SOMERSET HEALTH AND WELLBEING BOARD

Minutes of a meeting of the Somerset Health and Wellbeing Board held as a virtual meeting on Microsoft Teams, on Thursday 16 July 2020 at 10.00 am

Present:
Cllr C Paul (Chair), Cllr F Nicholson (Vice Chair), Ed Ford (Vice Chair), Cllr D Huxtable, Cllr L Vijeh, Cllr R Wyles, Cllr C Booth, Cllr J Keen, Cllr B Hamilton, J Goodchild, T Grant, L Woolway, J Wooster, M Prior, J Rimmer, M Lock

Other Members Present:
Cllr L Redman, Cllr R Williams, Cllr P Clayton, Cllr Munt, Cllr J Lock, Cllr B Revans

Apologies for Absence: Dr A Murray

429 **Declarations of Interest** - Agenda Item 2

Cllr J Keen informed the Board that she is a Board member for Homes in Sedgemoor.

430 **Minutes from the meeting held on 21 May 2020** - Agenda Item 3

The minutes were agreed and signed.

431 **Public Question Time** - Agenda Item 4

There were no public questions.

432 **Covid-19 Update** - Agenda Item 5

The Health and Wellbeing Board received a joint presentation on the Covid-19 response by Somerset County Council and the Somerset Clinical Commissioning Group.

The Covid-19 Public Health Dashboard was presented; this is updated every Wednesday. The main points were:

- There has been a total of 1287 detected cases thus far in Somerset
- The epidemic curve peaked in April and has been coming down well
- There are now only a few confirmed cases per week in Somerset
- The above statistics reflect the extremely positive behaviour of the Somerset population in following the rules and guidelines
- The R number (reproductive rate) is currently ranging from 0.7 to 1.1 in Somerset, with anything above 1.0 indicating an increase in cases; but because Somerset's numbers are so small, the R number is less reliable

on its own and must be viewed in relation to the number of cases, meaning that the transition rate is very low
- A total of 200 deaths due to Covid-19 have been registered, with a significant decrease in recent weeks and a particularly low number this week; most deaths are now non-Covid related.

The Health and Wellbeing Board discussed these findings and raised questions. It was responded that there had been three further cases in Burnham on Sea, which were not linked. In answer to whether any formal research had been carried out as to why there were such low numbers in Somerset, it was stated that there was none at the moment because everyone was still in major incident mode, so it was not a priority; but some national discussions had taken place regarding the statistics in rural vs. urban areas with suggestions that contributing factors might be less public transport, less of a 'café culture', less inequalities, and higher elderly populations who observed rules better.

A presentation was made on Adult Social Care Delivery, Activity and Support during Covid-19; it was noted that during the past four to five months, partnerships had been working extremely well, the infrastructure had been strengthened, and there had been provision of help for the most vulnerable as well as building blocks for communities to help themselves. With respect to the care provider market, it was noted that:

- Infection Control Grant funds had been made available (a total of $8.3 million for SCC), 75 percent of which was for care homes, 25 percent for home care, housing, and supported living, and a small portion for PAs, micro-providers and day services
- Use of these funds was intended to reduce Covid-19 transmission in and between care homes and also support the workforce
- ASC had been working very well together with CCG in supporting the care market and in response efforts
- PPE has been supplied to providers at no cost up until now, but beginning 20 July there will be a charge in order to ensure the supply
- The range of support provided in Somerset has been extraordinary, with 6350 people shielding, 5922 calls to the helpline, over 1000 food parcels provided, etc.
- Community Facebook and social media groups that have 'popped up' have been very helpful in providing communication and support

A presentation was made on the Public Health Nursing sector; it was noted that being part of a local authority has assisted them in focusing on the community and continuing to offer all mandated contacts. Data for the first two months reveals sustained performance with respect to all children and young people, not just those at higher risk. They are currently offering face-to-face contacts for ante-natal and new birth situations, as well as telephone contacts, where necessary. Other areas of development included:

- School readiness packs
- Group sessions via social media, such as Horizon Project
- Twelve Facebook sites as well as use of Instagram, WhatsApp, and Microsoft Teams
- Working with councils with respect to the most vulnerable children
- Working with Property Services to provide wider community services

It was noted that at the Southwest Public Health nursing meeting they were approached by other areas with respect to this area's successful media and restoration processes. There has been very good feedback on all services, not just those provided to the families in greatest need.

