Local Government Association

Community Wellbeing Board

Agenda

Tuesday, 9 June 2020
11.00 am

Online via Zoom

To: Members of the Community Wellbeing Board
cc: Named officers for briefing purposes

www.local.gov.uk

LGA Community Wellbeing Board

9 June 2020

There will be a meeting of the Community Wellbeing Board at **11.00 am on Tuesday, 9 June 2020** Online via Zoom.

Attendance:
Member Services will read out a register at the start of the meeting.

Apologies:
Please notify your political group office (see contact telephone numbers below) if you are unable to attend this meeting.

Conservative:	020 7664 3223	email: lgaconservatives@local.gov.uk
Labour:	020 7664 3263	email: Martha.Lauchlan@local.gov.uk
Liberal Democrat:	020 7664 3235	email: libdem@local.gov.uk
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LGA Contact:
Alex Saul, Assistant Member Services Manager.

Carers' Allowance
As part of the LGA Members' Allowances Scheme a Carer's Allowance of £9.00 per hour or £10.55 if receiving London living wage is available to cover the cost of dependants (i.e. children, elderly people or people with disabilities) incurred as a result of attending this meeting

Local Government Association

Community Wellbeing Board – Membership 2019/2020

Councillor	Authority
Conservative (7)	
Ian Hudspeth (Chairman)	Oxfordshire County Council
David Fothergill	Somerset County Council
Adrian Hardman	Worcestershire County Council
Colin Noble	Suffolk County Council
Jonathan Owen	East Riding of Yorkshire Council
Judith Wallace	North Tyneside Council
Sue Woolley	Lincolnshire County Council
Substitutes	
David Coppinger	Windsor & Maidenhead Royal Borough
Wayne Fitzgerald	Peterborough City Council
Arnold Saunders	Salford City Council
Labour (7)	
Paulette Hamilton (Vice-Chair)	Birmingham City Council
Helen Holland	Bristol City Council
Arooj Shah	Oldham MBC
Shabir Pandor	Kirklees Metropolitan Council
Natasa Pantelic	Slough Borough Council
Amy Cross	Blackpool Council
Denise Scott-McDonald	Royal Borough of Greenwich
Substitutes	
Mohammed Iqbal	Pendle Borough Council
Bob Cook	Stockton-on-Tees Borough Council
Edward Davie	Lambeth London Borough Council
Liberal Democrat (2)	
Richard Kemp CBE (Deputy Chair)	Liverpool City Council
Doreen Huddart	Newcastle upon Tyne City Council
Substitutes	
Carl Quilliam	London Borough of Merton
Independent (2)	
Claire Wright (Deputy Chair)	Devon County Council
Neil Burden	Cornwall Council
Substitutes	
David Beaman	Waverley Borough Council
Tim Hodgson	Solihull Metropolitan Borough Council

Local Government Association

Agenda

Community Wellbeing Board

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2.	**Sir Muir Gray** Sir Muir Gray will be joining the meeting to discuss his work on Healthy and Productive Ageing.	
3.	**Covid-19**	1 - 18
4.	**End of Year Report and 2020/21 Priorities** Paper to be sent to members later	
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Community Wellbeing Board

09 June 2020

Covid-19 Update

Purpose of report

For discussion.

Summary

This paper updates members on the LGA's activity undertaken within the remit of the Community Wellbeing Board in response to the Covid-19 emergency since the Board's last meeting at the end of March.

Recommendations

Members are asked to note the LGA's work to date around Covid-19 of relevance to the Board and to comment on what further work the Board should be undertaking to support the local government sector.

Actions

Officers will incorporate members comments and views into LGA work on Covid-19 going forward.

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Covid-19 Update

Background

1. At its meeting at the end of March the Board discussed the national, local authority and LGA response to the Covid-19 outbreak to that point. Since then the LGA's work as an organisation has shifted to focus almost entirely on supporting councils' response to Covid-19. All the Board's priorities and workstreams have been significantly impacted by the implications of the Covid-19 emergency, with the team supporting the Board and colleagues in the Care and Health Improvement Programme (CHIP) reconfiguring how they work around three main strands of work: adult social care; public health; and supporting vulnerable people.

2. This report updates the Board on the range of work undertaken to date. Much of this work will have to continue over the remainder of this year, and the separate report on the agenda covering the priorities for 2020/21 considers the implications for the Board's work going forward.

Adult Social Care

3. Adult Social Care is at the forefront of the Covid-19 challenge. As providers and commissioners for the major part of local provision, adult social care council teams have been prominent in leading local responses. Supporting councils with the adult social care response has been a dominant part of the LGA's programme over the last 2 months across improvement, policy, public affairs and media.

4. A key part of our role has been working with the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) alongside national partners, particularly the Association of Directors of Adult Social Services (ADASS), NHS bodies and the care provider associations, to ensure that government policy is informed by what can best support councils and local partners to help keep residents and staff safe and supported.

5. In the early days of the response social care played a huge role in protecting the NHS and preparing it for readiness, creating bed-space in hospitals by supporting the quick discharge of patients home and to care homes. In recent weeks the focus has shifted from hospitals to social care, particularly care homes, and we have pressed the need for a commensurate shift in focus to protecting social care.

LGA ASC "Hub"

6. Given the scale of the adult social care Covid-19 challenge we have established a cross-organisational workstream (the ASC "Hub") with ADASS. We have created this by temporarily refocussing the work of staff from the CHIP. This is ensuring that we are using the joint resources of the LGA and ADASS to best effect, avoiding duplication and co-ordinating sector leadership with Government and the NHS. We are able to co-ordinate communications including a daily ASC Update to complement the daily LGA chief executive/chairman bulletin and we now host a Knowledge Hub for key documents and exchange of information. The ASC Hub is integrated with the wider LGA Covid-19 programme management process.

Support to councils

7. We have supported our member councils in all aspects of this response including:

    7.1. the huge effort at the end of March to create bed-space in hospitals by supporting the quick discharge of patients home and to care homes.

    7.2. working with government and providers to ensure the fragile social care sector remains sustainable.

    7.3. support to ensure additional government funding is used to sustain local providers.

    7.4. working with government on guidance to the Care Act easements that is proportionate, sensible and gives councils flexibility in prioritising work through the emergency.

    7.5. working with government to ensure national and local data reporting requirements are balanced and proportionate.

    7.6. Lobbying for consistent access to appropriate personal protective equipment.

    7.7. Lobbying for a comprehensive and focussed testing regime for social care.

    7.8. Lobbying that social care be afforded the same "protected" status as the NHS.

Hospital Discharge

8. Following publication of new hospital discharge guidance on 19 March we mobilised CHIP staff and, in conjunction with the Better Care Support Team, launched a series of webinars that started the following day and continued through the following week,

reaching over a 1,000 council staff. This unprecedented effort to facilitate hospital discharge was a huge credit to all our councils.

Sustaining the Care Provider Sector

9. Given the fragility of the care provider sector, the Covid-19 emergency poses a real threat to its sustainability and we have established working groups with national partners and government to address key areas around workforce and finance as well as related issues such as widening indemnity insurance. Of particular note, we published a joint statement with ADASS and the CPA on 17 March on the steps councils could take to support providers' financial resilience and followed this up with a further joint statement with ADASS on 9 April, which included the issue of fee-uplifts. By promoting the importance of local discussions and a sector-led approach, we avoided the introduction of a national fee rate which, even if implemented temporarily, could have caused significant problems for councils.

Care Home Resilience

10. Subsequently we have worked with government on the development of a more coherent approach to care home resilience, bringing together all the elements needed to ensure safety of residents and staff:

    10.1. Infection control.

    10.2. Workforce recruitment and co-ordination.

    10.3. Use of alternative accommodation where appropriate.

    10.4. NHS support, including primary care, community services and specialist support.

    10.5. Access to and use of personal protective equipment.

    10.6. Access to testing.

11. We have successfully argued that this approach needs council leadership in bringing together key local partners to put the various elements in place. We will continue to argue that any additional costs related to the care homes resilience planning must be funded over and above previous council funding allocations.

Personal Protective Equipment (PPE)

12. Shortages and quality of appropriate PPE has persisted as a significant problem for council staff and for local social care providers. The promised national supply arrangements have not materialised for social care and councils are still reliant on what started as emergency drops to Local Resilience Forums (LRFs), with many councils still reporting supplies well short of what is needed. Councils are working hard with LRFs to ensure that the distribution of what is available is being prioritised according to need. The LGA is working with care provider associations and with DHSC to ensure greater consistency of supply and better clarity of what LRFs can expect.

13. There has also been confusion about appropriate use of PPE by social care staff. Following some unhelpful initial guidance which simply replicated advice to NHS staff, the LGA supported work with provider associations and with DHSC to develop quickly bespoke guidance for social care staff.

Testing

14. Following our extensive lobbying with councils and care providers the Government announced on 15 April that it would offer testing “for everyone who needs one” in social care settings. However, the prioritisation of testing for social care was undermined by the subsequent development of confusing multiple testing regimes, with social care staff and providers feeling they were often competing for testing slots as well as experiencing difficulty accessing test centres.

15. Following further lobbying by LGA, government announced that it would prioritise 30,000 tests per day for staff and residents in care homes with Directors of Adult Social Services and Directors of Public Health being asked to provide leadership to this initiative.

Funding

16. Early in the pandemic the LGA spoke strongly on the need for the funding necessary to enable councils to continue providing all their essential services. An important part of the focus for this work was on the funding needed for social care to help keep people safe and well. We know that the most significant share of the £3.2 billion allocated by government is being spent in adult social care, albeit that it is intended to provide for a much wider range of cost pressures, and that it falls well-short of the total costs and income losses that councils have experienced.

17. There has been some unfounded criticism of councils from the national care provider associations who have argued that councils have failed to pass on funding to local

providers. In instances where councils have been named, we have always been able to establish that this is not the case. We are also gathering information from our regions about how councils have allocated their Covid-19 funding. Notwithstanding our differences with national provider associations, we are continuing to work with providers and others connected to social care to fully understand the level of additional resource that may be needed, including for providers that operate predominantly in the self-funder market. We have been clear that the Government must honour its commitment to make available 'whatever it takes' to help the country through this emergency.

Data Returns

18. Maintaining effective relations with local providers is part of all councils' responsibilities to support an appropriate balance and range of social care service provision. This includes gathering appropriate data on market intelligence. As part of the Covid-19 response, government has imposed national requirements for data returns from social care providers. NHSE/I collect information from care homes; CQC from home care providers.

19. Together with ADASS, the LGA has worked very hard with government and with provider associations to try and keep this new requirement proportionate and complementary to local data gathering, rather than duplicating effort and potentially undermining council responsibilities. This has involved supporting the rapid transfer of national data returns into LG Inform so that councils have ready access to up-to-date local intelligence. We have also continued to argue that the limited and Covid-related national data collections are no substitute for local market intelligence; at the same time accepting that if the national returns are effective and comprehensive then providers should not be expected to supply the same information more than once.

Care Act Easements

20. Government passed legislation that came into force on 31 March allowing councils some limited flexibility to opt out of Care Act responsibilities during the Covid-19 crisis. Accompanying guidance set out how such decisions should be taken and made it a requirement that councils implementing easements would need to notify DHSC.

21. At the time of writing, 6 councils are operating under the easements. DHSC has asked CQC to provide some oversight of those councils, including the reasons for the decision and the expected impact. CQC have said they will use this information as part of their prioritisation for monitoring of providers.

22. There was some initial media attention on implementation of the easements largely due to the information emerging on social media prior to its publication. There is no evidence that any of the councils have failed to comply with the requirements with regard to implementing these easements.

