Enfield Council Review into the Impact of COVID-19

Contents

Purpose of this Report

1. This review will document and examine the impact of Covid-19 on the population of Enfield with a strong focus on how the health and Adult Social Care sector in Enfield was affected by the outbreak of Covid-19. The report will also make wider reference to how Enfield Council worked with the community and other public sector partners to galvanise a resilient response.

2. Whilst there are many and varied risk factors involved in increasing the likelihood of contracting the virus, we also know that factors such as old age, disability, being of black and minority ethnic background and having underlying health conditions significantly increases the risk of death once the virus is contracted. Communal living where residents and staff live and work in proximity were known risk factors from the onset. Placing vulnerable people in different settings using a variety of different services meant an increased risk from Covid-19. These include residential care, nursing homes, domiciliary care, supported accommodation and day centres. Each of these services had different arrangements and therefore were impacted differently. As part of this review areas covered will include:

    - A timeline of key events during the pandemic covering both national social care policy developments and Enfield Council's response.

    - Record of the impact of Covid-19 on Enfield adult care services including deaths, access to PPE, testing and vaccine capacity and staffing levels.

    - Enfield Council interventions and how they aligned or differed from national guidance at the time. Highlight positive interventions undertaken by the Council and how they were driven by or differed to national guidance at the time as well as where government guidance, or absence of guidance, provided challenges for the Council and sector.

    - How we supported our schools to stay open and enable key workers to continue to meet the ongoing needs of our society through lockdown.

    - Reflect on how Enfield Council launched, coordinated, and delivered a community programme of support. The Council led a public sector/community partnership response, the 'Enfield Stands Together' programme and its subsequent evolution to move us from 'crisis management' through to supporting the delivery of testing and vaccination programmes that have helped us move into a world where we begin to live with Covid-19.

    - Review how we established necessary governance to ensure decision making was robust, evidence based and inclusive and how

we linked into wider regional/national command and control mechanisms.

- Took action to support workforce flexibility and resilience and how this affected our existing ambitions for smart working and 'Build the Change' programming.

- Examine the role of effective communications to enable us to keep ourselves and our residents informed of the latest direction from Government and how we also used communications effectively to raise concerns and seek to improve the nature and quality of support we received.

- Provide a summary of lessons learned flowing from the scope to help provide valuable insight to inform future working

Covid-19 Impact on Enfield's Population

3. National lockdown began on 26th March 2020 and continued until the phased relaxation of restrictions on 20th June 2020. There were 157 Covid-19 related deaths in Enfield's care homes by mid-June 2020.

4. In the three weeks leading up to the end of April 2020, 46% of the 124 deaths (57 deaths) recorded in care homes were attributed to Covid-19. April 2020 alone saw 136 deaths due to Covid-19 recorded in Enfield's care homes.

5. By the 30th April 2020, 46 of Enfield's 81 care homes had outbreaks affecting 173 residents or just under 10% of the entire Enfield care home population. At the time systematic recording began across services (27th March 2020), there were 43 recorded cases across 14 care homes.

6. Within a month of the national lockdown legally coming into force in England on 26th March 2020, Enfield's population experienced an unprecedented increase in deaths, rising from a five-year average in April 2019 of 174 to 653 in April 2020, an increase of 375%. No other month since has seen a proportional increase of this magnitude in excess deaths.

7. Excess deaths between January and April 2020 in Enfield were proportionally higher than every other London Borough except for Brent and Harrow, and the highest in North Central London.

8. A Local Tier system was introduced from June 2020 until 4th November 2020 – a further 8 Covid-19 related deaths in care homes occurred in this period.

9. 5th November 2020 – second national lockdown began and was lifted on 2nd December 2020 – there are no Covid-19 related deaths in Enfield's care homes in this period.

10. 2nd December 2020 – tier system is reintroduced with London moved into Tier 4 on 21st December 2020 before re-entering national lockdown on 6th January 2021 – there were 4 Covid-19 related deaths recorded in Enfield's care homes in this period.

11. 6th January – 19th July 2021 – third national lockdown in place – From 6th January to 29th February 21 there are a further 19 Covid-19 related deaths recorded in Enfield's care homes.

12. In January 2021, Enfield experienced its second highest number of excess deaths in a month at 218 deaths. These were recorded in hospital and community settings.

13. There are no further Covid-19 related deaths recorded in Enfield's care homes between March and the lifting of lockdown in July 2021. Between July and the end of August 2021, a further 2 Covid-19 related deaths are recorded in care homes.

14. Between April 2020 and February 2021, Enfield sees a total number of 729 excess deaths. In the following months the excess death total goes into negative numbers with 67 fewer deaths compared to the five-year average between March 2021 and July 2021.

15. The two months of April 2020 and January 2021 account for 697 of Enfield's excess deaths.

16. As at 13th September 2021, there had been 6,218,198 diagnosed Covid-19 cases in England and 117,803 Covid-19 related deaths (1.9% rate). In London there had been 1,037,222 cases and 16,228 deaths (1.56%) and in Enfield, 38,959 cases with 607 deaths (1.55%).[1]

17. So far in England, there have been two periods during the Covid-19 pandemic when both weekly and monthly registrations of deaths from all causes were consistently higher than the five-year average – known as "excess deaths". Using weekly data, the first period was from the week ending 20th March to the week ending 12th June 2020 and the second was from the week ending 11th September 2020 to the week ending 5th March 2021. Using monthly data, the periods above average were from March to July 2020 and then from September 2020 to March 2021. This is also reflected in Enfield.

18. 'Excess deaths' is the clearest way to compare the likely impact of the pandemic over time, because a substantial number of non-Covid-19 excess deaths were recorded early in the pandemic, in March and April

[1] Source: https://coronalevel.com/United_Kingdom/England/London/

2020. One reason for excess deaths could be that Covid-19 was undiagnosed. It may also be the case that deaths from other causes increased due to reduced access to healthcare services because of the pandemic.[2]

19. Social Care staff data on deaths is not available by Local Authority area. However, nationally across England and Wales it was reported between 9th March 2020 and 28th December 2020.

20. A total of 469 deaths involving Covid-19 among social care workers were registered between 9 March and 28 December 2020, with rates of 79.0 deaths per 100,000 males (150 deaths) and 35.9 deaths per 100,000 females (319 deaths).

21. Care workers and home carers accounted for most of the deaths (347 out of 469 deaths, or 74.0%).

22. Early data on infection rates in staff working across different care settings was not considered reliable due to lack of testing capacity. Later, the number of recorded cases across care settings reached its peak in January 2021 with 74 recorded staff cases on 8th January 2021 in care homes alone.

23. The peak number of infections amongst care home residents was reached on 30th April 2020 with 173 recorded cases.

The Disproportionate Impact of Covid-19 on Communities in Enfield

24. The impact of cases and deaths was experienced disproportionately across certain parts of the population both nationally and in Enfield.

25. Local analysis carried out by Public Health in Enfield and national analysis carried out by Public Health England (PHE) provides evidence that BAME individuals are at increased risk of death from Covid-19 even after adjusting for geographical region.

26. Local Enfield analysis observed that 674 deaths of Enfield residents were reported between 15th March and 5th May 2020 and 299 excess deaths (relative to previous years) were related to Covid-19 (suspected, confirmed, or probable) during this period.

27. In the early stages of the pandemic there was an issue surrounding the ability of medical professionals to verify/record Covid-19 deaths in Enfield care homes due to restrictions on visiting. This concern was raised in correspondence from the Leader of the Council to Government on 16th April 2020 (see Appendix B).

[2] Source: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/excessdeathsinyourneighbourhoodduringthecoronavirusCovid-1919pandemic/2021-08-03

28. Covid-19 mortality rate after adjusting for age and gender are high among White Irish, Other Asian, Greek, Greek Cypriot, Bangladeshi, and Turkish communities in Enfield (Figure 1) between 15th March and 5th May 2020.

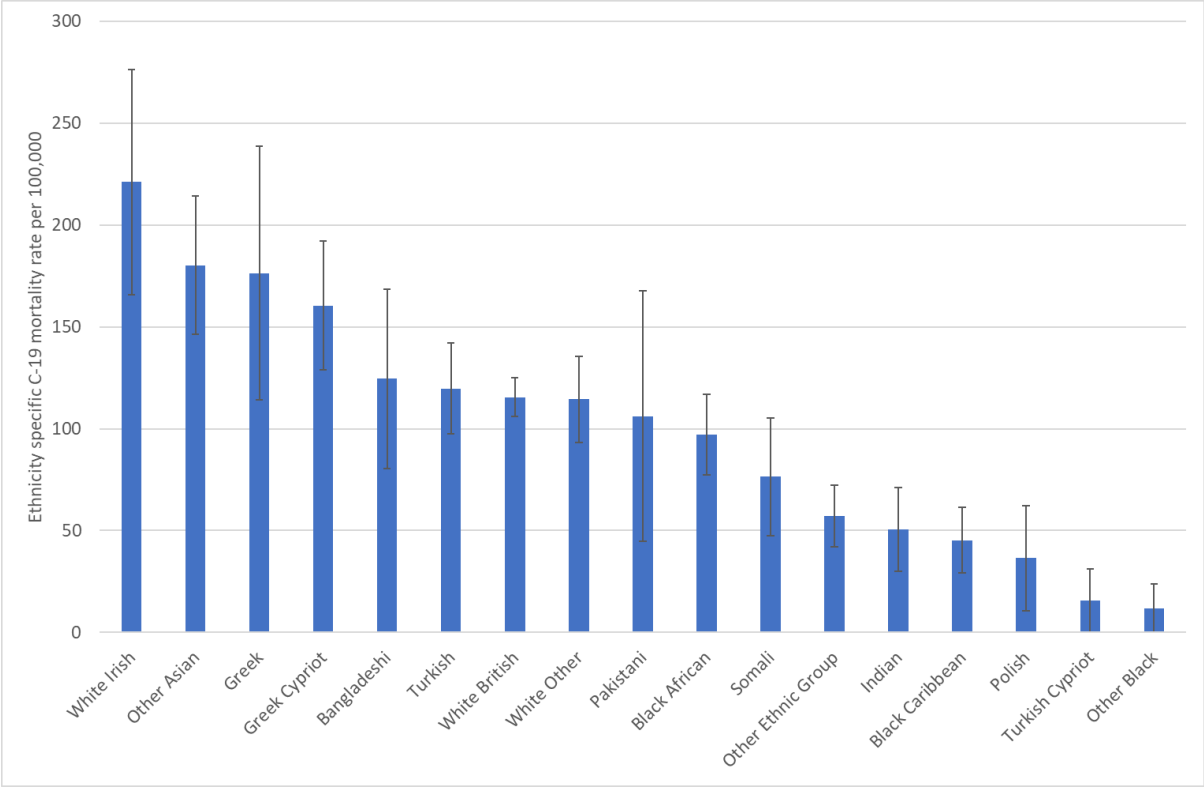

Figure 1: Covid-19 mortality rate per 100,000 by ethnicity in Enfield[3]

29. Death certificate data obtained from Enfield Registry demonstrated that people whose origin is Somalia, Muslim, Caribbean, Bangladeshi, Ghana, and Turkey had a high proportion of Covid-19 deaths (Table 1).

Ethnicity	**Number of Covid-19 deaths**	**Number of C-19 deaths as a % of total deaths**
Somalia	7	100%
Muslim	12	80%
Caribbean	<5	75%
Bangladeshi	5	71%
Ghana	5	63%
Turkey	17	59%
White- born in Wales	12	52%

[3] Source: Enfield Registry

Greek/ Cyprus	21	50%
Nigeria	<5	50%
Irish	15	48%
White- born in Scotland	13	45%
India	<5	43%
Netherlands	<5	43%
White- born in England	121	41%
Italy	6	30%
Jewish	<5	29%

Table 1: Number of Covid-19 deaths as a proportion of total death between 15th March and 5th May 2020 Enfield by ethnicity

30. In Enfield, in terms of languages spoken aside from English, people who speak Somali, Arabic, Bengali, Akan and Turkish were at high risk of Covid-19 deaths (Table 2).

Language spoken	**Number of Covid-19 deaths**	**Number of Covid-19 deaths as a % of total deaths**
Somali	7	100%
Arabic	18	72%
Bengali	5	71%
Akan	5	63%
Turkish	18	58%
Welsh	12	52%
Hindi	7	50%
Spanish	<5	50%
Yoruba	<5	50%
Punjabi	<5	50%
Dutch	<5	43%
English	155	42%
Greek	25	40%
French	<5	40%
Russian	<5	40%
Italian	6	30%
Polish	<5	25%

Table 2: Number of Covid-19 deaths as a proportion of total death between 15th March and 5th May 2020 Enfield by language spoken

31. Furthermore, certain occupational groups including drivers (bus, taxi), carpenters, health and social care professionals, childminders and carers have a higher risk of death due to Covid-19. People from BAME backgrounds are more likely to work in these roles.

32. A high proportion of people who died from Covid-19 in Enfield were born in Turkey, Greece or Cyprus Asian (South Asian, East Asian) and African-Caribbean countries (Table 3).

Country of birth	**Covid-19 death**	**Number of Covid-19 deaths as a % of total deaths**
Middle East	<5	33%
UK	109	41%
Europe (Western and Eastern)	32	42%
Turkey, Greece or Cyprus	51	52%
Asian (South Asian, East Asian)	25	61%
African-Caribbean	79	62%

Table 3: Number of Covid-19 deaths as a proportion of total death between 15th March and 5th May 2020 Enfield by country of birth

33. In England the death rate among British Black Africans and British Pakistanis from coronavirus in hospitals is more than 2.5 times that of the white population People from a Black Caribbean background were 1.7 times that of white British.

34. Possible factors could be:

- Around a third of working-age Black Africans are employed in key worker roles, 50% more than the White British population.
- Pakistani, Indian, and Black African men are 90%, 150% and 310% respectively more likely to work in healthcare than white British men.
- Two-thirds of British Bangladeshi men over the age of 60 have a long-term health condition that would put them at risk from infection, while underlying health conditions are also especially prevalent among older people of a Pakistani or Black Caribbean background.
- Existing health inequalities, such as higher levels of heart disease, diabetes, and kidney disease among the BAME population.
- BAME families are also more likely to live in crowded, multigenerational households than white populations, increasing the risk of exposure.
- A third of the UK Bangladeshi population, 15% of the Black African population and 16% Pakistani population are living in overcrowded housing, compared to 2% among the white British population.

35. Similarly, adverse outcomes are seen for BAME patients in intensive care units and amongst medical staff and Health and Care Workers. The exact reasons for this increased risk and vulnerability from Covid-19 in BAME populations are not known.

36. Contributing factors could include over-representation of BAME populations in lower socio-economic groups, multi-family and multi-generational households, co-morbidity exposure risks, and disproportionate employment in lower band key worker roles.

37. After adjusting for age, the highest diagnosis rates of Covid-19 per 100,000 population were in people of 'Other' ethnic groups (1,076 in women and 1,101 in men) followed by people of Black ethnic groups (486 in females and 649 in males). This compared to 220 per 100,000 among White females and 224 among White males (Figure 2). Other ethnic group include Greek, Cypriots and Turkish community groups.

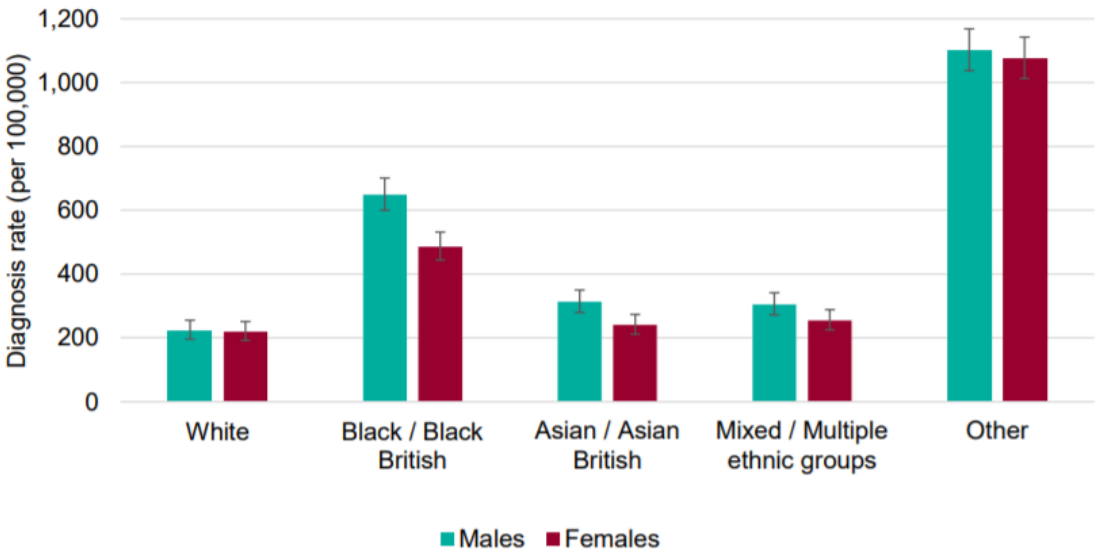

Figure 2: Age standardised diagnosis rates by ethnicity and sex, as of 13th May 2020, England. Source: PHE Second Generation Surveillance System.

38. After accounting for sex, age, deprivation and region, people of Bangladeshi ethnicity had twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British (Figure 3).

