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BOROUGH BASED PARTNERSHIP

Ealing COVID-19 Lessons Learned Review: Appendices

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Outline

Details of the learning are outlined below under 3 appendices:

Appendix 1 Delivery of services	Appendix 2 Outbreak prevention and management	Appendix 3 Pandemic response functions
• vaccination • testing • contact tracing • Ealing together – support payments • Ealing together – identifying and triaging food insecurity • Ealing together – food and parcel operations • COVID-19 respiratory hub • specialist COVID-19 clinical unit (Mary Robinson Unit) • clinical care	• early years settings • schools • universities • workplaces and public spaces • care homes and domiciliary care • frontline health and care settings • self-isolation accommodation	• pandemic response planning, emergency management and governance • public health response • community engagement • communications • intelligence and analysis • human resources

Appendix 1 – Delivery of services

Vaccination

The COVID-19 vaccination programme started in December 2020, and was delivered in Ealing via GP-led hubs at Ealing Town Hall and the Dominion Centre (in first phase), CP House, community pharmacies and a number of outreach sites across the borough. During the first year of the vaccination programme in Ealing, almost 500,000 vaccinations were delivered and almost two-thirds of eligible people had received two doses.

What went well?

Delivery and Access

- the team identified several immediate aims and partners were supportive and engaged in the collaborative vaccination programme
- effective use of data and intelligence informed the identification of outreach sites such as faith settings and community venues quite early on. The vaccine bus was visible and prominent from Southall Station, which improved its accessibility. The team used local insights and intelligence to identify pop-up sites, especially in Southall and Acton where there were significant numbers of people who were particularly at risk
- support was provided from NWL COVID-19 team to the delivery team to resolve issues and provide guidance on how to deal with problems, as they had the contact with national teams
- the service effectively supported residents with additional needs and the consent process
- analysis of GP lists undertaken to review patients who declined or were not responding to invites, as this supported targeted communications

Workforce

- support for vaccinators went well, and they could access e-learning for health modules, webinars and in-person sessions
- the vaccination site leads also developed robust processes for inducting new clinical and volunteer staff
- the support from military teams as needed was beneficial
- staff wellbeing was supported through a positive focus on celebrating successes

Vaccination

What went well?

Communications

- joint plan developed across partners, including targeted messaging
- there was consistent universal communication (for example weekly GP bulletins) and engagement to enhance awareness and reach of messages as well as targeted communication and engagement using local intelligence
- local community champions were supported to deliver vaccination messages to their networks. Having local voices disseminate and give the information was reassuring and helped to translate some of the nuances.
- webinars for key stakeholders enabled discussion about crucial information and guidance, which meant large documents didn't have to be distributed and sifted through for the critical and salient points
- vaccination messaging was embedded in local Covid services (testing, contact tracing, self-isolation support using a Making Every Contact Count (MECC) approach)

Underserved populations

- work was developed to deliver vaccination, testing and other health input to underserved population such as the homeless, asylum seekers and people with mental health issues
- Ealing's nonregistered population were supported to help them to register with a GP and or to be aware they could access the vaccine without any paperwork. Local residents who were volunteering at the vaccine sites also went to talk with people working in local warehouses to support them to access the vaccine, with assurance that they didn't need any ID. A number of major health needs were highlighted amongst this population

Vaccination

What went well?

Partnership working

- a multi-agency strategy was developed and implemented to support the NHS, with a joint governance system set up
- shared collective responsibility and desire to meet the needs of the population meant that everyone was working to the same outcome
- relationships between individuals and team were the ultimate thing that made this programme work.
- the vaccine bus was an excellent example of joint working
- local primary care providers volunteered their time for events and promoting vaccination.
- strong collaboration with community, voluntary and faith organisations, including willingness to provide premises
- joint approach by council, GP practice and community NHS teams to provide targeted vaccinations programme for people with learning disabilities. Also, a roving team established for providing vaccinations to people who were housebound.
- the LA's Safer Communities team provided crucial liaison between NHS and police teams to jointly plan for and respond to protests at vaccine centres.
- the NHS and LA teams worked collaboratively on identifying and setting up the logistics of the vaccine centres, for example parking.
- researchers worked locally to understand the context and reasons for vaccine hesitancy
- close co-operation with NWL, London and national partners on vaccine uptake and hesitancy
- Security teams working at the entrance of vaccination centres quickly adapted to play a dual role in signposting and supporting residents

Vaccination

Key challenges and what could be done better?

Workforce

- finding and training skilled staff was challenging as staff were required to work seven days a week, twelve hours a day. This was particularly difficult to fully staff the more intensive outreach sites, such as the vaccine bus. This included the need for people to support with multiple community languages. Could have worked more closely with covid marshalls to support outreach events better. Challenges for back-office NHS team as a number of staff had already been redeployed to support frontline health services, so very reliant on only a few individuals

Communications

- more precise messages sometimes required, as feedback indicated that some residents needed to understand the need for vaccination and who was eligible. This was particularly difficult with residents requesting specific vaccines at various stages of the programme

Telephone campaign

- there was a mixed response from residents who were called as part of the targeted telephone campaign: some were grateful for the contact, and others were not interested in having a vaccine and became frustrated with receiving an unexpected call about vaccinations but not from their GP practice. There were also language issues. More time was needed to plan the phone campaign to ensure it was targeted effectively

Partnership working and delivery

- information flow could be improved between all parties, and community pharmacy partners could have been involved earlier in the process. Although there were challenges, the local teams could have benefitted from having the NHS NWL roving team developed earlier on, especially for outreach. There were competing priorities amongst partners due to the multiple demands placed on the system, which was often changing and very difficult to manage

Vaccination

Key challenges and what could be done better?

