Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 16 July 2020 at 7.00 pm
Virtual via Microsoft Teams

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PLEASE NOTE: VIRTUAL MEETING

The meeting will be run on Microsoft Teams. Please contact jane.creer@enfield.gov.uk to request an invitation if you wish to view the meeting.

MEMBERSHIP

Leader of the Council – Councillor Nesil Caliskan (Chair)
Cabinet Member for Health & Social Care – Councillor Alev Cazimoglu
Cabinet Member for Public Health – Councillor Mahtab Uddin
Cabinet Member for Children's Services – Councillor Rick Jewell
Co-MD of the Local Clinical Commissioning Group – Ruth Donaldson
Co-MD of the Local Clinical Commissioning Group – Sarah D'Souza
Healthwatch Representative – Parin Bahl
NHS England Representative – Dr Helene Brown
Director of Public Health – Stuart Lines
Director of Adult Social Care – Bindi Nagra
Executive Director People – Tony Theodoulou
CEO of Enfield Voluntary Action – Jo Ikhelef
Voluntary Sector Representatives: Vivien Giladi, Pamela Burke

Non-Voting Members

Royal Free London NHS Foundation Trust – Natalie Forrest
North Middlesex University Hospital NHS Trust – Maria Kane
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Whittington Hospital – Siobhan Harrington
Enfield Youth Parliament representative

AGENDA – PART 1

1. WELCOME AND APOLOGIES (7:00 - 7:10PM)

Welcome from the Chair
To include some words relating to recent events.

2. CONFIRMATION OF VICE CHAIR

Notification of Vice Chair Amendment.
(Administrative change due to CCG Re-Organisation.)

3. DECLARATION OF INTERESTS

Members are asked to declare any pecuniary, other pecuniary or non-pecuniary interests relating to items on the agenda.

4. IMPACT OF COVID-19 IN ENFIELD (7:10 - 7:30PM) (Pages 1 - 30)

Darya Bordbar and Roseanna Kennedy-Smith of the Enfield PH Intelligence Team – to note

i. Summary of recent PHE reports with findings and recommendations.

ii. An assessment of the local impact of Covid-19.

iii. Impact of Covid-19 upon specific groups in the borough.

5. ENFIELD COVID-19 OUTBREAK CONTROL PLAN (7:30 - 8:00PM) (Pages 31 - 72)

Stuart Lines, Enfield Director of Public Health – to note

Presentation and review of current plan.

6. ENFIELD INFLUENZA IMMUNISATION PLAN (8:00 - 8:05PM)

Dudu Sher-Arami, Consultant in Public Health – to note

Brief discussion of flu season preparation in preparation for Winter 2020/21.

7. UPDATE ON ENFIELD'S JOINT HEALTH & WELLBEING STRATEGY (JHWBS) AND HEALTH INEQUALITIES (8:05 - 8:35PM) (Pages 73 - 84)

Dudu Sher-Arami, Consultant in Public Health, Mark Tickner (HWB Partnership Manager), Stuart Lines, LBE DPH, Ruth Donaldson Enfield CCG

- Post Covid-19 suggested updates to JHWBS Action Plans with particular reference to addressing health inequalities – **Mark Tickner – to note**

- Presentation on joint health inequalities work – **Stuart Lines and Ruth Donaldson – to note**

8. ENFIELD INTEGRATED CARE PARTNERSHIP UPDATE (8:35 - 8:55PM) (Pages 85 - 92)

Sarah D'Souza, Deborah McBeal and Stuart Lines – paper to follow

9. OTHER BUSINESS : PROPOSAL TO REVISE TERMS OF REFERENCE

Mark Tickner, HWB Partnership Manager

10. MINUTES OF THE MEETING HELD ON 26 SEPTEMBER 2019 (Pages 93 - 100)

To receive and agree the minutes of the meeting held on 26 September 2019.

11. DATES OF FUTURE MEETINGS AND DEVELOPMENT SESSIONS

Dates of meetings for the 2020/21 municipal year:

Thursday 1 October 2020
Thursday 3 December 2020
Thursday 18 March 2021

Development Session to commence at 4:30pm.
Formal Board meeting to commence at 6:30pm.
Unless otherwise advised.
Venues to be confirmed.

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Agenda Item 4

Glenn Stewart

Summary of PHE Reports on the effect of C19 on BAME

Background

PHE has produced 2 reports on the disproportionate effect of Covid-19 on BAME populations:

- Disparities in the risk and outcomes of COVID-19 (June 2020)
- Beyond the data: Understanding the impact of COVID-19 on BAME groups (June 2020)

Key points from Disparities in the risk and outcomes of COVID-19:

- The review is a descriptive look at surveillance data on the impact of COVID-19 on risk and outcomes.
- The review confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, exacerbated them further, particularly for black, Asian and minority ethnic (BAME) groups.
- The largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were 70 times more likely to die than those under 40.
- Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in BAME groups than in white ethnic groups.
- These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in white ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity, but they do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.
- When compared to previous years, the review also found a particularly high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations, including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes.
- These analyses do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and could explain some of these differences.

The terms of reference for the report indicated that there will be recommendations as part of the review, however, these were not been included. Rather the second report ‘Beyond the data: Understanding the impact of COVID-19 on BAME groups’ made the following recommendations:

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Public Health and the Borough Directorate are now working through these recommendations are part of the restart of the Integrated Care Programme.

Analysis of COVID-19 related data in Enfield

Roseanna Kennedy-Smith
Darya Bordbar

Public Health Intelligence

Agenda

1) **Summary of COVID-19 data trends in Enfield (Roseanna Kennedy-Smith):**
   i. Cases
   ii. 111 calls
   iii. Shielding residents
   iv. Deaths

2) Demographics of COVID-19 deaths in Enfield (Darya Bordbar):
   i. Occupation group
   ii. Ethnicity (as determined by “Origin” software)
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Current trends in Enfield

Cases

Trends in new reported cases of Covid-19

- Overall downward trend
- As of 11 July 2020 a total **1,186 overall lab confirmed cases** (pillar 1 & 2)

Deaths

Trends in excess mortality and Covid-19 deaths

- There were **385 COVID-19 deaths** as at 26th June
- **93 deaths (24%)** occurred in care homes
- **Excess mortality has fallen** below the 5-year (2014-2018) average number of death

111/ 999 calls

Trends in Covid-19 symptoms reported to NHS pathways and 111 online

- Total of **3,363 COVID-19 111 triages** in Enfield
- Includes **27 111 triages** within the last week

Shielding

Trends in residents currently shielding

- There are **9,022 people** shielding
- **2.7%** of the resident population

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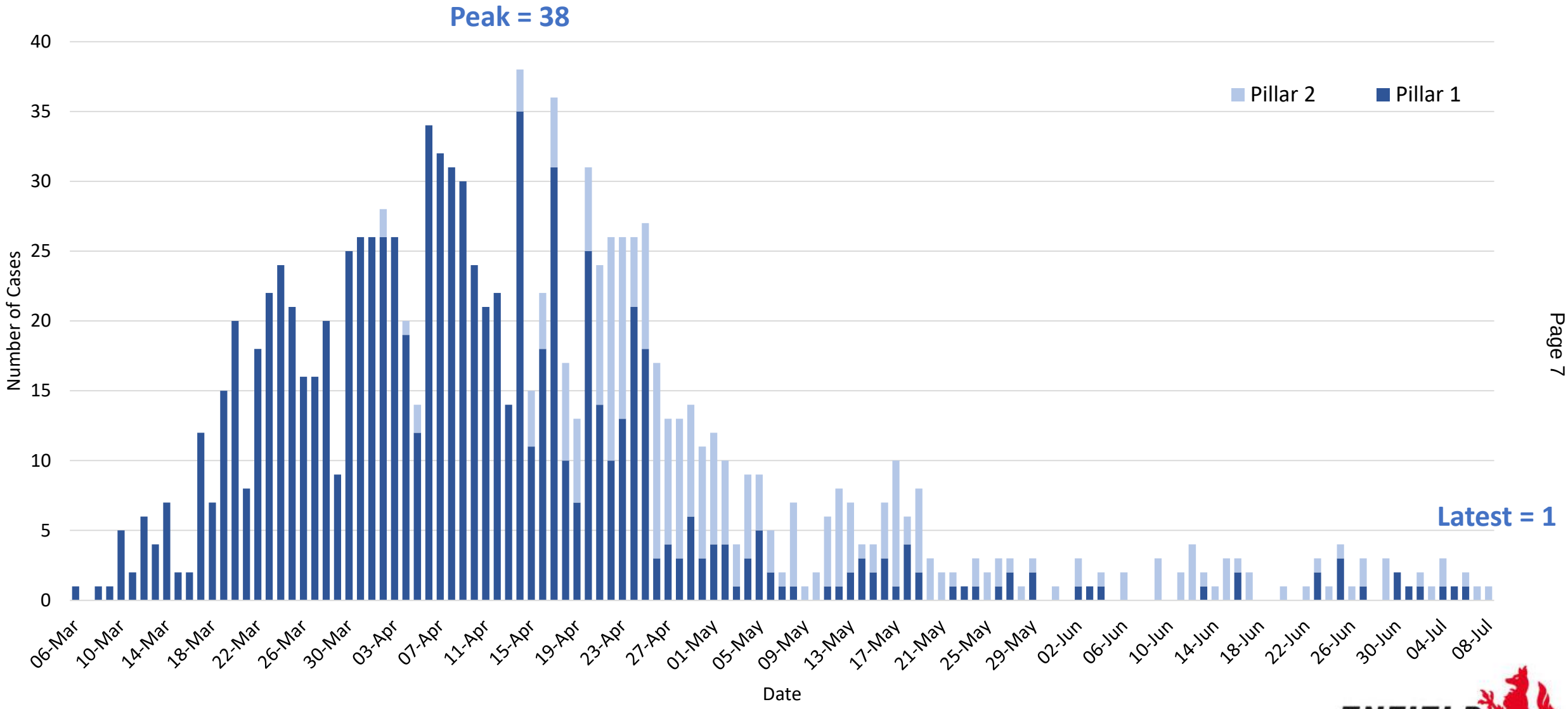
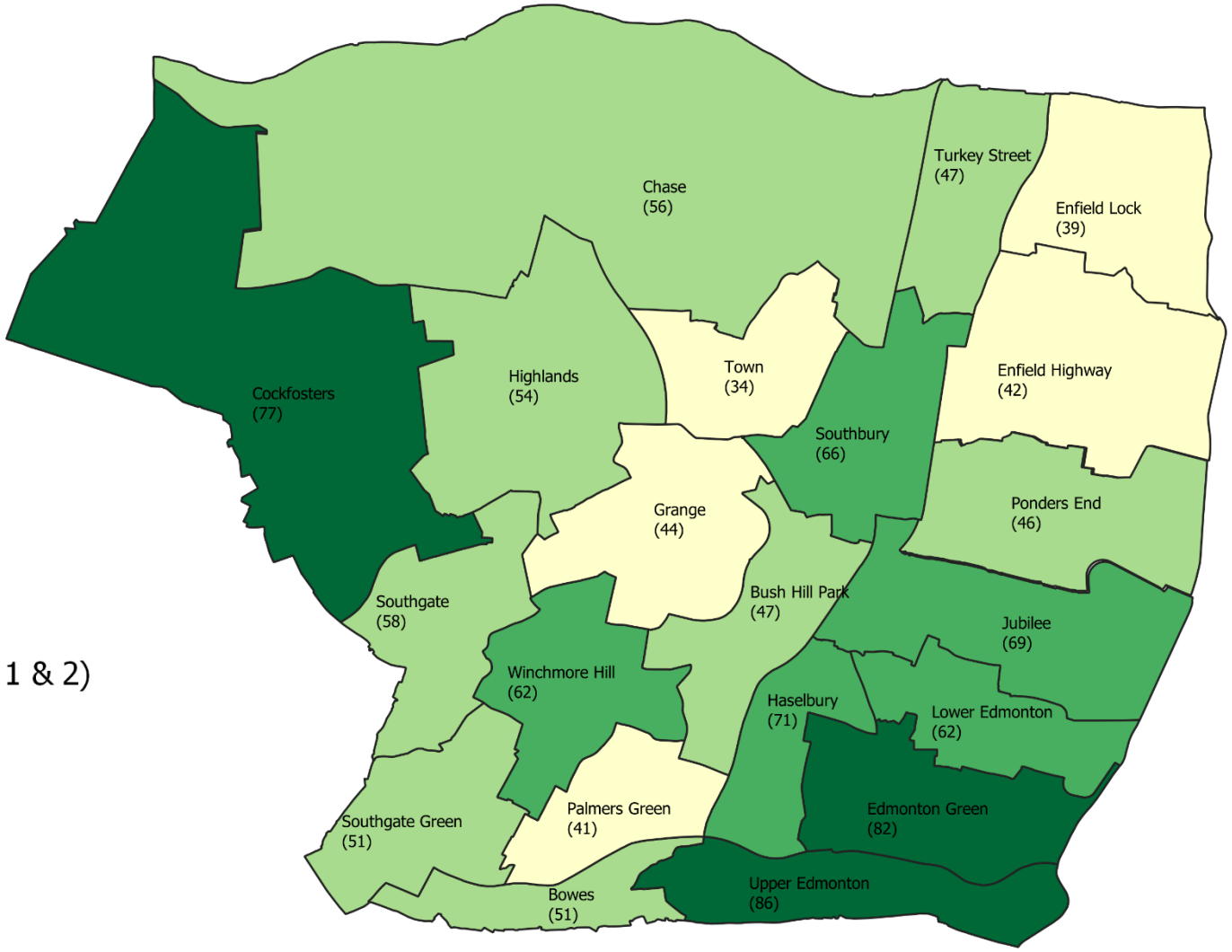
Longitudinal analysis of COVID-19 Cases in Enfield



Cumulative COVID-19 Cases in Enfield, by Ward (06 March – 08 July 2020)



Source: Public Health England - Case Test Results; most recent data available 13-Jul-20.

