WARRINGTON
Borough Council

To: **Members of the Warrington Health and Wellbeing Board**

Professor Steven Broomhead
Chief Executive

Town Hall
Sankey Street
Warrington
WA1 1UH

2 September 2020

Meeting of the Warrington Health and Wellbeing Board, Thursday, 10 September 2020 at 1.30pm

Venue - This meeting will take place remotely in accordance with the Coronavirus Act 2020 - Section 78

Members of the public can view this meeting by visiting www.warrington.gov.uk/committees

Agenda prepared by Jennie Cordwell, Senior Democratic Services Officer
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AGENDA

Part 1

Items during the consideration of which the meeting is expected to be open to members of the public (including the press) subject to any statutory right of exclusion.

1. Apologies

To receive any apologies for absence.

2. Code of Conduct - Declarations of Interest
Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012

Members are reminded of their responsibility to declare any disclosable pecuniary or non-pecuniary interest which they have in any item of business on the agenda no later than when the item is reached.

3. Minutes **5 - 18**

To confirm the minutes of the meeting of the Board held on 16 July 2020 as a correct record.

4. **Introduction to Thara Raj - Director of Public Health**

Verbal presentation

5. **Updates from Reference Groups**

(A) **Integrated Commissioning and Transformation Board - Update**

Verbal report of Catherine Jones, Director of Adult Services, Warrington Borough Council.

(B) **(i) Warrington Together – Delivery Reimagined, Team Reflections and suggestions** **19 – 30**

Report of Dr Andy Davies, SRO Warrington Place

(**ii) Warrington Together - Cheshire and Merseyside's Covid 19 System Plan Phase 3 Response** **31 - 46**

Report of Simon Kenton, Programme Director, Warrington Together

6. **Living Well H&WB Strategy thematic update** **47 - 56**

Report of Senior Health Improvement Specialist, Families and Wellbeing

7. **COVID 19 Situational Awareness** **57 - 66**

Update from Thara Raj – Director of Public Health

8. **Public Accounts Committee NHS/Social Care – Readying the NHS and Social Care for the Covid 19 Peak** **67 - 90**

Discussion Item – Lead by Chairman / Simon Kenton

9. **Reset Not Restart - Adult Social Care The Future Since Covid** **91 - 92**

Presentation by Cath Jones – Director Adult Social Care

10. **NHS 111 – First Programme North West Implementation** **93 - 96**

Report of Chief Executive, Warrington and Halton Hospitals NHS Trust

11. **Work Programme** **97 - 102**

To keep under review the Board's Work Programme.

12. **Future Meetings**

All on a Thursday at 1.30pm:

12 November 2020
21 January 2021
25 March 2021

Part 2

Nil.

Membership:

Chairman: Professor Steven Broomhead

Warrington Borough Council
Leader of WBC
Deputy Leader and Cabinet Member, Corporate Resources
Cabinet Member, Statutory Health and Adult Social Care
Cabinet Member, Housing, Public Health and Well-being
Cabinet Member, Children's Services
Opposition Spokesperson
Amanda Amesbury, Director, Children's Social Care
Cath Jones, Director, Adult Social Care
Paula Worthington, Director, Education and Early Help
Thara Raj, Director of Public Health

Standing Invitee (Not Member of the Board)
Cllr P Wright, Chair of Health Scrutiny Committee /
Cllr P Warburton, Deputy Chair of Health Scrutiny Committee

NHS Warrington Clinical Commissioning Group
Dr Andrew Davies, Chief Clinical Officer, NHS Warrington Clinical Commissioning Group
Ian Watson, Chair, NHS Warrington Clinical Commissioning Group
David Cooper, Chief Finance Officer, NHS Warrington Clinical Commissioning Group
Carl Marsh, Chief Commissioner, NHS Warrington Clinical Commissioning Group

Joint Appointments
Simon Kenton, Programme Director, Warrington Together

Other Representatives
Ruth Marie Dales, Chair, Healthwatch Warrington
Steve Cullen, Third Sector Network Hub
John McLuckie, Chief Financial Officer, NW Boroughs Healthcare NHS Trust
Colin Scales, Chief Executive, Bridgewater Community Healthcare NHS Trust
Simon Constable, Chief Executive, Warrington and Halton Hospitals NHS Trust
Vacancy, NHS England, Merseyside, Cheshire, Warrington and Wirral, Area Team
Richard Strachan, Independent Chair Warrington Safeguarding Children Board
David Cummins/Dave Thompson, Warrington Health and Social Care Voluntary sector alliance
Vacancy - Private Care Sector
Gill Healey, Group Head of Social Investment, Torus – Housing
Tim Long, Principal, Bridgewater High School - Education
Mike Larking – Cheshire Fire and Rescue
David Keane, Police and Crime Commissioner
Supt Martin Cleworth, Cheshire Constabulary
Emma Hutchinson, Culture Warrington/LiveWire
Dr Dan Bunstone, Clinical Directors, PCNs

WARRINGTON HEALTH AND WELLBEING BOARD
16 July 2020

Present:-

Professor S Broomhead (Chair), Councillor R Bowden, Councillor C Mitchell, Councillor R Knowles, Councillor M Smith, Councillor I Marks, A Amesbury, C Jones, E O'Meara, C Marsh, S Kenton, R M Dales, S Cullen, S Constable, G Healey, M Larking, Supt M Cleworth, E Hutchinson, Dr D Bunstone, L Carter, L Gardner

Also in Attendance:
Cllr P Warburton, T Smith

HWB71 Apologies

Apologies for absence were received from Cllr P Wright, Dr Davies, Dr Watson, C Scales, P Worthington and D Cummins.

HWB72 Declarations of Interest

There were no declarations of interest submitted at this meeting.

HWB73 Minutes

Resolved – That the minutes of the meeting of the Board held on 23 January 2020 be received as a correct record and be signed by the Chairman.

HWB74 Updates from Reference Groups

(A) **Integrated Commissioning and Transformation Board**

The Board received a report from C Jones, Director of Adult Services that provided an update on the work of the Integrated Commissioning Board. It was reported that since the Covid19 pandemic struck in February 2020, most business as usual work was suspended whilst organisations focused on service readiness for managing the outbreak across the Borough. The focus of the ICTB for the past 3 – 4 months has been

(1) Keeping the most vulnerable people safe and well at home in the community;
(2) Keeping flow through the hospital and acute services so those that are the most unwell can be cared for.

The peak infection and associated Covid death rate in the Community and Care Homes occurred in April 2020, with a continuing downward trajectory in the community with only 1 care home now reporting new cases.

With monies becoming available from Central Government, the Local Authority and CCG worked together to ensure a joined up approach to prioritising and allocation of

financial resources to meet main objectives. To date, around £4 million aligned investments have been made including enhanced temporary bed capacity at both a local and regional level, additional staffing, equipment and an ambulance service to support rapid community responses.

The Board were informed that the ICTB group was convened for Covid specific oversight to ensure key decision making and plans were aligned with a robust audit trail. The group met fortnightly from 22nd April due to the speed at which joint local decision making was required during the pandemic. All proposals funded by the aligned budgets were endorsed by ICTB and then submitted to the CCG management team for approval. It was noted that Finance Pre meetings had proved to be a useful forum and it was agreed that these would widened to include the Better Care Fund Steering Group to enable linking the management of BCF change programme focussed activity with the related Covid issues and more detailed financial discussions.

The following investments were endorsed and subsequently approved by the CCG IMT as part of the governance arrangements:

- Transitional Beds to support 'out of hospital' flow
- Temporary additional Intermediate Care Beds during Padgate closure
- Augmented Nursing Care Covid + beds
- Contingency payments to Care Homes, Domiciliary Care and Supported accommodation
- Additional staffing associated with Covid management
- Additional equipment requirements for support at home
- Private ambulance supporting Care Call Responses.

The ICTB also had oversight of the development of the Warrington Care Home Support Plan submitted to government at the end of May and the subsequent allocation of the £2.5m Infection Control Monies.

It was highlighted to the Board that as the pandemic stabilises, ICTB are now concentrating on 'Reset' and Phase 2 Covid planning. The focus going forward will be on the priority investment areas in the Better Care Fund that were developed during 2019-2020 – (a) Integrated Rapid Community Response Service, (b) redesign of Intermediate Tier Services both community and bed based, and the (c) the Enhanced Reablement Service. It has been increasingly recognised that the areas of work above have close synergy with the Frailty Programme of work led by the CCG and for example the Rapid Community Response developments and Integrated Community Teams. Further to this, there is now an opportunity and coalition of thinking amongst partners to develop an Integrated Work Stream with a wider system focus.

(B) **Regular Report of Provider Alliance and Warrington Together**

The Board received a report that provided an update on the progress of the Warrington Together programme, particularly in relation to collaborative working

amongst providers of health and social care.

Since lockdown in March 2020 due to COVID 19, the members of the Warrington Together Programme Office diverted their energies to meeting the system challenges faced during the pandemic. These included sourcing extra capacity and preparing for reset and recovery across mid-Merseyside; hospital discharge & rapid response; and staff welfare.

During the lockdown period, the system has worked effectively in collaboration. Staff in organisations have relegated organisational priorities to promote system working. This has been achieved by virtual conference meetings which concentrate on relatively few operational actions which are executed. There is a need to use recent experiences not to return to business as usual but to Build Back Better.

With the return to normal working practice, there is a need to embed and retain system working by default, align and establish system wide Programme Office resources, retain the excellent work undertaken by our Voluntary and Community Sectors, renew project working and the Enabling programmes of work under the Warrington Together ethos and banner.

It was reported that going forward, both the Board and Warrington Together will have to consider the impact of any forecasted legislation directing formal integration across geographical footprints, and the interrelationships between our place based programme, the Health Care Partnership and mid Mersey place programmes progressing in Halton and St Helens. A workshop is planned for the end of July, where stakeholders can initially consider these challenges with a focus to rationalise the complex architecture and governance arrangements, relating to Local Government and the NHS, established during the pandemic.

Resolved, that the Health and Wellbeing Board

(1) Noted the content of the reports
(2) Noted the progress of the Warrington Together Programme
(3) Endorsed the acceleration of integration and retention of the collaborative working ethos embodied by the Warrington Together Programme.

HWB75 Presentation – Health Inequalities and the impact of Covid 19

The Board received a presentation from the Director Public Health that detailed the findings of a piece of research commissioned by Directors' of Public Health from Liverpool John Moore's University on the impact of COVID 19 on health inequalities.

Resolved, that the Health and Wellbeing Board

(1) Noted the contents of the presentation
(2) Agreed to revisit the Health and Wellbeing Strategy to update with regards to findings from system wide key actions required from lessons learnt from working through Covid 19 pandemic. Update to be provided at November 2020 meeting.

HWB76 Public Health England Report on the impact of Covid 19 on BAME Communities

The Board received a report from the Director of Public Health, which provided an overview of the findings from Public Health England on the impact of COVID 19 on BAME groups and recommended key actions.

In July 2020 Public Health England published 'Beyond the Data: Understanding the impact of COVID-19 on BAME groups'. This demonstrated there is clear evidence that COVID-19 does not affect all population groups equally. It highlighted that many analyses have shown that older age, ethnicity, male sex and geographical area, for example, are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death. This work was commissioned by the Chief Medical Officer for England to understand the extent that ethnicity impacts upon risk and outcomes.

The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. Genetics were not included in the scope of the review.

This review found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all-cause mortality rates are lower in Asian and Black ethnic groups.

Comparing to previous years, all-cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when

comorbidities are included, the difference in risk of death between ethnic groups among hospitalised patients is greatly reduced.

As a result of this research Warrington's Health and Wellbeing Board was recommended to take forward 7 key actions outlined below;

(1) Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
(2) Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
(3) Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
(4) Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.
(5) Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
(6) Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
(7) Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

Resolved, that the Health and Wellbeing Board

(a) Noted the content of the report
(b) Endorsed the 7 recommendations as detailed in the report.

HWB77 <u>Overview of Covid 19 in Warrington including the Health Protection Board and the local Covid 19 Outbreak Hub and the Cheshire and Merseyside Outbreak Hub</u>

The Board received a report from the Director of Public Health, which provided a briefing of Warrington's position on COVID 19 Complex Outbreak Management and the associated governance.

On the 22nd of May the Government requested individual Covid-19 Outbreak Plans for complex settings be developed by all councils with funding to be provided; the deadline for these was June 30th. These were to be supported by a local Outbreak Office with mutual aid from Cheshire authorities which was stood up on the 6th July 2020.

It was explained to the Board that a complex setting is a setting outside of the health sector and includes:

1. Complex and high risk settings such as care homes and schools,
2. Complex cohorts such as those who are rough sleepers, faith communities, asylum seekers,
3. Complex individuals and households including our defined vulnerable and shielded cohorts Mental Illness; Victims of Domestic Abuse; complex social-economic circumstances.

Complex Outbreak Plans have been developed that meet the requirements and include;

- Outbreak Prevention Plan: Top 10 Ways to Prevent An Outbreak.
- Outbreak Plan for Educational Settings: Early Years Settings, Primary Schools, Secondary Schools, Further Education establishments.
- Outbreak Plan for Care Homes.
- Outbreak Plan for other complex settings including: workplaces, homeless shelters, prisons.

These plans have been published on the Councils website.

To ensure Warrington's outbreak plans were robust they were tested via two emergency planning exercises:

- An Educational setting scenario on 26th June 2020
- A workplace scenario on July 17th 2020

Training programmes will be run so staff in complex settings know how to prevent an outbreak and what to do if one occurs.

Outbreaks in Warrington will be overseen by a Local Outbreak Board which will be responsible for communication and engagement with the public and overseeing of any potential or real lockdowns that may be required. The Outbreak Board is responsible to the Health and Wellbeing Board and Warrington Borough Council's Cabinet.

The Outbreak Board will be supported by the Health Protection Board which includes all necessary expertise to advise on outbreak management and is chaired by the Director of Public Health.

The Board were advised that the Local Outbreak Office for Warrington is now up and running and has started to receive complex cases. It is currently staffed in house and these positions will be augmented by external appointments. The office will act as a central point of contact to the Cheshire Outbreak Hub and to the National Contact, Test and Trace and Engage facility. Most individuals that are identified as testing positive will be managed by either the national hub or by the Cheshire Hub, but there will be circumstances where a local outbreak needs to be managed locally, or additional support measures will need to be put in place.

Resolved, that the Health and Wellbeing Board noted the content of the report.

HW78 Warrington Town Deal Plane – Health Theme Update

The Board received a report of Lucy Gardner, Director of Strategy, Warrington Halton Hospital Health Theme Lead, which provided an update on the development of the draft Town Deal plan for Warrington, with a focus on the priorities being developed to improve health and wellbeing.

The Town Deal Programme is a national programme aimed at improving outcomes within 101 selected towns. Both Warrington and Runcorn have been selected. Warrington's Town Deal Programme and the development of the plan is led by Warrington Borough Council, supported by Atkins, who are commissioned consultants. Through development and approval of the plan the Council may access up to £25m to improve outcomes within Warrington.

There are four key themes which together form the focus of the plan and proposed investment, they are:

- Education, skills and employment
- Housing and infrastructure
- Health and wellbeing
- Arts, culture and digital

Theme groups have been established for each of the four themes. Through initial meetings of these groups, incorporating feedback from the public, proposed priority areas for investment have been identified.

The table below summarises the benefits of the priorities proposed within the health

and wellbeing theme that were detailed to the Board

Priority	Description	Benefits
Health and wellbeing hub in Warrington town centre	Potentially including: community wellbeing services and signposting, mental ill health prevention, frailty assessment and "pre-hab", minor illness/injury treatment, integrated diabetes service	• Improved productivity; both through increased training, increased employment and improvements to the health and wellbeing of the current Warrington workforce • Addresses skills shortage and difficulty in recruiting to certain roles, which in turn improves sustainability of health and care services • Improvement on deprivation; through the location of the health and wellbeing hub within an area of high deprivation, targeting both health inequality and increased economic activity in Warrington Town Centre • Reduction of congestion, as people are able to access health services both closer to home and closer to major transport infrastructure such as the bus depot and Warrington's two train stations • More town centre visitors, encouraging retail and cultural activity • Health outcomes improve, including the provision of services for Warrington's ageing population and services for the most deprived, including mental health and diabetes
Health and Social Care Academy	Led by Warrington and Vale Royal college, in partnership with Chester University, the health and care academy will bring together existing training and education provision for roles in health and social care and develop further training options for new roles.	

In addition it was reported that the health and wellbeing group will contribute to the proposal to further develop active travel, recognising the significant health benefits and the role that large employers play to increase the uptake of active travel.

Those ideas prioritised across all four themes are currently being worked up for review at the Town Deal Board on Friday 10th July. Atkins are developing the full plan, incorporating the priorities for investment. Warrington Borough Council intend to submit the plan at the end of July. Following review nationally the Council will be advised on approval or otherwise of the plan.

Resolved, that the Health and Wellbeing Board noted the update on the development of the Warrington Town Deal programme and specifically the health and wellbeing priorities proposed.

HWB79 Warrington and Halton Hospitals Covid 19 position statement and longer term strategic priorities

The Board received a verbal update that provided details of the position of Warrington and Halton Hospitals in terms of Covid 19 patients over recent months. It was reported that approximately 500 patients had been admitted to hospital for Covid 19 since March 2020, with 376 being discharged. The predicted spike in cases over the Easter weekend had been correct, however, admissions were less than anticipated and prepared for. During peak admissions, critical care capacity was 5 times higher than normal.

It was highlighted to the Board that during the peak of the pandemic, the Warrington & Halton hospitals did not become overwhelmed and it is believed that Public Health messages of 'Stay at Home, Save Lives' did help to support this. Neither

Warrington or Halton hospitals ran out of critical care capacity or PPE equipment, and this has been attributed to a successful relationship with mutual aid schemes where no clinicians had to work out of their specialist areas. Staff sickness did peak at 17%, however, this was better than the 'worst case scenario' that was planned for. Staff sickness has reduced to 10% however, this is also due to staff shielding and self-isolating.

The Board were informed the challenges now were to ensure that non Covid cases were supported and treated in a timely manner, with a particular concern for time related conditions, such as cancer, as there has been a reduction is patients accessing treatment. In addition, the management and preparation of a potential second wave were of high priority for both hospitals.

It was also noted that thanks be due to the local communities for their support during recent months and for helping lift the spirits of NHS staff whilst they were dealing with the unknown.

Resolved, that the update report be noted.

HWB79 Healthwatch Annual Report

The Board considered the Annual Report of the work Healthwatch Warrington had carried out from April 2019 to March 2020.

It was reported that the Healthwatch Team had been working remotely in recent months significantly increased the use of social media to gain the experiences of those accessing healthcare facilities and receiving care. Results of recent surveys were currently being analysed and will be provided to the Board at a future meeting.

Resolved, that the Board note the key activities made by the Warrington Healthwatch Team.

HWB80 Journey First – Employment Opportunities for People with Disabilities

The Board received a report from Tim Smith, Funding and Skills Manager, Warrington & Co, regarding activities to help people with disabilities move towards and into employment. It was reported that over recent months, it has been increasingly difficult for people with disabilities to gain employment however, it was highlighted that levels of support were increasing and more support is now available for Disability Confident Employers.