Access and Delivery

- estates are challenging in Ealing borough, with no large sites (for example stadium, conference centre) or large car parks available from where to run large vaccine programmes. Reliant on capacity of neighbouring boroughs for large sites and a good spread of smaller sites across the borough
- there were limitations in primary care estate and the buildings' suitability for new ways of working (for example social distancing, wifi requirements)
- it was challenging to manage the guidance changes and the logistics at the pace required and with the particular complexities of the covid vaccinations, for example refrigeration required
- there was limited specialist Infection Prevention and Control (IPC) capacity
- there were challenges with the capacity to support the number of different workstreams and sites across the borough. This was particularly the case for the targeted outreach sites in the community, for example vaccine bus, as there were key challenges in delivering a clinical service at this kind of site
- anti-vaxers targeted vaccination events, which made delivery challenging and impacted on team wellbeing
- challenges with sites being unmanned on certain days (for example weekend deliveries of equipment) or having to pack up when other events were taking place (for example at church halls)

Community

- challenges with knowledge and relationships needed to address vaccine hesitancy and low uptake in some communities

Vaccine bus

Testing

Testing was delivered initially for frontline health and care staff and then more widely for residents via in-person testing sites at council premises across the borough. It was subsequently delivered by community pharmacies and online. Ealing was one of the first boroughs to carry out a ‘surge testing’ initiative in response to a new variant being identified in February 2021. Vaccination centres were also used as opportunities to promote testing, and test kits were also supplied for more targeted support to communities, for example via a local food bank.

What went well?

Use of council sites

- as the sites used for testing were council-owned, there were no additional delays in setting them up, for example no need to negotiate lease arrangements with site owners, and costs were kept relatively low
- PHE contractors were, in the main, very good and worked at pace to get sites up and running

Workforce

- initial testing started with symptomatic frontline health workers to ensure they were able to isolate and reduce the risk to vulnerable residents
- using known resources with specific skill sets was a real help

Surge Testing

- Ealing was one of the first boroughs in the country to undertake surge testing and therefore develop a local model of how to undertake this, including communications assets, SOPs, etc.
- events company was commissioned quickly, and drivers collected tests regularly
- daily operational meetings meant that key council service areas were kept up to date, and cross-team council running of the operation was beneficial
- an internal process was set up, and council staff worked well with the operational lead to answer missed deliveries and collections queries
- the engagement with regional PHE and DHSC contacts was beneficial.

Testing

What went well?

Pharmacies

- the rollout of testing in community pharmacies worked well, with support from the local pharmaceutical lead. Due to its success, the programme continued for several more months than initially planned

Testing for frontline staff

- this was needed early on in the pandemic, and a lot of the learning was shared for when this was rolled out to residents and patients

Testing

Key challenges and what could be done better?

Workforce
- there needed to be more volunteers to support testing (and vaccination) once the initial sites, systems and processes were well established. The same limited number of people were asked to work long hours, weekends and bank holidays to provide ongoing support

Stakeholders
- getting all teams and stakeholders to understand the need to move more quickly than normal to identify and set up sites was challenging, with application of some business-as-usual policies resulting in a delayed start to testing services

Pharmacies
- the numbers tested varied between pharmacies and some areas of the borough had less coverage
- the transition from assisted testing to home testing could have been supported more proactively

Use of council sites
- there was not a list available of pre-identified sites for emergency purposes, for example for testing sites

Delivery
- third-party testing providers were best placed to provide the additional support for individual registration at testing sites, but the previous contract with PHE didn't include this
- estates are challenging in Ealing borough, with no large sites (for example stadium, conference centre) or large car parks available from where to run large testing programmes. Reliant on capacity of neighbouring boroughs for large sites and a good spread of smaller sites across the borough

Surge testing
- this was a complicated area with national decision-making impacting on local areas. However, there were good relationships with London teams and Ealing was able to feed in practical learning and the assets that were developed. This did have some impact on the subsequent phases of surge testing for Ealing and other boroughs

Underserved Populations
- work was developed to deliver testing to underserved populations such as asylum seekers

Testing for frontline staff
- early on, there was a lack of testing capacity and delays in obtaining testing capacity for asymptomatic staff

Surge testing:
Dean Gardens
Car Park Testing Site

- open 8am-3pm
- targeted at people who needed to be out and about for work
- 2281 tests carried out

Contact tracing

Residents who were in contact with people testing positive for COVID-19 were followed up as part of outbreak control measures, to find out about any symptoms, offer advice and advise testing or isolation as appropriate. This was initially undertaken at a national level. Local contact tracing services were subsequently established, and this service was delivered by Ealing council from Autumn 2021 for about 16 months. The local service successfully supported almost 13,000 residents.

What went well?

Workforce

- the working group to establish the service was efficient
- council staff who volunteered for redeployment to the team had a positive attitude and worked flexibly
- home working worked well with staff set up, trained and working effectively from home
- the government notify service for texts and emails worked well and was a mostly free service and easy to use

Data

- an excel database and dashboard were set up and supported by the Performance and Intelligence team, and the team found this worked well

Partnership working

- Ealing public health supported the response and escalation of queries
- regional network was a useful forum to share experiences and queries
- NHS touchpoint meetings worked well and enabled information to be cascaded and concerns to be discussed

Contact tracing

Key challenges and what could be done better?

Local phone number

- having a local number would have been more acceptable to residents and reflected adversely in completion rates, as many residents did not pick up ‘Unknown’ calls

National case management database (CTAS)

- there were issues with IT security which resulted in the database being blocked on several occasions
- the database was difficult to use in some ways and would not allow case or postcode search
- the process for returning cases to the central teams was manual and inadequate, pushing local teams to revert to different models of working rather than relying on the ability to return cases flexibly

Door-knocking

- this resource was not consistently in place but there would have been some benefit to doing this more often to support self-isolation

Communications

- more messaging to residents would have helped raise the profile – both the need for contact tracing, and to emphasise that this was a local team supporting local residents

Workforce

- the service relied on volunteers from the library staff, rather than any formal deployment process being enacted
- the team were able to speak a number of community languages which was reported to have helped with positive engagement and compliance among residents. However, despite the need for this, it was not a formal part of roles and translation services were not routinely available

Data

- local case data was managed on an excel spreadsheet. Although the team found this easy to use and effective, a number of other areas used customer management systems, which were integrated into other tools to allow further analysis

Ealing together – support payments

Self-isolation Payments were introduced in October 2020 to support people who would have missed out on income as a result of having to self-isolate at home. Eligible residents could apply for the £500 payment via an online form which was assessed by back-office staff. Successful applications were paid via existing payment processes ensuring residents got their money as soon as possible. The scheme ran until February 2022. In total, the council assessed 10,641 self-isolation payments, which resulted in £2.6m being paid out to Ealing residents.