- **Enclosed in brackets is the ward specific cumulative number of COVID-19 cases.**

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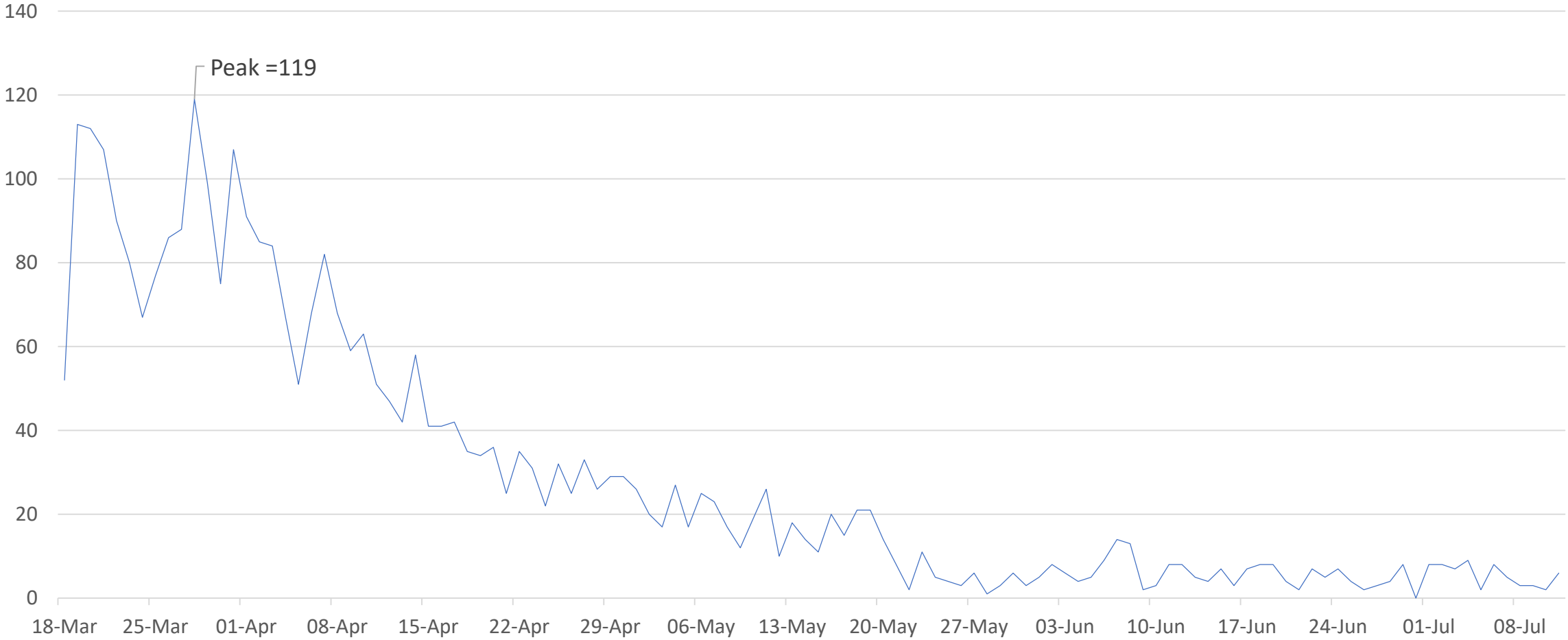
111 & 999 COVID-19 Triages in Enfield (18 March – 11 July 2020)



Source: NHS Digital Dashboard; most recent data available 11-Jul-20

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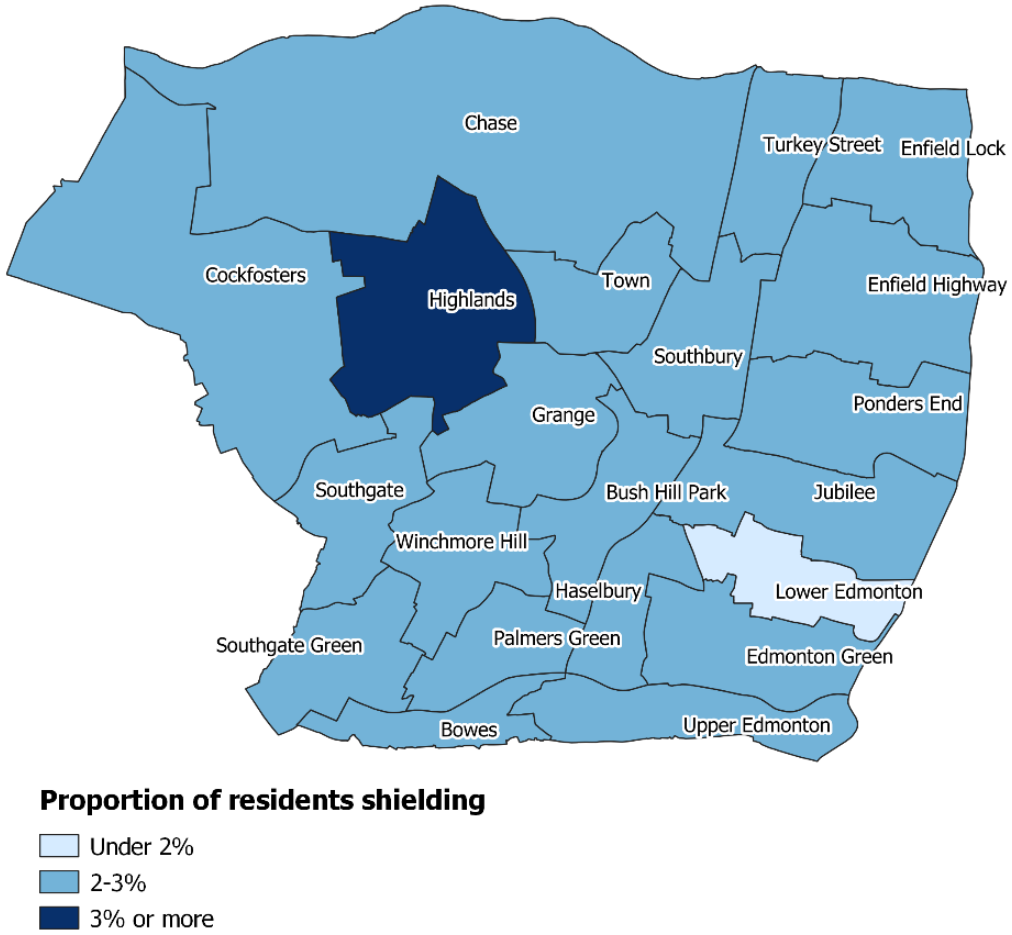
Shielding in Enfield



Currently in Enfield:

- There are a total of **9,220 people shielding**
- Rare diseases account for the highest proportion of those shielded by reason.
- The highest proportion of residents shielding from COVID-19 are in the **Highlands ward** (3.1%)
- The highest proportion of residents shielding from COVID-19 live in the 2nd and 3rd IMD decile

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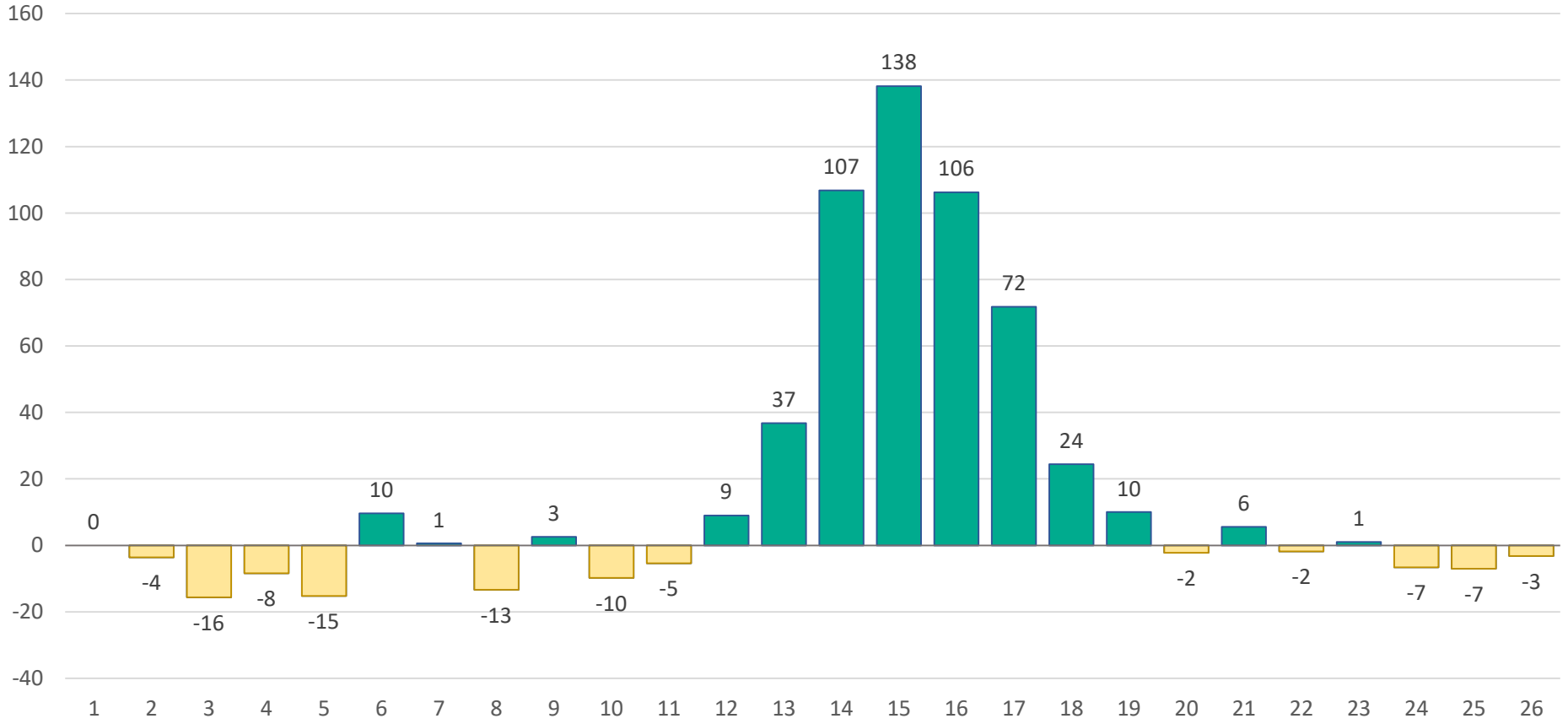
Excess Mortality in Enfield (Weeks 1 – 26)

- Weekly provisional figures on deaths occurring, minus the weekly average occurrence 2014 to 2018, with proportion where coronavirus (COVID-19) was mentioned on the death certificate (week 25 - up to 26 June 2020).



Greater than the 5 year average

Less than the 5 year average

More information on deaths by demographic on following slides

Source: Office for National Statistics.

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Death Certificate example

CONFIDENTIAL
RETURN OF DEATHS TO AREA HEALTH AUTHORITY

Date of Death	**Date/ month/ year**
Place of Death	North Middlesex Hospital, Edmonton
Name of Deceased	**(First name) (Surname)**
Sex	Female
Date of Birth	**Date/ month/ year**
Place of Birth	Edmonton, Enfield
Occupation	**Last occupation of deceased** (retired) Widow of **Name of husband**
	Last occupation of husband (retired)
Usual Address	**Address with postcode**
Cause of death	Ia) Corona Virus Disease 2019
	(b)
	(c)
	II) Asthma, Hypertension, Congestive Cardiac Failure, Osteoarthritis, Acute Kidney Injury

Using **Origin software** to determine ethnicity and language

Using occupation at the time of death investigated

This is an example of someone who had other underlying causes of death

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Occupation at the time of death

Occupation	Non COVID-19 deaths	Number of COVID-19 deaths	Number of C-19 deaths as a % of total deaths
Retired	206	157	43%
Housewife	42	27	39%
Husband	1	1	50%
Manager	9	9	50%
Driver	4	7	64%
Administrator/ Clerk	9	6	40%
Engineer	5	6	55%
Health and Social care professional	0	6	100%
Teacher/ Lecturer	7	6	46%
Childminder/ Carer	3	4	57%
Hospitality service	1	3	75%
Public sector employee	1	3	75%
Business owner	2	2	50%

Occupation	Non COVID-19 deaths	Number of COVID-19 deaths	Number of C-19 deaths as a % of total deaths
Carpenter	1	6	86%
Accountant	1	4	80%
Cleaner	5	4	44%
Director	2	3	60%
Factory worker	1	3	75%
Builder	0	2	100%
Other professional	2	4	67%
Other skilled labour	15	4	21%
Other unskilled labour	4	6	60%
Agriculture	3		0%
Entertainment Industry	3		0%
Machine worker	5		0%
Personal Assistant/ Shop Assisitant	1		0%
Shopkeeper/ Sales person	4		0%

- In terms of risk of deaths due to COVID-19 by occupation: Manual and routine occupational groups including Drivers (bus drivers, taxi drivers, delivery drivers), carpenters.
- There were 6 deaths among Health and social care professionals in Enfield and all deaths were due to COVID-19.
- 4 deaths out of 7 deaths during this period among childminders and carers were due to COVID-19

This include analysis of data from 15th March until 5th May

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Deaths by country of birth

Country of birth	Non-COVID-19 death	COVID-19 death	Number of COVID-19 deaths as a % of total deaths
UK	160	129	**45%**
Europe	45	38	46%
African-Caribbean	48	93	**66%**
Turkey, Greece or Cyprus	47	59	**56%**
Asian (South Asian, East Asian)	16	29	**64%**
Middle-East	6	4	38%

Key messages:

- The percentage COVID-19 deaths is **highest in individuals born in African/Caribbean countries (66%) followed by Asian countries (64%)**
- These trends are mirrored nationally

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Deaths by country of birth: deep analysis of Origin data

Ethnicity	Non COVID-19 deaths	Number of COVID-19 deaths	Number of C-19 deaths as a % of total deaths
WHITE- born in England	174	121	41%
IRISH REPUBLIC	16	15	48%
WHITE- born in Scotland	16	13	45%
WHITE- born in Wales	11	12	52%
GREEK/ CYPRUS	21	21	50%
TURKEY	12	17	59%
SOMALIA	**0**	**7**	**100%**
MUSLIM (UNSPECIFIED)	1	6	86%
MUSLIM (OTHER)	2	6	75%
ITALY	14	6	30%
BANGLADESH MUSLIM	2	5	71%
GHANA	3	5	63%
BLACK CARIBBEAN	1	3	75%
NIGERIA	3	3	50%
INDIA : HINDI	4	3	43%
NETHERLANDS	4	3	43%
JEWISH/ARMENIAN	5	2	29%

- Of the **White- born in England** residents who died, **41%** had C-19.
- People whose origin is **Turkey, Somalia, East Asia, Ghana** had high proportion of C-19 deaths.
- All analysis show people from **Muslim** background have high proportion of deaths due to C-19.

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Languages spoken at time of death: deep analysis of Origin data

Language spoken	Non COVID-19 deaths	Number of COVID-19 deaths	Number of C-19 detahs as a % of total deaths
ENGLISH	210	155	42%
GREEK	37	25	40%
ARABIC	7	18	72%
TURKISH	13	18	58%
WELSH	11	12	52%
HINDI	7	7	50%
SOMALI	0	7	100%
ITALIAN	14	6	30%
AKAN	3	5	63%
BENGALI	2	5	71%
DUTCH	4	3	43%
SPANISH	3	3	50%
YORUBA	3	3	50%
FRENCH	3	2	40%
POLISH	6	2	25%
PUNJABI	2	2	50%
RUSSIAN	3	2	40%

- In terms of languages spoken, apart from English, people who speak **Arabic, Bengali, Somali, Akan and Turkish** are at high risk of COVID-19 deaths.

This include analysis of data from 15th March until 5th May

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Death by Co-morbidities

Co-morbidity	Number of deaths as a % of total COVID-19 deaths among Enfield residents (n=299)
No comorbidity other than COVID-19	59 (20%)
CVD	158 (53%)
Respiratory	117 (39%)
Mental health	75 (25%)
Cancer	19 (6%)

- People with cardiovascular disease (CVD) had the highest percentage of COVID-19 deaths followed by those with respiratory disease
- Some patients may have more than one cause of death
- Certain long term conditions including cardiovascular deaths, respiratory illnesses, cancer and mental been reduced by improving physical activity, balance diet and reducing smoking.