The Board enquired if there was data available with respect to the number of families assisted; it was responded that the data collection practices at the moment do not provide those numbers, but they should be able to provide this information soon.

The Somerset Plan for Children, Young People and Families was then presented, with the following notable points:

- In supporting youth attendance at school, 48 percent of vulnerable children have been helped to achieve this
- Schools are having to deal with family crises during Covid
- Social workers are visiting families face to face where necessary and virtually in other cases
- Research shows that we can expect a significant impact on families after the Covid emergency
- Referral rates are down significantly

A positive point that was emphasised is that virtual learning has helped many vulnerable children to make great progress without having to cope with peer pressure and other negative influences. This is one of the practices developed during the Covid crisis that it is hoped will be continued and replicated. With respect to Healthy Lives, work regarding children stepping down from CAMHS and vouchers for free school meals were mentioned.

As regards Great Education and the response to the CQC/ OFSTED SEND inspection report, development of an action plan is underway. This will include the need to ensure sufficient staffing (as many resources are currently directed to the significant number of vulnerable over-50s), preparing for school transport in September, the challenging return to school during the first half-term, and digital poverty in families. Finally, under the heading of Positive Activities, it was pointed out that Outdoor Education Centres have been provided to assist vulnerable families, and there has been multi-agency support

for teenagers in an attempt to get them back to school despite the risk of negative peer pressure which can lead to crime.

In summation, there has been a huge demand for all of the above services during a time of rapidly and constantly changing guidelines.

The Health and Wellbeing Board then discussed the presentation and raised questions; it was stated that it had been very difficult to get detailed information regarding urgent health matters and it was asked how much liaising is being done with district councils regarding feeding vulnerable children and helping their parents to look after them. The presenter said that he could discuss these issues with individual Members outside the meeting if they so desired. Concern was expressed over the quality of the food in care packages being distributed; it was noted that SCC officers had resolved the size problem of large deliveries from caterers but that the quality was "dreadful" and needed to be improved. Another member, after paying tribute to the efforts of everyone involved in the work presented above, asked about the earlier declaration that the education of children had improved with virtual delivery and queried whether there were drawbacks such as isolation. It was responded, after an expression of praise for all the head teachers involved in the effort, that the benefits of taking children out of peer groups in these situations was significant, which raised issues regarding school organisation in general, as they wanted to encourage socialisation but also deal with other issues. The CQC/ OFSTED report was raised, with the comment that such a demanding report had never been seen heretofore, and it was requested that information on the resulting action plan be provided to the committee by the next meeting. It was responded that OFSTED is more challenging than the CQC and it will require significant help from partner organisations to respond to the deficiencies in the report; it was agreed that the requested information will be provided at September's meeting.

The CCG then presented the Restoration Update; it was pointed out that Public Health, Adult Services, Children's Services, and the Chair had all worked together to provide a truly positive model for providing care to children, families and those in homes. It was reminded that Phase 1 in mid-March entailed the standing down of all elective procedures by the end of that month; the Phase 2 Recovery began from the 30th of April through the following six weeks and addressed the problem of the reduction in non-Covid services and the need to reassure people that they still could and should come forward for these issues, in the first instance via remote means including calling 111, 999, and/ or their GP. The recommendations for this phase covered urgent and routine surgery, cancer, cardiovascular and stroke, maternity, primary care, community services, mental health and learning disability services, screening and immunisations, and the reduction of cross-infections via an increase in technology-enable care. Six system-wide restoration cells were also established dealing with:

- Elective care
- Urgent care
- Primary care
- Neighbourhood care
- Mental health and learning disabilities
- Children's services

The Phase 3 Plan will begin at the end of July and run through 2021; it will build on Phase 2 principles and apply the Seven Tests for Recovery:

- Covid treatment capacity – maintain critical care infrastructure in readiness for future Covid demand
- Non-Covid urgent care, cancer, screening and immunisations – identify highest risks and act to minimise them
- Elective care – Quantify backlog, slow growth, and develop plan to clear
- Public and mental health resulting from pandemic – Identify highest risks, slow growth, develop plan to mitigate
- Staff wellbeing and numbers – Catalogue interventions, provide additional support, plan for recovery
- Primary and community care – Catalogue innovations and plan for retention and widespread adoption
- New NHS landscape – Catalogue service and governance changes made or still to be made, define ICS role

It was stated that Fit for My Future is a strategic approach and that the policy will be forward looking and not back to previous ways of working, including more virtual technology which, as regards primary care, increased greatly during the pandemic. There is the necessity to meet patients' needs as regards Covid and urgent care and reassure the community that hospitals are safe; to ensure wellbeing via pre-diagnostic support and looking after staff; and to maintain the very positive coordination developed between GPs and hospitals, as well as between Public Health and Social Care. A national test for services will include addressing inequalities, whether racial or derived from social deprivation. The System Planning Sign-Off Process was displayed; it will bring together all teams and be coordinated by the CCG, and increasing finances will be an important part of the plan. The plans are to be signed off by the end of July.

