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Health and Wellbeing Board

Wednesday, 24 March 2021 2.00 p.m.
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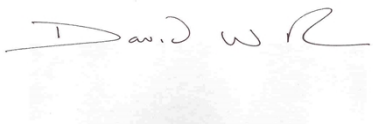

Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 7 July 2021

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

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7th July 2021
6th October 2021
19th January 2022
23rd March 2022

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 20 January 2021 held remotely.

Present: Councillors T. McInerney, Polhill, Woolfall and Wright S. Bartsch, L. Carter, P. Cooke, G. Ferguson, T. Hill, P. Hughes, P. Jones, M. Larking, E. O'Meara, K. Parker, D. Parr, M. Vasic and D. Wilson.

Apologies for Absence: None

Absence declared on Council business: None

Also in attendance: One member of the press

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB8 MINUTES OF LAST MEETING

The Minutes of the meeting held on 7th October 2020 having been circulated were signed as a correct record.

HWB9 OVERVIEW OF COVID-19 IN HALTON INCLUDING THE HEALTH PROTECTION BOARD AND THE LOCAL COVID-19 OUTBREAK HUB AND THE CHESHIRE & MERSEYSIDE OUTBREAK HUB

The Board received an update on the most recent data on COVID-19, including an update on Halton outbreak support team activity and the most recent information on testing and vaccination for the people in Halton.

On behalf of the Board the Chair thanked everyone within support team for their work.

RESOLVED: That Halton's position on COVID-19 data, testing and vaccinations be noted.

HWB10 HALTON'S ADULT SOCIAL CARE: COVID-19 WINTER PLAN 2020/21

The Board considered a report of the Director of Adult Social Services, which provided an overview of Halton's Adult Social Care COVID-19 Winter Plan 2020-21. On 18th September 2020, the Government published the National ASC: COVID-19 Winter Plan, which was developed from

the work undertaken nationally by the ASC COVID-19 Taskforce during the summer.

As part of the national plan, Local Authorities were required to write to the Department of Health and Social Care by 31st October 2020, confirming that they had put in place a winter plan and that they were working with care providers in their area on their business continuity plans. They were also asked to highlight any key issues in order to receive a second instalment of the Infection Control Fund. A copy of Halton's Plan was attached at Appendix 1 of the report.

The overall aim of Halton's Winter Plan 2020/21 was to ensure that high quality, safe and timely care was provided to everyone who needed it during the winter, whilst continuing to protect people who need care, their carers and the social care workforce from COVID-19. The objective and areas covered by the Plan were also outlined in the report.

The Board discussed the current position at Lillycross and the potential for the contract to be extended.

RESOLVED: That the report and associated appendices be noted.

HWB11 CHILDREN AND YOUNG PEOPLES MENTAL HEALTH JOINT LOCAL TRANSFORMATIONAL PLAN (LTP) - PRESENTATION - FAYE WOODWARD

The Board considered a presentation from Faye Woodward, Commissioning Manager Children and Families, NHS Halton CCG, on the refresh of the Halton and Warrington Joint Children and Young People's Mental Health Local Transformation Plan (LTP).

RESOLVED: That

1. the Children and Young People's Mental Health Joint Local Transformational Plan be noted; and

2. the Board approves the Children and Young People's Mental Health Joint Transformational Plan for sharing in the public domain.

HWB12 HALTON BOROUGH COUNCIL AND NHS HALTON CLINICAL COMMISSIONING GROUP : JOINT WORKING ARRANGEMENTS

The Board considered a report of the Director of Adult

Services, which provided an overview of the new working arrangements between the Council and NHS Halton Clinical Commissioning Group (CCG), which took effect from 1st April 2020. Since April 2013, the Council and NHS Halton CCG had a Joint Working Agreement (JWA) that included a pooled budget in place for the commissioning of services for people with complex care needs. From April 2015, the JWA included the Better Care Fund.

Following a review of the JWA which was undertaken during the first six months of 2019/20, it was agreed that the Continuing Healthcare (CHC) and Community Care budget elements of the pooled budget would be separated out. This had resulted in the development of a revised JWA for the Better Care Fund (including the Disabled Facilities Grant, Winter Pressures and Improved Better Care Fund). A copy of the revised JWA was attached as an appendix to the report.

RESOLVED: That the Board note the contents of the report and associated appendices.

HWB13 ONE HALTON - UPDATE REPORT

The Board received an update on matters relating to the development of One Halton, including the work of the One Halton Forum, the Integrated Commissioning Group and the Provider Alliance.

A meeting of the One Halton Forum had taken place on 15th December 2020 and the Board were requested to note the updates provided in relation to:

- Integrated Care Systems;
- Integrated Care Partnerships; and
- The role of One Halton in ensuring the primacy of the Place Halton.

With regard to finance, it was noted that One Halton had received £348,000 from the Cheshire and Merseyside Health and Care Partnership. Therefore, for 2020/21 the revised One Halton budget was £676,000. This included money carried over from 2019/20 although some of this was allocated to existing projects. It was also noted that for 2020/21 there was a balance of £336,000 available for investment to support the delivery of the One Halton Plan. This money could be carried over to the next financial year.

RESOLVED: That the contents of the report be noted.

HWB14 OUTLINE FOR A RAPID UPDATE OF THE ONE HALTON HEALTH AND WELLBEING STRATEGY 2017-2022 IN THE CONTEXT OF THE GLOBAL COVID-19 PANDEMIC.

The Board considered a report of the Director of Public Health, which advised on the intention to amend the One Halton strategy to take account of the global COVID-19 pandemic. The review would be carried out by a speciality in public health (Dr Matthew Atkinson) and would assess its impacts on the key priorities and refocus efforts to mitigate its effects on achieving the strategy's aims.

RESOLVED: That

1. the Strategy be updated and presented to the March 2021 Health and Wellbeing Board for approval; and

2. Board Member's contribute to the review by providing information on the impact COVID-19 had on services and health outcomes and by suggesting revised actions and goals.

HWB15 HALTON HOSPITAL AND WELLBEING CAMPUS STRATEGIC OUTLINE CASE

The Board considered a report which provided an overview of progress to date of the plans for new hospital developments in Warrington and Halton, and sought support to continue to progress the plans for Halton Hospital site redevelopment and to ensure the provision of hospital services in a modern fit for purpose estate.

Members welcomed Lucy Gardener, from Warrington and Halton Teaching Hospitals NHS Foundation Trust, who presented the update.

The Board was advised that following the Warrington and Halton Teaching Hospitals NHSFT's publication of its *Estate and Facilities Strategy 2019-2024*, the need for modernisation and reconfiguration on both the Warrington and Halton sites was reiterated. This included the provision of a new hospital for Warrington and the completion of the development of a hospital and wellbeing campus on the Halton site.

It was reported that the Strategic Outline Cases (SOCs) had been developed for both and reviewed by NHSE with positive feedback received. Further, the SOCs had been approved by the Warrington and Halton Teaching Hospitals NHSFT's Board and by Warrington and Halton

CCGs. In order to further progress the planning for the new hospitals to the next stage, Executive Board was asked to give their support to the programme and support in progressing to the next state of business case development, this was agreed at the last meeting of the Executive Board in November.

RESOLVED: That the report be noted.

HWB16 BETTER CARE FUND (BCF) 2020 – 21 UPDATE, QUARTER 4 RETURN AND RISK REGISTER

The Board considered a report of the Director Adult Social Services, which provided an update on the Better Care Fund (BCF) 2020/21, the Better Care Fund Register and the Quarter 4 submission to NHS England. The report highlighted that:

- due to COVID-19 the completion of Quarter 4 submission had been postponed and no further returns were required;
- the BCF guidance and templates for the BCF Plan 2021/21 had also been postponed due to COVID-19; and
- the BCF Scheme Level Risk Register had been developed through the Better Care Development Group and a copy of this was attached as an appendix.

RESOLVED: That the report be noted.

Meeting ended at 3.25 p.m.

REPORT TO:	Health and Wellbeing Board
DATE:	24 March 2021
REPORTING OFFICER:	Director - Public Health and Protection
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Public Health response to COVID-19 Coronavirus
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on the public health response to COVID-19 Coronavirus with a presentation covering the most recent data; latest update on Halton outbreak support team activity, Testing and Vaccination.

2.0 **RECOMMENDATION: That the update be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 This public health response is dynamic and in order to provide the most up to date information a presentation will be provided.

3.2 The update will cover the most recent COVID-19 Coronavirus figures for Halton. An update on how the Halton outbreak support team are working to successfully identify and manage local outbreaks and it will also detail the most recent information on testing and vaccination for people in Halton.

4.0 **POLICY IMPLICATIONS**

4.1 There are no specific implications in respect of Council policy.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There is ring fenced allocated funding for outbreak response.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

The outbreak response will protect the health of children and young people in Halton.

6.2 **Employment, Learning & Skills in Halton**

N/A

6.3 **A Healthy Halton**

The outbreak response will protect the health of people in Halton.

6.4 **A Safer Halton**

The outbreak response will protect the health of people in Halton.

6.5 **Halton's Urban Renewal**

None identified at present.

7.0 **RISK ANALYSIS**

7.1 The outbreak response team will reduce the risk to local people from an outbreak.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no equality or diversity issues as a result of the actions outlined in the presentation, however among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those from minority ethnic groups, in particular those of Black and Asian heritage.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 27th July 2020

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Overview of Covid-19 in Halton including the Health Protection Board and the local Covid-19 Outbreak Hub and the Cheshire & Merseyside Outbreak Hub

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide the Board with a briefing of Halton's position on Complex Outbreak Management and the associated Local Outbreak Management Plan Refresh and receive feedback from members of the Board.

2.0 RECOMMENDATION: That the Board

Receive a briefing of Halton's Local Outbreak Management Plan Refresh 2021 and provide feedback on the plan to the Director of Public Health.

3.0 SUPPORTING INFORMATION

3.1 On the 22nd of May 2020 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 30th June. These have now been refreshed and are out for consultation with partners. Local Authorities have also been asked to complete a template which outlines their analysis of the current situation including what works well and where there are challenges.

3.2 What is a complex setting?

A complex setting is a setting outside of the health sector and includes:

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

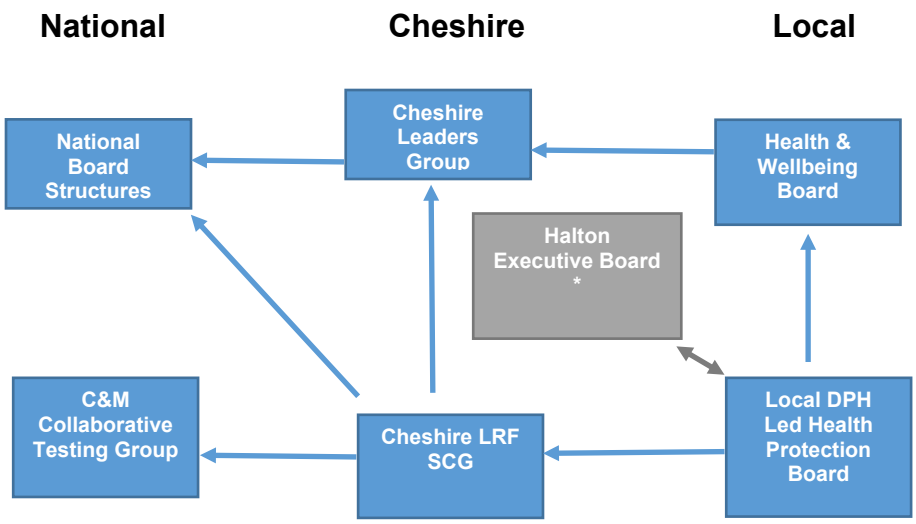
3.3 Governance of Outbreaks.

Outbreaks in Halton is overseen by a Local Outbreak Board which is responsible for communication and engagement with the public and overseeing of any lockdowns that may be required.

The Outbreak Board is responsible to the Health and Wellbeing Board.

The Outbreak Board is 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.

Framework for Governance across Cheshire



*Decision making authority

3.4 Halton Outbreak Plan 2021

Halton has refreshed its ***Local Outbreak Management Plans*** on high risk groups and complex settings. They include how we identify and address inequalities, compliance and enforcement, local governance, resource and capacity management, communications and data and intelligence. They also incorporate national and local developments in testing, tracing, containment and engagement. In addition they anticipate the changing nature of C19 in terms of the development of new variants of concern (VOCs) and the need for surge capacity and the move from a pandemic to endemic response.

We recognise the need to work as a whole system to address C19 so in tandem with the national Roadmap we have developed a comprehensive ***Halton Roadmap*** including all services within the Council to support recovery out of lock down and beyond. This sits beside our Local Outbreak Management Plan.

Halton was part of the recent PHE and Local Authorities Senior Leaders ***Cheshire & Warrington and Liverpool City Region Workshops for Roadmap and Recovery***.

The latter considered enduring transmission and frequent outbreaks, BAU and dealing with the dominant variant and sporadic outbreaks and VOCs. We shared what we can do together as local authorities, standardisation of procedures, joint contact tracing hubs, mutual aid, cross border working, protecting our vulnerable populations and health inequalities as well as supporting and re-opening the economy.