The Board were provided with key figures that included;

- Approximately 38,000 people aged 18 – 64 have a long standing illness or disability, with 2,730 adults having a learning disability
- Approximately 23,800 people aged 18- 64 experience a common mental health disorder
- Approximately 24,000 working age adults have a physical disability

- The number of working age adults with autism is thought to be approximately 990
- Latest figures indicate that 8% of working age adults who are receiving secondary mental health services and who are on the Care Programme Approach are recorded as being employed. This is in line with national figures for England
- Only 0.9% of working age adults in Warrington who were service users who received long term support with a primary reason of a learning disability were in paid employment. This is lower than the national figure of 5.9%

It was reported to the Board that employing disabled people is good for business as it can help to create a workforce that reflects the diverse range of customers it services and the community in which it is based. Creating employment opportunities for disadvantaged people is key to achieving social targets and aspirations, whether that be progress against statutory measures or corporate social responsibility indicators.

The overwhelming majority of young people with special educational needs and disabilities (SEND) are capable of sustainable paid employment, with the right preparation and support. Both the Children and Families Act 2014 and the Care Act 2014 strongly endorse participation in work as a legitimate and desired outcome. Studies show a positive cost:benefit analysis arising from supporting people with disabilities into employment, due to increased independence and self-sufficiency. For young people, programmes such as Supported Internships help to improve transition to adulthood, enabling young people with Special Educational Needs and Disabilities (SEND) to be more independent, potentially resulting in less support needed from public services. Delivering appropriate complementary services, for example independent travel training and accessible health services will help individuals to achieve long-term individual outcomes, which have significant impact on socio-economic targets. Creating more local vocational and employability education provision and opportunity can, not only reduce costs for sending individuals out of the borough, but also provide quality employability skills to vulnerable young people, bringing them closer to independent living and employment in Warrington.

Since August 2013, all young people in full or part-time education aged 16 to 19 (16 to 24 with an Education, Health & Care (EHC) Plan) have been expected to follow a study programme. A supported internship is one type of study programme, specifically aimed at young people aged 16 to 24 who have an EHC Plan and want to move into employment but need extra support to do so. By supporting Supported Internships, employment outcomes and providing work placement opportunities we are ensuring our EHC young people are getting closer to employment and independence. Delivering Supported Internships is an effective way of improving the disability employment gap, but more, good quality, employment opportunities are needed. An element of “job carving” is often required in order to develop a meaningful, achievable and appropriate role for both the young person and the employer. This can occasionally create

challenges in terms of process, including applications, pay scales and equal opportunity. However, significant hands-on and personalised support is available for both employers and participants via the Council's SEND Employer Engagement Co-ordinator, Job Coaches from contracted providers, and DWP's Access to Work scheme, which can help with advice and guidance for employers, and "reasonable adjustments" in the workplace.

Journey First is the joint Cheshire and Warrington Local Authorities' ESF project aimed at helping people furthest from the labour market into work. The bid has been approved and we are now at contracting stage. It is intended that we can go live and start supporting participants for up to 3 years from 1st June 2020. The project will provide intense, innovative, holistic and tailored support to young people who are NEET or at risk of NEET; and also focus on young people aged up to 24, who are disengaged from mainstream activity. It will also support people of any age with multiple and complex barriers to address these underlying issues and to move closer to or into the labour market. The project model recognises that there are many people in specific groups who are already known to and being supported by Council services. Councils employ staff who deal with these residents in a supporting / welfare role as part of their day job.

A further opportunity for employment is 'Supported Employment' which has been associated with helping disabled people achieve and maintain occupation since the 1980s. Paid employment must remain the ultimate goal of any supported employment opportunity or service, alongside the additional benefits such as community engagement and sense of purpose. Warrington Borough Council does not currently commission a dedicated Supported Employment service. Catalyst Choices previously delivered a local service, which unfortunately created few sustainable paid outcomes, and other agencies specialising in services for disabled people tend to offer support in a voluntary or care setting. Despite budget pressure there is local, regional and national focus on ensuring more disabled people participate in mainstream economy through a range of current schemes and campaigns including:

- Disability Confident
- DWP 'Proof of Concept' Local Supported Employment Trials
- Access to Work
- Local recommissioning of social care services
- National Supported Employment Quality Framework

This is driven by a collective acceptance that sustained employment opportunities deliver savings to statutory services, and improve health outcomes for individuals and communities. It is important to embed these strategies into local services, alongside an intrinsic, aspirational approach to employment for all, to ensure positive outcomes are sustained following the withdrawal of ESF funding.

People with a long-standing illness or disability make up a significant proportion of the working age population in Warrington. Despite our strong economy and high employment, there are some measures, particularly those relating to people

with learning disabilities in employment, where Warrington lags behind both regional and national rates. By adopting a coordinated approach and recognising that groups of people with contrasting needs can benefit from similar support services around employment and independence, partners can help to develop efficient services which maximise opportunities within the local community. Embracing employment as a significant outcome for vulnerable residents can lead to far-reaching improvements beyond individual economic factors, including improved health outcomes and community cohesion. Two key projects, Supported Internships and Journey First, are aimed at helping people with disabilities move towards, into and sustain work. Hands-on support is available, for both employers and participants. Partners can help to ensure the success of these projects and, in turn, help to increase the employment rates of people with disabilities by considering their own employment and recruitment practices. That could include offering opportunities such as

- short-term work-experience
- volunteering
- "job carving" to realise opportunities doing certain identified tasks for a certain number of hours per week
- part-time or full-time employment opportunities
- Supported Internships
- Traineeships
- Apprenticeships
- supported Apprenticeships

Success stories and case studies, including from the employer's point of view, would form part of further promotion to private sector organisations, who will be encouraged to participate at a level they feel is individually appropriate and achievable.

Resolved, that the Health and Wellbeing Board

(a) Note the information about current and forthcoming activities and will help to raise awareness through their own networks.

HWB81 <u>Primary Care Strategy 2019 - 2022</u>

The Board received a verbal update from Carl Marsh, Chief Commissioner, NHS Warrington CCG that confirmed that work is ongoing with stakeholders that will set the context of the NHS long term plan until 2022. The strategy implementation in March was delayed due to the Covid 19 pandemic and details have now been aligned with guidance on Covid 19 which has helped to develop some aspects of the strategy pushed forward sooner than planned. A further update of the progress of the strategy implementation will be provided at a future meeting.

Resolved – The Health and Wellbeing Board noted the update.

HWB82 Work Programme

The Board received the work programme for the remainder of 2019-20.

Resolved – The Health and Wellbeing Board agreed the details of the work programme.

HWB83 Date of Next Meetings

The Health and Wellbeing Board agreed that the future meetings will take place at 1.30pm on the following dates;

10 September 2020
12 November 2020
21 January 2021
25 March 2021.

Signed:……..

Date: ……

Warrington
Health & Wellbeing Board
10 September 2020
1.30 pm

Report Title	Warrington Together- Delivery reimagined, team reflections and suggestions
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To make proposals on changes to Warrington Together's (WT) governance and remit; namely • As WT has a single vision it is preferable to have a single forum consisting of commissioners and providers chaired by an elected member; • Consolidating WT programmes of work with Transformation and Sustainability programmes • Moving to a single programme team
Report author	Dr Andrew Davies, SRO, Warrington Place
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	*6 – 11; E1- 5*
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To agree to the proposals set out at the end of the document under suggested next steps

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
Strong and Resilient Communities	*1: Where communities are strong, well connected, and able to influence decisions that affect them*
	2: Where all local people can access and benefit from a strong economy with quality local jobs
	3: Where housing and the wider built environment promote health and healthy choices
	4: Where there are low levels of crime and people feel safe
	5: Where we work together to safeguard the most vulnerable
Starting Well	*6: Where children and young people get the best start in life in a child friendly environment*
Living Well	*7: Where there is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities*
	8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health
	9: Where both mental and physical health are promoted and valued equally
	10: Where self-care is supported, with more people managing their own conditions
	11: Where the best care is provided in the right place at the right time
Ageing Well	*12: Where people age well and live healthy fulfilling lives into old age*
Enabling Priorities	*E1: Where we have a valued, well-trained and supported work-force that is fit for the future*
	E2: Where the benefits from information and technology are maximised
	E3: Where we invest in the right intelligence to understand our local population
	E4: Where we utilise our collective estate so that it best supports local health and social care need
	E5: Where we get best possible value for our 'Warrington Pound'

2020

Warrington Together

DELIVERY REIMAGINED, TEAM REFLECTIONS AND SUGGESTIONS

DR ANDREW DAVIES SRO WARRINGTON TOGETHER

Warrington Together – Delivery Reimagined, Team Reflections and Suggestions

Recent Context

COVID – 19 has brought us all closer together as organisations even as we have sheltered and distanced as individuals. Technology has provided the opportunity for more contact and conversation, rapidly sharing ideas, and views. This has allowed us to find solutions without friction or being overburdened by process to convey knowledge and arrive at agreement.

A clear unifying purpose provided to us by the pandemic has also galvanised aligned action focused on the resolution of those common problems. The relationships that we have built across our borough have flourished over this time and been our biggest asset in taking timely and effective action.

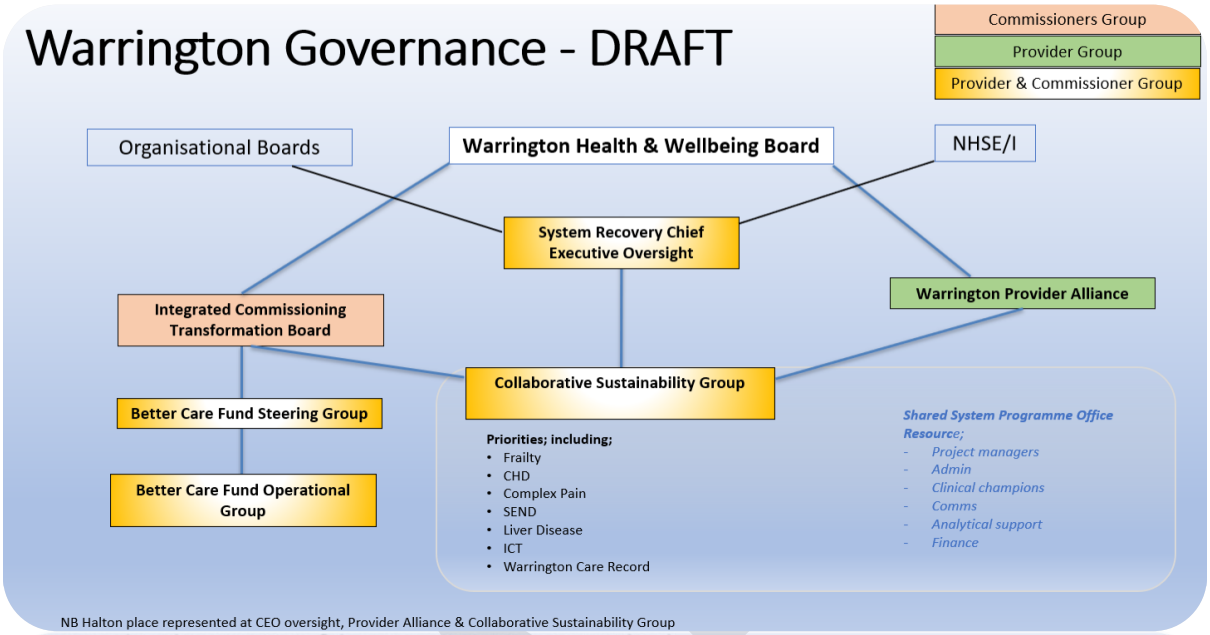
We should all be proud that we have been able to work in such a way and deliver so much in such a short period of time for the population that we serve. But we should also be cautious that in returning to our business as usual footing in the more stable but COVID present world that we do not also return to bad habits.

To that end officers from our respective organisations got together to consider how we might capture the benefits off our new working patterns and approach. These conversations have highlighted infrastructural problems with our current governance arrangements which have historically inhibited progress. The report makes recommendation to simplify governance arrangements underpinning our work, whilst providing the necessary assurances, public accountability and embedding the new.

To walk through that journey the report sets out in the following order;

- Feedback from Our Team
- Suggested common purpose for moving forward
- Our historical governance arrangements
- Inferred changes required

Historical Governance



In Warrington have iterated a few times on our governance arrangements which has resulted in the diagram above. There are complexities in this way of working which have gone away during our COVID response. The absence of those complexities has helped us to get on and do the right thing for the people that we serve.

As streamlined above over the preceding 12 months the structure above has been helpful in making certain that Warrington Together is everyone's business, but we have also had parallel work ongoing through sustainability and transformation projects. At times, our change programmes have been disconnected in purpose. Disconnected to the extent that individuals in attendance at the various groups have had conflicting priorities to meet the agendas of each stream.

Our governance structures therefore need further simplification and alignment to promote new ways of working. Following the feedback of our team there are suggested actions to resolve these conflicting priorities and parallel working.

Feedback from our Team

An interim COVID review was attended by our team who deliver our Warrington Together, Sustainability and Transformation work for Warrington across provision and commissioning. Meeting together to explore why things had clicked so well over our most recent partnership working. Sections below capture the prompt questions and the thoughts that were elicited, as such these are the group's collective reflections and form the basis for the recommendations of this short paper.

What has been different for you since COVID?

Remove process bureaucracy has expedited decision making; keen to maintain effective decision making through these more streamlined processes
Structures which previously allowed us to get together were stopped; the required ones have been reinstated and are now much more decision focused
We have shifted to a focus on unblocking problems via genuine partnership working across the system
Video conferencing has helped. There has been system ownership of key challenges (eg Care Homes); recognised that external factors may affect and impose more governance
Front-line staff have had more permission to do things better for the population
Command & Control structure has enabled quicker actions; historical issues have been put to the back of people's minds in the face of the pandemic, and we have just moved on
We are bringing together programmes of work as a system which is integrated; we recognise that the solution is an end to end system, not a fragmented offer
People's behaviours have changed; there is much more tolerance in the system of 'less than ideal' circumstances, and a much stronger approach to working together to solve the problem, rather than passing on blame
We had a single clarity of purpose with clear outcomes; we have known when to lead and when to follow (eg with Padgate house, Bridgewater has the Infection Prevention & Control capability so took the lead and WBC supported)
The pre-lockdown 'split' of commissioner / provider has been removed. Producing a collective effort maximising the benefit of individuals personal and organisational capabilities.
National guidance pulled people together; this increased our focus on what was really important and what was not (and recognition of the pressure our acute colleagues were on at the start); a lessons learnt process has been completed, happy to share this
Comms & Engagement; the daily system calls gave a single media focus with clarity of message and a clear call to action
Cllr / MP meetings have been less formal which has led to more openness not less; some of the information was not suitable for the public domain and was able to be shared in a spirit of trust and in confidence

Has that brought any benefits to patients or your work life?

Cooks meals and spends more time with the family for meals
Knows her neighbours now
Cycling much more so fitter
We need a strategy to manage teams calls to maintain boundaries; Cath does 20 mins' exercise in the morning!
Teams makes it easier to catch up with larger groups more quickly as a system; however there has been a contrasting experience for front-line managers who have remained on-site throughout the pandemic

What are the most important of those benefits to preserve?

We used to have lots of 'bitty' meetings; we have simplified governance; there is clear political ownership of the vision; there is commitment to system sustainability; there is a natural reporting structure up to HWBB
We have a single unifying purpose, which is working to deliver the best outcomes for the people of Warrington
We should maintain governance systems which are aligned to focusing on 'system outcomes', across the longitudinal pathway of care, rather than aligned to individual services and whether they have 'delivered' the required outputs. The outcomes we seek are only delivered through one system working and our governance should focus on the system's ability to deliver these outcomes
We should continue to be brave to challenge if things are not working, and if we see system and processes which are not working towards our common agreed objectives
The safe & well workstream linked to the VCSE sectors is very good; we are able to set up smaller working groups to get the work done, with everyone focused on the same shared outcomes; we need to continue to have core people together, to have informal time to progress the work on a system level
We need to maintain our capability and skills-driven focus, not working in previous organisational silos; we need a local politician to own the WT vision and be the steward of that vision. Cllr Knowles is very well placed to take the lead on this, along with Cllr Maureen McLaughlin's input. SK to own the vision with the politicians which will sustain the transformation programmes

Which bit of the old ways of working do you miss?

Checking in at the margins of meetings – the watercooler moments; there is less informal checking in and we need this to continue, it is harder over Teams
'real' engagement and gaining rich insight into service delivery. We need to consider how we engage effectively without big group face to face meetings and still get the same richness of insight needed to steer us.
We miss not being tied more broadly into the Warrington regeneration work

Finally, what are the 'big three' things you would focus on?

ICTB to be set up to deliver the three areas as outlined in fig 1 • Are the areas outlined in the original Warrington Together Vision still correct and valid, or so they need to be refreshed? They reflect our promises to our community. • How do we make the health, social care and VCSE sectors sustainable – and that they (we as a system) are able to work together to deliver our desired outcomes sustainably. Sustainability Plan • We have processes that mean we remain system outliers and this is where we are seeking 'system fixes' to change these areas. Transformation Programmes.
Maintain our unifying purpose as the root of all we do
Maintain close links with / working with primary care and VCSE colleagues
To reissue values from the Warrington Together offer

Our Common Purpose

Bring commissioners and providers closer together – one of the strengths highlighted has been to focus on our organisational and personal capabilities when delivering change. Bringing these to bear on problems as they have emerged without prejudging which organisation leads. Each participant bringing what is needed be that leadership, technical expertise, delivery assets or simply time. In contrast lead organisation has been a real issue in the past and often blocked us from even getting to the starting block or led to covert resistance.

Incorporate democratic representation into decision making – a vital part of the response to the pandemic has been closer and open working with Councillors and MPs without there being the usual filters in place. As an approach this has been welcome on both sides and fostered informative sharing of ideas outside of formal processes of scrutiny and partnership. Increased understanding has resulting in a desire to take collective action driven by both belief and technical method.

Address the Warrington Together Vision – agreed with our public and partners this vision has at times been challenging to deliver as the work programmes fragment the whole and are aligned to other priorities such as sustainability and/or transformation related to improvement opportunities. Each of these things are important but the vision we created risks getting lost or seen as less important when compared with the immediate imperatives of achieving financial balance or improving patient outcomes. Adherence to a guiding vision allows us to implement initiatives which reduce the fragmentation of our current systems of health and social care. Consistent with our best intentions and the other drivers of sustainability and quality improvement.