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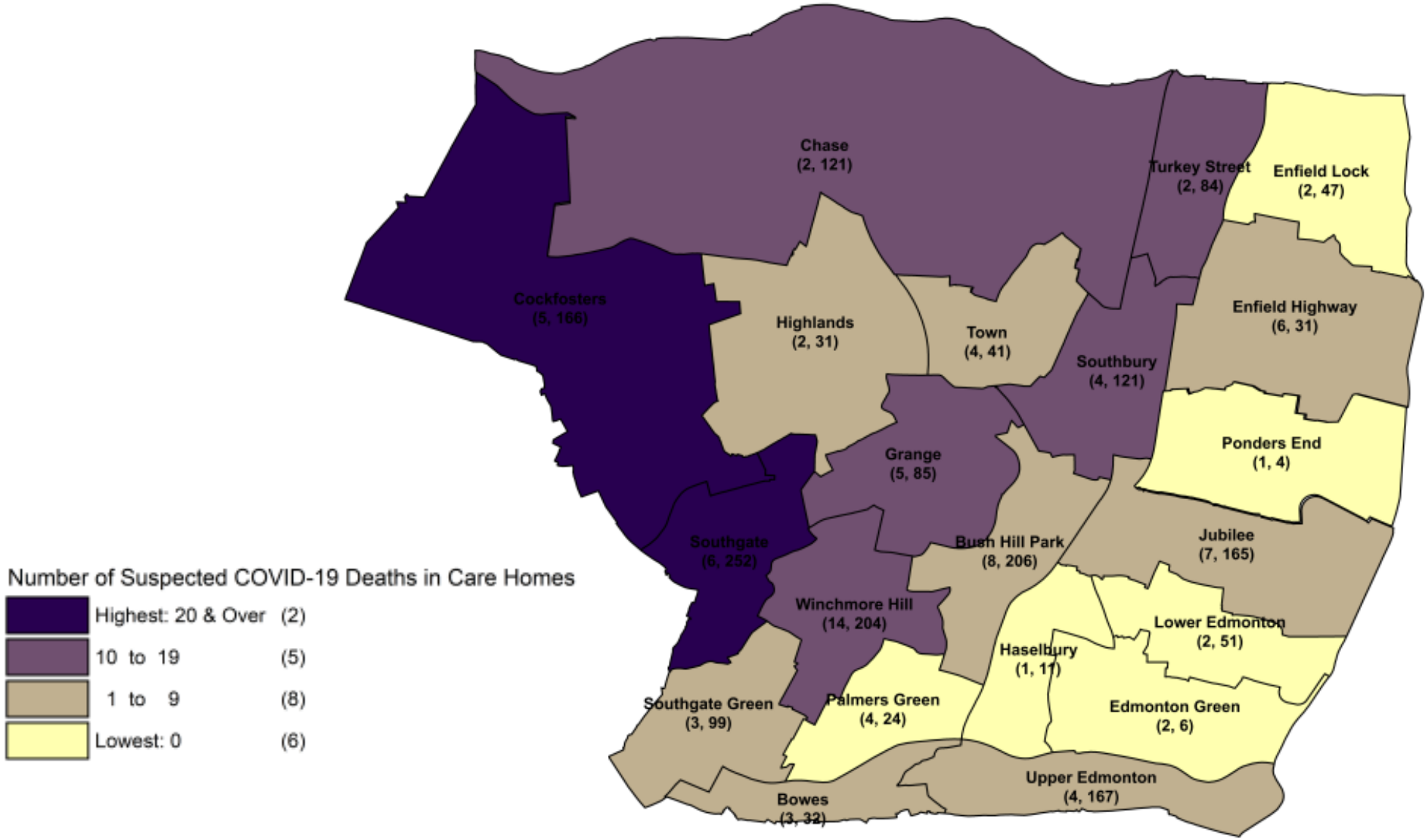
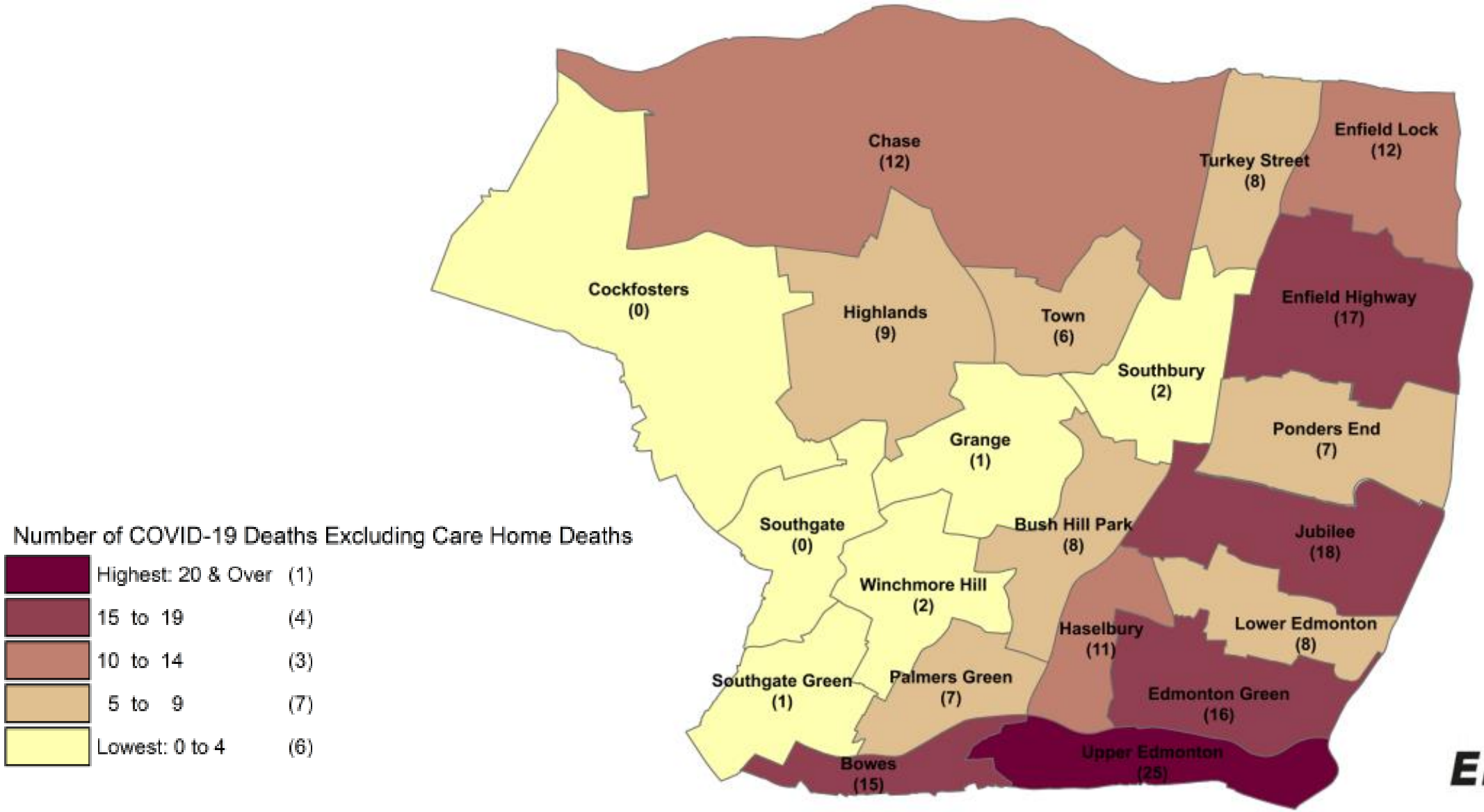
Covid-19 deaths by ward



Enclosed in brackets is the number of care homes and the corresponding size, by ward.

Covid-19 deaths by ward (excluding care homes)



Enclosed in brackets is the number of COVID-19 deaths, by ward.

Conclusions

1. 384 excess deaths have occurred during 15 March 2020 and 25th June 2020 due to COVID-19.
2. COVID-19 deaths in Enfield disproportionately affect in following groups:

   - Underlying conditions such as **CVD, respiratory conditions**.
   - Ethnic minority groups: **Turkish, Somalian, African Caribbean, East Asian, Bangladeshi and Ghanaian.**
   - High deaths among people who speak the following languages: **Arabic, Turkish, Akan and Bengali.**
   - **Routine and manual workers** (carers, drivers, labourers and carpenters) and health and social care professionals.

ENFIELD Council

Q & A

Any Questions?

For any questions we are unable to get to today, please email:

- Roseanna.Kennedy-Smith@enfield.gov.uk
- Darya.Bordbar@enfield.gov.uk

Enfield Local Outbreak Control Plan (LOCP)

This plan is maintained and updated by members of the Local Authority Outbreak Control Team (OCT). Members of the Local Authority OCT should approve any changes to the plan.

Version Control.

Version number	Actioned by	Type of change	Date
1.0	Glenn Stewart	Full plan draft	15/06/20
2.0	Glenn Stewart	Updates following comments	23/06/20

Review and Exercise Record

This plan will be reviewed annually or as required following learning from outbreaks.

Initial testing of the plan will take place via a workshop with scenario-based testing with the Outbreak Control Team. This will validate the plan, develop staff competencies and give them practice in carrying out their roles and to test procedures. Ongoing training will be dependent on an increasing incidence of COVID-19 cases and the mobilisation of surge capacity.

Exercise record:

Date	Type	Details
TBC	Workshop	

Contents

1. BACKGROUND

1.1 Introduction

The NHS Test and Trace service launched on 28 May 2020 across England and forms a key part of the government's COVID-19 recovery strategy. It aims to control the COVID-19 rate of reproduction (R) and reduce the spread of infection and save lives.

Anyone who now tests positive for COVID-19 will be contacted by NHS Test and Trace and will be asked to share information about their recent interactions. Those who are identified to have been in close contact with a confirmed case of COVID-19 and thus at risk of having contracted the virus, will be alerted by the NHS Test and Trace service and advised to self-isolate for 14 days, even if they do not have symptoms, to stop unknowingly spreading the virus. This will be complemented by the rollout of the NHS COVID-19 App.

Moving forward, contact tracing (NHS Test and Trace) will become a core component of England's response to COVID-19. NHS Test and Trace will require an expansion of our local outbreak support capacity working in close collaboration with PHE. The Council will take a lead in supporting local settings or communities with complex outbreaks, where local knowledge and insight is required.

This local plan sets out how the London Borough of Enfield will respond to outbreaks and support the management of cases in liaison with the London Covid Response Cell (LCRC). This plan focuses on identifying and containing potential outbreaks in places such as workplaces, accommodation settings, care homes and schools, ensuring testing capacity is deployed effectively and helping the most vulnerable in self-isolation access essential services locally.

It also supports an integrated approach between local and national government, with a range of other partners such as the NHS, GPs, businesses, employers, voluntary organisations, community partners, and the general public. Terms referred to in this plan are defined in the glossary found in Appendix 1.

1.2 Aim & Objectives

The aim of this plan is to provide a framework for the multi-agency response to COVID-19 outbreaks that occur within the London Borough of Enfield.

The key objectives of the plan are:

- To define the roles and responsibilities of key stakeholders in responding to outbreaks of COVID-19.
- To outline how the council, and other key local stakeholders, will work with Public Health England and in particular the LCRC in responding to outbreaks of COVID-19.
- To plan for local outbreaks in identified settings
- To outline the response and support to a number of linked cases or outbreak within identified settings

- To identify methods for local testing to ensure a swift response that is accessible to, and supports, the entire population, including those that are isolated.
- To summarise the plan for stand down and recovery.

1.3 Scope and Plan Limitations

This plan is intended as a response for COVID-19 specific outbreaks. It is not intended to be used as a plan for:

- Other types of communicable disease incidents or outbreaks.
- Outlining in detail the Public Health England response to COVID-19 and the Test and Trace Service.

1.4 Equalities Statement

In preparing this plan, care has been taken to promote fairness, equality and diversity, regardless of disability, ethnic origin, race, gender, age, religious belief or sexual orientation.

A data review conducted by Public Health England has highlighted that the impact of COVID-19 has been to replicate existing health inequalities and has in some cases increased them[1]. The following inequalities were observed amongst confirmed cases of COVID-19:

- Age: people aged 80 or over were seventy times more likely to die than those aged under 40.
- Gender: risk of dying was higher men
- Deprivation: risk of dying was higher for people living in more deprived areas compared to those living in the least deprived areas.
- Ethnicity: Black, Asian and Minority Ethnic (BAME) groups had a higher risk of dying than those in White ethnic groups.

2. GOVERNANCE FOR MANAGING AN OUTBREAK OF COVID-19

2.1 Roles and responsibilities of agencies and organisations in responding to COVID-19 outbreak

Agency or organisation	Roles and Responsibilities
NHS Test & Trace	• Provide testing of suspected cases of COVID-19 • Call handlers make initial contact (tier 3) • NHS professionals undertake initial contact tracing of confirmed cases (tier 2). If a risk assessment identifies the

[1] Public Health England (2020). Disparities in the risk and outcomes of COVID-19

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889861/disparities_review.pdf

	need for a specialist input (tier 1) this would then be referred to the LCRC.
Public Health England London Coronavirus Response Cell (PHE LCRC) **Tier 1**	**The LCRC is a pooled PHE resource from the three London Health Protection Teams will be responsible for:** • Initial detection of an outbreak from routine surveillance or ad hoc reporting • Initial risk assessment, escalation (if required) and notification to partners • Lead the initial response and investigation in order to allow an accurate risk assessment to be undertaken to inform any actions that may be necessary • Provide specialist health protection advice and manage cases and contacts, testing and infection control • Provide information materials to the setting affected • Recommend ongoing infection control measures • Convene an Incident Management Team (IMT) if required for specific high-risk complex situations, and also contribute to any IMTs convened by Local Authority • Provide information to Director of Public Health and advice/recommendations for ongoing support • Liaise with other sources of specialist advice, at PHE and from other experts/professionals • Ensure appropriate escalation of the incident where there is a wider geographical spread or increased seriousness of the threat to public health • PHE also provides system leadership and surveillance, some of this will take place at a national level.
Local Authority	• Lead role in protecting and improving health of the population across their jurisdiction • The Director of Public Health has a leadership role for the Local Authority contribution to health protection matters, including preparing for and responding to incidents that present a threat to public health • Supporting the LCRC in their initial response and investigation in order to allow an accurate risk assessment to be undertaken to inform actions that may be necessary • Deliver COVID-19 prevention work and respond to COVID-19 related enquiries • Ensure appropriate Local Authority representation at Incident Management Team (IMT) meetings if convened by LCRC • Providing Public Health advice to the LCRC IMT, particularly with regards to the vulnerability and resilience of the local community • Briefing the LCRC IMT on levels of media interest, in terms of both traditional channels and social media • Advising the LCRC IMT on issues relating to public information, especially in the communication of risk • Convene a local authority IMT if required for community cluster

	• Statutory duty to investigate infectious disease linked to workplace settings, undertake inspections, regulate workplace risk assessment processes and exercise powers under the Health and Safety at Work Act 1974, where they are the Health and Safety enforcement authority • Ensuring that contracted providers deliver an appropriate clinical response to any incident that threatens the Public's Health • Ensuring Business Continuity impacts are monitored and that the Council is able to continue to deliver on its priority services • Consider the authorisation of variations to contractual obligations where necessary, to respond to communicable disease outbreaks and incidents not covered by Major Incident clauses

2.2 Oversight for local outbreak management (subject to ratification)

There are two groups for managing local outbreaks. The Community Resilience Board will maintain oversight of all local outbreaks and provide strategic oversight. The Incident Management Team will be convened only in response to specific complex outbreaks where it is necessary to bring together a wider group of stakeholders.

2.2.1 Community Resilience Board (CRB)

The purpose of the Community Resilience Board (CRB) will be to review all outbreaks where LCRC has requested Local Authority support or management. The Outbreak Control Team (OCT) will be responsible for coordinating the local support response and following Standard Operating Procedure's (SOP) outlined in Appendix 3. The team will convene virtually on a regular basis (initially daily in the face of an ongoing incident). The chair of the OCT will attend the CRB to ensure full community engagement to incident responses. The Terms of Reference for the OCT is available in Appendix 2.

