

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

## Context

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

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

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

HWB Chair and Council Deputy Leader

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

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

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

## Methodology

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

## Overview

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

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

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

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

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

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

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

## **Common issues**

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

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

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

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

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

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

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

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

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

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

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

## **Positive things to take forward**

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

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

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

**“How can we keep that level of engagement with a peace-time focus?”**

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

**“What does a green and sustainable recovery look like?”**

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

**Things to share and promote as good practice**

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

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

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

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

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

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

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

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

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

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

### **Wider observations made by Associate conducting interviews**

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

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

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

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

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

### **Arising recommendations**

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

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

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

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

## **The role of HWBs going forward**

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

Views included:

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

## **The CHIP leadership offer going forward**

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

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

Comments about content and context included:

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

Comments about method of delivery included:

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

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

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

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

Report written by Steve Bedser, LGA Consultant



## **Appendix A**

### Questions used in the interviews with HWB Chairs

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

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

## Appendix B

### Summarised responses from HWB Chairs

#### 1. How has it been for you?

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

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

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

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

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

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

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

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

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

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

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

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

The new virtual set up has been weird.

Scary times. Scared about the financial situation.

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

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

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

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

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

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

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

The government support scheme has been enormously helpful.

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

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

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

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

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

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

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

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

PHE is handing over responsibility to Las without funding it.

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

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

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

The NHS have seen the importance of social care.

## 2. What issues has the pandemic raised?

'Care homes; that's been a real problem'.

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

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

Financial issues concerning the protection of people in care homes.

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

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

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

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

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

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

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

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

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

Making sure that we maintain effective communication with the public.

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

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

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

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

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

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

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

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

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

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

### 3. What have you learnt?

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

You can never be over-prepared.

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

Humans are very adaptable.

How resilient people are.

Good relationships within H&SC have paid dividends.

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

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

How positive the community spirit has been.

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

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

We've been learning as we go along.

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

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

Answering people quickly has been especially important.

Partnerships have to be built up very slowly over time.

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

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

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

Key leaders have emerged and demonstrated good communication.

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

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

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

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

#### 4. Any positives to take forward to the recovery?

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

People volunteering.

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

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

Increased cycling.

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

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

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

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

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

Value in the strength of community action.

The public health opportunities for air quality and the environment.

Change in the way we govern; virtual meetings.

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

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

Celebrate how brilliant the vast majority of people have been.

Police approach has been ham-fisted.

'Never let a good crisis go to waste'.

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

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

The importance of exercise and the wider determinants of health.

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

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

Use of technology, including getting iPads into care homes.

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

What does a green, sustainable recovery look like?

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

Home working and the value of virtual meetings.

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

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

#### 5. Has your HWB met?

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

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

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

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

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

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

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

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

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



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

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

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

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

#### 6. How have partner relationships played out?

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

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

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

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

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

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

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

In some ways very positively.

It's been an expensive end to DTOC.

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

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

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

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

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

Co-terminosity has helped greatly.

Relationships have been exemplary, including business and community partners.

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

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

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

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

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

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

Council procurement of PPE for distribution to care homes.

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

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

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

Our virtual HWB meeting to look at BAME mortality.

DTOC figures dramatically reduced.

Our support response to care homes.

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

Our discharge arrangements have proven their worth in the emergency.

The new social capital.

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

Maintaining child protection.

A strong and focussed effort around PPE procurement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental wellbeing is going to be an emerging issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Would welcome bespoke support.

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

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

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

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

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

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

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

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

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

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

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

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

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

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