Cheshire and Mersey have developed the ***CIPHA*** (Combined Intelligence for Population Health Action) data lake which gives us timely access to C19 data on infections, outbreaks, geographic locations, common exposure areas and vaccinations and allows us to be responsive and agile. This plays into our local intelligence teams and the Cheshire and Merseyside Intelligence Cells. It has also allowed us to jointly identify areas of concern, such as workplaces, and make recommendations to the national team.

In addition we have a ***Cheshire and Mersey Contact Tracing and Outbreak Support Hub*** which we would like to maintain in our move into an endemic situation. We developed this Hub jointly with PHE and it brings together Public Health Consultants, call handlers, environmental health officers etc and links into and supports our local Halton Contact Tracing and Outbreak Hub. Given the development of VOCs and the move towards Zero Hours Contact Tracing and Enhanced Contact Tracing we see resource for this Hub as crucial for surge capacity.

Halton is part of the ***Liverpool City Region SMART Testing Pilot*** and has a comprehensive Community Testing Programme. We would anticipate as testing continues to morph to suit population requirements for changing C19 requirements that we keep the capacity for surge testing and Pop Ups for complex cases and outbreaks. Halton has benefitted from the **in-depth research *Under The Skin*** just undertaken by Cheshire & Merseyside CHAMPS and our Health Care Partnership to look at vaccine hesitancy by Minority and Ethnic Groups and how to promote uptake and tailor communications.

4.0 POLICY IMPLICATIONS

4.1 Halton is in line with Government requirements to address COVID 19.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There is ring fenced allocated funding for outbreak planning and staff.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

These plans will protect the health of children and young people in Halton.

6.2 Employment, Learning & Skills in Halton

N/A.

6.3 A Healthy Halton

These plans will protect the health of people in Halton.

6.4 **A Safer Halton**

These plans will protect the safety of people in Halton.

6.5 **Halton's Urban Renewal**
N/A.

7.0 **RISK ANALYSIS**

7.1 These plans will reduce the risk to local people from an outbreak.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no equality or diversity issues resulting from this report.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 Halton Outbreak Management Plans 2021.

Halton Borough Council
COVID-19
Local Outbreak Management Plan

March 2021 (Update)

VER 6

Halton Borough Council

Public Health. Runcorn Town Hall, Heath Road, Runcorn. WA7 5TD.

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Glossary

Key words and abbreviations

BAU. Business as Usual.

CHAMPS. Cheshire and Mersey Public Health Collaborative**.**

Cases. Individual cases of COVID-19

CIPHA. Central Intelligence for Population Health Action – Cheshire and Merseyside data system.

Cluster. 2 or more cases associated with a specific setting in the absence of evidence of a common exposure or link to another case

COVID-19 outbreak. Two or more test-confirmed cases of COVID-19 among individuals associated with a specific non-residential setting with illness onset dates within 14 days, and one of:

- identified direct exposure between at least 2 of the test-confirmed cases in that setting (for example under one metre face to face, or spending more than 15 minutes within 2 metres) during the infectious period of one of the cases
- when there is no sustained local community transmission - absence of an alternative source of infection outside the setting for the initially identified cases

Community spread. Sporadic or linked cases on a limited or extensive basis

JBC.

LA. Local Authority

LAMP. Loop-mediated isothermal amplification saliva test.

LRF. Local Resilience Forum.

OCT. Outbreak Control Team

PHE. Public Health England

PH. Public Health

REACT. Real-time Assessment of Community Transmission. A research study led by Imperial College London and Ipsos MORI which seeks to understand how many people are currently infected or have been infected with the COVID-19 virus.

SOP. Standard Operating Procedure**.**

STAC. A Science and Technical Advice Cell.

Suspected. A cluster/outbreak, with two or more cases of illness with symptoms consistent with COVID-19 infection (as per the COVID-19 case definition).

Testing pillars. There are five pillars to testing, 1 is locally managed NHS swabbing, 2 is commercial testing, 3 is antibody testing, 4 is surveillance testing and 5 is diagnostics.

VOC. Variations of Concern.

VUI. Variants under investigation

1.0 Halton COVID-19 Local Outbreak Management Plan (March 2021)

1.1 Overview

COVID-19 is a rapidly evolving situation; guidance is being developed at a fast pace, and is therefore subject to change with little notice. This plan will be kept under review, and reflect changes to national guidance and other relevant information that will support local outbreak control.

The purpose of the Halton COVID-19 Outbreak Management Plan is to set out how we will respond to current and potential future outbreaks of COVID-19 in the borough and coordinate efforts across all stakeholders to keep residents safe. The primary audience for the plan is local decision makers, advisors, and stakeholders who may be affected by the plan but the plan is also available to the general public.

This plan is a collaborative effort developed locally across the council and with NHS and Voluntary Sector colleagues and describes our interface with various tiers of the national NHS Test and Trace Service, and with the regional services led by the JBC, Public Health England (PHE) (at the time of writing and through its successor organisation from April 2021) and across Cheshire and Merseyside through Cheshire and Merseyside's Health Care Partnership and Cheshire and Merseyside Public Health Network (CHAMPS). It details our governance arrangements with roles and responsibilities for stakeholder engagement.

The plan forms part of a series of documents, toolkits and guides that will articulate in more detail specific activities and processes that will be followed to support the local area. It will build upon the forthcoming new **National Contain Framework** which will set out how national and local partners will work with the public, businesses and other local partners to prevent, contain and manage outbreaks of COVID 19. While there is much we can do locally to prevent and manage outbreaks of COVID, there are many factors that will impact the spread of COVID in Halton that may be beyond our control locally. These factors include national policies on lifting lockdown and social interaction, availability of new treatments or vaccines, and testing technology and the speed of test results from the national programme as well as new variants with the potential for increased transmission.

The overarching aim of this plan is to establish clarity for the local system in terms of outbreak management across three broad areas:

(1) Enduring Transmission
(2) Dominant / 'Business As Usual (BAU)' Variant
(3) Variant of Concern

A key section of the plan outlines actions that will be taken by the local Public Health team in collaboration with other service areas to prevent outbreaks from occurring, promote uptake of testing and participation in contact tracing, support the vaccination programme and to facilitate the management of outbreaks when they do occur.

The purpose of this document is to set in one place a strategic management plan which will be adaptable and responsive to feedback, new learnings and best practice and enable the local system to manage and respond to Covid 19 outbreaks in the future. We recognise the need to work as a whole system to address COVID 19 so in tandem with the national Roadmap we have developed a comprehensive Halton Roadmap including all services within the Council to support recovery out of lock down and beyond. This sits beside our Local Outbreak Management Plan.

1.2 Aim

This plan aims to ensure that there is an effective and coordinated approach to prevention, early detection and good management of COVID-19 outbreaks across Halton. It builds on existing health protection plans to put in place measures to identify and contain outbreaks and protect the public's health. The plan will support the Local Authority and its partners to develop an understanding of what does and does not work locally. We want to develop a high level of population understanding of and compliance with covid secure measures and ensure that local businesses, employers and community partners are aware of their responsibilities. We want to ensure that there is a well-resourced, reliable 'test, trace and isolate' service and that Halton has a high vaccine uptake especially across population cohorts considered to be most at risk.

The plan acknowledges that Halton sits both within the Liverpool City Region as well as the Cheshire resilience forum area and has close collaboration through public health with teams in cross boundary areas as well as through its connections with Public Health England local office and the CHAMPS Hub, and will at times need to flex to accommodate wider than local issues.

We want to provide the leadership and oversight and ensure that surveillance and data sharing is in place to identify cases early, and also to respond to poor compliance or local threats and make sure there are strong links to enforcement.

We want to mitigate the impact of COVID on inequalities by ensuring equality of access to services, offering support for self-isolation and bespoke communications addressing concerns around testing and vaccinations for hard to reach groups, ethnic minorities and populations with high levels of deprivation. Strong outbreak management will support the local recovery plan to address health and economic impacts and enable Halton to be better prepared in the future.

1.3 Objectives of the Plan

- To outline the arrangements to protect public health by identifying and managing the source of COVID-19 outbreaks by collaborating with relevant stakeholders and implementing necessary control measures to prevent further spread as well as managing the consequences of the outbreak (consequence management)
- To set out an approach to prevent settings from developing a COVID-19 outbreak
- To outline roles and responsibilities at a local operational level.
- To outline the key tasks / activities involved in responding to COVID-19 outbreaks
- To give key considerations and outline some specific requirements needed for key settings where COVID-19 outbreaks may occur.
- To consider the wider impacts of COVID-19 on local communities including those related to inequalities and vulnerabilities.
- To ensure that arrangements reflect the need to quickly deploy resources to the most critical areas
- To set out the approach to self-isolation.
- To set out the arrangements for community testing
- To set out the local approach to contact tracing, its interface with other organisations at local regional and national level
- To set out the association between testing and outbreak control and management
- To set out the role of vaccination in reducing the likelihood of outbreaks and how vaccination will be offered.
- To set out the situations where additional measures to support compliance and or enforcement are required.

The plan provides the mechanism to assist responders to activate an effective and coordinated multi-agency approach to any outbreaks. This plan is integral to supporting the primary objectives of the NHS Test and Trace service which aims to control and reduce the spread of infection, save lives, and in doing so help to return life to as normal as possible, for as many people as possible, in a way that is safe and protects the health of our local community.

The plan has been developed to ensure clarity related to both strategic and operational roles and responsibilities for each responding organisation in the event of a COVID-19 outbreak. Actions undertaken as part of the outbreak control response aim to prevent a return to lock down in a geographical area or setting, to prevent wider spread and to protect individual health.

1.4 Scope

This plan provides an overall picture of the outbreak support measures in Halton and is intended to inform and support existing local plans to manage outbreaks in specific settings.

- This plan will be used by the Local Authority in collaboration with its stakeholder partners including the Local Resilience Forum and NHS for the investigation, management and control of community outbreaks of COVID-19 unless another locally agreed COVID-19 plan exists.
- There are already systems in place to deal with outbreaks within **care homes** using the North West Care Home Packs. Community Infection, Prevention and Control Nurse (IPCN) teams support care home staff to manage the outbreaks in line with North West care home resource pack and national guidance. PHE and Local Public Health Teams will be involved in the care home-based outbreak control teams in an advisory capacity where required, particularly if an Outbreak Control Team (OCT) is indicated.
- Outbreaks within **Schools** will be managed according to the Cheshire & Mersey Schools Outbreak pack and in line with PHE North West Schools SOP and national guidance. PHE and Local Public Health Teams will be involved in the schools-based outbreak control teams in an advisory capacity if required, particularly if an OCT is convened.
- The response to outbreaks confined to specific **NHS trust premises**, whether acute or community or mental health trust, will usually be led by the relevant NHS Trust in accordance with their operational plans.
- The great majority of outbreaks are dealt with as part of normal service provision, and may not impact greatly on routine services or require an OCT to be convened.

New guidance published in February 2021 requested Local Authorities to reflect the approach to the core aspects of the end-to-end COVID-19 response.

High risk settings, communities and locations.
Vulnerable and underserved communities.
Surveillance.
Community testing.
Contact tracing.
Support for self-isolation.
Compliance and enforcement.
Outbreak management (Responding to an outbreak of two or more linked cases).

Local plans are also required to review and consider the local arrangements for the provision of support in the following areas:

Resourcing.
Communications & engagement.
Data integration and information sharing.

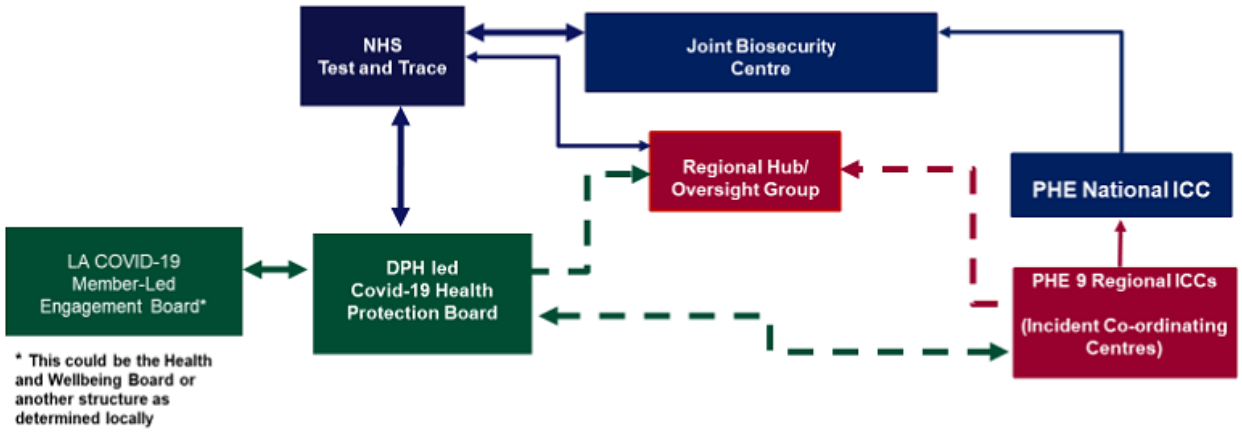
In addition, this local plans will need to address the following developments:

Interface with vaccines roll out.
Responding to Variants of Concern (VOC).
Action on enduring transmission.
Enhanced Contact Tracing, in partnership with HPT.
Ongoing role of Non-Pharmaceutical Interventions (NPIs).
Activities to enable 'living with COVID' (COVID secure).