The core membership of the CRB is:

	Chair, Leader of the Council
	Vice-Chair, Deputy Leader of the Council
	Chief Executive, Enfield Voluntary Action
	Chief Executive, Enfield Carers Centre
	CEO, Citizens Advice Enfield
	CEO, Age UK Enfield
	North Enfield Food Bank
	The Felix Project
	Healthwatch Enfield
	Enfield Over 50's Forum

	Lead Project Manager, Enfield Council
	Acting Executive Director of Resources
	Public Health Strategist, Enfield Council
	Head of Communications
	Head of Libraries
	Head of Schools Traded Services
	Head of Financial Assessment)
	Service Development Manager, Adult Social Care
	Head of Corporate Strategy
	Resources Team, Enfield Council

COVID-19 OCT Operational Management (reports into CRB)

Officer Composition

Name	**Role**	**Contact**
Director of Public Health	Chair & SPoC	
Deputy Director of Public Health	Vice Chair	
HWB Partnership Manager	Governance / General	
Head of Regulatory Services and Corporate H+S	EHO lead	
EHO	EHO resource	
PH Community Engagement Officer	Community Engagement	
Service Manager of Strategy and Development	Liaison with Adult Social Care	
Head of School & Early Years	Liaison with Educational settings	
Team Manager - Safeguarding Adults, Health & Social Care	Safeguarding/Provider Concerns	
Consultant in PH		
Technical Officer Food & Safety		
Head of Housing Services	Housing lead	
Resident Safety Director	Housing lead	
Press & New Media Manager		

Manager of Emergency Planning	Emergency planning lead	
Director if Customer Experience	Community Support lead	
Interim Head of Primary Care	Liaison with NCL CCG- Enfield Directorate	
North Middlesex University Hospital NHS Trust	Liaison with acute sector	
Public Health England	Liaison with PHE	
Language Shop ID number 82600617	Interpretation services	020 3373 1700

2.2.2 Incident Management Team (IMT)

For the purpose of this plan, the term 'Incident Management Team' (IMT) will be used to describe the group convened either by LCRC and / or by the local authority OCT to manage complex high-risk groups and community clusters.

The purpose of the IMT is to agree and coordinate the activities of the key stakeholders involved to manage the investigation and control of an individual outbreak situation. This includes assessing the risk to the public's health and ensure control measures are implemented as soon as possible.

Convening the IMT

The LCRC will normally be the agency to ask the Local Authority to convene the IMT and act as its chair. It would only be appropriate to convene the OCT if there was a major outbreak or community cluster:

a) there are a large number of associated cases within a setting or community

b) the setting is high risk and initial control measures have not successfully contained the outbreak

For lesser outbreaks, Public Health and Environmental Health teams will decide on the appropriate level of co-ordination. Section 3 outlines the principles of outbreak management and control, however serious.

The IMT will consist primarily of members of the OCT but may invite relevant Heads of Service appropriate to settings and / or vulnerable populations. Should demand

for resource threaten to overwhelm IMT / OCT capacity requests will be made through appropriate channels. This may include, for example, more staff to undertake contact tracing.

2.3 COVID-19 Outbreak Declaration & Alert Mechanisms

This section details the procedures for the notification and management of outbreaks and community clusters.

2.3.1 Outbreak management

Recognition of an outbreak

An outbreak of COVID-19 is defined as two or more cases that have tested positive for COVID-19, which are linked through common exposure, personal characteristics, time or location.

In care homes, an outbreak is defined as one case that has tested positive for COVID-19 in the setting. The OCT may be informed by:

- LCRC notification (direct telephone call or daily emailed line list)
- The setting
- Commissioners

The majority of outbreaks are “family outbreaks” affecting members of a single household but, within the context of sustained community transmission of COVID-19, these are not considered of sufficient risk to warrant management by the OCT.

“General outbreaks” affecting more than one household or based within a wider setting or community are the focus of this plan.

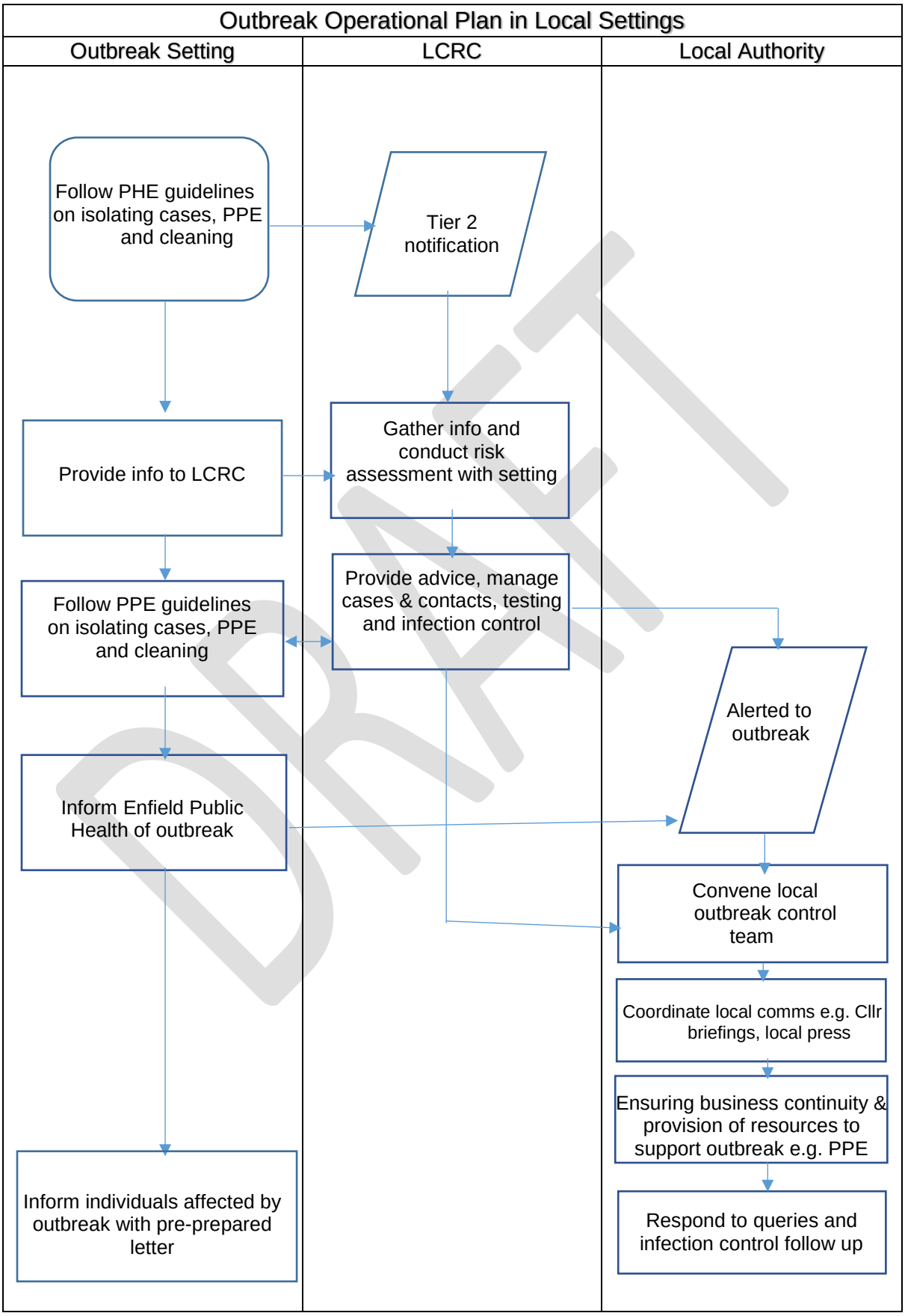
Once the OCT are notified that there is a general outbreak, the OCT are responsible for ensuring that all key information is gathered and stored securely in the OCT Assure case management system.

On the day that an outbreak is notified, steps must be taken to start managing the outbreak.

A risk assessment must be undertaken immediately to assess whether it is necessary to convene an IMT or to involve communications and/or emergency planning colleagues to support.

Figure 1 below sets out the flow of information and action between the outbreak setting, LCRC and the local authority.

Figure 1. Operational Plan for general COVID-19 outbreak in local settings



2.3.2 Community Cluster

A community cluster is a number of confirmed cases linked by geographical location or other similar characteristic e.g. linked to a neighbourhood or community group, specific buildings, or groups with social links e.g. through language or common interest. Interventions will depend on the common link between individuals in the cluster (e.g. all live within one building or linked by common social interaction).

The management of community clusters will follow the same process as for an outbreak (detailed in section above). The key difference is that in the community clusters, the local authority will undertake a risk assessment of and response to an identified community cluster with the support of LCRC. The local authority, in place of LCRC, will also convene an IMT and provide support to the community.

2.4 Data flow, reporting and data governance

Data will flow from a Single Point of Contact (SPoC) in the LCRC and in the local authority to facilitate data flow, communication and follow up. Any Test, Track and Trace Tier 2 and 3 data received locally, will be saved in a secure network. Data will be analysed to produce routine statistics for monitoring purposes and shared in an aggregate form within the organisation.

Published data on contact and tracing will also be used to monitor the local situation.

All information on complex outbreaks including setting, details of contacts, cases and actions taken to be held on a held on a secure system in a systematic way that makes information retrievable. Information on complex outbreaks to be shared with teams and services as needed to manage the outbreaks.

2.5 Local testing capacity

Mobile Testing Units (MTUs) are adapted vans that can be used to provide testing in a variety of different settings with a capacity of up to 500 tests a day. Directors of Public Health (DPH) may request an MTU for the following day in the event of an outbreak.

Operational process:

- The DPH notifies the MTU cell of the need for an MTU the next day, the number of tests needed, the location for the deployment, and that a list will be provided of the names of those advised to attend.
- LA, working with the school, workplace, or other setting, contacts all people or parents of children requiring testing in writing ideally by email· These people attending the MTU will be provided with a test kit by the MTU.
- LA confirms with mobile testing cell that the site meets the requirements (see DHSC guidance) for a full-scale MTU with vehicular accessor if a smaller

MTU deployment is required (e.g. pedestrian only) and provides a list of names.

- LA staff will support on the day to register people who attend but are not on the list of names provided in advance.
- All testing will be as per national testing protocols and results entered onto SGSS and CTAS systems.

Site selection

It is strongly recommended that the following features are considered when selecting a site for mobile testing:

- Parking for 30/40+ cars (smaller car parks for smaller communities can be used)
- Ability to implement a one-way traffic system on site
- Separate entry and exit points for pedestrian testing
- Away from buildings in use by other occupants (no dual access)
- Hard standing for drive in capability (preferably flat)
- Site entry height restriction above 2.8m
- Toilet Facilities that are on or near the site (required in all cases for staff use only)

There is no site selection criteria for smaller form MTU deployments (currently). Essentially, an MTU deployment can be consider for anywhere there is access to park a van and accommodate the MTU team (including toilet facilities nearby). Smaller sites may prohibit vehicular access meaning testing is available for pedestrians only. This will limit the daily testing capacity.

3. LOCAL AUTHORITY CONTROL MEASURES

This section details the actions and recommendations that the OCT will take to support and manage outbreaks and community clusters of COVID-19.

3.1 Interventions

A range of interventions are available to the OCT in planning the response to COVID-19 outbreaks and controlling the identified risks. These interventions are complimentary to those implemented by the LCRC.

I. Support for a setting where there has been an exposure to a suspected case of COVID-19

This will include public responding to specific questions as well as providing standardised guidance on next steps for the setting, both in term of anyone

who is symptomatic and close contacts within that setting. This support would be provided to both providers and commissioners (where appropriate).

II. Support for a single case in a complex setting

This will include prevention interventions such as the sharing of communications and national guidance, and supporting the setting with any enquiries, for example those relating to the implementation of guidance. Additional support will be provided to vulnerable people who require it during self-isolation. The OCT will liaise with the setting to provide ongoing advice and support for testing, communications, infection control and PPE. The OCT will also liaise with partners such as North Central London CCG, the Borough Directorate, GPs and other healthcare providers to provide coordinated support to the setting, where required.

III. Support for first report of outbreak or community cluster

In addition to the support provided for a single case in a complex setting the OCT will provide more intensive infection prevention and control advice. Where necessary, the OCT will provide advice on excluding multiple groups or recommend closure of the setting where appropriate. Further communication support will be provided to manage any press enquiries, communications with the public and briefings.

IV. Support for ongoing outbreaks and community clusters

In addition to the support provided for the first report of an outbreak the OCT will audit the settings outbreak mitigation processes and support the setting to improve them. The OCT will also provide advice on the closure of the setting. Ongoing communications support will be provided to manage any media interest, share information with the public and stakeholders, and to support briefings.

V. Intervention around those who refuse to be tested

Public Health will provide information to settings to share with those refusing to access testing to support them to making an informed decision, further details of which can be found in Appendix 5. If testing is still refused, a risk assessment will be undertaken to determine whether further self-isolation of any close contacts of those refusing testing is required (e.g. other members of the class “bubble” in an educational setting).

VI. Intervention around those who refuse to self-isolate

Public Health will develop guidance to support settings where there are individuals refusing to self-isolate, further details of which can be found in Appendix 5. If individual residents are non-compliant with self-isolation advice, EHOs have powers to visit local properties to gather more information and the local OCT will consider liaising with PHE to invoke new public health detention powers (subject to expected forthcoming legislation).

VII. Intervention to alert individuals identified as close contacts whom NHS Test and Trace has failed to contact

Where appropriate and feasible Environmental Health Officers and Public Health LBE staff will seek to contact those who the NHS Test and Trace Service has failed to contact.

3.2 Tailored intervention for specific settings and community clusters

Standard operating procedures have been developed to manage risks that COVID-19 cases pose within each setting and for local community clusters. These SOPs are provided in Appendix 3. An overview of these situations and their key characteristics are provided in the table below.

Table 1: Key characteristics of settings with outbreak control plans

Setting	Key characteristics
Residential care settings	• Agency staff working across multiple sites • Vulnerability of residents, including older adults and those with complex health and care needs • Have experienced a higher incidence of COVID-19 outbreaks • Systems for managing outbreaks are already in place • Challenges associated with enforcing social distancing and/or self-isolation within these settings
Schools, nurseries and children's centres	• Bubbles (groups of c.15 children) being implemented for teaching / play • Schools have recently opened up to more children • Implications and risks for having to close entire setting • Parental concern • Potential challenges of enforcing social distancing among children and young people
Other Educational Establishments (e.g. Universities, private nurseries, colleges)	• As above, but the local authority has limited influence • Also see complex residential settings
Workplaces & places of assembly	• Implications for business continuity & resilience
Places of worship	• Specific community groups e.g. a single ethnic group or geographical area may be affected • Community tensions
Complex residential settings (e.g. high-rise blocks, halls of residence, hostels, street populations)	• Residential – complex interactions • Mobile populations • Street populations – vulnerable group • Street populations – links to housing, drug and

	alcohol services
Community clusters	• A number of confirmed cases linked by geographical location or other similar characteristic e.g. linked to a neighbourhood or community group, specific buildings, or groups with social links e.g. through language or common interest. • Interventions will depend on the common link between individuals in the cluster (e.g. all live within one building or linked by common social interaction).

3.3 Ethical issues and anticipated challenges

The Council has a Public Health duty to promote and protect the health of the local population, and in doing so may need to undertake interventions to reduce the transmission and spread of COVID-19. Some of these interventions, including social distancing measures, self-isolation, and facilitating contact tracing, may have an impact on people's privacy, liberty or freedom to make certain choices. Interventions discussed and agreed upon by the OCT should use means that are the least coercive necessary to meet important public health goals and should be proportionate to the health risk being addressed. Most people will comply with interventions without the need for further actions. However, where voluntary cooperation is not forthcoming or has failed, health protection powers should be viewed as a last resort.