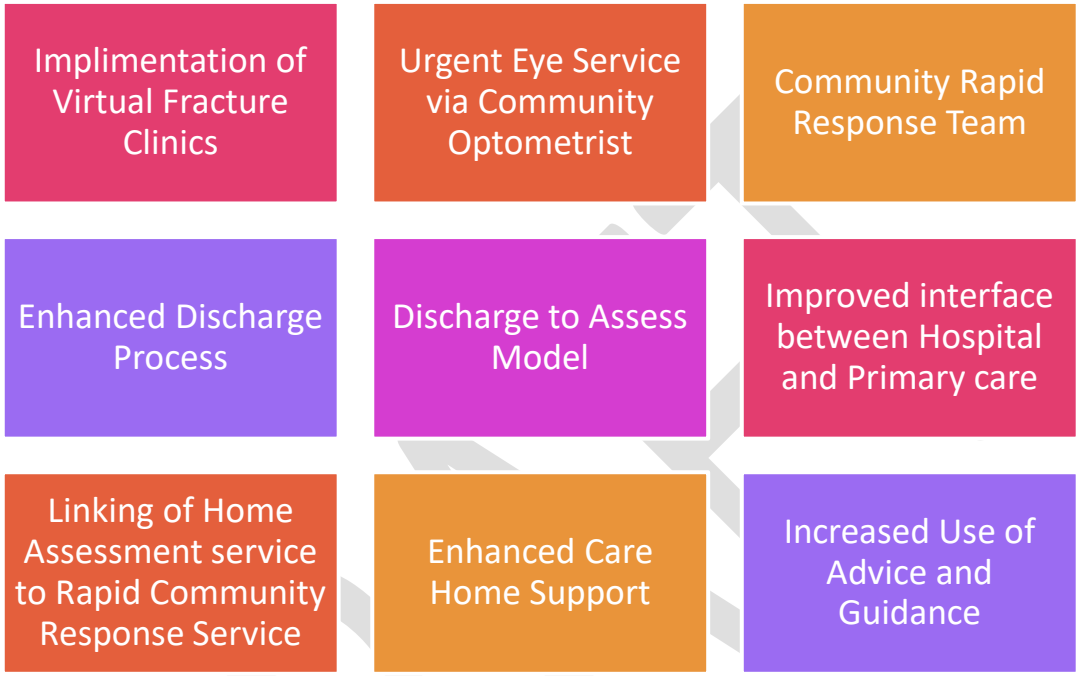
Ensure sustainability has a focus – both health and social care a financially challenged in Warrington and huge effort is taken to use the resources that we have go as far as possible but there are limits. We are close to those limits and for the first time the CCG was not able to deliver financial duties whilst supporting the healthcare system to avoid further debts. By moving forward with greater sharing of our spending power between the CCG and local authority we can improve this position through co-ordinated effort.

Provide oversight of transformational projects – our transformational programme will be aligned with both the Warrington Together vision and Sustainability programme by collective oversight. Also via connections with the provider partnership we can improve how these projects are implemented, considering the totality of cost in our system and moving assets and people to deliver more sustainable solutions, consistent with our vision and promoting improved outcomes for our population.

Enabling Changes

Much has been achieved since the onset of our COVID response and we should capture these successful initiatives through any new arrangements. Capture the positive learning from the true partnerships which delivered these changes and consolidating our operations within a lighter but sufficient governance infrastructure.

Some of Our Achievements – most not new ideas all had been stuck for years



Our existing point of common purpose and joint governance formally is the Integrated Commissioning and Transformation Board (ICTB). We can easily amend the operation of this board to incorporate the changes listed below and better deliver our collective intent and statutory duties.

The successes above highlighted that not every part of our system needs to be involved in every initiative many of these successful achievements were often delivered by pairs of teams supported by the commissioners acting as change agents.

- The mobilisation of RCRS through Bridgewater and Warrington Borough Council fully coming together and committing equally and jointly to the establishment of the service, overcoming challenges that had previously been difficult to address
- Acceptance of using a shorter assessment document for hospital discharge where there had previously been resistance
- The joint working by Warrington Borough Council and Bridgwater, providing therapy and social care services via a single point of entry to home based intermediate care services

All that we do exists within an engaged environment in which communities have told us what is important to them and their future wellbeing. Figuratively this interplay of environments is capture in the diagram below and forms the core of what the ICTB should be about. The three interlocking circles of our shared priorities within the context of neighbourhood plans.

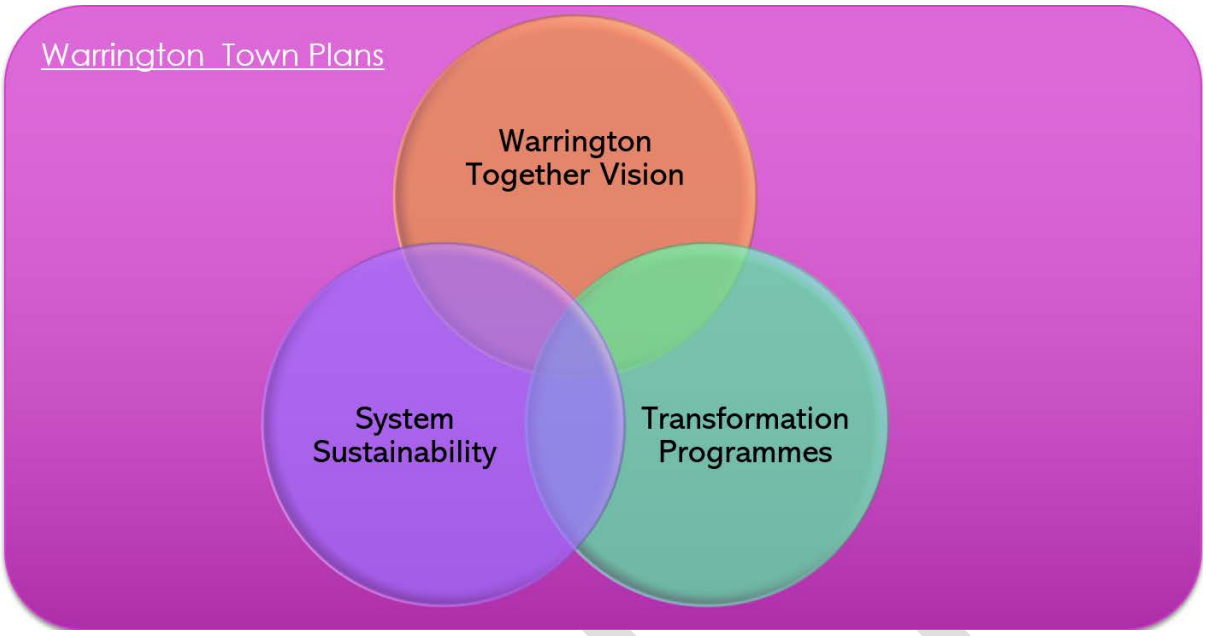


Fig 2

Suggested Next Steps

Democratically elected representatives as guardians of the Warrington Together Vision – fundamental to success is having consistent progress towards our vision described in Warrington Together. Our councillors can keep that vision at the fore as we work through our change programme ensuring that we honour those promises made. We understand too that our plan will not be perfect and may need to flex and change with time. Where we do need to veer from our course, as guardians of our vision, council colleagues will be there to prompt us all to ensure that appropriate engagement is undertaken, and clear rationale provided for those changes to plan.

Consolidate Reporting to ICTB from Transformation Programmes and Sustainability Programme – Under historic arrangements this has not been the case with these two programmes having other reporting routes. Such a clear consolidation puts everything under one set of governance which will help to see the full scope of work and ensure consistency. There are some issues of detail which may need to be compartmentalised within each organisation but the systemic impact of work both the benefits and risks can be shared through this combined forum to provide necessary oversight and assurances.

Warrington Together programme team aligned to core work reporting to ICTB – there have been various iterations of reporting for Warrington Together from an independent programme board to no formal oversight. To date the arrangements in place have not brought about co-ordinated system response or collective ownership

Closer interborough alignment where required to harmony between place plans – During COVID Halton and Warrington CCGs and local authorities have been working closely together. Both share the same Local Resilience Forum, Fire and Police. This has led to a sharing of knowledge expertise and approach which has brought out the best of both towns. Throughout the episode though the fundamental identity and uniqueness of each place has been preserved. True cooperation and partnership. This strength would be of huge benefit going forward.

Provider alliance across their footprint rather than different for each borough – differences exist between the skills, competencies and functions of commissioning and provider organisations. Also, our local hospitals, mental health providers, community providers, some housing trusts and VSFCE organisation exist at a scale which spans multiple boroughs. This leads to an artifice of borough-based provider alliances which may at time have conflicting agendas leading to operations difficulties in delivering consistent or viable pathways or services to each place. By consolidating integrated commissioning functions in place, the place can express its desired outcomes and needs for the population to a pan borough provider alliance who can then provide place focussed harmonised solutions. To achieve this there needs to be close connection between each place and the provider alliance.

Reciprocal presence between the ICTB and Provider alliance – strong links between the current governance structure for the provider alliances in addition to the benefits of interacting with an at scale alliance above will be required to deliver the Integrated Care Provider model that is part of our Warrington Together vision. Mechanistically this can be achieved by formally establishing reciprocal presence on a formalised provider alliance board and our ICTB. This needs to include VSFCE membership and representation to ensure that we build on community strengths and assets.

Refresh of ICTB TOR and Membership to enable the above – we could progress the commissioner element of this almost immediately through expansion of our current ICTB and a clarification of roles around the table. From there engaging in iterative design to gradually increase the scope of the agenda currently considered at ICTB, the scale of services considered and the realignment of other reporting lines in the system. Bringing the system recover and provider alliance reporting lines through the board. And producing the progress reports to parent bodies for each.

Personal Note

Thank you for making it through this document for those of you that did. I believe that as structured above we could do something special that has not previously been achieved in normal times for the borough a true partnership built into our processes without the parallel bypass routes which inadvertently drag us down. I know that we all want to achieve better for our population, and I hope this thought paper sets out a viable next set of steps towards that end.

Dr Andrew Davies
SRO for Warrington Place
13th August 2020

Warrington
Health & Wellbeing Board

10 September 2020

1.30 pm

Report Title	Warrington Together - Cheshire and Merseyside's Covid 19 System Plan Phase 3 Response
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To inform the Board of the System Plan Phase 3 Response for Restoration and Recovery
Report author	Simon Kenton, Programme Director, Warrington Together
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	*All*
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To note and discuss the proposals set out in the report.

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
Strong and Resilient Communities	*1: Where communities are strong, well connected, and able to influence decisions that affect them*
	2: Where all local people can access and benefit from a strong economy with quality local jobs
	3: Where housing and the wider built environment promote health and healthy choices
	4: Where there are low levels of crime and people feel safe
	5: Where we work together to safeguard the most vulnerable
Starting Well	*6: Where children and young people get the best start in life in a child friendly environment*
Living Well	*7: Where there is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities*
	8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health
	9: Where both mental and physical health are promoted and valued equally
	10: Where self-care is supported, with more people managing their own conditions
	11: Where the best care is provided in the right place at the right time
Ageing Well	*12: Where people age well and live healthy fulfilling lives into old age*
Enabling Priorities	*E1: Where we have a valued, well-trained and supported work-force that is fit for the future*
	E2: Where the benefits from information and technology are maximised
	E3: Where we invest in the right intelligence to understand our local population
	E4: Where we utilise our collective estate so that it best supports local health and social care need
	E5: Where we get best possible value for our 'Warrington Pound'

Warrington Together narrative for Cheshire and Merseyside's covid-19 system plan Phase 3 Response

Introduction

Warrington Together is a collaborative asset-based programme to deliver population health. Its core aim is to deliver integrated services for the people of Warrington across prevention, health, social care, and the Voluntary sector. Warrington Together's culture is built on the concept of equity rather than equality. Health Equity means that everybody, regardless of their location or circumstance, has a fair and just opportunity to access safe, secure health and social care when they require it. Health equity benefits the entire population; therefore, it requires a strong focus on removing obstacles to health such as poverty, substandard housing, discrimination and its consequences, access to quality education, a lack of jobs and unfair pay.

Our aims are to:

- Help people live longer and in good health
- Improve life expectancy
- Make better use of our resources and achieve sustainable services
- Provide co-ordinated care to the people of Warrington
- Ensure that care is effective and efficient and meets the needs of those we care for.

Our priorities are to:

- Focus on prevention
- Reduce health inequalities and unwarranted variation
- Focus on wider determinants of health
- Promote and Empower our communities
- Boost out of hospital care
- Build capacity and workforce
- Make use of improved digital technology

Our 5-year plan is to:

- Ensure our community has the best start in life in a child-friendly environment
- Ensure our community is able to live well by focusing on treating major health conditions such as cancer, mental health, heart disease, diabetes, and complex pain
- Ensure people in our community are able to age healthily

Post COVID 19 we need individual citizens, communities, voluntary groups, local authorities and NHS commissioners and providers across Warrington to continue to work together.

We do not want to waste this crisis. We want to come back better and part of this journey will be 'Restoration and Recovery'. At its heart, it can be summed up as saying that, when we come through the current crisis, we will evaluate what changes we made that we want to continue with, what further changes do we think we can make and what things we feel were working well that we wish to continue with. What we are clear about is that things should not simply go back to how they were before. And it is a commitment to recognise and take long-term advantage of all of the enormous energy, innovation, ideas, and solutions that have been introduced in recent weeks recognising that often "necessity is the mother of invention".

Our current thinking is that there are three stages to Restoration and Recovery:

- **Manage the immediate issues** – which is the current phase
- **Restore** – bring back essential services that may have reduced and ensure that patients are confident to engage with the NHS; and
- **Recovery** – address the backlog of need that has accrued. Developing our new ways of working; and consolidating the additional capacity created by the use of digital solutions, enduring that NHS and social care continue working collaboratively.

Some of the innovations we have introduced in the few weeks since lock down include:

- Moving significant parts of our business from a largely buildings- and desk-based operation to virtual and cloud-based
- Replacing staff face-to-face meetings with online and digital
- Introducing digital consultations between service users and clinicians
- Equipping scores of teams with the most up-to-date laptops and mobile devices to facilitate federated working
- Significantly reducing our carbon footprint through slashing the number of car journeys needed to get our people to work; and

- Introducing enhanced service user risk assessment processes to ensure we maximise the effectiveness of our service offer.

Doing all of the above has been a massive undertaking and has given us the opportunity to really 'think big' about what we can achieve when we combine common purpose, confidence with determination. But we also need to be aware that be aware that coming out of the current situation and returning to a "new business as usual" will not be without significant risk. So, we are thinking now about the where the risks are and how we can mitigate them. We have set out six interlinking programmes of work inour system wide recovery plan for Warrington.

Consolidating place-based programmes. Warrington Together isour vision for the future of care in Warrington and nowneeds to be consolidated, post COVID, with our transformational schemes and sustainability plans for the system. Each programme has prevention, collaboration, and strength-based community resilience at the core. Programme aims and outcomes,are expressed and delivered at a Primary Care Network/Integrated Care Team/Neighbourhood level. Some services and initiatives necessitate delivery at a scale across a larger geographical footprints for example, at a Mid-Mersey level and some on a Cheshire and Merseyside footprint.

These are challenging times which as a lot of people who are delivering care and services. Therefore, we are also focussing attention onprotecting and supporting our public service staff's mental, emotional, and physical wellbeing.

Bringing the NHS back to business as usual. Our plan will enable Acute, community, mental health, and primary care to return safely to normality and will encourage our communities to equitably access health care services, screening and vaccinationsto promote and maintain wellbeing whilst also ensuring that wediagnose and treat illnesses in a timely way. Warrington is using the experience of the pandemic to accelerate plans for integration of services such as those providinghealth visiting, safeguarding, allied therapies, pharmacy, Long Terms condition optimisation and wellbeing.

Our approach to working towards our new normal, restoration and recovery will include:

Supporting our care homes. To manage residents' health and through innovation, collaboration, adoption of technology, responsive support and sharing of resources.

Testing, Tracing and Containment. By implementing the Government's new tracing and isolation plans to prevent a second wave of infection.

Protecting Children. By **c**ontinuuing our work to promote resilience through our schools programmes and community whilst also safeguarding their mental and physical wellbeing.

Building additional capacity. Ensuring NHS and care services can cope with the inevitable surge in demand. Managing our profiled capacity in line with urgency and priorities informed by local need and national priority.

The System Response to the Phase 3 Planning requirements

All system partners are working in collaboration to deliver against the Phase 3 planning requirements, many of which are a continuation of the expected deliverables outlined during Phase 2.

	Phase 3 National Letter Ask	Warrington Plans
Accelerating return to near normal non covid health services. (making use of window before Christmas)	**A1 Restore full operation of all cancer services** Systems should commission Cancer Alliance to rapidly draw up deliver plans for September 20 to March 21. • Reduce unmet need and tackle inequalities • Manage growth in people requiring cancer diagnosis. (specifics in letter) • Reducing number of patients waiting.	Response from Place not required.
	A2 Recover maximum elective activity between now and winter • Specific activity target • maintaining block payments • waiting lists managed at system level as well as trust level to ensure equal patient access and effective use of facilities.	Response from Place not required.
	A3 Restore primary care and community services • Restart Primary Care (restore services, reach out to vulnerable people, address backlog of childhood imms and cervical screening, prevention support and LTC management)	**Primary Care re-start** In line with the standard operating procedure for General Practices all practices in Halton and Warrington are restoring services, where it is clinically appropriate, to pre COVID-19 levels. During the COVID-19 emergency, practices have rapidly changed their working patterns and introduced total triage, online and telephone appointments, video consultations as well as continuing to offer face to face appointments. Coronavirus has led to a significant increase in telephone and video contacts including same-day clinical triage interactions to assess and prioritise patient need, and a decrease in the number of traditional face-to-face scheduled appointments reported. This "new" way of working for practices in Halton and Warrington will continue given that the SOP requires all patients to receive total triage. Using disease registers patient management is proactive including ensuring the registers for patients who are extremely vulnerable to COVID-19 are maintained in case of any future lockdown. All disease registers, including those for long-term conditions, have been maintained throughout the pandemic. Patients who require review and/or follow up will automatically be contacted by practices. Between the period March 2020 to July 2020 all practices continued to offer childhood immunisations and cervical screening. The CCG has a "delivery dashboard" for areas such as childhood immunisations, learning disability health checks and cervical screening to monitor and work with practices to ensure that targets are met.

		The CCG will support practices and PCNs to achieve requirements of the COVID Standard Operating Protocol whilst implementing National Network DES requirements
	• Care Homes (enhanced support to care homes and medication reviews)	**Primary Care / Care Homes** GPs and their practices in Halton and Warrington have longstanding relationships with management and staff at the care homes. This enabled changes to be implemented to working patterns very quickly. Each home has a named GP and a routine visit schedule. Practices switched these visits to remote visits in mid-March to help reduce footfall through the homes, while keeping contact and care to a regular schedule. Over the coming months, GPs working with PCN employed Clinical Pharmacists and CCG employed clinical Pharmacists, will ensure that patients who would benefit from a structured medication review receive them. This includes patients resident in care homes, patients with complex polypharmacy and the severely frail patients. The CCG will ensure that the Network DES requirements are in place and being delivered, that effective utilisation of available resources are wrapped around care homes, and the implementation of Telehealth solutions to support. Working with the out of hospital cell and the hospital cell areas where self-referral can be expanded will be explored. At the moment self-referral includes services for drug and alcohol problems, as well as antenatal care and improving access to psychological therapies (IAPT). Areas currently under consideration include incontinence, hearing aid, and orthotics services. An interface has been established with the Medicines Management Team to support care homes' medication reviews and plans has been implemented with PCNs to deliver.
	• GP Appointments (expand self-refer, offer mix of face to face/video/online/phone appts)	During the COVID-19 emergency, practices have rapidly changed their working patterns and introduced total triage, online and telephone appointments, video consultations as well as continuing to offer face to face appointments. Coronavirus has led to a significant increase in telephone and video contacts including same-day clinical triage interactions to assess and prioritise patient need, and a decrease in the number of traditional face-to-face scheduled appointments reported. This "new" way of working for practices in Halton and Warrington will continue given that the SOP requires all patients to receive total triage. Explore with partners the areas already identified as being amenable to self-referral, building on the infrastructure put in place during COVID response to ensure this offer is available to all patients. Engagement with Cheshire & Merseyside Elective Care Programme for support and regionally consistent approach and learning from other centres, with planning is underway at local providers.