As far as learning from the Covid response, an exercise in inter-organisational lessons learnt has been completed, AHSN system-wide research will begin in July, and there is linking of patients and carers with Healthwatch, citizens' panels, and regional colleagues. It was emphasised that this all entails a new way of working, new procedures, and a new form of delivery of health services, which is a significant challenge in a Covid-present world.

The Somerset Health and Wellbeing Board expressed a big thank you to their NHS colleagues for the fantastic work carried out together and noted that the

relationships established over the past few years had been demonstrated to be vital, while the local NHS has performed to an extraordinary level. The Committee also thank all presenters and everyone who had worked so collaboratively across all services in Somerset, with the hope that it would continue.

433 **Local Outbreak Management Plan** - Agenda Item 6

This plan has been in place since the beginning of July; it is the role of Public Health to manage any outbreaks, and dealing with local outbreaks is very important. It was noted that an "outbreak" signifies two or more confirmed cases of Covid-19 amongst people linked by time and place, while a "cluster" entails two or more confirmed cases arising within 14 days which are linked by setting/ place. For example, Ebola is a cluster type of disease, influenza is not, and Covid-19 is somewhere in the middle. This plan builds on already existing plans such as those for the flu pandemic and has two parts:

- Day-to-day management of outbreaks
- Engagement and communication with residents, communities and visitors to PREVENT outbreaks

One of the main tools against Covid before a vaccine becomes available is behaviour, and we must keep safety measure in place indefinitely. Local outbreak control plans have been written in conjunction with surrounding authorities and will centre on seven themes:

- Care homes and schools
- High-risk workplaces, communities and locations
- Mobile testing units and local testing
- Contact tracing in complex settings
- Data integration
- Vulnerable people
- Local boards – communication and engagement

It has been nationally stipulated that there be a Covid-19 Engagement Board, which will meet once a month, and a Health Protection Board (a clinical board) which meets once a week. The Engagement Board may possibly be granted new powers of action to deal with outbreaks, but these powers may remain with other entities. The Health and Wellbeing Board still has an oversight role, not an active one.

The "TIME" acronym was explained and is critical during an outbreak:

- Track – Daily data and intelligence gathered by a daily public health cell meeting that reviews numbers, trends and issues and includes data from

national bodies such as the Joint Biosecurity Centre, Public Health England, the NHS, the Office for National Statistics, etc.

- Identify – Rapid identification of outbreaks, clusters, and contacts to be isolated in order to prevent further spread (test and trace)
- Manage/ Measures – Engagement including enforcement if required, testing, isolation, support to the vulnerable, prevention and control like cleaning, local lockdown if necessary (although currently no power to do the latter)
- End – Outbreak declared over (after 28 days from the last case), reopening and reinforcement of safety measures and recovery, continued support

A link to an illuminating illustration from New Zealand about how Covid-19 spreads was shared. It was noted that an action plan with very clear guidance regarding tourism and businesses is currently being developed because of gaps in the national guidance about how these sectors should handle outbreaks.

A Member of the Health and Wellbeing Board expressed thanks for Public Health's work and enquired if the situation in Leicester was being monitored and learnt from; it was responded that there have been weekly briefings about it and that personnel have been sent to Leicester to assist. There are also weekly meetings with the Chief Medical Officer where there is a discussion of lessons learnt from various sites, including Burnham on Sea. It was also asked whether persons donating blood are tested for Covid-19 and the authorities notified of any positives; the belief was expressed that they do test for it along with other conditions, but this will be verified and reported back.

The Committee noted that the Somerset Local Outbreak Management Plan was submitted nationally for audit, and it has been considered as one of the national examples of good practice, which is to be highly commended. The Committee also looks forward to collaborative working with the districts.