Specific ethical issues and anticipated challenges relating to managing outbreaks of COVID-19 locally, include:

Ethical issues or anticipated challenges	**Mitigating actions**
Testing and tracing	
Symptomatic individuals who are refusing to be tested	• Provide public health advice and risks in a clear and simple format. • Explore whether advice needs to be conveyed in a different format (e.g. language) • Explore whether additional support is required to organise or facilitate testing
Confirmed COVID-19 positive cases who refuse to share (with the NHS Test and Trace service) personal information of people they have been in contact with	• Provide public health advice and risks in a clear and simple format. • Explore whether advice needs to be conveyed in a different format (e.g. language) • Clarify the information governance requirements around data
Individuals who have been in contact with a confirmed COVID-19 positive case refusing to comply with the NHS Test and Trace	• Provide public health advice and risks in a clear and simple format. • Risk assessment around implications of this person not self-isolating (e.g. high-risk workplace)

service	• Explore whether advice needs to be conveyed in a different format (e.g. language) • Explore whether additional support is required to facilitate self-isolating (e.g. food, medicines, money) • Potential use of health protection powers
People's expressed concerns about information governance and sharing personal information via the app (when available) or telephone service	• Highlight the helpline as an alternative option • Communications plan to include proactive and reactive statements around data use
Requirement to self-isolate	
Refusal to self-isolate when symptomatic, or having been in contact with a symptomatic person (this has previously been raised as an issue for looked after children, and residents of drug and alcohol facilities)	• Provide public health advice and risks in a clear and simple format. • Explore whether advice needs to be conveyed in a different format (e.g. language) • Explore whether additional support is required to facilitate self-isolating (e.g. food, medicines, money)
Inability to self-isolate when symptomatic, or having been in contact with a symptomatic person (e.g. learning disability, homeless population)	• Proactive communication with settings about how to manage this • Provide public health advice and risks in a clear and simple format. • Explore whether advice needs to be conveyed in a different format (e.g. language) • Explore whether additional support is required to facilitate self-isolating (e.g. food, medicines, money, accommodation) • Consider environmental adaption (e.g. moving case or others temporarily, shadowing or 1to1 support)
Safeguarding concerns for both children and adults, who will be less visible and have reduced contact with public services	• Discussing risk and mitigation with Adult Social Care/Children's Services • Provide clear guidance to staff on when home visits are appropriate, how to conduct these safely, and alternative options for keeping children and adults safe
Difficulty in accessing necessities such as food and medication during period of self-isolation	• Ensure support is provided by the council, or VCS, for the duration of self-isolation if there are no friends or family who are able and willing to provide support
Whole front-line teams being required to self-isolate following contact with a COVID-19 positive staff member	• Ensure a resilience plan is in place to avoid all staff having to self-isolate at once

Community engagement	
Managing tensions within a specific community (e.g. religious group, estate, cultural group)	• Ensure all diverse communities have access to public health advice and risks in a clear and simple format. • Explore whether advice needs to be conveyed in a different format (e.g. language). • Communications plan to address this and engage community leaders as required. • Explore whether additional support is required to facilitate self-isolating (e.g. food, medicines, money)
Language barriers when communicating key messages about an outbreak and important information about isolation and testing	• Collate information materials in different languages so that these are readily available

Risks and mitigations for specific settings

Schools, nursery and early years settings	
School not knowing what actions to take and when - risk of schools closing unnecessarily	• Ensure regular communication from Public Health and any other relevant agencies to provide support when needed • Provide pro-active communications to explain what will happen if an outbreak happens in a school • Provide pro-active communication so that the setting knows what to do in an event of an outbreak
Staffing capacity affected by self-isolation requirements	• Ensure a resilience plan is in place to avoid all staff having to self-isolate at once • Ensuring early access to testing when staff are symptomatic
Anxiety among parents and staff	• Continue to provide clear and consistent public health advice to school staff and families if an outbreak does occur
Accessibility of information for diverse school communities	• Explore whether advice needs to be conveyed in a different format (e.g. language)
Care homes and residential settings	
Vulnerable older population	• Provide pro-active communication so that the setting knows what to do in an event of an outbreak • Ensure regular communication from Public Health and any other relevant agencies to provide support when needed
Emotional support for staff	• Staff should be signposted to available Employee

working in stress environment and experiencing bereavement	Assistance Programmes and mental health support where possible
Staffing capacity affected by self-isolation requirements	• Ensure a resilience plan is in place to plan for this • Staff trained and appropriately using PPE, and access to PPE supplies • Advice on appropriate infection control measures to prevent transmission and spread • Ensure that staff isolate as soon as they develop symptoms and have early access to testing
Workplaces & places of assembly	
Staffing capacity affected by self-isolation requirements	• Ensure a resilience plan is in place to plan for this • Ensuring early access to testing when staff are symptomatic
Business continuity affected by self-isolation requirements	• Ensure a business continuity plan is in place
Emotional support for staff working in stress environment and experiencing bereavement	• Staff should be signposted to available Employee Assistance Programmes and mental health support where possible
Places of worship	
People coming to places of worship in times of crisis	• Ensure clear signage and communications to attendees if the place of worship is affected by an outbreak • Signpost individuals to local support services • Ensure setting is implementing procedures that facilitate social distancing and wider infection control e.g. regular cleaning, particular in high touch areas
Complex residential settings (e.g. halls of residence, hostels, street populations)	
Staffing capacity affected by self-isolation requirements	• Ensure a resilience plan is in place to mitigate impacts
Anxiety among residents and staff	• Support the setting to provide clear and consistent public health advice if an outbreak does occur
Difficulty in delivering commissioned services to residential setting groups (I.e. substance misuse)	• Ensure commissioned service providers have plans in place to adapt their services if an outbreak does occur (e.g. remote consultations, using PPE appropriately)
Community clusters	
Anxiety among community members and increasing community tensions	• Continue to provide clear and consistent public health advice and work with communities to cascade the messaging

	• Proactive communications around preventative measures such as social distancing and importance of self-isolation • Increase awareness around Test, track and trace
Accessibility of information for diverse communities	• Explore whether advice needs to be conveyed in a different format (e.g. language) • Use a range of communication channels and approaches

4. STAND DOWN ARRANGEMENTS

4.1 Standing down the OCT

The Outbreak Control Team will make the decision to stand down when:

- There are no active outbreaks in the community or any settings
- There are no confirmed COVID-19 cases in the borough
- The incidence of COVID-19 regionally and nationally is low

Once the decision has been made, all relevant partners and stakeholders will be informed. More information can be found in the OCT Terms of Reference (Appendix 2).

4.2 Development and reflection

Lessons identified throughout the response need to be documented, shared and acted upon.

At the point when the OCT is stood down, a process will be set up to identify lessons learnt and any recommendations for future work. Local plans should also be reviewed and updated based on relevant lessons identified and recommendations following an outbreak as appropriate.

5. COMMUNICATIONS ARRANGEMENTS

5.1 Role of local Communications team

Proactive communications will focus on messages to ensure that residents know what NHS Test and Trace is, how to prepare for any need to self-isolate, what to do if you are asked to self-isolate, how to access support if needed, and the importance of complying with advice given.

The communications team will also support the local OCT with reactive and proactive communications to allay community concern in response to specific outbreaks and community clusters, should these be needed.

5.2 Role of the OCT

Public Health and the wider OCT are developing proactive communications for settings to ensure that commissioners, providers and other key stakeholders know about NHS Test and Trace and how it affects their setting. This includes clear guidance on what to do if there are exposures, confirmed cases or outbreaks related to these settings.

5.3 Role of PHE

The PHE LCRC will share tailored template letters and other communications materials with Public Health to support their management of outbreaks in specific settings and community clusters.

APPENDICES

Appendix 1 - Glossary of Terms

a. **Antibody test** means the type of test that looks for the presence of antibodies (produced by people with the virus to counteract the virus) against the COVID-19 virus. These antibody tests are also referred to as serology tests and can be conducted in a laboratory or through point-of-care testing. This test is not widely available yet.
b. **Community cluster** means a number of confirmed cases linked by geographical location or other similar characteristic (e.g. linked to a neighbourhood or community group, specific buildings, or groups with social links like through language or common interest).
c. **Confirmed case** means an individual that has taken the PCR swab test and has tested positive for COVID-19, with or without symptoms.
d. **Contact tracing** means a process in which when a person tests positive for COVID-19, they are contacted to identify anyone who has had close contact with them during the time they are considered to be infectious, and these close contacts are also contacted to give them the advice they need.
e. **Incident management team (IMT)** means team convened by either LCRC to manage a high risk complex outbreak, or team convened by local authority to manage a community cluster outbreak.
f. **Incubation period** means the period from exposure to the virus to the onset of symptoms. The incubation period for COVID-19 is 5-6 days on average, however it can be up to 14 days.
g. **Infectious period** means the period in which an individual may be contagious to others.
h. **Outbreak** means two or more people that have tested positive for COVID-19, which are linked through common exposure, personal characteristics, time or location; A greater than expected rate of infection compared with the usual background rate for the particular population and period.
i. **Outbreak control team** means team convened by local authority to manage the COVID-19 pandemic.

j. **PCR swab test** means the type of test that looks for the presence of genetic material from the COVID-19 virus within a swab or saliva sample. PCR stands for polymerase chain reaction. Evidence shows that an individual can test positive on a PCR swab test for COVID-19 from 1-3 days before the onset of symptoms. The highest levels of the virus in the nose and throat are in the 3 days following the onset of symptoms. After day 5, levels of the virus are too low for the PCR swab test to reliably detect and infection (the test may not be valid).
k. **Possible case** means an individual that may be presenting with symptoms of COVID-19 but has not been tested or are awaiting their PCR swab test result.
l. **Self-isolation** means when an individual stays at home because they have or might have COVID-19, which helps stop the virus spreading to other people.
m. **Shielding** means extra steps taken by individuals at high risk (clinically extremely vulnerable) from COVID-19 to protect themselves.
n. **Social distancing** means individuals avoiding close contact with anyone that they do not live with.

Appendix 2 – Terms of Reference OCT

The terms of reference for the OCT will be:

- To conduct risk assessments for local outbreaks of COVID-19.
- To develop a strategy to deal with each outbreak, and allocate appropriate responsibilities based on the risk assessment.
- To communicate with other professionals, elected members, the media and the public as required, providing accurate and timely information.
- To produce a post-incident report containing debrief information and lessons and recommendations identified which could apply to further outbreaks.

Appendix 3 – Standard Operating Procedures/ Roles and responsibilities for LAs and LCRC, by setting type

The following high-risk settings have been identified as venues where outbreaks may be more likely to occur and in which local outbreak control management support would be required as directed by the LCRC.

Settings:

a) Care Homes
b) Schools and Early Years (mainstream, academies, special schools, Pupil Referral Units, independent)
c) Workplace, Employers, Manufacturer's
d) Community Clusters
e) Fire stations and other Home from Home environments (sheltered and supported living, emergency/ temporary shared accommodation)
f) Homelessness/Hostels/ Rough sleeper encampments
g) Places of Worship
h) Leisure and Entertainment Venues (bars, restaurants, leisure centres, theatres, cinemas and similar venues)

i) Day Centre's, Youth Clubs
j) Vulnerable People

3a - Care Homes

Source of concern

- Positive test in staff or resident
- Notification from Level 2
- Symptoms of COVID-19 in a staff member of resident
- Household contacts of staff test positive or are asked to self-isolate and suspected COVID-19

Action

Care home

- Follow PHE guidelines on isolating cases
- Inform GP
- Inform LA SPoC
- Order tests for staff and residents

LCRC (*LCRC have Outbreak plans for care homes)*

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required
- Link with CCG named GP/person for the home.

Local Authority

Care Home Resilience and Support Plans submitted 29th May 2020

- Prevention work and responding to enquiries including;
    - Guidance sent to all providers
    - Advanced training on infection control delivered by CCG
    - Daily telephone contact during outbreak
    - Contact Tracing (following guidance)
    - Ordering PPE for all homes via NCL. This is going over to Clipper at some point.
    - Providers to order test kits via portal
    - Any staff with symptoms are directed to test centres

- Control follow up together with CCG named person
- LA SPoC informs Adult Social Care commissioners
- Liaise with the local CCG/ GP and other health providers in supporting the home.
- Support vulnerable contacts who are required to self-isolate
- Participate in IMT if convened by LCRC and provide further support to setting following IMT

Other

- NHS – CCG named GP/person for each Care Home links to ASC Commissioners and Public Health to follow-up re infection control, PPE, ongoing control measures.

Data and Reporting

- Total number of COVID-19 situations with principal context Care Home, by Borough
- Total number of deaths in patients with a Care Home address by local authority, confirmed and suspected COVID-19
- Number of care home testing results reported the previous day, that will be relayed to homes that day
- Graph: timeline of COVID-19 deaths in care homes (as reported to LCRC
- Graph: timeline of number of new care homes reporting suspected and confirmed COVID-19, by date of first contact with LCRC
- Number of tested individuals matched to care homes by postcodes by PHEC
- Number of tests matched to care homes by postcode by PHEC
- Number of COVID-19 cases matched to care homes over time
- Number of new care home postcodes with confirmed cases
- Age and sex distribution of COVID-19 cases matched to care homes

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3b – Schools and Early Years

Source of concern

- Positive test in Staff or pupil
- Notification from Level 2
- Symptoms of COVID-19 in a staff member of pupil
- Household contacts of staff or pupils test positive or are asked to self-isolate

Action
School

- Refer to school/setting risk assessment, which follows PHE guidelines on isolating cases, PPE and cleaning
- Inform LA SPoC (this can be via school/setting link officer/advisor).
- Inform parents with a pre-prepared letter/SMS (template provided by LCRC)

LCRC

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Liaison with school governors and support with communication to parents
- Support vulnerable contacts who are required to self-isolate
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required
- COVID Secure risk assessments support, where relevant
- Local communications e.g. briefings for Cllrs, local press

Other

- North London STP**,** NCL CCG and Hospital if symptomatic children are attending for diagnosis/testing

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3c – Workplace, Employers, Manufacturers

Source of concern

- Positive test in Staff
- Notification from Level 2

- Symptoms of COVID-19 in a staff member
- Household contacts of staff test positive or are asked to self-isolate
- When App in use some staff members

Action

Business

- Follow PHE guidelines on isolating cases, PPE and cleaning
- Inform LA SPoC
- Inform staff and clients with a pre-prepared letter/SMS

LCRC

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Inspection of food premises and enforcement as necessary
- Advice and support local business affected by workforce isolation
- Communication with local community
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required
- COVID Secure risk assessments support, where relevant
- Local communications e.g. briefings for Cllrs, local press

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3d - Community Clusters

Source of concern

- A number of positive tests in a locality or a common site or activity
- Notification from Level 2

- Symptoms of COVID-19/ requests for tests from a number of people in a locality or a common site or activity

Action

HPU/Local

- Follow PHE guidelines on isolating cases, PPE and cleaning
- Inform LA SPoC

LCRC *Working on an SOP for Community Clusters*

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Communication with local community
- Determine whether a mobile or hyper-local testing unit is required
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3e - Fire stations and other Home from Home environments (sheltered and supported living, emergency/ temporary shared accommodation)

Source of concern

- Positive test in Staff
- Notification from Level 2
- Symptoms of COVID-19 in a staff member
- Household contacts of staff test positive or are asked to self-isolate

Action

Fire Service

- Follow PHE guidelines on isolating cases, PPE and cleaning
- Inform LCRC
- Inform staff and their families with a pre-prepared letter/SMS
- Inform Gold Commander

LCRC

- Receive notification from Tier 2 or fire service
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and their families as well as contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Inspection of food preparation areas and enforcement as necessary
- Communication with local community
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”
-

3f - Homeless/Hostels/Rough sleeper encampments

Source of concern

- Positive test in Staff or residents
- Notification from Level 2
- Symptoms of COVID-19 in a staff member or resident
- Household contacts of staff test positive or are asked to self-isolate

Action

Hostels

- Follow PHE guidelines on isolating cases, PPE and cleaning

- Inform LA SPOC
- Inform staff and clients with a pre-prepared letter/SMS
- Follow locally developed SOP and risk assessment