23. The LGA has worked closely with NHS England and the Government to coordinate vital support provided by national and local voluntary and community services (VCS). We have been working hard to ensure that the NHS Volunteer Responders scheme, which was launched in March, is accessible to health and care professional and for vulnerable people to call on for help when they need it.

Public Health

NHS Test and Trace Service

24. Covid-19 is best understood as a pattern of local outbreaks, rather than a national pandemic with a similar impact in every community. As public health place leaders with a wealth of local knowledge and expertise, we have highlighted the crucial role councils have to play in the local design and delivery of the NHS Test and Trace service (TTS). A place-based approach will be key to the national efforts to reopen society and live with the virus. We welcome Government's recognition of this with local government involvement and leadership through the 11 Good Practice Network Councils and ongoing engagement.

25. On 28 May, NHS Test and Trace went live. This forms a central part of the Government's Covid-19 recovery strategy. It aims to control the Covid-19 rate of reproduction (R), reduce the spread of infection and save lives, and in doing so help to return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy. To be successful, a truly integrated approach between local and national government, with a range of other partners - such as the NHS, GPs, businesses, employers, voluntary organisations, community partners, and the general public - will be required.

26. A Joint Biosecurity Centre (JBC) set up on similar lines to the Joint Terrorism Analysis Centre - will identify changes in infection rates, using testing, environmental and workplace data, and advise chief medical officers. Work is progressing to understand how the JBC will work alongside Public Health England (PHE) and local authorities in supporting the local response to outbreaks as they develop across the country.

27. Councils have been tasked with developing Local Outbreak Control Plans (LOCP) to support the national rollout of the TTS, putting them at the very heart of the next phase of the national response to COVID-19. It is critical that Councils are empowered and given

the powers, flexibilities, data and sustainable funding to enable them to effectively plan, identify, respond to and manage the infection locally. With and on behalf of the sector, the LGA is working with Government - through the National Outbreak Control Plans Advisory Board - to ensure that expertise from across local government shapes the future TTS development and to share best practice across the sector. Through this process, and in conjunction representative sector bodies also working hard to ensure TTS works on the ground locally, we are calling for the approach to be based on the core principles set out below.

The role of local authorities and partners

28. That there is a whole system approach, with national, regional and local partners working together to ensure the programme works effectively. No single organisation or sector has the resources, skills or expertise to make this happen on their own.

29. That Councils must be able to influence decisions and codesign how the system will work at national as well as local level. Ensuring local government is properly involved and consulted at an early stage will be key to the success of local implementation on the ground.

30. Local governance should be based on what works well locally, in partnership with NHS and other colleagues. Across the country, local health protection systems and local public health leadership arrangements are already embedded and working well across many localities. Councils are concerned that some of the proposals under the TTS have the potential to create duplication of effort, and confusion within the existing local health system. Clear communication and alignment with existing arrangements will be important for local areas to be able to use and build on what is already happening to avoid duplication by creating new structures. For example, Health and Wellbeing Boards (HWBs) are existing local forums in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. In most localities, these are Chaired by a senior local authority elected member. Local areas may see their existing HWB as the most appropriate ‘member-led Board’ to communicate with the general public, and in these cases should have the freedom to do so.

31. That there is clarity and clear communication about what the responsibilities of each ‘level’ will be, and particularly what will be expected of local government. As an example, there needs to be greater clarity on purpose and function of the new Joint Biosecurity Centre to ensure it does not duplicate existing health protection structures locally and regionally through local councils and Public Health England.

32. That Councils' varying multi-layered governance structures and geographies are fully are recognised, with the flexibility for these to be reflected in design and delivery of the TTS. For example, whilst upper-tier authorities have been tasked with developing Local Outbreak Control Plans (LOCP), District and Borough Councils also have an important place-based leadership role within this, as well as environmental health expertise.

33. That the different roles and responsibilities within authorities - reflecting councils' local democratic mandate as well as wider local system leadership responsibilities – are fully considered and empowered accordingly. These include: Directors of Public Health; Leader and Mayors; Chief Executives; Health and Wellbeing Portfolio Holders; and Health and Wellbeing Boards. There needs to be clarity that Directors of Public Health - as local health experts and system leaders – are best placed to lead the local response and this statutory role should be made explicit. It is equally important new arrangements continue to recognise the local role of Leaders and elected members in providing political leadership through existing structures alongside the Local Outbreak Engagement Boards, as well as their public facing stakeholder engagement role.

34. That councils have the lead role as local public health leaders as the situation moves from the initial civil resilience response to the health protection work required as part of testing and tracing. Local Resilience Forums (LRFs), with councils as critical local partners and members of Strategic Coordination Groups (SCG), have been leading the local multi-agency emergency response to Covid-19. Clarity is now needed about the role of LRFs and their interaction with Local Health Protection Boards, given the likelihood that SCGs are likely to remain stood up for some time into the future.

35. That councils' have the powers they need to protect their local communities through managing outbreaks locally, and have clarity on the circumstances in which they can be deploy them and do so at pace. Additional powers may be required by councils to be able to respond to and control localised outbreaks, such as controlling movement and closing premises or local areas. For example, in the event of localised outbreaks the powers to close venues, schools, local areas and other settings swiftly as necessary, and to enforce social distancing without needing to rely on police enforcement.

Testing and Contact Tracing

36. That councils have control over prioritisation and deployment of testing capacity and access to rapid results. This needs to be supported by having the right networks in place to support people once tested positive. Councils are a key part of this, along with the NHS, GPs, businesses, employers, voluntary organisations, community partners, and the general public.

37. That Government shares vital and up-to-date data with councils alongside other agencies, to help councils understand where the outbreaks are happening and be able to act quickly to contain them. This crucial data must be shared with councils in a proactive manner, be at an appropriate level, and with real time data flows. Data sharing across all parts of the TTS is critical for contact tracing, outbreak management and ongoing surveillance.

38. That council's unparalleled skills, knowledge and experience on the ground in contact tracing is fully recognised and built upon to support the TTS. For example, environmental health, trading standards, public health (including sexual health services and infection control nurses) are all experienced in contact tracing. Whilst the expected nationwide rollout of the NHS COVID-19 app will be useful, it is important that Council's 'shoe leather' epidemiology is as integral a part of the TTS. There is no replacement for human beings, with knowledge of the local area, who will get in touch with people who may have been in contact with those who have Covid-19 symptoms. It will be essential to reach some areas in different communities where an app simply cannot reach.

39. That access is given to the lessons learnt by the 11 Good Practice Network Councils and other vanguard areas to share this learning across the sector, whilst recognising that each council will develop specific plans to fit their structures and the place they serve.

Supporting the vulnerable

40. That councils are best placed to work with local partners to support vulnerable local people who are required to self-isolate but have no other means of support such as friends, families or neighbours, making it easier for them to do so and reducing the risk of transmission. This locally led support can build on the learning from local areas in ensuring access to food and support for the shielded and other vulnerable groups, particularly the lessons around data flow and data quality where data is passed on to councils from government.

41. That the underlying principle of support be that people will be assisted to access food and key goods themselves, for example, through supermarket/other deliveries, volunteer shopping etc, rather than be provided with food parcels. As with the shielding systems, councils should be viewed as the emergency backup position for people struggling to access food.

42. That those who need to self-isolate, but lack support, should be referred directly to councils via the appropriate helpline number. Any monitoring requirements of the local response should be agreed with councils at the outset, should be proportionate and be used to inform future developments so the focus of activity can remain on supporting the vulnerable.

43. Councils will also be able to refer to statutory services such as Adult Social Care where necessary, and also signpost to local services that support wellbeing and reduce isolation. Councils will wish to develop specific approaches for 'hard to reach' vulnerable groups - such as rough sleeper and gypsy and traveller communities - and to also manage risks that have emerged during lockdown, such as the increase in domestic abuse. Local plans also will need to use the growing evidence based to minimise the impact on particular BAME groups and on existing health inequalities.

44. That sufficient and flexible hardship funding be made available at the local level to enable councils to respond most effectively to the different circumstances where this need could arise. For example, there may be some circumstances where people need additional financial support as a result of the requirement to self-isolate, despite the provision of statutory sick pay for those unable to work from home.

Funding, Resource and Capacity

45. That councils continue to have the capacity and resources necessary ensure the programme is run effectively and is sustainable. It is good that Government has acknowledged the crucial role of councils in the TTS and need to support councils with the additional responsibility through the announcement of £300 million much-needed funding. Clarity on how this funding will be distributed is now a priority to enable councils to plan effectively.

Deaths in care settings

46. We have responded to the latest Office of National Statistics and CQC figures on deaths from Covid-19 in the community. The appalling loss of life in our care homes and communities is another stark reminder of just how much more must be done to protect our most elderly and vulnerable. Social care is the frontline in the fight against coronavirus and we need to do all we can to shield people in care homes and those receiving care in their own homes.

Public health on the frontline: responding to Covid-19

47. This month we published a series of interviews, with directors of public health from across the country as they talk about the local response to Covid-19. DPHs have had to step in to ensure supplies of personal protective equipment get through to care homes, provided advice to schools, carried out vital modelling work for hospitals and helped redeploy staff and reconfigure teams to keep vital council services running. What has it been like to be on the frontline of the fight against the virus? https://www.local.gov.uk/public-health-frontline-responding-covid-19

Covid-19 and impact on BAME communities

48. Following the publication of the PHE review of disparities and risks in outcomes, we will also be developing work to support local authorities to tackle the disproportionate impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) Groups. The findings of the PHE review confirmed that the impact of Covid-19 has replicated existing health inequalities, and in some cases, increased them. PHE found the largest disparity was found to be by age. The risk of dying among those diagnosed with Covid-19 was higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups.

49. It is important to add that this takes into account age, sex, deprivation, region and ethnicity, but not comorbidities, which are strongly associated with the risk of death from the virus. Sadly, when compared to previous years, PHE also found a particularly high increase in all cause deaths among those working in social care and care homes. These findings leave some unanswered questions about why some are more affected than others, in particular those from BAME backgrounds, and we must now deal with the question of how to reduce these disparities. The Health Secretary announced that equalities minister, Liz Truss, will take charge of a review looking at what more can be done to address this.

50. On the 2 June the LGA held a successful webinar on Covid-19 and ethnicity. We were joined by 758 colleagues from across local and central government, ahead of the delayed publication of the report. We will look to engage more on this agenda in the coming months and ensure our members are supported to take action wherever possible to limit the disproportionate impact of Covid-19 on some communities.

Supporting vulnerable people

Shielding vulnerable people

51. The LGA's work in this area has focused on councils' role in supporting vulnerable groups affected by Covid-19, and in particular those identified as clinically extremely vulnerable (CEV) to the pandemic. To assist councils we produced a briefing on the role of local authorities in protecting vulnerable people, which covered how the shielded group of clinically vulnerable people were being supported, the use of volunteers and the VCS sector in responding to the pandemic at a local level, as well as setting out the range of vulnerable groups councils would need to consider.

52. A major strand of work has been to shape and influence the design of the infrastructure put in place to shield the most clinically vulnerable group where they do not have friends

or family to assist them. We have worked closely with the nine regional chief executives and member authorities in doing so, with this work covering:

52.1. Ongoing issues with data flows from the shielding team to local councils in relation to the CEV cohort and those among them whom the Government has successfully contacted to confirm their support needs.

52.2. An increasing interest within Government of the support needs and potential food vulnerability of groups who are not CEV but may have challenges in accessing food despite being able to afford it, and the mechanisms available to support this group.

52.3. Recognising the needs of a much wider group of people who are experiencing or are at risk of experiencing food poverty and financial hardship as a result of the Covid-19 emergency.

