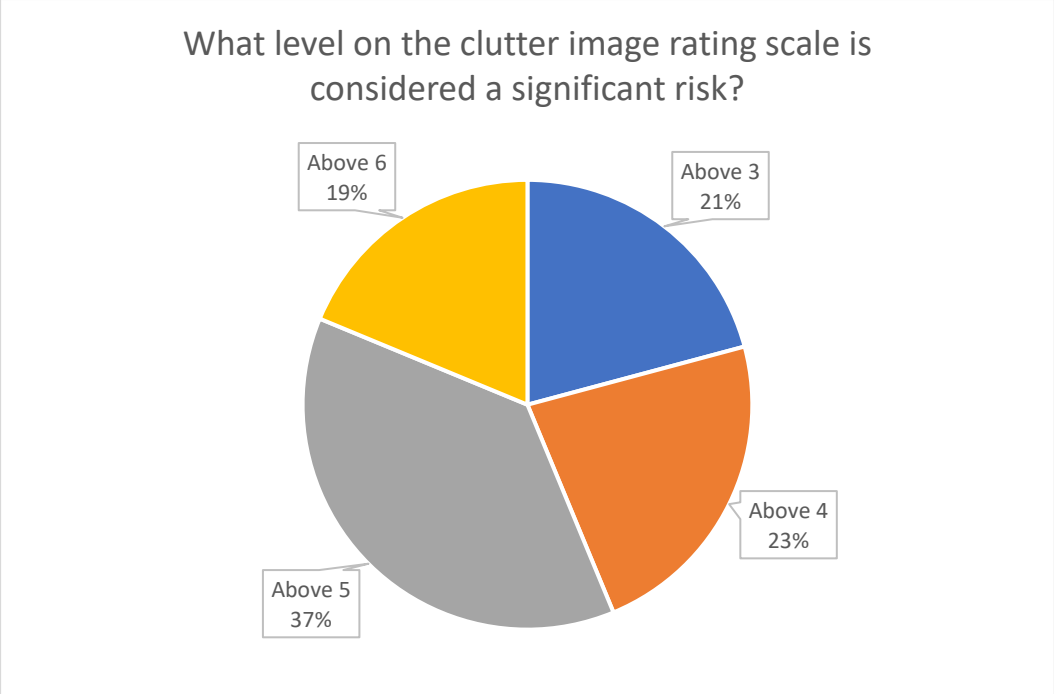
8.


Which of these is **not** a distinct characteristic of self-neglect?
Lack of self-care 2%
Lack of care of one's environment 6%
None of these 21%
Refusal of assistance that might alleviate these issues 18%
Lack of mental capacity 53%

9.


Do you know what a clutter image rating scale is?
No 31%
Yes 69%

10.



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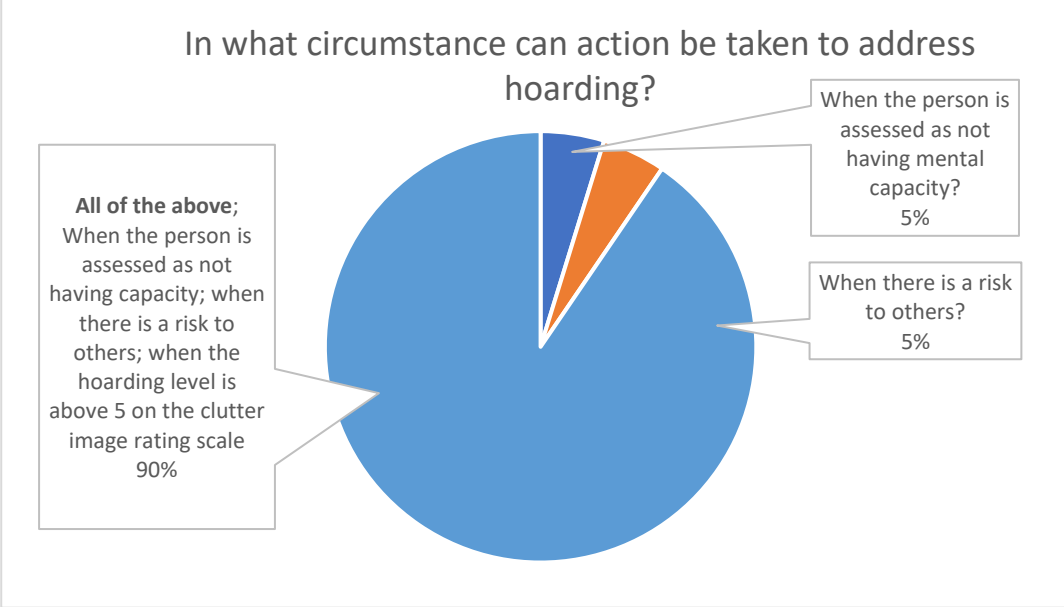
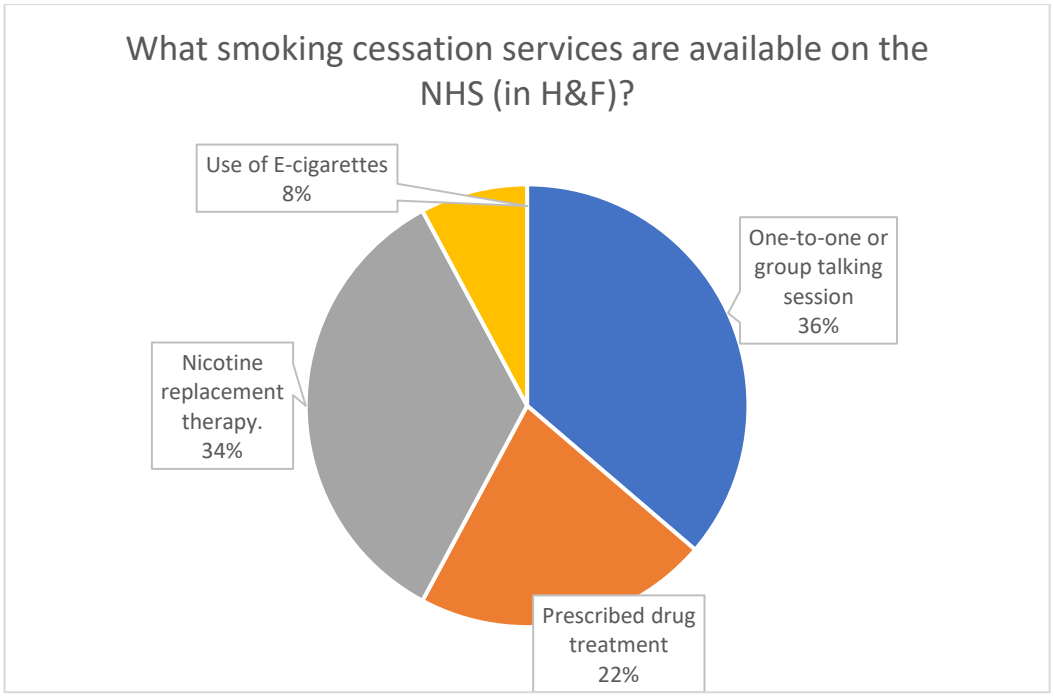
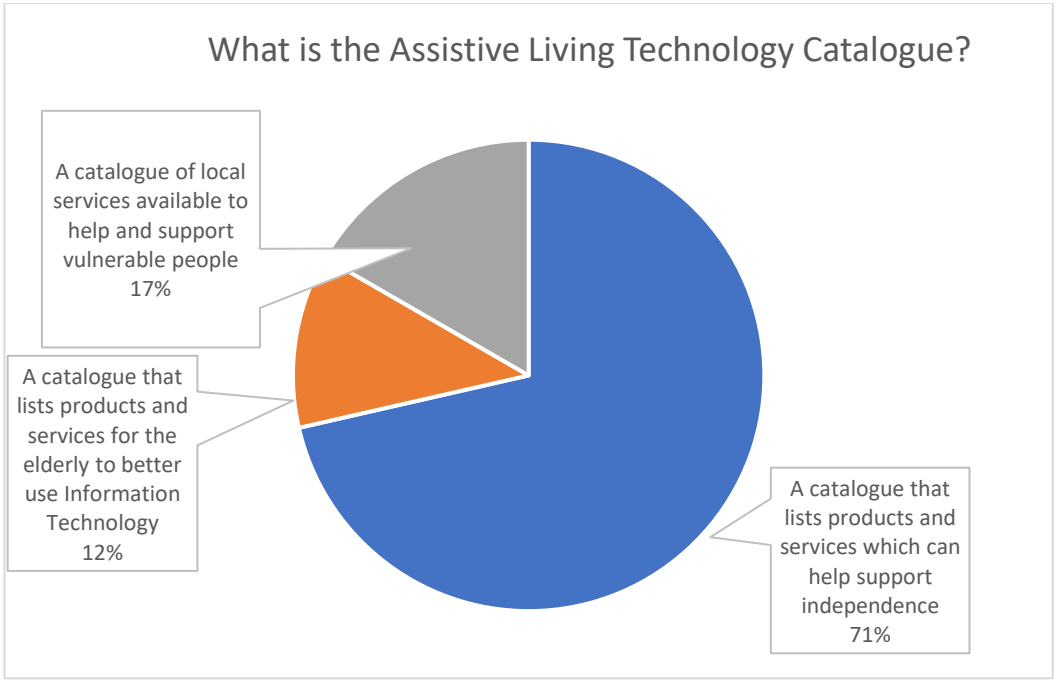


To Note: This only includes responses from Session 1. Session 2 attendees were given answer without poll question being launched.

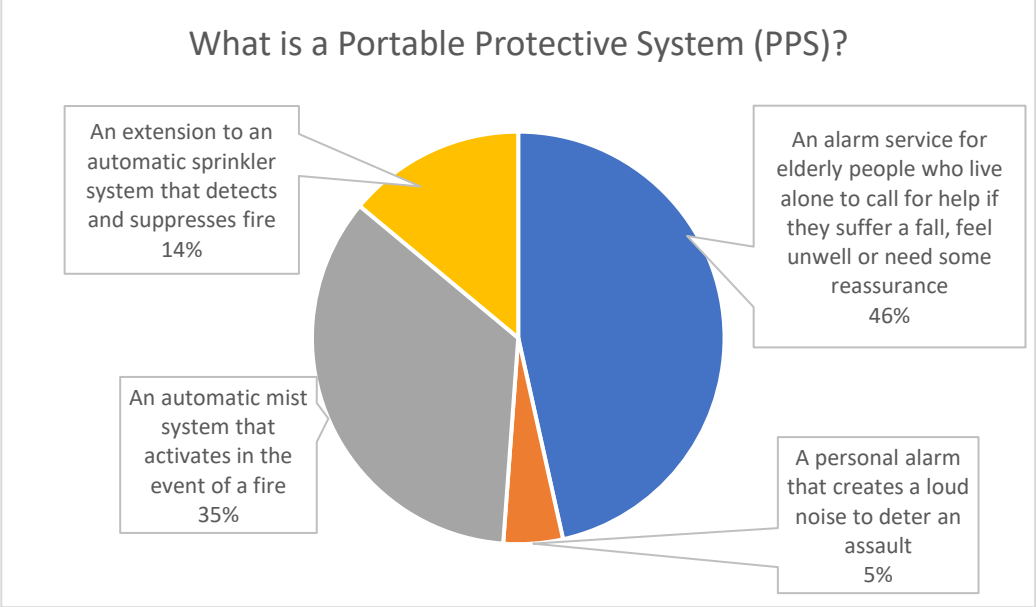
12.


What smoking cessation services are available on the NHS (in H&F)?
Use of E-cigarettes 8%
One-to-one or group talking session 36%
Nicotine replacement therapy. 34%
Prescribed drug treatment 22%

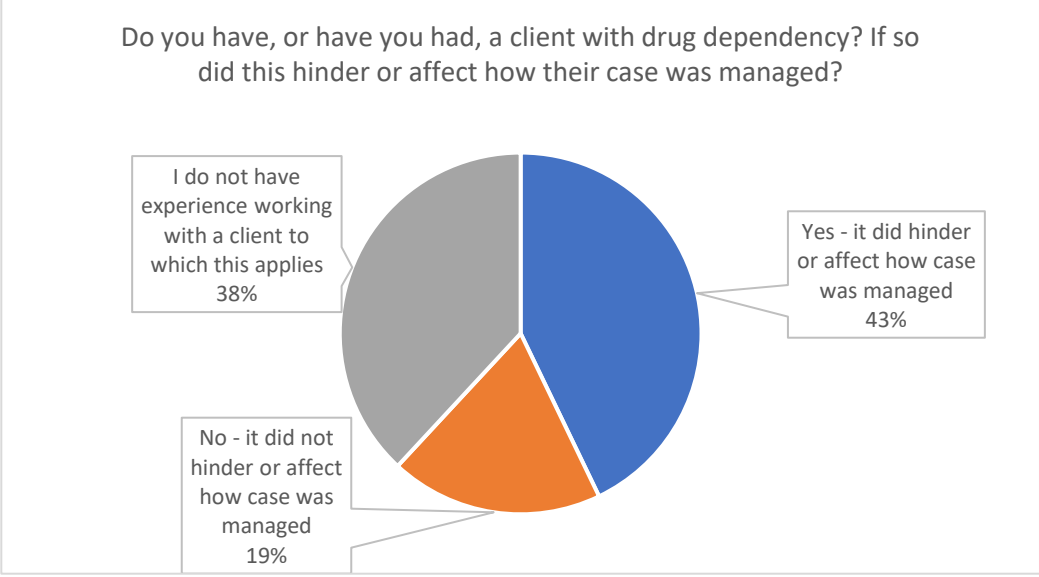
13.


What is the Assistive Living Technology Catalogue?
A catalogue of local services available to help and support vulnerable people 17%
A catalogue that lists products and services for the elderly to better use Information Technology 12%
A catalogue that lists products and services which can help support independence 71%

14.


What is a Portable Protective System (PPS)?
An extension to an automatic sprinkler system that detects and suppresses fire 14%
An alarm service for elderly people who live alone to call for help if they suffer a fall, feel unwell or need some reassurance 46%
An automatic mist system that activates in the event of a fire 35%
A personal alarm that creates a loud noise to deter an assault 5%

15.