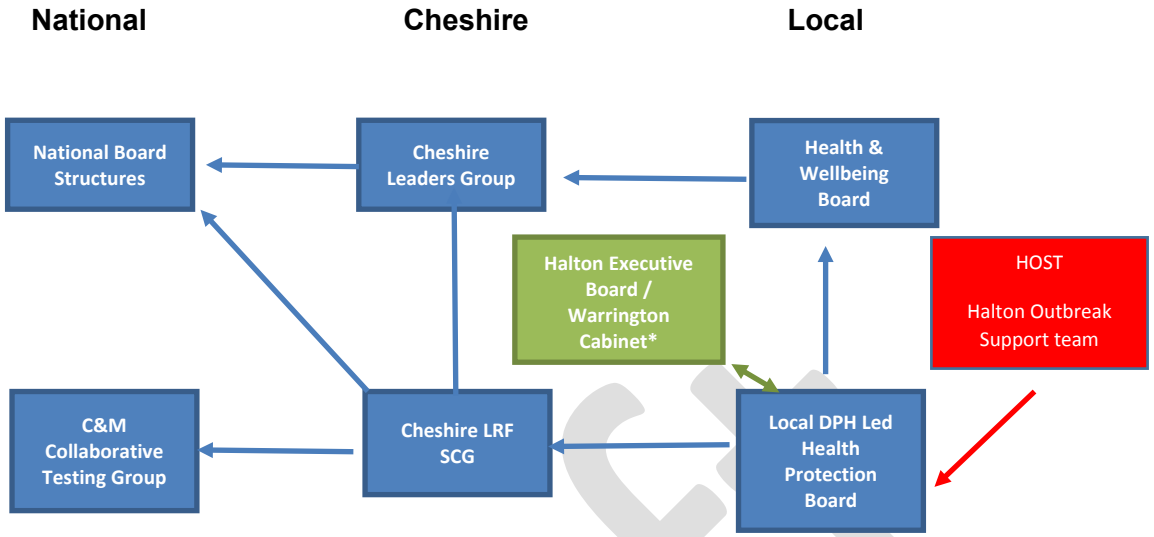
It is the purpose of this Local Outbreak Management Plan to describe the arrangements in Halton to support the delivery of an effective local response to Covid 19 based on the areas identified above.

1.5 Governance

Key Organisational Elements



Framework for Governance across Cheshire and Halton



In some cases, if there is significant local or media interest or the threat from the outbreak is severe, because the impacts on partners or communities are disruptive or need formal multi-agency co-ordination, a major incident can be declared and the formal input of local resilience partners will be required. Under these circumstances the command and control structures described in the respective LRF plans, or equivalent will be evoked. A Science and Technical Advice Cell (STAC) may need to be convened to advise the SCG and the Gold Commander.

1.6 Key themes for local response

The initial national response outlined seven key themes for local outbreak control plans for covid-19:

1. **Care homes and schools**: Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response).
2. **High risk places, locations and communities:** Identifying and planning how to manage high risk places, locations and communities of interest (e.g. defining preventative measures and outbreak management strategies).
3. **Local testing capacity:** Identifying methods for local testing to ensure a swift response that is accessible to the entire population (e.g. defining how to prioritise and manage deployment, examples may include NHS, pop-up etc.).
4. **Contact tracing in complex settings:** Assessing local and regional contact tracing capability in complex settings (e.g. identifying specific local complex communities, developing assumptions to estimate demand and options to scale capacity).

5. **Data integration:** Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g. data management planning, including data security, NHS data linkages).
6. **Vulnerable people:** Identifying and supporting vulnerable local people to get help to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc.) and ensuring services meet the needs of diverse communities.
7. **Local Boards:** Establishing governance structures led by existing Covid-19 Health Protection Boards in conjunction with local NHS and supported by existing Gold command forums and a new member-led Board to communicate with the general public.

Local Authorities are now in a position to review local plans to ensure that the local approach reflects the core aspects of the end-to-end COVID-19 response and can put in place local systems which are prepared for a move to an endemic environment.

2.0 RESPONDING TO COVID

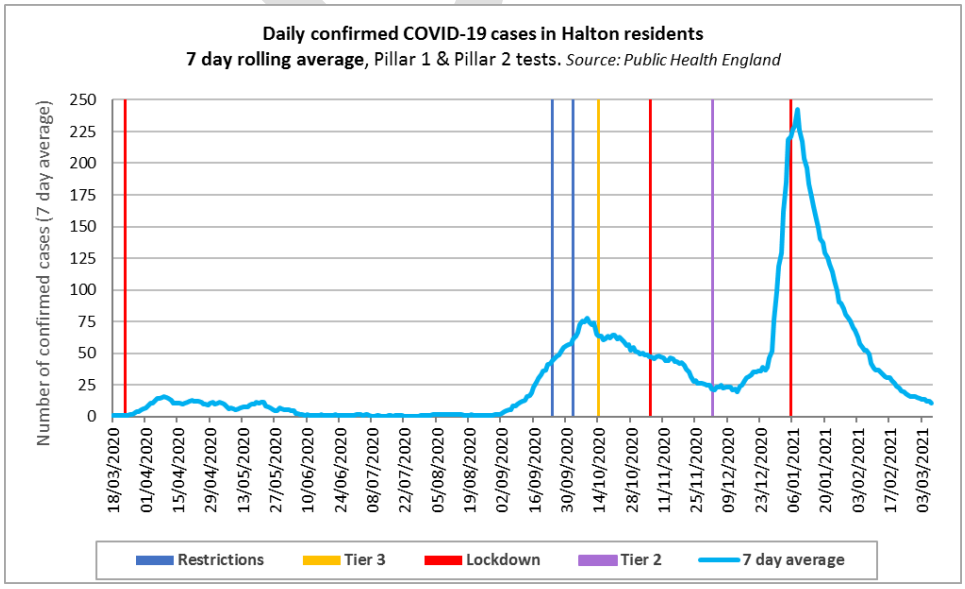
Halton has refreshed its Local Outbreak Management Plans on high risk groups and complex settings to focus on how we identify and address inequalities, compliance and enforcement, local governance, resource and capacity management, communications and data and intelligence. The plan also incorporates national and local developments in testing, tracing, containment and engagement. In addition the plan anticipates the changing nature of COVID 19 in terms of the development of new variants of concern (VOCs) and the need for surge capacity and the move from a pandemic to endemic response.

We recognise the need to work as a whole system to address COVID 19 so in tandem with the national Roadmap we have developed a comprehensive Halton Roadmap including all services within the Council to support recovery out of lock down and beyond. This sits beside our Local Outbreak Management Plan.

Halton was part of the recent PHE and Local Authorities Senior Leaders Cheshire & Warrington and Liverpool City Region Workshops for Roadmap and Recovery. The latter considered enduring transmission and frequent outbreaks, 'Business As Usual (BAU) and dealing with the dominant variant and sporadic outbreaks and VOCs. We shared what we can do together as local authorities, standardisation of procedures, joint contact tracing hubs, mutual aid, cross border working, protecting our vulnerable populations and health inequalities as well as supporting and re-opening the economy.

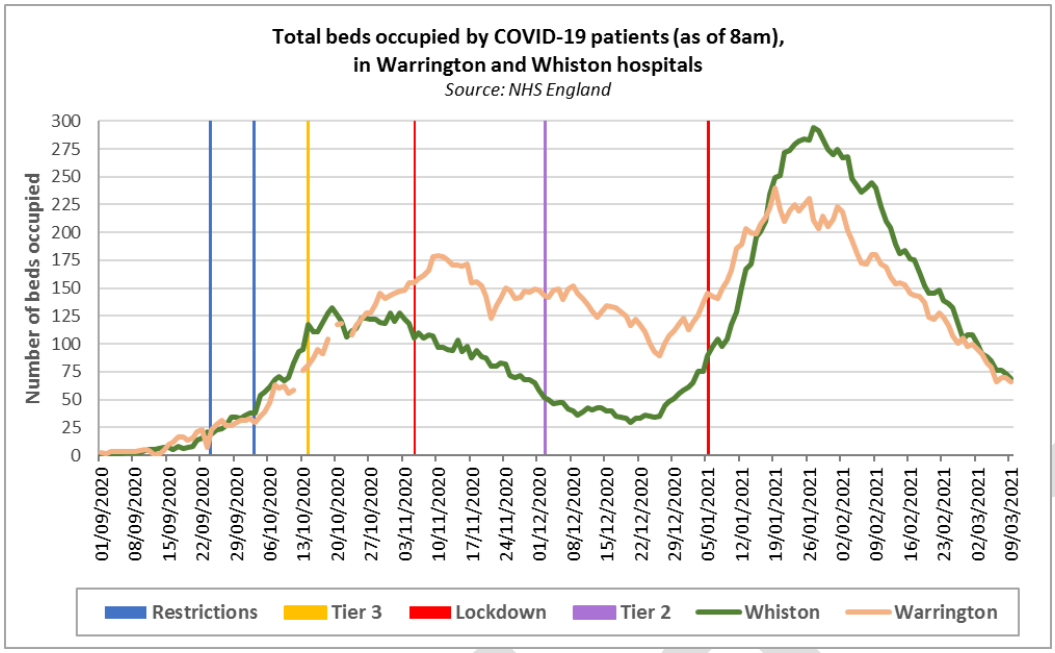
Trend in cases of COVID-19 (to March 2021)

The chart below shows the trend in confirmed COVID-19 cases in Halton residents since March 2020. There has been a reduction in cases since early January.



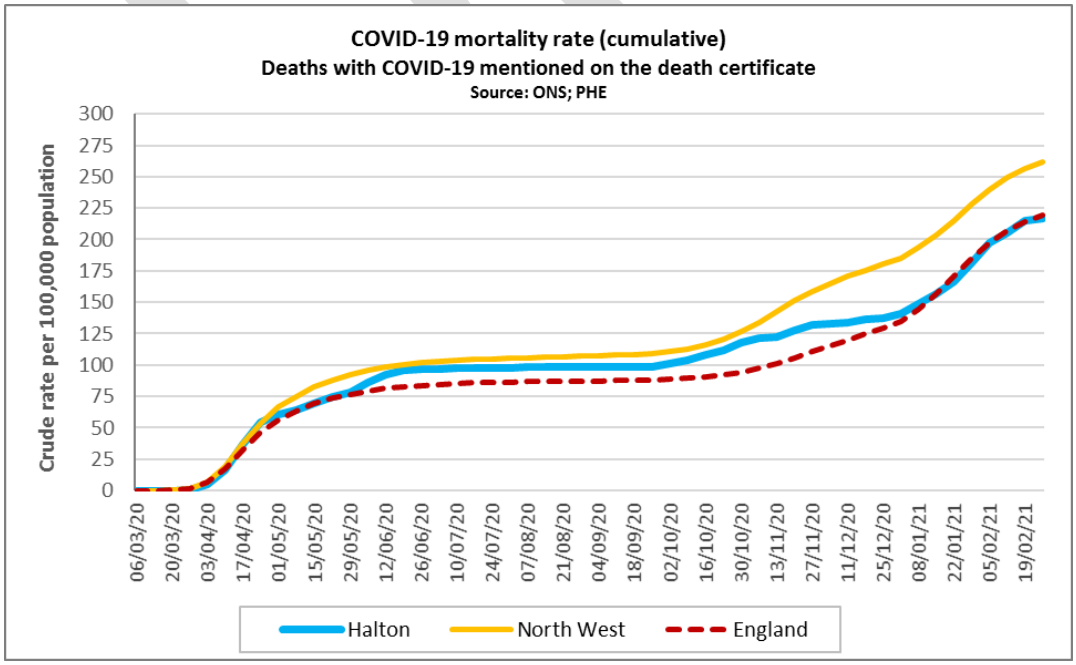
Hospital admissions

The chart below shows trend in beds occupied by COVID-19 patients at Whiston and Warrington hospitals. Both hospitals have seen a decline in beds occupied during February and into early March.



Deaths

The chart below shows the cumulative (total) death rate by week (for deaths that mention COVID-19 on the death certificate). The number of deaths have reduced since mid-February in Halton. The total death rate in Halton for week ending 19th February was lower to the North West and similar to the England average.



Vaccinations

As at 7th March, 93% of Halton residents aged 70 and over had received at least one dose of the COVID-19 vaccine and 24% of residents aged under 70.

Percentage of people vaccinated for COVID-19 with at least 1 dose (cumulative/total)

Residents of Halton

	Date			
Age	**14th Feb**	**21st Feb**	**28th Feb**	**7th March**
Under 70	12.8%	16.6%	21.3%	24.1%
70+	91.7%	92.7%	93.1%	93.3%

Source: NHS England https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

The above information demonstrates a positive trend towards recovery and reflects the hard work of the Council, the NHS, our partners and most importantly local people in following the guidance and advice and doing everything they can to stay safe.