	• Community (enhance crisis response, ongoing rehab support post covid, resume home visiting care for vulnerable/shielded)	**Community Health Services** During COVID-19, community services were delivered in line with the guidance issued (Prioritisation of Community Services: March 2020), which detailed services to be maintained, delivered within specified criteria, or paused. Staff were then redeployed to support and maintain priority front line service delivery. Support was provided to enhance discharge processes through collaborative pathway development and service delivery, with co-located staff within acute service discharge teams. Community service providers have absorbed many additional functions outside of their commissioned activity during this time to support the system, for example delivery of swabbing services and support for Care Homes and have expanded vital capacity in Equipment Services to facilitate discharges. Phase 2 Recovery planning detailed services for urgent restart and separate recovery guidance was issued for Children and Young People's services. The Phase 3 recovery requirement is for services to restore activity to usual levels where clinically appropriate and to proactively reach out to clinically vulnerable patients and those whose care may have been delayed. All redeployed staff have now been returned to their substantive posts to assist with Phase 3 requirements. Many community services have been maintained throughout the COVID-19 period, with face-to-face, video or telephone solutions based on guidance, clinical requirements and respecting of patient wishes. Prioritised lists have been compiled at service level to identify people who have clinically urgent needs and need to be prioritised within restart processes. Service level plans have been generated, so there is clear understanding of the specific and nuanced caseloads and priorities. Contract review and Clinical Quality Focus groups have been maintained throughout COVID-19 so there are open lines of communication between commissioners and providers and forums to raise clinical quality and patient safety concerns and issues. Challenges remain in restoring services to full capacity which are required to be face-to-face (for example phlebotomy) as extended appointment times to facilitate social distancing, PPE requirements and patient flow through estate are required. Local Enhanced Service Specification established with Primary Care to proactively manage clinically vulnerable people. The CCG will continue to monitor via Dashboards offering specific practice support where a backlog is identified As part of the restoration of services to invite patients who require their review to attend either virtually or Face to Face Work with Public Health & Third Sector to promote awareness and action to address behavioural issues through referrals to Warrington Wellbeing Community services are offering home visiting, telephone, and video consultations as appropriate for people's clinical needs and acuity. Home visits were prioritised during lockdown and shielded and vulnerable patients on caseloads were supported.
	• Discharge to Assess fully embedded.	**Discharge** In conjunction with Warrington & Halton Hospitals Teaching Foundation Trust, Bridgewater Community Healthcare Foundation Trust, and Halton Borough Council & Warrington Borough Council, the system has reviewed the latest guidance in respect to Discharge to Assess from NHS England (issued 21/08/20) and also completed the Emergency Prevention,

		Preparedness and Response (EPPR) North West 'HCV Self-Assessment' document. Implications of the guidance is to be fully considered and embedded within operational response.
	• CHC (resume from 1/9/20, review those discharged 19/3-31/8)	Response from Place not required. Plans in place with LA and CCG to resume pre-COVID-19 systems and processes. In regard to Continuing Healthcare and Complex Care, NHS Warrington CCG have during the Covid-19 pandemic monitored hospital discharges. We are on track to resume full CHC implementation of the framework from 1st September 2020 and have communicated this to our local authority colleagues to ensure planning is aligned. In regard those patients who have been fully NHS funded from 31st March 2020 to 31st August 2020 a programme of reviews has been drawn up to ensure full assessment and a decision regarding funding by the appropriate route is enacted, we anticipate we will complete this pre-March 2021. Communication with patients and families will be key and will partners to ensure consistency in messaging.
	A4 Expand and improve mental health services for people with LD/Autism • Increase investment (CCG in line with MHIS)	Cheshire & Merseyside Mental Health Programme Director has prepared an overarching response for Health. Place asked to contribute to local delivery. In expenditure terms, the Mental Health Investment Standard (MHIS) is planned to be exceeded during 2020/21. Long Term Plan investment priorities, outlined at the Operational Planning stage, have been paused to some effect during 2020/21 to date and dialogue will resume with system partners to gauge the ability to resume and deliver within this financial year. Across Cheshire & Merseyside, expenditure pressures against planned levels have been evident for both Mental Health related prescribing and out-of-area placements during the COVID-19 response period. Prioritised Transformation programmes for 24/7 Core Liaison, Intensive Support Teams, and Crisis offers within the locality are to be resumed with planned workforce expansions accelerated during the remainder of the financial year.
	• Mental Health expansion (restore IAPT, 24/7 crisis helpline retained and developed into national service, maintain growth in CYP, review CMHT caseloads, ensure local access is advertised, eliminate dormitory wards.)	As part of the COVID-19 response requirements, a 24/7 Crisis Line Service was co-commissioned by Mid Mersey CCGs and integrated into National 24/7 all age crisis service line. This offer ensures that those experiencing a mental health crisis can access mental health support and advice remotely. As Mental Health service provision reverts to business as usual, the impact on the IAPT access targets outlined at the outset of the financial year will be determined. Re-establishing the momentum will be a priority to ensure that the Long-Term Plans are deliverable over the medium term. The investment has been secured during 2020/21 but the impact on both GP Practices and community provision as part of the COVID-19 response period will inevitably have impacted on the reach to the population. Referrals through the 24/7 crisis line offer to be understood and assessed against the scope to deliver during 2020/21, with any remedial actions outlined to optimise delivery and regain momentum. Additional resource has also been identified within planning to support the ongoing IAPT staff training in North West Borough Foundation Trust's Children and Adolescent Mental Health Services (CAMHS) offer. Opportunities to expand the use of Video Consultation to create a culture and expectation of 'digital first' will be explored with providers for mental health and learning disability support. An increase

		in the use of telephone support and the provision of self-help material has already been a key mechanism for maintaining the community offer since the outset of the pandemic. The CCG will maintain prioritised and ring-fenced investment in CAMHS throughout the remainder of 2020/21, maintaining the momentum of enhanced investment in line with the Long-Term Plan objectives. Through this continued investment, the development of local Children & Young People (CYP) Mental Health services in Warrington continues to meet the National Access and Waiting time requirements in line with projected expectations. Local CYP Mental Health operational groups have been established in Halton and Warrington, chaired by Lead Commissioner for Maternity, Children, Families & Frailty, to ensure whole system response to CYP Mental Health over the COVID-19 response period. The advertisement of local access was included with the Terms of Reference for such groups. The 24/7 crisis resolution home treatment team model for adults, progressed during 2019/20 will be mobilise further during 2020/21 within Mid Mersey footprint, supported by transformational resource and commissioner contributions.
	• LD/Autism (reduce number in inpatient setting, Complete all LeDeR by Dec 2020, GP LD annual health checks)	Initial reporting on the Intensive Support Team (IST), commissioned across Mid-Mersey footprint, to enhance community provision for Learning Disability (LD) clients has identified a positive impact to date with improved pathways between health and social care. Referral pathways are still in development with expected outcome of managing more client needs within a community setting rather requirement for inpatient stays. Further training to be offered in September 2020 to social care to support objectives. All Age Transforming Care Tracker in place to monitor all admissions to inpatient facilities. Executive Lead in place. Numbers of inpatients within target (3 CCG, 1 Spec Comm admission. 2019/20 achieved 5) and expected dates of discharge in place. This is tracked weekly. CTR's done on all Blue light admissions, post admission and during admission to ensure progress of patient is monitored and planning for discharge is in place. **LeDeR** Quality Assurance and Governance mechanisms in place. On target to complete LeDeR by Dec 2020. Intensive support team in place to manage LD patients. LeDeR conference held in February 2020 and case studies used to share learning, a video has been produced and shared across system partners. Over 200 people attended. More work needed to join up Health and Social Care provision. LeDeR patient story taken to Governing Body of assurance and scrutiny and Warrington Adult Safeguarding Board

		LD Health Checks The Local Enhanced Service (LES) established with Primary Care to support LD Annual Health Checks has been supplemented with an additional scheme, funded through COVID-19 identified resource requirements, to further support / encourage LD clients in accessing primary care generally and encourage attendance for annual health checks to increase this uptake and to support other investigations including prevention screening, flu vaccination and hospital attendance.. LD Registers in place to support and monitor. Achieved 65.3% (75%) 2019/20.
Preparation for Winter and further Covid spikes locally	**B1 Prepare for local covid outbreaks** • Managing outbreaks (place role)	Warrington system partners have contributed to the Mid Mersey Winter Planning 2020 submission considering the plans to manage emerging demand on services, which includes consideration of a potential COVID-19 resurgence. Included within the Plan are accelerated developments within the following elements: 1. Implementation of 111 First as Early Adopter Site: Ambition to increase capability for patient needs to be managed in the most appropriate setting, hence protecting emergency services for appropriate demand whilst ensuring patients are seen by the most clinically appropriate person; and 2. Development of Community Rapid Response Services and Intermediate Care Review: Ambition to increase existing commissioned community management services with enhanced step up provision, improved rapid discharge processes, and an outcome of reduced LoS and DTOC for our patients. 3. Capacity planning for bed requirements over Winter 2020/21 at mid Mersey level via the Cheshire and Merseyside Out of Hospital Cell, which focusses on a range of COVID scenarios and predicted Winter pressures
	• Testing (Staff Testing, Infection prevention and control guidance, sustaining covid-safe services, Accessing PPE)	PPE supplies are now more stable, however, as more F2F appointments resume and practices start to participate in the expanded flu campaign, the availability of PPE remains an ongoing risk. Assumptions are made that the increase in PPE costs will covered centrally. All providers are following the national IPC Guidelines. Whilst single use PPE for each flu immunisation had been a concern, the recent change in national guidance should reduce the level of PPE required. Anti-body testing is currently being mobilised for adult social care staff.
	B2 Prepare for Winter • Capacity (Ensure adequate capacity is available - Take advantage of bed capacity in independent sectors, nightingale hospitals) • Flu vaccinations • 111 First, • UTCs • Continue to work with volunteers • Work with local authorities on resilient social care services	An extensive plan has been developed across Health and Social Care in response to Winter Planning for Warrington this year. This will feed into the overarching Mid Mersey Winter Plan and go through a formal governance process in the NHS. However locally we will take ownership on the management and implementation of the Warrington Winter Plan. It will continue to be a working document as we respond locally to winter and/or covid resurgence. NHS 111 First planned mobilisation date 08.09.20 expanding local Clinical Assessment Service for Emergency Treatment Codes to 24/7, enabling ED by appointment, UCC by appointment via NHS 111 and the clinical assessment service, Minor Injuries and ED Ambulatory by Appointment via the Clinical Assessment Service.

		Rapid Community Response Service mobilised March 20. Offering 2hour response, 2-day support.
Taking into account lessons learnt, lock in beneficial changes, support staff (people plan) and action on equalities and prevention.	**C1 Workforce**: People Plan; All systems should develop a local People Plan, working with local authorities and local partners. • Actions for NHS Employers to keep staff safe • Flexible working • Address systemic inequalities including BAME • New ways of working • Growing workforce Plans (50k nurses, 6k GPs, other PC 26k) • Workforce planning and transformation by systems to enable people to be recruited and deployed across organisations, sectors, and geographies locally.	**People Plan** The CCG is developing a draft People Plan based on the domains and actions with the NHS People Plan and Commitments. Governing Bodies have been engaged in the development and content of this work. This builds upon our existing local staffing priorities, effective working practices through the COVID Response, emerging actions from the Phase 3 letter and People Plan priorities. A robust risk assessment process has rolled out for all CCG staff including a 1-1 Health and Wellbeing conversation, COVID Risk assessment across risk factors and also 'Working from Home' checklist.
	C2 Health inequalities and prevention: How will you ensure that services are restored inclusively and address the needs of vulnerable groups? **Eight urgent actions to address inequalities:** • Protect the most vulnerable from COVID with enhanced analysis and community engagement • Restore NHS services inclusively so they are used by those with greatest need. • Develop digitally enabled care pathways in way which increase inclusion • Accelerate preventative programmes which proactively engage those at risk of poor health outcomes • Particularly support those who suffer mental ill-health • Strengthen leadership and accountability (with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation	**Health Inequalities** Dr Andrew Davies, Clinical Chief Officer, is the nominated Lead for inequalities and ensures ongoing regular reporting to Governing Body. Governing Body GP Representatives are also members of the Strategic Regional Equalities Advisory Group. Health inequalities training is planned for the Governing Body and staff in November 2020. The Workforce Race Equality Standard report and action plan is scheduled for the Governing Body Agenda in September 2020. The CCG will support NHSEI and PHE with preventative programmes aimed at those at greatest risk of poorer health outcomes. The CCG will continue to use a range of data sets such as JSNA, PHE, SHAPE alongside other available research and engagement insight to understand health inequalities within local "place" communities. To support "knowing our patch" we will utilise data sets to help inform decision making. The CCG will also review COVID related data and intelligence relating to at risk groups to ensure that post COVID-19 planning meets projected health needs of COVID patients – including mental health needs and long-term respiratory needs following acute care from the coronavirus. The CCGs Equality impact assessment tool now includes a health inequality section and will continue to be carried out for all service change / review / proposals including impacts for patients that face digital exclusion. Assessments will help to identify potential barriers of services.

	alongside action to increase diversity of senior leaders) • Ensure datasets are complete and timely • Collaborate locally in planning and delivering action to address health inequalities.	
	Please include as part of the response confirmation of the names of the executive board – level leads for every NHS organisation within the ICS area who are responsible for tackling inequalities. This should include confirmation of the named health equality champions for each of your PCNs.	C&M HCP will collate for NHS across C&M. **NHS Warrington CCG:** Dr Dan Bunstone, Clinical Director, Warrington Innovation Network (WIN) Dr Laura Mount, Clinical Director, Central & West Warrington Network Dr Ash Ahluwalia, Clinical Director, South Warrington Network (SWaN) Dr Mike Northey, Clinical Director, Central & East Network Dr Rakhi Raj, Clinical Director, East Warrington Network
Financial arrangements and system working	**Working across systems,** including NHS, local authority, and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes: • Collaborative leadership arrangements • Partnership Board and Governance (Providers and Commissioners agree actions in best interests of their population) • Streamline commissioning through single ICS. • Full Shared care record, allowing safe flow of patient data between care settings.	Response from Place not required.
	Finance and Activity	Response from Place not required.

Key assumptions underpinning plans:

- Referral levels will continue to increase back to normal pre-COVID-19 levels.
- There is not a further local or national lockdown.
- Staff absence due to sickness or need to shield does not increase.
- No material impact from BREXIT.
- Voluntary sector organisations continue to operate in Warrington

Main constraints Considered:

- Capacity to accommodate pre-COVID-19 volume of patients. This will not significantly increase upon current activity levels whilst social distancing and infection, prevention and control measures are required.
- Patient expectation that a face to face appointment with a GP is required may constrain general practice in continuing to harness new ways of working. This is also important as PCNs recruit to the ARRS where a contact may be offered with other clinical roles and not a GP.
- Workforce Capacity and Capability, Estates, and IT Infrastructure.
- Lack of funding.

Additional actions planned to sustain the recovery through the winter period:

- Mid-Mersey Winter Plan.
- Maximise the use of the voluntary and community sector.
- Continue to see as many new and follow up patients as clinically appropriate “virtually/non face to face” to support social distancing.

Key Risks and Issues:

- COVID second wave / Local Lockdown / Impact of a Local lockdown within Cheshire and Merseyside.
- Staff absence increases due to sickness or need to shield.
- Potential for higher DNA rates for face to face attendances.
- Patients may have been missed for routine screening/or not responded to their reminder. GP Practices have been asked to review.
- There are risks to locally to our VCFSE organisations, future sustainability, financial challenges, insufficient access to PPE that if mitigated can provide greater capacity and an improved community offer.

- Risk that patients will see services as “closed” particularly within Primary Care. Need to ensure Communication Plans are robust locally.

Key data constraints:

- Various data across all of the organisations. No central joined up BI team across Warrington for Health and Social Care.
- Local process in development to monitor appointment types to support intelligence for potential second wave (Primary Care).

Areas of delivery would benefit from a collective Cheshire & Merseyside -wide response or Mutual Aid:

- Warrington Together works closely with neighbouring areas of Halton and St Helens. (Mid Mersey Footprint) but also is aligned to Cheshire for Outbreak Management.
- NHS Organisations should maximise the social offer VCFSE can bring.
- Communications support – Clear messages about what services are available, how to access them and how they might look differently.
- Communications Support / Digital Support – Face to Face appointments not always required, but ensuring people have the right tools available to access the new digital technologies.
- Cheshire & Merseyside response to support care homes to improve their IT infrastructure would be beneficial.

Warrington
Health & Wellbeing Board

10 September 2020

1.30 pm

Report Title	Living Well Health and Wellbeing Strategy Thematic Update
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To present the Health and Wellbeing Board with an update on the Living Well theme of the Health and Wellbeing Strategy
Report author	Anne Marie Carr Senior Health Improvement Specialist, Public Health Team
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	*Strategic Priorities 7 – 11*
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	For the Health and Wellbeing Board to note the update report, including key areas of progress and work on-going under the Living Well theme.