Do you have, or have you had, a client with drug dependency? If so did this hinder or affect how their case was managed?
I do not have experience working with a client to which this applies 38%
Yes - it did hinder or affect how case was managed 43%
No - it did not hinder or affect how case was managed 19%

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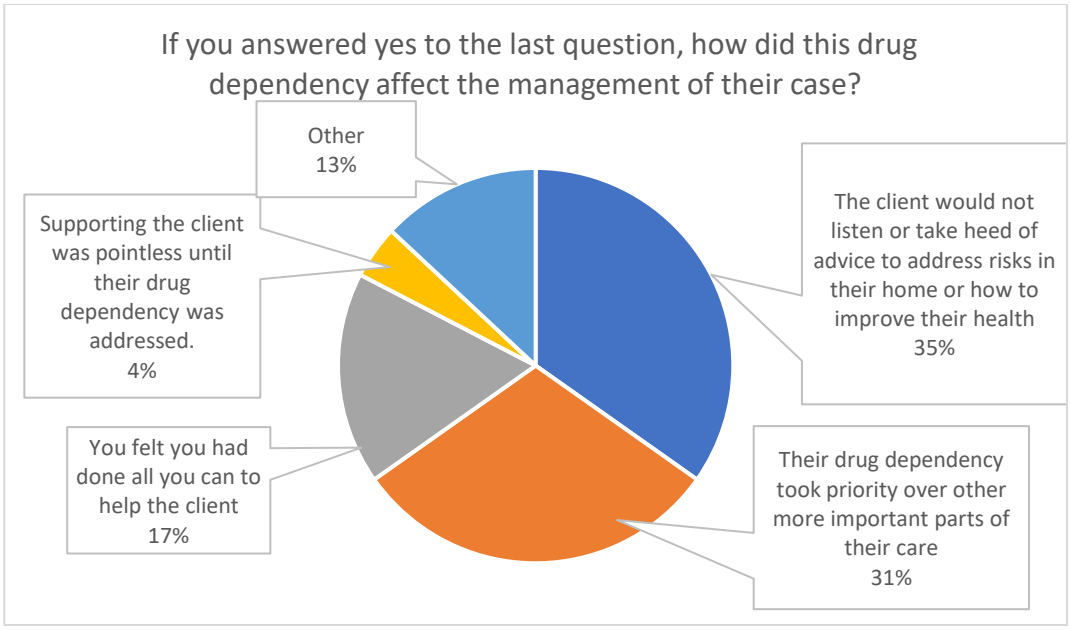
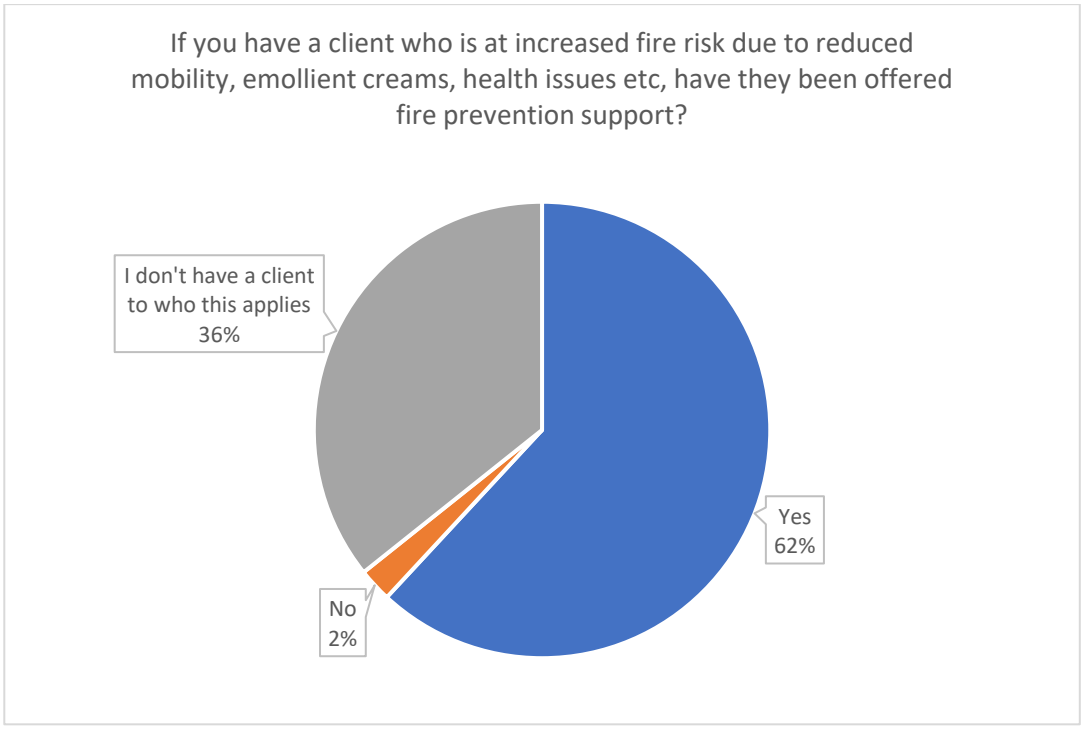


Note: respondents may have selected more than one

17.



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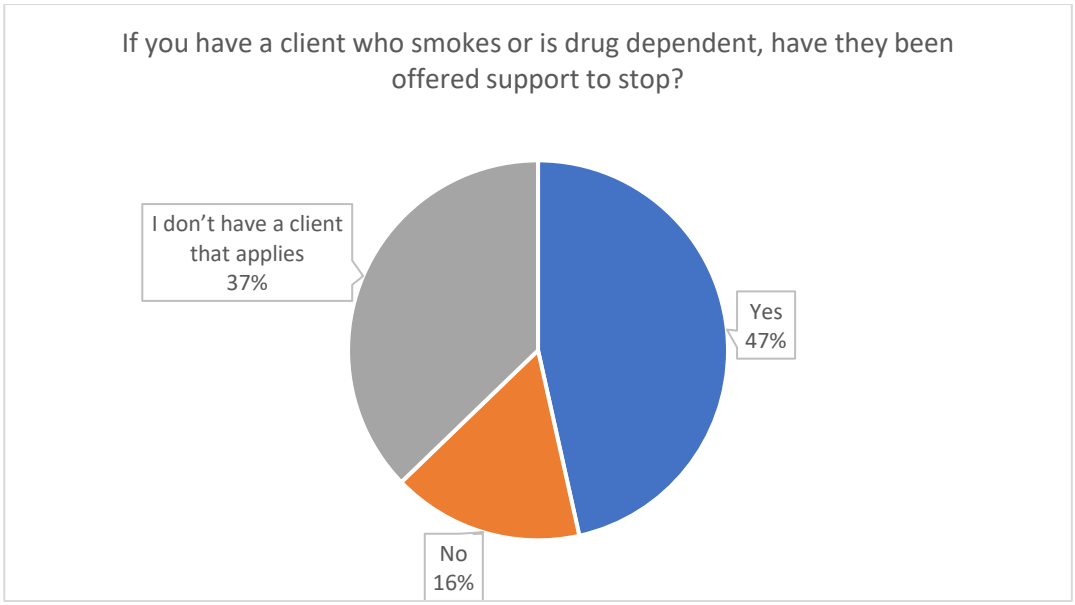
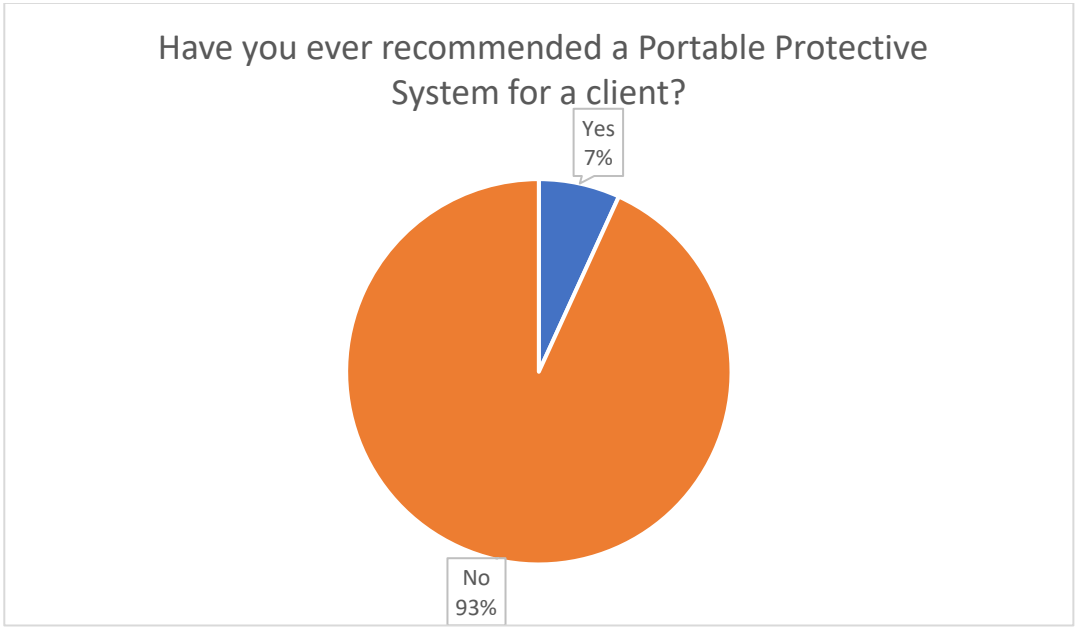
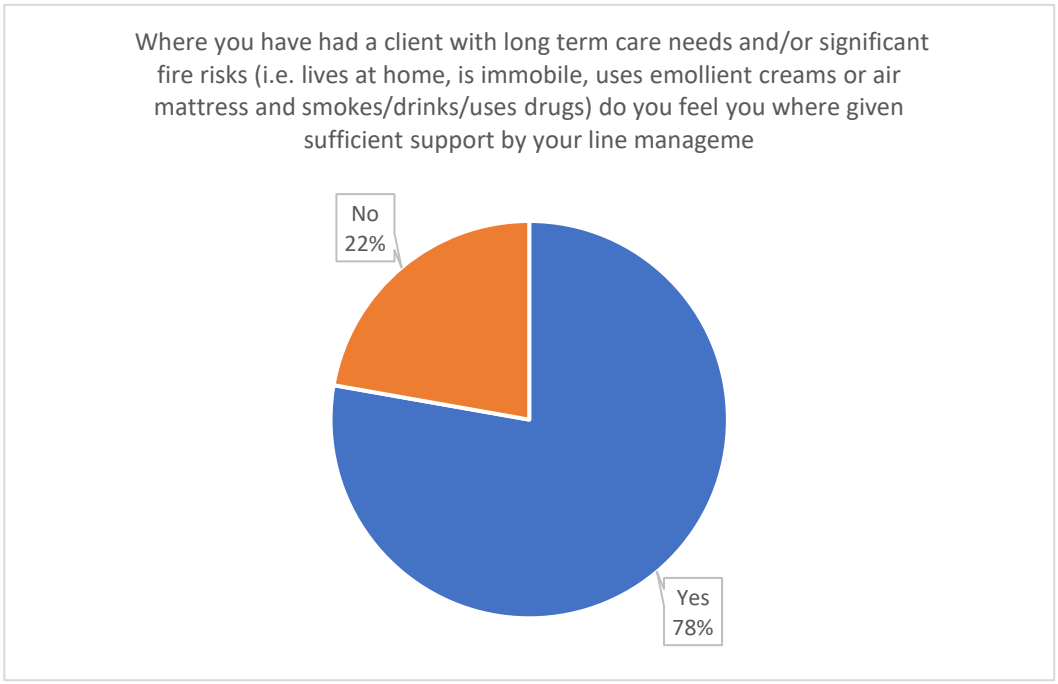

If you have a client who smokes or is drug dependent, have they been offered support to stop?
I don't have a client that applies 37%
Yes 47%
No 16%

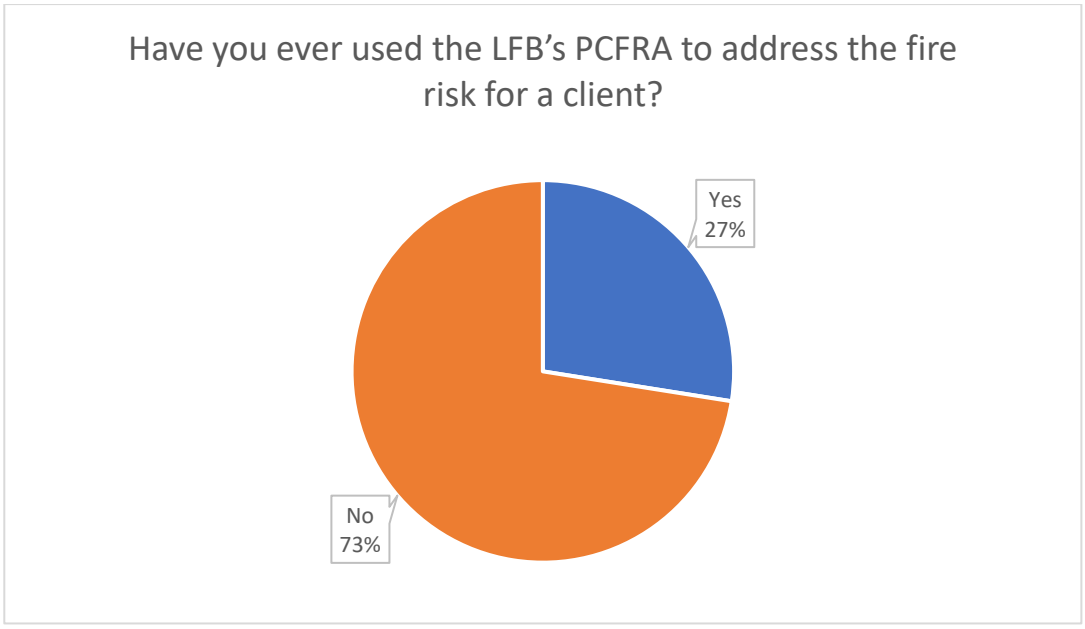
19.


Have you ever recommended a Portable Protective System for a client?
Yes 7%
No 93%

20.


Where you have had a client with long term care needs and/or significant fire risks (i.e. lives at home, is immobile, uses emollient creams or air mattress and smokes/drinks/uses drugs) do you feel you where given sufficient support by your line manageme
No 22%
Yes 78%

21.