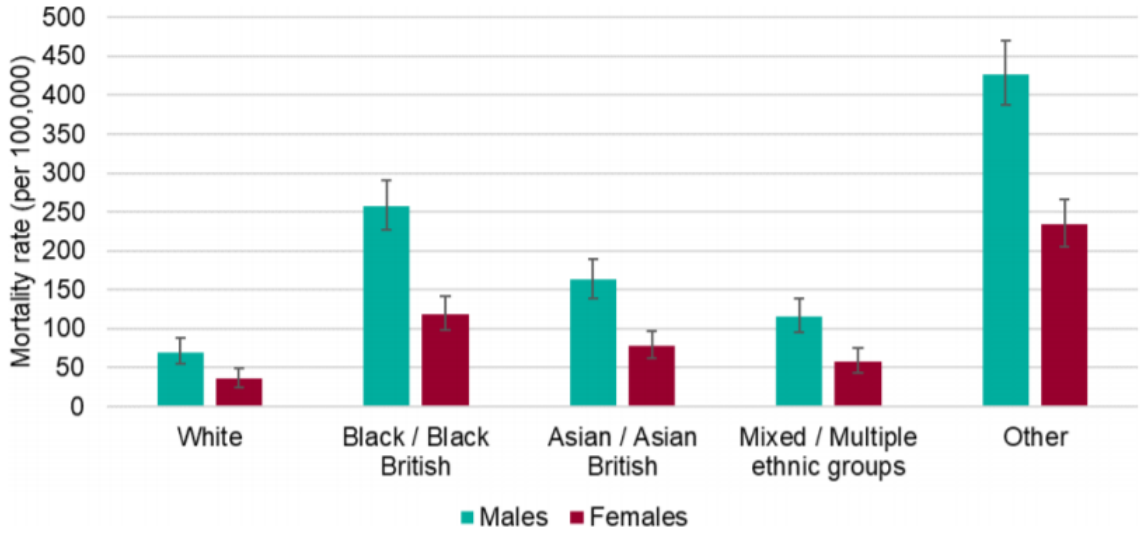

Figure 3: Age standardised mortality rates in laboratory confirmed Covid-19 cases by ethnicity and sex, as of 13th May, England. Source: PHE: Covid-19 Specific Mortality Surveillance System.

39. Within the working age population (aged 20 and 64), the increased risk of death is highest in those of Bangladeshi ethnicity (80% higher risk than White British ethnicity), Black Other ethnicity, Pakistani ethnicity (both 50% higher) and Black Caribbean ethnicity (30% higher). While this analysis adjusts for many important factors such as age and deprivation, it does not adjust for comorbidities and obesity, which are likely to have an impact on the risk of dying between ethnic groups.

40. Finally, and most importantly, we urge national authorities to record ethnicity in death records. It is difficult to ascertain ethnicity in death records as there is no provision to collect ethnicity data. Therefore, we urge to establish a national system to collect ethnicity data in death records.

Timeline & Advice to Providers of Services including Care Homes & Hospitals

41. 10th February 2020 - The government's Scientific Advisory Group for Emergencies (SAGE) advised on 10 February that "*It is a realistic probability that there is already sustained transmission in the UK, or that it will become established in the coming weeks.*"

42. 25th February 2020 – PHE issues guidance to social and community care settings including care homes about Covid-19. No restrictions on visits to care homes was advised. It was further stated that: "*This guidance is intended for the current position in the UK where there is currently no transmission of Covid-19 in the community. It is therefore very unlikely that anyone receiving care in a care home or the community will become infected."*

43. 13th March 2020 – PHE issues new guidance advising that visitors who are feeling unwell should not visit care homes. It does emphasise the positive impact of visits and residents seeing friends and family. Care home providers are advised: "*To minimise the risk of transmission, care home providers are advised to review their visiting policy by asking no one to visit who has suspected Covid-19 or is generally unwell, and by emphasising good hand hygiene for visitors… should also consider the wellbeing of residents and the positive impact of seeing friends and family."*

44. 19th March 2020 – NHS guidance is issued on hospital discharge arrangements stating that "*unless required to be in hospital, patients must not remain in a hospital bed."* There is no mass testing in place.

45. 23rd March 2020 lockdown is announced and comes into force on the 26th March 2020.

46. 2nd April 2020 – New guidance issued by the Department for Health and Social Care stating that visits should only be made in exceptional circumstances: "*Family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life."*

47. 2nd April 2020 – the rules on discharging to care homes are clarified stating that "*negative coronavirus tests are not required prior to transfers/admissions into the care home."* The wearing of PPE and isolation measures are advised to mitigate the risk.

48. 6th April 2020 – The Leader of Enfield Council releases a statement on the news of deaths in a local care home from Covid-19 (see Appendix B).

49. 15th April 2020 - the Adult Social Care Action Plan as referenced in the 19th March 2020 NHS guidance is published. At the point of publication, it is advised that all symptomatic residents will now be tested. <u>There is still no mass testing at this point, including for asymptomatic people.</u>

50. It is also announced as part of this guidance that hospital testing prior to discharge to a care home will be introduced. However, it also states that: "*Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a Covid-19-positive patient will be."*

51. In contrast, Enfield Council advises care homes that there should be no acceptance of referrals without a negative PCR Covid-19 test result confirmed – the usual rate of placements into care homes from hospital reduces from 29 to 9 for the months of March - April 2020.

52. 28th April 2020 – the Secretary of State for Health and Social Care announces that testing in care homes will be extended to all care staff and residents regardless of whether they have symptoms or not. The 100,000 tests per day target is introduced.

53. A Reuters news report published on 5th May 2020 examines the scale of the challenge that care homes in Enfield, including in Enfield, face (see Appendix C).

54. Advice from Enfield Council via the Director of Public Health on care home visits is sent as a regular reminder to care homes. The advice continues to reiterate the importance of appropriately supported and monitored visits where the health and mental wellbeing of residents is at risk but confirms the need to do this without placing staff and residents at risk.

55. The Local Authority Adult Social Care Team is making weekly calls to care homes to ascertain their position and seeking to provide additional support where possible.

56. 17th December 2020 – the guidance on discharges to "designated settings" is released by the Department for Health and Social Care, the Care Quality Commission (CQC, the health and social care regulator) and PHE. The guidance was co-produced with the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS). This followed on from communications to Directors of Adult Social Service departments on the 13th October 2020 and the 10th November 2020 requesting notification of settings officially designated and approved by the CQC for discharge from hospital of patients found to be Covid-19 positive pre-discharge from hospital. Designated settings could be NHS facilities (hospital wards) or care homes appropriately set up to manage a period of isolation of at least 14 days (or more if still symptomatic). A PCR test to be completed on each patient no later than 48 hours before discharge and where positive, discharge to a designated setting. Where a setting is not an NHS facility, this would have to be inspected by the CQC to determine whether appropriate and fit for purpose.

57. Working as part of the North Central London sub-region, Enfield Council agreed that all designated settings would be NHS locations and a capacity of 85 beds across the five boroughs (Enfield, Barnet, Haringey Camden and Islington) was agreed and established in partnership with North Central London Clinical Commissioning Group (NCL CCG). Pressure to also allocate care home capacity to designated settings was refused by all NCL local authorities. The Leader of Enfield Council reiterates this message in a letter to the Secretary of State for Health and Social Care on 23rd December 2020 (see Appendix B).

58. Also outlined in the letter to the Secretary of State was a specific ask that there should be no hospital discharges into care settings without evidence of a negative test.

59. The designated settings guidance is not clear on patients who have returned a negative PCR test but have been in subsequent contact (after PCR tested) with a Covid-19 positive patient. Enfield Council's position on this was discharge to a designated setting for a period of isolation (14 days) in all events.

60. By January/February 2021, Enfield's local hospitals (Royal Free Chase Farm and North Middlesex) are under considerable pressure due to the number of Covid-19 positive patients occupying hospital beds. North Middlesex experienced Covid-19 positive bed occupancy in excess of 310 beds out of a total normal bed count (excluding escalation beds) of 420 beds with over 90% of Intensive Therapy Unit (ITU) beds occupied by Covid-19 positive patients. At this point internal incidents are declared, and some blue light service diversions are enacted with ambulances diverted to other London hospitals.

61. The designated bed capacity (85 beds across NCL) remained sufficient to support safe discharges across the system.

62. Admissions to care homes are significantly reduced. Snapshot sitreps from the care home market indicated that:
    - 30th April 2020 – 46 care homes have reported outbreaks with 173 reported cases across all providers. 136 Covid-19 deaths and 101 vacant bed capacity across all care homes.
    - 26th February 2021 – 18 confirmed Covid-19 positive cases in care homes, deaths increased to 188 and 281 vacant bed capacity across a total bed capacity of around 1,800 beds
    - 26th August 2021 – 17 confirmed Covid-19 positive cases in care homes, 190 Covid-19 related deaths and 265 vacant bed capacity.

Provision of Personal, Protective Equipment (PPE)

63. 13th March 2020 – the government issues guidance on PPE in care homes indicating that PPE should be similar to that used in hospital settings and establishes the National Supply Disruption Response, a contact point for health and care providers to raise concerns they have linked to PPE supplies.

64. 19th March 2020 – the government promises to deliver 300 masks to each care home. It is was clear whether this is a one-off delivery or regular at this point. Subsequently, it was the case that this was a one-off supply due to national supply issues.

65. At this point our larger care homes are using around 300 masks for staff per day and supplies are extremely limited.

66. 10th April 2020 – government announces a PPE Action Plan with supplies being managed and distributed to local authorities through Local Resilience Forums.

67. 14th April 2020 – through its own supply chains Enfield managed to secure some PPE stocks, including 46,600 face masks with a further 21,600

secured through the new government supply chain network on the 16th April.

68. With one of the largest care markets in London, comprising almost 300 providers and 5,500 staff, stock levels in Enfield at this point were not sufficient to meet the needs until mid-April 2020.

69. All providers are highlighting shortages in all areas of PPE supply in March/April 2020.

70. Enfield Council is competing with all sectors including the public for PPE supplies but manages to secure additional supplies in March and April 2020.

71. Enfield Council, through its community equipment service, provides a collections and deliveries service to all local providers. By the end of April 2020 over 1 million items have been distributed to local providers, including families using direct payments.

72. Average weekly distribution of PPE by the Enfield Council was sourced both independently and through the Government supply chain. This reached its peak in mid-May 2020 at 282,972 items (face masks, gloves, aprons etc).

73. The government advises that free PPE through the government supply chain will continue to be available to providers directly and to local authorities until 30th September 2021. This later extended to 31st March 2022.

74. From July 2020 onwards, Health & Adult Social Care community equipment service continues to maintain a stock equivalent to at least 12 weeks' average demand.

Support from Enfield Council to the Care Homes Sector

75. The provisions within the Care Act 2014 place a legal duty on Councils to have a direct responsibility for Care Home Market Management and the extent of this is to ensure that quality standards are achieved and there is sufficient capacity to meet the needs of local people, both Council supported residents and self-funders.

76. In April 2020 Health and Adult Social Care Bronze recommends a financial support package to the care home market to fund the significant number of empty beds in Enfield's care homes. At this point the number of empty beds had risen from 62 out of a total of 1800 plus beds to 145.

77. The proposal to providers of providing a time limited 5% top up to existing spot-purchased placement fees, includes the option of further discussion

with commissioners, should any provider feel that the temporary financial aid was insufficient to meet their needs.

78. It was unclear at this stage how many or if any providers would become financially unstainable. None of our care home providers ceased trading as a direct result of the pandemic (to date). However, the following were considered as appropriate to be factored into any future decisions:

    a. CQC rating for the home;
    b. Any safeguarding concerns;
    c. The extent to which Enfield Council has purchased or not beds from the home;
    d. The extent to which other Council's and CCG's have purchased beds from the home;
    e. Any block contract that might exist with the home, which is paid regardless of occupancy level;
    f. The quality of the building and extent to which the home is considered viable in normal circumstances;
    g. Previous occupancy running levels in the home;
    h. Any specialist provision including client specific that the homes provided
    i. The extent to which any financial instability has been a direct result of Covid-19.

79. The recommendation to offer financial support to care homes was agreed at Cabinet in May 2020 with a financial support package of £345,000 agreed for the months of April and May 2020.

80. This direct financial support was in addition to other direct offers of support to our provider markets, including to families managing their own direct payments:

    j. Provision of free of charge of items of PPE to all of our providers prior to the establishment of the government supply chain and process;
    k. Maintaining information and advice and disseminating this to all of our providers via email, on our MyLife portal and through webinars for training and practical advice on all PPE and infection control matters relating to Covid-19;
    l. Provision of daily contact support, guidance and advice to care providers through existing and extended council quality assurance and commissioning functions;
    m. Launch of a London wide recruitment campaign #proudtocarelondon, which has attracted hundreds of north London residents to apply for roles in care;
    n. Supporting providers to access NHS mail to support better information flows;
    o. Supporting over 80 of our local providers to access tablets as a pilot to increase social contact with family and friends during the lockdown period;

p. Provision of vital signs equipment and training where needed and as appropriate for all of our providers to ensure we remain vigilant to signs of declining health;
q. Providing a £1000 grant payment to all of our local providers to support the purchase of PPE in the early stages of the pandemic;
r. Extending the Council's Employee Assistance Programme free of charge to all our providers in the borough, which is a confidential service that provides expert advice, specialist counselling and support to staff.

81. A joint market sustainability project is established across the NCL boroughs in July 2020. Enfield Council already has a market sustainability group in place focused on care homes with significant numbers of empty beds and potential staffing issues due to the impact of the pandemic. The data and analysis to support this meeting helps to inform initiatives to support the most vulnerable care homes and to distribute additional government discretionary funding.

82. Regular provider forums continue virtually to provide practical information, advice, and support to all providers in Enfield.

83. The Adult Social Care provider concerns process continues with an increased focus on infection control. Controlled in-person visits continue on priority cases in order to test provider adherence to infection control measures. These visits are still in place, supported by a newly recruited infection control lead officer working in partnership with Public Health and CCG colleagues.

Schools and Education

- **Covid-19 management in Educational settings**

84. At the start of the pandemic, workshops were held with head teachers to provide them with understanding of COVID-19 and government guidance.

85. A process for local reporting regarding the numbers of pupils and school staff with Covid-19 or self-isolating was established to help us understand the impact of Covid-19 on school communities and identify outbreaks quickly.

86. The Local Authority established a small team of individuals from public health and education teams who supported education settings with outbreak management and answering queries. Schools Health and Safety officers also provided schools with support regarding Covid-19 risk assessments. All of which enabled schools to maintain education and it should be noted that all Enfield schools remained open throughout the pandemic albeit for periods only to vulnerable children and those of key workers.

87. These virtual meetings with headteachers will continue although there will be some face to face meetings. Other forum meetings for teaching staff and school governors have also produced high levels of attendance.

88. The working from home approach for some teams has been very effective and has assisted in filling some skills gaps such as in Special Educational Needs and Disabilities (SEND).

89. The importance of schooling and being in school particularly for disadvantaged pupils has been demonstrated – achievement gaps have been widening over the past two years – schools play a vital role in reducing these gaps.

- **Protecting the mental wellbeing of children and staff in educational settings during the pandemic**

90. Educational psychology and public health teams have worked together to protect the mental wellbeing of pupils throughout the pandemic producing resources for schools early in the pandemic on bereavement, how to maintain physical and mental health whilst learning remotely, and others. Educational Psychology have developed the 'Enfield Thrives Together' partnership bringing together multiple agencies to focus on children's mental wellbeing during the pandemic.

- **Reducing impact of school closures on disadvantaged children**

91. Digital exclusion among pupils was of key concern to schools nationally. The Local Authority worked with schools to identify children at risk of digital exclusion and provide equipment.

92. Schools development of online learning platforms has been very beneficial and will allow pupils in future to do much more learning in terms of homework, if unwell and if not in school for any other reason.

93. Food poverty among children who have free school meals was also a key concern nationally as well as locally. Enfield Council made sure no child went hungry over the October half term by expanding the council's food voucher scheme.

94. The leadership demonstrated by the Council with schools was strengthened after years of the dilution of this relationship through the academisation agenda; with lessons learned to seek to maintain and further enhance this in the future.

Homelessness and rough sleeping

95. Homelessness Services responded effectively to help offer safe accommodation to homeless and rough sleepers who were another highly vulnerable group. Enfield Council supported approximately 500 rough sleepers or those at risk of rough sleeping through securing move on

accommodation. This included the offer of a health needs assessment to accepted by many of the homeless individuals who accepted accommodation through the 'everyone in' programme.

96. The Public Health team worked closely with the rough sleeping team to ensure Covid-19 secure accommodation, infection prevention and control and outbreak management were in place.

97. This work has since extended to a bespoke vaccination programme for homeless and health outreach.

Local Authority as community leader: Enfield Stands Together – Enfield Community Resilience Board & Covid-19 Resilience Board

98. The Local Authority had been engaged in preparatory work with key community and voluntary sector partners since the first signs of a significant threat from Covid-19 had appeared in early 2020, before any government initiative was announced. This had allowed for an initial mobilisation of food support to people affected by 'Lockdown Shielding'. By May 2020, Enfield Council had firmly established its community support service called 'Enfield Stands Together' and from Segro located on Lincoln Road it was engaged in delivering urgent food parcels and other support to residents who were unable to go outside. The hub also coordinated an urgent medical prescription service and 'call back' provision to provide some support to residents who were socially isolated.

99. A multi-agency working group, Enfield Community Resilience Board, was quickly established under the auspices of the Leader of the Council and was able to quickly devise and deliver a series of interlinked service provision that could consistently meet the needs of residents. These included representatives from the Local Authority and organisations such as Enfield Voluntary Action, Citizens Advice, the Felix Project, over 50s Forum and the North Enfield Food Bank (see Appendix D).

100. Enfield Council staff were redeployed to provide logistical support from the established hub, supported by a dedicated call centre. Over 80 Council staff (with the overall number being much larger as some rotas were in place) were engaged in this aspect of the response. Many more were redeployed on a temporary basis to ensure levels of service did not drop during the height of the pandemic.

101. Enfield Stands Together delivered targeted support and reached thousands of residents as evidenced by the following:
    - C.9,700 medical prescriptions delivered to residents
    - C.37,000 food parcels delivered to residents
    - 1,243 residents contacted via the befriending service set up to reach clinically vulnerable residents who may be socially isolated
    - Handled over 16,000 calls from residents via the Enfield Stands Together helpline

102. The Enfield Stands Together programme demonstrated the ability of the Local Authority to act quickly and in partnership with key statutory and voluntary and community sector partners to establish an effective borough-wide network of support. This illustrates the quality of working relationships that exist between the Local Authority and its partners and the ability of networks to pivot collectively to meet need.