As we enter the next stage of the local response to COVID, we can make a number of assumptions:

The virus is still circulating and we will enter into an endemic phase.

As a Local Authority we will need to ensure that there is a strong local, regional and national infrastructure to support testing and outbreak management, to provide clear guidance and advice and that resources are sufficient to support people to self-isolate when required to do so.

We must be prepared for fluctuations in local rates.

It is unclear how virus transmission will continue in the short and medium term and we need to be ready for this in terms of public trust, confidence and the epidemiological strategies to respond.to fluctuating rates. Surveillance, data sharing and clear communication with partners and the public will be essential. Services need to be flexible, adequately resourced, responsive and able to be stepped up and down to respond to local need.

A key priority must be to suppress the virus as much as possible for the foreseeable future.

We will all be living and working in a COVID-endemic environment and we will need to develop multiple strategies and responses to manage during this time. Focusing upon local inequalities, whether this be social or economic must be a priority and services need to be as accessible as possible. The role of both testing and vaccination are essential as part of

this process and all partners need to ensure that clear and consistent health promotion and protection messages are shared and acted upon to create COVID safe environments.

The virus and its variants are likely to continue to cause outbreaks.

The potential impact of continued circulation of the virus and new emerging variants have the potential to continue to cause local outbreaks. The local and national infrastructure needs to be responsive and continue to monitor the virus, consider the potential need for vaccine renewal and ensure local and national systems are equipped with adequate resources and support to respond.

The following sections reflect the current arrangements in Halton in terms of managing local outbreaks and providing an 'end to end' service for identifying infection, supporting local people and managing outbreaks when they occur. It is based on nearly a years' worth of activity and has had to be flexible and responsive to the ever-changing impact of the virus, constantly evolving national guidance and the availability of sufficient resources to enable it to happen.

2.1 Health Inequalities

High risk settings, communities and locations and Vulnerable and underserved communities.

Below are some examples of the priority groups and settings identified in Halton:

The clinically vulnerable: highest risk are the shielded, followed by those who are eligible for the flu vaccine (over 65s, underlying health conditions), men and those living with social or economic inequalities.	Personal and social circumstances: asylum seekers/hard to reach groups, homeless, gypsies and travellers, substance misusers, victims of domestic abuse and looked after children.
People who may not be able to socially isolate: people in houses of multiple occupation, people with dementia, people with learning difficulties, people with severe mental health problems,	People who have lots of contacts: frontline staff, teachers, drivers, factory workers, retailers
High risk settings: care homes, hostels, children's homes, special schools, hospitals	Geographical hot spots: street, neighbourhood, extended family

These can be distilled this into three categories of complexity:

1. Complex and high-risk settings (such as care homes, special schools, primary care),
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 and people unable to comply with guidance (such as: Learning Disability; diagnosed Mental Illness; Victims of Domestic Abuse; complex social-economic circumstances).

The following is a snapshot of the current numbers of individuals classed as 'vulnerable' in Halton

• Approx. 800 care home residents in 25 homes
• Approx. 800 adults receiving domiciliary care
• Approx. 200 adults in supported living environment
• Approx. 100 homeless in single hostel accommodation
• Approx. 34 children in residential care
• Approx. 600 refugees/asylum seekers
• Approx. 200 children in foster placements
• Approx. 80 children receiving community nursing care

Halton's approach has been, and will continue to be, to monitor these groups and individuals most at risk and to ensure that services are prioritised to meet their needs. Access to testing and vaccination will be focused upon those who are considered to be vulnerable, as well as targeted communications and interventions where needed. Outbreaks will be monitored and clear communication channels will be maintained with service providers and other partners to offer guidance and oversight as well as management of Outbreak Control Teams where required.

Long-standing structural inequalities and deprivation have been exacerbated by the pandemic and highlight the need to increase the drive to tackle these at a national level. There are opportunities to address the real and perceived and Halton will consider a range of approaches to engage our citizens and communities. While the priority remains provision of testing to people who are permitted to leave home for essential reasons and are unable to access asymptomatic testing through other routes, Halton will give particular consideration to those groups previously identified as having low engagement with COVID-19 testing within our community. We will continue our involvement with partner organisations (particularly the voluntary, community and faith sectors) as they give particular consideration to how to reach vulnerable, hard to reach groups and those with protected characteristics.

Halton has been part of the Cheshire and Merseyside "Under The Skin" research which looked at vaccine hesitancy by minority and ethnic groups and made recommendations as

to how to promote uptake and tailor communications. This work will be considered as part of the ongoing engagement with our local communities.

As part of our ongoing work we will consider the following when ensuring our work has the broadest reach:

- **Access to testing and vaccination: using highly devolved approaches to increase access to testing and vaccination, considering diversity in recruitment of testing administrators to encourage maximal participation from all groups**
- **Communications: considering accessibility, language, and media requirements for example reaching those without internet access.**
- **Encouraging participation: ensuring that any means used to encourage participation in testing, vaccination and support for self-isolation is open and relevant to all groups.**

2.2 Surveillance

Halton will maintain real time surveillance for infections in order to identify geographical 'hotspots' and trends that might indicate community spread. This will include surveillance of cases of COVID-19 as well as temporal and spatial analysis of Incidents.

Surveillance is critically dependent on receiving comprehensive, timely and accurate data from the 'Test' and 'Trace' tools provided by the national services. The Power BI Covid data provides a wide suite of data against which local data can be compared and triangulated with. To augment this, the Council will continue to carry out local contact tracing, focusing on those areas with the highest incidence of COVID-19 in order to maximise opportunities to identify potential sources of infection and settings and other contacts who may have been exposed.

We will continue to engage in intelligence sharing across the sub region and nationally. An example of this is the current daily meetings with the Cheshire and Merseyside Hub to discuss cases of concern. Epidemiology review meeting which are currently weekly with PHE currently are also essential in understanding the trajectory and impact of the pandemic.

Cheshire and Mersey have developed the CIPHA (Combined Intelligence for Population Health Action) data lake which gives us timely access to COVID 19 data on infections, outbreaks, geographic locations, common exposure areas and vaccinations and allows us to be responsive and agile. This plays into our local intelligence teams and the Cheshire and Merseyside Intelligence Cells. It has also allowed us to jointly identify areas of concern, such as workplaces, and make recommendations to the national team. The

introduction of CIPHA as a data management and reporting system has also enabled cross boundary analysis of data and has become an essential tool in overseeing the path of the pandemic both locally and regionally.

Where community spread is identified, this will be discussed with PHE (or its new successor organisation), through the LRF, with the COVID-19 member-led local outbreak control board and with the affected community to determine an appropriate response. The response may range from enhanced communications to promote hygiene and social distancing to additional restrictions to activities. A local escalation framework and Standard Operating Procedure (SOP) has been developed to guide when these might be introduced.

We will consider the outcomes of the pilot **Waste Water** test schemes. These consider the level of Virus fragments in local water supplies which are not active (low risk) but are indicative of variants and viral load in a particular area. This is a useful method as waste water is not reliant on people coming forward to be tested, and can be deployed in areas such as sewer networks outside specific buildings (like hospitals or student halls) or neighbourhoods and can use test site auto samplers. Whilst the pilot is still in its initial stages, early indications suggest there is moderate correlation with local testing and strong correlation to the REACT survey activity. At present the test scheme does not cover the Halton area but we are aware of this and its potential benefits.

To date, the local team has had little interaction with the data generated by the **NHS App** and this is an area for future development.

We will:

- **Continue to support the development of CIPHA and other local, regional and national data systems.**
- **Explore the potential of the Waste Water test scheme and the intelligence it can provide.**
- **Engage with regional and national partners to ensure surveillance remains a priority.**

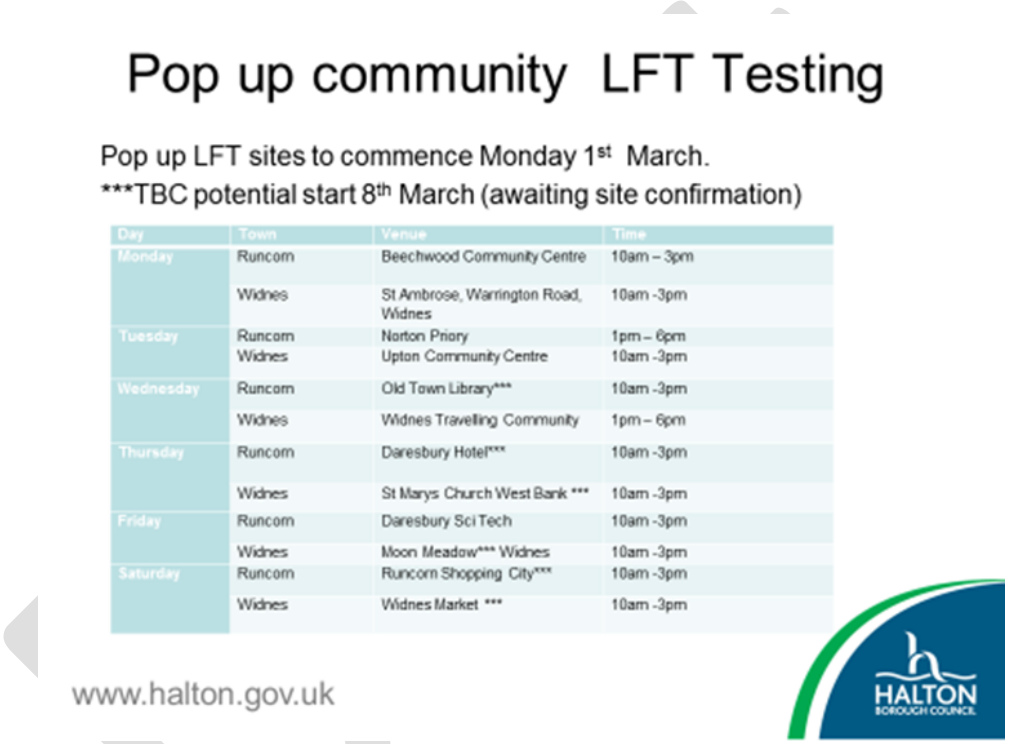
2.3 Community testing

The effective suppression of COVID-19 transmission will continue to be vital to manage the virus even as vaccines are rolled out in the UK and globally, including for those who cannot be vaccinated.

Halton has a comprehensive Asymptomatic Testing Programme which was developed as part of the Liverpool City Region SMART Pilot. It is outlined below. This is very flexible and can be stood up or down depending on need. It is particularly responsive to the

requirements of Hard to Reach Groups or people and areas of high prevalence. Halton is also an early adopter of Home Testing for the local population. We anticipate this will expand.

Halton has currently established two fixed community testing sites as well as establishing targeted interventions for key workers which are pre-bookable. These are targeted at frontline Council staff, Emergency Services, Health and Social Care staff, Early Years and Education and staff working at the vaccination centres. Halton has developed a flexible approach to the provision of community testing and an example of the availability is illustrated below. We will maintain a responsive and flexible approach.



Symptomatic Testing

PCR testing is a highly accurate (specific & sensitive) testing method for SARS-CoV-2. A swab of the nose and throat is most effective when taken within the first 3 days of symptoms. It requires laboratory testing, which can take 24-72 hours for the result to be available (compared with up to 2 hours for LFT).

PCR testing allows identification of new variants of concern (VOC) and vaccine-resistant strains. PCR has been used as a confirmatory test after a positive LFT. Those with a positive test should self-isolate along with close contacts for 10 days after symptoms started.

Current PCR Testing Provision in Halton

PCR Testing is provided externally to the Local Authority offer and is at the jurisdiction of the National system. Regional and local sites, mobile testing and home testing allow people who develop symptoms to quickly get a test and find out whether they need to continue to self-isolate.

Regular weekly PCR testing is available for staff who are working with vulnerable groups, such as health and social care staff and for care home residents.

Covid 19 PCR Testing for people with symptoms

- 3 sites for the public: Brindley Car Park, Heath Business Park, Widnes Police station/Magistrates area.
- MTU - Morrison's Car Park. Will move depending where we need it.
- Regular weekly PCR testing for all Care Home staff and domicillary care workers. Also provided for outbreaks.
- Care Home residents tested every 28 days.
- Regular testing of frontline workers, hospital staff and positive patients.
- Supported living and hospice testing.
- Children in Care weekly. Particularly for moving children.

Subject to continued national provision, guidance and resource availability, future actions for PCR testing will focus on:

- Maintaining high levels of PCR testing to prevent transmission of COVID as restrictions ease and to identify any new VOC.
- More emphasis on PCR if case rates increase/VOC and winter planning
- Ensuring PCR capacity can respond to increased case rates and meet surge capacity/new VOC
- Establishing a dual-approach to testing as model changes to increased home testing (Community Collect and 'Testing for access') without compromising symptomatic capacity
- Reinforcing messaging of getting tested if you have symptoms, reporting results and isolating even if you've been vaccinated
- Improving accessibility of PCR testing tailored to our local population e.g. non-car ownership higher in Halton
- Maintain and develop targeted PCR testing of hard to reach groups – e.g. asylum seekers, travelers, etc.