434 **Homelessness** - Agenda Item 7

A presentation was made on Covid – Rough Sleepers and Complex Homelessness. The purpose of the report was to outline the government advice during Covid, to describe the partnership response and lessons learnt, to discuss the pressures faced and responses to them, and to suggest ideas to take forward. In March, there were instructions from MHCLG to get rough sleepers off the street; the Somerset response was led by the Homelessness cell in finding accommodation. A significant problem is that most existing accommodation is not acceptable during Covid, so alternatives were needed quickly, including B&Bs, hotels, and student accommodation. The number of clients supported by Mendip District Council is 20 persons, Sedgemoor 27, Somerset West & Taunton 68, and South Somerset 53, with some clients refusing to engage or being evicted.

Rough sleeper numbers rose during the Covid emergency due to unemployment and changes in familial situations, such as a need to protect elderly members in the home leading to other family members being displaced. The biggest challenge was the urgency, along with the impossibility of using hostels or even hotels at the time. The biggest success was the stabilisation and moving on of 54 residents, along with other achievements including rapid delivery, speedy decision making, a partnership approach between Housing and Health, and a commitment from providers to assist. The most notable emerging themes are the success of joint working, recognition of the complexity of housing work, and the need to resolve the revolving door of patients going in and out of various services. The most important endeavour will be to realise long-term results in all of these areas, not just an emergency response, and they have been successful in this; partners are now understanding the complexity of the issues involved, i.e., there is always a reason for homelessness (drugs, alcohol, mental health), and these underlying, unresolved causes lead to relapse and loss of accommodation due to antisocial behaviour followed by eviction, and this vicious cycle self-perpetuates. Short-term pressures contributing to homelessness include economic issues (unemployment, etc.), pressure on families or family relationships breaking down, and the possibility of a second wave of Covid.

The demand for accommodation and its price are high while availability is scare, so there is a search for more intermediate accommodation, especially with a need to put people in non-shared sites. The advice from MHCLG centres on moving away from hostels, using a hub approach, joint commissioning coordinated by housing and health care sectors, and the provision of skills and job training.

Related work being done includes LGA improvement plan, Positive Lives, P21, vulnerability pathways, homeless health needs audit, neighbourhood work by CCG, and a Health-Care-Housing Memorandum of Understanding.

Going forward, there is a commitment to see rough sleeping as a combined health/ care/ housing issue, to maintain partner engagement, to explore the possibility of a Homelessness Reduction Board for Somerset, and to research a business case for integrated Health-Care-Housing commissioning, because housing is only a response to root causes.

The Health and Wellbeing Board then held a lengthy discussion about these issues. It was asserted that there was a large amount of funding available—£20,000 per person—and it was asked if the Homelessness cell operates as an integrated commissioner. If it does, why can it not be turned into an integrated cell and not have the need for a business case. It was responded that it is not an integrated commissioner and needs to mobilise/ react urgently along with partners to safeguard individuals; it is comprised of a group of operational partners, with the hope that in future there will be a commitment to form a

joint working group. It was asked if, since the district councils and SCC provide funds already, there will be more employees; the answer was no, they are asking only for a joined-up approach, and the funds that came from national government to local authorities were for a limited time only. It was pointed out that most of the rough sleepers do not fall into the category of statutory homelessness and would not receive accommodation, so this is why there is a need for a commission or group of joined-up partners. It is not about money but about ensuring that Housing-Health-Care are part of one commission.

It was noted that MHCLG have been pushing for the past 18 months for a Homelessness Reduction Board for all authorities and are asking why not in Somerset. Such a board would be a commitment from everyone involved (districts, Care, Health, providers) to meet regularly and to work together to resolve problems. There is the need to look at the pathways and journey to rough sleeping to understand if collaborative integrated commissioning could PREVENT rough sleeping. A two-tier approach needs to be established and is already in place in localities like Plymouth; there is the opportunity to do things better with the resources already available. It was added that there is a need for hospitals and homelessness bodies to join up earlier, because rough sleepers put huge pressures on emergency providers and they cost hospitals and police a great deal of resources. Prevention is the key, and it can be improved.

It was observed by the Health and Wellbeing Board that rough sleepers should be placed in one-bed properties, but these are not available, and housing providers strongly resist flat sharing, even though this is common amongst youths not in care. It was urged that homelessness be included as part of Strategic Housing and Care, and that there be more cooperative working with respect to Children and Families and young people. It was responded, however, that youths fall under statutory guidance, so the focus in this case is on single adults who are homeless and rough sleepers. They are very complex and difficult to manage, even in B&Bs, so accommodation in shared flats would be nearly impossible. It was pointed out that entrenched homelessness is indeed the issue, but one must also consider that children and their families are competing with adult homeless for limited housing, so all possibilities must be considered; it was responded that a Homelessness Reduction Board would in fact look at all these issues.