LCRC

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Inform the Find and Treat service (if funding agreed)
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing infection control measures
- Share risk assessment and details from HPZone with LA
- Convene Incident Management Team (IMT) if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- LA SPoC inform service commissioners
- Liaise with the local CCG/ GP and other health providers
- Liaise with GLA in their management of hotels, clarify roles to avoid duplication or gaps.
- Infection control follow up
- Provide support and ongoing management of settings
- LA to decide who may visit community venues and gather contact information and arrange testing (subject to NCL testing regime)
- Convene Local IMT if required

Other

- Links to housing, drug and alcohol services and CCG and their commissioners
- Links to GLA
- Follow up of cases and contacts if/when they leave their current accommodation, including referring to other LAs where appropriate

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3g- Places of Worship

Source of concern

- Positive test in Staff or congregation
- Notification from Level 2
- Symptoms of COVID-19 in a staff member
- Household contacts of staff test positive or are asked to self-isolate
- When App in use some staff members

Action

Business

- Follow PHE guidelines on isolating cases, PPE and cleaning
- Inform LA SPoC
- Inform staff and clients with a pre-prepared letter/SMS – need to prepare

LCRC

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Inspection of food premises and enforcement as necessary
- Advice and support local business affected by workforce isolation
- Communication with local community
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required
- COVID-19 secure risk assessments support, where relevant
- Local communications e.g. briefings for Cllrs, local press

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3h- Leisure and Entertainment Venues

Source of concern

- Positive test in Staff
- Notification from Level 2
- Symptoms of COVID-19 in a staff member
- Household contacts of staff test positive or when asked to self-isolate

Action

Business

- Follow PHE guidelines on isolating cases, PPE and cleaning
- Inform LA
- Inform staff and clients with a pre-prepared letter/SMS – need to prepare

LCRC

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contracts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Inspection of food premises and enforcement as necessary
- Advice and support local business affected by workforce isolation
- Communication with local community
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required
- COVID-19 secure risk assessments support, where relevant
- Local communications e.g. briefings for Cllrs, local press

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3i- Day centres, Youth Clubs

Source of concern

- Positive test in Staff
- Notification from Level 2
- Symptoms of COVID-19 in a staff member
- Household contacts of staff test positive or are asked to self-isolate

Action

Fire Service

- Follow PHE guidelines on isolating cases, PPE and cleaning
- Inform LCRC
- Inform staff and their families with a pre-prepared letter/SMS
- Inform Gold Commander

LCRC

- Receive notification from Tier 2 or fire service
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and their families as well as contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Inspection of food preparation areas and enforcement as necessary
- Communication with local community
- Liaise with the local CCG/ GP and other health providers
- Infection control follow up
- Convene Local IMT if required

Comms

- Awaiting Comms Toolkit from London Councils and GLA
- This will be in key community languages and pictorial form
- Key Message is “Keep London/Borough/Place/ Families etc. Safe”

3j- Vulnerable People

LCRC ***Working on an SOP for individual residents in the community***

- Receive notification from Tier 2
- Gather information and undertake a risk assessment with the setting
- Inform LA SPoC
- Provide advice and manage cases and contacts, testing and infection control
- Provide information materials to the setting
- Recommend ongoing control measures
- Convene IMT if required or refer to local team

Local authority

- Prevention work and respond to enquiries
- Communication with local community
- Determine whether a mobile or hyper-local testing unit is required
- Liaise with the local CCG/ GP and other health providers
- Support vulnerable contacts who are required to self-isolate
- Household contacts of resident test positive or are asked to self-isolate
- Infection control follow up Convene Local IMT if required
- Local communications e.g. briefings for Cllrs, local press

Appendix 4: Legislation, National guidance and supporting plans

Legislation

- Health and Social Care Act 2012
- Public Health (Control of Disease) Act 1984
- Civil Contingencies Act 2004
- Coronavirus Act 2020

National guidance

- NHS test and trace: how it works
- NHS test and trace: workplace guidance
- Infection prevention and control
- Covid guidance and support - home page

Supporting Plans

- Joint agreement between LCRC and LAs for outbreaks and complex settings

Appendix 5: Guidance on consent to PCR testing and refusal to PCR testing and self-isolation

Settings may experience challenges in getting service users to adhere to self-isolation if required and may experience challenges when it comes to testing for current infection (PCR tests).

Consent should be gained before administering a test. If a resident does not give consent, then a test should not be taken. To obtain consent, residents should be supported to understand the purpose of the test. Where people appear to lack capacity to consent, a mental capacity assessment should be completed and documented for this decision. If they are assessed as lacking capacity, a best interest decision needs to be made. The person who is administering the test should complete the capacity assessment and best interest decision.

When making a best interest decision, you need to consult with a family member or friend who has an interest in the resident's care. Where there is nobody appropriate to consult, an Independent Mental Capacity Advocate (IMCA) should be involved with the best interest decision. For advice on the need for an IMCA pls contact Fiana Centala (Fiana.centala@enfield.gov.uk) 0208 132 2154 or Sharon Burgess (Sharon.burgess@enfield.gov.uk) 0208 132 1854.

Whether or not the resident lacks capacity, the test should only be administered with their co-operation. It is important to consider if the test will make a difference to decision making or actions. Regardless of COVID-19 status, it is important to remember the importance of all infection prevention control precautions and correct use of PPE.

Testing is only one of many important infection prevention control measures that are used and not essential if there are particular challenges in gaining consent. In the situation where a test is not given because the person refuses (whether or not they have the capacity to consent) we recommend that those individuals are monitored more closely and frequently for signs and symptoms of COVID-19 (cough, fever, hypoxemia, anosmia) and isolated immediately if any clinical suspicion of COVID-19.

The below table provides further guidance for measures to take to support residents who are non-compliant.

	Timeline	**Measures**
1	**To enable residents to be compliant/ when first become aware of non-compliance**	• Provide the non-compliant individual with **verbal guidance** e.g. by member of staff explaining to non- compliant person about social distancing/ self-isolation/ keeping safe during pandemic. • Talk through the guidance with the individual highlighting that it is for their own safety (speak to them about being in a vulnerable group if they are) as well as others who may be more vulnerable.
2	**If above as no impact after (1-2 days)**	• **Provision of guidance in written format (if you become aware of non-compliance)** (including

		easy read, Makaton) - Provide written guidance / letter.
3	**(Consider as appropriate)**	• **Consideration of additional support** e.g. additional support package and promotion of expectations particularly on council owned land and property – for example posters, guidance newsletters etc.
4	**If 1-3 has no impact**	• **Police involvement** - police officers will take a common sense approach to maintain public support. For the general public; ○ Enhanced visibility in our communities ○ Engagement and encouragement to adhere to government direction ○ Support to local authorities in enforcing premises closure ○ Issue of fixed penalty notices where a power exists and is appropriate ○ Use of arrest powers when necessary and as a last resort In occasion of non- compliance; ○ Engage ○ Explain ○ Encourage ○ Enforce – Fixed Penalty Notice only if necessary ○ Arrest – only if absolutely necessary
5	**As and when required**	• For vulnerable people – for example rough sleepers, multi-agency working/solutions including with mental health to explore solutions via the Council's High Risk Panel.
6	**As and when required**	• **As a Landlord, when it is possible to establish a link to a particular property –** consider legal remedies including injunctions to cease non-confirming behaviour
7	**A multi-agency meeting will be held within 24 hours of receiving a referral**	• **Complete risk assessment tool (see Appendix 6).** • If all measures have been exhausted and non-compliance persists complete the risk assessment tool below and forward to (noncompliancovid@enfield.gov.uk, dudu.sher-arami@enfield.gov.uk and sharon.burgess@enfield.gov.uk). A multi-agency emergency meeting with Public Health, Social Care, Police, Housing, Legal Services, Regulatory Services will be arranged to agree actions.
8	**As and when required**	• Consideration of options involving legal remedies

		available to the Local Authority. • Legal Services, Comms (Press) and Lead Member for the service area concerned to be consulted / briefed.
9	**As and when required**	• Under public health legislation, PHE has powers to test and isolate individuals in limited circumstances. However, these are very much a last resort. • If it is agreed at the multi-agency meeting that we may need to utilise legislation, we will contact Public Health England to discuss.

Appendix 6: Risk assessment and referral form for non-compliance

Details of Alleged Non-Compliant Individual(s)		
Name(s)	Date of Birth	Address

Summary of Concern
(Please provide a brief description of the event/situations/individuals this involves, what actions are causing concern, who is at risk of infection, and if there are any social or health related vulnerabilities to be aware of)
(Type of residence or setting and any support they have in place)
(What are the views and wishes of the non-compliant individual(s) as they have been expressed or understood)

Have there been any measures taken to intervene on the situation?		
☐ First instance	☐ Previous warning or instructions given	☐ Multiple attempts made
Please specific the previous unsuccessful measures put in place		

Risk of the Alleged Non-Compliant Individual(s) Involved Due to COVID-19		
Are any likely to be infectious?		
☐ No symptoms / Unlikely	☐ Has symptoms consistent with infection (e.g. cough and/or fever)	☐ Confirmed COVID-19
Low to Moderate Risk	Moderate to High Risk	High Risk

Are any likely to be in a vulnerable group?		
Not in a vulnerable group	Vulnerable Health Group	Vulnerable Social Group
☐Not in a vulnerable group	☐ Aged 70+ years	☐ History of safeguarding concerns (please give details):
	☐ Pregnant	☐ Known or suspected mental health illness
	☐ Have an underlying health condition that requires a flu jab (see Table 1 for full list of conditions)	☐ Substance or alcohol misuse issues known or suspected
	☐ Have a serious underlying health condition requiring shielding (see Table 2 for a full list of conditions)	Concerns around: ☐ Modern slavery, ☐ Domestic violence, or ☐ Prostitution.
		☐ Homeless or ☐ Illegal encampment
		☐ Issues around verbal communication
		☐ Learning disability
		☐ Looked after child or care-leaver
		☐ Any other concerns (please describe):
Low to Moderate Risk	Moderate to High Risk	

Are there any concerns regarding their capacity?			
☐ No concerns regarding capacity	☐ Likely to have a medical or mental health condition that is affecting their ability to make decisions	☐ Minor (under age 18)	☐ Known Community Deprivation of Liberty Safeguard (DoLS) in place
	If Yes to any concerns regarding their capacity, please explain further: *(please explain here)*		

Risk of COVID-19 Infection to Others

What is the level of exposure to others?	
Please describe the settings in which the alleged non-compliant individuals have been observed:	*(List settings here)*

Based on the settings described above, try and estimate the level of potential contact/exposure to others as described below:

☐Low	☐Moderate	☐High

This may be where there is little likelihood that the alleged individual(s) are coming within a 2-meter distance of others, or contact has been limited to 1-2 people	This may be where the alleged individual(s) have come within a 2-meter distance among a small group of 3-4 individuals	This may be where the alleged individual(s) have come within a 2-meter distance among a large number (5 or more) individuals, **or** within a largely populated setting (residency buildings, care homes, hospitals, etc)

Are any contacts likely to be in a vulnerable group?		
Not in a vulnerable group	Vulnerable Health Group	Vulnerable Social Group
☐ Not in a vulnerable group	☐ Aged 70+ years	☐ History of safeguarding concerns (please give details):
	☐ Pregnant	☐ Known or suspected mental health illness
	☐ Have an underlying health condition that requires a flu jab (see Table 1 for full list of conditions)	☐ Substance or alcohol misuse issues known or suspected
	☐ Have a serious underlying health condition requiring shielding (see Table 2 for a full list of conditions)	Concerns around: ☐ Modern slavery, ☐ Domestic violence, or ☐ Prostitution.
		☐ Homeless or ☐ Illegal encampment
		☐ Has issues around verbal communication
		☐ Learning disability
		☐ Looked after child or care-leaver
		☐ Any other concerns (please describe):
Low to Moderate Risk	Moderate to High Risk	

Known Outcomes and Recommended Actions

Have there been any known negative outcomes or impacts to date?
If yes, please describe in further detail:
Are there any recommended actions for the Non-Compliance Team?
If yes, then please describe in further detail :

Please Provide Your Contact Details

Name:	Job Title:	Organisation:

Telephone:	Email:

Overall Risk Assessment (To be completed by Non-Compliance Team at LBE)			
Please fill out the risk assessment based on the information provided on this form			
Risk of Infection	☐ Low	☐ Moderate	☐ High
Risk of Exposure to Others	☐ Low	☐ Moderate	☐ High
Level of Vulnerabilities	☐ Low	☐ Moderate	☐ High
Likelihood of Persistence without Intervention	☐ Low	☐ Moderate	☐ High
Overall Risk	**☐ Low**	**☐ Moderate**	**☐ High**

Plan of Action

MUNICIPAL YEAR 2020/21

Meeting Title:
HEALTH AND WELLBEING BOARD
Date: 16th July 2020

Contact officer: Glenn Stewart

Telephone number: 020 8132 0605
Email address:
glenn.stewart@enfield.gov.uk

Agenda Item:

Subject: Enfield Local Outbreak Control Plan

Report of: Stuart Lines, Director of Public Health

1. EXECUTIVE SUMMARY

The government has asked councils to produce local outbreak control plans to respond quickly to any outbreak of the virus and to help stop the virus from spreading. This is important as lockdown restrictions ease and is a key part of trying to return to a more normal way of life. There are 7 themes to the plan:

- Care homes and schools
- High risk places, locations and communities
- Local testing capacity
- Contact tracing in complex settings
- Data integration
- Vulnerable people
- Local governance

It was asked the plan should be published on the Council website by the end of June (https://new.enfield.gov.uk/services/community-safety/emergency-planning/#4) and attached. This paper provides an overview of the plan and it's governance structure.

Recommendations

The Board is asked to endorse the Enfield Local Outbreak Plan and to note that LBE has already successfully dealt with 2 potential outbreaks.

Background

1.1 The NHS Test and Trace service launched on 28 May 2020 across England and forms a key part of the government's COVID-19 recovery strategy.

1.2 Anyone who now tests positive for COVID-19 will be contacted by NHS Test and Trace and will be asked to share information about their recent interactions. Those who are identified to have been in close contact with a confirmed case of COVID-19 and thus at risk of having contracted the virus, will be alerted by the NHS Test and Trace service and advised to self-isolate for 14 days.

1.3 Moving forward, contact tracing (NHS Test and Trace) will become a core component of England's response to COVID-19. NHS Test and Trace will require an expansion of our local outbreak support capacity working in close collaboration with PHE. The Council will take a lead in supporting local settings or communities with complex outbreaks, where local knowledge and insight is required.

1.4 This local plan sets out how the London Borough of Enfield will respond to outbreaks and support the management of cases in liaison with the London Covid Response Cell (LCRC).

1.5 It also supports an integrated approach between local and national government, with a range of other partners such as the NHS, GPs, businesses, employers, voluntary organisations, community partners, and the general public.

Themes / priorities

2.1 The plan includes the seven following themes / priorities:

1. Care homes and schools (Planning for local outbreaks in care homes and schools)

2. High risk places, locations and communities (Examples included, sheltered housing, dormitories for migrant workers, detained settings, rough sleepers, ports and airports).