What went well?

Processes

- setting up the schemes, getting approvals and going through sign-off processes fairly quickly

Workforce

- staff were able to be redeployed at short notice
- staff morale was good considering the circumstances and staff worked really hard to support residents
- breaking barriers between teams and working together
- the team participated in Ealing Together meetings, which meant the frontline workers were informed on the position of the team and any backlogs to be processed
- the team was set up and staff trained in the short timeframes
- the team worked with the council's payments team to set up payments systems and replace the request-to-pay form with automated payments and an online process

Ealing together – support payments

Key challenges and what could be done better?

Workforce

- managing resources was challenging, due to national underestimates of how many applications for self-isolation payments to expect
- confusion on eligibility due to rapidly changing national criteria, which resulted in additional work on processing ineligible applications and also the need to re-train staff and change communications frequently
- covid support grants were extended at very short notice
- the ability to recruit additional staff was challenging as all councils were recruiting benefit staff to process self isolation payments
- high turnover of staff and setting people up on the systems ready for work
- the team were able to speak a number of community languages which was reported to have helped with positive engagement and compliance among residents. However, despite the need for this, it was not a formal part of roles and translation services were not routinely available

Communication

- volumes of work coming through and frequent changes in eligibility were challenging

Ealing together – identifying and triaging food insecurity

The Ealing together team quickly mobilised to offer a number of routes available to any Ealing resident who was concerned about access to food. Both an online form and incoming telephone number was widely publicised and high volumes were received via both channels. A team of 19 customer service advisors were trained to take incoming calls and also proactively contacted over 24,000 residents who had been identified as ‘shielding’ in the borough. The team was able to offer a wide range of support on a variety of issues including food, benefits advice and financial support.

What went well?

Approach

- team took a 'no risk' approach whereby they didn't refuse any requests for food initially, which may have led to a certain amount of abusing the system. On reflection, this was felt to have been the appropriate approach to take
- this was an example of the council being much more proactive and was reported to be valuable, for example checking in with residents. Learning was taken forward for the approach to community hubs and cost of living crisis, for example by undertaking proactive welfare calls for vulnerable residents

Delivery

- very helpful to have been given flexibility and resources to mobilise at speed
- rapid development of multiple channels for residents to contact the council about food insecurity, including an online form and calls into the contact centre alongside the proactive calls being made to ‘shielding’ residents
- customer management system developed to support the triage process. This resulted in food and other referrals being more automated and enabled the team to easily track delivery

Ealing together – identifying and triaging food insecurity

What went well?

Process

- good referral pathways to free food supplies across the borough
- using the community support directory so that food support could be mapped, and residents could independently find support close to their home
- a large team of contact centre staff were quickly briefed on all covid related issues and provided with information to enable them to effectively triage and signpost residents

Partnership working

- Ealing Together partnership group met regularly and was a valuable forum. Learning from this has influenced the partnership work on cost-of-living crisis

Key challenges and what could be done better?

Process

- emergency food requests – for residents who did not have enough food to see them through to their delivery, this resulted in the need for a bespoke order

Policy

- a more robust policy could have been developed earlier for both standard and emergency food requests. Potentially all requests for food for non-shielding residents could have been put through the contact centre instead of the automated webform, to ensure that there was an element of triage to every request

Ealing together – food and parcel operations

The Food Parcel Operations Team operated out of Greenford Depot and worked alongside Ealing Community Transport who carried out all of the deliveries. In the first wave of the pandemic (between March and end of July 2020), the council provided just over 9,700 food parcels to shielded residents. This was in addition to a further 3,600 food parcels to non-shielded residents. Each parcel consisted of 38 items and catered to specific dietary requirements.

What went well?

Process

- supply, warehousing, data management and delivery system were established from scratch and operations were established quickly
- the team also had the ability to secure required products quickly at a good price, due to successfully negotiating discounts with food suppliers
- there was a good standard food box with 38 items, which were nutritionally balanced and good quality items

Delivery

- the team got operations up and running within a week and worked with Ealing community transport (ECT) to make deliveries

Workforce

- the 'can do' attitude of the team was important
- the service was reliable and very few complaints and missed deliveries were reported
- the team worked with Ealing community transport (ECT), which provided a good value-for-money option and initially unused contract hours were used
- ECT took time to support vulnerable people who needed help – feeding back about the welfare of residents if required and looking out for general wellbeing

Data

- a data dashboard was developed, which the team used to see key statistics relating to food ordering and distribution as well as incoming and outgoing calls and requirements. This enabled the team to make data-driven decisions

Ealing together – food and parcel operations

Key challenges and what could be done better?

Delivery

- residents did not want to move over to the national scheme and preferred the local scheme, especially households with specific requirements for example pet food and baby food or those that required items that were not part of the standard offer, for example sanitary products
- having mechanisms to purchase supplies and services would have helped as there was heavy reliance on personal credit cards at first until formal payment options were put in place

Workforce

- lots of staff volunteered but there was no formal process and policy to ensure good matching of skills and experience

Data

- initially there was heavy reliance on spreadsheets until development of required systems was complete. Spreadsheets were difficult to manage and could be unreliable
- data sharing on vulnerability and shielding was initially difficult between NHS and council, to provide food parcels

Food Parcels

COVID-19 respiratory hub

Across Northwest London, a number of COVID-19 Respiratory Hubs were developed at the very early stages of the pandemic to ensure people who had a health condition or concern that needed a face-to-face review were able to do so in a safe environment – not putting themselves, other people or staff at risk of infection. The hub in Ealing was delivered out of Mattock Lane Health Centre which was the only site to have a suitable car parking space and be in a central enough location for the borough. The workforce came from a range of primary care providers, who worked collaboratively in developing the standard operating procedures, setting up the hub and thinking creatively about how to manage patients safely and in a timely way.

What went well?