103. This partnership approach was vital in allowing the Local Authority to lead the transition from 'crisis' management to 'response' management as the Enfield Community Resilience Board managing the Enfield Stands Together programme evolved into the Covid-19 Resilience Board. It enabled messages to be agreed and transmitted quickly into the community and for localised actions to be taken where 'hotspots' were identified.

104. The Covid-19 Resilience Board terms of reference are as follows (see Appendix D):

> *"It is a focused group, established to assist the Local Authority, with the help of key strategic community partners, in managing its community response to the current coronavirus pandemic through the 'Enfield Stands Together' programme and Local Outbreak Control Plan (LOCP). The Board is not a formal committee and is not a decision-making body but may have limited commissioning power. The Board will report back to the Cabinet and the Health & Wellbeing Board (HWB) and make recommendations for decisions where and when appropriate to do so"*

105. During 2020 and into 2021, EST called upon over 1,100 people over 6 months plus approximately 100 staff over 6 months to protect our most vulnerable residents. The speed of the set-up, willingness to get involved and sense of purpose was noted. See Appendix E for an example of communication sent out to volunteers.

106. More Council staff were redeployed to EST during the 2nd and 3rd waves of the pandemic. Although obviously very helpful some staff found using new IT systems a challenge, quicker training may have been useful to overcome this.

107. The council officer that coordinated EST Project Group managed a series of diverse and unpredictable funding streams to support vulnerable residents. This included a new telephone referral pathway and integrated support for food poverty (including acceleration and establishment of the Enfield Food Alliance), social isolation and financial hardship. New services were created to deliver the test, track and trace payments of £500 for households struggling financially.

Enhancing delivery of emergency food programme: meeting local needs

108. The Local Authority provided support to the governments emergency food parcel delivery programme for those shielding during lockdown but recognised that dietary needs that could support wellbeing of some of our residents were not be met by the standardised government-issued emergency food parcels that were in distribution during the lockdown.

109. To this end it initiated an investment in acquiring food that could augment that being prescribed and this was then stored at the Community Food Hub established on Lincoln Road in the borough and provided additional financial and logistical assistance to food banks in the borough in partnership with local organisations.

110. Furthermore, in April/May 2020, a further investment was agreed to work with grass roots organisations to provide localised 'small grants for hot food' with c.£30,000 being provided for local groups to meet neighbourhood/cultural food needs for our diverse communities. For some families with particular hardship white goods were purchased, and essentials like baby food and nappies were available for others.

Governance

Internal Governance

111. The Local Authority moved quickly to establish a chain of operational command and guidance based on its emergency planning procedures. Weekly Gold, Silver and Bronze meeting were put in place to allow for information to pass through the organisation and for business to be carried out effectively. The ability to hold extraordinary meetings was also enshrined in the approach to allow for maximum flexibility as more Government announcements came through.

112. Emergency Planning (EP) provided the coordination function between Gold, Silver and Bronze teams as well as coordination and communication with outside partners/agencies such as the NHS and other Local Authorities. The EP team were able to ensure the Council's nine Emergency Management Response Teams (EMRT– on-call) remained resilient and that the Borough Emergency Communications Centre (BECC) remained operational throughout. Comparison to other Local Authority arrangements indicated that this seemed to have been the most useful model.

113. The Leader of the Council held a fortnightly 'All Members' briefing to update councillors on the latest Covid-19 situation and response of the council. In this briefing, senior officers also attended to answer questions.

114. The Public Health Intelligence Team was able to supply accurate and timely information (see Appendix F) to support decision making and clear

reporting lines were established to ensure that feedback could be received from leads attached to essential frontline services and the Enfield Stands Together hub. The three-tier system allowed officers to work quickly to bring new proposals to help mitigate the pandemic to legitimate decision-making forums where support could be agreed and steps to deploy resources taken. In later meetings, it also allowed for a transparent process by which proposals for funding assistance could be tested and approved.

115. The Communications team provided vital assistance in helping get key messages out to the workforce (and residents/partners) and were members of all three-tiers of command for this purpose. This enabled agile and highly responsive communications to be delivered across the organisation at a time of huge churn for the organisation.

External and partner governance

116. Gold Command played an active part in helping to shape and respond to the pandemic across London. Enfield was able to share best practice and receive vital shared intelligence on how the response was being coordinated across the Capital. Gold was also able to feed in vital data sets and provide accurate and insightful situation reports that helped guide the regional response and provided a strong line of communication into Whitehall.

117. Colleagues in Public Health were also quick to mobilise and connect proactively with the Department for Health and Social Care. Weekly meetings were quickly established that provided a highly productive line of information and emerging policy steer and helped consistency of response. This could then be effectively fed into the actions of the Gold, Silver and Bronze Boards as well as helping to shape some of the focus of the multi-partner Enfield Stands Together/Covid-19 Resilience Board.

118. The Leader had weekly calls with the London Resilience Board as well as the Public Health England London Director, along with other London Council Leaders.

119. This network of interdependent and mutually supportive forums and decision-making groups helped to ensure a joined-up response was delivered where possible.

Partnerships and System Resilience (HASC)

120. 17th April 2020 – Joint support planning group for Enfield providers established with membership from Health and Adult Social Care and NCL CCG Enfield directorate chaired by the Head of Strategy, Service Development and Resources.

121. The purpose of the group is to share information and develop a joint response to challenges across the Enfield care markets

122. On 20 March 2020, the first NCL Covid-19 Provider Preparedness meeting was held. Subsequent development of NCL's approach led to various Gold/Silver level resilience groups to manage the health and social care response to the Pandemic. Meetings between NCL CCG, local Councils, community health providers and acute hospital trusts continue. These meetings have flexed up or down according to the level of the pandemic. Currently they are focused on Covid-19, recovery, and overall increased demand on acute services.

123. Joint approach to the pandemic across NCL Councils' Adult Social Care departments is managed within the already established and DASS led NCL Adult Social Care group with jointly funded programme support.

Workforce Resilience

124. The response of the Council's workforce was commendable, and staff displayed resilience, flexibility, and professionalism, often balancing their personal circumstances such as home-schooling whilst working flexibly to ensure work was completed on time.

125. The resilience displayed by the workforce only reinforces the vitally important role of having a sustainable organisational culture that invests in its workforce to ensure the smooth running of services and the Borough.

126. Since the start of the pandemic, the Council has had on average 1,900 staff working from home per day. This figure sat at 2,400 during the peak when the most severe government restrictions were in place. Many activities previously considered only possible face to face have successfully continued via video meetings including recruitment interviews and large-scale meetings. The importance of fast IT developments meant that business continuity was upheld. Improved connectivity in turn improved efficiency and reduced travel time without the necessity to compromise on outcomes. The positive environmental impact of remote working cannot also not be ignored.

127. Steps were taken to quickly ensure staff had the right work equipment, tools, and PPE for them to work efficiently, effectively, and safely in ensuring internal and external service deliveries were not adversely impacted. These measures included:

- Toolkits rolled out to ensure managers could manage and support a remote workforce including prompts and expectations about keeping in touch with their teams and maintaining regular contact
- Covid-19 risk assessments completed for both services and individual staff to ensure they can run their services and work safely

- Any potential impacts on mental health and wellbeing quickly identified and staff and manager guidance circulated, including regular online sessions that were well attended

128. In Spring 2021, a session on 'creating a safe environment and positive culture for mental health and wellbeing at work' was delivered to the senior leadership and middle managers network. In addition to this the Council partnered with Mind, Enfield, who ran several workshops through the Council's Learning and Development team. Over 500 staff and managers have attended mental health resilience training.

129. Examples of other initiatives provided include managing stress in remote teams; relaxation; taking care of yourself; resilience perspective; emotional intelligence; resilience drivers; networking remotely and resilience self-care.

130. The Council worked with its six staff network groups Women into Leadership, Disability Working Group, Ethnic Minority Network, Young Professional Network, LGBTQ+ and Mental Health and Wellbeing network to ensure activities and support were inclusive.

131. To support staff further, the Council introduced and implemented a Domestic Abuse policy and a Smart Working Policy.

132. A key learning outcome was the successful transition for many staff to home or hybrid working. This has informed the Council's approach to the new Smart Working policy and led us to develop the new working style classifications that will support hybrid working and help deliver the 'Build the Change' Programme, whilst also supporting and promoting healthy work-life balance. The work to support mental health and wellbeing has now been further developed and the Council is now introducing Mental Health First Aiders as additional support for our workforce. This will be important coming out of the pandemic and will help to support staff with any anxieties about working arrangements post-pandemic and returning to the office.

Government Funding Interventions

133. On 9th June 2020, Government announces the Infection Control Grant worth £600m to be allocated to Local Authorities. Paid in two tranches, the first is paid on the 22nd May 2020 with the second tranche paid in July 2020. The purpose of the grant is to support providers with additional costs linked to the pandemic, including infection control. 75% of the grant must be passported to care homes within the borough's geographical area on a per bed basis. The discretionary 25% can be used to support other parts of the care market with issues/costs related to infection control. Enfield's allocation was £2,478,334. Period covered – between May and September 2020.

134. A further Infection Control Grant (Round 2) was made available from October 2020, this one worth £546m and again payable in 2 tranches with the first in October 20 and the second in December 2020. The conditions and purpose although slightly revised, remained largely the same. Enfield's allocation was £2,527,930. Period covered – between October and March 2021.

135. 23rd December 2020 – government announces a further Rapid Testing Fund grant worth £149m nationally. The grant is intended to support new and additional testing responsibilities for visitors to care homes. Visits resumed in the hiatus between the second lockdown and the third (over the festive period). Enfield's allocation is £598,841. Period covered – between January and March 2021.

136. The Infection Control Fund and Rapid Testing Grant were consolidated into a final tranche of funding issued in June 2021 worth £341m nationally. Enfield's allocation is £957,479. Period covered – between April and September 2021.

137. The government also introduces additional Discharge to Assess funding to support Local Authorities and CCGs (the national discharge fund). This is jointly agreed with ADASS and the Local Government Association. This is announced on the 19th March 2020 with the fund totalling £1.3 billion nationally. Funds are held centrally by each CCG and both CCG and the Local Authority can use it to fund up to six weeks of free care and support for services which help to avoid hospital or to support hospital discharge arrangements. This funding is allocated until 31st March 2021. Enfield and the other North Central London boroughs agree an addendum or variation to the existing Section 75 agreement to provide governance over the allocation and spending of funding. The funding is intended to free up NHS hospital capacity by providing additional time (up to six weeks) to complete needs assessments either in the community or in a care home setting.

138. A further £588m is made available for the discharge fund from September 20 to March 21 and then a further £594m to fund the discharge scheme from April 21 to September 21. An additional £478m announced on the 6th September to fund the scheme up to the end of March 2022.

139. Health and Adult Social Care successfully secures funding from the Control Outbreak Management Fund (£220,000) in order to provide funding for care homes and supported living schemes to obtain visiting pods which will enable safe and secure visiting for establishments where the physical layout of the building renders safe visits more difficult. Funding is awarded to 22 establishments in June 21 to prepare for the easing of restrictions.

140. The full effects of the pandemic are still to be determined and it is noted that presently there is no long-term funding commitment from Government to assist with mitigating the full impact of the pandemic.

Government Four-Step Programme out of Lockdown and Enfield Response

141. **Step 1: Between 8th and 29th March 2021**

Government Announcement (Changes on 8th March 2021)

- Return of children and students to face to face education
- Childcare and supervised activities to resume where necessary to enable parents to work
- People able to leave home for recreation or exercise outdoors with household or support bubble or with one person outside of their household
- Care home residents allowed one regular visitor

Local Authority Response

- Enfield care homes implement on an individual and risk-assessed approach – advised by Council/Public Health although this remains an individual business decision for each provider.
- At this point there are seven reported positive Covid-19 cases Enfield's care homes (6 staff and 1 resident) with no new reported Covid-19 positive deaths.
- Enfield Council supports the reopening of its own day centres for vulnerable adults and older people using bubbles of five. There is regular mass testing of all staff and service users as well as other infection control measures.

Government Announcement (Changes on 29th March 2021)

- Outdoor gatherings of either six people or two households resume
- Outdoor sports facilities allowed to reopen to include formally organised outdoor sports
- The stay at home rule ends but with restrictions still in place
- People should continue to work from home where they can and minimise journeys
- Travel abroad still restricted

Local Authority Response

- Review of day service provision continues with no reported outbreaks or issues. Limited numbers of people attending with provision made for alternatives for those unwilling or unable to attend.
- At this point there are no reported Covid-19+ cases or new Covid-19 related deaths in Enfield's care homes

142. **Step 2: Not Before 12th April 2021**

Government Announcement

- Reopening of non-essential retail, personal care premises and public buildings as well as indoor leisure facilities (though only for household groups)
- Outdoor attractions and settings reopen
- Hospitality venues can serve people outdoors with no restriction on orders or curfews
- Funerals can continue with up to 30 mourners with weddings, receptions etc rising to 15

Local Authority Response

- The Council continues to review day-care activity with bubble numbers increased to ten. All testing and other measures remain in place. No reported cases at this stage
- At this point there are four reported Covid-19+ cases in Enfield's care homes (2 staff and 2 residents) and no new Covid-19 related deaths
- Care homes continue to allow or restrict visits according to guidance from Public Health protection service and local decision-making routes dependent on level of assessed risk.

143. **Step 3: Not before 17th May 2021**

Government Announcement

- Most legal restrictions on meeting other people outdoors lifted though number still limited to no more than 30
- The indoor rule of 6 continues
- Indoor entertainment venues reopen, and larger outdoor sporting or performance events reopen with limits on numbers
- Up to 30 people can now attend commemorative events such as weddings

Local Authority Response

- The Council continues to review day-care reopening and support bubbles continue at no more than 10 service users. Alternatives continue to be in place and funded for those unwilling or unable to attend.
- At this point there are no reported Covid-19+ cases or new Covid-19 related deaths in Enfield's care homes.

- Care homes continue to allow or restrict visits according to guidance from Public Health protection service and local decision-making routes dependent on level of assessed risk.

144. **Step 4: Not before 19th July 2021 (Postponed from 21st June)**

Government Announcement

- Legal limits on social contact removed

Local Authority Response

- Enfield Council increases number of day-care attendees but maintains bubbles of no more than 15 people. Alternative services continue, including new virtual day-care offer.
- At this point there are 2 reported Covid-19+ cases (staff) in Enfield's care homes and 1 Covid-19 related death.
- Care homes continue to allow or restrict visits according to guidance from Public Health protection service and local decision-making routes dependent on level of assessed risk.

Leading recovery

Testing

145. The aim of the Community Testing project was to ensure that residents had every opportunity to take a lateral flow test (LFT) to prevent the onward transmission of the virus.

146. It should be noted that LFT testing (from which results are available in 30 minutes) was under the remit of the Local Authority and is distinct from PCR testing (Polymerase Chain Reaction; more accurate but needing to be sent to a laboratory) which was under the remit of the NHS.

147. On 19th December 2020, the first assisted lateral flow testing centre (Assisted Testing Site, ATS) was opened at Klinger Hall, in N18. This was followed in quick succession by a further eight Community Testing sites. In addition, three sites were opened at businesses in Enfield to assist in the testing of their staff. Finally, a site at Morson Road Depot (LBE site) was then opened for the testing of LBE staff. By the 1st February 2021 we had 13 Assisted Testing Sites open giving us a good spread across the borough.

148. The Public Health project was supported by the Transformation Service from its inception at which point a project group was formed, with representatives from all over the council, meeting weekly to ensure the project ran effectively and followed national guidance. The group developed excellent relationships with the Department for Health and

Social Care (DHSC), meeting weekly to both update the DHSC on our progress and learn from other boroughs.

149. Over a period of more than eight months, the project carried out more than 98,000 assisted lateral flow tests, registering 2,400 positive results, enabling those residents to self-isolate and thereby help stop the spread of the virus.

150. In addition to the community testing sites, the project group also developed community collect; distribution of home testing kits all over the borough. Weekly project meetings were used to gather data on areas of high infection/low testing rates and exposure sites. This information was used to inform a borough wide distribution plan that ensured our two distribution teams were able to hand out kits to residents in key areas. This has been very well received by residents and to date the project has distributed over 360,000 home testing kits.

151. The final community testing site closed in September 2021. However, the project is continuing to coordinate the distribution of home testing kits across the borough via pop up sites and at eight libraries for residents and ten LBE satellite sites for employees.

152. A Council run testing site was set up at Park Avenue Resource Centre in July 2020 to support social care service users and carers to receive their PCR test. Trained Learning Disability Nurses and day centre staff provide a service every Monday. The testing site is open to all social care residents and their carers who require this support. Positive feedback has been received, particularly from parents/carers who have relatives with complex needs who would have not been able to be tested otherwise.

153. We have established a strong working relationship with University College Hospital and the Crick Institute who provide the testing equipment and test results.

154. The Council has been able to reopen all day centres in line with Covid-19 precautions as all service users and staff are PCR tested which is administered through the Park Avenue testing site. Each month the site processes between 1000 - 1200 tests.

Vaccination Programme

155. Before the national vaccination programme commenced in December 2020, LBE was working with the NHS to ascertain where mass vaccination centres could be best located and what the most effective model of delivery might be to meet local conditions.

156. Modelling indicated that the only cost-effective mass vaccination site in the borough would be the Dugdale Centre. This was duly handed over to the

NHS from 5th Jan to 6th Sept 2021 providing capacity of up to 1500 vaccinations per day.

157. Vaccinations were also delivered through Primary Care Centres, notably Carlton House, Winchmore Hill, Evergreen practices and later through Pharmacies; Park View, Aldermans and Elgon. In addition, 54 pop ups were held facilitated by Medicus Health Partners primary care network as well as a vaccine bus commissioned during Summer 2021.

158. This model proved to be very effective and in the first few months of roll-out Enfield had the highest take-up of vaccines in North Central London.