53. We have also been making the case that any monitoring information gathered by government departments should build on existing data sets or councils own monitoring information to minimise the burden on councils. We continue to stress the need for local solutions to support local needs, and some of the many examples of good practice from councils are being collated on our website.

54. In addition we have highlighted the need now to plan around the future of the programme, with the next clinically led review of the timeline for shielding expected to conclude by the middle of the month; we have emphasised to MHCLG both that it will be a challenge for councils to maintain their existing support for this work as redeployed officers transition back to their normal jobs, and that wherever possible people should be supported into accessing food through other means, such as supermarket delivery slots. To facilitate this, we have worked with the Department of Environment Food and Rural Affairs to promote the roll out of pilots for priority access to supermarkets slots and their list of commercial offers.

Volunteering

55. There has also been a considerable amount of work related to volunteering and the ability of councils to access and make use of the over NHS Volunteer Responders (NHSVRs) in their work to support those who need to be shielded or self-isolate, such as providing help with shopping and making regular phone calls to check they are fine and offer much needed telephone companionship. Although there were indications from government that the NHSVRs would be made available to assist in a social care context, this was not clear from the way the scheme was launched and people encouraged to volunteer through the GoodSam app.

56. We made the case therefore for government to be clear that councils could task the NHSVRs to assist with collecting and delivering shopping and medicines as well as providing support to those who are lonely. In addition we supported proposals for vulnerable people themselves to request support from the volunteers, and for councils alongside some other bodies to be able to make 'bulk' referrals. As a result government confirmed that councils are able to make use of the NHSVRs, and subsequently could make 'bulk' referrals'.

57. We also worked closely with NHS England on a webinar on the NHS Voluntary Responders scheme specifically for local government. The webinar attracted over 150 participants, who had a wide range on questions and comments regarding NHSVR and its use by among local government, which NHSE found invaluable in considering future developments of the scheme.

58. We have been discussing with a range of national voluntary organisations and Government departments on the impact of Covid-19 on the role and contribution of the voluntary and community sector to community resilience and supporting vulnerable people. There is a strong sense, both nationally and locally, that the upsurge of interest in volunteering is hugely positive and should be nurtured and maintained. The LGA is keen to contribute to the national narrative around the role of the voluntary and community.

Mental Health and Wellbeing

59. Councils have been working hard with the NHS and other local partners, especially the voluntary and community sector, to support the mental health and wellbeing of their residents during Covid-19.

60. Actions across the mental health spectrum include continuing to meet statutory responsibilities for adults and children's mental health, supporting the mental wellbeing of frontline staff, bereavement support, suicide prevention, helping residents to stay connected, and supporting people who might need additional help such as carers and new parents. As well as promoting mental wellbeing through, for example, safe access to parks, open spaces and expanding public libraries' online offer.

61. Mental health issues will be one of the key legacy impacts from Covid-19. It is central to local planning for the next phases and recovery. People will continue to need support as they adjust to the 'new normal', for example support in the workplace and schools. Additional support will be needed for people who do not benefit from the easing of restrictions at the same time as everyone else, for people required to self-isolate as a result of track and trace, and for people affected by future more localised restrictions.

62. Addressing the mental health and wellbeing impacts must be locally-led. Given the differential nature of those impacts, local insight and understanding will be vital to effectively target interventions and to provide reassurance. Councils also own most of the assets where community action could or should take place in line with safety guidance, such as parks, libraries and schools, with councillors creating the localised neighbourhood partnerships to deal with a range of mental and physical health issues.

63. According to new research published by the Centre for Mental Health:

    63.1. The Covid-19 pandemic is likely to lead to an increase in mental ill health in the UK, as a result of both the illness itself and the measures being taken to protect people from the virus.

    63.2. If the economic impact is similar to that of the post 2008 recession, then we could expect 500,000 additional people experiencing mental health problems, with depression being the most common.

    63.3. The economic impact is likely to affect different parts of the country differently and therefore the likely increased prevalence of mental illness will be unevenly distributed.

    63.4. The various 'safety net' initiatives introduced by the Government are likely to be offering some significant protection to people's wellbeing. How and when these are dismantled are also likely to be critical to the fallout in terms of mental wellbeing following this crisis.

    63.5. Some communities will be more adversely affected by the outbreak of Covid-19 and we already know that people from BAME communities are overrepresented in critical care and mortality statistics.

    63.6. The mental health impact of Covid-19 will not be experienced equally: people with existing mental health difficulties and risk factors for poor mental health are likely to be affected disproportionately.

64. Since the last Board, we have supported councils work around mental health and wellbeing in a number of ways:

    64.1. To assist councils think through local responses to the loneliness and social isolation impacts of the pandemic, we published an advice note joint with the Association of Directors of Public Health. This highlighted the potential impacts on unpaid carers, alongside other people in vulnerable circumstances.

64.2. On 21 May, over 370 people joined an LGA webinar on the mental wellbeing impacts of Covid-19 with presentations from Hertfordshire County Council, Centre for Mental Health and Peer Power. We are writing up the question and answer session for the LGA's website.

64.3. Commissioned Centre for Mental Health to update the mental health case studies on wider determinants that we commissioned before Covid-19, to share the early learning from the last two months. Alongside the wealth of research that has been commissioned by PHE, universities and others into the mental health impacts, this will give us a local government owned narrative that can be further developed over the coming weeks and months.

64.4. Through our membership of various national groups, we continue to make the case for a locally-led approach to mental health and wellbeing recovery, and for statutory mental health services and public health services, to have the resources they need to meet demand that has built up during the pandemic, as well as new demand and vital preventative work. In addition to weekly PHE meetings on mental health and DHSC meetings on suicide prevention, we have also joined DHSC's mental health and psychosocial working group, which is coordinating national recovery planning.

64.5. Discussions continue with the voluntary sector about councils' role supporting the mental health and wellbeing needs of people at greater risk of mental health impacts, including Macmillan in relation to people living with cancer.

64.6. Submitted evidence to the Loneliness APPG that highlights how the pandemic has shown the importance of preventative work at scale.

64.7. Participated in a Centre for Ageing Better roundtable on community responses during Covid-19, which explored locally-led responses for older people, including to support mental wellbeing.

64.8. The Adult Social Care Hub has consulted with the Association of Directors of Adult Social Services mental health network to identify issues, good practice and recovery priorities (which are reflected in the priorities paper). The Hub continues to influence DHSC and NHSE/I guidance that is being developed to support statutory mental health services during Covid-19, in particular emergency changes to the Mental Health Act and proposed changes to guidance on councils' responsibilities for after-care services (section 117).

64.9. Supported last month's Mental Health Week and its theme of kindness through social media activity.

64.10. The LGA's workforce team continues to provide practical guidance to councils during this time, including a pack of wellbeing information to support the wellbeing of social care staff produced jointly with NHS England.

65. Much of the above is ongoing work and being taken forward in partnership with the Children and Young People's Board in recognition of the importance of mental health and wellbeing to the whole family. Going forward, we would welcome Members' steer on the emerging areas of focus for policy and practical support:

65.1. Continuing to help councils support communities' mental health and wellbeing for key recovery transitions, especially schools reopening and more people going back to work.

65.2. The role of councils supporting the mental wellbeing and mental health of people and their families, who continue to shield or who are in vulnerable circumstances while restrictions are eased for others, those who are no longer shielding or who have to self-isolate as a result of track and trace.

65.3. Embedding the positive developments in the delivery of mental health services during the pandemic, such as greater access to digital services, as part of increasing people's choice rather than the default option.

65.4. Preparing for the impact of future potential local restrictions on people's mental health and wellbeing and the public health messaging and support that will be required.

65.5. Continued focus on people more at risk of the mental health impacts, such as unpaid carers.

Implications for Wales

66. Health policy is a devolved responsibility of the Welsh Government.

Financial Implications

67. The LGA's work in relation to Covid-19 so far has been met from existing resources. There have of course been significant financial implications for councils in responding to Covid-19, and the LGA's Resources Board has been undertaking a considerable amount of work to understand what these are and that they are full funded by government.

68. While the LGA's response to COVID-19 has been met from existing resources there has been a significant increase in the LGA's general volume of work, particularly in dealing

with national media queries, and new areas of work have had to be developed across the Board's remit.

69. As a result nearly all of the team supporting the Board have since the last Board meeting dedicated all (or very nearly all) of their time to the Covid-19 response. This will mean that work on the Board's priorities agreed at the Away Day in October, has had to be scaled back and in many areas paused for the moment.

Next steps

70. Members are asked to note the LGA's work to date around Covid-19 of relevance to the Board and to comment on what further work the Board should be undertaking to support the local government sector.

71. Officers will incorporate members comments and views into LGA work on Covid-19 going forward.

Community Wellbeing Board

09 June 2020

HWB Covid-19 Reset: rapid research with HWBs

Purpose of report

For direction.

Summary

1. The LGA Care and Health Improvement Programme commissioned rapid research with health and wellbeing board (HWB) chairs to review the support offer for HWB chairs and political leaders.

2. The report attached as **Appendix A** will inform the development of the reset improvement offer and is also a valuable commentary on the issues for HWBs as they re-assert their system leadership role in the evolving situation.

3. The report makes recommendations for revising our support offer for HWBs.

Recommendation

That the suggestions in section 10 are considered by the Board on how the support offer needs to develop in the context of COVID-19.

Action

The support offer for HWBs is revised to reflect decisions of the Board

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HWB Covid-19 Reset: rapid research with HWBs

Background

1. The improvement support for Leading Healthier Places was paused in response to the COVID-19 pandemic. Moving into the reset phase, the offer needs to reposition the HWB for the current context and transfer the delivery methods to virtual channels.

2. In order to inform our review of the offer we undertook some rapid research with a sample of 15 Health and Wellbeing Board Chairs, with a good representation of political affiliation, geography and authority type, using an experienced associate and a structured interview process.

3. The attached report **Appendix A** informs the development of the improvement offer and is a valuable commentary on the evolving nature of the HWB as they review and re-assert their system leadership role.

4. We plan to repeat the exercise in a few months' time to add to the bank of intelligence but will also continue to connect virtually with HWB chairs, creating a dialogue and work in a more engaged and responsive way through the phases of COVID-19.

Issues

5. The report provides valuable insights into local experiences during the emergency, highlights key issues of concern, shares some examples of innovation and provides useful ideas on support needs that we can act upon.

6. The key issues that were highlighted for HWBs are:

    6.1 Strong and consistent themes both negative: PPE, care homes, testing, contact tracing, perceived disconnect between national and local government, exacerbated health inequalities, frustrations with data flow and positive: Community and volunteer response and step changes in processes like rapid reductions in DTOC.

    6.2 A widely shared opinion that the COVID-19 emergency has changed the future purpose of HWBs, and chairs are actively thinking about this and the opportunity this presents.

6.3 The support offer is welcome in helping HWB Chairs to influence the post-recovery system, and understanding where HWBs can add value at council, combined authority, STP/ICS and regional level.

6.4 An overwhelming acceptance of channel shift from face-to-face care and support to virtual services, though a recognition that not everyone has the same access to digital technology.

7. In the light of the findings of the review we recommend that the support offer needs to develop in the context of COVID-19 and the following immediate changes to the HWB support offer:

7.1 Develop and launch a simple HWB reset agenda tool that HWBs can use themselves: https://local.gov.uk/sites/default/files/documents/HWB%20Reset%20Offer%20.pdf (**Appendix B**)

7.2 Offer bespoke facilitated virtual support with the tool, ranging from individual telephone support to a virtual development workshop.

7.3 Keep in contact with HWBs that use the tool and ask to virtually observe the HWB.

7.4 Establish a webinar programme on key leadership topics, which commenced with COVID-19 and ethnicity on 2 June.

7.5 Develop our autumn Leadership Essentials programme into a virtual offer with a menu of live sessions, live action learning sets, individual personal leadership calls plus on-line distance learning and speaker videos to be viewed flexibly.