Have you ever used the LFB's PCFRA to address the fire risk for a client?
Yes 27%
No 73%

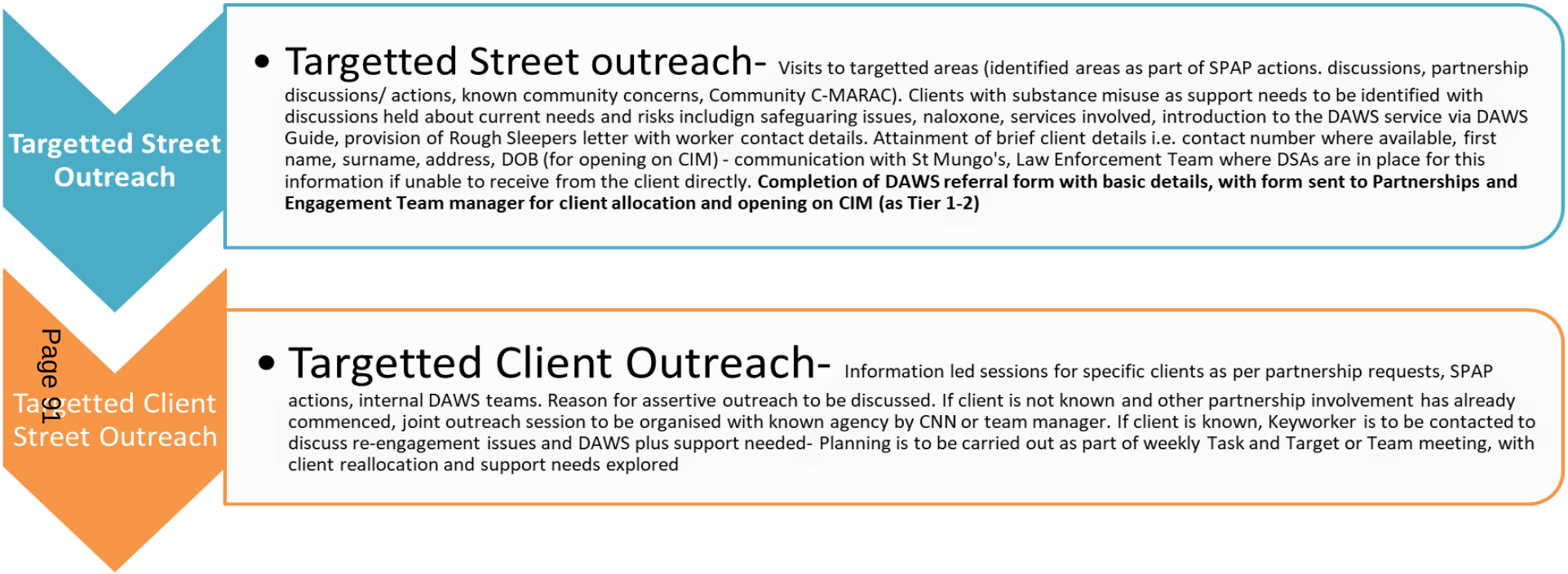
Appendix 2 DAWS Plus Assertive Engagement

Introduction/ Aims:

DAWS plus work as a dedicated outreach team, working alongside partner agencies within the Hammersmith and Fulham area, with the overall aims to support more reach of clients, raise insight into a client's own use, provide harm reduction support to ensure clients are able to make informed decisions about whether or not to engage in treatment and support. We use the assets of the client and local community to reinforce permanent change and support sustained recovery, via:

1. **Change Resistant Clients-** Joint action plan and intensive community support depending on client needs, using joint service approach where possible to have a 3way conversation with the client holding harm reduction discussions, provide the service guide and introduction to treatment, discuss what engagement would look like, check injecting sites and other harms and ensure link to health services, work with referrer to support client into treatment in a scaled way, offer community key-working and support to bring treatment to the client if barriers are in place. Address social barriers including housing, employment and other areas that may be hindering the client's engagement
2. **Street Outreach-** Targeted areas as identified during weekly **DAWS Plus Task and Target** meetings, **Street Population Action Partnership (SPAP)** monthly meetings and as requested from **St Mungo's Outreach** Team, **Rough Sleepers and Mental Health Programmes** Team and **H&F Law Enforcement** Team. Work with Peer Needle Exchange Lead and Get Connected Team Coordinator to ensure notification of street areas where high levels of needle use have been identified for additional

harm reduction outreach sessions, arrangement of litter picking or support/ signposting around community needle exchange requirements. Use of **DAWS Plus Useful Numbers** where additional support needs have been identified



3. **Case Management-** Support client once referral is accepted, by tailoring engagement according to need. This includes offering within 2-week window:
    i. Assessment
    ii. Harm Reduction
    iii. Support from our clinical team
    iv. Key-working/ casework

v. Signposting and referring to additional recovery/ wellbeing support services within DAWS/ the CGL Alcohol Service
vi. Digital recovery packages
vii. Provide naloxone, locked boxes for medication, needle exchange.

4. **Support to Community Outreach/ Hostel teams-**
    - Consultation and support to staff on casework issues. Support in bringing clients with multiple needs into treatment
    - Substance Misuse Training
    - Naloxone Training and supply to staff and service users
    - Street outreach to any potential resident who needs extra support and treatment to take up their bed
    - . Provision of sharps bins and safe storage boxes
    - Intensive engagement of clients identified as part of hostel bed-list meetings, guided by Partnerships and Engagement Team Manager

5. **DAWS Plus Team Role/ Support Outline**

DAWS+ Wellbeing Workers:

- Building therapeutic relationships with clients
- Advocating on the client's behalf
- Onward signposting to appropriate services
- Completing referrals to appropriate services
- Attending Appointments with clients
- Coordinate client care where appropriate
- **Joint working to support client in**

Report on Vaccination Services in the London Borough of Hammersmith & Fulham

Prepared by: NHSE (London) Immunisation Commissioning Team, North West London Integrated Care Board & Hammersmith & Fulham Public Health Team.

Presented to: Hammersmith & Fulham's Health and Adult Social Care Policy and Accountability Committee

November 2023

Contents

Aims

This paper provides an overview of Section 7a vaccination programmes in the London Borough of Hammersmith & Fulham (H&F). It covers vaccine uptake and an account of what NHS England (NHSE) London region and system partners are doing to improve this.

The paper focuses on childhood vaccinations, but data is included where pertinent on the wider schedule.

Members of the H&F Health Scrutiny Committee are asked to note and support the work that system partners across London, including NHSE London, the Local Authority (LA), and the Integrated Care Board (ICB) are doing to increase vaccination uptake in H&F.

Background

The World Health Organisation (WHO) states that vaccinations are one of the public health interventions that have had the greatest impact on the world's health. Vaccination is also one of the most cost-effective public health interventions. High immunisation rates are key to preventing the spread of infectious disease, protecting from complications and deaths. Childhood immunisation in particular helps to prevent disease and promote child health from infancy, creating opportunities for children to thrive and get the best start in life.

Section 7a vaccination programmes are population-based, publicly funded immunisation programmes that cover the life course and include:

- Routine childhood vaccination programme for 0-5 years
- School-age (young person) vaccinations
- Adult vaccinations (including in pregnancy and older age)
- Seasonal COVID-19/flu vaccination programme

The full immunisation schedule can be found in the Green Book and as a summary table here. Changes to this schedule are regularly reviewed and recommendations are made at the UK Joint Committee on Vaccination and Immunisation (JCVI).

The European region of the WHO currently recommends at least 95% of children are immunised against diseases preventable by vaccination and targeted for elimination or control, specifically, diphtheria, neonatal tetanus, pertussis, polio, Haemophilus influenzae type b (Hib), hepatitis B, measles, mumps, and congenital rubella.

There is an expectation that UK coverage rates of all routine childhood vaccinations up to 5 years of age achieve 95%.

Roles and responsibilities

The Department of Health and Social Care (DHSC) provides national strategic oversight of vaccination policy in England, with advice from the independent JCVI and the Commission on Human Medicines. They also set performance targets.

NHSE is responsible for commissioning national vaccination programmes in England under the terms of the Section 7a agreement, National Health Service Act 2006. NHSE is accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. NHSE is also responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required. A summary table of NHSE responsibilities can be found at appendix 2.

The UK Health Security Agency (UKHSA) undertakes surveillance of vaccine-preventable diseases and leads the response to outbreaks of vaccine-preventable diseases. They provide expert advice to NHSE immunisation teams in cases of vaccination incidents.

Integrated Care Systems (ICSs) have a duty of quality improvement, and this extends to primary medical care services. ICBs provide opportunities for improved partnership working across NHSE (London), local authorities, voluntary and community sector partners to improve vaccination uptake and reach underserved areas and populations. NHSE (London), alongside ICBs, local authorities and others, will work to progress delegated commissioning for vaccination and screening.

LA public health teams deliver population health initiatives including improving access to health and engagement and promotion of vaccinations overall.

Pre-school and adult vaccinations are usually delivered by GP surgeries. They are commissioned through the NHS GP contract. Five core GP contractual standards have been introduced to underpin the delivery of vaccination services: a named lead, provision of sufficient convenient appointments, standards for call/recall programmes and opportunistic vaccination offers, participation in nationally agreed catch-up campaigns, and standards for record-keeping and reporting. One of the five Quality and Outcomes Framework (QOF) domains is childhood vaccinations and shingles vaccination, rewarding GP practices for good practice.

School-age vaccinations are commissioned by the seven regional NHSE teams and delivered through school age immunisation services (SAIS).

Vaccinations are also provided by maternity services, some outreach services, and community pharmacies.

Inclusion and Equity

The challenge is not just overall immunisation coverage but the variation in coverage across groups, which can increase the likelihood of preventable outbreaks locally. Groups with lower coverage include migrants, urban communities, more deprived communities, and certain ethnic groups.

People migrating to the UK may originate from countries that have different vaccination schedules or lower vaccination rates overall. Individuals may also have missed vaccinations in the country of origin or missed opportunities for vaccination after arrival to the UK.

National vaccine coverage varies geographically, with lower coverage in urban areas and London, compared to England as a whole.

At a national level, there are some small inequalities by socioeconomic status, with coverage being slightly lower in lower socio-economic groups.

For the routine childhood vaccinations, there is no simple relationship between ethnicity and coverage. The relationship varies by immunisation programme and by area. However, coverage in certain ethnic groups does appear to be lower than in white-British children, for example, black Caribbean, Somali, white Irish, and white Polish populations. Some ethnic groups, notably South Asian ethnicities, have broadly similar and sometimes higher vaccination coverage than white children. For MMR (measles, mumps and rubella) these relationships are less consistent, in that coverage in children of white ethnicity could be lower or the same as other non-white groups, thought to perhaps reflect differences with respect to awareness of the MMR controversy.

H&F have undertaken a childhood immunisation joint strategic needs assessment[1]. This report included Child Health Information Service (CHIS) data from the borough demonstrating lower % uptake of childhood vaccination in African and Caribbean ethnic groups. Certain vaccinations such as MMR, suffered low rates of uptake across most ethnic groups. It was also recognised that deprivation impacts vaccination uptake, which has many overlaps with ethnicity and socioeconomic factors.

National vaccination coverage

Overall, coverage for most vaccines in England is high and comparable with other high-income countries although there has been a small but steady decline in the last few years. Nationally, in 2021-2022, vaccine coverage decreased by 0.2% to 1.1% depending on the vaccine. No vaccines met the 95% target. Coverage for the 6-in1 vaccine amongst children 5 years of age (measured at

[1] Childhood Immunisation JSNA January 2021 London Borough of Hammersmith and Fulham, H&F childhood immunisation report - January 2021 (lbhf.gov.uk)

this age to allow time for ‘catch-up’ of missed doses earlier in life) decreased from 95.2% in 2020-21 to 94.4% in 2021-22.

Regional vaccination coverage

Historically and currently, London performs lower than the national (England) average across all the immunisation programmes. Uptake in London has also fallen over the past 6 years and has fallen further than elsewhere in the country.

Every borough in London is below the 95% WHO target. For some vaccines such as MMR, all London boroughs have an uptake below 90%. Two-thirds of all measles cases in 2023 in England were in London.

London has a highly mobile population, a large migrant population, and areas of high deprivation. In London, vaccine uptake is lower in areas of higher deprivation compared with areas of low deprivation across all ethnicities.

Local vaccination coverage

The focus of this report is childhood vaccinations (for children 0-5 years old) but data is also included on key aspects of school-age, prenatal, older adult and seasonal programmes.

Routine childhood immunisation programme (0-5 years)

The routine childhood immunisation programme for 0-5 years can be found at appendix 1. Coverage data for the country, region, ICB and local authorities (LAs) within North West London (NWL) is presented in table 1.

Overview of COVER data for NWL at 2023-24 Q1

Immunisation	England	London	NWL	Brent	Ealing	Hammersmith and Fulham	Harrow	Hillingdon	Hounslow	Kensington and Chelsea	Westminster
12m_DTaPIPVHibHepB	↓ 91.5%	↓ 86.7%	↓ 85.5%	↓ 85.7%	↓ 90.3%	↑ 82.9%	↓ 84.9%	↑ 90.3%	↓ 85.7%	↓ 70.1%	↑ 84.5%
12m_MenB	↓ 91.2%	↓ 86.4%	↑ 85.8%	↓ 85.2%	↓ 89.7%	↑ 83.4%	↓ 84.4%	↑ 91.0%	↑ 86.3%	↓ 72.0%	↑ 87.4%
12m_PCV1	↓ 93.6%	↓ 89.4%	↓ 90.2%	↓ 91.0%	↓ 92.9%	↑ 88.1%	↓ 89.4%	↑ 94.4%	↑ 91.1%	↓ 77.3%	↑ 89.8%
12m_Rota	↓ 88.7%	↓ 83.8%	↓ 83.9%	↓ 84.1%	↓ 87.9%	↓ 80.0%	↓ 82.0%	↑ 90.3%	↓ 84.2%	↓ 70.1%	↑ 83.3%
24m_DTaPIPVHibHepB	↓ 92.8%	↑ 88.9%	↑ 90.2%	↑ 88.2%	↑ 92.5%	↓ 88.8%	↑ 89.7%	↓ 90.2%	↑ 91.3%	↑ 89.1%	↑ 89.6%
24m_HibMenC	↑ 89.5%	↑ 82.7%	↑ 84.4%	↑ 84.6%	↑ 87.3%	↓ 80.2%	↓ 83.8%	↑ 90.6%	↑ 85.8%	↓ 72.9%	↑ 79.5%
24m_MenBBooster	↓ 88.1%	↓ 81.1%	↑ 81.3%	↑ 81.5%	↑ 84.1%	↓ 77.3%	↓ 81.4%	↑ 87.5%	↑ 81.8%	↓ 68.0%	↑ 79.7%
24m_MMR1	↓ 89.5%	↑ 83.1%	↑ 85.2%	↑ 86.3%	↑ 87.6%	↓ 80.2%	↓ 85.3%	↑ 90.3%	↑ 85.3%	↓ 75.3%	↑ 83.3%
24m_PCVBooster	↓ 89.0%	↓ 81.9%	↑ 83.5%	↑ 83.6%	↑ 86.7%	↓ 79.9%	↓ 83.2%	↑ 87.1%	↑ 84.5%	↓ 74.4%	↑ 81.2%
5y_DTaPIPV	↓ 82.8%	↓ 72.8%	↓ 75.3%	↓ 75.8%	↓ 79.0%	↑ 72.0%	↓ 74.1%	↑ 83.5%	↓ 78.2%	↓ 59.4%	↓ 65.1%
5y_DTaPIPVHib	↓ 93.1%	↓ 88.0%	↓ 87.1%	↑ 87.6%	↓ 88.9%	↑ 86.9%	↓ 87.5%	↑ 89.9%	↓ 85.6%	↓ 84.0%	↓ 81.9%
5y_HibMenC	↓ 90.5%	↓ 83.9%	↓ 84.5%	↑ 86.0%	↓ 84.4%	↑ 84.0%	↓ 84.7%	↓ 88.6%	↓ 84.4%	↑ 79.9%	↓ 77.0%
5y_MMR1	↓ 92.5%	↓ 86.1%	↓ 86.7%	↑ 87.0%	↓ 86.5%	↑ 86.1%	↓ 87.3%	↓ 90.2%	↓ 88.1%	↓ 82.1%	↓ 79.8%
5y_MMR2	↓ 83.9%	↓ 73.1%	↓ 74.1%	↓ 74.7%	↓ 77.3%	↓ 69.0%	↓ 74.2%	↑ 82.4%	↓ 75.6%	↓ 60.5%	↓ 63.4%

Key

>90% coverage

80-90% coverage

<80% coverage

↑ Increase from 2022-23 Q4

↓ Decrease from 2022-23 Q4

Table 1: Overview of 'cover of vaccination evaluated rapidly' (COVER) data for NWL ICB and LAs. *Source: UKHSA COVER quarterly data*
Cover of vaccination evaluated rapidly (COVER) programme 2022 to 2023: quarterly data - GOV.UK (www.gov.uk)

For almost all childhood immunisations (except for Hib MenC and MMR1 in 5-year-olds, as compared to London) H&F have lower coverage than both the London and NWL ICB average.