159. As of 12th February 2022, 202,077 people had had their 1st vaccine jab i.e. 68.1% of the population aged 12+ registered with an Enfield GP. 108,042 (63.4%) had had their 2nd jab and 136,738 (48.0%) had had their 3rd / booster jab.

160. Enfield Council has had a significant and prominent role promoting the vaccine programme through media and social media campaigns, it has become increasingly evident that vaccine hesitancy is an issue within the borough. This has often been in those communities most vulnerable to the virus; Gypsy Romany Traveller (GRT), Eastern European and Black African communities. In January 2022 LBE was awarded £485k has been won from the Department for Levelling Up, Communities and Housing to address this issue.

161. 8th December – the national vaccine programme begins with the first jab given on 8th December 2020. Pfizer BiONTech and Oxford AstraZeneca vaccines are approved and available for deployment at this point.

162. Phase 1 of the government rollout plan prioritises the most vulnerable but is based on age and clinical vulnerability. Table 1 below shows the deployment dates set according to the priority list:

Table 1 – Government Vaccine Priority Levels and Rollout Dates

Start date	Appointments available for	Priority group
8th December 2020	Residents in a care home for older adults and their carers; and all aged 80 and over	1 and part of 2
Procedures set out on 9th and 14th January 2021	Frontline health and social care workers	Part of 2
18th January 2021	All aged 70 and over, and clinically extremely vulnerable individuals	3 and 4

15thFebruary 2021	All aged 65 and over; and those aged 16 to 64 with underlying health conditions which put them at higher risk of serious disease and mortality	5 and 6
1st March 2021	All aged 60 and over	7
6th March 2021	All aged 56 and over	8 (age adjusted from 55)
17th March 2021	All aged 50 and over	9
13th April 2021	All aged 45 and over	
26th April 2021	All aged 44 and over	
27th April 2021	All aged 42 and over	
30th April 2021	All aged 40 and over	
13th May 2021	All aged 38 and over	
18th May 2021	All aged 36 and over	
20th May 2021	All aged 34 and over	
22nd May 2021	All aged 32 and over	
26th May 2021	All aged 30 and over	
8th June 2021	All aged 25 and over	
15th June 2021	All aged 23 and over	
16th June 2021	All aged 21 and over	
18th June 2021	All adults (ie aged 18 and over)	

163. Enfield's deployment follows the government's rollout plan except for care homes and younger vulnerable client groups in adult social care. Vaccines are deployed in Enfield to all care homes (not just those for older people) and available vaccine capacity is also offered to vulnerable community clients through the Care Home Assessment Team and local GPs. The vaccine rollout plan is overseen by the Vaccine Steering Group established in January 2020 chaired by the Director of Public Health and attended by Councillors, officers, and Health stakeholders.

164. Front-line staff working in care settings are also offered the vaccine at the same time given the level of risk (both to care staff and to service users with whom they work).

165. A bespoke vaccine drop-in centre is developed by Enfield Council for people with learning disabilities and for people with mental ill health. Evidence locally collected on deaths shows that people with complex learning disabilities are particularly at risk with the average mortality rate for this client group was 6.3 times greater than the whole population during the first wave. The site is located on Chase Farm Hospital and was operational in January 2021.

166. An accessible webpage explaining the hub was designed and the link circulated widely through Partnership Board and providers. This site received over 500 hits in the first month. The site also supplied easy read

downloads answering questions about the vaccine, and accessible consent forms. It also contained several videos encouraging people to have the vaccine, including one filmed at the hub featuring a member of the Enfield Learning Disabilities and Autism Council.

167. Access to vaccine supply was controlled nationally by the NHS.

Communications

168. Effective communications quickly became central to the coordination of key messages and actions initiated as we responded to the pandemic.

169. The Local Authority Communication Team embedded itself in all relevant governance structures (internal and external) and worked tirelessly to ensure all Government and locally agreed key messages were shared with audiences at speed and with accuracy.

170. Bespoke communications packages were developed over the course of the pandemic as it was acknowledged that mass mail-outs and boroughwide communications would need to be supplemented. The team worked with local elected members, faith and community groups to release a series of media messages (visual and written) to help penetrate into communities where English was not necessarily a first language.

171. Messages were able to dispense sound advice on how to engage with a dynamic and diverse community where a significant proportion of its population did not have English as a first language and was able to mobilise to ensure all appropriate avenues of media were available options to decision makers.

172. The Local Authority and its partners were also able to draw upon the resources of an in-house Design and Print Team. This meant that valuable time could be saved in terms of translating key messages into literature and promotional flyers that could be distributed quickly. Officers in the Design and Print Team worked flexibly and with resilience to ensure that requests were handled quickly and effectively and helped to ensure branding was consistent and clear.

173. Some example of literature sent (see Appendix B) include: the Leader writing to residents about securing access to testing for frontline key workers (22nd April 2020); guidance and Covid-19 advice (11th September 2020) and urging residents to take up mass testing (11th January 2021).

174. Covid-19 related communications remain of critical importance as we move into the present stages of the pandemic and the Local Authority retains dedicated additional ‘Covid-19 communications’ capacity at the time of writing (March 2022).

175. In terms of national media, the Leader of the Council and others made themselves available for broadcast opportunities with media channels (BBC News 24 and others). This allowed Enfield to have a degree of prominence on a wider stage that could give local people assurance that the Local Authority and partners were lobbying on their behalf and also helped to break through the communications barriers many were experiencing through lockdown.

Summary of Lessons Learned

176. The Covid-19 pandemic has been the greatest health crisis to confront the Council in its history. Many staff were asked to work in different roles often working long hours over considerable periods of time. The emergence of new Variants of Concern (VOCs) always threatens to reignite the pandemic and there is some understanding that the effects of this pandemic may continue to last for a number of years, and this may be considered an interim report. However, within that, several recommendations might be made to potentially mitigate the effects of any future health crisis.

PPE

177. The ability of the Local Authority to use existing and seek new networks to support workforce resilience and seize the initiative in terms of acquiring PPE to help keep staff and residents safe was a key success early in the pandemic when supplies were in short and sometimes trapped in chaotic supply chains.

178. The Local Authority quickly mobilised its community equipment service to oversee a robust ordering, collection/delivery process for all PPE with stock levels regularly monitored and distribution tracked. Having a central point of access through an already established logistical infrastructure made it possible to begin to meet the PPE needs of services, providers, and partners from an early stage in the pandemic. The LA will continue to maintain stock levels to provide for any similar situation in future.

Support to Care Homes and Day Care Services

179. Keeping People safe – the Local Authority quickly grasped the risk of the virus to staff and residents in care homes. Government was lobbied to provide regular mass testing as a preventative measure and no Covid-19 positive admissions to care homes were made from the outset, contrary to government advice at the time with regards to the level of risk. Community support was bolstered, particularly to informal carers/family members, to enable more people to remain living in their own homes as opposed to entering a care home. Importantly, this position was agreed across all Adult Social Care departments in NCL, providing a consistent position both to the public, providers, and the NHS.

180. Infection control measures were bolstered by additional recruitment of key staff working in partnership with health and public health colleagues which supported providers with practical help, advice and guidance to understand the plethora of government guidance being issued. Feedback from our providers has indicated that this worked particularly well, was responsive to need and supportive in nature. Provider concerns processes already well established proved invaluable in co-ordinating responses and maintaining good, regular communication with the CQC. In addition, new and innovative ways of supporting families to maintain contact throughout the pandemic were quickly established to reduce the impact of lockdowns on the most vulnerable. This included the free distribution of significant amounts of IT equipment, for example tablets, enabling families to visit their loved ones virtually.

181. Care Act Easements (see Appendix G) – Processes and equipment to enable mobile and flexible working was already established in the Local Authority, which enabled more front-line staff to work safely and effectively from home, making assessment, support planning and review visits where these were required (established through a robust risk assessment and triage process). Staff absence levels because of the pandemic were minimised and no care act easements were enacted.

182. Market sustainability – the provider quality assurance function was quickly mobilised to maintain regular contact with all our providers, collecting key data and disseminating information, guidance and advice in partnership with Public Health colleagues. The Local Authority also made additional relief funding available to providers who had lost a significant number of their service users because of the pandemic. Similar processes already established then enabled additional government funding, strongly lobbied for in partnership with all other local authorities, to be distributed quickly, efficiently, and fairly. Enfield has not lost any of its providers as a direct result of the pandemic.

183. Community Services – daycare services presented a heightened level of risk during the pandemic and this risk was largely missing from government guidance. The Local Authority quickly established a day-care oversight group to ensure that all necessary measures were in place to enable safe attendance at day centres to continue, particularly for those most at risk of social isolation, family breakdown and mental ill health. Although services were suspended for a period due to government legislation, safe and rapid reopening was effected much more quickly in Enfield than other areas. As a result, many more people were able to safely attend activities which supported their mental health and wellbeing. Enfield's care markets are particularly well developed and supported. As a result, other community services were able to continue during the entirety of the pandemic with minimal disruption. The flexibility inherent in Enfield's successful direct payments approach with service users and providers had a large part to play.

Schools and educational settings

184. The provision of support to schools was vital during the pandemic as they remained open throughout to allow key workers to continue to keep the country running. The early establishment of a process for local reporting regarding the numbers of pupils and school staff with Covid-19 or self-isolating was established was effective and provided vital real time intelligence.

185. The joint working between small teams of individuals from public health and education teams supporting education settings with outbreak management and answering queries was successful as was the provision of support to schools on COVID-19 risk assessments. This contributed fundamentally to all Enfield schools remaining open throughout the pandemic albeit for periods only to vulnerable children and those of key workers.

186. The shift to virtual meetings with headteachers was effective and will continue with the reintroduction of some face to face meetings. The move to virtual meetings allowed for higher levels of attendance and this learning will inform how the split of virtual and face to face meetings will continue in future.

187. The experience of the pandemic validated many positive outcomes in terms of those being required to be working from home approach and will continue and has assisted in filling some skills gaps such as in SEND.

188. The leadership demonstrated by the Council with schools was strengthened after years of the dilution of this relationship through the academisation agenda; with lessons learned to seek to maintain and further enhance this in the future.

Supporting the homeless

189. The Homelessness Service and partners responded well to the direction to house those highly vulnerable to the pandemic as a result of not being in safe accommodation. The robustness of the response to an unprecedented requirement to house homeless people at scale and with speed can be adjudged a success.

Enfield Stands Together and Community Response

190. The ability of the Local Authority to move at pace and decisively with key local partners was critical to getting the response initiated on the best footing. Strong network relationships with key local VCS partners such as Enfield Voluntary Action, Citizens Advice Enfield, Age UK Enfield, The Felix Project, Enfield Food Bank, Healthwatch Enfield, Enfield Over 50s

Forum and all of the groups linked to our adult social care operation meant that a response with depth and flexibility to meet rising need was enabled.

191. The soundness of decision making by the Community Resilience Board and latterly the Covid-19 Resilience Board is evidenced in the scale of the deployment of support to vulnerable people during the early stages of the pandemic and through lockdown to ensure that those most vulnerable were given the best support at scale over a prolonged period.

192. The Local Authority and partners must also be credited with recognising that the well-intentioned 'emergency food' parcels could not fully reflect the dietary needs of a diverse community. The decision to work collectively and assign specific resources to create dietary options and food availability that could reflect Enfield's demography and cultural diversity was a welcome relief to many who resident who were seeking to stay resilient during the height of the pandemic.

193. From the critical aspect of adult social care, Enfield's well-developed VCS market was invaluable in supporting the partnership to maintain contact with its community during the pandemic. A well-established set of Adult Social Care VCS service provision was able to be quickly mobilised to support the wider Council initiative, Enfield Stands Together, in order to provide key support to people in the community, particularly those who were socially isolated, enabling people to access critical basics such as medication, food and regular social contact for those living on their own.

Workforce Resilience

194. Processes and equipment to enable mobile and flexible working enabled more front-line staff to work safely and effectively from home.

195. IT was able to adapt to working remotely very quickly. This, together with Covid-19 safe measures enabled the service and supplier support to be provided throughout the pandemic.

196. As a result, staff absence levels because of the pandemic were minimised and no care act easements were enacted.

197. Adopting safe ways of working and moving away from presentation / face to face service delivery to phone/teams and on-line delivery allowed critical services to continue.

198. However, there were some issues to managing staff remotely, especially in keeping in touch with staff and checking on their mental health / loneliness.

199. Overwhelmingly LBE staff demonstrated a willingness and ability to a rapidly developing and changing environment. This did not preclude a high dependency on some key managers.

200. This included working from home, collaborating with other Council Services and Local Authorities across London.

201. There were inevitably issues that have either been addressed or will need consideration in preparation in case of the next pandemic.

Governance

202. The governance structures and approach that were already in place in terms of Emergency Planning, business continuity and related decision making provided a sound basis for the mobilisation and establishment of a clear chain of command and control. The pre-existence of plans for this purpose allowed for these mobilisations to assemble at pace and with transparency and accountability quickly established. This was vital in a fast-moving environment where and mechanisms for regional linkages into wider pandemic crisis management and response were found to be effective. These chains of command provided clear lines of accountability and responsibility that meant decisions could be effectively taken and information shared.

203. Oversight – Bronze meetings were quickly established with links to Council Silver and Gold meetings as well as escalation meetings across the health and social care partnerships. This regular oversight, ability to discuss and make decisions rapidly supported by regular access to robust data enabled the Local Authority to quickly appraise itself of rapidly changing situations on the ground, mobilise resources quickly and deploy them appropriately.

204. Partnerships – already robust partnerships were strengthened throughout the pandemic. Sharing of data to better understand a rapidly evolving situation throughout the pandemic, enabled rapid and shared decision making, particularly across the North Central London Sub-Region. Working together, planning for and responding to a fast-changing health and social care landscape resulted in clear, consistent messages to the public and to our providers with mutual aid made available within the system to support hospital flows, safe discharges into the community and care homes and the rapid development of designated bed capacity to provide for Covid-19 positive discharge cases.

205. The Local Authority connected quickly and effectively into regional/national command and control and was able to share best practice from our response as well receive and disseminate best practice from others. In addition our senior management, including the Chief Executive, were able to play a leading role in helping to shape the London response within local authorities and in working with statutory health partners such as the NCL

CCG/NHS as illustrated in positive joint working on the establishment of testing and vaccination centres.

Testing

206. Access to testing for all services was sporadic at the outset, particularly care homes and community services. The Local Authority quickly established a series of testing hubs, including one specifically for the most vulnerable in our community at Park Avenue. This bespoke provision enabled simple and regular access for key front-line staff, vulnerable clients and their families to access testing in the community.

207. As community testing was a Local Authority responsibility, in November 2021 a meeting was held to consolidate 'lessons learnt' from this part of the borough response. A separate report has been produced on the main recommendations included:

- Staffing:
  - Need to be wary of taking staff from their normal work and to employ external support

- Governance:
  - Clear reporting lines and communication between Gold, Silver and Bronze
  - Clear inclusive agendas and avoid jargon
  - Learn from other boroughs

- Resources:
  - Keep very clear records of communication to and from central Government
  - Be very clear on scope of funding pots
  - Prioritise Personal Protective Equipment (PPE)

- Buildings:
  - Take photos of buildings pre-Covid-19 use to ensure no misunderstandings when returning to normal use
  - Ensure prioritisation of repairs to buildings during Covid-19 usage

- Communications:
  - Utilise comms resources of partners
  - Be ready to expand the comms team
  - Simplify the message

- IT and Systems:
  - Ensure kit is logged in and out
  - Be ready to provide more equipment if necessary

208. Specifically with regards to Health and Adult Social Care, the absence of mass testing at an early stage in the pandemic, a focus on the NHS with rapid and untested discharges as well as the time taken to increase testing capacity was a significant factor in the impact on care home staff and residents. The Council's position was an advisory one but supported by the DPH where no admissions to care homes were to be accepted without first having a negative PCR test was one which put the health and wellbeing of staff and care home residents first.

Vaccinations

209. Vaccine roll-out – partnerships in Enfield worked particularly well, were well served with the right data to identify those most at risk and critically, worked at a very early stage to secure vaccinations for those people most at risk and was not limited by age (as government guidance was). A bespoke vaccine hub was established with help from health partners (Barnet Enfield and Haringey Mental Health Trust) at Royal Free Chase Farm hospital enabling people with mental ill health and complex learning disabilities where standard vaccine facilities proved difficult to access appropriately, to access the vaccine in a more discreet, quiet and managed environment. The partnership with health worked extremely well, in particular the ability to operate with a degree of flexibility through regular access to timely data which enabled more people to access the vaccine more quickly and the level of vaccine left unused (the Pfizer vaccine in particular).

210. The mobilisation of the vaccine programme during December 2020 in Enfield as nationally, was managed by the NHS. Already well-established partnerships with the Local Authority worked extremely well, particularly in targeting those residents most at risk. The government produced a timeline and hierarchy of different elements of the population in order of priority.

211. Whilst Enfield did follow the government plan, better and more flexible use of available vaccine stock and resources enabled the partnership to target more rapidly those people it considered to be at equal risk compared to older care home residents. This included vulnerable people with learning disabilities, mental ill health and extreme frailty living in the community. In addition, a bespoke location was established on the Chase Farm Hospital site to provide access to vaccines for people with mental ill health and learning disabilities where standard vaccine locations would prove difficult to access. Discretely located and quiet, the site proved to be more accessible to those service users for whom busy and noisy vaccine centres (GP surgeries and pharmacies for the most part) would prove to be too much of a barrier to accessing the vaccine.

212. Only 1 site in Enfield was identified that met the NHS criteria for a mass vaccination site. However, roll-out was extremely quick and at one point was had the highest coverage in North Central London. This was achieved through the mobilisation of Primary Care Networks.

213. Vaccine hesitancy in certain parts and sections of the community proved to be a major obstacle to uptake. Often this has been apparent in those populations most affected by the pandemic.

214. A variety of different events were hosted including by respected community leaders as well as voluntary and community sector groups in order to reach out to those more hesitant elements of the community with varying degrees of success.