7.6 Continue to provide our political mentoring offer for HWB chairs virtually.

7.7 Share different leadership perspectives and learning through videos - 'Fireside Chats'.

7.8 Maintain a flexible approach through our bespoke offer to support HWB chairs during the different phases of COVID-19.

8. Board members are requested to provide their views and input to shape the support into the autumn and beyond.

Implications for Wales

9. The research is not relevant to the Welsh system and we are not funded to provide support to Wales.

Financial Implications

10. The improvement support is funded by DHSC through the CHIP programme

Next steps

11. Following this discussion, the support offer on Leading Healthier Places and specifically the leadership elements for members and HWBs will be progressed quickly to ensure there is an immediate and initial offer for members on how to re-set their HWB and assert their system leadership role in the new landscape.

12. Other elements of the support offer, around prevention and public health encompassing support for local outbreak planning and health inequalities will continue to be progressed with stakeholders.

HWB Chair touch base
Debrief and moving into the next phase of COVID-19

Context

Most Health and Wellbeing Boards (HWBs) have not met during the COVID-19 emergency, with the exception of a small number that had meetings planned in late March and elected to use the diary slot to brief HWB members about the emergency or, in at least one case, identified the need for an extraordinary HWB meeting to discuss an urgent COVID-19 related issue (e.g. Birmingham's special HWB session to look at BAME mortality).

The decision not to meet has been taken by HWB Chairs who have immediately understood that there was (in most circumstances) no locus for a HWB meeting during the emergency. The HWB is not an operational arm of place and most of the key HWB members (e.g. DPH, DASS, DCS, CCG AO, Acute CEO) were fully engaged in urgent and all-consuming frontline activity.

"I stood down the Health and Wellbeing Board straight away. It was obvious that the professionals [that support it] were going to be far too busy."

HWB Chair and Council Deputy Leader

Now that the immediate emergency phase is coming to an end, most HWB Chairs are revisiting the strategic purpose of the HWB with an eye to the important contribution that the HWB will make to the local system as we move towards recovery. They are striving to strike the appropriate balance between ensuring progress towards eliminating health inequality, the need to reassess needs and priorities in the light of the impact of the pandemic and being vigilant that any short-term activity does nothing to compromise readiness for ongoing containment of the virus.

In light of this, the Care and Health Improvement Programme commissioned a piece of work to make contact with a representative sample of HWB Chairs and understand the key issues facing them as a consequence of COVID-19, alongside their support needs going forward.

N.B. This document is being prepared at the end of May 2020 based on intelligence gathered during interviews conducted in mid-May. It is important to acknowledge that the report's content is heavily contextualised by the then contemporary understanding of the pandemic. Events are moving quickly and there are several subsequent issues of national import that are not captured in this report.

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Methodology

- 21 HWB Chairs were invited to participate in telephone interviews in the w/c 11th May 2020.
- 15 interviews were undertaken and, with the exception of one interview, where there was a competing time pressure, all of the interviews lasted about an hour.
- Within the 15 interviews there was a good representation of political affiliation, national geography and authority type.
- A semi-structured interview technique was adopted, using the questions in Appendix A.
- The interviews were conducted by an experienced Associate with extensive working knowledge of HWB areas.
- Extensive notes were taken, and Appendix B is an edited overview of the collated responses.

Overview

There was a high level of engagement from HWB Chairs. The exercise was well received as timely and there was a strong desire to think about the future of HWBs and the right activity to support HWBs going forward.

Strong and consistent themes emerged: PPE, care homes, community and volunteer response, testing, contact tracing, perceived disconnect between national and local government, exacerbated health inequalities, frustrations with data flow and rapid reductions in DTOC.

Every participant identified the community and volunteer response as one of the key positives to take forward into recovery.

In the main HWBs have not met since the crisis began, although key stakeholders have been played into other crisis response fora, but many HWB areas are now giving careful consideration to the need for and content of virtual meetings in the coming quarter.

Relationships with partners have largely played out well and there are examples of innovation and good practice both crafted in the heat of crisis and as a result of pre-existing arrangements playing out strongly under pressure. BCF arrangements were frequently cited as being helpful.

HWB Chairs are actively thinking about the role of the HWB going forward and many said that they found the interview a helpful space for them to articulate their thoughts to date.

Respondents expressed high satisfaction with the existing CHIP HWB Leadership offer and a desire for that offer to continue. There was an overwhelming acceptance of channel shift and an appetite to move forward in a socially distant world. There was an expectation that future working methods should be able replicate much of the beneficial content of previous approaches, including some windfall improvement e.g. much reduced national travelling.

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Common issues

The supply of PPE for residential care homes and domiciliary care. Respondents were typically critical of a perceived failure of a national government led activity and several were able to assert that by making rapid local procurement decisions, they were able to buy PPE in bulk and achieve acceptable supply level in their own area.

Mixed reviews about the centrally driven supplementary funding for care homes. Some believing it helpful, others worried that it might undermine previously well-managed markets. All concerned about whether or not this and other announced monies are recurrent or not and an expectation that the LGA will fiercely lobby to maximise LA finances.

A concern about the quality of the data coming from and timeliness of communication from national government and, in particular CQC and PHE.

Frustration with organisation availability of testing and contact tracing and trepidation as those responsibilities are being devolved to local authorities.

Widely held perception of transfer of care from A&E and other acute settings back into care homes, without individuals testing negative or, in most cases, being tested at all.

Very poor data about shielded individuals and a disconnect between the national volunteering initiative and local need.

Emerging evidence of disproportionate impact of Covid-19 on those communities already experiencing worse health inequality. A particular focus on the apparent increased morbidity and mortality rates amongst BAME communities.

A general view that national government has been implementing top down solutions and then handing over to local government. A view that local places are far better at planning and working as a system.

In places where partner relationships were previously felt to be good, the work involved in establishing those good relationships appears to have paid dividends during the emergency response. In places where partner relationships were previously felt to be not so good, relationship dynamics have sometimes been a barrier to an effective emergency response.

“Locally, I don’t think we’ve ever worked together so well or so closely”.

A passionate appreciation of the community volunteer response and a profound respect for the public service ethos of staff in the health and social care and wider public sector family.

Positive things to take forward

Many HWB Chairs reported step changes in processes (discharge, day-centre provision, food bank provision) that were catalysed by the emergency but, in their view, should now be embedded in the new normal.

“Why on earth would you want to go back to all the previous ways of working?”

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The emergence of a new cohort of community volunteers and a view that this phenomenon needs to be recognised, cherished and nurtured.

"How can we keep that level of engagement with a peace-time focus?"

New conditions are in place for wider public health issues such as air quality, climate change and physical activity. These need to be capitalised upon.

"What does a green and sustainable recovery look like?"

We need to adopt some of the changes that have been implemented in the way we govern e.g. virtual meetings and thereby open up the recovery to meaningful co-production.

Things to share and promote as good practice

Wigan established three squads of 8-10 staff with care experience, redeployed from other (mainly adult social care) Council roles to work with care homes experiencing difficulties, either through staff sickness absence or through elevated numbers of residents with COVID-19.

Wigan took over a local 88 bed hotel. 3 floors are dedicated to (46) rough sleepers, the other two as a step-down facility from the acute trust. The rehabilitation work with rough sleepers has been supported by voluntarily redeployed staff from the Council and CCG.

South Tyneside are funding their three main food banks at a rate of £5k per month, rising to £7k, and they only have to ask if there is more unmet need.

Birmingham convened a virtual meeting of the HWB to examine the reported phenomenon of COVID-19 having a disproportionate impact on BAME communities. They had early anecdotal evidence of a worrying pattern of deaths and intelligence that BAME communities were beginning not to trust the health service. In discussion with partners, including the acute trust CEO, it was agreed the HWB was the appropriate neutral place to have the discussion. They invited questions from the public and 210 people sent in 600 questions.

In Lincolnshire the local HealthWatch have been sending out a weekly questionnaire to a large cohort of people. They will report to the next HWB to help inform the assessment of the community response.

Wigan have seven Service Delivery Footprints in the borough, each covering a population base of 30-50K. The main anchor for these SDFs are GPs and schools. They are coterminous with their PCNs and Police, housing and council services are configuring their services to align with the SDF. The SDFs are a hub for local voluntary organisations and have been co-ordinating local volunteers and food bank activity. Wigan have had about 1,000 volunteers who came forward outside of the government volunteer recruitment process.

Devon County Council have seen over 1,400 applications to become carers through their existing 'Proud to Care' campaign. https://www.proudtocaredevon.org.uk

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Oxfordshire County Council made the proactive decision to procure £2 million worth of PPE and used it to ease shortages in the local care system. Norfolk County Council adopted a similar strategy with a £1.5 million procurement initiative.

Stockton-on-Tees initiated proactive testing of people being discharged from hospital into care homes. Early on they didn't allow discharge without a negative test. They appear to have the lowest prevalence of Covid-19 in care homes in their region.

In South Tyneside all Councillors were asked by the local (but not nationally affiliated) Age Concern to contact six vulnerable people in their own ward and maintain weekly contact with them.

Wider observations made by Associate conducting interviews

Local community responses appear to have mobilised much more quickly than nationally announced initiatives, creating frustration for community volunteers who have not been able to comprehend the reasons for delay.

Most, but not all, HWB Chairs were critical of the national government's co-ordination with local authorities. This sentiment came from all political affiliations. There were two (again politically diverse) HWB chairs who were more complimentary about the local and national government dynamic.

The experience of HWB Chairs who are also Leaders or Deputy Leaders has been different. They presented as more engaged in the emergency response and more able to inject health and wellbeing perspectives into the fast-changing landscape. Portfolio Holders have had variable experience, but some reported frustration about not being included or involved.

Places that enjoy co-terminosity with other important delivery footprints have reported a benefit arising from said co-terminosity. Places where the footprints are more complex have reported more frustrating experience, notably where the local NHS arrangements cover multiple local authority areas.

One Council reported that Domestic Violence referrals had not increased. This was counter-intuitive and therefore worrying to the HWB Chair. The same Chair expressed concerns about the low numbers of vulnerable children attending school and the potential hidden child protection concerns.

Arising recommendations

In anticipation of a theoretical second spike, to initiate an audit of community responses so that some of the lessons learned in the initial crisis can be recorded and designed out as the pandemic ebbs and flows.

A piece of rapid work is commissioned to inform the agenda planning for HWBs in the coming period. There is an opportunity to reset the purpose of HWBs, about which some have been struggling in recent months, and skilful agenda planning has the potential to accelerate development of HWBs an cement their place in a new normal.

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There is a need to provide technical commissioning support to ensure that specifications about PPE preparedness are adequate in the future.

Develop a detailed understanding of the processes that resulted in such rapid discharge arrangements and the overall reduction in DTOC statistics. Many HWB Chairs, whilst complimentary about what has been achieved in such a short time, expressed frustration that it's taken an emergency to make change possible.

The role of HWBs going forward

There was a widely shared opinion that the COVID-19 emergency has changed the future purpose of HWBs.