In the most recent data for Quarter 1 2023/24 (April – June 2023) there was a decreasing trend in coverage across all childhood vaccinations as measured at 24 months of age compared to Quarter 4 2022/23, but improving trends in coverage measured at 12 months of age for most vaccinations (except rotavirus) and 5 years of age (except for MMR2)

Decline in MMR1 coverage at 24 months may be (as has been suggested by parents locally) due to ongoing (incorrect) perceptions of a link between MMR vaccination and autism. There is then a recovery for the 5 year cohort for MMR1 as parents are waiting until children reach certain developmental points (where autism is generally diagnosed) and then deciding to bring them in for vaccination. Hammersmith and Fulham sees an increase of nearly 6% when comparing dose 1 of MMR at 24 months compared to dose 1 at 5 years.

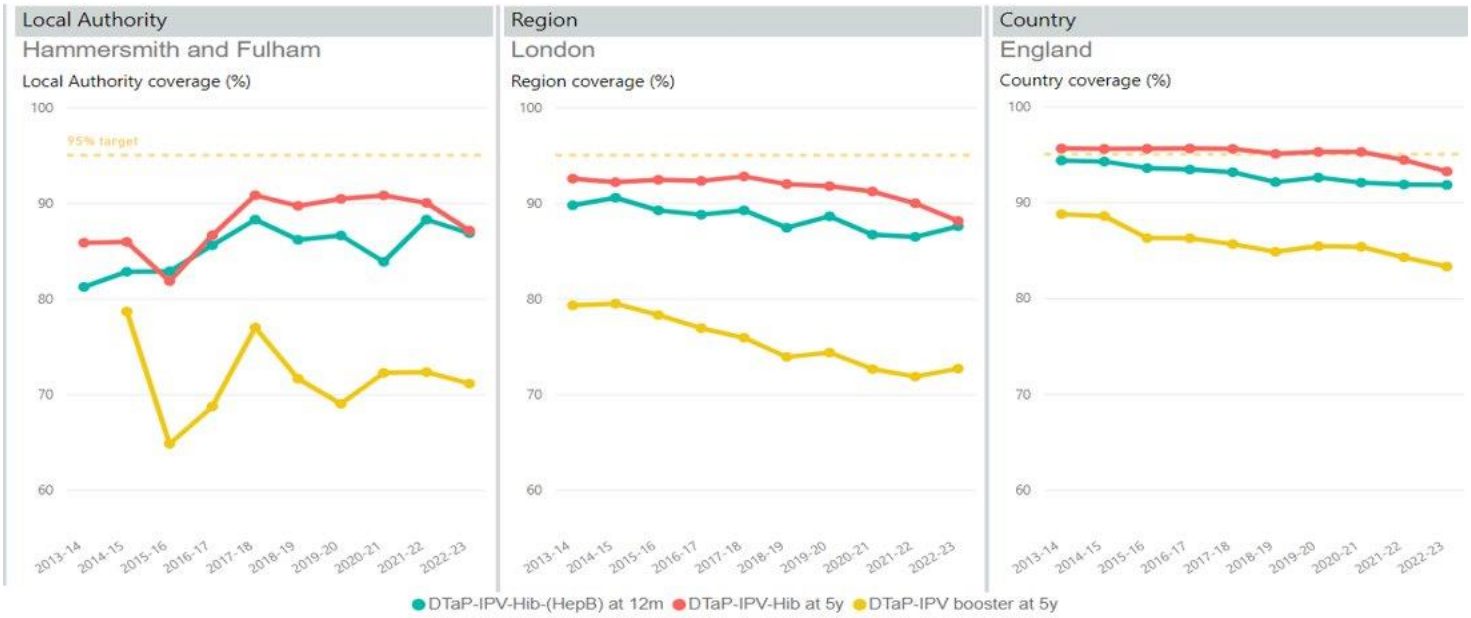


Figure 1: DTaP-IPV-Hib-HepB coverage (%) for Hammersmith & Fulham, London and England over time from 2013-14 to 2022-23. *Source: NHSE Childhood Vaccination Coverage Statistics.*

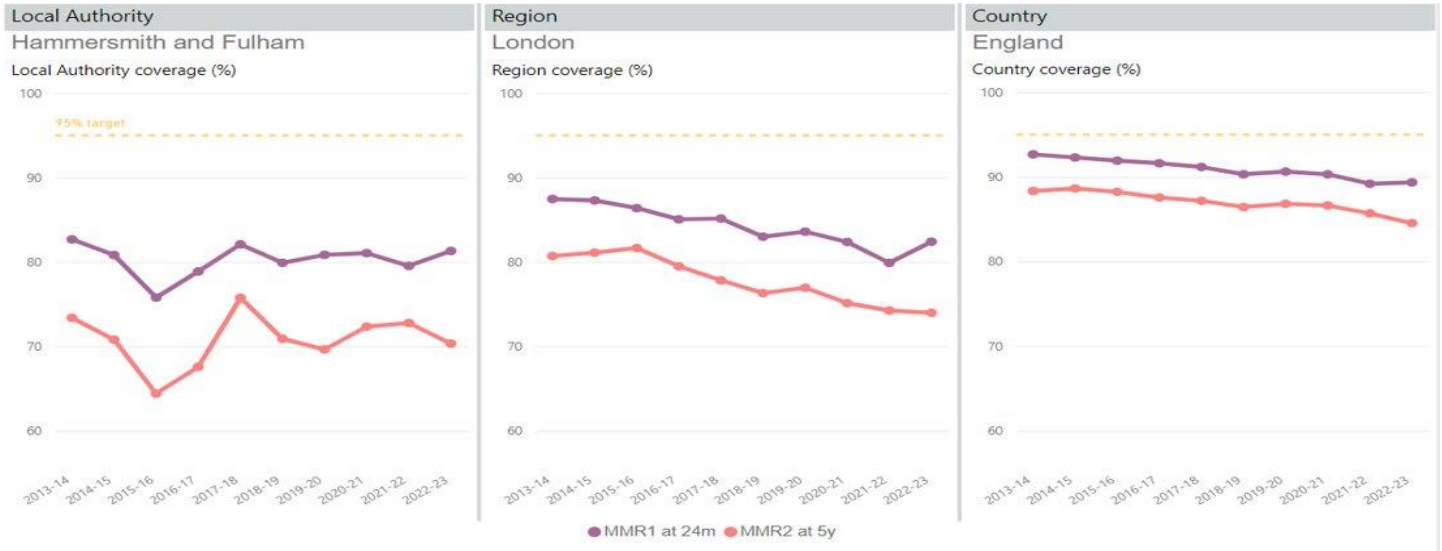


Figure 2: Measles, mumps & rubella (MMR) vaccination coverage for Hammersmith & Fulham, London and England over time from 2013-14 to 2022-23. *Source: NHSE Childhood Vaccination Coverage Statistics. (note: there was a change in child health information service (CHIS) providers in 2017/18 which may have led to the anomalous change in that year)*

Annual time trend information for selected vaccinations where there is a particular focus due to the current risk of outbreaks of disease (particularly measles and polio) are presented above (figures 1 and 2).

The coverage of MMR1 (1st dose) in 24-month-olds in Hammersmith & Fulham has increased since 2021/22 in a similar pattern to that in London but remains below both the London and national average. MMR2 (2nd dose) coverage of 5-year-olds however remains low, the position has deteriorated over the last year and is below that of both London and England.

It should also be noted that a drop in apparent coverage of the pre-school booster (PSB) and MMR2 may be in part due to the polio phase 1 vaccination campaign and this is being replicated across London as children who are now due their pre-school booster (PSB) are having to wait a year between their extra dose of polio-containing vaccine administered during the campaign and receiving their PSB.

Vaccinations for school-age young people

Vaccinations in this group consist of:

- HPV vaccine offered to 12-13 year olds (since September 2019 boys receive the vaccine as well as girls).
- Tetanus, diphtheria, polio booster (teenage booster) at age 14/15
- Meningitis ACWY at age 14/15.
- Annual child 'flu vaccination programme which in 2023/24 covers:
    - Reception to Year 6 in primary schools.
    - Children aged 2 or 3 years on 31 August 2023 (born between 1 September 2019 and 31 August 2021)
    - Some secondary school aged children (Year 7 to Year 11)
    - Children aged 2 to 17 years with certain long-term health conditions

Local and regional data on the school aged routine schedule coverage is presented below in figure 3.

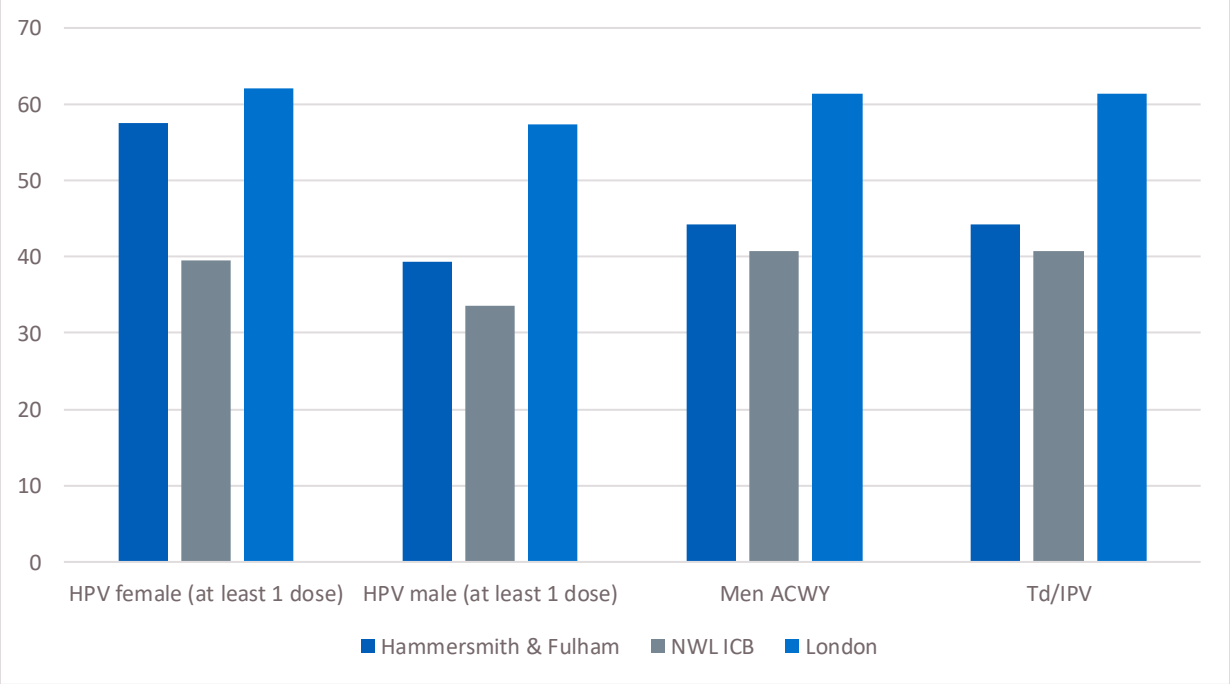


Figure 3: Percentage (%) eligible adolescents vaccinated September 2022 – August 2023 in Hammersmith & Fulham, NWL ICB and London. *Source: UKHSA 'ImmForm'[2].*

[2] ImmForm data is validated and analysed by the UKHSA to check data completeness, identify and query any anomalous data and describe epidemiological trends

H&F perform better on immunisations in this age group, as compared to the NWL ICB average, though less well than London as a whole.

Seasonal vaccinations

Influenza (flu)

- The national flu immunisation programme offers protection for those who are most vulnerable from increased risk of illness. It is important in ensuring flu associated morbidity and mortality is reduced to protect those most vulnerable, but it is also a critical part of reducing pressures on inpatient hospital stays during a time when the NHS and social care is under increased demand.
- The London Flu Plan reflects the ambitions of the national programme, in relation to the targeted patient cohorts and desired high vaccine uptake levels. It also refers to the key learning from previous flu immunisation and delivery of the COVID-19 vaccination programme.
- Vaccinations are provided free to those who are at increased risk from the effects of flu. The eligible cohorts are determined based on evidence and published in guidance from the JCVI.
- Considering changes in risk balance from a new COVID-19 variant, flu and COVID-19 vaccination for adults was brought forward for this year to start in September to maximise uptake of both vaccines.
- The latest available UKHSA published uptake data is for the 2022 flu season and performance for an illustrative selection of eligible groups is presented below in Table 2.
- Data for October 2023 vaccine uptake will be available on the ImmForm website by Wednesday 23 November 2023. Further information on available data and release dates can be found here.

	Percentage (%) vaccination uptake						
Geography	**65 and over**	**Under 65 (at-risk only)**	**All Pregnant women**	**50 to under 65 years and NOT in a clinical risk group**	**50 to under 65 years and IN a clinical risk group**	**All 2 year olds**	**All 3 year olds**
Hammersmith & Fulham	60.6	32.7	28.6	23.6	45.5	35.1	32.7
NWL ICB	71.0	43.9	35.8	30.6	55.6	38.4	37.2
London	68.3	40.9	29.9	27.0	53.1	38.2	37.7
England	79.9	49.1	35.0	40.6	60.4	42.3	45.1

Table 2: Provisional end of February 2023 cumulative percentage uptake data in GP patients for Hammersmith & Fulham, NWL ICB and England on influenza vaccinations

given from 1 September 2022 to 28 February 2023. *Source UKHSA Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 - GOV.UK (www.gov.uk)*

COVID-19

- A dose of the COVID-19 vaccine is being offered this autumn to people aged 65 and over, residents in care homes for older people, anyone aged 6 months and over in a clinical risk group, and health and social care staff.
- The autumn programme is targeted at those at high risk of the complications of COVID-19 infection, who may have not been vaccinated for a few months.
- Where people are eligible for a flu vaccine, there is an aim to enable co-administration where possible.
- COVID autumn booster uptake data can be found here.
- COVID vaccination uptake for H&F was at 22.92% as of 23/10/23, with 11,830 of the eligible population vaccinated.[3] Uptake for London at 23/10/23 was 26.0% and for NWL ICB 23.2%.