- huge amount of flexibility among teams to set this up quickly
- the NHS and LA teams worked collaboratively on identifying and setting up the logistics of the hub, for example car parking dispensation
- transport service established for anyone that could not get to the hub other than on public transport

Key challenges and what could be done better?

- there were limitations in primary care estate and the buildings' suitability for new ways of working (for example social distancing, wifi requirements). This resulted in displacing the main local sexual health clinic at Mattock Lane to be able to provide a respiratory hub
- supporting the wellbeing of staff was challenging, as staff were concerned about being redeployed to support the hub and there were issues with using the space (for example water and heating)
- the hub was set up in the early stages of the pandemic, so SOPs and pathways were being developed with limited and rapidly changing understanding of risks and requirements. This included aspects of clinical governance in the SOPs, such as supply of prescriptions and medication
- sourcing equipment was also challenging early on, for example PPE, laptops, lockable medicines cabinet. There was a huge national demand for some of these items and limited local stock for emergency situations, plus the need to go through standard procedures (for example assets registration for laptops)
- processes were not set up to support the purchase of equipment early on (for example with a team credit card or slush fund), so staff were paying themselves for things like stationery and a gazebo for outdoor cover

Specialist COVID-19 clinical unit (Mary Robinson Unit)

Ealing set up England's first dedicated transitional facility for covid-positive care home residents, led by Ealing community partners. This was set up to protect care home residents and support hospital flow. The aim was to establish a specific pathway for patients who were fit for discharge, but where discharge would otherwise endanger residents in their residential care home, by providing a homely transitional facility for a period of quarantine prior to onward transfer to a long-term placement. 79 Ealing patients used this facility between June 2020 and April 2021. The pathway was re-established in other sites during subsequent covid waves.

What went well?

- unit set up within 6 weeks following early identification of increasing infections in care homes
- this included rapid recruitment and training of staff, identifying and equipping the site and establishing governance and referral pathways from local hospitals
- positive feedback on patient experience

Key challenges and what could be done better?

- ideally would have started this service sooner, but government policy was evolving at this time
- a partnership model with an existing care home would have been preferable from the start, although perhaps slower to set up
- costs were relatively high, though in an emergency context where it needed to be set up quickly
- the unit was established as stand-alone from Intermediate Care due to their capacity and pressures, but more of a joint pathway approach would have been preferable

Clinical care

What went well?

Maintained critical hospital services

- separating sites and or areas using infection prevention control measures, elective surgery and urgent imaging ring-fenced at Central Mid Hospital
- NW London and London-wide collaboration, for example Royal Marsden Partners' co-ordination of cancer surgery
- transition to digital working and the rapid widespread adoption of telephone and digital consultations
- use of the independent sector to maintain cancer, urgent elective and diagnostic capacity

Extended Access at weekends and evenings in primary care

- extended Access hubs were set up so patients at weekends and bank holidays had support in a non-acute hospital setting. These became a critical infrastructure during the peaks of infections for patients who were not so unwell that they needed acute care
- hubs became the overflow for 111 from calls about Covid symptoms
- hubs had a flexible workforce infrastructure which allowed for increases in capacity at very short notice and within hours at weekends and evenings
- whatsapp group across NWL leads became a relied-upon source for advice on how to manage some of the capacity planning and to answer questions where clinicians were unsure on how to manage

Redirecting clinical resources to pandemic response

- redeployment of clinical staff
- redirection and repurposing of physical resources, notably the doubling of critical care capacity
- standardised plans to enable the systematic reconfiguration of facilities and services, for example surge bed plan and or critical care expansion, ED reconfiguration, site reconfiguration

Clinical care

What went well?

Internal and system coordination

- site and sector emergency response and “Gold command” infrastructure
- closer working of clinical and managerial leadership, more integrated and collaborative ways of working
- data sharing, dashboards and predictive modelling
- investment in tools to support communication and remote working
- discharge hubs available seven days a week
- pro-active ambulance services and system support for patient transfers to reduce pressure on the Trust’s emergency and critical care services
- establishing of assessment and vaccination infrastructure in the community and internal engagement and advocacy to address vaccine hesitancy

GP Practices

- GPs were quickly enabled to work remotely with immediate deployment of additional laptops with VPN access and new software designed to allow video and efficient remote consultations
- GP practices re-opened with one-way systems and access into and out of practices to maintain infection control
- infection control webinars and audits were a very efficient way to ensure the minimal IPC specialist resource was able to support practices to provide safe environments
- advice and guidance from Consultants helped GPs manage patients in the community and keep more people away from the hospital setting, reducing the risk to residents

Clinical care

Key challenges and what could be done better?

Mitigating impacts on other services (for example elective inpatients) and groups (for example young people)

- factor the need to maintain [some] service continuity and restore capacity quickly into service changes and redeployments
- use service-cessations only as an absolute last resort
- introduce estate changes to give greater flexibility to address infection control, safety and flow
- expand the scope of point of care testing and measures to reduce turnaround times

Staff preparation and resilience

- diversify training and experience to make the clinical skill base more flexible to redeployment. for example intensive care support training
- expand training of non-clinical staff and volunteers
- update guidance and use simulations to speed up the pace of response
- reduce the frequency of new guidance, where possible at a local level
- tactical health and wellbeing actions were welcome, but staff resilience benefits from strong foundations
- strategic approach to PPE fit testing and other staff safety measures – protected time, co-ordination and standardisation of processes and equipment
- expand and enhance communication and organisational development support to staff
- staff vaccination hesitancy and myth busting

Discharge bottlenecks

- step up senior clinical support and oversight 7 days a week
- expand access to out-of-hospital capacity, both beds and community service “hubs”
- broaden “trusted” assessors
- provide targeted pathways for key groups like homeless

Clinical care

Key challenges and what could be done better?

Supply chain

- resilient supply and stockpile management of critical consumables, including oxygen supplies and medication supply chains
- strengthen early warning and stock control systems
- automate the ability to track utilisation

Data collection and reporting time-consuming and resource intensive

- put in place systems that streamline data collection
- increase the emphasis and technical capability to provide analysis and insight
- capture a broader range of critical information on staff capabilities (for example for redeployment) and physical infrastructure capacity across the system

Appendix 2 – Outbreak prevention and management

Outbreak prevention and management – early years settings

What went well?