- Integrated approach as more of population is vaccinated to ensure clarity of pathway and communications

Effective testing is crucial to preventing onward transmission of COVID-19. It remains a key tool to investigating and managing outbreaks and will need to be delivered long-term. Halton is committed to ensuring that testing is accessible to all residents, supporting and enabling them to obtain a COVID-19 test quickly, minimising lives lost as well as the social and economic impact of the pandemic. Halton's testing plan will be flexible in its ability to respond accordingly to changes in demand, new methods of testing and reviewed as per the latest evidence. Prioritisation of testing capacity will continue to be implemented as agreed by Cheshire & Merseyside's testing prioritisation framework with increased emphasis on establishing regular testing as a habit amongst the population in line with National priorities. We will also monitor the use of new and emerging technolgoies, such as LAMP to enhance the local testing offer.

- **Key priorities**

- **Monitor and optimise testing capacity and sustainability as demand from other services previously on hold increases through the recovery phase**
- **Ensure the system can appropriately respond should demand exceed capacity e.g. new VOC, increase in cases, winter planning.**
- **Optimising testing access for Halton's residents by addressing barriers such as practical, financial, knowledge and trust**
- **Ensuring equality and equity through targeted support for vulnerable groups and high risk complex settings to access testing**
- **Integration of data across Cheshire & Merseyside to coordinate and target COVID-19 testing**
- **Surveillance – to develop a greater understanding of numbers accessing testing, their demographics and location to identify and support vulnerable groups to access testing.**
- **Support transition to recovery phase BAU through home testing and other new testing models e.g. Community Collect, 'Testing for access' e.g. theatres**
- **Clear communication on testing guidance especially as number vaccinated increases with continued emphasis on testing as prevention. To provide testing as the community goes back to business as usual, in community hospitality, entertainment and sports venues.**
- **Moving to a community collect model, and encouraging regular testing.**
- **Using testing appropriately as vaccination roll out widens, and understanding of the impact of vaccination improves.**

2.4 Contact Tracing

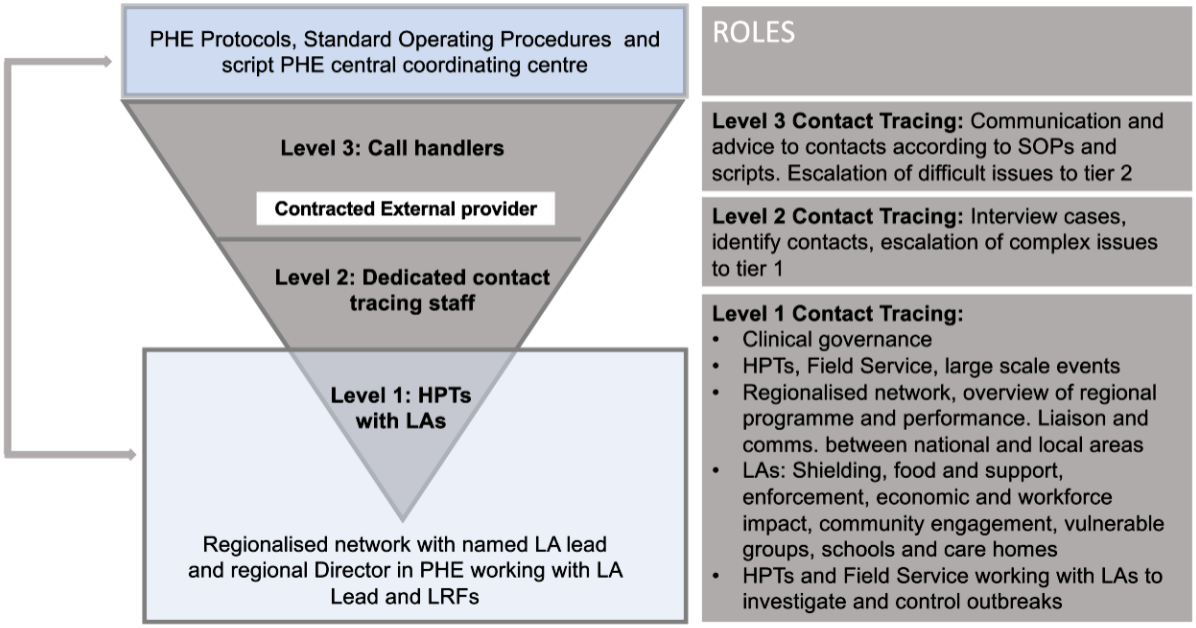
Contact tracing is one of the ways we protect the public from infectious diseases. If a person tests positive for COVID-19, we speak to them in order to identify anyone who has had close contact during the time they were considered to be infectious and then attempt to find these people as soon as possible. Once we have made contact we can then give them the advice they need to self-isolate and protect others. If they are in groups considered to be a higher risk, we make sure that we follow up with them to see how they are. If they become unwell we are then able to assess them quickly and take appropriate action. Presently contact tracing is carried out both by the national NHS Test and Trace Service and by the local Public Health Team.

The NHS Test and Trace Service will input and host information on both LFT and PCR (lab-confirmed) cases and contacts onto the national data system (CTAS) which is an invitation only system that is accessed through two routes: automatically by cases and contacts through text message or email invitation or by the phone-based contact tracing team.

CTAS receives details of all positive cases of COVID-19 via NHS Digital. Cases will be categorised into automatic follow-up (have provided email details/can use web-based tool) or phone follow-up. Cases following the automated pathway upload details of contacts into CTAS which are then followed up either automatically or by phone.

NHS Test and Trace is a National Service, and the role of the local authority is to support that service using our detailed knowledge of local communities and settings. The Local Authority has established the **Halton Outbreak Support Team (HOST)** team to support local people and a primary role for the authority is to offer support to vulnerable residents who have been asked to self-isolate, and also additional support to help with the management of complex sites and situations (for example schools and care homes). This is not a new role for the local authority, and Public Health teams routinely work with the Health Protection Team in PHE to support additional actions around outbreaks of other infectious disease within these settings.

Currently, the national system is broken down into the following levels:



Currently Tier 1 of the contact tracing service is subcategorised into:

• **Tier 1a** – this is the national co-ordinating function and will lead on quality assurance, data science, guidelines and protocols and clinical governance.
• **Tier 1b** - Health Protection Teams (HPT) and PHE Field Service Teams (FST) who will manage complex outbreaks and situations in conjunction with local authority Public Health support.

For Cheshire and Merseyside, Directors of public Health have invested in the provision of the Cheshire and Mersey Contact Tracing and Outbreak Support Hub (**HUB)** to coordinate much of the action required at Level 1. The HUB is a partnership between the nine Local Authorities, PHE and CHAMPS and provides additional contract tracing and outbreak management and we would like to maintain its essential role as we move into an endemic situation. We developed this Hub jointly with PHE and it brings together Public Health Consultants, call handlers, environmental health officers etc. and links into and supports our local Halton Contact Tracing and Outbreak Hub. Given the development of VOCs and the move towards Zero Hours Contact Tracing and Enhanced Contact Tracing we see resource for this Hub as crucial for surge capacity.

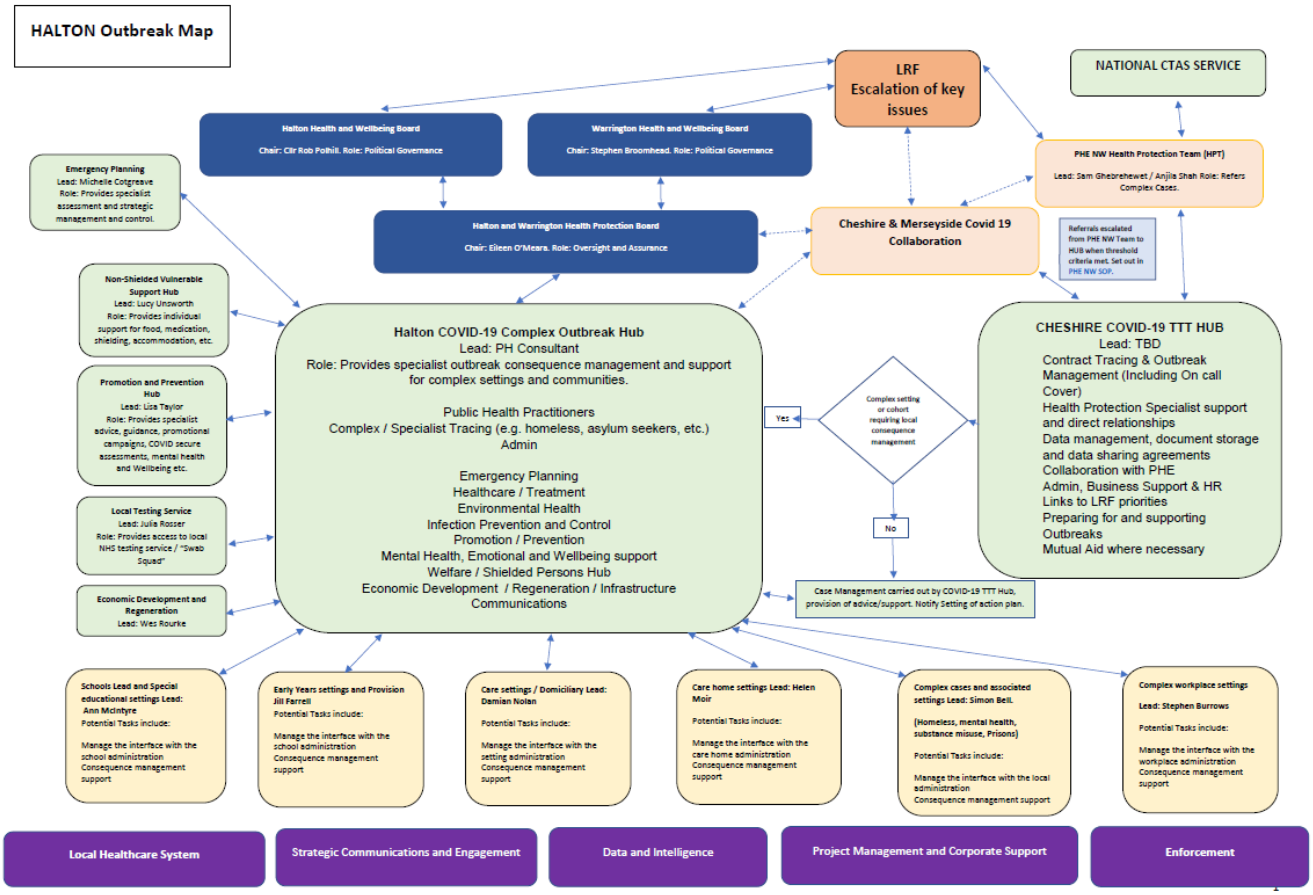
Each Local Authority area has also developed its own bespoke local offer in terms of additional contract tracing and consequence management.

In Halton, since the early days of the pandemic, the **HOST (Halton Outbreak Support Team)** has provided an outbreak monitoring and response service. The team aims to contact all positive cases to explore isolation, identify additional contacts and any support

needs, and has been instrumental in work around contacting those “Lost to Follow Up” through the National T&T service and those harder to reach individuals and communities.

Utilising the national CTAS data system, the team also provides welfare calls, home visits, text messaging and posted letters to ensure local people are supported and have access to the information they need, whilst reinforcing core health protection messages and prevention advice.

The Local structure is demonstrated below:



Operationally, there has been some disconnect between the National T&T system, regional PHE and local teams, with timely information for local areas not always clear or specific as to who will / should be dealing with specific issues. The balance between national and regional is now working more efficiently however improvements can still be made. Communication with Local Authorities is required as to what is expected on a local level, which will enable local authorities to plan and adapt their local contact tracing model and consider their own resources.

The regional Cheshire and Merseyside HUB has been vital in pulling together local areas, sharing best practice and reducing the burden on local teams and we are keen that

resources are continued to be made available to support this function, as well as ensuring core local teams can continue to serve in this essential function.

As we enter the next stage of the pandemic, there needs to be a clear conversation with Local Authorities as to what the future structure will look like and what will be managed by PHE and the national and regional systems. If there is an expectation that local areas commence detailed **enhanced contact tracing** there will need to be sufficient resource and training opportunities made available for local teams to pick this up. There will also need to be clarity on how local systems can better integrate case management systems with the national data systems.

2.5 Support for self-isolation

It has been recognised that some individuals may need additional support in order to complete the ten day period of self-isolation. We are aware from various studies that there is limited compliance with the requirement to self-isolate for 10 days as required for positive cases or contacts of positive cases. Self-isolation is a critical element of reducing the spread of Covid-19 including any new variants and makes a significant contribution to keeping our family, friends and community safe, enabling us all to return to normal life as soon as possible.

In Halton, the HOST (Halton Outbreak Support Team) encourages individuals that it contacts to share any problems they might have with self-isolating for the required time, where there are additional support needs identified appropriate signposting or direct support has been arranged.

It is currently a legal requirement to self-isolate following a positive test. Individuals who fail to do so may be fined. The NHS T&T team will identify people who need additional support and pass their contact information to the Local Authority and the local HOST team will also ask all cases if they require additional support.