Vaccinations in pregnancy

Vaccinations in pregnancy consist of:

- Seasonal flu and COVID-19 vaccination
- Pertussis – aimed at providing protection for newborns – see Figure 4 for ICB and regional performance.

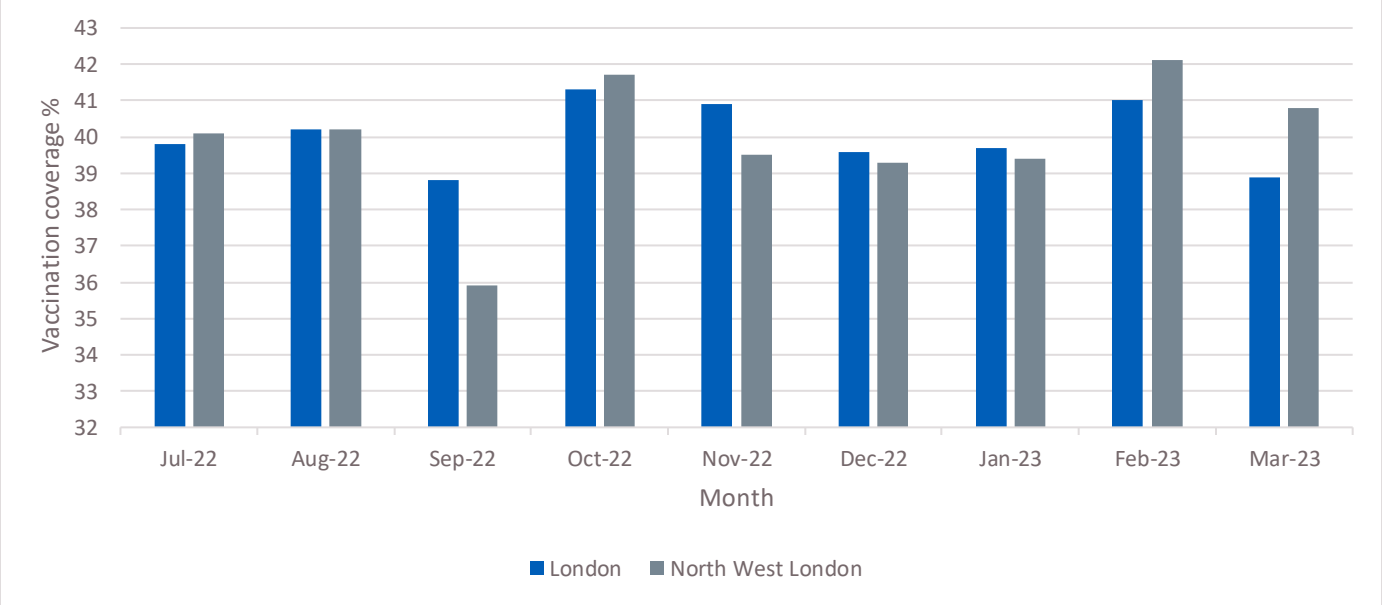


Figure 4: Prenatal Pertussis Vaccine Uptake 2022-23 - Monthly GP Collection. *Data Source: Pertussis immunisation in pregnancy: vaccine coverage (England) - GOV.UK (www.gov.uk)*

[3] Source: NHS Foundry

Other adult (older person) immunisations

Other adult immunisations consist of:

- Pneumococcal vaccine (PPV) at 65 years
- Influenza (covered in seasonal vaccinations) for 65 years and over
- Shingles – 65 years from September 2023 – Shingrix
- Shingles - 70-79 years (plus immunosuppressed) – Zostavax. Shingles uptake has traditionally been challenging nationally. Coverage from the last vaccination season was 54% for H&F for those turning 71 to 80 years old between 1 April 2022 and 31 March 2023 and vaccinated up to end of March 2023. This compares with 63% coverage for both NWL ICB and London as whole[4].

Data sources for local authority stakeholders

- The vaccinations and screening Future NHS page provides a range of vaccination dashboards for local use and can be accessed here: https://future.nhs.uk/vaccsandscreening/view?objectID=42174992

- In addition, there are interactive dashboards on the NHS Digital website on childhood vaccinations here: Childhood Vaccination Coverage Statistics, England, 2022-23 - NHS Digital

[4] *Source: Shingles vaccine coverage (England): report for quarter 2 of the financial year 2022 to 2023 - GOV.UK (www.gov.uk)*

Vaccination programme challenges

System

- COVID-19: pausing some programmes, redeployment of workforce and introduction of the COVID-19 vaccination programme.
- Complexities in data collection: some data is not recorded, not uploaded, not correctly cleansed, or the denominator population may not be up to date.
- Access to appointments: wider pressures on GP services and limited workforce.
- Inconsistent reminder systems- call/ recall.

Community

- London's high population mobility affects data collection and accuracy. There is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions. A 2017 audit showed that by the age of 12 months, 33% of infants moved address at least once.
- Large numbers of underserved populations who are associated with lower uptake of vaccinations than the wider population.
- Large migrant population who may not be registered or have their past immunisation history accurately recorded.

Individual

- Lack of trust or confidence in vaccines or other health service or complacency.
- Saturation of vaccine offer post the COVID-19 pandemic and COVID-19 vaccination programme.
- Increasing disinformation
- Lack of awareness of the immunisation schedule

Actions to improve vaccination uptake

Increasing vaccination uptake is complex and requires a suite of interventions. Work is ongoing at a national, regional, system, and place level to increase uptake in H&F.

A London-wide and NWL immunisations strategy have been agreed to both improve vaccination uptake and reduce inequalities. Multi agency action plans are being taken forward to support delivery of the strategy aims. More information on the oversight of this work in NWL can be found at appendix 3.

The London Immunisation Board, Mayors Health Board, and ICBs have all agreed on the 10 principles for London vaccination (figure 6). Action will now focus on developing this into a comprehensive delivery approach tailored to community needs and building on Borough-led health initiatives.

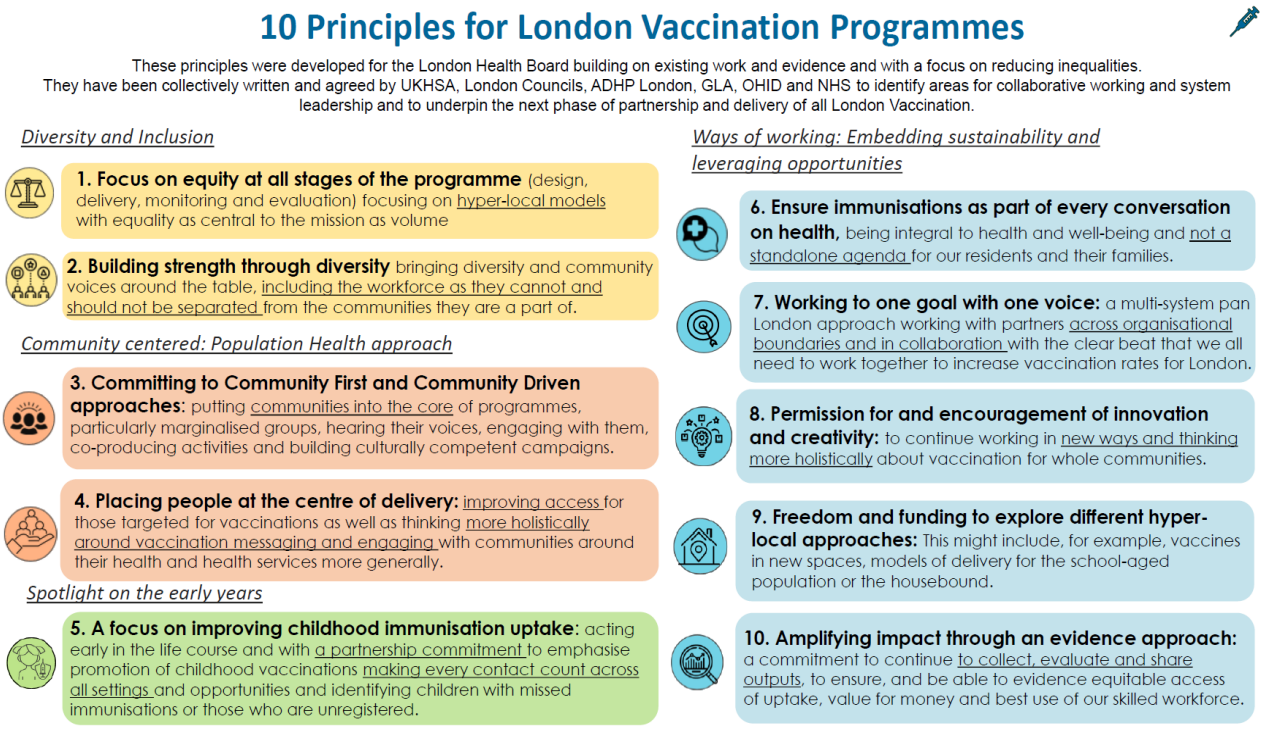


Figure 6: 10 principles for London vaccination programmes.

A range of cross vaccination programme actions are in place to maximise uptake in line with these principles including:

- An ICB level operational working group regularly discusses delivery of all vaccination and immunisation programmes.

- NHSE London fund immunisation coordinators to support GP practices with a focus on those with the lowest uptake and community outreach work within their relevant boroughs as highlighted by performance dashboard.
- NWL immunisation webinar programme for healthcare professionals

Further actions targeted to specific programmes are outlined below.

Childhood vaccinations

A strong focus for Hammersmith & Fulham, NWL and London is to increase childhood vaccination coverage overall to pre-pandemic levels and to identify the communities which are persistently missed from vaccination and other health services.

A particular risk in 2023 is the sub-optimal childhood MMR1 and 2 coverage (below 95%) which increases the risk of preventable measles outbreaks. To reduce the risk of poliovirus transmission, focus also remains on identifying and supporting underserved communities of H&F and London.

Actions to improve uptake include:

- A national NHSE MMR vaccination call and recall service was implemented between September and December 2022. This promoted the take-up of the MMR vaccine amongst individuals between the ages of 1 to 25 years through letters and texts.
- A new national call/recall service will start in January 2024 working through each vulnerable cohort, primary school aged, secondary school age and then 21-25 year olds.
- A regional communications campaign took place across London in March 2023 to encourage the uptake of missed MMR doses. This included media, social media, health ambassadors, translated materials, and attendance at local events and community groups
- NHSE London commissioned UKHSA to deliver immunisation training to all vaccinators in London. Vaccinators were trained to build and maintain trust, address parent concerns and queries and deliver a high-quality service.
- Vaccinations have been added to the MECC London resource hub to facilitate using every available opportunity to engage with the public to increase vaccination.
- A funded regional catch-up programme through the SAIS (for children aged 4-11) led by NHSE and GP practices (for children aged 0-4) led by ICBs is underway to provide DTaP, MMR, and full-schedule catch-up. This programme is focused on targeting under and un-vaccinated children. We anticipate that the first quarter findings and uptake rates for London will be available by January 2024.

- Solution focused workshop on childhood immunisation held with key partners invited from across NWL. This workshop aimed to develop a shared understanding of the challenges and opportunities for NWL around childhood vaccinations. The group focused on three key areas:
    - Exploring existing good practice, for vaccines and immunisation in children, to build upon and share
    - Developing a set of shared ambitions around an integrated approach for NWL immunisations
    - Co-creating a tangible action plan to achieve the identified ambitions

Key long term ambitions that the group identified were:

- One shared data system for all providers to allow for parents having their children vaccinated in different locations
- Long-term contracts for 'roving vaccination teams' to make it an attractive employment opportunity
- Annual 'train the trainer' programmes on communication around vaccines
- Alignment between GPs and community pharmacies, to ensure there is collaboration not competition between the providers
- '119' conversion to a national immunisation line, not just COVID- 19
- LSOA level data analysis to capture the areas most in need of intervention, to improve vaccine uptake rates

- Utilisation of the new NWL childhood dashboard at borough, PCN and GP practice level to identify local trends and issues
- Completion of return to school letters for primary and secondary school pupil, outlining forthcoming vaccination programmes over next school year and reminders to ensure that their routine schedule is up to date.
- MMR outreach delivery model by a NWL roving team has started with activity taking place in asylum seeker hotels and community clinics with a focus on providing catch-up MMR and polio vaccination opportunities for communities that encounter access inequalities. Their key focus is on:
    - Asylum seeker/refugee hotel residents
    - Known areas of low vaccine uptake and deprivation e.g. places of worship, food banks etc
    - Child focussed community centres during the school holidays
    - Static sites in community settings e.g. warm-hubs, libraries, sports centres
    - Large-scale community events in conjunction with NHSE and local partners e.g. Eid in the Square

- Venues visited by the roving team over the past year locally to deliver outreach in the form of MECC (Making Every Contact Count) adult winter and childhood vaccinations include: Meridian Ward Hammersmith, Claybrooks Centre, Charing Cross Hospital Car park, 145 King Street, Normand Park, Bridget Joyce Square, OYO Sino Hotel 85 Shepherds Bush Road, Hotel Orlando 83

Shepherds Bush Road, Old Oak Community Centre, Westfield Shopping Centre, Our Lady of Fatima, Fulham Pools, Council Depot 25 Bagleys Lane, Macbeth Centre, 25-27 Matheson Road and Askew Road

- Alignment of the work of roving team together with local grass roots organisations enabling facilitated discussions to take place that address vaccine concern as well as promoting benefits of immunisations is being undertaken.
- Individual MMR borough plan for H&F developed in May 2023 in response to the measles outbreak in Hillingdon seen in Spring 2023.
- Enhanced access hubs within H&F offer locally registered patients additional access to childhood immunisation clinics in the evenings and at weekends. There are multiple sites arranged by Primary Care Network's across the borough, one in the north (Parkview Practice), one in the south of the borough (Cassidy Medical Centre), one in the centre (Brook Green Medical Centre).
- H&F has a dedicated Immunisation Co-ordinator working across the borough with multiple stakeholders to increase immunisation uptake. This post is funded by NHSE. A summary of the work they are currently doing is shown below:
    - Working with practices to support adherence to the GP Core Contractual Standards, ensuring they are running their call/recall effectively, addressing barriers to uptake with patients and supporting overall delivery.
    - Encourage all practice staff to feel confident in discussing childhood immunisations with their patient population (clinically appropriate to the role).
    - Supporting practices to support national and local agreed catch-up campaigns e.g. London polio phase 1&2 campaigns and national MMR campaigns.
    - Ensuring that practices have knowledge of resources available to support immunisation delivery and how to access them, including those in multiple languages.
    - Ensuring patient lists are up to date and accurate.
    - Encouraging attendance at UKHSA/NHSE webinars around childhood vaccinations and local webinars delivered by NWL ICB.
    - Ensuring practices are using the correct and most up to date IT templates to record vaccinations.
    - Using a targeted, local approach based on demographics and vaccine update to link with Community Champions to support outreach to the local population to disseminate appropriate vaccine information.
    - Attending engagement sessions within the local communities to ensure that educational support around immunisations can be provided to families. This has included working closely with maternity

champions and community staff, within children centres and Team Around the Family Hubs (TAFH).
    - Training provided to family hub practitioners, and children centre staff around the importance of childhood immunisation.
    - Attending local primary care network (PCN) meetings, sharing data and relevant resources to ensure consistent messaging
    - Facilitate good working relationships between the ICB, NHSE and GP Practice/Primary Care.