215. In addition, LBE ran a vaccine bus targeting those communities. This absorbed considerable staff resource but did not prove to be an effective means of encouraging more to be vaccinated and the uptake was limited.

216. Extensive communication campaigns over multiple channels were run in relation to vaccine uptake. It was unclear at what point these began to become less effective.

217. Overall, the uptake of the vaccine in Enfield, as in London more widely, was and continues to be below the national uptake figure. Part of this may be explained by the presence of a larger population under the age of 18 and proportionally larger elements of various ethnic groups less inclined to accept the vaccine or to engage with services generally.

218. A particular area of success was the deployment of vaccines within care home settings both for residents and for staff. Regular communication and strong relationships between the provider market and Enfield Council were particularly effective in building trust, establishing clear lines of reporting and accountability and regular, targeted support where needed. As a result, when the government vaccine mandate was introduced into care homes Enfield care homes lost fewer than 30 staff from a total workforce of just under 2,200.

Communications

219. Communication was of paramount importance throughout the pandemic either indicating where and why people should be tested, for vaccine uptake and to advertise Council services such as Enfield Stands Together. In getting sometimes complex messaging out to the wider public the response was effective and allowed us to penetrate into the community with a large degree of success.

220. The use of an internal print service proved to be invaluable in terms of speed of turnaround.

221. Mounting pressure and the need for constant comms led to the recruitment of further staff reflecting the huge demand for accurate and inclusive communications during all stages of the pandemic.

222. Targeted communications sessions with Public Health specialists also proved to be invaluable, particularly in distributing key, accessible messages to staff working across services both in the Council and across its care markets. The CQC has remarked that Enfield's provider markets, amongst the largest in London, were particularly well supported compared to many other areas.

223. Communications between Local Authority Gold, Silver and Bronze meetings was particularly effective and well served by the Public Health Intelligence team with regular access to key data supporting key decision-making processes across the partnership. The focus, not just on cases but on the wider impact of those cases on health and social care services was instrumental in enabling the Local Authority to plan more effectively, avoiding the need to enact Care Act Easements, deploying front line staff where they were most needed and prioritising access to assessment and support services for those people most in need within the community.

224. The communications team also worked well with Elected Members, members of the faith community and voluntary sector partners to produce bespoke 'Covid-19 Communications' in a variety of formats. The recording of video clips in different community languages to reinforce guidance on how to stay safe was a particularly helpful innovation and has positive implications for the future deployment of inclusive communications on a range of issues.

225. Externally, the Local Authority and leadership was proactive in engaging with key media channels to both highlight the emerging pressures as the pandemic began to take hold but also to provide a presence on national media outlets that could demonstrate that Enfield was being championed and resources were being lobbied. This created effective learning and has positive implications for how we position Enfield effectively to secure support and gain interest in our borough.

APPENDIX B

Rt Hon Matt Hancock MP
Secretary of State,
Department of Health and Social Care,
39 Victoria Street,
London SW1H 0EU

Please reply to: Cllr Nesil Caliskan
Leader of the Council
Email: Cllr.nesil.caliskan@enfield.gov.uk
Phone: 020 8379 4116
Textphone:
Fax:
My Ref:
Your Ref:

Date: 16 April 2020

Dear Secretary of State

Ongoing Government response to the Covid-19 crisis

I am writing to you regarding the ongoing impact of the Covid-19 outbreak on the care sector. I have concerns about how key information and coronavirus related deaths are is being collated and then shared with the public. I am also increasingly worried about the lack of support to frontline workers in care homes.

My borough has a large ageing population with an extensive network of care homes looking after many thousands of vulnerable elderly residents in our borough. The London Borough of Enfield has ninety care homes (and 60 domiciliary care homes). Our intelligence is telling us that localised Covid-19 outbreaks in our care homes are rapidly increasing. This will be the same picture across the country. Government should be able to answer what proportion of care homes have declared an outbreak of the coronavirus at any one time.

Daily updates on the number of fatalities directly linked to Covid-19 released by government are not fully accurate. The numbers shared only relate to hospital deaths. This means the public are not being given the full picture of the extent to which Covid-19 is affecting our population.

Whilst understanding that the process of registration and verification means there is a comparative delay in obtaining and verifying figures beyond deaths in hospitals, I do believe that it is in everyone's interest to include fatalities in care homes and in the wider community in official reporting. Death numbers of those who have shown clear symptoms of Covid-19 should also be published and death certificates should be capturing this information fully to help provide an accurate picture of impact.

We also need government to increase its efforts to direct energy and resources into directly supporting front-line workers in our care homes and those delivering home care in the community.

Enfield Council is doing all we can to support our local care homes and those who reside in them as well as our home care workers. We are working very closely with these vital partners by making daily calls to care homes to discuss support requirements. Enfield Council support to our local care sector has included extending our own occupational health team available to support care home staff affected by deaths. We are also playing a dedicated role in monitoring infection control steps and other valuable support.

It is clear that care homes in my borough are doing all they can to protect and look after their residents. However, like elsewhere in the country they continue to experience incredible challenges. I note that on the 11th April 2020 the Association of Directors of Adult Social Services wrote to Jonathan Marron expressing deep concern about testing, funding, mixed messages from government and personal protective equipment (PPE). Enfield Council shares the concerns outlined in that letter.

Specifically, in relation to PPE, frontline care home workers must be provided with the what they need to allow them to care for patients safely. Enfield Council has provided a grant to every care home in the borough and we have played a proactive role in trying to secure and distribute supplies to care homes. Despite local coordination and efforts, there remains a chronic undersupply of PPE from Government. This is causing considerable distress to our care homes, many of whom have contacted Enfield Council to share their concern and ask for our help in securing equipment.

The response from Government to get protective equipment out to those who desperately need it has to be escalated. In Enfield we were waiting for over a month for PPE supplies at the beginning of this crisis and the amount we initially received was completely inadequate given the level of need. Our care homes were telling us of their concerns about PPE from the outset and the need for immediate Government assistance, one of these care homes has subsequently suffered the highest number of covid-19 related deaths in the borough.

The right equipment, in the right volumes must be distributed to care homes and care workers quickly. To date, this has not been the case and in Enfield there has never been enough stock to at anyone time to last more than two or three days, causing great anxiety to care homes.

The timely distribution of the right PPE needs to be underpinned by a testing programme that is agile, targeted and deployed at sufficient scale to keep workers and those being cared for safe. I am very concerned that the recent pledge to accelerate testing for Covid-19 presently remains well below the 100,000 tests per day you have committed the Government to providing by 30 April 2020. I would hope that you can now share a clear trajectory with us to show how that target will be met.

In Enfield, the offer made, up until last week, for care workers to be tested has not been of a volume that suggests the machinery and logistics were in place to ramp up testing. In the week beginning 6th April 2020 this offer totalled 10 testing places to a workforce of around 5,000 staff. It was also not hugely helpful that the highly limited offer of testing initially made to us required staff to travel miles across London to Wembley in a car to participate.

As we enter the next three weeks of lockdown, we are aware the care homes across the country may be facing their most difficult time yet and as are those workers delivering home care. The care sector as a whole feel like it has been forgotten about by Government in this crisis. In coming weeks this needs to change and our front-line care workers, who are too often undervalued and on low pay, looking after our most vulnerable residents, are made a priority for receiving the protective equipment they need and are offered testing alongside our NHS frontline workers.

I hope that the government will now escalate its response and take meaningful steps to prioritise the concerns I have outlined in this letter. Enfield Council is committed to working with you and all partners, nationally and locally, to do whatever we can to support the care section in my borough.

I look forward to hearing from you in due course.

Yours Sincerely

Cllr Nesil Caliskan
Leader, Enfield Council

Cc: Rt Hon Robert Jenrick MP,
Secretary of State for Housing, Communities and Local Government

APPENDIX B

6th April 2020

Statement from Leader of Enfield Council on news of deaths in local care home

I am deeply saddened to hear that over the weekend a number of our most vulnerable residents in one care home in Enfield have died of what is believed to be coronavirus. On behalf of Enfield Council I would like to offer our deepest sympathies to their friends and family. Every life lost to coronavirus leaves behind grieving and heartbroken loved ones.

I would also like to express my deepest gratitude and support to the many care staff working in Enfield's residential and nursing homes who are providing vital social care in the community at this difficult time.

Enfield Council officers continue to have daily contact with every care home in our borough. Together with many frontline staff we will continue to do everything we can to support and help the most vulnerable members of our community.

Cllr Nesil Caliskan
Leader of Enfield Council

APPENDIX B

Please reply to: Cllr Nesil Caliskan
Leader of the Council
Email: Cllr.nesil.caliskan@enfield.gov.uk
Phone: 020 8379 4116
Date: 23 December 2020

Matt Hancock MP
Secretary of State for Health

Dear Secretary of State for Health,

High number of Covid positive in-patients means hospitals either unable to accept new urgent cases or an increase in requests to admit Covid positive people into care homes

I am writing to you to express my grave concerns about the ongoing and significant impact of this pandemic on our local NHS services in Enfield. I am particularly concerned that the increasing pressure on our local NHS Hospital Trusts, North Middlesex and Royal Free Chase Farm, will result in significant Covid positive in-patients with the hospitals either unable to accept new urgent cases or an increase in requests to admit Covid positive people into care home beds in order to free up hospital bed capacity.

In the first wave of this pandemic, the impact of this virus on care homes was nothing short of catastrophic. In Enfield we have one of the largest care home markets in London and the impact has been disproportionately felt here with 60% of our 83 care homes suffering outbreaks.

Many dedicated care staff and vulnerable residents lost their lives as this virus entered our care homes. A significant contributing factor in that was lack of testing before people were discharged back to these care homes from hospital. It is for that reason that Enfield Council has taken a very clear position that care homes in our borough should not accept any admissions from hospital settings where people have not received a negative PCR test result immediately prior to their discharge. We simply cannot have a repeat of what happened in the first wave of this pandemic.

Locally we are currently in a position where North Middlesex NHS Trust, our local A&E hospital and one of the busiest in London, is operating at in excess of 97% capacity, with, as at today, 166 of its 382 general and acute beds occupied by patients who are Covid positive. All cases are being actively tracked and the number of Covid positive patients occupying hospital beds within this trust is expected to increase to 250 over the next two weeks.

This is generating significant pressure within our Health and Social Care system. With effect from Tuesday 22nd December, North Middlesex University hospital announced all non-emergency activity has been ceased, with the exception of cancer and radiology treatments. The hospital is rapidly approaching a point where it will have to begin diverting blue light services to other areas. This in itself creates an enormous amount of risk and with it comes pressure to discharge in order to free up beds for people who really need them.

The designated bed capacity established across the North Central London sub-region to support our hospitals with Covid positive discharges is also approaching capacity and we are now being asked to explore the option of creating additional designated bed capacity within our care homes. To be clear, that is a request to receive

admissions into care homes for people who are either Covid positive or who have tested negative and then subsequently come into contact with someone who has tested positive.

Whilst I am fully aware of the pressures facing our local NHS services, I simply cannot accept our care homes being used in this way. No Covid positive patient should be discharged into a care home, whether there is capacity to isolate or not. The risk is simply too great. Over 10% of our most vulnerable people living in care homes died as a result of this pandemic in the first wave. These deaths accounted for half of our total deaths in wave one in Enfield. Behind that shocking statistic are hundreds if not thousands of lives impacted in the cruellest possible way with loved ones being lost in homes where they believed they were being helped to stay safe.

Given that local hospitals in Enfield find themselves limited in bed capacity because of the Covid-crisis, it is critical the government and the NHS consider now the need for additional and alternative hospital stepdown facilities for patients who in normal circumstances would remain in hospital until Covid free. Therefore, I am formally asking you, what the government's plans are to achieve this.

We understand that this is an unprecedented and very fast-moving situation. However, time and again this Council has stepped up and shown itself ready and willing to work with government and other agencies to deliver what is needed on the ground to help keep our community safe.

Enfield Council stands ready to continue this work and to deliver in partnership with government, the NHS and our partners, temporary, safe, alternative NHS accommodation for Covid positive people being discharged from hospital where they can be cared for safely and appropriately until they are free of the virus. For instance, as a local authority we can swiftly identify land for additional temporary hospital beds for elderly and vulnerable residents who are Covid positive.

Our local NHS is on its knees. They are doing the very best that they can, but they simply cannot cope and require urgent government assistance. A failure to act urgently and at pace will result in our local hospitals closing their doors to new admissions, including those who are Covid positive. Government must, therefore, act now for the sake of our most vulnerable residents.

Yours sincerely,

Cllr Nesil Caliskan

Leader of the Council

Copied to:

Helen Whately MP, Minister of State for Social Care

APPENDIX B

22 April 2020

Covid-19 testing for front-line care sector workers in Enfield

After many weeks of lobbying Government to demand that all of our frontline key workers in Enfield should have access to testing for Covid-19, I am pleased to confirm that we now have been able to secure some dedicated local testing provision in our borough.

The tests are being offered to NHS staff or staff working in a care setting, or members of their household, with Covid-19 symptoms.

The tests are being provided as a drive through service at **Lee Valley Athletics Park in Edmonton, N9 0AR** and by pre-booked appointment only**.** If you are eligible you can book a testing slot online at**:**
https://feedback.camdenccg.nhs.uk/camden-ccg/ncl-covid-19-staff-testing-drive-thru/

This is a helpful start, but we will not rest until all of our 5,500 frontline care sector workers in Enfield have all been able to access tests as a matter of urgency. We will continue to call for more testing and a clear process for all frontline care workers, NHS staff and other key workers to be able to book appointments for tests going forward. We are calling for more sites for testing in Enfield so testing of frontline key workers can be made more easily accessible.

Yours Sincerely,

Cllr Nesil Caliskan
Leader of the Council

KEEP ENFIELD SAFE

APPENDIX B

ENFIELD Council

Important information from Enfield Council on COVID-19

Update from Enfield Council's Leader, Councillor Nesil Caliskan

11 September 2020

COVID-19 advice

I know how difficult the last few months have been for our communities with many loved ones having lost their lives to COVID-19. Enfield Council continues to do all it can to support you and keep you safe.

Over the last week the number of COVID-19 cases across the country and in Enfield has steadily increased. We know that our most vulnerable residents, especially people who are over 60, are the worst affected.

That is why it remains really important that we all continue to follow social distancing rules and all other public health advice to stop the spread of the virus and reduce the chances of a local lockdown.

Please remember that you must:

- Wear a mask on public transport and in indoor places
- Regularly wash your hands
- Socially distance - stay at least two metres away from other people not in your household

The latest government legislation also says that **you must not socialise in groups of more than six people** either indoors or outdoors (with some exemptions such as schools, households, social bubbles, workplaces, weddings and funerals). For more information and guidance visit www.gov.uk/coronavirus

If you have the symptoms of COVID-19 it is important you self-isolate and **book a test** by ringing 119 or visiting www.nhs.uk/coronavirus

The NHS is planning for winter flu

As well as doing everything we can to reduce the spread of COVID-19 in Enfield we are also encouraging all residents to get the winter flu vaccine.

The NHS is preparing to treat patients with COVID-19 this winter as well as serious illnesses and seasonal bugs, which could put immense pressure on our GPs, hospitals and emergency services. **By having the winter flu vaccine, you can help reduce this pressure and help to protect yourself and others from winter flu.**

For the first time, people aged 50 to 64 are eligible for a free flu vaccine this year. Locally the NHS is preparing to make the vaccine available from Autumn 2020.

Enfield Council is working to support our local NHS partners to increase resident access to vaccination sites across the borough. We will post locations on our website and social media. Residents will be able to book appointments on-line or through their GP.

I know many residents are anxious about the months ahead and a possible second wave. I want to let you know that Enfield Council is doing everything it can to support our communities and keep residents safe. If you need our help with anything, please do get in touch - www.enfield.gov.uk

Show your support by displaying the back of this leaflet in your window

APPENDIX B

KEEP ENFIELD SAFE

ENFIELD Council

WASH YOUR HANDS

for 20 seconds

WEAR FACE COVERINGS

on public transport and indoor spaces

KEEP YOUR DISTANCE

two metres if possible

COVID SYMPTOMS?

Get tested now

nhs.uk/coronavirus or call 119

APPENDIX B

KEEP ENFIELD SAFE

ENFIELD Council

Cllr.Nesil.Caliskan@enfield.gov.uk

Dear Enfield Resident,

It has been a difficult year again for our communities in Enfield and I know that many of you have lost loved ones. With the news that we have entered a national lockdown again it is important that we all follow the government guidance to stay at home, unless you need to leave for a permitted reason, to control the spread of the virus, protect the NHS and save lives. Please also remember to follow the hands, space, face guidance.

While these measures will help slow the spread of the virus, Enfield Council is using another, extremely effective tool to tackle the virus – mass testing for people without symptoms.

Enfield Council has now set up mass testing centres throughout the borough in response to rising coronavirus rates and the emergence of a new more contagious strand of the virus. To keep our residents safe, we are carrying out more rapid flow tests than any other borough in London and are in the top ten local authorities in the UK.

We have six testing centres in Enfield and they are all open between 9am and 6pm, seven days a week. You do not need to book an appointment and residents without symptoms can simply turn up during the centre's opening hours.

One in three infected people do not show symptoms of coronavirus, but can still pass it on. The centres provide an opportunity for residents without symptoms who might not know they are infectious to take a test without an appointment and take precautions to protect themselves and their families.

We urge residents who cannot work from home such as key workers and front-line staff who we rely on to keep Enfield open and deliver vital services, as well as those caring for our vulnerable residents, to take tests regularly so they know they are free of the virus and are not spreading it to others.

You will receive your results on the same day and residents testing positive will be referred for a follow-up test to confirm the result.

You can find your nearest test centre on our website **www.enfield.gov.uk/masstesting**

You must wear a mask at test centres (unless exempt) and strict social distancing arrangements will be put in place to protect residents and staff.

If you have coronavirus symptoms you must not go to a mass testing centre. You must immediately self-isolate and book a test for people with symptoms by ringing 119 or visiting nhs.uk/coronavirus.