The **Halton/DHSC motivational text pilot** is ongoing with evaluation in-built to understand the impact of localised messages to people who test positive, and a campaign has been developed locally to inform local people about the support available to self-isolate and what their obligations are. Information is available through a variety of mediums (online, print, etc.) and the role of the Councils contact centre has been essential in providing information and effective support to local people. Halton has also invested in the development of a local programme - **“Halton - 10 days, 10 ways” – Self Isolation support.**

The objectives of the campaign are:

1. Encourage full compliance with self-isolation for those identified as positive cases or contacts of positive cases
2. Ensure anyone needing to self-isolate is aware of the full range of support that is available to them
3. Encourage people to plan for self-isolation and have necessary contingency arrangements in place

The Key messages are:

- If you have been told to self-isolate by NHS Test and Trace or a public health official because you have tested positive for Covid-19 or you are identified as a contact of someone with Covid-19, you are required by law to stay at home for 10 days. Failing to do this could result in a fine of up to £10,000.
- There is lots of support available for anyone needing to self-isolate including help with money such as the £500 self-isolation grant, arranging volunteers to help with shopping or dog walking and to take over caring responsibilities if needed. Please check our 10 days, 10 ways self-isolation guide at www.halton.gov.uk/selfisolation or call us on 0303 333 4300.
- Self-isolating is much easier if you have a simple plan in place – what to do if you can't get out to buy food, get medicines, go to work or to care for someone else. Having a few basic supplies, important information ready and discussing with family, friends or neighbours all helps in the event that you have to self-isolate due to Covid-19.

If local residents are identified as **clinically extremely vulnerable**, they are advised to reduce social contact as much as possible to minimise the risk of infection and to limit all contacts, particularly with people that they do not live with. Those defined, on medical grounds, as clinically extremely vulnerable to coronavirus are people with specific serious health conditions. Access to food, medication and advice on wider support including pet care is provided on a dedicated self-isolation support webpage – www.halton.gov.uk/selfisolation

2.6 Compliance and enforcement

The overall approach to compliance and enforcement will continue to be to **Engage, Explain, Encourage** and then **Enforce** compliance with control measures.

The intention is to work with individual people, settings as well as wider communities to implement whatever control measures are required. The expectation is that the majority will be compliant with public health advice. Occasionally it may be necessary to enforce control measures in relation to an individual setting, self-isolation and testing of a person, or wider restrictions in a community.

Under the Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations 2020 the Council has powers to close premises, public outdoor places and prevent specific events, without having to make representations to a magistrate. The expectation is that these powers are used with discretion, and only to be used having had regard to any advice given by the Director of Public Health. Further enforcement is provided in partnership with the local **Police** force.

Enforcement in relation to individual settings

Care settings - Through the Care Quality Commission.

Schools - Via the Secretary of State and/or Ofsted.

Businesses – The council has a range of enforcement powers to ensure workplaces and venues are Covid secure. Existing powers under the Health and Safety at work act can be used to ensure businesses implement adequate measures to control the spread of corona virus. This responsibility is shared with the Health and Safety Executive (HSE). In general the addition of specific powers in relation to corona virus have been provided to the Council under legislation implemented by the Public Health (control of diseases) Act 1984. These powers mainly relate to enforcement of business restrictions (e.g. Fixed Penalty and Prohibition notices) – however there is also a general power to issue directions in any circumstances where there is considered to be an imminent risk to public health.

In relation to businesses **the Environmental Health** team will initially provide advice and support to help businesses comply with COVID-19 control measures. Where this is insufficient then a process is in place for referral to the Council to consider use of enforcement powers.

If a direction notice is issued the Council must notify the Secretary of State as soon as reasonably practicable after the direction is given and review to ensure that the basis for the direction continues to be met, at least once every seven days.

To ensure consistent application and enforcement of these requirements the council liaises regularly with **Cheshire Police**, the **Health and Safety Executive** and other council's across Cheshire and **the Liverpool City Region**.

Premises which form part of essential national infrastructure are out of scope of the power to issue direction notices. A non-exhaustive list of the types of categories of infrastructure is set out in HM Government guidance.

Enforcement of self-isolation and testing - All reasonable measures should be taken to persuade people to voluntarily comply with requirements for isolation and testing, with checks to ensure they have the capacity to understand what is being asked of them.

If a person is unwilling and/or unable (e.g. because of lack of mental capacity) to comply with requirements for isolation and testing, then arrangements to impose proportionate restrictions are set out in the **Potentially Infectious Persons Schedule 21 (Coronavirus Act 2020)**.

There must be reasonable grounds to suspect that an individual is, or may be, infected or contaminated with COVID-19 and that there is a risk that they will infect or contaminate others. Reasonable grounds would include:

- tested positive for COVID-19
- presenting with symptoms of COVID-19 (regardless of whether the person has been tested)
- is, or has been, in contact with another person with symptoms of COVID-19, regardless of whether that other person has been tested for COVID-19
- has arrived within the last 14 days from an infected area

Wider restrictions

Where there is wider community spread of COVID-19 then the Council may advise restrictions. For example on household gatherings and movement of people into and out of an area. These will need to be negotiated carefully with the community affected as they are likely to be acceptable only if they are perceived as proportionate and practical.

The Council does not have powers to enforce these sort of wider restrictions. Legal restrictions on household gathering and movement of people can only be made by HM Government.

In areas of intervention, HM Government will be able to use their existing powers (under the **Public Health (Control of Disease) Act 1984)** to implement more substantial restrictions with regulations produced and approved by Parliament on a case-by-case basis) which could include:

- closing businesses and venues in whole sectors (such as food production or non-essential retail), or within a defined geographical areas (such as towns or counties)
- imposing general restrictions on movement of people (including requirements to 'stay at home', or to prevent people staying away from home overnight stays, or restrictions on entering or leaving a defined area)
- imposing restrictions on gatherings - limiting how many people can meet and whether they can travel in and out of an area to do so
- restricting local or national transport systems - closing them entirely, or introducing capacity limits or geographical restrictions
- mandating use of face coverings in a wider range of public places

HM Government also have powers to take action against specific premises, places and events, as well as a power to direct local authorities and to consider whether a local authority direction is unnecessary and should be revoked, including in response to representations from those affected by it.

Plans have been drawn up locally to support the national “reopening of society”. However there is still uncertainty as to the timing and content of national regulations and associated guidance. Any announcement on regulations and guidance needs to be made in a timely manner to allow the Council time to work with partner agencies and support businesses in advance of them reopening. This local action needs to be supported by clear and consistent national messages. Additionally there may be cross boundary issues as there are not necessarily consistent regulations, e.g. Wales/England.

There is also a need for an urgent review of large events as they are being planned now, and it unclear how local teams should respond. One example is locally we may advise on the use of PPE, which will need to be ordered now, but may not be required (bringing unreasonable costs to organisers, etc.)

Environmental Health teams have also indicated that they will be very busy in July, should the regulatory inspections all be required as society reopens, alongside other local support and enforcement activity with regards to covid security. The team have requested clarity on the FSA requirements with regards to business as usual with regards to hygiene visits.

In addition, the requirements of the recent White Paper and the potential political and organisational turmoil that will be created with the development of Integrated Care Systems (ICS) will have significant impact locally, as will the creation of the NIHP and the loss of PHE.

2.7 Outbreak management (Responding to an outbreak of two or more linked cases)

On a sliding scale, there are a range of outbreak scenarios that require appropriate actions:

- **cases** refer to individual cases of COVID-19
- **clusters** refers to 2 or more cases associated with a specific setting in the absence of evidence of a common exposure or link to another case
- **outbreaks** refer to 2 or more confirmed cases associated with a specific setting with evidence of a common exposure or link to another case
- **community spread** refers to sporadic or linked cases on a limited or extensive basis

The generic outbreak control plan described below has all the principles and approaches needed to guide a response to different outbreak scenarios. However, the plan cannot be prescriptive but has flexible elements which can be implemented appropriately by competent and trained public health professionals with support from local stakeholders.

The limitations of a prescriptive or detailed outbreak control plan include omission of key events unknown at the time of writing will fail to address the nuances of a different, unexpected or developing outbreak and thus could lead to an unnecessary focus which could lead to an inappropriate response. Any relevant and comprehensive generic outbreak control plan needs to have sight of surge capacity arrangements at the local and regional level which can be triggered as needed. Plans should dovetail with the PHE and NHS plans as well as other relevant stakeholders in the local and regional strategic partnerships to deal with high volumes of hospitalisation and deaths and other unexpected outcomes.

Regular reviews and testing of the plan will be undertaken, at present the plan has had multiple live tests, as happens with other emergency plans at the local level. Debriefs of unusual situations are undertaken to assess the competency of the plan and to make appropriate changes to the plan.

In the majority of scenarios, local teams will be able to control the outbreak by drawing on their expertise in epidemiology, analysis, good communications and engagement, infection control, enhanced testing and effective local contact tracing.

They may impose restrictions on the specific setting, such as cleansing or temporary closure. In exceptional cases, an outbreak in a setting will require additional support or intervention. NHS Test and Trace Teams will work with local areas to ensure that settings of national significance, for example those which form part of the UK's critical national infrastructure or underpin major supply chains, are identified proactively and managed appropriately.

The following table summarises the key roles for managing outbreaks within an individual setting, within a local authority area, and which cross regional boundaries.

Level	Decision-maker(s)	Coordination, advice and engagement
Individual setting (for example restaurant, school, factory)	Setting owner – with appropriate support.	
May vary depending if the setting is deemed a setting of national significance.	PHE (local health protection teams) Director of Public Health NHS Test and Trace and PHE setting specific action cards	
Within a local authority area	Decisions may be taken by the chief executive, Director of Public Health or Head of Environmental Health	COVID-19 Health Protection Board (including NHS, faith, community partners, PHE) Local Strategic Co-ordination Group Local Outbreak Control Board or other political oversight bodies
Regional (cross-boundary)	N/A – agreed cross-boundary decisions will be implemented at local authority level	# Local resilience forums (LRFs) Mayoral and combined authorities Integrated care systems Regional health directors (PHE and NHS)

Notification and Activation of the Outbreak Control Plan

Notification

If a setting has two or more confirmed cases, or there is a high reported absence which is suspected to be COVID-19 related, the setting should promptly report to the local public health team.

Where local Public Health teams are made aware of a possible outbreak in the first instance they need to contact local PHE NW team to ensure that the team is aware and to confirm what actions may already have taken place, in order to avoid duplication of effort and to ensure that outbreaks that cross settings are not missed and a local pathway has been established.

There is an expectation that PHE will also inform the LA PH team via the Single Point of Contact (SPOC).

When two or more linked cases are identified, activation will occur, the linked cases may include a person, resident, client or visitor who attends the setting or staff member who work at the setting testing positive for COVID-19. Business settings are contacted by Environmental Health who will ask whether there are comfortable in identifying cases,

about case numbers and existing covid secure arrangements. They will also request a line list if more cases are involved.

Care or domiciliary care will be supported by the Infection Control Team and Schools by the 0-19 Team.

Contact Tracers are based in the National Test & Trace Service, in Regional PHE teams and in the Cheshire and Merseyside HUB and are expected to do the majority of the contract tracing activity. In the event of a very complex outbreak perhaps involving multiple settings or cross boundary, it will require mutual aid and additional workforce as whilst PHE teams will be involved, Local Authority teams may need to provide additional contact tracing activity or consequence management support.

Either the Public Health England (PHE) Consultant in Communicable Disease (CDC) and Director of Public Health (DPH) / Consultant in Public Health (CPH) will decide if an outbreak control team (OCT) is required, if so the convener would lead on declaring an outbreak and carry out an initial risk assessment (RA). If outbreaks are detected through local information, this function may also be coordinated by the HOST, with the support of PHE.

The great majority of outbreaks will be dealt with as part of normal service and may not require an Outbreak Control Team (OCT) to be convened. Most outbreaks can be managed using existing guidance and standard operating procedures (SOPs). If the initial RA indicates a complex situation requiring an OCT, relevant stakeholders will need to be engaged, additional checklists to support this process are available.

Roles and Responsibilities

The responsibility for managing outbreaks is shared by all the organisations who are members of the OCT.

Leadership for managing incidents and outbreaks of COVID-19 will be agreed jointly at the first OCT meeting. This may be PHE, the Local Authority or other appropriate agency depending on the situation.

Suggested members of OCT
Usual Members:

Local Authority Director of Public Health (or nominated deputy)
Health Protection Public Health Consultant
Local Authority Environmental Health Practitioner
PHE Consultant in Communicable Disease Control/Consultant in Health Protection or Consultant Epidemiologist
Consultant Microbiologist /Virologist
Communications Manager
Administrative Support

Additional Members: (this is not an exhaustive list)

PHE Consultant Epidemiologist
PHE Health Protection Surveillance/Information Officer
PHE Data Analyst/Statistician
PHE Health Protection Nurse/Practitioner
PHE Director (if relevant)
PHE Emergency Preparedness Manager
NHS England Strategic Commander
NHS Community Provider co-ordinator
CCG Representative
North West Ambulance Service
Local Authority or provider service infection prevention and control nurse
General Practitioner
Consultant Physician
Immunisation co-ordinator
Pharmaceutical Advisors
Legal Adviser (PHE or LA as appropriate)

Others who may be called upon to attend include representatives from:

Health & Safety Executive
Care Quality Commission
Ofsted
Relevant institution e.g. School, University, Business

There is no specific criteria to determine who will lead however where the focus is on infection transmission and control it is more likely that PHE will lead, whilst if the focus is community interest or consequence management the Local Authority is more likely to lead.