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
Strong and Resilient Communities	*1: Where communities are strong, well connected, and able to influence decisions that affect them*
	2: Where all local people can access and benefit from a strong economy with quality local jobs
	3: Where housing and the wider built environment promote health and healthy choices
	4: Where there are low levels of crime and people feel safe
	5: Where we work together to safeguard the most vulnerable
Starting Well	*6: Where children and young people get the best start in life in a child friendly environment*
Living Well	*7: Where there is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities*
	8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health
	9: Where both mental and physical health are promoted and valued equally
	10: Where self-care is supported, with more people managing their own conditions
	11: Where the best care is provided in the right place at the right time
Ageing Well	*12: Where people age well and live healthy fulfilling lives into old age*
Enabling Priorities	*E1: Where we have a valued, well-trained and supported work-force that is fit for the future*
	E2: Where the benefits from information and technology are maximised
	E3: Where we invest in the right intelligence to understand our local population
	E4: Where we utilise our collective estate so that it best supports local health and social care need
	E5: Where we get best possible value for our 'Warrington Pound'

Health and Wellbeing Strategy thematic update report 2019/20

Living Well

Thematic leads: Carl Marsh (Warrington CCG), Dot Finnerty (Warrington CCG), Tracy Flute (WBC) and Dave Bradburn (WBC)

Key Strategic Groups: Health and Wellbeing Board, Mental Health Prevention and Promotion Partnership, Early Help Strategy Group, Healthy Weight Strategy Group, Active Warrington Strategy Group, Strategic Drug and Alcohol Action Team, Tobacco Control Strategy Group, Health Protection Forum, Warrington CCG and Collaborative Clusters, Warrington Together and Integrated Commissioning Transformation Board, Health and Wellbeing partner organisations,

Priority Theme	Specific sub-theme commitments	Review of activities/achievements over the previous 12 months	Actions to be taken over the coming 12 months
7: There is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities	Foster a common understanding across all partners of the prevention agenda Systematically embed prevention at all levels Detect ill-health and risk factors and intervene early with evidence-based interventions Ensure our collective workforce knows that prevention is everyone's business and we 'Make Every Contact Count' Secure whole system commitment to upstream interventions to ad- dress the wider determinants of health Ensure that health and wellbeing is in all policies and social value is maximised	The Local Government Association and the Design Council ran a national project to improve the effectiveness of public services. Representatives from WBC Public Health, Adult Social Care, Warrington & Halton CCG and Warrington Voluntary Action formed the working group. The local focus of this work was to embed prevention and the 'healthy ageing' agenda into future planning, commissioning and investment. The process gave insights and practical opportunities for future prevention focussed large scale projects. The expansion and development of front line capacity to offer emotional	Learning from the LGA and Design Council work will inform future cross system projects, in particular agreeing a shared purpose and language in initial stages of the process. This relates to supporting people in their middle years to 'age well' to improve their long-term health outcomes, as well as programmes for people in later years. We will continue to work closely with Primary Care Networks to embed new Social Prescribing support roles to help strengthen and enhance current

		wellbeing support and early intervention has continued. There is ongoing partnership work with primary care to understand how new social prescribing roles can work in synergy with existing offers in the town. CHAMP's have coordinated a sub-regional CVD programme that has improved frontline staff knowledge and increased capacity for brief interventions. A mobile health kiosk has been placed in both community and workplace settings. A CHAMPS led re-branded 'Every Contact Counts' training and briefing have continued up to March. Currently being updated to reflect post-Covid world. Recommendations from the internal Health Inequalities audit will be reviewed to take into the account the impact of COVID-19	commissioned and community led offers. The sub-regional 'Healthy Hearts' CVD prevention programme is continually being updated to be deliverable in the post-Covid context. Warrington will continue to host community kiosks, with increased hygiene measures. The local lifestyles team will also be delivering on the programmes' objectives, in particular work with the East PCN will target people on CVD registers to receive early interventions. New elements of 'Every Contact Counts' will be developed in response to the Covid-19 crisis. MECC conversations will equip front-line workers to support the public to navigate the 'new normal' and increase confidence in self-care strategies. Health and social data will continue to be robustly analysed to track and monitor impact on different parts of the local population. Timely work programmes will be developed to address any emerging inequalities.

8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health	Ensure opportunities to deliver evidence-based interventions around a healthy diet are delivered consistently across the life course Ensure the built environment, our policies, infrastructure and services support people of all ages to be physically active and maintain a healthy weight Ensure we work together to reduce the harm caused by alcohol and substance misuse, and use appropriate measures to promote the responsible supply and availability of alcohol Ensure continued sustained focus on addressing entrenched smoking, and on de-normalising smoking Ensure adequate plans are in place to protect the health of the local population and encourage uptake of screening and immunisation programmes	An initial 'Whole Systems Approach to Food Choices and Activity' is complete and consultation with partners was due to begin before lockdown. The new national Obesity Strategy offers a new opportunity to engage with a range of professionals across the system. Links between the local lifestyles team and primary care were strengthened via project that offered in surgery lifestyle support to 'pre-diabetic' patients. Links between the local lifestyles and leisure services and the National Diabetes Prevention Programme were also made. A new Local Tobacco Control Plan was launched. An alliance of senior officers have shown commitment to ensuring local ambitions are met. Development of An Addictive Behaviours Strategy. Cancer JSNA chapter was completed and agreed via consultation with health colleagues.	The 'Whole Systems Approach to Food Choices and Activity' strategy will continue to be developed in line with latest evidence and guidance. The new national obesity strategy and the accompanying new public facing campaign 'Better Health' are the foundation for updated healthy weight and active lifestyles delivery. Increasing skills across the workforce and public to improve lifestyle choices helping to build health resilience in case of future outbreaks. Development of support for public, community groups and personal trainers to access green spaces safely to help support physical and mental wellbeing. Smokefree environments and support for smokers to quit will play an important role in both recovery and controlling future outbreaks. The Tobacco Alliance will continue to exist and deliver against the local plan. There will be focus to increase referrals from

		Multi-agency seasonal flu plan was delivered. Still would like to improve uptake of vaccination among under 65's with long-term conditions.	health partners into smokefree services. A cancer partnership group will deliver on the recommendations made in the new Cancer JSNA a chapter. Flu season for 20/21 action plan been developed. Additional flu cohorts this year include children in year 7 and from November people between the ages of 50-64 (vaccine dependant). National targets increased to 75% for all at risk groups.
9: Where both mental and physical health are promoted and valued equally	Promote positive mental health and wellbeing and address wider determinants of health Ensure that our services address the needs of the individual as a whole	CHAMPS money secured locally to support middle-aged men's health. Funding has been split to further enhance the evidence based Warrington 'Time to change' hub and a range of community based projects to enhance men's Mental Health. MovMENt has been the main project funded to date, which is a partnership between Directions for Men, LiveWire and the Warrington Wolves Foundation. MovMENt will ensure that middle aged men in Warrington are provided with a portfolio of varied opportunities for regular social	To increase the reach of existing men's mental health provision led by community and voluntary groups across Warrington in partnership with Warrington Voluntary Action. Outcomes include: A reduction in male suicide Middle-aged men are better able to manage in a crisis Middle-aged men have improved awareness around mental health. Middle-aged men have improved ability to identify and talk about mental health.

		connectedness in the local community. The time to change hub was launched in October 2019 and driven through Warrington Speak Up. It has enabled the voice of people with lived experience to be heard and to challenge stigma and discrimination around mental health through campaigning and events. Funding continues until May 2021.	Time to Change Employer Pledge is a commitment to changing the way we all think and act about mental health in the workplace. Locally, 5 organisations have signed up historically and through the motivation and commitment of the champions, established partnerships with a number of organisations including, golden square management, Warrington Wolves, New Balance and Cineworld etc. As a local authority, and importantly, as the host of the Time to Change hub in Warrington, plans for Warrington Borough Council sign up to the employer pledge (we have not currently).
10: Where self-care is supported, with more people managing their own conditions	Enable people to take greater control over their own health and wellbeing Ensure that lifestyle interventions are considered and promoted for people diagnosed with long-term conditions Ensure that there is accessible, coordinated information available to support self-care	Warrington Wellbeing Evaluation was completed showing a positive return on investment. The service was also expanded to include externally funded specialist posts. Support to the National Diabetes Prevention Programme will continue once new provider is announced. Public Health commissioned lifestyle service remained operational	A number of recommendations made as part of the Wellbeing Service evaluation process will be actioned to help position and define the role of the service in synergy with other offers. The local lifestyle service model will evolve to meet new performance management targets aligned to national and local recovery plans. This includes more

		throughout crisis period and will be developed to meet changing need across population. The NHS Health Check programme was suspended over the crisis period. In the last 12 months previous mobile provider had withdrawn from the contact as it was no longer financially viable for the organisation.	work with primary care but will also blur the lines between leisure, lifestyles and wellbeing so individuals have more choice in staying well in a way that suits them best. We are awaiting national guidance about the re-introduction of the NHS Health Check programme. The advice and guidance given as part of this assessment will play an important role in embedding personalised and self-care. A new local mobile provider will be commissioned who will work as part of the existing local system.
11: Where the best care is provided in the right place at the right time	Ensure that health and care services are effective and efficient Integrate care to ensure we have a single approach to using resources and to improving health outcomes Coordinate the work that GPs, community services and hospital in order to better meet the needs of our population Ensure there is better integration between physical and mental health care	Due to Covid pressures and re-prioritisation of resources the Primary Care Dashboard has been delayed in its development.	In respect to the Integration of Services, there have been some great examples of how this has been happening and plans going forward, these include: Establishment of the Rapid Community Response Service providing a 2 hour rapid response and up to 72 hours of reablement to those experiencing a health and social care crisis. This multi-disciplinary team made up of health and social care practitioners working to maintain people in their homes and communities to prevent avoidable hospital

			conveyances and admissions. The service has recently incorporated the Paramedic led, 'Primary Care Home Visiting Service' following work with Primary Care Network Clinical Leads. Integrated Hospital Discharge Team now in place made up of health and social care practitioners Plans to restart the work around the 'Integrated Community Teams' model. Partnership between Primary Care, statutory and non-statutory services will proactively identify and respond to need in our communities, ensuring coordinated care and support, and improving experience and outcomes.

Additional Key Documents:

Warrington
Health & Wellbeing Board

10th September 2020

1.30 pm

Report Title	COVID-19 Situational Awareness
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To provide the Board with an overview of the latest position in relation to COVID-19 in Warrington.
Report author	Report of Thara Raj – Director of Public Health Dave Bradburn - Deputy Director of Public Health (Acting) Tracy Flute – Consultant in Public Health (Acting)
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	Priority 8
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	For Health and Wellbeing Board to receive this update, note the work on-going and commit to continued support and partnership working to help manage and respond to the on-going challenges as they arise.

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
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	E5: Where we get best possible value for our 'Warrington Pound'

Report purpose

To provide the Board with an overview of the latest position in relation to responding to and managing COVID-19 in Warrington.

1. Introduction/background

Leadership of Warrington's response during the Covid-19 pandemic has been strong during the most unprecedented attack on the health and economic wellbeing of the country and large parts of the world.

As Director of Public Health I appreciate the huge amount of work that has been undertaken by individuals, communities and volunteers and statutory and private sector partners across the town to prepare for and respond to COVID-19. Thank you for all the tremendous efforts and sacrifices that have been made, they have put us in a strong position to keep people as safe as possible and reduce the risks of the virus, while maintaining their wellbeing.

The Council in partnership with the voluntary sector, quickly established a team who contacted almost 9,000 Warrington residents who are on the NHS shielding list to check they were okay and whether they needed any support. People that were identified as needing follow up support were referred to the safe and well service. We distributed over 4300 food parcels and supported our residents to stay safe.

In addition the council and partners have made huge efforts to support our local businesses, schools and care homes to reduce the impact of COVID-19 on them and to ensure that they are supported to be able to operate in line with COVID secure guidance.

Our frontline staff and essential services need a special mention as our appreciation to all of them for keeping our services running, preventing the spread of COVID as much as possible and caring for those who needed it. We have been fortunate to have a willing army of volunteers to support our shielded and vulnerable residents through regular reassurance calls. Many Council staff volunteered to work extra hours over week-ends, bank holidays and at unsociable times. The community spirit and dedication of our front line workers has been one of the highlights of our local response to this pandemic.

Warrington has also been playing a crucial leadership role working closely with partners across Cheshire and Merseyside to ensure our response to coronavirus has been focused on containing the spread as much as possible, and minimising the impact on our residents and services.

Our Public Health team continue to provide vital data analysis, intelligence and modelling to inform the local response to COVID-19. They also worked closely with Public Health England (PHE) and our infection control team to provide advice and local

guidance for a range of services, to enable them to deal with issues responsively. This includes providing assured guidance to care homes, schools and workplaces.

There has never been a more important time for the public to keep well and stay healthy. Keeping active and socially connected is also crucial to our mental health which for many will have been affected during lockdown and those experiencing bereavement. Our role as a Health & Wellbeing Board is to ensure that we continue to actively promote opportunities for health and support our residents to lead healthy lives whilst maintaining our efforts to tackle inequalities.

2. Content

2.1 Situational awareness

Robust surveillance processes are in place, and there is daily monitoring of key metrics to ensure there can be timely intervention should there be a rise in infection rates within the borough. In addition to the local surveillance, the Warrington Public Health team have worked closely with Public Health England and colleagues across Cheshire and Merseyside to develop a dashboard with key 'trigger' metrics and thresholds for action. This consistent approach to surveillance on a broader geographical footprint is crucial to ensure that we remain vigilant and sighted on trends beyond our borough.

Incidence: At the time of writing, the number of new cases within Warrington is low. Infection incidence rates are amongst the lowest across the North West. The rate of testing per head of population within Warrington is slightly higher than the average for England but the positivity rate (the proportion of all tests undertaken that are positive) is generally lower.

Hospitalisations: The rate of new hospitalisations due to COVID-19 peaked within Warrington in early April. Numbers decreased through June, and have been very low throughout July and into August, with an average of less than one admission per day

Deaths: Similarly, the number of deaths recorded with mention of Covid-19 amongst Warrington residents peaked in April and has continued downwards since. Numbers are now very low, with an average of less than 2 deaths per month in July and August nevertheless every death is a tragedy that has affected families and communities.

Whilst the current picture for Warrington remains reasonably reassuring and stable, it is important to ensure that we do not become complacent, and keeping lines of communication open with our residents needs to continue to find the right balance between reporting the low numbers and encouraging people to remain vigilant, follow guidance and adhere to social distancing and prevention measures.

2.2 Testing

The approach to testing, nationally and locally has evolved through the course of the pandemic to date, with priorities for testing changing as testing capacity increased.

Locally, in addition to the home testing kit option, testing is available at the regional testing sites at Haydock and Liverpool John Lennon Airport, and this is currently complemented with provision form the mobile testing unit deployed at Orford Jubilee Hub on a regular basis. Whole Care Home testing continues to be undertaken across all Warrington care homes, in line with national guidance

The next iteration of the local Testing Plan is currently underway. The plan considers the demand for testing, particularly for vulnerable populations and sets out how this demand can be fulfilled. The plan needs to be responsive to local needs and will include actions to improve the local system. The priorities for this next iteration also include access to antigen testing for different cohorts and the development of an action plan to address any issues in particular around access to antibody testing.

Linked to this, there are a number of developmental areas which help to define the content of the plan. The most critical of these has been work around developing the Local Testing Site (LTS) for Warrington Town Centre. LTS are smaller (relatively) local testing sites which are designed to be accessible to people on foot or bike to help further improve local access. Two options have been submitted and are currently being assessed for technical suitability. Whilst Warrington was initially allocated 1 LTS we are now exploring the potential of adding 2 more sites to the programme to ensure sufficient local access for our residents. Planning for this work is still in early development.

There are a number of other considerations that are being worked through in this iteration of the local testing plan in order to ensure sufficient local capacity. One is to ensure that the provision currently sited at Orford continues to provide the most effective option for residents, and that reliance on mobile provision is reduced as the permanent testing sites are established.

Work is also underway to refined testing pathways for our most complex cohorts especially for those individuals who are unable or unwilling to access testing via the national Pillar 2 routes. A key element of this will be ensuring there is enough capacity within the system both to meet the ongoing requirements based on the current levels of need but also design in additional surge capacity as required.

The refreshed Testing Plan will be submitted to the Health Protection Board on the 24th September for comment. The Plan will remain a work in progress and will need to be updated and refined as the system for testing develops.

2.3 Local Outbreak Management

Local office: As part of the local response, a local outbreak management team for Warrington has been established and recruited to. The team will help ensure we have the capacity locally to manage the consequences of any local outbreaks. Some of the posts are funded for 12 months through the national Covid-19 grant, and include an Outbreak and Testing Co-ordinator, Outbreak and Prevention Practitioners and additional analytical capacity. The funding is also being used to increase capacity in the Local Infection Prevention and Control Team, and within the Environmental Health Team. This increased capacity, and the range of posts within the Outbreak Management Team will help ensure that effective prevention work can be scaled up, and there can be a timely response to any rise in cases.

Collaborative working will continue with the Cheshire Hub which we have jointly invested in with PHE and other Local Authorities across Cheshire.

Local Response: 99% of cases in Warrington that have been escalated to Tier 1 (Local Authority Public Health Team and Public Health England/Cheshire Hub), by the national Test & Trace service to manage because they are complex, are followed up successfully.

In addition to the cases that are received via the national Test & Trace service, our local outbreak team are often informed via local intelligence from our communities, schools, care homes and workplaces of potential cases before the national system. In addition to ensuring a timely response, this provides opportunity for engagement and further prevention work.

National T&T: Although case numbers are relatively low, latest figures for Warrington show that the national system is not meeting the 80% target for completed cases, furthermore approximately 40% of contacts are not contacted by the national system. It is crucial that there is timely follow-up of all cases and their contacts to prevent potential further outbreaks. Local areas are not currently funded to follow up these 'non-complex' cases this is an important issue that needs to be addressed promptly to ensure the whole system works as effectively and efficiently as possible.

2.4 Outbreak Management: Preparedness and Governance

The joint Halton and Warrington Health Protection Board has been established and continues to meet bi-weekly. The Board receives the surveillance information and has agreed the alert metrics and trigger thresholds. The Board has oversight of the local Testing Plan and signed off the Outbreak Management plans published in June.

Work is currently underway to develop an exercise to test local lockdown plans for both boroughs. This will provide an opportunity to ensure there is clarity about the mechanisms and processes by which enhanced mitigation measures will be activated and the roles, responsibilities and considerations for local partners.

2.5 Key prevention and communication messages

Effective, clear communications continue to be crucial. Local residents are being encouraged to continue to take responsibility for protecting themselves, their families and communities. Local workplaces are being supported to understand that adhering strictly to Covid-safe practices is both good for the health and wellbeing of their staff and customers and also for business.

Local Communications teams continue to work collaboratively to ensure that there is on-going effective messaging through a range of media. The focus of the communications response has been to reiterate the most important prevention messages, to share national campaigns and to deliver targeted, localised output where necessary.

The key to driving desired behaviours is by consistently reinforcing the most important messages over a sustained period of time. To that end, the communications focus continues to be around supporting people to 'play their part' in preventing outbreaks, as well as encouraging people to get tested ASAP if even mildly symptomatic.

The most recent, localised campaign being delivered moves the conversation on to reinforce a sense of ownership to help prevent the spread of the virus, without it "passing the blame". The "It's in your hands" approach (attached in Appendix 1) is being supported by key delivery partners like LiveWire and Warrington Wolves, to help amplify messages to a broader audience.

In total, since the start of the coronavirus communications response, we have:

- Reached 9.5 million social media accounts through 620 social media posts
- Issued more than 80 media/leadership statements communicating important COVID-19 messages
- Had 408k page views of our website's coronavirus web pages, from 250k unique visitors (i.e. different people accessing our information)

On-going Covid prevention messages need to align with communications about seasonal flu to ensure vulnerable groups are protected as we head into winter.

3. Summary and Conclusion

The impacts of Covid, both direct and indirect, continue to be felt across many sections of our community. In responding to the crisis the strong partnership working, within Warrington and beyond has proved invaluable. Whilst the situation in Warrington at the moment remains relatively stable, it is important that collectively, we emphasise through all of our channels the importance of continuing with the key measures we know are effective in keeping our communities safe.

4. Recommendations

For Health and Wellbeing Board to receive the update, note the work on-going and commit to continued support and partnership working to help manage and respond to the on-going challenges as they arise.