Guidance

- there was a clear process put in place for implementing guidance for outbreaks including reporting processes, and these were effectively implemented
- early years settings (for example private nurseries) and childminders were also supported to follow correct processes for reporting to DfE and PHE

Support for Providers

- early years settings reported they felt supported as they had a named person to contact and were kept updated via email and during designated online briefing sessions
- additionally, the team made regular wellbeing calls and contacted via email to share updates and guidance
- the Ealing families directory was also valuable as a point of contact for support and advice and for updated guidance
- national updates were shared with providers via email and queries were responded to with clarification from PHE
- PPE resources were shared by settings that were closed with those who were open and offering provision
- key worker families were supported to find available childcare
- children's Centres supported providers to source food and clothing for families in crisis
- surplus vaccination was targeted and shared with front line workers
- children's Centres supported nursery tenants in planning building management to support social distancing and preventing outbreaks
- financial support was continued through all available childcare funding schemes
- post Lockdown discussions and reflections were explored in the designated safeguarding leads network meeting

Data

- standardised reporting forms were sent to all providers and a central spreadsheet created for recording of cases

Outbreak prevention and management – early years settings

Key challenges and what could be done better?

- guidance for close contacts and access to testing kits in early years settings (for example private nurseries) needed to be clearer
- guidance for settings on reporting cases needed to be clearer as it led to confusion and frustration from settings
- training could have been provided to early years staff to support a basic knowledge around health protection to support interpretation of guidance

Outbreak prevention and management – schools

What went well?

Guidance
- schools appreciated the interpretation, version and change control of guidance, felt supported by the local authority and appreciated that they could speak to an actual person
- the DfE guidance and PHE Resource Pack (with defined criteria for escalation) were used to manage outbreaks
- public health team presented covid update at the schools' consultative group and the ward forum meetings and met with headteachers to explain guidance
- parent letters and staff letters informing of outbreak situations or surge testing were developed and sent out

Flowchart
- a flowchart was created for schools to show what to do and how long to isolate for, which was well received by schools
- schools became very adept at managing covid cases and outbreaks
- the health and safety team provided advice and support to schools when needed
- when there were complex situations or outbreaks, public health team or PHE also advised the schools

Partnership working
- cross-London learning around the implementation of guidance in schools, via meetings and FAQ documents
- complex cases (for example SEND) and complex outbreaks were referred to PHE for specialist support and advice

Workforce
- the schools' health and safety adviser was trained by public health on which questions to ask when cases were high in schools, to inform decision-making on whether to escalate an outbreak to PHE

Data
- covid cases captured and monitored at an individual school and individual case level
- PHE, council teams (schools and public health) and headteachers contributed to decision-making around school-wide testing and isolation of classes

Outbreak prevention and management – schools

Key challenges and what could be done better?

Guidance

- rapid changes in national guidance with little notice given before implementation, consequently there is a need to look at how to manage guidance updates and changes better at a local level
- DfE updates lacked detail of exactly what changes had been made, which made navigating the updated documentation more difficult

Process and data

- sometimes the teams were overwhelmed with the number of calls and questions from schools, which made it difficult to ascertain whether a school situation needed escalation to PHE
- consideration should be given to the level of data needed to be collected, for example does the council need to log all cases for each school or only relevant high-level summaries of outbreaks
- an appropriate system and infrastructure to log and monitor cases and outbreaks would be beneficial
- a process for gathering key data from schools would be helpful, so all relevant information is gathered rather than having to go back to ask for more information, this may require training for council teams and or schools on how health protection specialists assess situations

Outbreak prevention and management – universities

What went well?

- there was good collaborative working and universities were happy to share their knowledge and resources to support the local outbreak management
- working with universities enabled the council teams to develop relationships
- the London-wide approach worked well. Where a single university had residential halls in multiple boroughs, a lead borough was identified in managing outbreaks and this was deemed to be an effective model
- as the pandemic progressed, universities needed minimal support to manage their outbreaks and deliver testing

Key challenges and what could be done better?

- case management could have been more effective as it was challenging to link data to universities
- an excel spreadsheet was used to record cases but a data management system would have been more effective and would have enabled epidemiological analysis

Outbreak prevention and management – workplaces and public spaces

What went well?

Workforce

- environment health officers (EHOs) moved effectively from business as usual (BAU) to Covid work over the 18 months that regulations were in place. EHOs and others took on and effectively delivered new work areas
- regular communications with local businesses via newsletter and or forum
- support provided proactively as well to VCFS sites, such as food banks, on the best ways for staff, volunteers and residents to keep safe
- proactive liaison on outbreak prevention with businesses and residents via the covid stewards

Outbreak prevention and management – workplaces and public spaces

Key challenges and what could be done better?

Workforce

- the process of redeploying the workforce away from areas of work wholesale could have been done more effectively to ensure transparency and skills matching
- standard recruitment and finance processes resulted in challenges for rapid recruitment and creation of new posts and could be reviewed for emergency situations
- consideration could have been given on how to proactively mitigate and resource the backlog of BAU work for environmental health

Risk assessment

- a risk assessment could have been undertaken to understand the impact of stopping some areas of BAU work
- this needs to be updated as an emergency progresses to take into account how communities and businesses are responding and therefore where the council may need to take additional actions, for example shisha delivery services which were established as a new area of business during the covid pandemic

Guidance and legislation

- a more precise distinction could have been made to colleagues and stakeholders about the difference between guidance, legislation and enforceable mandates. Expectations about rules and the extent to which they would be enforced locally by council or Police could have been managed more clearly with communities and partner organisations.

Outbreak prevention and management – care homes and domiciliary care

What went well?