Best wishes,

Councillor Nesil Caliskan
Leader of Enfield Council

www.enfield.gov.uk/masstesting

? If you need this document in another language or format contact the service using the details above.

APPENDIX B

ENFIELD Council

NHS Test and Trace

Get your rapid Covid-19 test now

One in three people with coronavirus do not have symptoms but can still pass it on. Get your free rapid test now, especially if you cannot work from home or are caring for others. We advise you get tested twice a week.

Do not come to our rapid test centres if you have coronavirus symptoms. If you have symptoms, immediately self isolate and book a symptomatic test at www.gov.uk/get-coronavirus-test

Our test centres are open from 9am - 6pm:

- Brigadier Hall, Cedar Road, Enfield EN2 0NL
- Green Towers Community Centre, Plevna Road, Edmonton, N9 0TE
- Kempe Hall, Kempe Road, Enfield, EN1 4QS
- Klinger Hall, Copperfield Mews, Edmonton, N18 1PF (access from Silver Street)
- Southgate Library, High Street, Southgate, N14 6BP
- John Wilkes House, 79 High Street, Ponders End, EN3 4EN

GET YOUR FREE, FAST TEST NOW

www.enfield.gov.uk/masstesting

Special Report: In shielding its hospitals from COVID-19, Britain left many of the weakest exposed

By Stephen Grey, Andrew MacAskill
33 MIN READ

LONDON (Reuters) - On a doorstep in the suburbs of north London, three-year-old Ayse picked up a tissue to wipe away her grandmother's tears - tears for one more victim of the virus.

Ayse Mehmet, whose daughter Sonya Kaygan died from coronavirus disease (COVID-19), has tears wiped by her three-year-old granddaughter, also named Ayse, at her home in Enfield, Britain, April 27, 2020. Picture taken April 27, 2020. REUTERS/Peter Nicholls

The little girl was waiting for her mum, Sonya Kaygan. Her grandmother hadn't broken the news that Kaygan, 26, who worked at a nearby care home, was dead, one of over 100 frontline health workers killed by the coronavirus in Great Britain.

The grandmother, also called Ayse, spoke through sobs. "Why? Why?" she repeated. Why couldn't she visit the hospital to say her goodbyes? Why did so many die in her daughter's workplace? At least 25 residents since the start of March, of whom at least 17 were linked to the coronavirus. It was one of the highest death tolls disclosed so far in a care home in England. And why did Kaygan and her colleagues resort to buying face masks on Amazon a month ago, protection that arrived only after she was in hospital?

A Reuters investigation into Kaygan's case, the care home where she worked, and the wider community in which she lived provides an intimate view of the frontline of Britain's war on the coronavirus. It exposes, too, a dangerous lag between promises made by Prime Minister Boris Johnson's government and the reality on the ground.

Even as the government was promising to protect the elderly and vulnerable from the deadly virus, local councils say they didn't have

the tools to carry out the plan, and were often given just hours to implement new government instructions.

Policies designed to prevent hospitals from being overwhelmed pushed a greater burden onto care homes. With hospitals given priority by the government, care homes struggled to get access to tests and protective equipment. The elderly were also put at potentially greater risk by measures to admit only the sickest for hospital treatment and to clear out as many non-acute patients as possible from wards. These findings are based on documents from government agencies seen by Reuters, interviews with five leaders of local authorities and eight care home managers.

It is too early to reach final conclusions about the wisdom of these policies. Still, staff and managers of many care homes say they believe the British government made a crucial early mistake: It focused too much attention on protecting the country's National Health Service at the expense of the most vulnerable in society, among them the estimated 400,000 mostly elderly or infirm people who live in care homes across Britain.

The government summed up that policy in the slogan "Protect the NHS." The approach gave the country's publicly-funded hospitals priority over its care homes. A UK government spokesman defended the strategy. "This is an unprecedented global pandemic and we have taken the right steps at the right time to combat it, guided by the best scientific advice."

The effects of this approach have been felt desperately in Elizabeth Lodge, in Enfield, north London, where Kaygan worked.

The first coronavirus test of a resident of the Lodge only took place on April 29. That was 34 days after the first suspected case at the home, said Andrew Knight, chief executive of residential services at CareUK, a private company which operates the home. It was also 14 days after Matt Hancock, the UK health secretary, pledged tests would be available to "everyone who needs one" in a care home.

“The government’s response on testing has come way too late to have any meaningful effect on keeping the virus out of our homes,” said Knight, the CareUK executive, in a statement to Reuters.

So far, at least 32,300 people have died in Britain from the coronavirus, the highest toll in Europe, according to official UK data processed by 2 May. Out of those deaths, more than 5,890 were registered as occurring in care homes in England and Wales by April 24, the latest date available. These figures don’t include care home residents who were taken to hospital and died there.

Many care home providers believe the figures understate the number of deaths among care home residents because, in the absence of testing, not all are being captured. During the 10 weeks prior to the outbreak, including the height of the flu season, an average of 2,635 people died each week in care homes in England and Wales. By April 24, that weekly death toll had risen to 7,911. According to Reuters calculations, the pandemic has resulted in at least 12,700 excess deaths in care homes.

“I think the focus early on was very much on the acute sector,” or urgent hospital treatment, “and ensuring hospitals were able to respond in an effective way,” said Graeme Betts, acting chief executive of Birmingham City Council, which oversees the UK’s second-biggest city. “And I think early on care homes didn’t get the recognition that perhaps they should have.”

Helen Wildbore, director of the relatives and residents association, a national charity supporting families of people in residential care, said while it was right for the initial focus to be on protecting the NHS, “I think it has taken too long for the government to turn its attention” to vulnerable people outside hospital. “I think it’s fair to say that the sector has felt like an afterthought for quite a long time.”

Jeremy Hunt, a former Conservative Party health secretary and now chairman of the House of Commons health select committee, advocated banning visits to care homes by friends and family from early March, advice that wasn’t followed. Speaking to Reuters, he

drew a parallel between the UK's response to the coronavirus and the way it deals with peak winter demand for hospital services.

"What happens with any NHS winter crisis is the focus of attention immediately switches to the hospitals and dominates the system's thinking," he said. "Many people in the social care sector told me exactly the same thing happened with COVID-19."

The government spokesman said protecting the elderly and most vulnerable members of society had always been a priority, "and we have been working day and night to battle coronavirus by delivering a strategy designed to protect our NHS and save lives."

THE COCOON

Born in Northern Cyprus in 1993, Sonya Kaygan had come to the UK after studying English. She settled in Enfield, a north London borough of 334,000 people with a large community of Turkish origin, and one particularly hard-hit by the virus pandemic.

Kaygan lived with her mother and together they looked after her child. Both worked in different care homes: She worked night shifts and her mother worked the day shift. Kaygan's monthly wages for three or four weekly 12-hour shifts added up to a take-home pay of about £1,500 - just short of the monthly rent of their home.

By the time a "lockdown" was imposed by the prime minister on March 23, the virus was spreading fast and Kaygan was beginning to feel sick. "She started feeling a bit uncomfortable," her uncle Hasan Rusi said. "She had a temperature and was coughing. It might have been a cold, it might be a virus."

Established plans drawn up by the government for dealing with a flu pandemic had always been clear that care homes could be a place for infection to spread. But on February 25, Public Health England, a government agency overseeing healthcare, stated it "remains very unlikely that people receiving care in a care home or the community will become infected."

The guidance was widely reproduced on care home websites and stayed in force until March 13. It meant that few care homes restricted visits and few families withdrew their relatives from homes. No plan was put in place for testing staff. A government spokesman said that advice “accurately reflected the situation at the time when there was a limited risk of the infection getting into a care home.”

On March 12, the government shifted from what it termed a “contain” to a “delay” phase, after the World Health Organisation declared an international pandemic. The UK now focused efforts on mitigating the spread of virus through the general population, allowing “some kind of herd immunity” to develop, as the chief scientific adviser, Sir Patrick Vallance, explained on BBC radio on March 13. But, said Vallance, “we protect those who are most vulnerable to it.”

David Halpern, a psychologist who heads a behavioural science team - once nicknamed the “nudge unit” - advising the UK government, had expanded on the idea in a separate media interview on March 11. As the epidemic grew, he said, a point would come “where you’ll want to cocoon, you’ll want to protect those at-risk groups so that they basically don’t catch the disease.”

Nonetheless, Reuters interviews with five leaders of large local authorities and eight care home managers indicate that key resources for such a cocoon approach were not in place.

There weren’t adequate supplies of protective equipment, nor lists of vulnerable people, they said. National supply chains for food were not identified, nor was there a plan in place to supply medicines, organise volunteers, or replace care staff temporarily off sick. Above all, those interviewed said, there was no plan for widespread testing in vulnerable places like care homes or prisons, let alone an infrastructure to deliver it.

On March 23, Johnson announced another shift in strategy, replacing the mitigate-plus-cocoon approach with a broader lockdown. Schools, pubs and restaurants were shuttered, sport cancelled and everyone was told to stay at home.

For local leaders, caring for the most vulnerable became increasingly challenging. Typically, they said, new plans were announced in an afternoon national press conference by a government minister, with instructions to implement them, sometimes the next day, arriving by email to councils later that night. Ministerial promises, handed off to the councils, included drawing up a “shield list” of the most vulnerable, delivering food to them and organising and delivering prescription medicines. Even plans for using volunteers were announced nationally, without taking account of volunteer infrastructures that many councils had in place.

“From our vantage point, it sometimes looked like policy made up on the hoof,” said Jack Hopkins, leader of Lambeth Council in south London, an early hotspot for the virus outbreak. Local councils knew they had to act quickly, but there was no dialogue about how things should happen. “It felt very much like government by press release, with local government left to pick up the pieces,” Hopkins said.

It was the same experience in Birmingham, which was also hit hard by the virus. Betts, the council’s chief executive, wants to avoid dishing out criticism in a situation that is “new for everyone.” But, he said, “it did make it quite challenging from a local authority perspective, when, you know, the prime minister says at 5 pm or 6 pm that something’s going to happen. Eleven o’clock or midnight you get some guidance on it, and you’re meant to be off and running in the next day.”

The most acute problem identified locally early on was the shortage of adequate personal protective equipment (PPE) for NHS and care home staff. Yet Jenny Harries, England’s deputy chief medical officer, declared on March 20 that there was a “perfectly adequate supply of PPE” for care workers and the supply pressures have been “completely resolved.”

Five days later, Johnson told parliament every care home worker would receive the personal protective equipment they needed “by the end of the week.” This didn’t happen, and more than a month later,

the government's chief medical officer conceded publicly that shortages remained.

According to Nesil Caliskan, leader of Enfield Council, early statements that local shortages were caused by distribution difficulties proved to be a "downright lie." The government simply didn't have enough kit, she said.

The government didn't respond directly to claims that it gave false assurances or insufficient time and support to councils to implement ministers' instructions. A spokesman said an alliance of the NHS, industry and the armed forces had built a "giant PPE distribution network almost from scratch." Councils had been supported with £3.2 billion in extra funding to support their pandemic response, he said, and 900,000 parcels of food have been delivered to vulnerable people.

DO YOU WORK FOR THE NHS?

Three days into the lockdown, on 26 March, the nation was urged to stand at their doorstep or window on a Thursday evening and applaud the NHS. Boris Johnson, by now already infected himself, led the cheering on the first occasion.

For some workers in Enfield, the chants left them uneasy. Working 12 hours shifts for barely £9 per hour, below the non-statutory London Living Wage of £10.75, they wondered if those cheers for caregivers were also meant for them.

"I'm one of them," one care home employee, who asked not to be named, recalls telling her 12-year-old daughter as her neighbours clapped. The daughter teased her: "Oh, Mummy, they don't talk about you. They talk about the NHS. Mum, do you work for the NHS?"

The caregiver replied: "No. But it's the same. We care for people."

The caregiver was one of three workers who recounted their experiences at an Enfield care home run by a firm called Achieve Together. Each described how, after a patient was sent to hospital on March 13 and confirmed to have the coronavirus, staff were issued

with thin paper masks. After a fortnight, staff were told the masks should be saved for dealing with patients with symptoms, and they were taken away. And although several staff developed symptoms and had to isolate, no tests were available. A spokesperson for Achieve Together said staff had access to “more than sufficient supplies of PPE, including face masks and face shields, which are supplied and worn directly in line with Government advice.”

One night, caring for a resident with a lung infection who hadn’t been tested, she’d worn a thin blue surgical mask as she performed close-up procedures like feeding him and brushing his teeth.

The day she spoke to Reuters, April 24, health secretary Matt Hancock had reiterated to the BBC that tests were available for care workers. But for now, none was available for this care worker. Her only option was a drive-through centre, but she had no car.

“I want to be checked and really want to be checked as soon as possible,” she said. “If I had the choice.”

The spokesperson for Achieve Together described the health and wellbeing of residents and staff as “our absolute priority.” Staff and residents were tested “when the Government made testing available.” The company did not specify when those tests took place. It declined to comment on details of the home, citing a need to protect patient privacy.

AN INVISIBLE TRAIL

Kaygan’s workplace, the Elizabeth Lodge, in a leafy Enfield suburb, was built in the grounds of two former hospitals of infectious diseases. It is operated by CareUK, a large privately owned healthcare provider, and normally home to about 90 residents, looked after by 125 staff.

The borough has been hit hard by the coronavirus, with Enfield Council recording outbreaks in at least 42 out of 82 care homes, according to the council. The council and the Care Quality

Commission, which regulates the sector, declined to disclose individual death tolls, citing privacy.

Elizabeth Lodge, according to several people with direct knowledge, was one of two Enfield homes most savagely stricken by the virus. The other, these people said, is Autumn Gardens. A senior manager at Autumn Gardens, which is privately owned, declined to comment.

Determining how Kaygan and so many residents at Elizabeth Lodge and other homes became infected will be hard. That is partly because, as Reuters has previously reported, as the outbreak began Britain had no plan for widespread testing for the virus once it started spreading in the community.

The Lodge's management says it hasn't identified the source of the outbreak there. The home began cutting down on visitors from the start of March, with almost all non-emergency visits barred from March 17.

"At this point anyone coming into the home, including team members and essential health care professionals, had their temperatures checked and went through a health screening questionnaire," CareUK said in a statement to Reuters.

Kaygan's last day of work was Friday, March 20th, and she called in sick the following week.

On Sunday, March 22, Mother's Day in England, Kaygan popped round to drop off a bunch of flowers to two relatives, Kenan and his wife Ozlem, who helped bring her up as a child. They spoke on the doorstep. "She told us she had to go back to work. But I was adamant she should stay at home," Kenan said. The day after, Johnson announced the nationwide lockdown.

According to the Lodge's management, none of the residents displayed symptoms until March 26, in the home's York wing. This was six days after Kaygan last worked, and 11 days after she had last worked in the York wing.

Across Enfield care homes, 48 cases of COVID-19 had been identified by March 27 and at least two people had died of the disease. By then all homes had essentially banned all visitors.

So how did infection take hold in care homes?

According to several care home managers, a key route for infection was opened up by an NHS decision taken in mid-March, as Britain geared up for the pandemic, to transfer 15,000 patients out of hospitals and back into the community, including an unspecified number of patients to care homes. These were not only patients from general wards. They included some who had tested positive for COVID-19, but were judged better cared for outside hospital.

In a plan issued by the NHS on March 17, care homes were exhorted to assist with national priorities. “Timely discharge is important for individuals so they can recuperate in a setting appropriate for rehabilitation and recovery – and the NHS also needs to discharge people in order to maintain capacity for acutely ill patients,” the plan said.

A Department of Health guidance note dated April 2 and published online further stated that “negative tests are not required prior to transfers / admissions into the care home.”

Jamie Wilson, a former NHS dementia specialist and founder of Hometouch, which provides care to people in their own homes, said that, based on his discussions with colleagues in the industry, he believes that care homes across the country had taken dozens of patients at risk of spreading the infection. While noting he wasn’t aware of specific cases, he described what he called an egregious and reckless policy “of sending COVID positive patients back into care homes and knowing that it’s so infectious a disease.”

The UK government didn’t respond directly to the question of whether discharges from hospitals had put the vulnerable at risk. But a spokesman said enhanced funding, testing and quarantine procedures should address those concerns.

One NHS infectious diseases consultant, who manages COVID-19 patients, said sending people sick with the coronavirus back to a care home could, in many cases, be the best thing for the patient, provided they could be cared for in the right way. Ideally, she said, all patients should be tested before transfer, and quarantined for up to a fortnight.

The problem was that most patients had not been tested for COVID-19, and care homes have few facilities to quarantine new arrivals.

In Birmingham, over 300 people were discharged into care homes from the start of March, “which is significantly higher than normal,” said council chief executive Betts. In Enfield, 30 patients were sent to care homes, about average, according to Enfield Council. One care manager in the borough, who manages several homes, said some of those transfers caused concern.

This manager recalled that, shortly after Johnson announced the lockdown, she had an argument with officials at a nearby hospital who wanted her to take back a resident who had been treated for sepsis. The hospital had coronavirus patients at the time. The manager would not name the hospital, to avoid identifying the patient. She said she agreed to the demand on one condition: that the resident, who was not displaying coronavirus symptoms, be tested. But the hospital refused, saying it did not have enough tests to assess asymptomatic patients.

Eventually, the manager backed down. A week or so later, several residents in the home began displaying symptoms consistent with COVID-19, she said. She didn’t give a precise figure. It is not known whether the transferred patient was the source of the outbreak.

“It was just so reckless,” she said. “They were not thinking at all about us. It was like they were saying, let’s abandon the old people.”

At the Elizabeth Lodge, between March 1 and March 19, four new residents arrived - two from hospitals and another two from other care homes. The Lodge’s management said, in a statement, there was no evidence these residents brought the virus into the home, “but we are continuing to review.”

Knight, the residential services chief executive at Lodge operator CareUK, said it was essential that hospital patients be tested before they were transferred. “We need to ensure not just that the test has been done, but that the results are available prior to making the decision about admission” to the home, he said in a statement to Reuters.