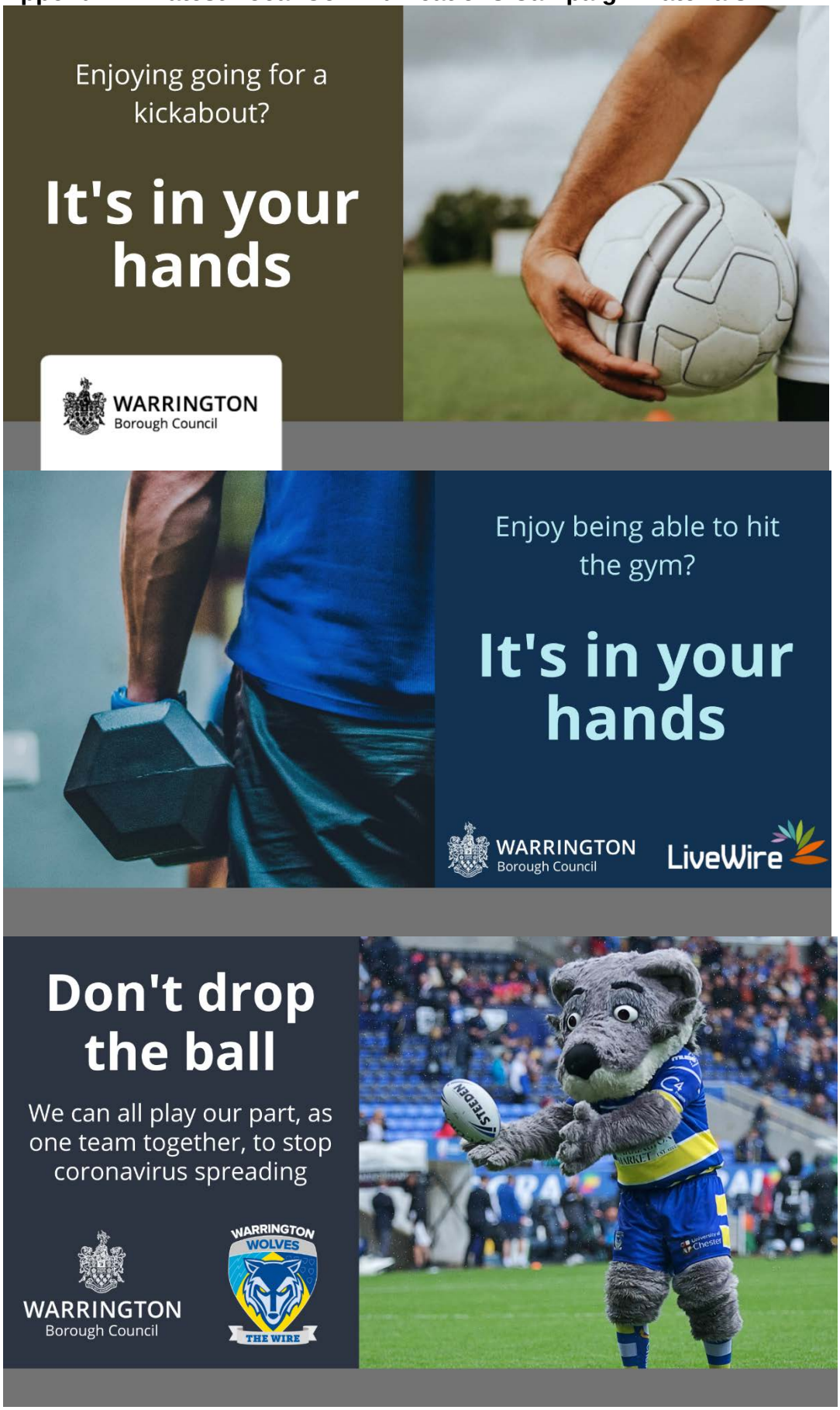
5. Background Papers

Nil

Contacts for Background Papers:

Name	E-mail	Telephone

Appendix 1: Latest Local Communications Campaign materials



Warrington
Health & Wellbeing Board

10 September 2020

1.30 pm

Report Title	House of Commons Public Accounts Committee – Readying the NHS and social care for the COVID – 19 peak
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☐ Note or Endorse a Report or Action by Others
Report Purpose	To discuss the contents of the Public Accounts Committee report of 20 July 2020 (attached)
Report author	House of Commons
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	*Strategic Priorities 5 & 12*
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To have a discussion, led by Professor Broomhead, on the contents of the report particularly the executive summary and how we look at local resolution.

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
Strong and Resilient Communities	*1: Where communities are strong, well connected, and able to influence decisions that affect them*
	2: Where all local people can access and benefit from a strong economy with quality local jobs
	3: Where housing and the wider built environment promote health and healthy choices
	4: Where there are low levels of crime and people feel safe
	5: Where we work together to safeguard the most vulnerable
Starting Well	*6: Where children and young people get the best start in life in a child friendly environment*
Living Well	*7: Where there is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities*
	8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health
	9: Where both mental and physical health are promoted and valued equally
	10: Where self-care is supported, with more people managing their own conditions
	11: Where the best care is provided in the right place at the right time
Ageing Well	*12: Where people age well and live healthy fulfilling lives into old age*
Enabling Priorities	*E1: Where we have a valued, well-trained and supported work-force that is fit for the future*
	E2: Where the benefits from information and technology are maximised
	E3: Where we invest in the right intelligence to understand our local population
	E4: Where we utilise our collective estate so that it best supports local health and social care need
	E5: Where we get best possible value for our 'Warrington Pound'

House of Commons

Public Accounts Committee

Readying the NHS and social care for the COVID-19 peak

Fourteenth Report of Session 2019–21

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 20 July 2020

HC 405
Published on 29 July 2020
by authority of the House of Commons

The Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine "the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit" (Standing Order No. 148).

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Committee reports are published on the Committee's website and in print by Order of the House.

Committee staff

The current staff of the Committee are Bradley Albrow (Second Clerk), Hajera Begum (Committee Assistant), Jessica Bridges-Palmer (Media Officer), Ameet Chudasama (Senior Committee Assistant), Richard Cooke (Clerk) and Shai Jacobs (Chair Liaison).

Contacts

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Contents

Summary

The COVID-19 outbreak posed severe and immense challenges to health and social care services in England. After the first cases of COVID-19 in England were reported on 31 January 2020, the NHS and the adult social care sector had to act quickly to prepare for the impact of the pandemic within hospitals and care homes. By the end of April, the government had allocated an additional £6.6 billion to support the health and social care response, and £3.2 billion to local government to help with pressures on local services, including social care. On 15 May it announced a further £600m for infection control in care homes. We were told that in mid-March SAGE predicted that in the worst-case scenario more than 4% of the population might be hospitalised, and 30% of those would require critical care and that ICU capacity in London may well be breached by the end of the month, even if additional measures were in place.[1]

Thanks to the commitment of thousands of staff and volunteers and by postponing a large amount of planned work, the NHS was severely stretched but able to meet overall demand for COVID-19 treatment during the pandemic's April peak. From early March to mid-May, the NHS increased the quantity of available ventilators and other breathing support, which are essential for the care of many COVID-patients. The number of mechanical ventilators rose from 9,600 to 13,200. The number of beds available for COVID-patients also increased from 12,600 to 53,700 between mid-March and mid-April.

Unfortunately, it has been a very different story for adult social care, despite the hard work and commitment of its workforce. Years of inattention, funding cuts and delayed reforms have been compounded by the Government's slow, inconsistent and, at times, negligent approach to giving the sector the support it needed during the pandemic. This is illustrated by the decision to discharge 25,000 patients from hospitals into care homes without making sure all were first tested for COVID-19, a decision that remained in force even after it became clear people could transfer the virus without ever having symptoms.

Reflecting on the Government's response to the pandemic so far, we are also particularly concerned by its failure to provide adequate PPE for the social care sector and testing to the millions of staff and volunteers who risked their lives to help us through the first peak of the crisis. The Government needs to work urgently now to ensure that there is enough capacity—including both testing and PPE—and continued support for staff and volunteers so we are ready for future COVID peaks.

There are many lessons that the government must learn, not least giving adult social care equal support to the NHS and considering them as two parts of a single system, adequately funded and with clear accountability arrangements. No-one would expect government to get every decision right first-time round during such an emergency. Rather than seeking to give the impression that it has done so, the government urgently needs to reflect, acknowledge its mistakes, and learn from them as well as from what has worked.

1 4% of the population is 2.7 million people based on the current Office of National Statistics estimated UK population of 66.7 million.

This is our first examination of the health and social care response to COVID-19. The committee will be examining the ventilator challenge and the procurement of PPE in more detail in the autumn.

Introduction

In England, the Department of Health and Social Care (the Department) has overall responsibility for health and social care policy while NHS England and NHS Improvement (NHSE&I) leads the NHS, providing oversight and support for NHS trusts and foundation trusts. Local NHS trusts provide hospital, community and mental health services, alongside GPs, while local authorities assess care needs and commission social care and public health services. In March this year, NHSE&I was given temporary emergency powers to lead and organise all NHS services directly as it responded to COVID-19.

The Ministry of Housing, Communities & Local Government (the Ministry) has responsibility for the local government finance and accountability systems. Public Health England, working with local authorities and NHS partners, provides health protection services and public health advice, analysis and support to government and the public. This includes monitoring of, preparing for and responding to public health emergencies such as COVID-19.

Conclusions and recommendations

1. **Unclear responsibilities and accountabilities at the outset and a failure to issue consistent and coherent guidance throughout the pandemic have resulted in confusion and poor central control over critical elements of the pandemic response.** The health and social care sector had to react quickly, including making necessary changes to the way services are organised and provided, to respond to the COVID-19 crisis. While it was clear that the NHS had responsibility for ensuring there were enough beds, oxygen and ventilators to provide treatment for COVID-patients when required, it was unclear who was leading on the social care response. The Department is responsible for overall policy across health and social care but leads a fragmented system of adult social care, where responsibilities are spread between the Department, local government and care providers. Several bodies, including the Department, Public Health England and NHS England and NHS Improvement (NHSE&I) are involved in COVID-19 testing and reporting, and the provision of Personal Protective Equipment (PPE) for NHS and social care staff. Yet there have been frequent reports of the lack of timely testing for both staff and the public and the inadequate provision of PPE for social care workers and residents, with numerous updates to PPE guidance leading to confusion and stress. We note that Lord Deighton, since mid-April, has taken the lead on PPE supply. This direct accountability is a welcome step and we note there have been fewer issues with supply since then.

   Recommendation: ***The Department should write to us by September 2020 setting out the named individuals who are the Senior Responsible Owners or relevant national leads for all critical elements of the pandemic response, including, for adult social care, an equivalent to the Chief Executive of NHS England; PPE provision and supply; and testing. The Department should ensure these leads work with all relevant local and national bodies and have both the authority and data they need to do their jobs.***

2. **Discharging patients from hospital into social care without first testing them for COVID-19 was an appalling error.** Shockingly, Government policy up to and including 15 April was to not test all patients discharged from hospital for COVID-19. In the period up to 15 April, up to a maximum of five symptomatic residents would be tested in a care home in order to confirm an outbreak. Belatedly, after discharging 25,000 people from hospitals to care homes between 17 March and 15 April, the Department confirmed a new policy of testing everyone prior to admission to care homes. Public Health England confirmed that it was already becoming clear in late March, and certainly from the beginning of April, that the COVID-19 infection had an asymptomatic phase, when people could be infectious without being aware they were sick. The Department does not know how many of the 25,000 discharged patients had COVID-19. The number of reported first-time outbreaks in individual care homes peaked at 1,009 in early April. Between 9 March and 17 May, around 5,900 care homes, equivalent to 38% of care homes across England, reported at least one outbreak. The Department says that it took rational decisions based on the information it had at the time, but acknowledges that it would not necessarily do the same thing again.

Recommendation: ***The Department and NHSE&I should review which care homes received discharged patients and how many subsequently had outbreaks, and report back to us in writing by September 2020. The Department along with NHSE&I should develop procedures so that all patients deemed fit to leave hospital are safely discharged into settings in a way which limits the spread of COVID-19.***

3. **This pandemic has shown the tragic impact of delaying much needed social care reform, and instead treating the sector as the NHS's poor relation.** This Committee has highlighted the need for change in the social care sector for many years, particularly around the interface between health and social care. Despite the intentions of successive Governments, there have been ongoing delays to reforming and integrating the two sectors. The stark contrast between the approach taken towards protecting the NHS compared with the care sector has been highlighted by many since the start of the pandemic. Various pieces of guidance were issued to the social care sector, but it took the Department until 15 April to publish their action plan for adult social care, over 4 weeks after the initial NHS letter on plans to respond to the COVID-19 outbreak. The Department has much better and more timely information in the NHS than for social care. It is simply unacceptable to hear reports of inadequate PPE, lack of testing and insufficient guidance on training. There have been warnings of an increased risk of provider failure in the care sector, and the Local Government Association and NHS Providers have reiterated the need for urgent reforms to put social care on a sustainable footing after years of under-funding.

Recommendation: ***After years of promises and false starts, we expect the Department to set out in writing to us by October 2020 what it will be doing, organisationally, legislatively and financially, and by when, to make sure the needs of social care are given as much weight as those of the NHS in future. We will be challenging them on this at future sessions.***

4. **Public confidence is likely to be further undermined without an open and honest debate about current capacity and tangible plans to address gaps, for example, in testing and PPE.** Government has had to and will continue to have to make quick decisions with sometimes imperfect information as the pandemic develops. Yet too often the basis for decisions or changes, such as on PPE, has been unclear; sometimes seemingly based upon what the system could cope with, rather than clinical advice and 'what was right', and at other times without regard to the reality on the ground. On PPE, guidance was changed 40 times without consulting service providers, leading to confusion on the ground. There has been a lack of transparency around the availability and supply of PPE, and a tendency for Government to over-promise and under deliver. After squandering the opportunity to build up supplies in January and February, it remains to be seen whether the Department can meet its intention to have a 90-day PPE stockpile. Testing for COVID-19 is vital for controlling the virus and informing and assuring the public. It will be essential as 'track and trace' is rolled out, yet testing capacity was insufficient for much of the pandemic and, as highlighted by the UK Statistics Authority, public reporting has been inconsistent and lacking transparency.

Recommendation: ***Among other measures, the Department should assess the capacity it needs, particularly for PPE and testing, and how it will meet this, to***

cope with a second peak; and report transparently and consistently on progress. It should write to the Committee by September 2020 with further details of its assessment and plans.

5. **Staff in health and social care cannot be expected to be ready to cope with future peaks and also deal with the enormous backlogs that have built up unless they are managed well.** We are deeply concerned about the frontline workers and volunteers who have endured the strain and trauma of responding to COVID-19 for many months. Failure to protect staff by providing adequate PPE has impacted staff morale and confidence, while a lack of timely testing, until after the pandemic had passed its first peak, led to increased stress and absence. These same staff will be called upon in the event of a second peak and the NHS will need extra staff to deal with the backlog of treatment. While the NHS says it is providing much needed support to staff, details are limited, and we remain concerned about the Department's ability and capacity to safeguard the mental health and well-being of the thousands of health and social care staff and volunteers from the lasting effects of the pandemic.

   Recommendation: ***The Department and NHSE&I should identify and agree with relevant professional bodies specific actions to support health and social care staff to recover from the impact of the first peak and how they will monitor and provide further support to staff through to the end of the pandemic.***

6. **Policies designed to create additional capacity quickly, while necessary, have resulted in a lack of transparency about costs and value for money.** The NHS boosted its potential maximum capacity for the peak in April by building Nightingale hospitals across the country and signing contracts with independent providers for 8,000 additional beds, which was announced on 21 March. The contract ended on the 28 June. The Department expects to continue these arrangements in anticipation of future peaks. However, we are concerned by the scarcity of information on contracts and costs. When asked, NHSE&I was unable, or unwilling, to provide any estimate of the cost of private sector capacity or the Nightingale hospitals. We are fortunate that the Nightingale hospitals have not been required so far during the pandemic, but it will not be a good use of public money if we continue to let them remain empty while elsewhere the NHS requires additional capacity for normal services.

   Recommendation: ***After failing to provide detail in the session, it is imperative that the Department and NHSE&I write to the Committee as soon as possible – and no later than 1 September 2020—with information on the cost of private hospital contracts, how these have been used, and their intentions for how private and Nightingale hospitals will be made best use of in the coming months, including:***

   - ***details of what the second phase of contracts will provide;***
   - ***the total cost and pricing mechanisms; and***
   - ***how capacity in these hospitals will be allocated?***

   They should come to subsequent sessions prepared to disclose cost information on key elements of the pandemic response.

1 Lessons from the NHS and adult social care response to the COVID-19 pandemic

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department), NHS England & NHS Improvement (NHSE&I), the Ministry of Housing, Communities & Local Government (the Ministry) and Public Health England on Readying the NHS and adult social care in England for COVID-19.[2]

2. In England, the Department has overall responsibility for health and social care policy while NHSE&I leads the NHS, providing oversight and support for NHS trusts and foundation trusts. Local NHS trusts provide hospital, community and mental health services, alongside GPs, while local authorities assess care needs and commission social care and public health services. The Ministry of Housing, Communities and Local Government (MHCLG) has responsibility for the local government finance and accountability systems. Public Health England, working with local authorities and NHS partners, provides health protection services and public health advice, analysis and support to government and the public.[3] This includes monitoring, preparing for and responding to public health emergencies such as COVID-19. Public Health England (PHE) is an executive agency of the Department.[4] At the start of the outbreak, the only central stock pile—held by PHE was designed for a flu Pandemic. We welcome Lord Deighton's appointment to lead on PPE supply.

3. COVID-19 is an infectious respiratory disease caused by a newly discovered coronavirus, first identified in China in December 2019. On 31 January 2020, England's Chief Medical Officer confirmed the first cases of COVID-19 in England. Over the following months, the UK government mobilised a wide-ranging response to COVID-19, covering health, social care and other public services, and support to individuals and businesses affected by the pandemic. By the end of April, the government had allocated an additional £6.6 billion to support the health and social care response to COVID-19 and £3.2 billion to local government to respond to COVID-19 pressures across local services, including adult social care.[5]

Accountability arrangements for the COVID-19 response

4. The scale and nature of the COVID-19 pandemic are without precedent in recent history and the NHS and the adult social care sector have had to reorganise their services at great speed.[6] Before the pandemic, NHSE&I commissioned most NHS services through NHS local commissioners (clinical commissioning groups).[7] In March this year, the Department gave NHSE&I temporary emergency powers to lead and organise all NHS services directly as it responded to COVID-19.[8]

2 C&AG's Report, *Readying the NHS and adult social care for COVID-19*, Session 2019–2021, HC367, 12 June 2020
3 C&AG's Report, para 4
4 https://www.gov.uk/government/organisations/public-health-england
5 C&AG's Report, paras 4, 9
6 Department of Health and Social Care, *The Exercise of Commissioning Functions by the NHS Commissioning Board (Coronavirus) Directions 2020*, 23 March 2020
7 C&AG's Report, *NHS financial management and sustainability*, Session 2019–21, HC 44, 5 February 2020
8 C&AG's Report, para 1.17

5. NHSE&I told us that it declared a level 4 incident, the highest level of emergency response the NHS can provide from 30 January. This was followed by a series of actions to prepare the NHS for the expected surge in COVID-19 patients, including weekly briefings for NHS leaders from early February, and, in a 17 March letter to NHS service providers and commissioners, outlining detailed preparations to free up beds and redirect staff and other resources.[9] But it was not until the 15th April that the Government published an Action Plan for Adult Social Care.[10] Actions taken by the NHS, alongside the Government's social distancing policies, ensured that there were sufficient beds and ventilators to provide treatment for COVID-patients when required.[11]

6. When challenged on the lack of similarly clear leadership in the social care response, the Department acknowledged that statutory responsibilities for social care are spread between national government, local government and individual providers. The Department is responsible for overall policy across health and social care but it recognised the "considerable ambiguity in how social care is managed" and that the fragmented system had made it "*considerably more difficult*" for Government to take action.[12]

7. There have been serious and widespread concerns about the lack of timely testing for both staff and the public and inadequate PPE provision particularly in social care.[13] When we queried the arrangements for ensuring access to testing, we were told that several bodies were involved, including the Department, Public Health England and NHSE&I. For example, NHS laboratories tested patients and some NHS staff, while other parts of the testing programme were run elsewhere.[14] NHSE&I told us it had followed Public Health England's strategy on whom to test.[15] Public Health England clarified that its testing policy in March was based on the limited testing capacity at the time as agreed with the NHS and the Chief Medical Officer.