Views included:

- There's a big piece of work to do to make sure that we look at the changes we made in crisis and identify which changes might support our work in the future.
- We need to identify, protect and develop the social capital that has emerged.
- Big businesses will survive, local businesses will suffer. We need to be in the business of community wealth building using the Council as an anchor institution to promote local procurement, local supply chains, skills development and other economic opportunities. This is an opportunity to bring the Marmot principles to the fore of Council strategy.
- The role is changing dramatically. Wellbeing has come to the fore in the system setting.
- We need to review our membership and refresh a number of things.
- Get our heads around the changed nature of health and wellbeing and what people might require of the town that they live in to achieve health and wellbeing.
- Get going with developing the new JHWBS using the best possible process; an open and co-produced process.
- How do we involve the people [of our place]? More so than large meetings and advocacy through representative bodies?
- JSNA data will have changed as a consequence of missed visits, missed diagnosis, people not going to the GP.
- We need to revisit the existing JHWBS and ask is anything more or less important? Is there anything we need to add or subtract?
- We need to build on the new adopters of physical activity.
- Mental wellbeing is going to be an emerging issue.
- I intend to use my status as Chair to give congratulation and recognition.
- We need an informed, join debrief session, including an emotional debriefing.
- The HWB needs to co-ordinate the transition to recovery and the 'new normal'.
- I'm really glad that we've got providers on the HWB.

The CHIP leadership offer going forward

There was a strong appreciation of the CHIP leadership offer to date and a unanimous desire to see it continue in a changed world.

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"We don't want a return to business as usual. [Our place] was a low skill, low pay economy with probably the worse social mobility in the country. How do we harness all this new energy?"

Comments about content and context included:

- Help us to understand what Councils can do and what they can contribute to.
- Help Councils and Elected Members to influence the new post-recovery system.
- How do we capture and harness the energy and social capital?
- We need to continue to get developmental support, helping us to understand our strengths and where we can add value at Council, Combined Authority, STP and regional level.
- It's a real opportunity for CHIP to push for joint working. 'Why wouldn't you work like that?'. Health &Social Care needs to be a team where Social Care is no longer the poor relation.
- One of the strengths of the LGA is that it's in a pivotal position to share experiences and facilitate knowledge sharing.
- LGA should lead national discussion on the integration of services and the best use of the public £, including the integration of CCGs with LAs.
- As a Council Leader and HWB Chair I need to get on top of 'new' integration.
- Explaining and promoting policy to new Leaders and HWB Chairs has been helpful to date and needs to continue.

Comments about method of delivery included:

- I'm very comfortable with the channel shift that's happened and I'm willing to receive the support via Zoom and Teams.
- Would welcome bespoke support.
- Willing to be guinea pigs for a new bespoke refresh offer.
- The organisational landscape is changing around us rapidly. COVID-19 has brought added complexity to this. A refresh of our Peer Challenge might be helpful?
- It might be helpful to ask again about our support needs in a while.
- Prior to COVID-19 many of our agenda items were presentations; these can just as easily be done as webinars.
- We need to get the right people there at the right time.
- This is an opportunity for time-efficient networking with statistical neighbours using Zoom etc. as a tool.
- I'm comfortable to a point with using virtual approaches, but some of the difficult conversations need to happen face-to-face.

With grateful thanks to the following HWB Chairs who were all very generous with their time and ideas:

Cllr Bill Borrett – Norfolk County Council
Cllr Paulette Hamilton – Birmingham City Council
Cllr Keith Cunliffe – Wigan MBC
Cllr Ruth Dombey – LB of Sutton
Cllr Sue Wooley – Lincolnshire County Council
Cllr Ben Stokes – South Gloucestershire Council

Cllr Iain Malcolm – South Tyneside Council
Cllr Yvonne Davies – Sandwell MBC
Cllr Jim Andrews – Barnsley MBC
Cllr Graeme Hoskin – Reading Borough Council
Cllr Jim Beall – Stockton-on-Tees Borough Council
Cllr Carol Runciman – City of York Council
Cllr Rebecca Charlwood – Leeds City Council
Cllr Andrew Leadbetter – Devon County Council
Cllr Ian Hudspeth – Oxfordshire County Council

Report written by Steve Bedser, LGA Consultant

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Appendix A

Questions used in the interviews with HWB Chairs

HWB Chair touch base – debrief and moving into the next phase of COVID-19

1. How has it been for you as a political leader in care, health and wellbeing in your area? – What are your reflections? broad opening question
2. What issues has the pandemic raised for you?
3. What have you learnt?
4. Any positives to take forward into recovery?
5. Has your HWB met virtually?
6. How did your partner relationships play out?
7. Anything you want to promote and share with the sector/good practice?
8. What are your reflections on the role of the HWB going forward?
9. What kind of support should we be offering going forward? (our ideas are about virtual/webinars on sharing and debriefing, on line learning on things like health in all policies and health inequalities, remote/virtual Leadership Essentials on Leading Community health and wellbeing

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Appendix B

Summarised responses from HWB Chairs

1. How has it been for you?

The initial pressure was the supply of PPE for care homes and domiciliary care. As a Council we've added 500,000 items of PPE to supplement the regional and national supply.

We established three squads of 8-10 staff with care experience, redeployed from other (mainly adult social care) Council roles to work with care homes experiencing difficulties, either through staff sickness absence or through elevated numbers of residents with COVID-19.

We took over a local 88 bed hotel. 3 floors are dedicated to (46) rough sleepers, the other two as a step-down facility from the acute trust. The rehabilitation work with rough sleepers has been supported by redeployed staff from the Council and CCG.

'It feels like we're in the eye of a storm. How do we manoeuvre out?'

We've coped very well, in spite of everything.

I'm proudest that we've been able renegotiate our care contract with domiciliary care agencies to ensure that staff now receive a minimum of £10 per hour.

It's been frustrating. It took time for various bodies to get into gear. Local community groups were up and running two weeks before the Local Resilience Forum.

Local H&SC systems have worked well, particularly at a local level. National government response has been frustrating.

CQC approach to care homes has been a nightmare. The PPE need was obvious, but the guidance was to procure centrally. A localised system has been able to move much, much faster.

Testing and contact tracing has been a dog's breakfast and the expectation for LAs to be responsible has suddenly appeared out of nowhere.

The centre hasn't shared appropriate information. E.g. our DPH has been unable to get information on a local level on exactly where the outbreaks are.

We've been unable to transfer terminally ill people to a hospice setting. So we are inappropriately receiving palliative care in a care setting and there has been a shortage of end of life medication.

The new virtual set up has been weird.

Scary times. Scared about the financial situation.

There's been a really strong, proactive, over and above response from staff and the town.

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A deep frustration how the NHS sees this as an NHS crisis and not a public health crisis in the community. The controlled national approach has been clinical and not about care homes and people in their own homes.

I was surprised by the command control approach taken by the government and the amount of control taken away from local government.

It was very frustration initially; food parcels, food hubs, lists of people. Not helpful to the development of community relationships that we will need post-COVID.

I have two hats. Deputy Leader and Chair of the HWB. I have daily meetings with the Leader, MD and Head of Comms. I'm able to bring the HWB agenda to those daily discussions. And we've been having weekly updates with the DASS and DPH.

Resilience planning has been first rate and partners have been working together. There's been no friction and everyone is stepping up to the plate.

The response in [our place] has been exemplary. I can evidence that by the (lack of) interaction with residents. Even though I'm Leader, I've had no more than 15 emails from across the borough and these have been recycling and green waste enquiries, rather that urgent emails about key vulnerable people.

The government support scheme has been enormously helpful.

There's been a tension between my role as a ward councillor and as the portfolio holder.

Locally, I don't think we've ever worked together so well or so closely.

If partnership working hadn't been in place, it's not something that we could have invented overnight.

I don't think that central government understand what social services do.

It's been a stressful thing; I've not felt worse since the firefighters' strike.

It's been frustrating because I wanted to remain in the decision-making process and I've felt outside of all that.

I've been incredibly impressed by the DASS and DPH.

Care homes, PPE, discharge and testing have all been big local issues.

PHE is handing over responsibility to Las without funding it.

Discharge to assess, which bedevilled the NHS, was implemented within 48 hours; progress that ASC wanted to see.

Surprisingly very good; everyone's forgotten the barriers and are dealing with organisational interests, control and risk differently.

Care homes have been challenging re PPE. We've created our own stockpile and helped distribute it.

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The NHS have seen the importance of social care.

2. What issues has the pandemic raised?

‘Care homes; that’s been a real problem’.

The acute trust discharging care home residents taken to A&E with COVID-19 symptoms without testing them prior to discharge. Care homes didn’t want to receive residents back unless there was a negative test; the hospital would only test a patient pending admission, not pending discharge.

Health inequalities, especially arising from age, ethnicity and disability.

Financial issues concerning the protection of people in care homes.

National government implementing top down solutions and then handing over to local government when they get it wrong. Cities and regions are far better at planning and working as a system.

The information about shielded people came from government in dribs and drabs and food distribution was a real challenge as a result. In [our place] we had 14,000 shielded people.

The supply of PPE. Who should be wearing it? Who shouldn’t?

PPE within care settings. We’ve not placed enough emphasis on ensuring those running care homes provide PPE to support staff and residents. With hindsight it’s a commissioning detail issue.

Plans and strategies have been blown out of the water. The top down approach has been frustrating. I naively assumed that we would do this and implement strong testing and contact tracing, but it’s been impossible to do when it’s been directed by Whitehall. I’ve been frustrated by the failure to respond because a lot of it has been out of our hands. The result is a disaster.

It’s clear that 3 years ago there was a warning. I’m shocked by the lack of preparation in care homes. It’s unbelievably painful what’s going on in care homes.

It’s raised the profile of health protection and is giving recognition to issues around social care; putting them in public thinking.

It’s shown how important and effective parts of our service can be.

Appropriate PPE, infection control and testing in care homes and domiciliary care.

Making sure that we maintain effective communication with the public.

We are a coastal area; how do we stop people travelling to the sea?

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We've been learning as we go along. For instance, there was very low take up of free school meals (parents not comfortable with their children attending school to receive them) so we switched to local supermarket vouchers.

Independent food banks have not been helpful and have got in the way of the work of our three main food banks (which we are funding at a rate of £5k per month, rising to £7k, and they only have to ask if there is more unmet need).

Everything has switched to local, local, local and there's been an accelerated and greater use of technology.

There's been a major problem with people queuing at pharmacies.

It's highlighted the weaknesses of our mental health services and their ability to provide resilience support for children and adults.

I'm reminded about how the spirit created by the Olympic Gamesmakers fell apart when people went back to their normal lives; how do we make sure that doesn't happen again.

I've a fear of domestic violence. We had a bad record anyway, but lockdown has tipped that edge for people on the verge.

Care homes have felt vulnerable. PPE procurement; discharge; not being able to properly isolate; not testing.

The fragmented nature of the care system has highlighted how vulnerable and fragile the market is.

3. What have you learnt?

[In our place] data isn't where it should be. We've found it particularly difficult to get data from the CQC, PHE and the acute trusts.

You can never be over-prepared.

We had all our faith in China (supply chain).

Humans are very adaptable.

How resilient people are.

Good relationships within H&SC have paid dividends.

Decisions made on a local basis pay dividends. E.g. local discharge arrangements

How strong public service ethos is and how people are determined to serve.

How positive the community spirit has been.

Gob-smacked at the level of assistance in all of our communities.

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Don’t want to lose what we’ve been able to build in our communities; a community offer can better help.

We’ve been learning as we go along.

We have a bank of volunteers to help with mental health, wellbeing, shopping etc.

The initiative to put services into the community has been the right approach. Get services to people, not people to services.

Answering people quickly has been especially important.

Partnerships have to be built up very slowly over time.

We don’t have as strong a relationship with local businesses as we thought.

Skills and employment are going to be absolutely crucial going forward.

It’s increased how much I do trust the public health team; how much I value them.

Key leaders have emerged and demonstrated good communication.

There is a new opportunity through the HWB to capitalise on the tightness of the network.

The hospital discharge process has taken huge strides in weeks that would have taken 18 months.