3. Local testing capacity

4. Contact tracing in complex settings

5. Data integration between partners and between national and local interface through the Joint Biosecurity Centre.

6. Vulnerable people – Help for self-isolation.

7. Local Boards (Establishing governance structures).

Roles and responsibilities

3.1 The following table outlines roles and responsibilities

Agency or organisation	Roles and Responsibilities
NHS Test & Trace	• Provide testing of suspected cases of COVID-19 • Call handlers make initial contact (tier 3) • NHS professionals undertake initial contact tracing of confirmed cases (tier 2). If a risk assessment identifies the need for a specialist input (tier 1) this would then be referred to the London Covid Response Cell (LCRC).
Public Health England London Coronavirus Response Cell (PHE LCRC) **Tier 1**	**The LCRC is a pooled PHE resource from the three London Health Protection Teams will be responsible for:** • Initial detection of an outbreak from routine surveillance or ad hoc reporting • Initial risk assessment, escalation (if required) and notification to partners • Lead the initial response and investigation in order to allow an accurate risk assessment to be undertaken to inform any actions that may be necessary • Provide specialist health protection advice and manage cases and contacts, testing and infection control • Provide information materials to the setting affected • Recommend ongoing infection control measures • Convene an Incident Management Team (IMT) if required for specific high-risk complex situations, and also contribute to any IMTs convened by Local Authority • Provide information to Director of Public Health and advice/recommendations for ongoing support • Liaise with other sources of specialist advice, at PHE and from other experts/professionals • Ensure appropriate escalation of the incident where there is a wider geographical spread or increased seriousness of the threat to public health • PHE also provides system leadership and surveillance, some of this will take place at a national level.
Local Authority	• Lead role in protecting and improving health of the population across their jurisdiction • The Director of Public Health has a leadership role for the Local Authority contribution to health protection matters, including preparing for and responding to incidents that present a threat to public health • Supporting the LCRC in their initial response and investigation in order to allow an accurate risk assessment to be undertaken to inform actions that may be necessary • Deliver COVID-19 prevention work and respond to COVID-19 related enquiries • Ensure appropriate Local Authority representation at Incident Management Team (IMT) meetings if convened by LCRC • Providing Public Health advice to the LCRC IMT, particularly with regards to the vulnerability and resilience of the local community • Briefing the LCRC IMT on levels of media interest, in terms of

	both traditional channels and social media • Advising the LCRC IMT on issues relating to public information, especially in the communication of risk • Convene a local authority IMT if required for community cluster • Statutory duty to investigate infectious disease linked to workplace settings, undertake inspections, regulate workplace risk assessment processes and exercise powers under the Health and Safety at Work Act 1974, where they are the Health and Safety enforcement authority • Ensuring that contracted providers deliver an appropriate clinical response to any incident that threatens the Public's Health • Ensuring Business Continuity impacts are monitored and that the Council is able to continue to deliver on its priority services • Consider the authorisation of variations to contractual obligations where necessary, to respond to communicable disease outbreaks and incidents not covered by Major Incident clauses

Governance

4.1 The LOCP was written by officers from across the Local Authority including Public Health, Environmental health, Adult Social Care, Emergency Planning, Children's Services, Housing and Communications, This group (the Operational Control Team) will oversee the plan and it's operational management.

4.2 Members of the OCT will also form the main part of any incident management team (IMT) that will operationally manage any outbreak working with partner agencies. The plan includes drawing in other relevant depending on where an outbreak occurs.

4.3 Strategic oversight of the LOCP will be from the Community Resilience Board (CRB). This is community focused body chaired by the Leader with representation from numerous BAME, faith and voluntary sector groups.

To note

5.1 The Board is asked to note that LBE has already successfully responded to 2 potential outbreaks; one in 2 GP surgeries where the authority was mentioned favourably by Matt Hancock, the Secretary of State for Health and once in a school. LBE as a borough has measures in place to respond to the emerging threat from Covid 19.

5.2 Members of the HWB Board are invited to comment upon the above.

COVID-19 & Tackling Health Inequalities in BAME Communities

Stuart Lines
Director of Public Health, Enfield

Ruth Donaldson
Managing Director – Enfield Directorate, NCL CCG

Enfield's Joint Health & Wellbeing Strategy

The Enfield Joint Health & Wellbeing Strategy sets out how Enfield's Health and Wellbeing Board will work with local people to improve health and wellbeing across the Borough. The five priorities are:

- Ensuring the best start in life;
- Enabling people to be safe, independent and well and delivering high quality health and care services;
- Creating stronger healthier communities;
- Reducing health inequalities – narrowing the gap in life expectancy; Promoting healthy lifestyles and making the healthy choice.

Together with David Sloman's vision articulated in, *Journey to a New Health and Care System,* now more than ever these priorities are crucial in building community resilience.

ENFIELD Council

PHE COVID-19 Review of Disparities

- The evidence from Public Health England (PHE) *COVID-19: review of disparities in the risk and outcomes* shows that Black, Asian and Minority ethnic (BAME) communities, as well as those individuals with other protected backgrounds such as age, gender, specified underlying health conditions and pregnancy are disproportionately affected by COVID-19.
- Report highlights stark inequalities that persist in the country.
- The impact of COVID-19 has replicated existing health inequalities and, in some cases, exacerbated them further, particularly for (BAME) groups.
- The largest disparity found was by age: Among people already diagnosed with COVID-19, people who were 80 or older were 70 times more likely to die than those under 40.
- Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in BAME groups than in white ethnic groups.
- These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in white ethnic groups.
- People of Bangladeshi background had twice the risk of death than white people and African Caribbean people -up to 50 per cent the number of deaths.
- People who have been worst affected by the virus are generally those who had worse health outcomes before the pandemic, including people working in lower-paid professions, those from ethnic minority backgrounds and people living in poorer areas. These groups generally experience poorer health than the overall population and significant health inequalities exist between different population groups.
- The subsequent PHE Report *Beyond the data: Understanding the impact of COVID-19 on BAME groups* makes important recommendations on the back of established policy and evidence on the disproportionate impact of the Pandemic on BAME communities, and is a emphatic call to action.

ENFIELD Council

PHE Report Beyond the Data: 7 Recommendations

1. Mandate **comprehensive and quality ethnicity data collection** and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities

2. Support **community participatory research**, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

3. **Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities** including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

4. Accelerate the development of **culturally competent occupational risk assessment tools** that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

5. Fund, develop and implement **culturally competent COVID-19 education and prevention campaigns**, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to target **culturally competent health promotion and disease prevention programmes** for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

7. Ensure that **COVID-19 recovery strategies actively reduce inequalities** caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

ENFIELD Council

Wider Determinants of Health

Evidence shows that as little as 10% of a population's health and wellbeing is linked to access to healthcare. We need to work with partners to look at the bigger picture, including:

This is why we want to work together to make sure residents in Enfield, start well, live well, and age well.

ENFIELD Council

Partnership Working

Taking on board the 7 recommendations, the group sought to look at how NHS and social care data collection could be used to inform local government and integrated care systems to minimise the impact of inequalities for Enfield residents. In the short/medium term this would be looking at those ethnicities and occupations that were unduly affected by COVID; and in the long term developing culturally competent health promotion/ prevention and early intervention and community development approach to build and reinforce community resilience. This will contribute to building a consensus for addressing inequalities and addressing the wider determinants of health.

The group worked in collaboration to:

- **Baseline** Enfield's Inequalities;
- Overlay Public Health and Primary Care data of **impact of COVID** on Enfield's inequalities
- **Create a framework using Beyond the Data 7 Recommendations** to establish short, medium and latterly, long terms ambitions.
- **Explore innovative interventions** that build capacity and capability in Enfield's most deprived communities to minimise the impact of COVID on those inequalities;

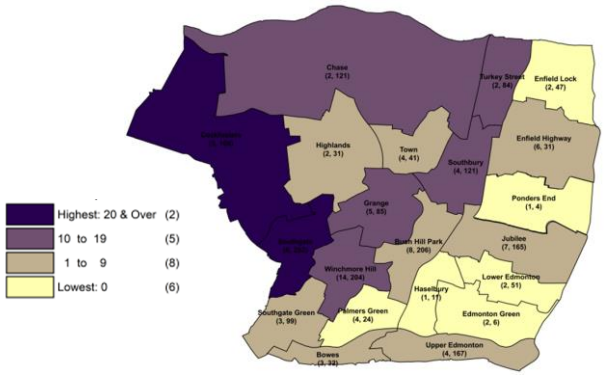
ENFIELD Council

COVID Impact in Enfield

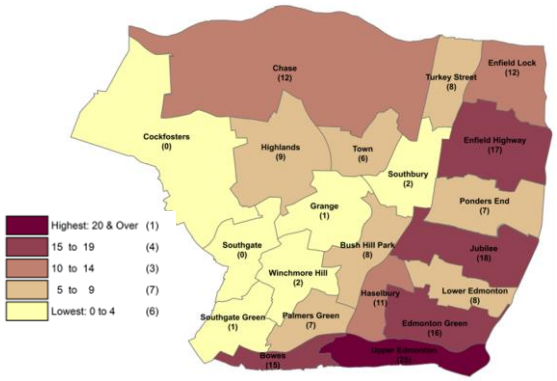
- 381 excess deaths have occurred during 15th March 2020 and 5th June 2020 due to COVID-19.
- COVID-19 deaths in Enfield disproportionately affect in following groups:
  - Underlying conditions such as CVD, respiratory conditions.
  - Ethnic groups- Turkish, Somalian, African Caribbean, East Asian, Bangladeshi and Ghanian.
  - High deaths among people who speak the following languages - Arabic, Turkish, Akan and Bengali.
  - Routine and manual workers (carers, drivers, labourers and carpenters) and health and social care professionals.

COVID-19 Deaths in Enfield Care Homes by Ward

Enclosed in brackets is the number of care homes and the corresponding size, by ward.



COVID-19 Deaths Excluding Care Home deaths in Enfield by Ward



ENFIELD Council

Using Beyond the Data as a Framework for Scoping Interventions (1)

PHE - Beyond the data: Understanding the impact of COVID-19 on BAME groups

No.	Recommendation	Enfield Activity
1	Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.	1. Review Coroners Records to create evidence base and look at impact on BAME Communities (Completed) 2. Explore Bereavement offer (Doug Wilson) 3. Continued surveillance of COVID 19 data sources to enhance understanding of impact on BAME communities
2	Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.	1. A Rapid Data and Evidence Review undertaken and disseminated to support local decision-making 2. Engagement with VCS to support local communities regarding recovery 3. Engagement with BAME communities/ VCS / faith groups regarding mitigation for a second wave of COVID Pandemic (June 2020). 4. Scheduled community engagement session planned for 22nd July (facilitated by EHW).
3	Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.	1. Representation of BAME groups: statutory and VCFS organisation – equal BAME representation 2. Equality Impact Assessment
4	Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.	1. Staff risk assessments to be conducted across, Local Authority, CCG, NHS Trust and Primary Care settings. 2. Enfield Directorate HoPC worked with NCL CCG Primary Care and NHSE/I to organise a COVID-19 Assessing the Risk Webinar for Primary Care (09.07.20) which helped to employers understand how best to undertake risk assessments, particularly for those staff 'at risk' groups including BAME. National experts presented, including senior NHSE and subject matter experts. Recording and slides have been sent out to all practices across North Central London (10.07.20). Also HoPC working with NCL Training hub and organised x2 further webinars on the practicalities of carrying out 'staff at risk group' risk assessments, including national experts from NHS Employers and study authors of the x2 major risk assessment tools being deployed in primary care (BAPIO and SAAD 2 tools): 15th and 16th July. 3. NCL are establishing a dedicated BAME Cell in line with the *Journey to a New Health and Care System* which states we need a disproportionate focus on areas of unequal access.

On 4th June 2020 Public Health, Enfield and NCL CCG – Enfield Directorate Executive Management Team met to discuss types of evidenced based prevention models which could be utilised to tackle health inequalities, particularly those compounded by COVID.

ENFIELD Council

Using Beyond the Data as a Framework for Scoping Interventions (2)

PHE - Beyond the data: Understanding the impact of COVID-19 on BAME groups

No.	Recommendation	Enfield Activity
5	Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.	1. BAME Communications and Engagement plan to be scoped to ensure interventions and approaches are co-produced with local communities.
6	Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.	1. Explore use of PCN data/disease registers to target BAME people with Diabetes, CVD, obesity 2. Explore development of targeted health promotion/ behaviour change/ environmental change and disease prevention programmes for Enfield residents.
7	Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.	1. Explore reviewing of socioeconomic factors including housing conditions and fuel poverty and impact on protective factors/community resilience 2. LBE COVID 19 recovery plan focuses of wider determinants

ENFIELD Council

Using Beyond the Data (PHE) as a Framework for Scoping Interventions (3)

Immediate Interventions	Medium Term Interventions	Longer Term Interventions
Use NCL level public health data on Shielded and Vulnerable lists to develop and engagement programme in collaboration with Public Health to give holistic guidance on conditions management. Joint Communications and Engagement campaign – general leaflet providing enhanced advice Scope mobilising VCS to support culturally competent engagement	Scope the extension of health checks remit to invite/re-invite all BAME over 40.(NEED TO RECONSIDER THIS ONE) Explore focus on pre-diabetes and newly diagnosed to improve HbA1c scores eg promotion of National Diabetic Prevention Programme (NDPP) for prevention of Type 2 diabetes. Scope culturally competent identification programmes for the undiagnosed eg COPD, Type 2 diabetes and Hypertension Promotion/targeting of physical activity and health eating programmes Explore opportunities to work together to change the obesogenic environment. Consider recommending shielding at the start of any significant cluster (economic impacts would need to be considered) Impact scoping for predicted 30% increase on COVID related anxiety in people who do not meet or no longer meet the threshold for Secondary Mental Health Care.	Ramp up communications campaigns in advance of any predicted peaks Explore use of PCN data/disease registers to target BAME people with Diabetes, CVD, obesity Review of housing conditions to target fuel poverty advice/grants and target known socio-economic groups that have been adversely affected by COVID.