Adult & seasonal vaccinations

Innovation Example

NWL ICB are working on a pilot with North Fulham Surgery in partnership with the NWL IT team. Any registered children under 5 now have a pop up of questions that appear, to have opportunistic conversations with parents around childhood immunisation. This will be expanded to all practices if successful.

- A GP toolkit (available here) has been produced in the NHSE London region to support improvements in uptake for the shingles vaccines, along with a range of other resources.
- NHSE commissioners are working to understand a more accurate picture of maternal pertussis coverage in London including areas of low uptake or whether data has not been correctly uploaded onto the GP clinical record.
- A Maternity Flu Action Plan has been completed by each unit in NWL in preparation for this season's delivery and a maternity immunisation webinar was held on 20th September 2023 for all clinicians delivering vaccinations to pregnant women, whether in primary care or trusts.

Next Steps

Both NHSE London and NWL have planned further vaccination uptake and broader strategic work in relation to vaccinations including:

- Review of funding models with LAs offering funding streams that allow for greater integration.
- Phase 2 polio/MMR programme is on track and we anticipate completion of the campaign by Quarter 2 2024. The future focus will include how to embed learning from this catch-up programme into business-as-usual vaccination services.
- As part of Polio Phase 2, funding has been allocated to NWL ICB for additional activities that contribute to:
    - Comms/ engagement activities that raise awareness of the childhood vaccination schedule and the importance, individual and community benefits of vaccination
    - Outreach activities for children aged 1-4 or geographical that make contact with those families whose children are un- or under-vaccinated for their age and offer a vaccination appointment/event
- This must be outside of existing functions, funding routes or mechanisms. NWL ICB are currently drafting the plans for the utilisation of this funding in conjunction with local stakeholders.
- The findings from the above analysis has informed the overall approach to inequalities in NWL with both the autumn/winter capacity and outreach plans incorporating learning from this analysis and reflecting this in the availability of local infrastructure as well as the way the offer is made to underserved groups.
- Focused areas of work to address inequalities within underserved groups which we see across all vaccination programmes including:

1) Community outreach and education via the NWL roving team as well as other health organisations

- Develop culturally sensitive and multilingual educational materials about vaccines' safety and benefits.
- Train community health workers to provide information, address concerns, and facilitate vaccine appointment.

2) Vaccine Clinics in Underserved Settings

- Continue to partner with community organisations, places of worship, and schools to host vaccine clinics.

- Ensure that clinics are welcoming, culturally sensitive, and staffed by diverse healthcare professionals.

3) Data Collection and Monitoring

- Continue to analyse vaccination data broken down by demographic factors (race, ethnicity, income, etc.) to identify disparities.
- Continuously monitor vaccination rates and address disparities in real-time.

4) Organise tailored Campaigns:

- Customise vaccination campaigns to address the unique needs and preferences of underserved communities, including visuals and messaging.

5) Engage Trusted Messengers:

- Look to continue work with local leaders and influencers within NWL: Partner with community leaders, influencers, and healthcare professionals from underserved communities to advocate for vaccination.
- Healthcare Workers: Ensure healthcare workers administering vaccines reflect the diversity of the communities they serve

6) Pregnant Women

- Continuation of the ongoing NWL work to support pregnant women (through maternity services) in getting both the flu, pertussis and COVID-19 vaccines which is critical for the health and well-being of both mothers and their unborn children. Ensuring healthcare workers are discussing the unique vulnerabilities associated with pregnancies and that both the flu and COVID-19 can pose serious risks to pregnant individuals and their babies – strongly advocating for flu and COVID-19 vaccination during pregnancy.
- All maternity units have a delivery plan in place which is overseen via the quarterly contract meetings with NHSE which the flu and child imms lead also attends so that the ICB can support as required. ICB lead also attends the monthly London Maternity Immunisation Forum. Each maternity meetings covers performance, delivery plans and models, stock allocation and programme risks.

7) Access and Inequality Funding

- Plans provide commitment to address disparities in vaccine uptake by implementing the Access and Inequality (A&I) funding initiative, which aims to increase vaccination rates in deprived areas through working with our borough leads

Appendix 1: Immunisation schedule

Routine childhood immunisations				
Age Due	**Diseases protected against**	**Vaccine given**	**Trade name**	**Usual Site**
8 weeks	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
12 weeks	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
16 weeks	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB	MenB	Bexsero	Left thigh
1 year	Hib and Meningococcal group C (MenC)	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV booster	Prevenar 13	Upper arm/thigh

	Measles, mumps and rubella (German measles)	MMR	MMRvaxPro or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Eligible paediatric age groups	Influenza (each year from September)	Live attenuated influenza vaccine LAIV	Fluenz Tetra	Both nostrils
Three years four months	Diphtheria, tetanus, pertussis and polio	dTaP/IPV	Boostrix-IPV	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMRvaxPro or Priorix	Upper arm
12-13 years	Cancers and genital warts caused by specific human papillomavirus (HPV) types	HPV (2 doses 6 to 24 months apart)	Gardasil	Upper arm
14 years Year 9	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y	MenACWY	Nimenrix	Upper arm

Selective childhood immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, 4 weeks and 12 months old	Hepatitis B	Hepatitis B (Engerix B/HBvaxPRO)
Infants in areas of the country with tuberculosis (TB) incidence >= 40/100,000	Around 28 days old	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country	Around 28 days old	Tuberculosis	BCG
Children in a clinical risk group	From 6 months to 17 years of age	Influenza	LAIV or inactivated flu vaccine if contraindicated to LAIV or under 2 years of age

Adult Immunisation Programme

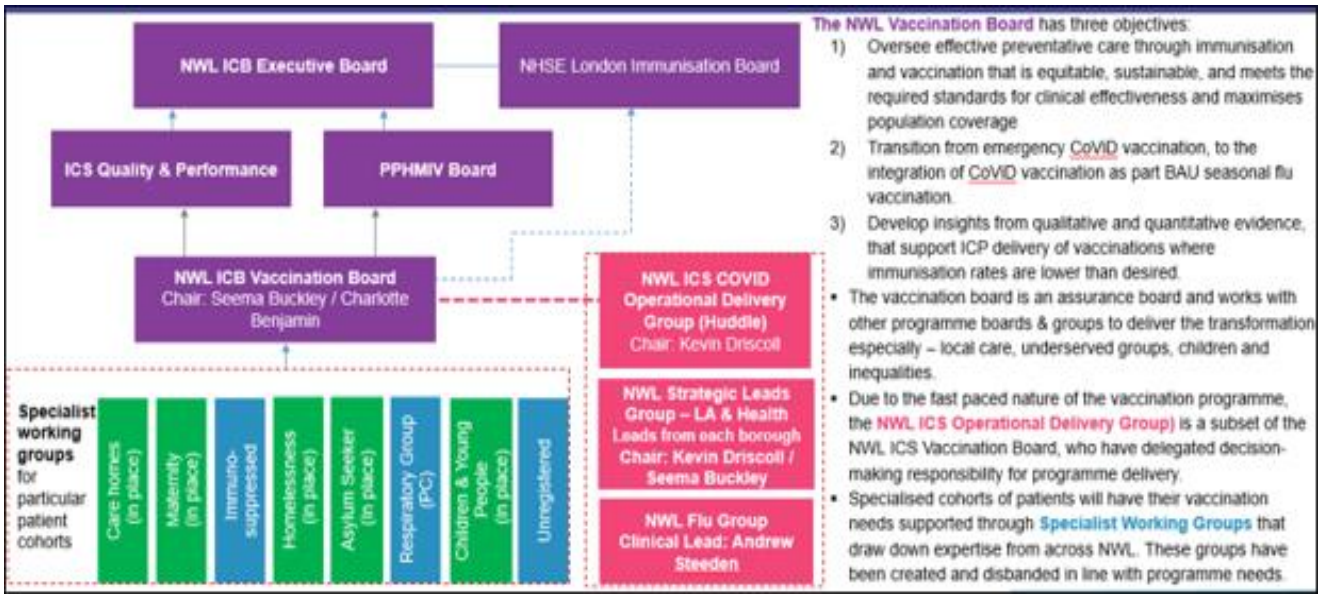
65 years old	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Pneumovax 23
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple
70 to 79 years of age	Shingles	Shingles	Zostavax3 (or Shingrix if Zostavax contraindicated)
Pregnant women	At any stage of pregnancy during flu season	Influenza	Inactivated flu vaccine
	From 16 weeks gestation	Pertussis	dTaP/IPV (Boostrix-IPV)

The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)

Appendix 2: NHSE current responsibilities & performance targets

Cohort	Immunisation Programme	Who we commission	National Target
Routine 0-5 imms	Diphtheria, Tetanus. Poliomyelitis, Pertussis, Hib and Hepatitis B (DTaP/IPV/Hib/HepB)	General Practice, Essential Service in GP Contract	95%
	Meningitis B (Men B)	General Practice, Essential Service in GP Contract	95%
	Rotavirus	General Practice, Essential Service in GP Contract	95%
	Pneumococcal	General Practice, Essential Service in GP Contract	95%
	Hib/Men C	General Practice, Essential Service in GP Contract	95%
	Diphtheria, tetanus, pertussis and polio dTap/IPV (pre-school booster)	General Practice, Essential Service in GP Contract	95%
	Measles. Mumps and Rubella (MMR)	General Practice, Essential Service in GP Contract & opportunistic catch up via School Aged Immunisation Providers	95%
Routine	Seasonal Influenza Immunisation for children - Eligible age or risk group	School Aged Immunisation Providers – 8 in London	70%
Routine School-aged	Human Papillomavirus (HPV)	School Aged Immunisation Providers	95%
	Td/IPV (Teenage Booster)	School Aged Immunisation Providers	90%
	Meningitis ACWY (Men ACWY)	School Aged Immunisation Providers	95%
Routine	Seasonal Influenza Immunisation for adults	General Practice (Enhanced Service), Maternity Units, Acute& Community Trusts, Community Pharmacy	Adults under 65 years - 75% Over 65 years & HCW - 85%
Routine Older adults	Pneumococcal	General Practice, Essential Service in GP Contract Pharmacy	75%
	Shingles	General Practice, Essential Service in GP Contract	65%
Selective	Hepatitis B for babies born to hepatitis B infected mothers	General Practice, Essential Service in GP Contract	100%
	BCG for at risk newborns	Community Providers – 11 in London	80%
	HPV for Men who have sex with men	Acute Trusts	No Target
	Pertussis for pregnant women	Maternity Units and General Practice, Essential Service in GP contract	London ambition is 70%
TBC	COVID-19 Immunisation Programme in Development	GPs, Community Pharmacies, Acute Trusts,	100% universal offer

Appendix 3: Vaccination and immunisation oversight in NWL



Appendix 4: Data collection

Data is uploaded into Child Health Information Service (CHIS) from GP practice records via a data linkage system. The CHIS provides quarterly and annual submissions to the UKHSA for their publication of statistics on 0-5s childhood immunisation programmes. This is known as Cohort of Vaccination Evaluated Rapidly (COVER) and these are the official statistics. Annual data is more complete and should be used to look at longer-term trends.

COVER monitors immunisation coverage data for children in the UK who reach their first, second, or fifth birthday during each quarter. Children having their first birthday in the quarter should have been vaccinated at 2, 3, and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

There are known complexities in collecting data on childhood vaccinations. Indeed, since 2013, London's COVER data is usually published with caveats, and drops in reported rates may be due to data collection or collation issues for that quarter.

Production of COVER statistics in London involves a range of individuals and organisations with different roles and responsibilities. London has four CHIS Hubs – North East London (provider is North East London Foundation Trust, NELFT), South East London (provider is Health Intelligence), South West London (provider is Your Healthcare CIC), and North-West London (provider is Health Intelligence). These hubs are commissioned by NHSE to compile and report London's quarterly and annual submissions to UKHSA for COVER.

A 'script' or algorithm is utilised to electronically extract anonymous data from the relevant data fields to compile the reports for COVER within the caveats specified. For example, for the first dose of MMR, any child who had their MMR vaccination before their first birthday is not included and so appears unvaccinated.

CHIS hubs are commissioned to check the reports run and are expected to refresh the reports before final submission to UKHSA. CHIS Hubs are also commissioned to 'clean' the denominator by routinely undertaking 'movers in and movers out' reports. This is to ensure the denominator is up to date with the children currently resident in London. They are also expected to account for the vaccinations of unregistered children in London. There are ongoing issues with CHIS hubs keeping up to date with movers in and out which is picked up in contract performance meetings with the NHSE (London) commissioners.

Vaccination data is extracted from London's GP IT systems and uploaded onto the CHIS systems. This isn't done directly by the CHIS Hubs. Instead, data linkage systems provided by three different providers provide the interface between general practices and CHIS. Two of these providers – QMS and Health Intelligence – are commissioned by NHSE whilst 4 boroughs in outer North-East London commission a separate system.

NHS (London) Immunisation Commissioning Team receives data linkage reports from QMS and Health Intelligence. This provides a breakdown by general practice of the uptake of vaccinations in accordance with the COVER cohorts and cohorts for Exeter (for payments). This information is utilized by the team as part of the 'COVER SOP', to check against the COVER submissions by CHIS to question variations or discrepancies.

While data linkage systems provide an automated solution to manual contact between CHIS and General Practices, data linkage does not extract raw data. General practices must prepare the data for extraction every month. This will vary between practices how automated the process is, but it can be dependent upon one person to compile the data in time for the extraction by the data linkage system providers and should this person be on annual or sick leave, there will be missing data.