Dramatic change is possible in a very short time if all of the partners are properly incentivised.

The NHS are still sending messages out from the centre that are entirely NHS-centric.

4. Any positives to take forward to the recovery?

The hospital was very efficient about discharging patients to clear the hospital. If we can clear the decks for the emergency, why is it so difficult to do in normal times? Are there behaviours and processes that have been implemented in the emergency that can endure?

People volunteering.

We have been able to identify and reach pockets of deprivation (mainly through food banks) that previously were reluctant to use Council services.

In the last few weeks we’ve been able to achieve a step change in the delivery of day centre services to people with learning and/or physical disabilities. This is something we’ve been trying to achieve for some time and the crisis created the right conditions for it to happen quickly.

Increased cycling.

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Protect the improved conditions for nursing and care staff. We're setting up a unit to dedicate officer time to fight for recurrent funding.

DTOC numbers are down to zero which shows what can be achieved when cost is not an issue.

Working relationships in a two-tier setting has ensured contact with local communities.

Local community responses have been phenomenal; literally hundreds of local groups delivering significant value (socially and financially). And the community response has been a new cohort of people who need to be cherished, nurtured and recognised. Notably IT literate, in their 30s, 40s and 50s.

Why on earth would you want to go back to all of the previous ways of working?

Value in the strength of community action.

The public health opportunities for air quality and the environment.

Change in the way we govern; virtual meetings.

Evidence that we can open up recovery to co-production.

It's disappointing that the government have positively dissuaded communities from getting involved. In spite of that the voluntary sector has been amazing.

Celebrate how brilliant the vast majority of people have been.

Police approach has been ham-fisted.

'Never let a good crisis go to waste'.

One of our five HWB strategy pointers is addressing an assets-based approach to tackle loneliness. We've worked hand in hand with the VCS (which we still give core funding to) focussed on food, medication and keeping an eye out for neighbours, moving onto listening, befriending and dog walking (for the shielding and self-isolating). We've engaged the community and voluntary sector (with no need to access the government volunteer scheme).

'How can we keep that level of engagement with a peace-time focus?'.

The importance of exercise and the wider determinants of health.

Community engagement. A new community spirit. Neighbours are talking to each other. New friendships are being formed.

New volunteers are coming forward; people we've not seen before.

Use of technology, including getting iPads into care homes.

Huge volunteering, including ex-professionals with skills that can be used. In [our place] we've had 4,000 volunteers and haven't been able to use them all; we need to use volunteers much better.

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What does a green, sustainable recovery look like?

Community spirit. Wrap it up and bottle it and haven't got to let it go.

Home working and the value of virtual meetings.

Previously the STP has paid lip service to primary care and the voluntary sector, but we'd like to keep the sense of common endeavour across the system. It will be an important job for the HWB. It will be really difficult.

We all work together very well in a crisis, so we don't want to go back.

5. Has your HWB met?

No, but we are talking about a meeting in early June, in person, with a limited number of people in attendance.

I've been in regular contact with the Chair of the CCG, the DASS +/- others, including GPs via Skype, Teams and 'phone.

Yes. We convened a virtual meeting of the HWB to examine the reported phenomena of COVID-19 having a disproportionate impact on BAME communities. We had early anecdotal evidence of a worrying pattern of deaths and intelligence that BAME communities were beginning not to trust the health service. In discussion with partners, including the acute trust CEO, it was agreed the HWB was the appropriate neutral place to have the discussion. We invited questions from the public and 210 people sent in 600 questions.

No. The support arrangements are led by public health and they haven't had any capacity. Weekly updates have been sent out and we've held weekly briefing calls with local MPs, the Police and public health. Cabinet is meeting via Teams.

No. Our March meeting was pulled and we're planning to meet virtually on 9th June. Our agenda will include the strength of the community response; are our priorities fit for purpose in a post-COVID world?; a report back from our local HealthWatch who have been sending out a weekly questionnaire to a large cohort of people; mental health issues for the elderly; coping with bereavement. Also, as of 1st April our 4 CCGs have become one and we need to use the HWB to maintain good working relationships with the new Chair and CEO.

We met on 14th March. I was shocked by the then prevailing public health advice that asymptomatic peopled and children were not transmitting coming top down from the public health hierarchy.

Our next meeting is due in July. If it happens, it will be a virtual meeting. We need virtual formal and informal meetings. HealthWatch and the VSC are feeling out of the loop.

No. We've been refreshing our HWB, which needs to continue.

We haven't even attempted to put together a HWB meeting yet; the key people are run ragged.

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We had a virtual meeting when the crisis started to set out our local position and we're due to have a conference call next week. It will be short and to the point. Agenda items will be how are you managing? What is the recovery plan for the new normal? What are the consequences of missed health interventions at the acute trust? Messaging around open for business including what GPs and dentists are doing.

In the meantime, we've been having conference calls with myself (Leader), the Deputy Leader and senior officers three times a week.

No. it's not been possible. The seniority of our HWB members means they've all been up to their ears. We're aiming for a virtual HWB in September.

No. We've yet to set one up but it will be a virtual meeting in June.

6. How have partner relationships played out?

Our relationships with the local acute trust are historically poor, but there has been a change of key personnel in the last six months. The situation has been improving and the experience of the emergency has probably strengthened relationships with the Chair and the CEO.

We have seven Service Delivery Footprints in the borough, each covering a population base of 30-50K. The main anchor for these SDFs are GPs and schools. They are coterminous with our PCNs and Police, housing and council services are configuring their services to align with the SDF. The SDFs are a hub for local voluntary organisations and have been co-ordinating local volunteers and food bank activity. We've had about 1,000 volunteers who came forward outside of the government volunteer recruitment process.

Relationships with the CCG and residential care are absolutely great. We have a significant amount of involvement in care homes and proactive work has improved relations over time. Every care home in the borough (currently) has adequate PPE.

A slight rankle is the pressure that Unison have put the PH under to sign their care pledge. The PH has refused to sign on the grounds that it asks for guarantees that can't reasonably be given.

Relationships have played out well, building on existing good relationships.

We are very fortunate. We might not always agree, but we do work well together. COVID has galvanised good relationships, particularly in care settings. The hiccup has been the free flow of information.

The SoS 10% uplift for care homes is going to cause us problems. Our market is well managed and this has created perverse incentives.

In some ways very positively.

It's been an expensive end to DTOC.

We were developing a new JHWBS; we need to get it back on track.

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Playing very well. Good partnership generally. Especially given the mindset of the acute provider. The emergency has helped foster co-operation.

HWB stakeholders are using a single voice to government saying why haven't you used our local expertise?

Partnership working is a feature of [our place] and it's paid dividends.

We've made good use of the BCF and been working in an integrated way. People haven't been working in silos.

Co-terminosity has helped greatly.

Relationships have been exemplary, including business and community partners.

One small niggle is the Police approach to ASB with there being a tendency to redirect complainants to the Council.

Relationships have very much improved with the CCG who were underfunded and always in deficit and looking at the bottom line.

We have a new community provider and the contract officially started in April. That's gone really well.

The STP process has developed relationships that have served us well. Relationships have been very important. We couldn't have achieved what we have without the relationships developed in recent times.

When you have strong partnership that works and a crisis comes along it's unhelpful that the NHS regulatory system pulls the NHS in a vertical way.

7. Anything that you want to share and promote as good practice?

Council procurement of PPE for distribution to care homes.

Rough sleeper provision and the use of staff who have agreed to voluntary deployment to provide support.

Service Delivery Footprints as a basis for our emergency community interventions.

The way in which we were able to bring the system together in a short period of time.

Our virtual HWB meeting to look at BAME mortality.

DTOC figures dramatically reduced.

Our support response to care homes.

We've seen over 1,400 applications to become carers through our existing 'Proud to Care' campaign. https://www.proudtocaredevon.org.uk

Our discharge arrangements have proven their worth in the emergency.

The new social capital.

The community response was strong, positive and rapid., as was the setup of the community hub.

Maintaining child protection.

A strong and focussed effort around PPE procurement.

The Birmingham BAME deaths investigation. (NB This was volunteered by a different authority).

Our local acute trust offered spare capacity to get key workers in the LA tested.

We've been able to work effectively with the voluntary sector because we've never abandoned them financially.

Our proactive testing of people being discharged from hospital into care homes. Early on we didn't allow discharge without a negative test. We appear to have the lowest prevalence of Covid-19 in care homes in our region.

BCF found us a way to act to facilitate early discharge and reduce hospital admissions; we already had the systems and resources in place e.g. 7 day working.

All Councillors were asked by our local (but not nationally affiliated) Age Concern to contact six vulnerable people in their own ward and maintain weekly contact with them.

I welcome the way in which the government sought to involve Council Leaders with the SoS. I'm confident that the LGA has been working flat out and I've been able to raise questions and concerns via the LGA leadership. I was pleased to get a call from the LGA Chair.

People are seeing their Councils in a new light. The public are seeing their local authority in a strong leadership role. We are the 4th emergency service.

Our Group made a donation from its own funds to buy 20 fire tablets for COVID-19 patients.

The role of Districts has been key and exceeded my expectations.

8. What are your reflections on the role of the HWB going forward?

There's a big piece of work to do to make sure that we look at the changes we made in crisis and identify which changes might support our work in the future.

We need to identify, protect and develop the social capital that has emerged.

Big businesses will survive, local businesses will suffer. We need to be in the business of community wealth building using the Council as an anchor institution to promote local procurement, local supply chains, skills development and other economic opportunities. This is an opportunity to bring the Marmot principles to the fore of Council strategy.

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The HWB has an important part to play in the delivery of adult social care, children's care and in addressing health inequalities.

It's been a steep learning curve. We need to focus on the positives as well as understanding what didn't go well.

The role is changing dramatically. Wellbeing has come to the fore in the system setting.

We need to review our membership and refresh a number of things.

Get our heads around the changed nature of health and wellbeing and what people might require of the town that they live in to achieve health and wellbeing.

Get going with developing the new JHWBS using the best possible process; an open and co-produced process.

How do we involve the people [of our place]? More so than large meetings and advocacy through representative bodies?

JSNA data will have changed as a consequence of missed visits, missed diagnosis, people not going to the GP.

I've been very impressed by the BCF pre-COVID. In the emergency BCF has been important in enabling us to move resources into community focussed settings.

We need to revisit the existing JHWBS and ask is anything more or less important? Is there anything we need to add or subtract?

We need to build on the new adopters of physical activity.

Mental wellbeing is going to be an emerging issue.

Use the post-COVID response as a platform for a review of the way forward and prevent us falling back to the way it was.

I intend to use my status as Chair to give congratulation and recognition.
We need an informed, join debrief session, including an emotional debriefing.

It seems likely that we are going to get operational responsibility for testing and contact tracing. This is a double-edged sword.

The HWB needs to co-ordinate the transition to recovery and the 'new normal'.

I'm really glad that we've got providers on the HWB.

We've really got to concentrate on mental health and health inequalities.

There's a real role for strong leadership from the HWB in involving the public in the health process. The CCG/STP/NHS struggle with this. We know that we can't do it in the way we've done it in the past. The HWB needs to give this legitimacy in a conversation with the public and sharpen up comms with the public.

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We need restratification; identifying vulnerable people and intervening earlier. We were very good at identifying those people during the emergency; why not before?

9. What kind of support should we be offering going forward?

Help us to understand what Councils can do and what they can contribute to.

Help Councils and Elected Members to influence the new post-recovery system.

How do we capture and harness the energy and social capital?

'We don't want a return to business as usual. [Our place] was a low skill, low pay economy with probably the worse social mobility in the country. How do we harness all this new energy?'.

We need to continue to get developmental support, helping us to understand our strengths and where we can add value at Council, Combined Authority, STP and regional level.