ENFIELD Council

Initial Interdependencies

- **Formation of NCL CCG** – the agreement to merge the five boroughs into one single CCG from April 2020 will ensure a greater focus on differential outcomes across NCL. For example, work is underway to As part of the consitituon, any new money must be directed towards areas of greatest need. This is also in line with the guidance *Journey to a New Health and Care System*, which states that there must be a disproportionate focus and resource in areas of unequal access or outcomes

- **Integrated Care Partnerships** – the Enfield borough priorities are in the process of being agreed, with clinical leaders keen to focus on targeting at risk populations – i.e. flu vaccinations and smoking cessation services for those at greater risk of Covid complications

- **Mental Health** – at least 50% of SMI communities have at least one long term condition and the impact of COVID related anxiety is also predicted to have a 30% increase on people with Common Mental Health disorders seeking help. How to connect to existing support services where appropriate eg Improving Access to Psychological Therapies (IAPT) or Council's Mylife portal to provide brief interventions for emotional support for this group

- **NCL and Long-Term Conditions Steering Group**

- **Poverty Commission Recommendations**

- **Health and Wellbeing Strategy Action Plan**

- Council Commissioned **Voluntary & Community Sector** and Enfield Directorate VCS Lead Provider for IAPT

ENFIELD Council

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Enfield Borough Integrated Care Partnership
Progress Update for Health and Wellbeing Board Meeting

16th July 2020

Enfield ICP Stakeholders

NHS North Central London Clinical Commissioning Group

ENFIELD VOLUNTARY ACTION — PROVIDING SERVICES TO LOCAL VOLUNTARY AND COMMUNITY ORGANISATIONS IN ENFIELD

NHS North Middlesex University Hospital NHS Trust

ENFIELD GP Federation

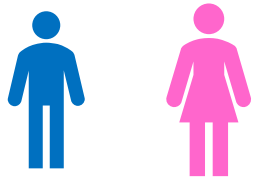
Enfield Directorate

NHS Royal Free London NHS Foundation Trust

ENFIELD Council

Barnet, Enfield and Haringey Mental Health NHS Trust

Patient Representatives



Enfield South West Primary Care Network

Enfield Unity Primary Care Network

Enfield Patient and Public Group

healthwatch Enfield

West Enfield Collaborative Primary Care Network

Enfield Over 50's Forum

Enfield LGBT NETWORK

Enfield Racial Equality Council (EREC)

Enfield Care Network Primary Care Network

Our Voice, Enfield Parents Forum

Voluntary and Community Stakeholder Reference Group

Background and context

- Enfield Integrated Care Partnership was established in 2019 to deliver the national and local vision for integrated health and social care
  - Good progress made between partners in agreeing vision, principles and governance structure

- Initial work focused on the frailty pathway
  - All organisations in the ICP, and therefore a catalyst for joint working

- Work on the ICP paused following the onset of the Covid-19, as partners focused on managing the immediate impact of the pandemic

- Now that the system is focusing on recovery from Covid-19, the Enfield Integrated Care Partnership (ICP) is being re-established

Enfield Integrated Care Partnership (ICP) re-established

Local Stakeholder interviews held to inform ICP re-start and the outputs of this initial workshop (externally facilitated)

Restart & Design Workshop, 26th June 2020

To re-engage all local stakeholders from across health, social care and voluntary and community groups in developing a shared vision and long list of potential initiatives:

- Maximises the collective benefits from our ongoing collaboration,
- Improves outcomes and addresses health inequalities in line with our wider HWB Strategy
- Incorporates learning from the Covid-19 pandemic
- Supports delivery of the 12 expectations for Integrated Care System Programmes nationally

Refine & Define Workshop, 15th July 2020

- Draft Vision for the ICP - Healthwatch Enfield co-ordinated the development of a the draft vision with Patient, Community and Voluntary sector groups
- Review outcome of partner survey to agree 3 priority areas from long list of potential initiatives
- Agree to the next steps and programme governance
- ICP Partnership Board - to be held in August 2020

Draft vision statement for the Enfield Integrated Care Partnership

Healthwatch Enfield co-ordinated the development of a the draft vision with Patient, Community and Voluntary sector groups

*"Together, we will change the way we work with you, to support **all** people in Enfield to live happy, healthy and rewarding lives"*

Key Principles:

- **Q**uality
- **A**ccessible
- **L**istening and responding
- **I**ntegration
- **T**imely
- **E**qual and inclusive

Refinement taking place following feedback from workshop

ICP Agreed Priorities

Ref	Priority Initiatives
1	Aggressively identifying and addressing **inequalities** in BAME communities including: • Mental Health • Long Term Conditions (LTCs) • Education and engagement – through schools etc to support self-care and access • Reinforcing the work on the LBE / CCG joint action plan on BAME inequalities • Driving up representation of those impacted by inequalities in PPRGs • Greater engagement with BAME, hard to reach, and deprived communities
2	Driving uptake of **screening and immunisations** to keep residents healthy and catch conditions earlier, including for cancer, giving people the best possible intervention/treatment: • Focus on childhood vaccs • Focus on flu imms (particularly in preparation for the coming winter) • Driving uptake of cancer screening programmes • Local comms/engagement campaign linked to national Stay Well in Winter campaign
3	Driving greater focus on improving **mental health** among residents: • Focus on proactively preparing for post Covid MH • Proactively identifying and addressing lower level MH issues eg through schools and other forums • Disproportionate focus on BAME communities including de-stigmatising
	Above priorities linked to working with all stakeholders including voluntary, community, faith groups, etc to identify and encourage hard to reach groups to engage in uptake of these services

Further refinement will take place within the T&F working groups

Next Steps for the Partnership

- Defining the programme of work to deliver of the initiatives
- Agreeing leadership and members from all stakeholder organisations for ICP Board and Task & Finish Groups
- Setting Up Task and Finish Groups
- ICP Board meeting to approve governance, priorities and plans – August
- Taking forward plans with renewed urgency and joint commitment to delivery

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 26 SEPTEMBER 2019

MEMBERSHIP

PRESENT Nesil Caliskan (Leader of the Council), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Parin Bahl (Chair of Enfield Health Watch), Stuart Lines (Director of Public Health), Tony Theodoulou (Executive Director of Children's Services), Vivien Giladi (Voluntary Sector), Pamela Burke (Voluntary Sector) and Jo Ikhelef (CEO of Enfield Voluntary Action)

ABSENT Alev Cazimoglu (Cabinet Member for Health & Social Care), Rick Jewell (Cabinet Member for Children's Services), Mahtab Uddin (Cabinet Member for Public Health), Dr Helene Brown (NHS England Representative), Bindi Nagra (Director of Adult Social Care), Natalie Forrest (Chief Executive, Chase Farm Hospital, Royal Free Group), Maria Kane (Chief Executive North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

OFFICERS: Dr Glenn Stewart (Assistant Director, Public Health), Niki Nicolaou (Voluntary Sector Manager), Mark Tickner (Senior Public Health Strategist), Jane Creer (Secretary)

Also Attending: Graham MacDougall (representing Enfield CCG), Richard Gourlay (representing North Middlesex University Hospital NHS Trust), Doug Wilkinson (LBE Director of Environment Operational Services), Doug Wilson (LBE Head of Strategy and Service Development), Dudu Sher-Arami (Consultant in Public Health), Margherita Sweetlove (Health in All Policies Strategist), Gayan Perera (Health Intelligence Manager), Evie Lodge (Public Health Intelligence Specialist), Desmond Wright (Consultant in Dental Public Health)

1
WELCOME AND APOLOGIES

Councillor Nesil Caliskan, Chair, welcomed everyone to the meeting and noted that chairing of the Board by the Council Leader reflected the corporate commitment to the Health and Wellbeing agenda.

Apologies for absence were received from Councillors Alev Cazimoglu, Mahtab Uddin, and Rick Jewell, and from Rob Larkman, Bindi Nagra, Ian Davis, Natalie Forrest, Jinjer Kandola and Siobhan Harrington. Enfield CCG was represented by Graham MacDougall, and North Middlesex University Hospital NHS Trust by Richard Gourlay.

2
DECLARATION OF INTERESTS

There were no declarations of interest in respect of any items on the agenda.

3
BETTER CARE FUND - SECTION 75 AGREEMENT AND BETTER CARE FUND UPDATE

RECEIVED the report of the Director of Health and Adult Social Care 'Section 75 Agreement: Approval of Revisions for 2019/2020' (sent to follow) and the Update Report from the Joint Health and Social Care Commissioning Board, for information.

NOTED

Introduction by Doug Wilson, including:
- The Section 75 Agreement involved a pooled fund with Enfield Council and Enfield CCG, who were committed to working together on services to benefit the local community and improving the lives of local people.
- Presentation to Health and Wellbeing Board was part of the formal sign off process.
- The Section 75 Agreement was also subject to CCG governance bodies' approval, reinforcing the joint commitment.

IN RESPONSE comments and questions were received, including confirmation that there would be engagement with organisations affected by reallocation of funding as part of a larger voluntary and community sector (VCS) contract. Doug Wilson would be happy to discuss individual cases outside the meeting.

AGREED that Health and Wellbeing Board noted:
(1) Arrangements for pooled funding.
(2) The delegation of formal sign off of the Section 75 Agreement between NHS Enfield CCG and the Council to the Director of Health and Adult Social Care as the approved statutory DASS (Director of Adult Social Services).
(3) The Director for Adult Social Care, in agreement with the Director of the CCG, to make minor amendments throughout the year to the schemes and funding arrangements to reflect any change in circumstances.
(4) That the Section 75 Agreement must be in a form approved by the Director of Law and Governance.

4
JOINT PRIORITIES FOR HEALTH AND SOCIAL CARE UPDATE

RECEIVED the report on the development of Joint Health and Adult Social Care Service Priorities for information.

NOTED

Doug Wilson's introduction of the report highlighted:
• There had been work over the last 12 months across health and social care to develop commissioning priorities.
• The focus was supporting local people's access to good information and offering support to regain independence.
• There had been significant engagement, particularly with partnership boards and patient participation groups.

IN RESPONSE comments and questions were received, including:
1. Proposed changes to walk in services were discussed, and that patients liked the ability to walk in and see a GP without booking an appointment. There should also be a facility to cancel appointments once booked.
2. It was confirmed that feedback was being sought in advance of the final version of the joint priorities document to be submitted to the Joint Commissioning Board. Any more views should be provided within the next two weeks. There would be regular updates to the Health and Wellbeing Board on progress.
3. Communications were important and that users were aware of facilities available.

AGREED that Health and Wellbeing Board noted the update report and any further feedback to be sent to Doug Wilson directly.

5
CHILDREN'S AND YOUNG PEOPLE MENTAL HEALTH LOCAL TRANSFORMATION PLAN - REVIEW

RECEIVED the briefing note from Enfield CCG (sent to follow).

NOTED

The introduction by Graham MacDougall, including:
• The 2019 Enfield Children & Young People Local Transformation Plan was in the process of being drafted and would be published by 31 October 2019, and the due governance processes were being gone through.
• This was a system plan, involving the local authority and CCG and VCS, but funding came through the CCG.
• Child and Adolescent Mental Health Services (CAMHS) was a significant priority for the NHS. Enfield was a Wave 2 trailblazer area and funding was to be allocated to be focussed into schools and based around the clinical model, and overseen by a steering group.

IN RESPONSE comments and questions were received, including:
1. It was confirmed that the main provider would be Barnet, Enfield and Haringey Mental Health NHS Trust. There would be a process around which schools were prioritised. Headteachers would make referrals. The money was purely for clinical posts.

2. Members questioned the small amount of the funding, and the need for preventative work. It was advised that the CCG invested into CAMHS and this money was in addition.

AGREED that Health and Wellbeing Board noted the briefing note.

6
ORAL HEALTH NEEDS ASSESSMENT

RECEIVED the briefing paper on oral health and dental services in Enfield.

NOTED the presentation by Desmond Wright, Consultant in Dental Public Health, including:
• Dental health of children in Enfield was improving, but in relation to other London boroughs there was still work to be done.
• Dental decay showed inequality across wards, with areas of least deprivation having the lowest levels of tooth decay.
• The Public Health Team had commissioned a prevention programme, with an action plan being delivered by Whittington Health. Oral health promotion activities were provided at schools, children's centres, community groups, and care homes. Additionally, a national programme was being rolled out.

IN RESPONSE, comments and questions were received, including:
1. Members welcomed the report and were pleased to note improvements over recent years; and noted the links with obesity and other risk factors.
2. In response to queries, it was advised that older people were retaining teeth longer, and demand for crowns, bridges and implants was growing.
3. With loss of stay and play groups in the community, networks for sharing information with parents were lost, including appropriate advice about child dental health. Social media could sometimes contain misinformation. A child's first dentist visit should be when the first teeth erupt. Health Visitors were being asked to distribute toothbrushing packs.
4. It was advised that increasing fluoride levels in water in London was difficult technically and politically, but alternative measures were available including toothpaste and varnish.

AGREED that Health and Wellbeing Board noted:
• Importance of oral health improvement programmes for children including the school fluoride varnish programme in addressing trends in dental decay.
• Continued public health investment in oral health programmes.
• Embedding oral health within the Health in All Policies agenda.
• Oral health embedded within the 0-19 health visiting and school nursing contract. This includes health visitors disseminating toothbrushing packs and oral health messages.
• Encouraging settings to sign up to Sugar Smart.
• Embedding oral health policies within settings through healthy early years and healthy schools.
• Oral health to be included within the Making Every Contact Count programme.

7
INFLUENZA UPDATE

RECEIVED a verbal update from Dr Glenn Stewart, and NOTED

• The flu season was approaching and some GP practices were now starting vaccinations. Over 65's vaccinations were expected to commence the week beginning 7 October or 14 October. There would also be focus on 2 – 3 year olds and pregnant women.
• Information on vaccination of staff was being presented to departmental management teams.
• Vaccine availability was not expected to be an issue: confirmed at a recent planning meeting.
• High levels of coverage were needed. There were targets for take-up.

8
JOINT HEALTH AND WELLBEING STRATEGY - UPDATE AND FORMAL SIGN OFF

RECEIVED the finalised Enfield Joint Health and Wellbeing Strategy 2020 – 2023.

NOTED that Health and Wellbeing Board had been involved throughout the development of the strategy and approval was now sought to progress to the next stages for adoption.

IN RESPONSE comments and questions were received, including:
• The strategy fitted with the Council's priorities and other strategic documents. It would underpin decisions by the Council and the CCG.
• Action plans would be updated as the strategy progressed, and updates provided to the Board.

AGREED that Health and Wellbeing Board approved the finalised Joint Health and Wellbeing Strategy.

9
JOINT HEALTH AND WELLBEING STRATEGY METRICS UNDERSTANDING PUBLIC HEALTH OUTCOMES FRAMEWORK AND LIFE EXPECTANCY (AND RELATION TO POVERTY)

RECEIVED the presentation by Gayan Perera and Evie Lodge, Public Health Intelligence, highlighting:
• Over the next five years, the overall population in Enfield was projected to grow by around 5%. Different wards had varying projected percentage changes.
• Key demographics showed the more affluent areas had higher life expectancy, but also higher levels of dementia and loneliness.
• The main three causes of deaths in Enfield were circulatory disease, cancer and respiratory disease.

• The ways that success would be measured were explained, with focus on three key behaviours: healthy diet; being active; being smoke free; and a fourth priority: being socially connected.
• There were also targets against long term conditions indicators.

IN RESPONSE comments and questions were received, including:
1. It was confirmed that targets were chosen to be relevant and meaningful, and ambition was tempered with realism.
2. The importance of healthy lifespan as opposed to just life expectancy was raised, and the concerning differences between areas of the borough.
3. It was confirmed that the Health Improvement Partnership would be the group monitoring the action plans. The Health and Wellbeing Board would be kept updated.

AGREED that Health and Wellbeing Board noted and endorsed the presentation Health in Enfield: Measuring Success, and the actions.

10
COUNCIL'S HEALTH IN ALL POLICIES IMPLEMENTATION PLAN

RECEIVED the presentation by Dudu Sher-Arami and Margherita Sweetlove, highlighting:
• Health in All Policies related to Enfield Council's decision-making and the way the organisation was working toward achieving the goals of the Joint Health and Wellbeing Strategy, to improve residents' health and wellbeing.
• The Year 1 action plan worked along with the three behaviours identified in the Joint Health and Wellbeing Strategy.
• The next steps focussed on Making Every Contact Count training for Council staff and partner organisations, and thematic years for the priorities.

IN RESPONSE comments and questions were received, including:
1. The concerted efforts were welcomed to accelerate measures. There would be opportunities to work collectively. Consistent communications were important.
2. Extension of smoke-free areas in Council properties and amendments to tenancy agreements had been suggested and had Board support.
3. It was requested that social isolation be added as a priority area for Year 4.

AGREED that Health and Wellbeing Board noted the presentation.

11
HEALTH AND WELLBEING LOGO CONFIRMATION

AGREED that Health and Wellbeing Board welcomed the adoption of a logo to improve the Board's visibility and identity, and agreed the logo option which had received the most votes.

12
UPDATE FROM NHS ENFIELD CCG ON EU EXIT PREPARATIONS

RECEIVED a to follow report from Enfield CCG.

NOTED
- Graham MacDougall confirmed the current position and that the NHS remained on-track with preparations.
- The Council's Brexit Panel had also ramped up activity, with focus on the most vulnerable, and a detailed risk register had been published.

AGREED that Health and Wellbeing Board noted the update.

13
MINUTES OF THE MEETING HELD ON 20 JUNE 2019

AGREED the minutes of the meeting held on 20 June 2019.

NOTED that Jo Ikhelef would still like to meet with Mark Bradbury in respect of Loneliness and Social Isolation and utilising buildings for community use.

ACTION: Mark Tickner

14
DATES OF FUTURE MEETINGS

NOTED the dates scheduled for future meetings for the 2019/20 municipal year, advised by the Chair as subject to potential amendment.

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