TEST, TEST, TEST

On March 12, Britain’s chief medical officer, Chris Whitty, announced the ending of most testing of the general population to focus on patients admitted to hospital. But Vallance, the chief scientific adviser, clarified to parliament a week later there would still be testing in isolated clusters of cases in the wider population.

By April 6, the Enfield council had recorded at least 26 deaths in care homes, and 126 suspected cases. Yet only 10 tests per day were being offered for the thousands of care staff across the whole of north London, said Enfield Council leader Caliskan.

Knight said that at Elizabeth Lodge, no tests were available for staff until after April 15, when Health Minister Hancock announced plans to test all residents and care home workers if they had symptoms. Even after Hancock’s pledge, only six tests were made available to Lodge staff and none to residents, Knight added.

Guidance from the Government, which has struggled to rapidly increase the overall availability of tests, remained that staff should simply stay at home and isolate if symptomatic. In his statement to Reuters, Knight said he and others in the industry had appealed to “senior members of the government to explain the challenges we were facing and how best they could support us.” He didn’t say who he spoke to.

Finally, on April 28, Hancock said all care home residents and staff could be tested even if they were not displaying symptoms. Again, the words didn’t match the experience on the ground.

Lisa Coombs, manager of the Minchenden Lodge in Enfield, home to up to 25 residents, said she had only secured a pack of 10 tests. Eight of these had returned a positive result. She'd been unable to secure tests for a further 10 residents even though some were displaying symptoms.

"What the government says is a load of rubbish," she said. I "I am angry because we are not being supported." She declined to discuss how many residents have died.

At Elizabeth Lodge, no residents were tested until April 29, said Knight. Even after that date the government's Care Quality Commission, which has been supplying tests to homes, only provided enough for residents showing symptoms of coronavirus. Things improved "in a very limited way" in the last two weeks of April, said Knight, and now "appear to be gaining momentum."

Getting access to testing on a meaningful scale now could reduce the impact of the virus in the coming months, he added.

A government spokesman said that a policy of testing everyone prior to admission into care homes was now being instituted, with a recommendation that hospital patients discharged into care homes are isolated for 14 days, even with negative test results.

MASKS

Sonya Kaygan, her mother Ayse recalled, never said much about her work or conditions at the Lodge. But one day, at the start of the outbreak, Sonya saw the long-sleeved gloves that her mother, a caregiver at another home, was using. "We don't have those at our place," Kaygan said. The Lodge told Reuters staff had all the equipment that was required.

Unbeknown to her family, Kaygan had ordered surgical facemasks on Amazon. They arrived in early April after she was hospitalized. Other carers at the Lodge ordered masks, too, said another staff member. And after Kaygan's death, a different fellow employee posted on

Twitter: “I work there and all of this has (been) very hard on us all and every one is right. We as carers don’t have enough PPE.”

Another employee at Elizabeth Lodge told Reuters that although staff raised concerns, many had to operate for weeks without face masks or visors. “I was petrified. Every time I went in there, I worried for myself, my family, the people living there, my colleagues,” she said.

She said at the start of March, she remembers two meetings where managers discussed with staff how they would respond if there was a coronavirus outbreak. She said employees questioned why they did not have more protective equipment. The management responded saying they were doing their best to bring more in.

Reuters could not independently verify this account. The Lodge’s management told Reuters that neither Kaygan nor any other employee raised concerns to managers about protective equipment.

It said in a statement that at the time Kaygan worked at the Lodge, face masks were not being used. That, according to the home, was because official guidance then recommended such masks were only necessary when working within a metre (three feet) of someone with COVID-19 symptoms. Public Health England said the home’s interpretation was in line with advice then in force that masks were only needed when in personal contact with someone, such as washing.

Across Enfield, supply of PPE was a major problem. According to council leader Caliskan, by the end of March, supplies in some homes were inadequate, and others were running out. The government repeatedly promised to send supplies, but when a much-anticipated delivery by the army arrived at the council depot on March 28, it took just 6 minutes to unload, she said. It contained only 2,000 aprons and 6,000 masks, which aren’t designed for repeated or prolonged use, for Enfield’s 5,500 care workers.

GETTING TO HOSPITAL

On March 31, just after 2 pm, Sonya Kaygan was picked up by an ambulance from the two-up, two-down home she shared with her

mother and daughter. Kaygan was finding it increasingly difficult to breathe. As she walked to the ambulance, she turned to her mother and said: “If I never make it back, look after my baby.”

The ambulance crew said Kaygan would be taken to the nearby North Middlesex Hospital, but when the family called there later, there was no one of that name. Uncle Hasan tracked her down to Whipps Cross Hospital in Leytonstone, northeast London. Kaygan made video calls to her family, and asked Ayse to come and visit. But, as is the case in many countries, the hospital wouldn’t allow it.

In an email to Reuters, the NHS trust managing Whipps Cross said all visiting was “currently suspended other than in exceptional circumstances” to stop the spread of COVID-19.

Then news came that Kaygan would be intubated - sedated and put on a ventilator. Her last call was to a family member in Cyprus, about 6 am on April 2. “I’m going in now,” she said.

Kaygan’s hospital admission was swift. Many others have reported difficulties getting in.

Munuse Nabi, 90, lived in a care home in Ilford, East London. She was extremely fragile, with heart, lung and kidney problems. But she was also mentally strong with a pin-sharp memory, able to talk on the phone and flick through TV channels. “She was all perfect,” said son Erkan Nabi, a driving instructor.

In early April, Munuse developed a temperature and a dry and persistent cough, and lost her voice. As she got worse, a doctor examined Munuse by video link. When she began to struggle to breathe, Nabi urged the home to send her to hospital.

A nurse, he said, told him: “We’ve been told not to send people to hospital. Just leave them here. They’re comfortable.” He was upset. “They were trying to encourage me to leave her there basically to die.” He insisted they call an ambulance, and she was taken to hospital.

A spokesperson for the care home involved said staff were “doing everything we can to make sure our residents and colleagues stay safe and well throughout these challenging times.”

This approach to hospitalisation reflects what many homes took to be national guidance. An NHS England policy document issued on April 10 listed care home residents among those who “should not ordinarily be conveyed to hospital unless authorised by a senior colleague.”

The document was withdrawn within five days, after public criticism. The NHS did not respond to a request to discuss the document.

London’s ambulance service also issued new guidance.

Ambulance crews assess patients using a standard scoring system of vital signs. According to the Royal College of Physicians, a professional body for doctors, a patient who scores five or more on a 20-point scale should be provided with clinical care and monitored each hour. A patient scoring five would normally be taken to hospital.

But in early March, London’s ambulance service raised the bar for COVID-19 patients to seven.

“I have never seen a score of seven being used before,” said one NHS paramedic interviewed by Reuters. The medic spoke on condition of anonymity.

On April 10, the required score was lowered to five. In a statement, the London Ambulance Service told Reuters its previous guidance was one of several assessments used and clinical judgment was the deciding factor. Asked if the guidance reflected the national approach, the NHS did not respond.

Possible evidence of restrictions on admissions came in a study of 17,000 patients admitted for COVID-19 to 166 NHS hospitals between February 6 and April 1. The study showed that one-third of these patients died, a high fatality rate.

Calum Semple, the lead author and professor of outbreak medicine at Liverpool University, said, in an interview with Reuters, this

indicated, among other things, that England set a “high bar” for hospital admission. “Essentially, only those who are pretty sick get in.” But, he said, there was no data yet on whether that high bar ultimately made people in Britain with COVID-19 worse off. The NHS didn’t comment.

FALSE VICTORY

On the hospital wards of London, by Easter Sunday, April 12, there was a sense of light at the end of the tunnel. Over the long holiday weekend, according to several doctors contacted by Reuters, some hospitals saw just a handful of new admissions.

But on the frontline of the efforts to protect the capital’s most vulnerable people, the worst was far from over. According to an official closely involved in London’s response to the coronavirus, the capital’s mayor, Sadiq Khan, was getting reports that food banks were close to running out. Crisis meetings were held all weekend to replenish stocks.

In Enfield, by Easter Sunday a total of 39 care home deaths linked to COVID-19 had been recorded, and 142 residents had suspected infections. By the end of last month, nearly 100 more residents of Enfield care homes would die. The total in the borough, as recorded by the council, would rise to 136 deaths linked to the virus in care homes by April 30, including care home residents who died in hospital.

On the national stage, the government projected a picture of success. Prime Minister Boris Johnson, at his first daily Downing Street briefing since recovering from coronavirus, said on April 30 that Britain was past the peak and had avoided overwhelming the health service.

“It is thanks to that massive collective effort to shield the NHS that we avoided an uncontrollable and catastrophic epidemic,” said Johnson.

Even so, deaths in care homes were surging.

On the third night of 90-year-old Munuse Nabi's hospital stay, a doctor called her son Erkan to say her COVID-19 test had come back positive. As her condition was worsening and she was too fragile for invasive treatment, they would not be able to save her life.

Erkan, urged to visit, went to the hospital and was dressed up by staff in what he calls the "full battledress" protective gear, including visor and gown.

As doctors gave Munuse small doses of morphine to make her comfortable, Erkan stayed by her bedside all through April 19 and into the early hours of April 20, holding her hand as she slipped away.

It was in the early hours of April 17 that Kaygan's family got the call they dreaded. She, too, had passed away.

Her mother posted a message on Facebook: "My soul, my angel, I lost the most beautiful angel in this world. We lost the most beautiful angel in this world."

She still hasn't worked up the strength to tell Kaygan's daughter, three-year-old Ayse, that her mother is dead.

ENFIELD COMMUNITY RESILIENCE AND OUTBREAK ENGAGEMENT BOARD

Purpose

The purpose of the Enfield Community Resilience and Outbreak Engagement Board is to provide political ownership and community leadership for outbreak and community responses as part of the current coronavirus pandemic.

Membership and Terms of Reference

The panel shall be known as the 'Enfield Community Resilience and Outbreak Engagement Board'.

It is a focused group, established to assist the local authority, with the help of key strategic community partners, in managing its community response to the current coronavirus pandemic through the 'Enfield Stands Together' programme and Local Outbreak Control Plan (LOCP). The Board is not a formal committee and is not a decision-making body but may have limited commissioning power. The Board will report back to the Cabinet and the Health & Wellbeing Board (HWB) and make recommendations for decisions where and when appropriate to do so.

Membership

1 The Leader of the Council will Chair the Enfield Community Resilience and Outbreak Engagement Board. The Deputy Leader will be Vice-Chair. The Executive Director for Resources will act as Senior Responsible Officer with the Head of Corporate Strategy in support.

2 The Enfield Community Resilience and Outbreak Engagement Board shall consist of senior operational officers from across the Council and senior representatives of strategic external partners in the community to successfully manage a coordinated and sustained response to Covid-19 and local outbreaks. The core membership is set out below.

3 The Enfield Community Resilience and Outbreak Engagement Board may as it sees fit invite other members, representatives from other partner organisations, other public and private and third sector bodies to take part in the work of the group where and when appropriate to do so.

Core Membership (subject to Board approval):

Cllr Nesil Caliskan	(Chair, Leader of the Council)
Cllr Ian Barnes	(Vice-Chair, Deputy Leader of the Council)
Jo Ikhelef	(Chief Executive, Enfield Voluntary Action)
Pamela Burke	(Chief Executive, Enfield Carers Centre)
Nnenna Anyanwu	(CEO, Citizens Advice Enfield)
Ben Ingber	(CEO, Age UK Enfield)
Kerry Coe	(North Enfield Food Bank)
Anne Elkins	(The Felix Project)
Tony Watts	(Over 50's Forum)
Noelle Skivington	(Healthwatch Enfield)
Fay Hammond	(Acting ED of Resources – Group Coordinator)
Stuart Lines	(Director of Public Health)
Glenn Stewart	(Assistant Director of Public Health)
Sue McDaid	(Head of Regulatory Services)
Helen Papadopoulos	(Head of Emergency Planning)
David Greely	(Head of Communications)
Shaun Rogan	(Head of Corporate Strategy)
Heather Littler	(Notary, Enfield Council)

Terms of Reference (subject to Board approval)

The Community Resilience and Outbreak Engagement Board will focus on the following main areas of interest:

- To work proactively with communities to help increase community resilience in relation to Covid-19 outbreaks

- Develop capacity through successful promotion of local volunteering, targeted project delivery and development of mutual aid networks to build resilience during and after the coronavirus pandemic as part of a successful 'Enfield Stands Together' programme.

- To ensure that key prevention messages (such as handwashing and social distancing) are heard, understood and implemented across the borough, with a focus on high-risk and disadvantaged groups

- To ensure a clear focus on individual financial resilience can be coordinated

- To receive and comment upon reports from the LOCP Outbreak Control Team on outbreaks and their management

- To identify, lead and coordinate bespoke workstreams and research of the likely impact on partner services and residents as a result of coronavirus pandemic;

- To identify potential means of reducing the number and / or severity of Covid-19 outbreaks in the borough

- To ensure consistent communications to local residents on how they can be involved in the 'Enfield Stands Together' programme (including accessing help)

- To agree the framework for and then manage commissioned added value projects that can be drawn down from the £100,000 Community Resilience Fund

The Board will agree work streams to deliver a formal work programme and allocate leadership on identified workstreams in its first formal meeting based on some or all of the suggested following areas.

- ***Coordination/management of Enfield Stands Together programme***
- ***Community Support and Involvement (Volunteering and care)***
- ***Food strategy***
- ***Support for people facing financial hardship (Individual financial resilience)***
- ***Identification of value projects and interventions (VCS Support Fund)***
- ***Communications***

Meetings of the Community Resilience Board

1. The frequency of meetings of the Community Resilience Board will be determined by the Chair.

2. The meetings will be facilitated through dial-in via skype / Teams.

3. In the absence of the Chair or Vice-Chair, the Board will elect a person to Chair the meeting.

4. Meetings of the Panel will not be held in public.

5. Relevant officers will assist with the successful convening of the Enfield Resilience and Outbreak Engagement Board.

6. The meeting will not be formally minuted but agreed actions will be recorded, agreed and allocated by the Enfield Resilience and Outbreak Engagement Board for taking forward

APPENDIX E

26 March 2020

Enfield Stands Together
Our community response to the Coronavirus crisis
Safeguarding Information

Dear Enfield Residents

Thank you for volunteering to support your fellow residents during these challenging times. Your support will be crucial in protecting our borough's residents and building a resilient community.

When volunteering in your community, you may be interacting with extremely vulnerable residents. It is therefore important that you are aware of the Council's safeguarding procedures and that you are confident with what actions to take in case of an emergency.

The following document offers some guidance on how to protect both yourself and the person you are providing support for, and what to do in case of emergency or if there are signs of neglect or abuse.

Please read through this guidance and familiarise yourself with the relevant information. You can find more information about safeguarding vulnerable people at

https://mylife.enfield.gov.uk/enfield-home-page/content/safeguarding/about-safeguarding-adults/

https://new.enfield.gov.uk/enfieldlscb/children-young-people/worried-about-the-safety-of-a-child-report-it-now/

https://new.enfield.gov.uk/services/children-and-education/childrens-portal/

Thank you for your support and dedication to ensuring that Enfield remains a vibrant and caring community.

Councillor Nesil Caliskan
Leader of the Council
Enfield Council
Civic Centre, Silver Street
Enfield EN1 3XY

Email: Cllr.Nesil.Caliskan@enfield.gov.uk **www.enfield.gov.uk**

Yours Sincerely,

Cllr Nesil Caliskan
Leader of the Council

Our Community Response to Covid 19 Volunteer Safeguarding Guidance

Thank you for volunteering to support your fellow community members. As a volunteer, you may be assisting vulnerable residents. It is important to know what to do if you recognise signs of neglect or abuse and be aware of how to respond in emergency situations.

Please remember that someone who is self-isolating will be anxious and potentially lonely. We must avoid breaking their isolation if this isn't necessary for their own protection. If they would benefit from more social contact, let your volunteer coordinator know and phone conversation befriending services can be arranged.

What to do in an emergency?

If you visit someone and they are in crisis, please call whatever emergency service is appropriate and stay with them until the services arrive. Unless necessary for their own protection and safety, continue to follow social isolation guidance.

When you have an opportunity, please also call your volunteer coordinator to let them know what has happened and to allow them to support you (e.g. by completing outstanding visits or coming to relieve you if you have to go due to your own commitments).

If a crime has occurred…

If a serious crime occurs whilst you are helping a resident, which requires immediate assistance by the police, please **call 999**

If you are concerned that a crime has occurred (but no urgent attendance by Police is required) then you can **dial 101** to report.

If there is a medical emergency…

If a serious medical emergency occurs whilst you are helping a resident, which requires immediate ambulance assistance, please **call 999.**
If someone requires medical advice, e.g. suspected Coronavirus symptoms over and above what can be dealt with at home or another medical issue, then they **can dial 111** for medical advice. Please be aware that this service is experiencing very high demand at the moment so there may be a considerable wait.

Do not take the patient to Accident and Emergency (A&E) Department unless advised to by a medical professional, as this would risk spread of the virus.

Reporting Abuse or Neglect

Whilst volunteering there is a possibility you will come into contact with adults or children who show sign of abuse.

Adult abuse is the violation of an individual's human and civil rights by any other person or persons. Safeguarding adults means upholding the rights of adults to live in safety, free from abuse and neglect. To achieve this, we may take or prompt action to minimise risks, prevent and/or stop abuse and/or neglect.

Child abuse is defined as any form of maltreatment of a child. This can be abuse or neglect of a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

Suspected neglect or abuse of an adult

If you believe that an adult you have visited is being, or has been, abused or neglected, then you must report this to Enfield Council.