Process

- the development and use of outbreak management processes through a weekly care home co-ordination cell and sub-cell replaced ad hoc incident management team (IMT) meetings and enabled key partners (ASC, PHE and NHS) to work in a co-ordinated and complementary way together
- once the national PPE portal and allocation process was established this worked well

Partnership working

- the social care team received briefing and guidance from PHE (usually via the council's public health team) on communications and escalations and these communication channels worked well
- council's HR team attended the meetings to provide advice regarding frontline council staff
- the social care team was already skilled in engaging with care providers and had established relationships
- weekly calls with care home and domiciliary care managers helped to support their staying up to date with IPC, PPE and testing guidance

Communications

- coordinated communications on PPE to providers and via the infection prevention and control (IPC) lead were effective
- coordinated communications on vaccination was sent to providers and this supported vaccination uptake

Workforce

- specialist GP service for care homes was already in place
- a specialist infection prevention and control lead for care providers was recruited, and this made a real change on the ground

Outbreak prevention and management – care homes and domiciliary care

Key challenges and what could be done better?

Communications
- there were initial challenges with rapidly changing guidance and the different online platforms, including the data capture platforms
- data flow about cases could have been improved

Approach
- there were differences in the approach to internal and external staff, which caused some challenges, particularly where agency staff worked across multiple care homes.

Vaccinations
- there were two vaccination services to support care homes, which resulted in some challenges

Workforce
- reliance on senior staff in public health who had training and skills in health protection. Training up other team members would have reduced this dependence
- having a dedicated specialist infection prevention and control lead in place from an earlier stage would have been beneficial
- limited testing for social care staff in the initial phase of the pandemic

PPE
- there were tensions in the supply of PPE across the care sector and this could have been more effectively managed

Outbreak prevention and management – Self-isolation accommodation

Self-isolation accommodation was provided for people who were testing positive early on in the pandemic and couldn't safely self-isolate, for example homeless or families with shared facilities in their usual temporary accommodation

What went well?

- the council was able to source accommodation to meet the initial demand
- the council was able to build relationships with new accommodation suppliers, some of which remain in place today
- the service was developed to enable more virtual ways of working

Key challenges and what could be done better?

- challenges around how different teams could work together on this and what role each could play to complement each other whilst ensuring clarity on decision-making
- the council does not have a dedicated facility or budget to support quarantining, either in council housing or a hotel room with food and drinks required. This was a particular challenge early on when prices for self-contained units increased substantially after the national 'everybody in' policy for rough sleepers
- joint working options could have been considered at an earlier stage with neighbouring boroughs, for example a joint accommodation with dedicated social care and NHS teams to support residents. This would involve a number of teams all committing to a joint service offer, with clarity on processes for residents placed out of borough (for example a hotel in a neighbouring borough) for a short time period to enable quarantine
- a clearer 'offer' could have been made to persuade some suppliers to provide accommodation, for example clarity on the care plan in place and standard infection control support to reduce risks for staff and provide greater reassurance
- risk of some new suppliers taken on and below-standard units acquired, as the usual in-person inspections were not able to be carried out. A list of suppliers was built up during the pandemic, so this is less likely to happen in future

Appendix 3 – Pandemic response functions

Pandemic response planning, emergency management and governance

What went well?

Governance and planning

- the local outbreak management plan (LOMP - published in summer 2020 and then updated in spring 2021 as the COVID-19 Prevention and Management Plan) and the governance to support it was useful in planning, framing and guiding the work of local teams
- the COVID-19 response team (joint between council and NHS) worked effectively, and members had clear roles and responsibilities
- emergency response structures were put in place based on the responses required for the pandemic, and these developed over the course of the pandemic. This included gold, silver and bronze groups (in individual organisations and also a gold group between the council and NHS).
- after the first LOMP was developed, a regular sitrep group and subsequently a more strategic outbreak prevention and control (OPC) group were established (both joint between council and NHS).
- the OPC group allowed for a data-driven local response informing universal and targeted (hyper-local) interventions

Partnership work

- close collaboration and flexible approach between council and NHS teams and local partners, which benefitted from existing relationships between partners and teams
- joint council and NHS briefings were introduced regularly for senior councillors and managers, which were especially beneficial for the vaccine programme
- benefits of close cooperation with national and regional partners
- whatsapp became a critical rapid communication tool within and between teams and organisations, especially with remote working

Pandemic response planning, emergency management and governance

Key challenges and what could be done better?

Workforce

- the redeployment process across organisations and within organisations was not clear, which delayed and limited expansion of the workforce available to support the COVID-19 response, the response teams created (for example contact tracing and testing) relied either on volunteers or on commissioning external support
- teams across the local organisations were not trained up in basic emergency management skills and knowledge. No training on basic emergency management for people who were part of Silver meetings or who needed to deputise at gold meetings. Scenario-based training exercises before the covid pandemic highlighted that different teams had different views of how to respond in an emergency
- a number of small teams were intensively involved in the response and not initially resourced for the scale of work needed. Additional staffing resources with a basic level of training would have been beneficial, for example for public health, communications, engagement, etc

Governance and planning

- the standard or 'traditional' emergency response plans were not fully applicable to the specific context of the covid pandemic, especially the broad impact for communities (including lockdowns) over a substantial period of time
- some teams were only brought into the response at a later stage, for example community engagement, housing, community safety, business liaison, education
- there was not always clarity around levels of decision-making appropriate for different parts of the emergency response structures
- although covid funding was incredibly valuable, the short-term announcement of central funding made strategic planning difficult. Sometimes decisions had to be made based on local understanding of need, without yet having specific additional funding sources identified
- team email accounts and inboxes were found to be very valuable but were not available for every team. These allow a single point of contact by other teams, and shared access to information within teams
- the council's Business Continuity plans were updated during March 2020 but they were not updated to truly reflect the type of response needed as the situation continued to develop. Consideration needs to be given to how to adjust the business continuity response for similar types of situation

Partnership work

- the local understanding of vulnerabilities in the communities was spread between multiple teams and organisations, with no single overview of residents who were vulnerable

Public health response

What went well?