8. Similarly, procuring and distributing PPE involved a range of bodies, including the Department, Public Health England, local NHS providers and care homes, yet until the appointment of Lord Deighton in mid-April no one took the lead in making sure there was sufficient PPE.[16] Public Health England told us that it was responsible for holding and adjusting the PPE stockpile on behalf of the Department, but did not make policy decisions on its contents, management or use.[17] When challenged on its part in ensuring sufficient PPE supply, the Department explained that it had worked with NHSE&I, alongside the Foreign Office and others, to source international supply, but it stressed the difficulties it faced given worldwide demand. We noted the significant increases in PPE supplies since Lord Deighton's appointment.[18]

9 Q 10; C&AG's Report, para 1.3, 1.13
10 C&AG's Report, para 1.3
11 Qq 58, 63, 118–119; C&AG's Report, paras 10–13,18
12 Qq 11, 120
13 Committee of Public Accounts, *NHS capital expenditure and financial management*, Eighth Report of Session 2019–21, HC 344, 8 July 2020, para 22; C&AG's Report, paras 19, 20; RSC0010 NHS Confederation submission; RSC0004 NHS Providers submission; RSC0001 Care England submission
14 Qq 18–20, 23–26, 34, 98
15 Qq 17–19
16 Qq 62, 75, 79, 87–88
17 Qq 75
18 Qq 62, 87–88

Discharging people from hospitals to care homes

9. On 17 March the NHS told trusts to discharge urgently all medically fit hospital patients with COVID-19 to maximise inpatient and critical care capacity. On 2 April, the Department told care homes that they needed to make their full capacity available and could admit patients with COVID-19 by isolating suspected or confirmed cases. Some Local Authorities were pressurising Care Homes to take patients discharged from hospitals.[19] Yet until 15 April there was no policy to test patients for COVID-19 before discharging them to care homes. By this point 25,000 people had been discharged from hospitals to care homes and the Department does not know how many had COVID-19.[20]

10. Some organisations such as Care England highlighted to us the flawed nature of this policy and reported that, given the absence of testing and inadequate PPE, social care felt abandoned.[21] When we challenged the Department and the NHS on such a reckless and negligent policy, the Department told us that when the NHS issued its guidance in March COVID-19 was not widespread.[22] NHSE&I said it has always been the case that they want to discharge people who are clinically fit and staying in hospital could be harmful for the elderly.[23] When asked why those discharged had not been tested, it told us it was following testing advice provided by Public Health England.[24] Public Health England clarified that, at the start of the outbreak, testing was limited to 3,500 tests a day nationally and so it had agreed with the NHS and the Chief Medical Officer priority groups for testing: those in intensive treatment units; those with respiratory infections; and limited testing in care homes to diagnose outbreaks. Public Health England also told us that "what was becoming clear in the back-end of March and certainly from the beginning of April was that there was an asymptomatic phase, which means that people can transfer the virus without ever having symptoms, or a significant pre-symptomatic phase, which is where the virus could be shared".[25] It is clear that the availability of test and testing should have been ramped up much more quickly after the NHS had declared Level 4 National Incident (its most severe incident level) on the 30th January 2020.

11. We remained concerned that the Department had continued its policy of discharging people untested into care homes even once it was clear there was an emerging problem.[26] The number of first-time outbreaks in individual care homes peaked at 1,009 in early April. Between 9 March and 17 May, around 5,900 care homes, equivalent to 38% of care homes across England, reported at least one outbreak of the disease.[27] The Department defended the decisions it took as rational based on the information it had at the time and stated its belief that the clearest correlations between social care outbreaks and other issues related to staff with the disease rather than patients discharged from hospital. However, it also acknowledged "that is not the same as saying that we would do the same again".[28]

19 Q13
20 C&AG's Report, paras 3.19–3.20
21 RSC0001 Care England submission
22 Qq 21–22
23 Q 16
24 Qq 14, 16–18
25 Qq 20, 84
26 Qq 19, 21–23
27 C&AG's Report, para 3.15
28 Qq 23, 43

Delays to reforming adult social care

12. This Committee has warned before that the Department lacked an effective overall strategy or plan to integrate health and care and that poor outcomes could arise as a result.[29] As Care England told us, for too long "adult social care has been kicked into the long grass by governments of all stripes."[30] Despite numerous white papers, green papers, consultations, and independent reviews over the past 20 years, meaningful integration of health and social care was yet to occur going into the pandemic.[31] The Department noted that the experience with COVID-19 had heightened the need for reform.[32]

13. We heard how frequently social care had taken second place to the NHS's needs, particularly in accessing test kits and results, and securing reliable PPE supply for care homes, which had been neither timely nor coordinated.[33] When questioned, the Department denied that social care had been forgotten, citing the work it had done in the sector and that it had "taken a more national and more interventionist role in social care than ever before" when issuing guidance and additional funding, for example. It said that testing capacity had been limited but as it increased was opened up to all care staff.[34] On the subject of PPE supply, the Department asserted, "at no point has there been an instruction for the NHS to be prioritised over the care sector".[35] When we pressed the Department on why it did not publish its action plan for adult social care until 15 April, over four weeks after the initial NHS letter on plans to respond to the outbreak, it told us the plan brought together and enhanced previous guidance given.[36] Government Policy prior to the action plan was that the social care sector procure their own PPE. This was against a background of the NHS's huge purchasing power and tightening domestic and worldwide demands for PPE. It did acknowledge, however, that the thousands of independent providers and the funding model for social care made for a very challenging and tough context in which to respond to COVID-19. This was apparent in the imperfect data it had to work with. The Department told us that data was much better and more timely in the NHS than for social care, due to the structural differences between the two.[37]

14. This Committee has also challenged the Department before over not delivering on its overarching responsibilities towards the care market, and having no credible plans to ensure the sector was sustainably funded.[38] We note it was not until June 2020 that the Department appointed a director general for adult social care to lead on its social care policies, four years after the previous director general left the post.[39] The Ministry of Housing, Communities & Local Government told us that it had provided £3.2 billion additional funding to local government with instructions to prioritise social care and, of the £1.25 billion spent so far, £500 million had gone on social care.[40] On 15 May 2020 the

29 Committee of Public Accounts, *Interface between health and adult social care*, Sixty-Third Report of Session 2017–19, HC 1376, 19 October 2018
30 RSC0001 Care England submission
31 C&AG's Report, foreword
32 Q 121
33 RSC0002 Local Government Association submission; RSC0005 Association of Anaesthetists submission
34 Qq 11–12, 27, 38
35 Q 42
36 Qq 11–12
37 Qq 31–38, 40; C&AG's Report, para 13
38 Committee of Public Accounts, *The adult social care workforce in England*, Thirty-Eighth Report of Session 2017–19, HC 690, 9 May 2018
39 HSJ article: *Government's social care directorate restored after four-year gap*, 15 June
40 Qq 28–29

government also announced a £600 million Infection Control Fund for local government, to tackle the spread of COVID-19 in care homes in England, which was in addition to the £3.2 billion.[41] Given reports of increased risk of provider failure and calls from the Local Government Association and NHS Providers to secure a sustainable future for social care, we pressed the Department on whether it would have to rescue any failing providers in the weeks ahead. It told us it was focusing on ensuring the continued provision of services to individuals but was looking closely at the evidence base to understand the different challenges faced by different providers, including increased costs and in some, but not all, cases, reduced demand.[42]

41 C&AG's Report, *Overview of the UK government's response to the COVID-19 pandemic*, Session 2019–21, HC 366, 21 May 2020, Figure 4

42 Qq 30, 92–93; C&AG's Report, para 14; RSC0004 NHS Providers submission; RSC0002 Local Government Association submission

2 Resuming services and preparing for the future

Public trust

15. The Department stressed that it had to respond quickly to the COVID-19 pandemic often with "imperfect knowledge", which was why its approach had altered over time.[43] But Care England told us that PPE guidance had changed no fewer than 40 times, causing confusion and anxiety to service providers and staff.[44] When we asked why the PPE guidance had constantly changed, the Department said that when updating its guidance it was trying to match clinical advice, as understanding of the virus changed, to available supply. We challenged it on why it would in effect toughen guidance when it knew there was already insufficient supply. For example, guidance which said care homes needed new PPE for each patient had caused considerable anxiety. The Department told us it could not "simply be driven by supply in this case".[45]

16. By comparison, because testing capacity was limited during the earlier stages of the pandemic, the Department said it had sought clinical advice on where that capacity was best deployed. Eligibility for tests changed as capacity increased and the Department noted that testing was the area which had evolved the most over time.[46]

17. Concerns about the transparency of Government's reporting about the measures it has taken, particularly around PPE and testing, have been widely publicised.[47] We heard from stakeholders in the health and social care sector who highlighted issues with inadequate and unreliable PPE supply.[48] For example, despite the fanfare around a large consignment of PPE being secured from Turkey, it did not contain the volume expected nor meet required standards.[49]

18. Testing for COVID-19 is fundamental to controlling the virus, and to informing and reassuring the public.[50] Yet, while Government's announcement of its 100,000 daily test target by the end of April had a galvanising effect to start with, NHS Providers reported that it had ended up being a distraction from developing the right kind of capacity and testing approaches in all areas of the country.[51] The UK Statistics Authority publicly criticised the Government for the way it counted tests and has urged greater clarity about how testing targets are defined, measured and reported.[52] Similarly to PPE, we heard how unkept promises on tests had led to a loss in confidence among some providing NHS services.[53]

43 Q 32
44 RSC0001 Care England submission
45 Qq 90–91
46 Qq 20, 25
47 For example, BBC news on its Panorama programme on PPE and BBC statement on Panorama, Monday 27 April: Has The Government Failed the NHS?
48 RSC0001 Care England submission; RSC0002 Local Government Association submission; RSC0004 NHS Providers submission; RSC0005 Association of Anaesthetists submission; RSC0010 NHS Confederation submission
49 HSJ, *Exclusive: Turkish delivery contained just a few hours' worth of gowns*, 23 April; *The Guardian, Coronavirus PPE: all 400,000 gowns flown from Turkey for NHS fail UK standards*, 7 May
50 Qq 24–26
51 RSC0004 NHS Providers
52 Sir David Norgrove letter to Matt Hancock regarding COVID-19 testing
53 RSC0010 NHS Confederation submission

19. We were keen to know how the Department would ensure sufficient stockpiles of PPE and testing capacity as it rolls out its ambitious 'track and trace' programme and the NHS resumes routine services while continuing to deal with COVID-19 this autumn and winter.[54] It reiterated that testing capacity had now expanded significantly.[55] Public Health England also explained that it was "ramping up" the size of its local health protection teams from 360 staff to 1,100 by the end of July, in light of the test and trace part of the programme.[56] Given its failure to boost the PPE stockpile during January and February despite recommendations from the New and Emerging Respiratory Virus Threats Advisory Group, we asked how the Department was going to ensure lessons were learned so there would be adequate PPE this winter. The Department claimed it had been in the process of responding to this advice when COVID-19 hit. It said it was aiming in future to have PPE supply for 90 days ahead by signing longer-term contracts to guarantee overseas supply; increasing the proportion of PPE made domestically; and better understanding demand.[57]

Managing staff well-being

20. NHSE&I explained that the NHS was carrying 100,000 staff vacancies going into the pandemic.[58] It said the workforce had been boosted by around 20,000 students; retired NHS staff; and a further 600,000 volunteers (working across a range of public services, including the NHS) who stepped forward to work on the frontline during the crisis.[59] Given the potential reliance on the student workforce in the event of a second wave, we asked about the operational impact of the NHS's June decision to cut short its student nurse programme, which was providing paid placements. NHSE&I told us that this had always been the intention as final year students who qualified would move into substantial placements at more senior grades while second year students would need to return to the academic part of their courses.[60]

21. There have been numerous media reports of PPE shortages for health and social care staff and stakeholders have told us how the failure to provide adequate and timely PPE has impacted staff morale, trust and confidence.[61] In the period from 6 April to 19 May, more than 80% of local resilience forums reported that PPE was having a high or significant disruptive impact in their area across health and social care services, putting staff and others at risk.[62]

22. Testing for NHS workers (with symptoms) only began from 27 March, with eligibility extended to social care workers (with symptoms) from 15 April, after the pandemic had passed its first peak. In the period up to 15th April up to a maximum of five symptomatic residents in each care home would be tested, and from the 28th April all symptomatic care home residents were offered testing but this was capped at 30,000 tests per day between residents and staff. From 28 April, all social care workers were eligible for tests, but the Department capped the daily amount of care home tests at 30,000 (to be shared between

54 Qq 51–52, 56–57, 78–79
55 Qq 25, 27
56 Qq 49–50; Public Health England letter from Professor Paul Johnstone to PAC Chair, 2 July 2020
57 Qq 76, 78, 79
58 Q 109
59 Qq 5, 94
60 Qq 96–97
61 Qq 21,23, 26–27; Committee of Public Accounts, *NHS capital expenditure and financial management*, Eighth Report of Session 2019–21, HC 344, 8 July 2020; RSC0010 NHS Confederation submission; RSC0001 Care England submission; RSC0002 Local Government Association submission; RSC0004 NHS Providers submission
62 C&AG's Report, para 4.28

staff and residents).[63] Stakeholders told us that failures in testing had also led to increased anxiety and frustration as well as increased absence due to unnecessary isolation. For example, the NHS Confederation told us that the NHS had had an unprecedented level of absence during the first weeks of April.[64] When asked about testing staff, the Department said it had made this available in care homes as capacity increased and there were now around 70,000 tests a day available to all care home staff as well as residents. NHSE&I told us it had now started testing asymptomatic staff and referenced Public Health England's large-scale study testing staff to see if they had COVID-19 now, or had previously had it, which would provide more information on how and when it was best to test.[65]

23. We were concerned about the NHS needing to call on the same staff who have already worked exceptionally long hours during the first peak in order to deal with the backlogs of treatment, while also standing ready for a potential second peak.[66] NHSE&I explained that it was "encouraging people to take leave, so that they are refreshed going into the autumn and winter, as well as encouraging people who have returned to stay with us and those who have volunteered to continue to offer their support".[67] We asked how the NHS was looking after its workforce given the emotional trauma of treating patients with COVID-19 and the fact that the NHS interim people plan had not referred to treating the mental health of its staff. In response, NHSE&I sought to assure us that staff health and wellbeing was a "primary focus nationally, regionally and locally". It recognised the need for targeted psychological and mental health support for staff across the health service and pointed to plans to roll out more widely an existing mental health programme for doctors as well as helplines and other support for particular staff groups.[68]

Securing additional capacity

24. Under its reasonable worst-case scenario, the Government expected over 4% of the population might require hospital admission for COVID-19 and 30% of those would require critical care. NHSE&I told us that the number of COVID-19 patients admitted to hospital had risen from a few hundred in mid-March to 18,000 two weeks later.[69] As NHS Providers stated, the healthcare sector responded at pace to ensure that the NHS had enough capacity for the expected large number of COVID-19 patients.[70] The additional capacity secured by NHSE&I included new Nightingale hospitals as well as contracts with independent providers for an additional 8,000 beds, 18,700 staff and 1,200 ventilators. The contracts were to run until 28 June but could be extended. Use of the Nightingale hospitals so far has been limited.[71]

25. Between mid-March and mid-April, the NHS and armed forces are to be commended for increasing the number of beds available for Covid-19 patients from 12,600 to 53,700 in

63 C&AG's Report, para 3.16

64 RSC0012 National Institute for Health Research (NIHR) Health Protection Research Unit in Merging and Zoonotic Infections; University of Liverpool, Institute of Infection and Global Health, and University of Oxford, Nuffield Department of Primary Care Health Sciences submission; RSC0010 NHS Confederation submission; RSC0004 NHS Providers submission; RSC0005 Association of Anaesthetics submission

65 Qq 98–101

66 Qq 102–105, 108–111; C&AG's Report, para 4.30; RSC0010 NHS Confederation submission; RSC0004 NHS Providers submission

67 Q 57

68 Qq 102, 105, 111

69 Qq 14,109, 116

70 RSC0004 NHS Providers submission

71 C&AG's Report, paras 10, 2.6, 2.7, 4.4; Ev Independent Healthcare Providers Network submission

a very short space of time. The additional capacity inside existing NHS hospitals helped to ensure that at no point during the pandemic did the number of patients exceed the number of available beds.[72] Independent and Nightingale capacity created a 'buffer' on top of that, and NHS Providers also welcomed the private sector support which had been offered to date.[73] We recognise the need to have moved at speed to set up these arrangements. However, we were also concerned about the trade-offs with securing value for money and an apparent lack of transparency. We asked NHSE&I about the use and cost of the capacity secured through independent hospitals. NHSE&I told us that "several hundred thousand patient treatments", such as chemotherapy and diagnostic tests, had been delivered as well as equipment. Despite the open book accounting arrangements in the contract, NHSE&I would not provide even a rough estimate of costs until these had been audited and said it might be "several weeks" before it could share the data with us.[74] The use and cost of the Nightingale facilities are also not yet known. We also noted with concern some evidence from stakeholders that contracts awarded during the period have lacked transparency.[75] When asked about stories of bonuses to directors in independent hospitals being charged to the taxpayer, NHSE&I told us the contract explicitly prohibits compensation for bonus payments beyond what would have been acceptable in the NHS.[76]

26. Access to NHS services has reduced significantly during the COVID crisis, potentially creating huge pent-up demand, which will add to the substantial waiting lists that existed before the pandemic.[77] NHSE&I told us that access to emergency and critical services, such as cancer, has been maintained throughout the crisis although use of these services had been lower than usual. It also told us that it was now encouraging the NHS to resume more routine services.[78] Stakeholders from the NHS and independent provider sectors have expressed concerns that resuming services, while the pandemic is still ongoing and with the potential for a second peak, will be challenging and will require full use of capacity across both sectors.[79] We asked NHSE&I what plans it had to address these concerns in the near future. NHSE&I told us that the arrangements with the private sector were likely to continue for the rest of the year in order to provide a continuing 'buffer' for routine surgery, cancer care and other conditions but it noted that the basis on which it contracted with independent hospitals was likely to change and it was likely to follow a competitive procurement. As discussions are still ongoing, NHSE&I could not provide details on how independent hospital capacity would be allocated but assured us that it would be available for networks of hospitals and GPs in a given area to draw on. It also said that the Nightingale hospitals would be on standby in case of a second pandemic peak.[80]

72 Q 56; C&AG's Report, para 10; RSC0007 Independent Healthcare Providers Network submission; RSC0010 NHS Confederation submission

73 Q 63; RSC0004 NHS Providers submission; RSC0007 Independent Healthcare Providers Network submission; RSC0006 Spire Healthcare submission

74 Qq 64–74

75 C&AG's Report, para 2.7; RSC0011 Future Care Capital submission

76 Q 65

77 Q 59; C&AG's Report, para 12; Committee of Public Accounts, *NHS waiting times for elective and cancer treatment*, One Hundredth Report of Session 2017–19, HC 1750, 12 June 2019; and *NHS capital expenditure and financial management*, Eighth Report of Session 2019–21, HC 344, 8 July 2020; C&AG's Report, *NHS financial management and sustainability*, para 4; RSC0007 Independent Healthcare Providers Network submission; RSC0006 Spire Healthcare submission; RSC0005 Association of Anaesthetics submission

78 Qq 56, 59; C&AG's Report, para 2.21

79 RSC0010 NHS Confederation submission; RSC0007 Independent Healthcare Providers Network submission; RSC0005 Association of Anaesthetics submission

80 Qq 56–59, 63

Formal minutes

Monday 20 July 2020

Virtual meeting

Members present:

Meg Hillier, in the Chair

Olivia Blake	Sir Bernard Jenkin
Sir Geoffrey Clifton-Brown	Mr Gagan Mohindra
Dame Cheryl Gillan	James Wild
Peter Grant	

Draft Report (*Readying the NHS and social care for the COVID-19 peak*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 26 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Fourteenth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 21 July at 9:45am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 22 June 2020

Sir Chris Wormald, Permanent Secretary, Department for Health and Social Care; **Sir Simon Stevens**, Chief Executive, NHS England; **Amanda Pritchard**, Chief Operating Officer, NHS England and NHS Improvement; **Catherine Frances**, Director General, Communities, Ministry of Housing, Communities and Local Government; **Rosamond Roughton**, Director General, Adult Social Care at, Department for Health and Social Care; **Professor Steve Powis**, National Medical Director, NHS England; **Professor Paul Johnstone**, National Director for Place and Regions, and Deputy SRO for PHE COVID-19 response, Public Health England Q1–121

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

RSC numbers are generated by the evidence processing system and so may not be complete.