When to convene an Outbreak Control Team (OCT)

- Large number of close contacts
- Cluster of cases
- High numbers of vulnerable people as potential contacts within the setting
- Potential impact on service delivery if staff are not in the workplace for 14 days from exposure
- Death or severe illness reported in the case or contacts
- Significant likelihood of media or political interest in situation

When an OCT has been convened they will decide on the response actions required.

Response arrangements

There are a number of response arrangements and decisions required:

- Contact tracing
- Issuing advice to contacts
- Identifying any consequence management required
- Recording information
- Communication
- Testing
- Advice to non-contacts
- Actions related to complex settings closure
- Additional cleaning requirements
- Stand down / declaring the end of an outbreak

Identifying any consequence management required

Local Authority Public Health teams will be informed if any individual would experience difficulties in keeping to guidance on self-isolation or there are additional challenges where consequence management may be required such as non-compliance with advice on social distancing, breach of environmental health etc.

Local teams will decide if a local multi-disciplinary meeting should be convened to identify key issues and lead the response or rely on use of existing arrangements

Actions related to complex settings closure

Most complex settings do not need to close on public health grounds. Settings will generally only need to close if they have staff shortages due to illness or being identified as contacts.

It is expected that only the immediate floor, room or working team of a confirmed case will need to be asked to stay home.

If there are a number of confirmed cases across different locations within a complex setting then they may be advised to close by the Health Protection Team in consultation with other partners.

There are different legal powers that can be relied on around closure, in the rare occasions where this may be required, the OCT will need to make a decision on which is most appropriate.

Stand down / declaring the end of an Outbreak

It is important that there is continued vigilance for new potential cases as well as adherence to infection prevention and control principles once the outbreak is over to reduce the chance of a further outbreak. The OCT will decide when the outbreak is over and will make a statement to this effect.

If there has been no OCT convened the outbreak will be declared over by the DPH / CPH / other nominated lead / PHE. The decision to declare the outbreak over should be informed by ongoing risk assessment and considered when:

- there is no longer a risk to the public health
- the number of cases has declined;

The outbreak will usually be declared over when there have been no new cases of confirmed or suspected COVID-19 within a continuous 28 day period.

Management of COVID-19 cases and outbreaks in Halton educational settings

Key personnel

The settings will liaise with the HBC education lead who works closely with the Public Health team and will access support and advice where necessary. The Public Health response is led by the duty consultants, with routine enquiries dealt with by a member of the 0-19s team.

Single cases

Educational settings report all cases in students and staff on a notification form or line list to the public health team. The setting are responsible for identifying contacts and advising isolation with support from the public health team where necessary. Those who were tested at home using a LFD will be asked to obtain a confirmatory PCR test.

Multiple cases

Where an educational setting has notified the Public Health team of more than one case within a 14-day period (a cluster[1]), the information will be reviewed to exclude links between them. Additional cases in bubbles that have already been collapsed may be expected.

The 0-19 team member will contact the school for further information where required. If it is likely that transmission occurred on site, advice will be given or an IMT (Incident Management Team) meeting arranged.

Outbreaks in educational settings

Where information suggests links between cases, we will manage as an outbreak. Note that there is an epidemiological definition of a COVID-19 outbreak, which is unchanged:

Outbreak criteria[1]
Two or more test-confirmed cases of COVID-19 among individuals associated with a specific non-residential setting with illness onset dates within 14 days, and one of:

[1] https://www.gov.uk/government/publications/covid-19-epidemiological-definitions-of-outbreaks-and-clusters/covid-19-epidemiological-definitions-of-outbreaks-and-clusters-in-particular-settings

- identified direct exposure between at least 2 of the test-confirmed cases in that setting during the infectious period of one of the cases
- when there is no sustained local community transmission - absence of an alternative source of infection outside the setting for the initially identified cases

However, PHE NW have continued to revise their operational definitions as criteria for escalation to the local authority public health team[2], though in practice, we will proactively investigate clusters as discussed above.

Criteria for referral[2]
More than 10% of a bubble positive for COVID in the previous 14 days (primary or early years settings)
More than 5 confirmed COVID cases in a single year group in the previous 14 days (secondary settings)
More than 10% (approximately) of all staff been confirmed as positive for COVID in the previous 14 days
Positive COVID cases reported from three or more different bubbles in the previous 14 days
Any admissions to hospital or deaths among staff or students in the previous 14 days

Actions during (potential) outbreak

- Regular contact with school to ensure cases and direct contacts are isolating appropriately.
- Review of social distancing, hygiene, facilities management and other measures and relevant policies.
- If concerns that practices may be contributing to spread, large or escalating outbreak, consider IMT.

Incident management team (IMT) meeting

Chaired by consultant in Public Health or Senior Registrar using set agenda. Invitations to senior manager or head of setting; HBC Education Operational Director; HBC Principal Health and Safety advisor, HBC lead Communications officer, HBC Environmental Health lead.

Discuss and document cases, contacts, settings and control measures.

Escalate to Public Health England North West (through direct referral or invitation to IMT) if large or escalating outbreak, vulnerable students at risk (e.g. special needs), or other concerns such as extensive media interest.

[2] PHE NW COVID-19 Template Resource Pack for Schools - Version 5.0

Framework for responding to COVID-19 Outbreak - Generic

Action	Response activity	Stakeholders/Setting	Considerations, comments or potential issues
Initial assessment and Investigation	Risk assessment Decision on if outbreak team should be convened/composition Questionnaires / Interviews/ Consent Issue Letters Signpost to relevant guidance Understand local vulnerability and develop local approach to address these Signpost to testing	PHE Hospital IPC team For Acute Trust incidents EHO Compliance and Enforcement - Environmental Health/Public Health Care Homes- Adult social Car Children's Services –School Nurse team Health and Safety, Communications, Representatives from key services linked to high-risk settings (ASC, CSC, Education, Housing), consideration of representation of critical partners (Local CCGs, Health provider trusts, and the Police), Consideration of representation from local VCS and faith groups)	Utilise protocols and scripts Checklists Shielded Hub Out of hours PHE/HUB will conduct the investigation Settings with access to Occupational Health, Health& Safety Lead the investigation will be delivered through them
Access to Testing	Test Sampling Request test at nhs.uk/coronavirus or by calling 119 If case or contacts are Key workers these can be arranged via national key worker self-referral portal Local pathway for testing to be made available as appropriate including home testing	Testing sites Care Homes Schools Workplaces Complex settings	Regional drive-through testing centres Satellite testing centres (STC) Mobile testing units (MTUs) Home testing Swab squads for hard to reach and transient population groups See appendix for definition of key workers

Control	Advice on infection, prevention & control measures Cleaning Workforce development needs / training Information to support daily reporting of cases Content of daily email agreed Convene OCT/IMT	Care Homes Schools Workplaces Complex settings	Provide advice on Cleaning and PPE if relevant for the setting **COVID-19: cleaning of non-healthcare settings guidance**
Consequence management	Isolation advice and support Advice on Support to maintain isolation for 7-14 days Isolation Mental Health support Medication Food Financial advice- access to information to support employers, employees,	Local authority support for the vulnerable non shielding groups- food and medication Links with voluntary sector Mental Health and Wellbeing Support Accommodation providers Business continuity and risk assessments	**COVID-19: guidance for households with possible coronavirus infection guidance** Guidance for contacts of people with possible or confirmed coronavirus (COVID-19) infection who do not live with the person note that a possible diagnosis could be very frightening esp. to already vulnerable groups

			May need to arrange for accommodation to enable the period of isolation whilst awaiting test results Advice on how to continue work as usual
Enforcement of control measures	Engage, Explain, Encourage and then Enforce Official Notices Closures	Trading Standards Police LA community safety officers HSE	Understand legal powers available Liaison with police
Data	Collect and store Information on cases and contacts Workforce development needs / training	PHE-HP Zone/ Power BI Covid Data HUB LA Other health partners	Content of daily email agreed Information to support daily reporting of cases - as yet not confirmed what system will be used
Comms / Engagement	Public/ Media Health and other partners		Information for staff and other individuals who work or visits a setting where an outbreak has occurred (no exclusion required) Letter for direct and proximity contacts (10 day exclusion)

3.0 SUPPORTING LOCAL OUTBREAK MANAGEMENT

3.1 Resourcing

Local Authorities have been awarded additional funding to support the Test and Trace service and to mitigate against and manage local outbreaks of COVID-19. This funding will support the development of the action plans and their implementation to reduce the spread of COVID-19 in our boroughs.

Implementing the local outbreak control plan is a council wide effort and this is reflected in how the grant funding will continue to be used to increase capacity to manage potential outbreaks across council directorates, with central coordination and support from the Public Health team.

Currently there is a strong team that has responded to local outbreaks and increases in transmission. In order to respond to VOC or future outbreaks there is a need to ensure adequate resources are continued to be provided and that they are ring fenced and not to the detriment of other services and functions. There is a need for more funding for self-isolation e.g. in the event of a VOC.

There is concern that there will not be the capacity within the local teams for management to deliver on all aspects of the plan, as the impact of the resumption of 'Business as Usual' (BAU) activities and / or the end of temporary contracts will have a considerable effect.

Halton has developed a 'Road Map back to BAU' which considers the whole system and its journey back to recovery. This is further complimented by a wider Cheshire & Merseyside Road map.

There is a risk to the resilience of the local system, however, if sufficient resources are not made available to sustain its work and maintain a focus on ongoing and routine prevention work, outbreak management, and ensuring that surge capacity is built in to all plans should it be needed.

3.2 Communications & engagement

Prevention is the single most effective method of reducing transmission and outbreaks of COVID-19. There must be stringent attention to social distancing advice, respiratory hygiene and hand washing, appropriate cleaning in line with PHE advice. A nominated lead for COVID-19 should be in place in all settings during the COVID-19 pandemic and all individuals within a setting must know how to make contact with the COVID-19 lead.

Timely, proportionate and accurate communications will be essential to engaging the public in measures to prevent and manage outbreaks, as well as maintaining public

confidence. Halton Borough Council's Communications Team will lead on communications, linking other partners and NHS communications teams where appropriate.

A communication protocol has been developed to support communications activities and we will continue to promote social distancing, good hygiene and the NHS Test and Trace service.

Plans are also in place to provide both broader and targeted communications to manage incidents across the county. This includes messaging via media and social media and working with partners, residents, businesses, MPs, community leaders and influencers to ensure communications is relevant to settings or areas affected by outbreaks.

Targeted communications will be especially important in the event that it becomes apparent that there may be community spread associated with particular high risk places, locations and communities such as workplaces or areas with a high proportion of the population from economically of socially challenged backgrounds. This will require materials to be appropriately translated, and engagement of community leaders and influencers to disseminate key messages.

Our communications team will work with the COVID-19 Outbreak Control Board to ensure strategic and operational communications are aligned. The intention is to provide members with aggregate information about outbreaks in their area, and specific information about those outbreaks which may be particularly sensitive.

Effective communications is a vital part of the response to an outbreak. In most cases it will be the local authority who coordinate communications activities. If an OCT is set up, it will be the communications representative of the organisation leading the response who will lead communications. In circumstances where an issue is of regional importance PHE may lead communications.

The lead will have responsibility for updating the relevant Resilience Forum Communications Cell on the position and actions being taken. While media interest will vary dependent on the scale and nature of the outbreak, in all cases, consideration should be given to who the spokesperson will be for the outbreak. A media protocol has been established outlining where responsibility for responding to media enquiries sits.

A communications toolkit has been developed to support the response. The content of this toolkit has been agreed by the Director of Public Health and relevant Strategic Director. Any variation from the content provided should be agreed by Director of Public Health and Strategic Director in advance of issuing.

Further advice and guidance on how to maintain COVID-secure workplace/ settings will be distributed and shared and made available through the Council and Government websites.

3.3 Data integration and information sharing

The council, NHS and any other partners involved in the management of incidents will ensure that information is shared in a timely way. There has been significant investment is systems across the LRF, such as CIPHA and the development of a regional Case Management system. There is significant intelligence and data systems that have been established, as well as the flows of information from national systems such as CTAS. It's also known that CTAS is due to change, any such change would benefit local areas by communication with local case management systems.

The COVID-19 Local Outbreak Co-ordinating Team will ensure effective data management including:

- Timely review of surveillance data on infections
- data recording to enable receipt, logging, monitoring and reporting of progress of Incidents, and assurance on effective management
- temporal and spatial analysis of incidents to identify geographical 'hotspots' and trends
- information governance protocols to allow secure and timely sharing of data and information

The Public Health Team will need to keep an accurate and contemporaneous record of information relating to any outbreak reported to them.

Any setting should record all detail required using checklists and templates that will be provided, the setting retains this document. It will enable them to identify patterns of illness and also normal registers for daily visitors/ absence for their setting as required. A daily line list of cases and contacts is required in settings with an ongoing outbreak.