There are different ways to do this depending on the time of day:

To report abuse via the Multi-Agency Safeguarding Hub, Mon- Friday, 9am- 5pm.	Tel: 020 8379 3196 Email: TheMASHteam@enfield.gov.uk
Report abuse via dedicated phoneline any time day or night.	Tel: 020 8379 5212
Report abuse via a text phone	Tel: 18001 020 8379 5212

Please note that these are not emergency services – always dial 999 if an ambulance or Police are required

Suspected neglect or abuse of a child

All children and young people have the right to live in safety, without emotional cruelty, neglect, violence, or sexual abuse.

If you are worried about the welfare of a child you encounter whilst volunteering, please contact Enfield Council and speak about your concerns so that somebody can help.

Report abuse via the Children's Multi-Agency Safeguarding Hub: during office hours: Mon- Friday, 9am- 5pm.	Tel: 020 8379 5555 Email: childrensMASH@enfield.gov.uk
Report abuse via a dedicated phoneline	Tel: 020 8379 1000

outside of office hours.	
Make a referral via the Children's Portal	www.enfield.gov.uk/childrensportal

Please note that these are not emergency services – always dial 999 if an ambulance or Police are required.

If you think a resident requires support from a care service…

If you believe someone needs support from carers or occupational therapy etc on a non-urgent basis then please call the Enfield Single Point of Access:

During office hours: Mon- Fri, 9am- 5pm.	**Tel:** 0208 379 1001 **Email:** adultsocialcare@enfield.gov.uk
Outside of office hours:	020 8379 1000

If a resident's carer has not shown up…

If someone is usually visited by a carer but they have not attended that day – without prior arrangement – then please call **020 8379 1001** (Mon- Fri,9am-5pm), to let Enfield Council know so that enquiries can be made.

Keeping safe

If you feel at all unwell, do not volunteer.

Before and between running errands, you must wash your hands thoroughly for 20 seconds with soap and water, following NHS guidelines: https://www.nhs.uk/live-well/healthy-body/best-way-to-wash-your-hands/

If you make a delivery, stay two metres away from the person who is in isolation at all times. Place the items outside their door and then step away, to prevents potential transmission.

It may be someone you visit tries to thank you with money. You must not allow them to give you a 'tip' or buy you anything from their own funds. Though it may seem harmless to allow someone to express their gratitude in this way, you run the risk of them feeling that this is expected and being reluctant to accept the service in future. If they suffer from memory issues, they could also forget that they had asked you to do this.

Handling money

Enfield Council is setting up a system of food distribution from hubs to vulnerable households which are self-isolating.

We advise that cash **should not be exchanged** between volunteers and isolating residents. You should not allow residents to tell you their PIN number or hand you a bank card. This would leave them vulnerable to fraud and you vulnerable to potential allegations or misunderstandings. If there is an exceptional circumstance where payment is required, please seek advice from the volunteer coordinator.

Reporting financial abuse

You should also be very clear with the resident that a genuine volunteer will not accept their money – there have unfortunately been examples of fraud and burglary already with fake volunteers taking advantage of those in need.

If you are worried that someone you are helping is being taken advantage of, please tell someone. You will be listened to and your concerns will be taken seriously.

You can report abuse to the 24-hour **Enfield Adult Abuse Line - 020 8379 5212**.

You can also report fraud Mon- Fri, 9am-5pm on **Enfield Council's Fraud Hotline - 020 8379 4683**

Caring for pets in case of emergency

If a vulnerable person has a pet and is taken to hospital, and there is nobody to look

after the animal, then you should ask the hospital to contact the relevant council officers directly to ensure that the pets are cared for. It may be helpful to mention to the ambulance crew (or others) that there is a pet at home.

General Data Protection Regulations (GDPR)

If you are required to deliver supplies or contact a resident for a friendly phone call, you may be given access to their personal data, such as their name, address or phone number. It is essential that you safeguard this information in accordance with the data protection regulations.

Personal information should not be shared with anyone unless it is essential in order to support that individual. You should always, where possible, inform the person whose details you intend to share, letting them know why you need to share and giving them the opportunity to object.

Information should be stored securely and should not be held for longer than necessary when the individual no longer requires your assistance. This means that you MUST destroy it when your engagement with the individual is completed.

Protecting vulnerable resident's data is extremely important in order to keep them safe. For more information about the regulations please visit: https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/

Other Advice and Guidance

The London Mayoral Office has produced some guidance for Londoners who would like to volunteer to support other residents during the COVID-19 pandemic. To read more, including advice from the NHS and Public Health England, please visit:

https://www.london.gov.uk/what-we-do/volunteering/coronavirus-covid-19-volunteering

Appendix F

ENFIELD COVID-19 DATA

(11 – 17 Jan 21)

TOTALS

06 Mar 20 - 17 Jan 21

TOTAL CASES
25,506

NEW CASES*
2,258

TESTS*
5,126
per 100,000
(PCR = 9,398 tests, lateral flow = 7,711 tests)

VACCINATIONS
11,030 1st DOSES

INFECTION RATE PER 100,000*
676

AGE GROUP

0-29	30-59	60+
515	861	608

INFECTION RATE RANK*
NCL# = 1
LON= 10; Eng= 24

TESTING RATE RANK
NCL# = 1
LON=13; Eng= 61

06 Mar 20 – 08 Jan 21

TOTAL DEATHS
544

17 Jan

RECENT COVID DEATHS*
46
(45 excess#)

18 Jan update

CARE HOMES AFFECTED
34

No of deaths= 2
Staff = 66 cases
Residents = 72 cases

DOM CARE AFFECTED
40
Care Staff = 87 cases
Clients = 39 cases

18 Jan update

SCHOOLS AFFECTED
37

Staff = 63 cases
Students = 40 cases

WARDS WITH MOST CASES* (TOP THREE)
1. **Enfield Highway (162)**
2. **Upper Edmonton (151)**
3. **Edmonton Green (146)**

#According to ONS weekly mortality analysis.

#North Central London includes Camden, Barnet, Enfield, Haringey & Islington

Change since last week of data

APPENDIX F

Enfield COVID-19 Dashboard (08- 14 Dec 21)

CASES =06 Mar 20 - 14 Dec 21
DEATHS = 30 Mar 20 - 3 Dec 21

7th - 14th Dec update

TOTAL

CASES = **51,059**
DEATHS = 859
(EXCESS# = 742)

*RECENT DEATHS**
(3- 10 December)
0
(-10 excess deaths*)

NEW CASES

2168

Variants of Concern
Delta = 575
Omicron (confirmed)= **22**
(For 30 Days till 10/12)

HOSPITALISATIONS

On Oxygen =31
Not on Oxygen =32

AGE GROUP (%)

0-34	35-64	66+
12	49	39

INFECTION RATE PER 100,000*

659.9

AGE GROUP

0-29	30-59	60+
809	691	197

TESTS*

7,639
per 100,000

PCR = **9,758** tests;

Lateral Flow = **15,751**

13 Dec update

VACCINATIONS

Healtheintent GP registered 12+ Population (inc. care homes)

197,653 (66.6%) 1st DOSES
181,957 *(65.6%)* 2nd DOSES

PHE resident 12+ Population (inc care homes)

211,215 (67.0%) 1st DOSES
192,927 *(67.7%)* 2nd DOSES

13 Dec update

VACCINATIONS

12-15s Uptake

4,396 (22.5%) 1st DOSES

Boosters (18+ population)

97,847 Doses (34%)

9 Dec update

ADULT SOCIAL CARE

CARE SETTINGS
CARE HOMES = 3
Deaths=0;
Staff=3
Residents=0

CASES IN DAY SERVICES
(8 - 15th Dec)
Sites =4
Staff=4
Service users=9

13 Dec update

SCHOOLS/ EARLY YEARS AFFECTED

53

Staff = 59 cases
Students = 349 cases

WARDS WITH HIGHEST INFECTION RATES*

1. **Winchmore Hill (944)**
2. **Bush Hill Park (803)**
3. **Town (771)**

*ONS weekly mortality records compared with 2015- 19 deaths.

#North Central London include Camden, Barnet, Enfield, Haringey & Islington

Change since last week of data

Appendix G: Summary of changes to the legislative framework – Coronavirus Act 2000 and Care Act 2014 easements

The Coronavirus Act 2020

1. Receives Royal Assent on 25th March 2020.
2. Specifically, for Health and Social Care the Act aimed to:
    a. increase the available health and social care workforce: the Act removes barriers to allow suitably experienced people to be part of the workforce during this period (such as recently retired NHS staff and social workers returning to work);
    b. reduce the burden on frontline staff: the Act aims to reduce the number of administrative tasks frontline staff must perform, so that actions can be focussed where most needed and public services maintained;
    c. support people: provisions of the Act make it easier for people and businesses impacted by coronavirus to access financial support when they need it;
    d. contain and slow the virus: provisions of the Act facilitate actions to promote social distancing and mitigate spread, including preventing gatherings of people and closing schools, and encouraging people to self-isolate by making Statutory Sick Pay (SSP) payable from day 1;
    e. Manage the deceased with respect and dignity: The Act enables the death management system to deal with increased demand for its services.

Provisions of the Act

3. The provisions of the Coronavirus Act, which are time-limited for two years, enable the government to restrict or prohibit public gatherings, control or suspend public transport, order businesses such as shops and restaurants to close, temporarily detain people suspected of Covid19 infection, suspend the operation of ports and airports, temporarily close educational institutions and childcare premises, enrol medical students and retired healthcare workers in the health services, relax regulations to ease the burden on healthcare services, and assume control of death management in particular local areas. The government has stated that these powers may be "switched on and off" according to the medical advice it receives.
4. The act also provides for measures to combat the economic effects of the pandemic. It includes the power to halt the eviction of tenants, protect emergency volunteers from becoming unemployed, and provide special insurance cover for healthcare staff taking on additional responsibilities. The government will reimburse the cost of statutory sick pay for employees affected by COVID-19 to employers, and supermarkets will be required to report supply chain disruptions to the government.
5. The act has a two-year time limit that may be shortened or lengthened by six months at ministerial discretion. Following a government amendment, the act is additionally subject to parliamentary renewal every six months; it would originally have been returned to Parliament for debate one year after its enactment.
6. Section 88 of the act enables national authorities to suspend (and later revive, if appropriate) many of the act's provisions, and section 97 requires the Secretary of State to publish, every two months, a report on the status of the non-devolved provisions. On 7 May 2020, the Department of Health & Social Care published a table showing the status of each provision, including those not at that time in force. This was followed on 29 May by the first two-monthly report, which gives for provisions not

yet in force a brief explanation of the reason, and for those in force an outline of the extent to which the provision has been used.

7. Further two-monthly reports were published on 31 July, 1 October and 1 December 2020; and on 28 January, 22 March, 27 May 2021and 21 July 2021.
8. By September 2020, the provisions addressing potential staff shortages in mental health services had not been required in England. An instrument to remove these provisions was laid before Parliament on 21 October and came into force on 9 December 2020.
9. As part of the one-year review in March 2021, the government stated its intention to expire twelve sections of the act and suspend three provisions.
10. Several sections of the act were expired early, on 17 July 2021, by The Coronavirus Act (Early Expiry) Regulations
11. Alongside this the government produced its four-step programme out of Lockdown in Spring 2021 beginning on 28th March 2021.

Care Act Easements

12. **Purpose of the easements** - Local authorities and care providers are already facing rapidly growing pressures as more people need support because unpaid carers are unwell or unable to reach them, and as care workers are having to self-isolate or are unable to work for other reasons.[1]
13. The government puts in place a range of measures to help the care system manage these pressures. Local authorities should do everything they can to continue meeting their existing duties prior to the Coronavirus Act provisions coming into force. In the event that they are unable to do so, it is essential that they are able to streamline present assessment arrangements and prioritise care so that the most urgent and acute needs are met.
14. The powers in the Act enable them to prioritise more effectively where necessary than would be possible under the Care Act 2014 prior to its amendment (referred to in this guidance as the Care Act). They are time-limited and are there to be used as narrowly as possible.
15. **What the powers changed -** The changes fall into 4 key categories, each applicable for the period the powers are in force:
    a. Local authorities will not have to carry out detailed assessments of people's care and support needs in compliance with pre-amendment Care Act requirements. However, they will still be expected to respond as soon as possible (within a timeframe that would not jeopardise an individual's human rights) to requests for care and support, consider the needs and wishes of people needing care and their family and carers, and make an assessment of what care needs to be provided. Annex B of the guidance provides more information
    b. Local authorities will not have to carry out financial assessments in compliance with pre-amendment Care Act requirements. They will, however, have powers to charge people retrospectively for the care and support they receive during this period, subject to giving reasonable information in advance about this, and

[1] Source: https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities

a later financial assessment. This will ensure fairness between people already receiving care and support before this period, and people entering the care and support system during this period. Annex B of the guidance provides more information

c. Local authorities will not have to prepare or review care and support plans in line with the pre-amendment Care Act provisions. They will however still be expected to carry out proportionate, person-centred care planning which provides sufficient information to all concerned, particularly those providing care and support, often at short notice. Where they choose to revise plans, they must also continue to involve users and carers in any such revision. Annex B of the guidance provides more information

d. The duties on local authorities to meet eligible care and support needs, or the support needs of a carer, are replaced with a power to meet needs. Local authorities will still be expected to take all reasonable steps to continue to meet needs as now. In the event that they are unable to do so, the powers will enable them to prioritise the most pressing needs, for example enhanced support for people who are ill or self-isolating, and to temporarily delay or reduce other care provision. Annex C provides further guidance about the principles and approaches which should underpin this

16. **Protections and safeguards** - The overriding purpose of these easements is to ensure the best possible provision of care to people in these exceptional circumstances. In order to help ensure that they are applied in the best possible way, with the greatest regard towards the needs and wishes of care users and their carers, the following protections and safeguards will apply.

    a. The easements took legal effect on 31 March 2020 but should only be exercised by local authorities where this is essential in order to maintain the highest possible level of services. They should comply with the pre-amendment Care Act provisions and related Care and Support Statutory Guidance for as long and as far as possible.

    b. They are temporary. The Secretary of State will keep them under review and terminate them, on expert clinical and social care advice, as soon as possible.

    c. All assessments and reviews that are delayed or not completed will be followed up and completed in full once the easements are terminated.

    d. Local authorities will remain under a duty to meet needs where failure to do so would breach an individual's human rights under the European Convention on Human Rights (ECHR). These include, for example, the right to life under Article 2 of the ECHR, the right to freedom from inhuman and degrading treatment under Article 3 and the right to private and family life under Article 8.

    e. The Care Quality Commission (CQC) will continue to provide oversight of providers under existing legislation. Throughout this period the CQC will take a pragmatic approach to inspection and proportionate action as necessary while maintaining its overriding purpose of keeping people safe.

17. **Other important duties on local authorities remain in place:**

    a. Duties in the Care Act to promote wellbeing and duties relating to safeguarding adults at risk remain in place.

    b. Duties in the Mental Capacity Act 2005 relating to Deprivation of Liberty Safeguards (DoLS) remain in place.

    c. Local authorities' duties relating to prevention and providing information and advice also remain in place. The provision of information and advice for public

reassurance will be particularly important during this period. To aid good communications, local authorities should continue to draw on their helpful relationships with trusted partners in the voluntary sector as well as on a full range of digital and other channels which help reach people with differing needs and in different circumstances during this period (for example, to make up for any closure or reduced service of libraries)

d. Duties imposed under the Equality Act 2010 also remain, including duties to make reasonable adjustments, the Public Sector Equality Duty and duties towards people with protected characteristics. These should underpin any decisions made with regard to the care and support someone receives during this period

18. **Principles to govern use of the powers** - The Care Act embodies a principled, person-centred and values-based approach to all aspects of the provision of social care. It is essential that these principles and values are maintained during this period.

19. Local authorities are expected to observe the ethical framework for adult social care. This provides a structure within which local authorities must measure their decisions and reinforces that the needs and wellbeing of individuals should be central to decision-making. In particular, it should underpin challenging decisions about the prioritisation of resources where they are most needed.

20. Alongside the framework, local authorities should continue to respect the principles of personalisation and co-production. These are embodied in the following statement produced with the support of Think Local, Act Personal (TLAP): I am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health. (Making it Real).

21. **Steps local authorities should take before exercising the Care Act easements:**

a. A local authority should only take a decision to begin exercising the Care Act easements when the workforce is significantly depleted, or demand on social care increased, to an extent that it is no longer reasonably practicable for it to comply with its Care Act duties (as they stand prior to amendment by the Coronavirus Act) and where to continue to try to do so is likely to result in urgent or acute needs not being met, potentially risking life. Any change resulting from such a decision should be proportionate to the circumstances in a particular local authority.

b. Social care varies greatly across local authorities and the decision to operate the easements should be taken locally. It should be agreed by the director of adult social services in conjunction with or on the recommendation of the principal social worker (PSW). The director of adult social services and the PSW must ensure that their lead member has been involved and briefed as part of this decision-making process. The Health and Wellbeing Board should be kept informed. The decision should also be fully informed by discussion with the local NHS clinical commissioning group leadership.

22. **Local authorities should have a record of the decision with evidence that was taken into account. Where possible the record should include the following:**

a. the nature of the changes to demand or the workforce

b. the steps that have been taken to mitigate against the need for this to happen

c. the expected impact of the measures taken

d. how the changes will help to avoid breaches of people’s human rights at a population level

e. the individuals involved in the decision-making process

f. the points at which this decision will be reviewed again

g. This decision should be communicated to all providers, service users, carers and local MPs. The accessibility of communication to service users and carers should be considered.

23. **Local authorities should notify the Department of Health and Social Care (DHSC) using the Care Act Easements Notification Form when:**

    a. they decide to start streamlining assessments and/or prioritising services under these easements

    b. the use of easements changes

    c. they resume full Care Act duties

    d. Information received will be held and shared with CQC, the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and other relevant parties. Details of which local authorities are operating under easements will be publicly available for transparency.

24. The Care Act easements provision in the Coronavirus Act 2020 expired on 16 July 2021 and is no longer in force.

25. Enfield Council did not enact any Care Act Easements during this period. Staffing levels consistently remained at a level where this was not required (above 95%) and adjustments to working practices were in line with government guidelines (for example, remote assessments or face to face as required by individual case circumstances).