1 ADASS (ADASS, Deputy Chief Officer) (RSC0013)

2 Association of Anaesthetists (Jenny Gowen, Advocacy and Campaigns Manager) (RSC0005)

3 Care England (Mrs Louisa Collyer-Hamlin, External Affairs) (RSC0001)

4 Future Care Capital (Dr Peter Bloomfield, Head of Policy and Research) (RSC0011)

5 Gumber, Dr Anil (RSC0003)

6 Independent Healthcare Providers Network (Ms Megan Cleaver, Senior External Affairs Manager) (RSC0007)

7 Johnson, Elliott Aidan (RSC0008)

8 Johnson, Dr Matthew Thomas (RSC0008)

9 Local Government Association (Miss Jade Hall, Public Affairs and Campaigns Adviser) (RSC0002)

10 Nettle, Prog Daniel (RSC0008)

11 NHS Confederation (Mr Niall Dickson CBE, Chief Executive) (RSC0010)

12 NHS Property Services (Miss Rosalia Wood, External Communications Manager) (RSC0009)

13 NHS Providers (Ms Susan Bahl, Head of Policy and Public Affairs) (RSC0004)

14 The Royal College of Nursing (RSC0014)

15 Spire Healthcare (Paul Lehmann, Head of External Communications) (RSC0006)

16 University of Liverpool, Institute of Infection and Global Health, andUniversity of Oxfo (Dr Paul Atkinson) (RSC0012)

17 Webber, Dr Laura (RSC0008)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2019–21

First Report	Support for children with special educational needs and disabilities	HC 85
Second Report	Defence Nuclear Infrastructure	HC 86
Third Report	High Speed 2: Spring 2020 Update	HC 84
Fourth Report	EU Exit: Get ready for Brexit Campaign	HC 131
Fifth Report	University Technical Colleges	HC 87
Sixth Report	Excess votes 2018–19	HC 243
Seventh Report	Gambling regulation: problem gambling and protecting vulnerable people	HC 134
Eighth Report	NHS expenditure and financial management	HC 344
Ninth Report	Water supply and demand	HC 378
Tenth Report	Defence Capability and the Equipment Plan	HC 247
Eleventh Report	Local authority investment in commercial property	HC 312
Twelfth Report	Management of tax reliefs	HC 379
Thirteenth Report	Whole of Government Response to Covid-19	HC 404

Warrington
Health & Wellbeing Board

10 September 2020

1.30 pm

Report Title	Presentation - Reset, not restart: shaping the future of social care in light of COVID-19
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	Awareness raising regarding the ADASS survey and Report on Adult Social Care and the need for Reform
Report author	Catherine Jones Director Adult Social Care
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	*(1,7,11,12)*
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To note and support the principles of Reform in Adult Social Care.

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
Strong and Resilient Communities	*1: Where communities are strong, well connected, and able to influence decisions that affect them*
	2: Where all local people can access and benefit from a strong economy with quality local jobs
	3: Where housing and the wider built environment promote health and healthy choices
	4: Where there are low levels of crime and people feel safe
	5: Where we work together to safeguard the most vulnerable
Starting Well	*6: Where children and young people get the best start in life in a child friendly environment*
Living Well	*7: Where there is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities*
	8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health
	9: Where both mental and physical health are promoted and valued equally
	10: Where self-care is supported, with more people managing their own conditions
	11: Where the best care is provided in the right place at the right time
Ageing Well	*12: Where people age well and live healthy fulfilling lives into old age*
Enabling Priorities	*E1: Where we have a valued, well-trained and supported work-force that is fit for the future*
	E2: Where the benefits from information and technology are maximised
	E3: Where we invest in the right intelligence to understand our local population
	E4: Where we utilise our collective estate so that it best supports local health and social care need
	E5: Where we get best possible value for our 'Warrington Pound'

Warrington
Health & Wellbeing Board
10 September 2020

Report Title	NHS 111 First – Early Implementer Site
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To update Warrington Health & Wellbeing Board on the NHS 11 First initiative with Warrington Hospital being an early implementer site.
Report author	Chris Evans, Chief Operating Officer – Warrington & Halton Teaching Hospital NHS FT Daniel Moore, Director of Operations & Performance - Warrington & Halton Teaching Hospital NHS FT
Related Health and Wellbeing Strategy Priority *see addendum attached to this report	Living Well: 11: Where the best care is provided in the right place at the right time
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To note the content of this briefing and associated launch on the 8th September 2020.

Health and Wellbeing Strategy 2019-2023: Strategic Priorities

Strategic Theme	***Strategic Priorities***
Strong and Resilient Communities	*1: Where communities are strong, well connected, and able to influence decisions that affect them*
	2: Where all local people can access and benefit from a strong economy with quality local jobs
	3: Where housing and the wider built environment promote health and healthy choices
	4: Where there are low levels of crime and people feel safe
	5: Where we work together to safeguard the most vulnerable
Starting Well	*6: Where children and young people get the best start in life in a child friendly environment*
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	9: Where both mental and physical health are promoted and valued equally
	10: Where self-care is supported, with more people managing their own conditions
	11: Where the best care is provided in the right place at the right time
Ageing Well	*12: Where people age well and live healthy fulfilling lives into old age*
Enabling Priorities	*E1: Where we have a valued, well-trained and supported work-force that is fit for the future*
	E2: Where the benefits from information and technology are maximised
	E3: Where we invest in the right intelligence to understand our local population
	E4: Where we utilise our collective estate so that it best supports local health and social care need
	E5: Where we get best possible value for our 'Warrington Pound'

1. Report purpose

To update Warrington Health & Wellbeing Board on the NHS 11 First initiative with Warrington Hospital being an early implementer site.

2. Introduction/background

NHS 111 First is a national programme which will encourage the use of the NHS 111 service to access a range of urgent care services including, for the first time, direct booking of slots in A&E (ED).

NHS 111 First aims to ensure that patients can access the clinical service they need, first time, both in and outside of hospital, with the convenience of a booked appointment or time slot for ED or an Urgent Care Centre. Importantly, it will help to reduce the risk of transmission of COVID-19 for patients and NHS staff by reducing crowding in waiting areas across services.

3. Content

This a new initiative and each region had to select 'first mover' sites to roll out NHS 111 to ED, following a request from NHS England in mid-July. First mover sites in the North West will be Blackpool, scheduled for 25 August, and Warrington, scheduled for 8 September. A number of 'fast follower' sites have also been identified to roll out NHS 111 First between 10 October and 23 November with a national target to have slots for ED and urgent care bookable by NHS 111 First implemented across all areas by 1 December 2020.

From 8 September NHS 111 First will encourage patients in Warrington and Halton to call NHS 111 in the first instance if they need urgent, but not emergency, NHS care. Patients will still be encouraged to dial 999 in life-threatening emergencies and contact their GP practice directly online (via eConsult on their surgery website) or via phone if they need to access services at their surgery. If appropriate, NHS 111 can book time slots for patients at local urgent care centres, the emergency department at Warrington Hospital and other NHS services.

Patients who do attend urgent care centres or Warrington Hospital ED without a booked time slot will NEVER be turned away. Local processes will be developed over time to help manage the flow of patients by appropriately streaming patients to other health services in addition to urgent care.

NHS 111 First has many patient benefits including:

- Reducing the risk of infection in crowded waiting rooms
- Greater convenience for patients by being directed to the right care, in the right place
- Booked time slots will reduce waiting times for patients and in many cases, patients will be able to access care closer to home

- By managing attendances in the ED during the winter months, NHS 111 First will help reduce pressures on the system and support our ability to cope with increased demand
- It supports the move to Urgent Treatment Centres - following a public consultation exercise, NHS Widnes Urgent Care Centre and NHS Runcorn Urgent Care Centre will move to become UTCs on 1 October 2020. Part of this change involves patients being able to access booked time slots at UTCs via NHS 111.

A wide-ranging local communications campaign will launch in September to support the changes. It will involve promotion on NHS and partner websites and social media, press releases, posters, leaflets and advertising. There will also be wider regional communications from NHS England to detail the approach across the North West and from November it is expected there will be a national communications campaign as more sites go live.

NHS 111 First is a whole system project that is being co-ordinated by NHS Warrington Clinical Commissioning Group, NHS Halton Clinical Commissioning Group, Warrington and Halton Teaching Hospitals NHS Foundation Trust, North West Ambulance Service NHS Trust, who deliver the NHS 111 service, NHS England, Bridgewater Community Healthcare NHS Foundation Trust, GPs and other local healthcare providers. Although Whiston Hospital is not part of the first mover programme, St Helens and Knowsley Teaching Hospitals NHS is set to go live with NHS 111 First before the end of the year.

4. Summary and Conclusion

NHS 111 First is a national programme which will encourage the use of the NHS 111 service to access a range of urgent care services including, for the first time, direct booking of slots in A&E (ED).

Warrington Hospital has been selected as an early implementer site with the service launching on Tuesday 8th September 2020.

5. Recommendations

To note the content of this briefing and associated launch on the 8th September 2020.

6. Background Papers

Nil

Contacts for Background Papers:

Name	E-mail	Telephone

HEALTH AND WELLBEING BOARD WORK PROGRAMME 2019/20

10 September 2020			
Item	**Details**	**Officer**	**Action required for HWBB**
Updates from Reference Groups - Integrated Commissioning and Transformation Board - Warrington Together Alliance - Cheshire Merseyside Proposed Third Phase of NHS Response to Covid 19	Standing item Update on response to proposals	Cath Jones / Simon Kenton Dr Andy Davies	Noting
Living Well	H&WB Strategy thematic update	Anne Marie Carr	Discussion / noting
Public Accounts Committee NHS/Social Care – Readying the NHS and Social Care for the Covid 19 Peak	Details to be provided to HWBB around 'negligent approach towards adult social care' – discharging patients to care homes without COVID testing beforehand	Professor Broomhead / Simon Kenton	Discussion / noting
Reset Not Restart - Adult Social Care The Future Since Covid	Updates from Association of Directors of Adult Social Services	Cath Jones	Discussion / noting
NHS 111 – First Programme North West Implementation	Details of implementation progress	Simon Constable / Lucy Gardner	Discussion / noting
Covid Situational Awareness	Details of implementation progress	Thara Raj	Discussion / noting

Possible Future Work Programme Items			
Issue	**Rationale**	**Anticipated Timescale**	
Standing Agenda Items	Written Updates from Reference Groups: (A) Integrated Commissioning and Transformation Board (B) Provider Alliance Warrington Together – Programme Director's reports (C) Health and Wellbeing Strategy Progress Update		
	New Hospital - written update to be added as a standing item SB requested future updates come to HWB every six months. Next report expected – March 2020 (update postponed, date TBC)	September 2019 March 2020	Updated at 12/9/19 meeting
Report from Healthwatch	*Regular report to be scheduled every 6 months*	July 2020 / January 2021	
Warrington Care Record Strategic Appraisal	Phill James – from 28 March HWB meeting phillip.james@nhs.net	Moved to later 2020 meeting, at request of S Broomhead	
JSNA Programme	Annual report	Postponed To May 2020	
Starting Well	H&WB Strategy thematic update – lead officers – Elaine Bentley/Steve Tatham 12/9/19 Further report requested by Chair in six months' time	July 2020 Deferred TBA	
Living Well	H&WB Strategy thematic update – lead officers Carl Marsh/Dave Bradburn/Dot Finnerty/Tracy Flute 12/9/19 Further report requested by Chair in six months' time	September 2020	
Ageing Well	H&WB Strategy thematic update – lead officers Sara Garrett/Rick Howell	November 2020	
WSAB/SCB ½ yearly and annual report	As per 30 May 2019 meeting – lead officer to be advised (see email dated 11/07/19).	May 2019 November 2019 May 2020 TBC	
Strong and Resilient Communities	H&WB Strategy thematic update – lead officers Chris Skinkis/Nick Armstrong/Tracy Flute	Deferred from January 2020 to March 2020 Deferred again from July 2020 meeting to date to be confirmed	

Enablers	H&WB Strategy thematic update – lead officer Nick Armstrong	May 2020 Deferred TBA	
Warrington Together: New proposed arrangements for the delivery of a partnership to deliver integrated health and social care services in Warrington	As per request at 30 May 2019 meeting (Minute HWB12). Updates to be provided to HWB when appropriate	TBA	
Draft Health and Wellbeing Board Annual Report 2018-19.	S Kenton - As requested by Chair	TBA	
Best Value Decision making in light of NHS long-term plan	As per email from Simon Kenton dated 26/6/19	TBA	
Public Health Annual Report	As per email from Tracy Flute dated 27/6/19	TBA	
Primary Care Strategy 2019-2022	Deferred from January 2020 to March 2020. Subsequently deferred to July 2020	July 2020	Verbal Update from Carl Marsh
BCH and WHH Collaboration Update	As per email request from S Broomhead dated 16/8/19 Further report requested by SB in 3-4 months' time at 12/9/19 meeting	September 2019 January 2020	
Joint Working Arrangements across Halton and Warrington – position to date	As per email request from S Broomhead – letter from Dr Andrew Davies	TBA	
5 year Local Place Plan	As per email request from S Kenton dated 24/10/19 Delayed due to purdah (General Election) as per email from S Kenton 13/11/19	Deferred from November 2019 Initial discussions at January 2020 meeting	Current draft plan endorsed by HWBB Workshop to discuss further to be arranged for HWBB
Tobacco Alliance	Details required	TBA	
Integrated	Regular update	S Kenton /C Marsh	

Commissioning and Transformation Board Programme – annual report			
GP Access in Burtonwood	Following Healthwatch update at January 2020 meeting, update requested to monitor access concerns to GP surgeries in Burtonwood area	TBA	
Winter Wellbeing Advice	Following Healthwatch update at January 2020 meeting, update requested regarding how information have been received	TBA	
Integrated Care Hubs (Orford & Great Sankey)	Update on how hubs are operating since opening	TBA	
Pharmaceutical Needs Assessment	Refresh / update of current assessment	Tracy Flute – short briefing at March 2020 meeting, followed by full review July 2020 Deferred - TBA	
Local Transformation Plan for Children's and Young People's Mental Health		Collette Woolley (Paula Worthington)– March 2020 Deferred - TBA	
Warrington Wellbeing Evaluation and Next Steps	Overview of findings from the evaluation of the Warrington Wellbeing Service.	Tracy Flute – Deferred from July 2020	
Public Health England Report on the impact of COVID 19 on BAME Communities	Initial report presented to HWBB July 2020 Further report requested to detail how Warrington / Halton impacted against other regions	November 2020 Healthwatch to be involved with research / findings	
Health Inequalities and Impact of COVID 19	Initial report presented to HWBB July 2020 Further report requested to detail wider impact, key actions undertaken	November 2020 Officer TBC	
Integrated Care System	Further details to be provided to HWBB on the statutory powers for Integrated Care Systems – what measures are required – vision	November 2020	

	statement of healthcare systems	Officer TBC	
Primary Care Strategy 2019 - 2022	Verbal report at July 2020 meeting that informed HWBB that due to COVID 19 strategy refresh postponed. Strategy has now been aligned with guidance on COVID19 and has helped to develop some aspects sooner than initially thought - including the wider use of technology. Final version of the strategy to be presented at September 2020	Carl Marsh? TBC	

Completed Work Programme Items			
Issue	**Rationale**	**Presented to HWB**	**Action**
Impact of transition to Warrington Safeguarding Partnership on the Child Death Overview Panel	Information noted	September 2019	Complete
BCF Plan 2019/20	Requirement for HWB to sign-off prior to submission to NHS England on 27/9/19	November 2019	Complete
One Year Spending Review	Members analysed what spending review means to them. Members to forwarded comments to Simon Kenton.	November 2019	Complete
Minimum Unit Pricing (MUP) - Update	As per emails from MAA/SB dated 21/10/19 re support for collaborative work across the north and to lobby nationally.	November 2019	Complete
Update on Commissioning at Scale	Information noted – further updates at future meetings if required	November 2019	Updates to be agreed
Revised Terms of Reference	To update Health and Wellbeing Board Terms of Reference to include reference to governance arrangements for the Child Death Overview Panel (CDOP). Email from S Peddie dated 30/8/19 refers. And to amend WBC Member titles	January 2020	Updates to be sent to WBC Constitutional Sub Committee to amend constitution
Update on Flu vaccination and flu-pandemic related issues: Reflection on success of	To update the Board on the recent flu vaccination programme and issues arising from the delay in supply	January 2020	Report noted and Board Members agreed to encouraged future

the process during winter 2018/19			vaccinations To be included in the Health Protection Annual Update report.
Marmot Communities	Supports all of Warrington's Health and Wellbeing Strategy 2019-2023 strategic priorities – Board to discuss if to adopt an evidence based approach to tackling health inequalities by becoming a Marmot Community	January 2020	HWBB agreed to adopt Marmot Community practices
Overview of Cancer JSNA following public consultation	Tracy Flute	January 2020	Report content noted and recommendations endorsed by the HWBB