- supportive and flexible approach of team members, with redeployment of whole team to support the covid response through different phases
- team inbox was created early on, which helped manage queries and information cascades. Emails were stored in sub-folders, which helped with saving information and auditing how the inbox was being used. A couple of inbox audits were carried out, which helped with learning on processes. The audit also broke down the number and types of internal and external queries received
- rapid communication between the team via whatsapp groups
- training through online platforms
- strengthened networks and relationships with other teams, and a shared vision of what needed to be achieved together. Further joint working of teams is important to integrate and learn more about each other, for example for consideration when re-designing office space so teams can be supported to mix more
- strengthened networks and relationships with other teams, and a shared vision of what needed to be achieved together. Further joint working of teams is important to integrate and learn more about each other, for example consideration when re-designing office space so teams can be supported to mix more.
- regional networks were very useful, although learning could have been shared more proactively across the teams
- commissioned services (for example sexual health and substance misuse) continued to provide a service offer to residents during the pandemic, although this was very challenging
- Regular briefings provided jointly with other teams to a range of partners and Boards, for example health and wellbeing board, health and adults scrutiny committee, GPs, councillors

Public health response

Key challenges and what could be done better?

- as for other health protection situations, the Public Health team were the primary route for information to come into the council and often to the NHS teams. Even with redeployment of the whole team and some covid roles created later in the pandemic (with national funding), consideration in future could be given to rapidly expanding the team from an early stage, especially in terms of capacity to answer queries, and to provide additional workforce development for Public Health and other teams
- clear processes for directing queries to other teams could be set up at an earlier stage, so that the public health inbox isn't the only nor primary route, for example for notification of cases in schools. Other council or NHS teams can then forward queries onto the public health inbox if specific guidance or support is required. Consideration could also be given to how best to handle urgent queries vs. general information updates coming into the public health inbox
- public health team was one of many primarily office-based teams that moved suddenly to home working. Given how involved the team was in the covid response, it was difficult to prioritise wellbeing with back-to-back meetings. With continued hybrid working, there is learning around being very mindful of supporting wellbeing, for example managing diaries well, ensuring desk space set up properly
- there was a lot of rapid learning about health protection, both within the team and with other teams. To help support resilience in the future, some of this learning should be undertaken proactively in advance of future health protection emergencies
- some confusion around what each team or individual does, which resulted in sometimes not liaising with the right team quickly enough. Job titles don't always reflect what people actually do. Team emails were found to be very useful when they were available, especially when individuals were on sick leave or redeployed

Community engagement

What went well?

- area task groups were set up by the council in October 2020. They were used to amplify messages with local communities and to help design services that would be accessible and relevant for local communities. The groups used people who were already grounded in the geography and culture of an area and are known to local people, which meant key messages were received quickly and efficiently. Different teams attended the group meetings as required, for example to discuss vaccination. The groups also used whatsapp to keep conversations going and share social media assets for sharing with communities
- the council's community engagement team had trusted relationships with those who attended ward forums and could go to them when required. The intelligence of the team about the key trusted community leaders in an area supported the development and success of the area task groups
- a consortia of smaller grassroots community and voluntary organisations was set up through a commissioned service provided by EACH
- the liaison with the faith sector, organised via faith forum meetings chaired by the Leader of the council, was viewed to be positive and incredibly helpful.
- positive learning from recruiting volunteers, with joint co-ordination from council and NHS. Also benefitted from widely sharing information about national volunteering apps
- the regular and frequent liaison with both voluntary and community sector and mutual aid groups, together with key professionals, helped to establish open communications and the beginning of a more trusted relationship

Community engagement

Key challenges and what could be done better?

- community engagement was not automatically part of the initial pandemic response
- following the success of the vaccination bus at a Gurdwara in Southall in spring 2021, there was a lot of interest from the community in doing something similar again. However, with the practicalities and the rapidly changing pressures within the vaccination programme, it meant this kind of pop-up was not possible to run again and also that other pop-up sites had to be set up at very short notice. This resulted in some community members feeling they were not being treated as an essential part of the work. Consideration could be given as to how key community leaders could be included in decision-making processes
- the EACH consortium took time to mobilise effectively and experienced challenges recruiting a project manager, which may have destabilised new relationships and meant the work was delayed and then lost momentum. Consideration could be given as to whether commissioning an external provider is the best way of achieving the aim of the work, and how best to complement and build on existing engagement work and relationships.
- The area task groups could be used more to upskill some community leaders, to enable conversations to be had about where residents get their information from, what might help them to understand and access services and how to be health advocates, potentially as Community Champions. This is particularly important where community leaders have a range of community languages
- careful balance to be struck between maintaining relationships that the community engagement team have built up over time whilst enabling direct relationships to be built with other council and NHS teams. Structures like the faith forum and the area task groups did enable this to happen and should be considered for day-to-day working
- an appropriate data protection and safeguarding policy was necessary to quickly establish a relationship with the voluntary, community, and religious sectors that would provide them access to data on vulnerable persons. The process of creating the connection would have moved more quickly if the council had a template for both

Communications

What went well?

Workforce

- council Communications team rota provided 24/7 cover but also allowed for BAU to be picked up
- the communications team split into 3 teams which covered media and comms, web, marketing with each team led by one of the 3 managers
- further into the pandemic a small team was established to focus solely on the covid response and team numbers were flexed up when required

Process

- the introduction of direct messaging via mobile advertising sites proved very useful and the team developed their own assets to engage with the audience they were targeting
- the sign off process worked very well, and the team was aware of their role and how to deliver it

Links with community engagement

- messaging coming from councilors and out via local community leaders was seen as highly beneficial
- the introduction of the online web toolkit for community leaders to use proved to be very successful

Partnership work

- work with London councils was very successful. Coming together across the whole of London, and at times focusing on West London comms, meant that the messaging was joined up and the council could share activity without duplicating it
- the council communications team proactively supported the messaging on programmes led by the NHS (for example vaccinations)
- joint messaging between NHS and council was particularly effective and wide-reaching

Communications

Key challenges and what could be done better?