General practices have to prepare data for four immunisation data systems – COVER, ImmForm (although this is largely done by their IT provider of Vision, EMIS or TPP SystmOne, all of whom are commissioned by their ICS), CQRS (the payments system run by NHS England for the payment of administration of the vaccine) and Exeter (payments system, whereby practices receive targeted

payments for achieving 70% or 90% uptake of their cohorts – these cohorts are different to the COVER cohorts of children). Preparation of data for the systems again will vary between practices but this can be time and resource intensive. There is also an array of codes that can be used to code the vaccination (if a code different to what the data linkage system recognises is utilised, it results in the child looking unvaccinated) and there are difficulties with coding children who received their vaccinations abroad or delays in information on vaccinations given elsewhere in UK being uploaded onto the system in time for the data extraction.

Whilst NHSE (London) commissioning team verify and pay administration of vaccines that are part of the Section 7a immunisation programmes, they do not commission GPs directly. Vaccination services, including call/recall (patient invite and reminder systems) are contracted under the General Medical Services (GMS) contract. This contract is held by primary care commissioning directorates of NHSE.

For most newer vaccine programmes and for those targeting people older than 5 years vaccination and population data is extracted directly from general practice systems using ImmForm, an online platform.

Appendix 5: Abbreviations

Abbreviation	Definition
CHIS	Child health information Service
COVER	Cover of vaccination evaluated rapidly
DHSC	Department of Health & Social Care
dTaP/IPV	Diphtheria, tetanus, pertussis, inactivated polio combined vaccine
GP	General practitioner
Hib	Haemophilus influenzae B
HepB	Hepatitis B
H&F	Hammersmith & Fulham
HPV	Human papillomavirus
ICB	Integrated care board
ICS	Integrated care system
JCVI	Joint committee on vaccination and immunisation
LA	Local authority
MECC	Making every contact count
Men B	Meningococcal group B
Men C	Meningococcal group C
MMR	Measles, mumps and rubella combined vaccine

NHSE	National Health Service England
NWL	North-West London
PCV	Pneumococcal conjugate vaccine
PPV	Pneumococcal polysaccharide vaccine
PSB	Pre-school booster
Rota	Rotavirus
QOF	Quality and outcomes framework
SAIS	School age immunisation services
UKHSA	United Kingdon Health Security Agency
WHO	World Health Organisation

Appendix 6: Contacts

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This publication can be made available in a number of alternative formats on request.

Vaccination Coverage Update

London Borough of Hammersmith & Fulham

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Susan Elden (NHSE)

Childhood Vaccinations

Roles & Responsibilities for Childhood Immunisations

Local Authority & DPHs: Oversight & Scrutiny

- Local authorities are responsible for providing oversight and scrutiny of the Immunisation arrangements of NHS England, UKHSA and providers, and play an important role in promoting immunisation through services they commission and a range of local channels including newsletters, social media and community champions.
- Local authority public health teams deliver population health initiatives including improving access to health and engagement and promotion of immunisations overall.

UKHSA: Disease Surveillance and Outbreak Management

- The UK Health Security Agency (UKHSA) undertakes surveillance of vaccine preventable diseases and leads the response to outbreaks of vaccine preventable disease.
- UKHSA provide expert advice to NHSE immunisation teams in cases of immunisation incidents.

DHSC: Strategic Direction

- The Department of Health and Social Care (DHSC) provides national strategic oversight of vaccination policy in England, with advice from the independent Joint Committee on Vaccination and Immunisation (JCVI) and the Commission on Human Medicines.
- DHSC also set performance targets

NHSE: Commissioning & performance management

- NHS England is responsible for commissioning national immunisation programmes in England under the terms of the Section 7a agreement, National Health Service Act 2006.
- NHS England is accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels.
- NHS England is also responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required

ICBs & ICSs: Quality Improvement & Partnership Working

- Integrated Care Systems (ICSs) & ICBs have a duty of quality improvement, and this extends to primary medical care services.
- ICBs provide opportunities for improved partnership working across NHSE (London), local authorities, voluntary and community sector partners to improve immunisation uptake and reach underserved areas and populations.
- NHSE (London), alongside ICBs, local authorities and others, are working to progress delegated commissioning for vaccination and screening.
- The structures and resources have not yet been confirmed but it is anticipated that the first wave of delegation of the commissioning of immunisation services will be over course of 2024/25.

Provider Immunisation Delivery

- Pre-school and adult vaccinations are usually delivered by GP surgeries. They are commissioned through the NHS GP contract.
- Five core GP contractual standards have been introduced to underpin the delivery of immunisation services: 1. a named lead for vaccination service; 2. provision of sufficient convenient appointments; 3. standards for call/recall programmes and opportunistic vaccination offers; 4. participation in national agreed catch-up campaigns; 5. standards for recordkeeping and reporting.
- One of the five Quality and Outcomes Framework domains is childhood vaccinations and shingles vaccination, rewarding GP practices for good practice.
- School age immunisations are commissioned by the seven regional NHS England teams and delivered through School Age Immunisation Services (SAIS).
- Vaccinations are also provided by maternity services, some outreach services and community pharmacies.

Childhood vaccinations

What vaccinations does your child need if they are under 12?

For more information search 'NHS vaccinations and when to have them'

8 weeks old
6-in-1 vaccine
Rotavirus vaccine
MenB

12 weeks old
6-in-1 vaccine (2nd dose)
Pneumococcal (PCV) vaccine
Rotavirus vaccine (2nd dose)

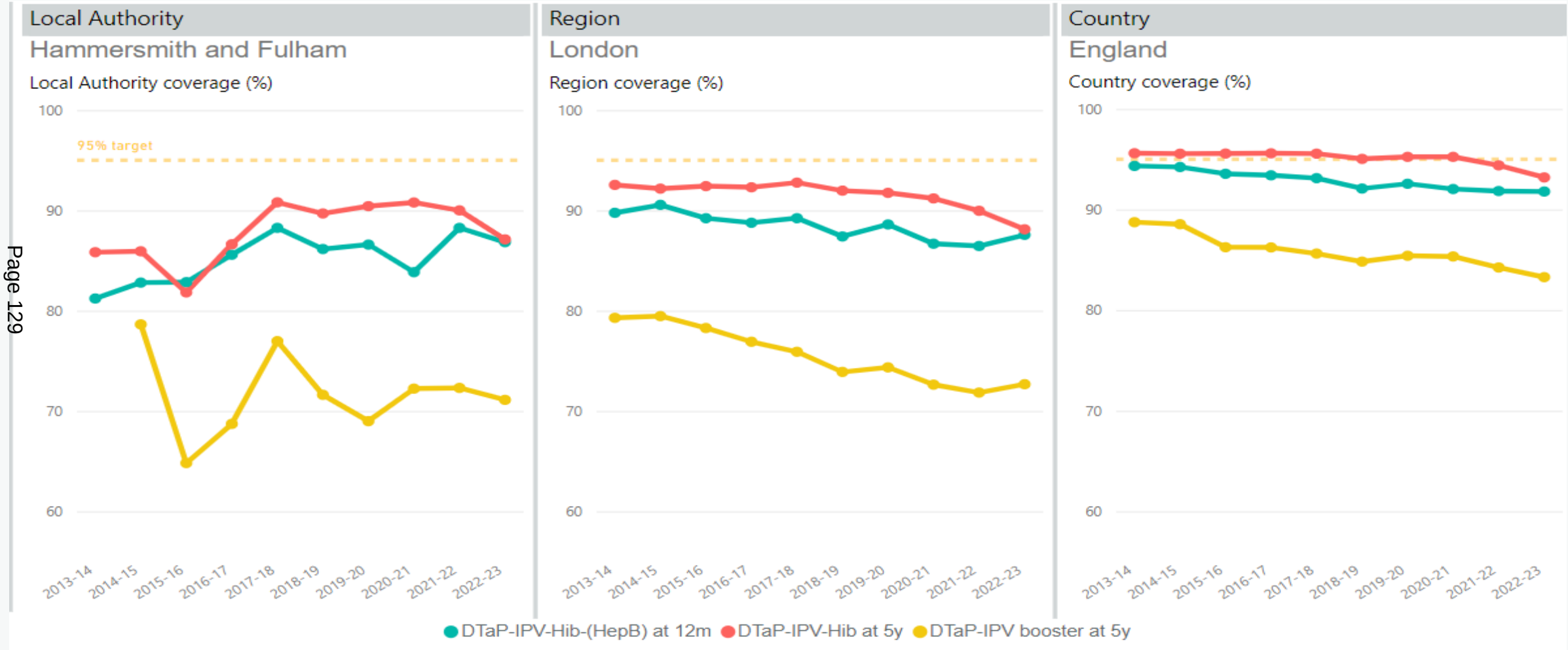
16 weeks old
6-in-1 vaccine (3rd dose)
MenB (2nd dose)

1 year old
Hib/MenC (1st dose)
MMR (1st dose)
Pneumococcal (PCV) vaccine (2nd dose)
MenB (3rd dose)

3 years and 4 months
MMR (2nd dose)
4-in-1 pre-school booster

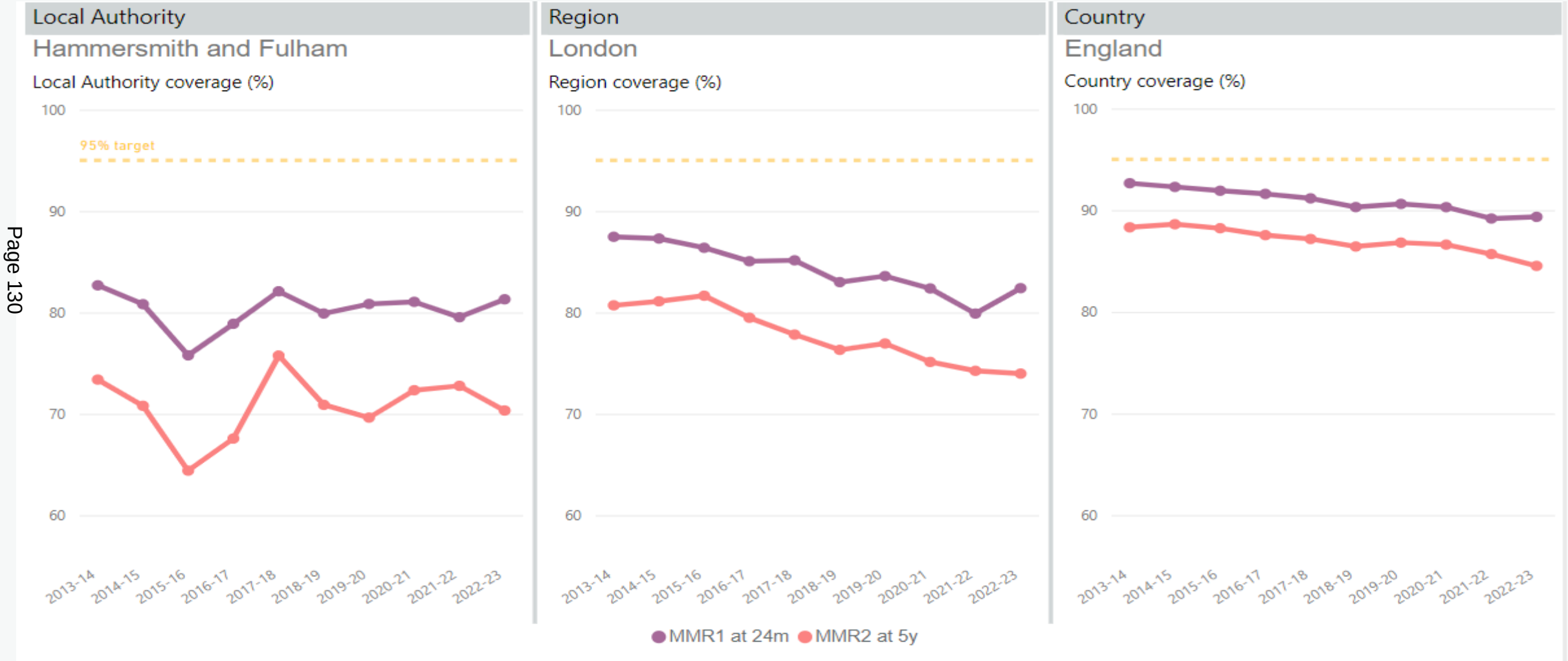
2 to 10 years old
Flu vaccine (every year)

Vaccination Coverage – 6 in 1 vaccine* and booster



*Protects against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae B & hepatitis B

Vaccination Coverage – measles, mumps & rubella (MMR)



Key Actions - London

MMR/polio catch up campaign:

Identified >320,000 children either missing or only partially vaccinated for MMR across London.

Call centres and additional clinics set up focusing on nursery (1-4 years) and schools (5 to 12 years). Called almost 10,000 families who have unvaccinated children

Schools in measles hotspot areas where have been outbreaks or high rates of under vaccination have been called and vaccinated first

Protected thousands of unvaccinated children against measles. In the last quarter alone an additional 14% of eligible children were immunised.

Digital marketing campaign targeting those most at risk

Key Actions – integrated care board (ICB) & local authority

- NWL roving team running outreach clinics for underserved groups across the ICB footprint alongside out of hours (OOH) hubs run at primary care network (PCN) level.
- Utilisation of the new NWL childhood dashboard at borough, PCN and GP practice level to identify local trends and issues
- Solution focused workshop on childhood immunisation held with key partners from across NWL to develop a shared understanding of the challenges and opportunities around childhood vaccinations.
- Hammersmith and Fulham shares an Immunisation Co-ordinator with Bi borough, working with multiple stakeholders to increase immunisation uptake.
- Focused areas of work to address inequalities within underserved groups which we see across all vaccination programmes – see main paper.
- LA-led outreach with faith communities, homeless hostels and asylum centres
- Artwork explaining how the immune system works

Seasonal Vaccinations

Seasonal Vaccinations

Flu and COVID-19 vaccinations

Offered to those at higher risk of getting seriously ill from these illnesses including those who:

- are aged 65 or over (including those who will be 65 by 31 March 2024)
- have certain health conditions or a learning disability
- are pregnant
- live with someone who has a weakened immune system
- are a carer
- are a frontline health or social care worker
- live in a care home

Most children can get the children's flu vaccine. This includes children who were aged 2 or 3 years on 31 August 2023, school-aged children (Reception to Year 11) and children with certain health conditions.

