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.

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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.

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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.