A Member of the Health and Wellbeing Board made the case for creating the Board in question at the next HWBB meeting in September, urging that it be added to the Work Programme for September, with draft terms circulated before the meeting in order that it be ready for approval in September. He stated that we owe it to residents to aim higher and move more quickly, and above all to do even more than has been done during the Covid crisis as far as preventing the root causes of homelessness by using all agencies to build prevention into any action plan. He opined that we don't need a data

gathering phase, as we already know that we should have coordination and collaborative working.

Another Member pointed out one aspect of homelessness that had not been mentioned, that of the neighbours of homeless accommodation who have to endure the negative behaviour and lifestyles of many homeless persons. It was urged that there be a massive increase in the number of officers who can persuade rough sleepers to change their behaviour and lifestyles. It was pointed out that many properties are used for emergencies but their purpose is not long-term use for the homeless, and there need to be alternatives. The neighbours and the community need to be considered, and rough sleepers need to become part of the community. This was agreed with wholeheartedly, with an example being given of a Mendip accommodation which took three years of searching to determine the right place. There is currently the need to bring properties into use quickly to save lives, but then the occupants must be moved on to non-emergency accommodation. We are still currently in emergency phase, but a new Homelessness Reduction Board would assist with prevention and finding the right accommodation. Compassion was urged for the homeless, whose average age of death is 57 compared to 77 for the general population. The concern was expressed that whilst there is considerable funding at the moment for the Covid emergency, clients will struggle to get drug and alcohol support services once the situation returns to normal. Joint commissioning of services helps significantly to get value for money, and there needs to be a person-centred and flexible approach. It was noted that Lindley House has a difficult reputation as it has evolved to be the only place available for some rough sleepers; a solution could be the voluntary sector using their donations to complement statutory services, as there are good local solutions available.

It was stated that we can move quickly toward establishing the new Homeless Reduction Board, as an extension of the homelessness cell and other working groups, but integrated commissioning will be more complex and will require a Memo of Understanding beforehand to establish the parameters of what should be explored, finances, budgets, etc. Therefore, a business case, data and more time are required.

The Somerset Health and Wellbeing Board agreed that more information would be brought back to them and made the following recommendations:

1) **The Board reaffirmed the commitment to collective working with respect to the rough sleepers and complex homelessness cohort in order to bring a Memo of Understanding regarding Housing/ Health/ Care to the September meeting of the Health and Wellbeing Board.**
2) **The Board agreed to explore the creation of a Somerset Homelessness Reduction Board with a reporting mechanism directly to the Health and Wellbeing Board.**

435 **NHS Trust Quality Response** – Agenda item 8

In the Chair's response, approval was expressed for equal priority given to physical and mental health, for the focus on self-management, and for promotion of independence; and it was pointed out that this is a move toward prevention. The Somerset Health and Wellbeing Board commended and encouraged this.

436 **Members Briefing Information** – Agenda Item 9

Information was sent to Members on 15 June 2020 regarding safeguarding of adults and children.

437 **Somerset Health and Wellbeing Board Work Programme** - Agenda Item 10

It was noted that there had already been a Member's request for a briefing on how Adult Social Care is administered in communities, and data requested on the Children's action plan established in response to the OFSTED SEND report will be included. It was also noted that there are now fewer agenda items and a shorter timeline but the meeting still over-ran on time. It was suggested that updates be sent between meetings regarding matters of importance and making additions to the Work Programme. A comment was made that receiving updates nine months after the OFSTED inspection, for example, was unacceptable, and it was requested that there be earlier updates. With respect to how many items could be covered on the Work Programme, it was pointed out that virtual meetings take much longer and there is much more work behind the scenes, thus there is the need to balance less items with more debate, and it must be kept in mind that very long meetings can lead to Members leaving to attend other meetings, thus endangering quora. It was agreed that member information briefings between meetings would greatly assist.

The Somerset Health and Wellbeing Board agreed to submit suggestions for the Work Programme via email in consultation with Board Members.

435 **Any other urgent items of business** - Agenda Item 11

There were no other items of business.

(The meeting ended at 12:52 Pm)

Chair