Key Actions

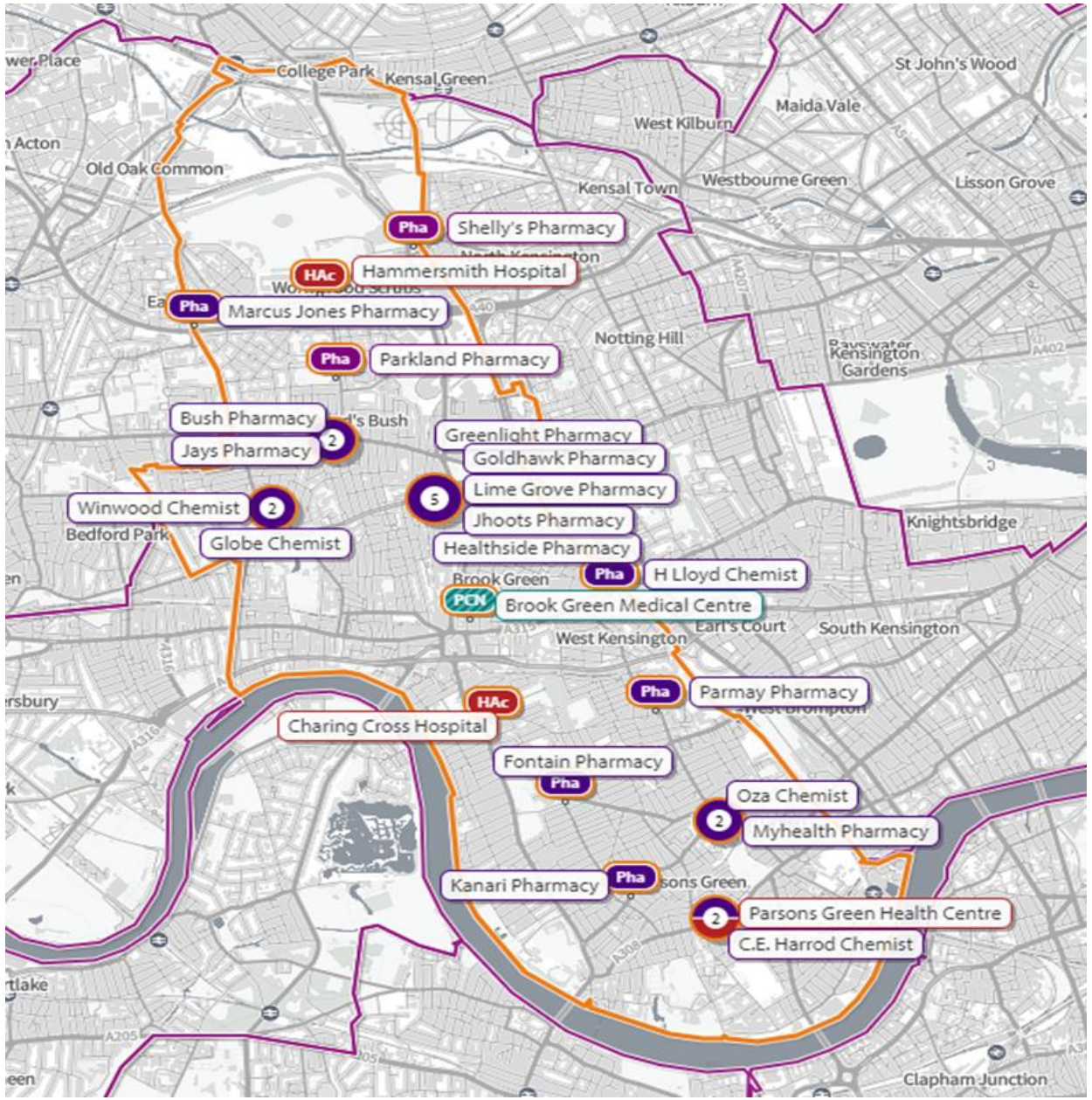
- The flu season has now started with providers receiving flu vaccines enabling early vaccinations to take place for those most vulnerable to infection.
- Co-administration (flu and COVID) opportunities maximised through aligning delivery of vaccines and administration at PCN or GP Practice level, through expansion of community pharmacy estate and through a roving team offer to care home and housebound patients
- New COVID vaccine has been made available to tackle the new variant
- Large numbers of new community pharmacies included in the programme for this season
- Communications resources for staff page and flu resources & myth busters published on NWL website
- Allergy pathway for Non-mRNA vaccine implemented
- LA-led 2nd year of intensive educational and empowerment programme with nursing home staff to encourage and improve flu and Covid uptake

Summary of NWL ICB Winter Vaccination plan

Overview

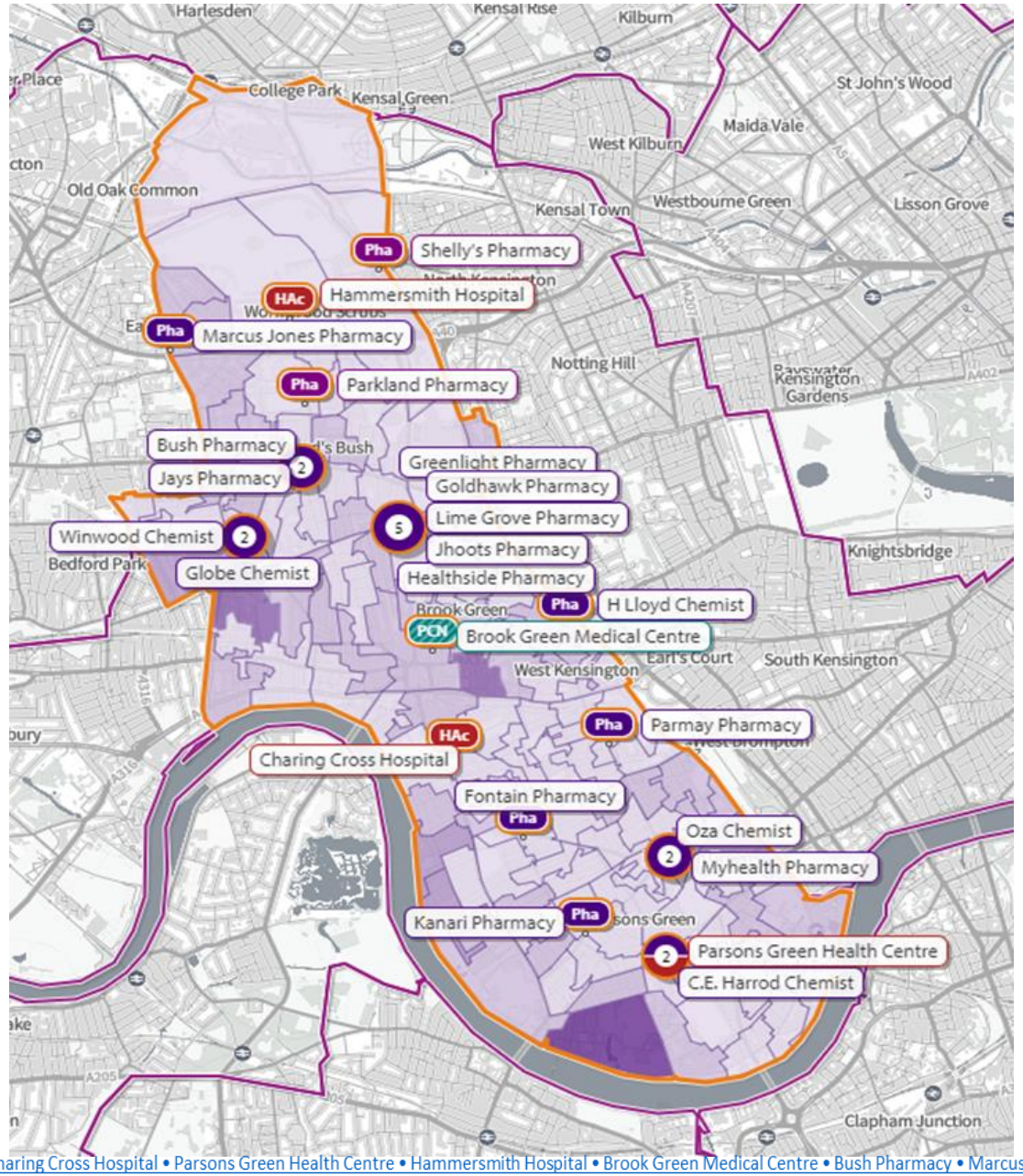
- The NWL infrastructure for the Autumn / Winter campaign currently sits at **185 locations** which incorporates, hospital hubs, PCN-led sites, vaccinations centres and community pharmacies.
- Most available capacity in **NWL (79%) is focused around community pharmacy locations** which at the time of writing total 158 with 97 being new to the COVID vaccination programme. The approval and on-boarding of community pharmacies is the responsibility of NHS London and based on the current timeline we expect all new and existing sites to be approved and on-boarded by the 15th September 2023 at the latest.
- Demand and capacity modelling for NWL has identified a **weekly capacity of over 90,000** meaning that there is sufficient capacity across the system based on an initial 7 week delivery schedule and an assumed uptake of 47.8%. **Surge planning with each site has identified an additional weekly capacity of 91,925 enabling** NWL to flex delivery up to 182,725 vaccinations per week if required.
- Co-administration opportunities have been maximised through three specific delivery models: 1. PCN or GP Practice delivery; 2. expansion of community pharmacy estate; 3. a roving team offer to care home and housebound patients.
- **Qualitative and quantitative data will inform NWL's approach to communication and engagement** across the course of the campaign and early use of these data sources will help identify where resources might be more appropriately targeted to support uptake especially amongst communities with historically low vaccine uptake.
- The NWL immunisation Team have utilised both regional and ICB inequalities data to understand how a more comprehensive offer might be provided to its underserved communities including specific outreach interventions framed around the NWL roving team.
- **The NWL roving team** will continue to play a pivotal role in the AW campaign and operationally the team have planned resources around an initial intensive 6-week delivery programme for care home residents and housebound patients with the workforce expanded accordingly in order to meet the 22nd October completion deadline.

Map showing H&F Health Borough plotted with Active Sites for the Autumn 23 COVID-19 Vaccination Campaign



SHAPE Place • Charing Cross Hospital • Parsons Green Health Centre • Hammersmith Hospital • Brook Green Medical Centre • Bush Pharmacy • Marcus Jones Pharmacy • Globe Chemist • H Lloyd Chemist • Kanari Pharmacy • Fontain Pharmacy • Parmay Pharmacy • C.E. Harrod Chemist • Myhealth Pharmacy • Oza Chemist • Jays Pharmacy • Greenlight Pharmacy • Goldhawk Pharmacy • Healthside Pharmacy • Jhoots Pharmacy • Lime Grove Pharmacy • Winwood Chemist • Parkland Pharmacy • Shelly's Pharmacy (shapeatlas.net)

Map showing H&F Health Borough plotted with Active Sites for the Autumn 23 COVID-19 Vaccination Campaign with Population 65 plus plotted



Location | Focus | Interpretation

Age profile quinary bands: Mid-year 2020

Population estimate: Persons: ages 65-90+

The analysis focuses on the estimated percentage of the population ages 65-90+.

Hammersmith and Fulham's estimated population in mid-year 2020 for ages 65-90+ is **11.27%** within a range of 5.13% to 28.98% across 113 LSOAs.

The England-wide LSOA distribution is 0.13% to 62.39% with a mean value of 19.43%.

Key

The colours represent the quintiles:

- 27% to 62%: 1 area
- 21% to 27%: 2 areas
- 17% to 21%: 4 areas
- 12% to 17%: 35 areas
- 0% to 12%: 71 areas

Data

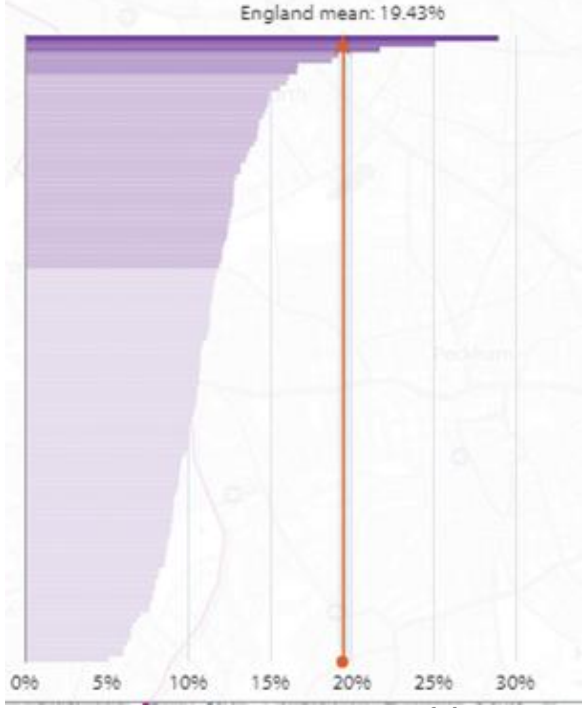
Numerator:
Persons: ages 65-90+ estimate: 20,687

Denominator:
Total estimated population: 183,544

Small Area Population Estimates for mid-year 2020
ONS: ons.gov.uk/.../populationestimates

Distribution

The chart shows the percentage of the estimated population ages 65-90+ in mid-year 2020.



SHAPE Place • Charing Cross Hospital • Parsons Green Health Centre • Hammersmith Hospital • Brook Green Medical Centre • Bush Pharmacy • Marcus Jones Pharmacy • Globe Chemist • H Lloyd Chemist • Kanari Pharmacy • Fontain Pharmacy • Parmay Pharmacy • C.E. Harrod Chemist • Myhealth Pharmacy • Oza Chemist • Jays Pharmacy • Greenlight Pharmacy • Goldhawk Pharmacy • Healthside Pharmacy • Jhoots Pharmacy • Lime Grove Pharmacy • Winwood Chemist • Parkland Pharmacy • Shelly's Pharmacy (shapeatlas.net)

Next steps

Forward Plan

- Phase 2 polio/MMR programme is ongoing, catch-up campaign expected to conclude Q2 2024. Our focus will include how to embed learning from this catch-up programme into business-as-usual vaccination services.
- ICB developing plans for additional funding received from NHSE as part of phase 2 to deliver:
  - Communications/engagement activities that raise awareness of the childhood vaccination schedule and the importance, individual and community benefits of vaccination
  - Outreach activities for children aged 1-4 that contact families whose children are un- or under-vaccinated for their age and offer a vaccination appointment/event
- ICB level operational working group meeting regularly to discuss delivery of all vaccination, immunisation and screening programmes.
- Review of funding models with LAs offering funding streams that allow for greater integration.
- Focused areas of work to address inequalities within underserved groups

Recommendations

- Health Overview and Scrutiny Committee to note actions being taken
- As a partnership, we would welcome support in shaping regional work for the local population needs and context

H&F Public Health Vaccination Initiatives

- **Enhancing training** for Health Visitors and School Nurses on vaccinations.
- Senior Lead for Public Health Nursing to support Children's Centre Staff, Family Hub Staff, as well as Early Years Settings, and Maternity Champions having conversations about vaccinations as part of **MECC**.
- Detailed discussions with **targeted communities** including work with Somali Community and Faith Forum
- Training young people as **health advocates** to talk about vaccinations in their **communities**
- Educating **care home staff** on vaccinations to **encourage uptake**
- Vaccination material and information available in **community languages**
- Developing the vaccinations **webpage and social media comms**
- **Pop-up** at 145 King street for **covid and flu vaccinations**
- H&F immunisation webpage developed and supported by an **infographic** which explains how **vaccinations** work in relation to the **immune system** (to be displayed in CC, FH, GPs, EYS).