I'm very comfortable with the channel shift that's happened and I'm willing to receive the support via Zoom and Teams. X4

Would welcome bespoke support.

Willing to be guinea pigs for a new bespoke refresh offer.

It's a real opportunity for CHIP to push for joint working. 'Why wouldn't you work like that?'. H&SC needs to be a team where SC is no longer the poor relation.

The organisational landscape is changing around us rapidly. COVID has brought added complexity to this. A refresh of our Peer Challenge might be helpful?

It might be helpful to ask again about our support needs in a while.

Prior to COVID many of our agenda items were presentations; these can just as easily be done as webinars.

We need to get the right people there at the right time.

One of the strengths of the LGA is that it's in a pivotal position to share experiences and facilitate knowledge sharing.

This is an opportunity for time-efficient networking with statistical neighbours using Zoom etc. as a tool.

CHIP should lead national discussion on the integration of services and the best use of the public £, including the integration of CCGs with LAs.

As a Council Leader and HWB Chair I need to get on top of 'new' integration.

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Explaining and promoting policy to new Leaders and HWB Chairs has been helpful to date and needs to continue.

I'm comfortable to a point with using virtual approaches, but some of the difficult conversations need to happen face-to-face.

We need to bolster the role of public health about leading a wider conversation to join up the dots.

We need help to develop 3way HWB joint working in our STP area. External support will be very important.

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Local Government Association

Health and Wellbeing Boards reset tool

To support HWB chairs move into the next stage of COVID-19

Note: this guidance is correct as of 29 May 2020

Introduction

The Local Government Association (LGA) has developed this simple tool to support Health and Wellbeing Board (HWB) chairs/chairmen move into the next stage of COVID-19. Please adapt it to your local circumstances over the forthcoming period.

We can offer free bespoke support to your HWB in this ‘reset phase’ through virtual channels. This support is very flexible ranging from a telephone call to talk through issues and planning a meeting to a virtually facilitated workshop to help reset the HWB.

We welcome feedback on using this tool and would also like the opportunity to observe a HWB in action in this phase.

For further information and support please contact:
caroline.bosdet@local.gov.uk or katherine.mitchell@local.gov.uk

Model agenda for Health and Wellbeing Boards June-September 2020

Most Health and Wellbeing Boards have not met during the COVID-19 emergency, with the exception of a small number that had meetings planned in late March and elected to use the diary slot to brief HWB members about the emergency or, in at least one case, identified the need for an extraordinary HWB meeting to discuss an urgent COVID-19 related issue (eg Birmingham's special HWB session to look at Black, Asian and Minority Ethnic (BAME) mortality).

The decision not to meet has been taken by HWB chairs/chairmen who have immediately understood that there was (in most circumstances) no locus for a HWB meeting during the emergency. The HWB is not an operational arm of place and most of the key HWB members (eg directors of public health, directors of adult social services, directors of children's services, clinical commissioning group accountable officer, acute chief executive officer) were fully engaged in urgent and all-consuming frontline activity.

"I stood down the Health and Wellbeing Board straight away. It was obvious that the professionals [that support it] were going to be far too busy."
HWB chair and council deputy leader

Now that the immediate emergency phase is coming to an end, most HWB chairs/chairmen are revisiting the strategic purpose of the HWB with an eye to the important contribution that the HWB will make to the local system as we move towards recovery. They are striving to strike the appropriate balance between ensuring progress towards eliminating health inequality, the need to reassess needs and priorities in the light of the impact of the pandemic and being vigilant that any short-term activity does nothing to compromise readiness for ongoing containment of the virus.

In a recent set of interviews with HWB chairs/chairmen, most were contemplating holding virtual meetings in June, July or September and it is worth noting here that channel shift to online platforms appears to be universally accepted and, in some places, (eg large and rural) universally welcomed. HWB chairs/chairmen are thinking incredibly carefully about the content of the agenda for their first post-emergency HWB meeting and are determined to position their HWB meetings as a forward-looking event that reasserts the system leadership role that the legislation intended the HWB to fulfil.

"We know that we can't do this in the way that we've done it in the past. The Health and Wellbeing Board needs to give this legitimacy by having a conversation with the public. We need to sharpen up our communication with the public."
HWB chair in a two-tier setting

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Local Government Association company number 11177145 Improvement and Development Agency for Local Government company number 03675577

To that end and drawing upon the ideas of HWB chairs/chairmen from up and down the country, here is a suggested menu for the content of your next HWB meeting(s). We would be particularly pleased to hear from HWBs that find these suggestions useful and would welcome the opportunity to observe their meetings online. Equally, in this fast-moving world, please tell us if you think we have missed anything important.

This document is being prepared at the end of May 2020. It is important to acknowledge that the thinking that has gone into preparing it is heavily contextualised by contemporary understanding of the pandemic. HWBs need to ensure that their thinking and decision making takes account of a range of potential scenarios including a successful and early vaccine, a severe second spike and a long, tapered recovery.

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HWB reset agenda

1. Welcome from the chair/chairman

This might be the opportunity for a joint welcome from the vice- or co- chair(s)/ to underscore the positive partnership working that has taken place during the emergency.

2. One minute's silence in memory of those lost during the pandemic

It might be appropriate to highlight particular deaths here if there have been notable local issues.

3. Message of thanks

The chair/chairman might want to use the opportunity to use their status as a system leader to give a clear message of recognition and congratulation to all that have played their part in the local system response.

4. Understanding the new health and wellbeing landscape

A discussion to cover the following:

- an assessment of the local impact of COVID-19
- an analysis of how that impacts on the existing Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), including local priority actions
- outlining broad proposals for review and refresh of the JSNA and JHWS in the medium-term, including manageable and realistic timescales
- the financial environment going forward, anticipating challenging choices and decisions as the long-term consequences of the emergency response crystallise.

Local authorities and HWBs are uniquely placed to align and lead policy in a place setting, taking account of the wider health determinant impact of COVID-19. The HWB should be looking at wider impacts. Key areas for consideration could include:

- homelessness
- worklessness
- poverty
- food poverty
- domestic violence.

Furthermore, the HWB needs to look at forecasts of medium- and long-term impact and agree mechanisms for adjusting the JSNA and JHWS in a timely way as new evidence emerges over time. These should also be linked to an understanding of the wider context including, but not restricted to, the council's priorities for regeneration, community resilience, adult social care, children and young people etc.

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Finally, there needs to be an open and candid discussion about ongoing NHS reorganisation. HWBs need to be clearly sighted on all such proposals and be confident that they are able to effectively advocate for place in any decision making. In particular, careful thought needs to be given to any changes in the local implementation plans and structures for Clinical Commissioning Groups, Sustainability and Transformation Partnerships and Integrated Care Systems during, or as a result of, COVID-19.

5. What do we need a sharp focus on now?

(a) Including the identification of any urgent and immediate corrective action that needs to take place, mindful of lessons learned during the emergency period.

Which JHWS priorities are coming to the fore in this post-emergency phase? This could include:

- wellbeing
- mental health, especially at a low-level in the community
- physical activity, sustaining recent new adopters and encouraging those who have not been physically active during the lockdown, targeting those most at risk
- local health inequalities that have increased morbidity and mortality, notably amongst BAME communities. Examining what this means for targeting prevention, health promotion, care and support.

And how do we do this where there is an imperative for urgency and speed?

Additional emergent issues for immediate strategic oversight could include:

- ongoing support for care homes
- population health consequences of postponed NHS activity
- specific mental health needs of COVID-19 patients who required aggressive clinical intervention
- specific mental health needs of frontline workers.

(b) Public protection priorities

To be briefed about the next phase of public protection work, including the local system readiness for testing and contact tracing.

6. What positives have come out of the emergency?

What good practice needs to be recognised, cherished and sustained?

This could include:

- partnership
- agile use of the Better Care Fund
- hospital discharge arrangements
- community response and wider social capital
- co-production
- new approaches to governance through online platforms.

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And what needs improving?

- a no-blame approach to what didn't work – not just in terms of the local response but co-ordination between national and local organisations, consistency of information to communities etc
- in terms of future emergency responses, medium-term of addressing the long tail of COVID-19 and the long-term co-ordination of the health, wellbeing and care system.

7. What do we need to do next?

What are the medium- and longer-term actions we need to consider for our future agendas and related workstreams?

These might include:

- agenda items for future formal HWB meetings
- issues for intervening HWB development sessions
- have we still got the right people around the table?
- involvement of parishes and districts (where relevant)
- understanding how our place will influence strategy and decision-making in wider footprints
- mechanisms to be candidly aware of and vigilant about the relevance of our plans for the wider system
- revisit the HWB engagement and communications strategy with partners and the community.

8. Are there existing tools and frameworks that can help us?

HWBs might want to discuss framing the response in the context of pre-existing tools and frameworks. These could include:

- Health in All Policies
- Marmot 10 year review

Additionally, as HWBs grapple with the enormity of the task ahead, HWBs might want to contribute experience and intelligence to the national representational thinking of bodies such as the LGA, ADASS, ADPH, NHHCC particularly as they identify key policy and resource challenges.

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Update on other board business

Purpose of report

For information.

Summary

This report sets out other updates relevant to the Board, and not included elsewhere. Due to the focus of LGA work on responding to Covid-19 there are only a limited number of items in this report.

Recommendations

Members of the Community Wellbeing Board are asked to:

1. **Provide oral updates** on any other outside bodies / external meetings they may have attended on behalf of the Community Wellbeing Board since the last meeting; and

2. **Note** the updates contained in the report.

Action

As directed by members.

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Update on other board business

Annual Public Health Report 2020

1. The LGA's 2020 public health annual report published this month, shows how public health in local government, working closely with the NHS and other partners, continues to go from strength to strength. After eight years, public health is well embedded in the work of councils and the message that 'health is everyone's business' continues to gather pace. The annual report was written prior to the introduction of national measures to reduce the spread of coronavirus in the UK.https://www.local.gov.uk/public-health-transformation-seven-years-prevention-neighbourhood-place-and-system

Immunisations

2. We continue to work with NHS and PHE to highlight the risks of low uptake in routine childhood immunisations. We have called for high level communications to reassure parents regarding take up of vaccination and their safety whilst attending health settings. In conversations we have stressed the key role of local authorities in encouraging uptake in their communities and called for increased oversight of Directors of Public Health in local immunisation strategies.

Health devolution

3. On 28 May, Cllr Ian Hudspeth gave evidence to the independent commission on health and social care devolution, supported by Devo Connect. The commission is co-chaired by Rt Hon Andy Burnham, former Secretary of State for Health and Mayor of Greater Manchester and Rt Hon Sir Norman Lamb, former Minister for Care and Support. Members of the Commission are drawn from national health and care leaders, and a number of former Secretaries of State for Health and Ministers from across the political spectrum, including: Rt Hon Alistair Burt, former Minister for Care and Support ; Rt Hon Stephen Dorrell, former Secretary of State for Health; Phil Hope, former Minister of State for Care Services.

Note of last Community Wellbeing Board meeting

Title:	Community Wellbeing Board
Date:	Thursday 26 March 2020
Venue:	Virtual meeting

Attendance
An attendance list is attached as **Appendix A** to this note

Item	Decisions and actions	Action

1 Welcome, apologies and declarations of interest

There were no apologies and no declarations of interest.

2 Update from the Office for Veterans' Affairs (OVA) on the Armed Forces Covenant

The Chairman welcomed Damian Paterson, Deputy Director of the OVA, to the meeting and invited him to give his presentation.

Damian thanked the Board for the opportunity to come and speak to them and he began by thanking local councils for everything they did to support the armed forces community, and veterans in particular. He said that they were a key partner and the OVA would be looking to work with them closely in the future.