Workforce

- initially setting up a response that involved the whole team was challenging. Setting up the staff rota and splitting into 3 teams worked well, but there were still challenges with ensuring that all staff members had ‘down time’, especially among the senior team members. Identifying a small core team of responders may be helpful in future emergency situations

Links with community engagement

- engaging with the community was challenging at times, the team were getting mixed feedback on the messaging put out and sometimes it didn't get picked up by community leaders in a timely fashion. The introduction of the online toolkit helped a lot. Consideration could be giving to processes that involve communities more in development of communication assets
- relying on national communication campaigns was not always appropriate in terms of targeting for Ealing’s communities. More joint working across West London may be helpful in future situations, to deliver messaging that was developed for local communities – where this happened it was very successful
- careful balance to be struck between maintaining relationships that the community engagement team have built up over time whilst enabling direct relationships to be built with other council and NHS teams (for example Communications). Structures like the Faith Forum and the Area task groups did enable this to happen and should be considered for day-to-day working
- building up links with community leaders may have also allowed more joint understanding of the challenges, delays and rapid changes relating to national guidance publication
- quite often NHS and council teams were advised of policy decisions at the same time as the public through national briefings. This raised challenges of managing expectations of residents, such as the expansion of cohorts of people eligible for vaccination. NHS systems and teams had to adapt systems and booking processes, which meant there was a delay in operationalising national policy.

Communications

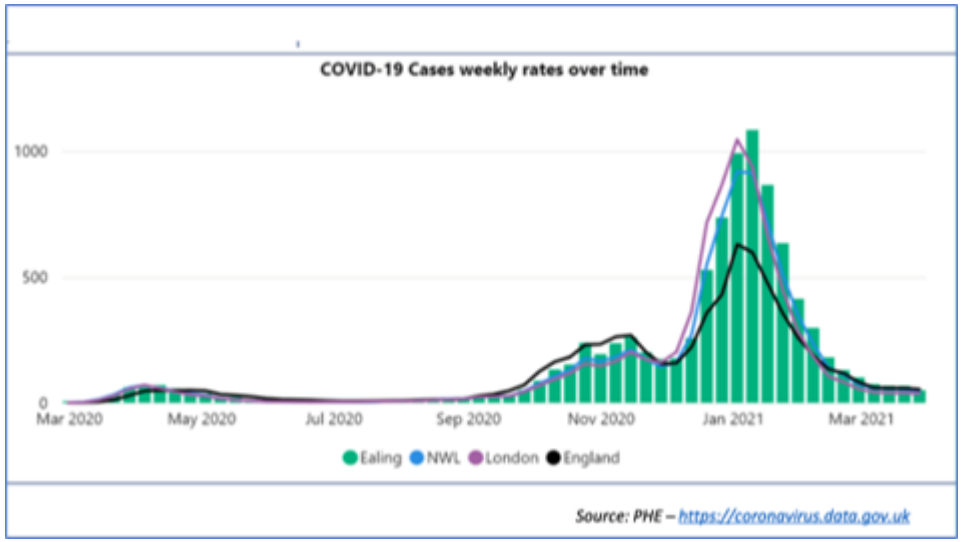
Intelligence and analysis

What went well?

- dashboards were a key part of the response, providing the core evidence to determine how the council responded to the pandemic as it evolved
- powerbi was also a new tool used for the first time in this way and dashboards were customised by the council's data team to meet local needs in contrast to the standard reports provided through national routes

Key challenges and what could be done better?

- the data team needed more capacity to take on additional work and workforce could have been increased earlier on to support this
- there were a number of challenges with data sharing in the first few months, as national rules were put in place preventing publication of some detailed local data. Some colleagues felt that these national rules weren't communicated clearly and there was a lack of explicit reasoning given for the restrictions. However, these rules were followed for some time in Ealing, which had a major impact on relationships with local communities. Eventually, Ealing developed a way to publish the data in similar ways to other local authorities. However, it did damage relationships and led to understandable concerns about a lack of transparency in information about inequalities
- detailed breakdown of inequalities data was very valuable (for example analysing differences within the standard ethnic group categories), and should be done at a town level wherever possible



Human Resources

What went well?

Governance and process

- HR tactical (silver) cell set up in council early on to oversee and discuss all key elements that needed covering from a HR perspective. council's director of HR was part of the gold command meetings
- HR directors across NHS providers in NWL established a joint governance and calls to ensure consistency in application of policy and to support staff working across the NHS system
- dedicated intranet page for all guidance and templates for staff and managers

Partnerships

- London HR network to learn from each other and share best practice. The London framework on deploying staff during an emergency was adopted and used.
- cross-team working in an agile way to help develop and refine key policies and procedures on an on-going basis, and to ensure clear communications for staff, for example on how to manage cases in the workplace

Staff wellbeing

- development and delivery of an extensive programme of work to support staff health and wellbeing across council and NHS organisations. Helpful to consider whether there is anything that should be carried forward for day-to-day work, for example expanding the number of staff members who are trained as mental health first aiders
- staff risk assessment policies were developed for all staff working in the NHS
- NHS re-deployment was co-ordinated across organisations in NWL, to ensure staff were deployed to where there was the need

Recovery and hybrid working

- 'new ways of working' recovery cell subsequently set up with representation from multiple teams. This helped ensure there was a clear plan developed and implemented to enable the elements of recovery related to workforce and workplace to be delivered in a co-ordinated, well-managed and safe way across 4 key workstreams of 'Health, safety and wellbeing', 'Workforce development and planning', 'Prepping the building', 'Prepping the workplace'
- clear process put in place for agreeing the return of services to the workplace with relevant governance, sign-offs and check points embedded within this
- implementing logistics around social distancing in the workplace in our HQ office Perceval House as staff began returning to work and having clear guidance for staff on expectations
- ensuring that vulnerable and shielded staff got the right support and had clarity with regards their return to work

Human Resources

Key challenges and what could be done better?

Governance and process

- challenges with interpreting broad government guidance and developing clear communications for staff and managers, for example on managing cases in the workplace

Staff wellbeing

- different ways to recognise the contribution of staff could be considered in this type of situation, for example staff awards event (which could be virtual)

Recovery and hybrid working

- difficult at times to get all requested elements signed-off before staff and services began returning to workplaces
- focused on Perceval House as main council office building and took a long time for some other buildings to be re-opened and there were numerous hurdles to be overcome in some cases
- NHS staff working in Perceval House offices sometimes had slightly different IPC policies in place to staff from the council, which caused some confusion at times