Damian explained that the OVA was a new unit in the Cabinet Office set up in October 2019 to improve the coordination of veteran services and advice. He said that moving the oversight of veterans' affairs from the Ministry of Defence to the Cabinet Office would enable a more co-ordinated approach to the support veterans and their families needed, drawing on all parts of Government to ensure improved delivery and support.

Damian said that the OVA had taken on responsibility for the UK Government's Strategy for our Veterans and its associated Action Plan, published in January 2020 and had been tasked by the Prime Minister to tackle two specific challenges – namely, changing perceptions about veterans in society and tackling negative stereotypes; and ensuring that veterans and their families know where to find information to support them should they need it. He added that the overall aim was to not just to ensure that veterans were not disadvantaged in society compared to other citizens but to consciously provide them with positive advantages.

Damian went on to talk about the OVA's work programme as set out in the report and said that unfortunately, Covid-19 would undoubtedly have an impact on the timescales for its delivery. However, he did say that the

OVA were still hoping to be able to launch the veterans' railcard on Armistice Day in November 2020.

Damian finished by asking Board members to consider how local government could best work with the OVA to ensure the best possible outcome for veterans and to address some of the specific questions in his report.

Following Damian's introduction, there followed a discussion during which the following points were raised:

- It was considered that there were definitely challenges for councils around supporting veterans but good practice was out there and needed to be shared more widely. Having the link with the MoD in Johnny Mercer MP was considered important.
- There were many CVS groups working with the armed forces and veterans providing valuable support and this would benefit from greater central coordination.
- OVA had an opportunity to form much clearer partnerships with the voluntary sector, which would improve awareness of the local offer and help to identify gaps in support that could be plugged.
- It was considered that transition remained a key issue. Whilst the vast majority of veterans did not experience significant problems, a minority would need coordinated support from a variety of partners. There was an opportunity to get better at predicting which veterans will have the greatest needs. The work of the Defence Transition Service was noted. There was important work going on for example around giving veterans priority for social housing and the MHCLG was currently evaluating how effective this had been.
- Could the LGA arrange regional meetings of Veterans' Champions to help share best practice?
- There was considered to be an opportunity for more linkages to be made with local authority Health & Wellbeing Boards.
- Most councils had veterans' champions, but they were not always given the necessary profile and status to get things done.
- Could a live database be set up with the LGA and OVA in order to better disseminate information, coordination and best practice?
- It was considered important to better understand local veteran communities so that support could be targeted – for example, places with Gurkha communities.
- Lead members asked for information about which areas

they had settled in? Damian said he would circulate a map with this information. He added that the 2021 census would include a question on veterans which should help to give a better picture of their locations and needs.

- Birmingham set up a sub-group of its HWB to look at veterans' needs which reported back into the main HWB. This was considered to be a good model for integrating local and national issues.

- There was a welcome for the OVA's intention to move from not disadvantaging veterans over the rest of society to positively 'advantaging' them.

Decision

Members of the Community Wellbeing Board noted the update.

3 COVID-19

The Chairman invited Mark Norris, Principal Policy Adviser, to introduce the update.

Mark highlighted 3 key areas that the Government expected councils to work on:

- Supporting the NHS in preparing for the expected increase in Covid-19 victims needing hospital treatment. This would involve freeing up 30,000 beds in English hospitals to accommodate Covid-19 patients.

- Supporting the 1.5 million most at risk people identified by Government who needed to self-isolate for 12 weeks. Councils should now have received guidance from MHCLG on this. Delivery of medicines would be taken care of by the NHS and community pharmacies. Out of the 1.5 million, there were likely to be 300,000 who would not be able to rely on friends, family or online deliveries to get food. These people would get parcels delivered to their doors under a national contract with a food wholesaler. 132 hubs had been set up to hold food and deliver to those who would run short of food before doorstep deliveries could be made. Physical space would be needed to store this food. Supermarkets were not in a position to ramp up the number of home deliveries at this stage. In the longer-term DEFRA was exploring greater use of 'click and collect', possibly through an App buddying people up with a volunteer to collect on their behalf. Homeless people would also need to be helped with accommodation and support services.

- Supporting local businesses and the local economy.

Paul Ogden, Senior Adviser, updated Members on the public health situation:

- 100,000 people now tested, 9,529 tested positive – likely to pass 10,000 today (26/3/20). 459 deaths so far – likely to pass

500 today.

- London had 4 times more cases than any other region.
- There were likely to be many more cases as people were not being routinely tested in the community.
- Mortality rate was not accurately known and depended on population characteristics of individual countries but likely to be between 1-2 per cent in UK.
- 81 per cent of those infected so far had mild symptoms. 14 per cent had more serious symptoms and 5 per cent became critically ill.
- 70 per cent of cases were men, and smokers were significantly more vulnerable.
- Now in 'suppression' phase of Government's 4 phase strategy – lockdown aimed at flattening the curve of cases and taking strain off NHS. The success of this would not be seen for 2-3 weeks.
- The peak of the epidemic was predicted to be mid-June and the outbreak could last 18 months in total. This may require 'adaptive suppression' – i.e. periodically lifting and then re-imposing lockdown restrictions.

Alyson Morley, Senior Adviser, updated Members on volunteering and stated that there were 2 specific groups of volunteers:

- The national appeal for 'help your NHS' volunteers to register with the NHS Volunteer Responders scheme had now got over 400,000 people signed up. It should have been made clear when launching the appeal that it was for health *and* social care. LGA was now working with officials to try and establish a system to connect some of these volunteers to the local hubs and LRFs that needed them and to highlight that the scheme was also for adult social care.
- Appeal for qualified NHS and adult social care staff who had left the sector to return to the profession temporarily. The Coronavirus Bill provided for these people to take limited periods of unpaid leave from their current jobs to undertake health and social care roles voluntarily and to be reimbursed by Government. The LGA was working with the DHSC to set up a process of certifying and checking these people to make sure they were fit and proper to do the job being asked of them.
- LGA officers were also working with DHSC, providers and the voluntary and community sector to develop guidance which distinguished between care and support tasks that could be done with minimal training and those that could only be done by fully-trained adult social care professionals.

In the discussion that ensued, the following questions and comments were raised:

- Although money was starting to come into councils from

Government this wouldn't be enough. Could councils apply for more funding? The Chairman said that there was a commitment from the Prime Minister and the Secretary of State that funding would be made available. He said that councils should spend what they needed and Government would sort out the funding later. He suggested contacting MHCLG if councils were in this position.

- More testing was needed and fast. The Chairman said that testing was being ramped up every day.
- Was training for people to use equipment, such as ventilators, being provided? Alyson said that this would normally be down to councils but with such large numbers needing refresher training, help may need to be brought in, for example through organisations such as 'Skills for Care'.
- What could the LGA do to retain volunteers and their good will once the crisis was over? Alyson said that this would be a challenge for councils and their VCS partners. Sustaining the initial wave of enthusiasm over what may be a long period would be difficult. Important that there was a swift response to give volunteers meaningful tasks or they would drift away.
- Slough had almost run out of PPE. The Chairman said that Clinical Commissioning Groups and Local Resilience Forums should be identifying where hotspots were and getting PPE in.
- In Bristol it was reported that residential and nursing homes were not taking in new clients due to threat of infection which could cause serious problems. The Chairman said that the Government was aware of this.
- What were the legal/HR implications for workers taking advantage of the 'furlough' scheme whereby Government covers 80 per cent of salary? The Chairman said that the LGA had pressed for more detail on this and also on what support was available for the self-employed.
- Government needed to be issuing clearer information. The Chairman said that the Government recognised difficulties in communication in such a fast-changing environment and were trying to improve.
- Apart from the 1.5 million people identified by Government, there was another group of people who were also very vulnerable and who were in danger of slipping through the net. How could they be helped? Alyson said that this was where very local neighbourhood and mutual aid groups were vital. However, there were concerns that a small minority of people may exploit the situation by targeting isolated and lonely people. Alyson said that officers would work with DHSC and the community and voluntary sector to ensure that the balance between safeguarding and supporting the vulnerable was maintained.
- The biggest stumbling block for local mutual aid groups was

considered to be logistical issues with money, as many elderly people only used cash and cheques. Could the LGA press the Government to get supermarkets to be more flexible? Alyson said that there was no simple answer to this and that there were also concerns around possible financial exploitation of vulnerable people. It was suggested that money could be funnelled through established organisations such as Age UK? Mark agreed to refer this issue on to the LGA's coronavirus enquiry hub and respond as soon as possible.

- What could the LGA do to ensure that councillors got accurate and trustworthy information that they could then cascade to residents and community groups? The Chairman said that the LGA's Chairman's and Chief Executive's briefings were extremely useful. Could something similar be produced for public consumption for councillors to cascade? Mark said that there could be an issue with staff capacity in producing an entirely new briefing but adapting the Chairman's briefing could be looked at. He agreed to take it back to fellow officers.

- Now was the time when politicians should see what a vital role ASC plays – could the LGA take advantage of this and collate some of the good practice that was happening to help argue the case for funding in the future? The Chairman agreed that ASC was still not getting the national plaudits that the NHS was currently receiving.

Laura Caton, Senior Adviser, said that mental health and suicide prevention were going to be key issues moving forward as people continued to self-isolate and have limited social contact. There was an urgent need to determine what role councils could play.

Matthew Hibberd, Senior Adviser reported that he had just received communication about developing Government thinking around whether there needed to be a temporary national fee rate for care providers to ensure they had the resources they needed in the current crisis. Matthew said that there were a range of risks associated with this and there were different options for providing assurance to providers. He said that the emerging preference from LGA/ADASS officers was to keep local determination but to have an uplift to account for the new and additional pressures providers were facing. Lead members agreed with this option in principle but asked to see the paper before making a final decision. Matthew said he would circulate this but would need a decision by the weekend.

Decision

Members of the Community Wellbeing Board noted the update.

Actions

- Alyson Morley to report issue of cash and inability of some residents to make card payments for food on the LGA Covid-19

log.

- Mark Norris/Alyson Morley to investigate practicality of producing an information bulletin for members to circulate to local community groups.
- Matthew Hibberd to circulate paper on care providers fee rate to Lead Members and Lead Members to make comments by the weekend.

4 Confidential note from the previous meeting

The confidential minutes of the previous meeting held on 29 January were agreed.

5 Update on Housing and Social Care

Lead members agreed to have a separate meeting in a few weeks to discuss items 5 and 6 which they couldn't do justice to in the time available.

Ahead of the follow-on meeting, Alyson reported that the DHSC's 'every day is different' scheme had been relaunched in light of the Covid-19 crisis. In the same vein, Naomi Cooke said that all the unsuccessful applicants for the LGA's Return to Social Work Programme had been contacted to offer training and recruitment with a view to them being employed in the sector.

Decision

Lead members agreed to have a separate meeting to discuss items 5 and 6.

Action

Officers to arrange additional meeting date.

6 Workforce Team activity around the social care workforce

7 Leading Healthier Places 2020/21

Decision

Members of the Community Wellbeing Board noted the update.

8 Any other business

No other business was raised.

Appendix A -Attendance

Position/Role	Councillor	Authority
Chairman	Cllr Ian Hudspeth	Oxfordshire County Council
Vice-Chair	Cllr Paulette Hamilton	Birmingham City Council
Deputy-chair	Cllr Richard Kemp CBE	Liverpool City Council
Deputy-chair	Cllr Claire Wright	Devon County Council
In Attendance	Damian Paterson (for Item 2)	OVA
LGA Officers	Mark Norris Alyson Morley Paul Ogden Laura Caton Matthew Hibberd Naomi Cooke Jonathan Bryant	