4.0 AREAS OF DEVELOPMENT

4.1 Interface with vaccines roll out.

The objectives of the COVID-19 immunisation programme is to protect those who are at highest risk from serious illness or death. The Joint Committee of Vaccination and Immunisation (JCVI) have set out a prioritisation for persons at risk. JCVI ranked the eligible groups according to risk, largely based on prevention of COVID-19-specific mortality.

Vaccine roll out began in December 2020 with Hospital Hub sites being the first to receive quantities of approved vaccines. The sites and vaccines has and will continue to be expanded as the programme progresses nationally.

Evidence from the UK indicates that the risk of poorer outcomes from COVID-19 infection increases dramatically with age in both healthy adults and in adults with underlying health conditions. Those over the age of 65 years have by far the highest risk, and the risk increases with age. Residents in care homes for older adults have been disproportionately affected by the COVID-19 pandemic.

The UK Joint Committee for Vaccination and Immunisation (JCVI) have identified a risk based approach to the UK vaccination programme, with those age groups and risk groups being prioritised for the vaccination, and cascading though a list of prioritised groups based on vaccine availability and supply.

The Table below sets out JCVI advice on priority groups for Phase 1 of the COVID-19 vaccination programme.

1	Residents in a care home for older adults and their carers
2	All those 80 years of age and over Frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over Clinically extremely vulnerable individuals*
5	All those 65 years of age and over
6	All individuals aged 16 years** to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality***
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over
*	Clinically extremely vulnerable individuals are described here. This advice on vaccination does not include all pregnant women or those under the age of 16 years (see above)

**	The Pfizer-BioNTech vaccine is authorised in those aged 16 years and over. The AstraZeneca vaccine is only authorised for use in those aged 18 years of age and over
***	This also includes those who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill

The NHS is currently offering the COVID-19 vaccine to people most at risk from coronavirus. There are a number of different approaches adopted locally and nationally. The local key delivery mechanism is through Primary Care Networks (PCNs) though a nationally agreed Enhance Agreement. Halton has 2 PCNs delivery vaccination on behalf of their affiliated GP practices and covered the entire registered population of Halton. The delivery is being undertaken out of 2 key facilities, presently, The DCBL Stadium in Widnes and The Brindley Theatre in Runcorn. The PCNs are also undertaking roving vaccination models to vaccinate at risk settings such as Care homes and residential settings.

The national mass vaccination program is also running alongside local delivery mechanisms to invite and vaccinate eligible persons at designated Mass Vaccination Sites and participating Pharmacy Sites. Currently Halton has 1 designated pharmacy site at Appleton Pharmacy, Widnes. The nearest Mass Vaccination Site is St Helens Rugby Stadium.

Warrington and Halton Hospital is also acting as a key hospital hub and facilitating vaccinations across the area, primarily vaccinating Health and Social Care staff and identified eligible members of the local communities in conjunctions with other local systems.

Phase 2 of the delivery of the vaccination programme has just been identified by the JCVI which will include the vaccination of all UK population above 18 years of age by 31st July 2021

The Table below sets out JCVI advice on priority groups for Phase 2 of the COVID-19 vaccination programme.

10	All those age 40-49 years
11	All those age 30-39 years
12	All those age 18-29 years

There is, as at 8th March, no agreement on the delivery mechanism for phase 2 of the Vaccination programme

To the 8th March, around 44,000 vaccinations have been administered for Halton residents vaccinations had been administered locally, with over 65% of the total eligible persons within Phase 1 of the vaccination programme already vaccinated.

Based on national targets, it is anticipated that the majority of eligible personas within Phase 1 groups will have been vaccinated by 15th April 2021.

Locally, local delivery programme is overseen through a Halton and Warrington Vaccine Steering Group. The Halton and Warrington Health Protection Board provides oversight of all Pandemic activities and will continue to ensure there is a clear interface between the vaccine programme, outbreak management and the wider resumption of services as lockdown measures reduce.

4.2 Responding to Variants of Concern (VOC).

Identification of novel variants

All viruses naturally mutate over time. Changes can build up in the genetic code of the virus, and these new viral variants can be passed from person to person. Most of the time the changes are so small that they have little impact on the virus and are not a cause for concern, but every so often a virus mutates in a way that benefits it, for example allowing it to spread more quickly. For this reason, very early on in the response to the COVID-19 pandemic, a genome sequencing capability was established in the UK to monitor changes in the genome of the virus over time. If a variant is considered to have concerning epidemiological, immunological or pathogenic properties, i.e. anything that changes the way the virus behaves, it is raised for formal investigation and designated a variant under investigation (VUI). Following risk assessment with the relevant expert committee, they may be designated a variant of concern (VOC).

Scientists around the world have been monitoring these throughout the pandemic. In the UK, we have a comprehensive genomics system which allows us to detect these different mutations, whilst supporting international capacity to identify variants of concern. Currently, the UK has contributed around half of the sequences in the global SARS-COV-2 genome repository (GISAID). The UK developed 'The New Variant Assessment Platform', which is led by PHE working with NHS Test and Trace and academic partners, as well as the World Health Organization's SARS-CoV-2 Global Laboratory Working Group. This has allowed us to detect the emergence of the variant first seen in South East England, which has since become the dominant variant in the UK, and respond to alerts about other variants first seen in South Africa, Brazil and Japan which have been found in the UK. It is likely that many more will be identified in the coming months.

Response to novel variants

In response to the emergence and spread of new SARS-CoV-2 VOC and VUI in different countries and regions, specific precautions and actions are required in

relation to the management of patients who have recently returned from areas where these VOC or VUI are known or are believed to be circulating, as well as their contacts. Specific precautions are also required for the management of patients with a VOC or VUI identified by genomic sequencing even where there is no travel history.

Guidance for the UK's response is regularly updated and detailed here:

https://www.gov.uk/government/publications/sars-cov-2-voc-investigating-and-managing-individuals-with-a-possible-or-confirmed-case/guidance-for-investigating-and-managing-individuals-with-a-possible-or-confirmed-sars-cov-2-variant-of-concern

The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), advises the government on the threat posed by new and emerging respiratory viruses and on options for their management.

For more information:

https://www.gov.uk/government/groups/new-and-emerging-respiratory-virus-threats-advisory-group

Public Health England (PHE) produces a technical briefing outlining any new information on any novel SARS-CoV-2-variants, which is updated regularly.

For more information:

https://www.gov.uk/government/publications/investigation-of-novel-sars-cov-2-variant-variant-of-concern-20201201

Locally we intend to keep monitoring these key sources of information in order to develop an appropriate local response.

The national government and Public Health England (PHE) produce a document detailing the distribution of cases which are variants of concern or under investigation, which is updated regularly.

For more information:

https://www.gov.uk/government/publications/covid-19-variants-genomically-confirmed-case-numbers/variants-distribution-of-cases-data

Variant of Concern 202012/01 (B.1.1.7)

The novel SARS-CoV-2 variant **202012/01**, or commonly known as the **UK variant, British variant or Kent variant**, was designated a variant of concern (VOC) on 18th December 2020. The specimen date for the first COVID-19 case with the VOC 202012/01 variant in England was 20th September 2020. The specimen date for the first COVID-19 case with the VOC 202012/01 variant detected within Halton was W/C 10th November 2020.

The VOC 202012/01 (B.1.1.7) has increased transmissibility compared to previously circulating variants and has spread rapidly to become the dominant variant in the UK, accounting for ~97% of sequenced cases. Previous transmissibility assessments are available in NERVTAG papers and PHE technical briefings. At this time, available evidence suggests that VOC 202012/01 (B.1.1.7) has no negative affect on naturally-acquired immunity or vaccine-acquired immunity.

In order to identify what the current state of the VOC 202012/01 variant is, genomic sequencing is being performed on cases across the UK. A small fraction of VOC 202012/01 cases are identified using whole genome sequencing but this data typically lags test date by approximately 2 weeks, therefore S gene target failure (SGTF) is used as the proxy to indicate whether a case is the VOC 202012/01 variant.

Only samples processed in TaqPath labs can be tested for SGTF. It is important to note that only Whole Genome Sequencing can be used to identify VOC. The SGTF proxy reported here only identifies a single gene mutation, which is likely to be shared by other (current and future) variants. Use of SGTF is therefore considered suitable for surveillance in the short term, but the sensitivity and specificity of SGTF as a proxy is being continuously monitored to assess its usefulness.

As some samples are processed in other labs, the proportion of cases from TaqPath labs with SGTF can only provide an **estimate of the overall proportion.**

HALTON

The specimen date for the first COVID-19 case with the VOC 202012/01 variant detected within Halton was W/C 10th November 2020. Since then, the proportion of cases which are VOC 202012/01 has rapidly increased and from W/C 20th February 2021, the VOC 202012/01 variant accounts for 100% of cases in Halton.

Table 1. Weekly Number of Pillar 2 Cases detected by TaqPath Labs. Specimen Date represents represent rolling 7-day periods with the exception of the most recent week. *This most recent week includes 3 days of data, which are susceptible to reporting delay (most recent week contains data up to 08/03/21).

Week Commencing W/C	Number SGTF cases	Number non STGF cases
05/12/20	14	101
12/12/20	40	125
19/12/20	62	107
26/12/20	303	266
02/02/21	711	375
09/02/21	734	225
16/01/21	568	85
23/01/21	416	30
30/01/21	263	11
06/02/21	186	1
13/02/21	134	2
20/02/21	64	0
27/02/21	51	0
06/03/21*	12	0
Grand Total	**3558**	**1328**

Figure. Weekly Number and Proportion of Halton Pillar 2 Cases with SGTF among those tested in TaqPath Labs between week commencing 05/12/2020 and

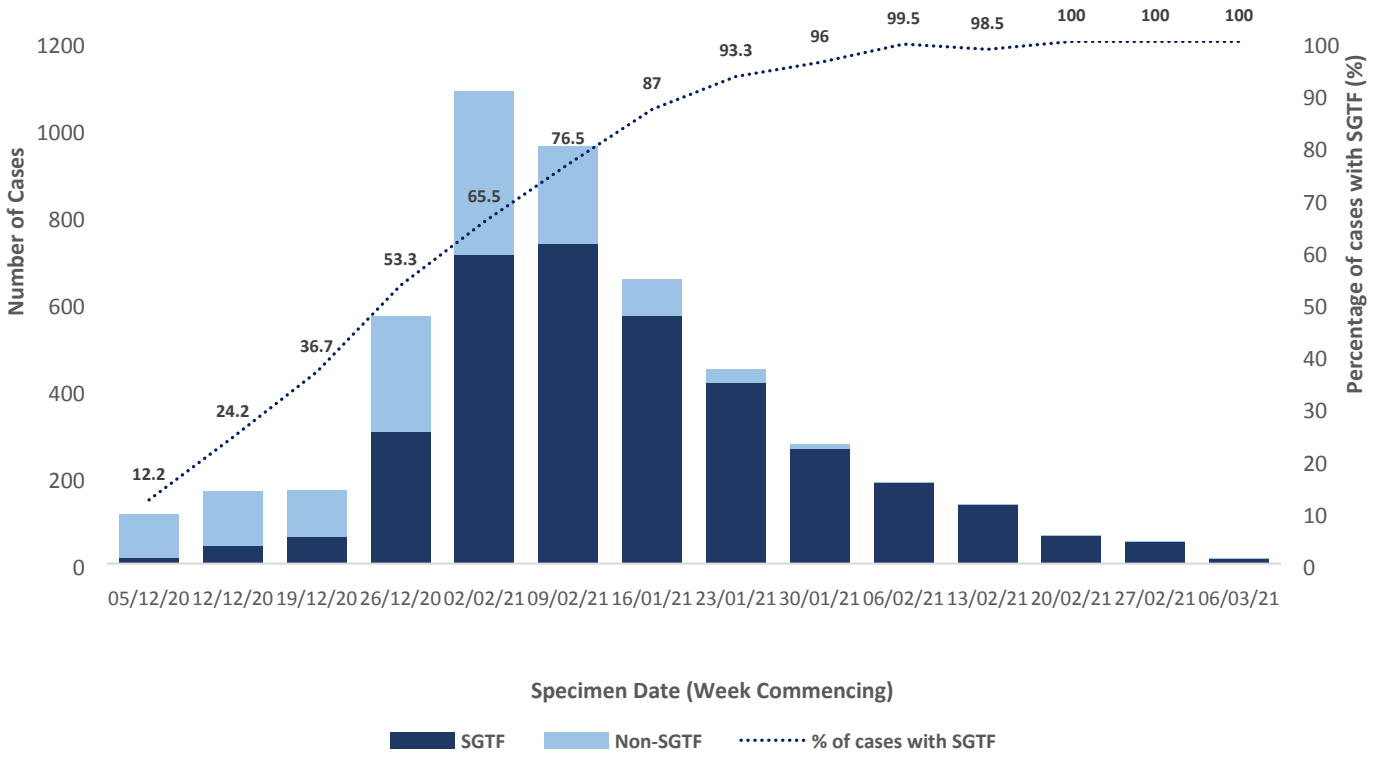
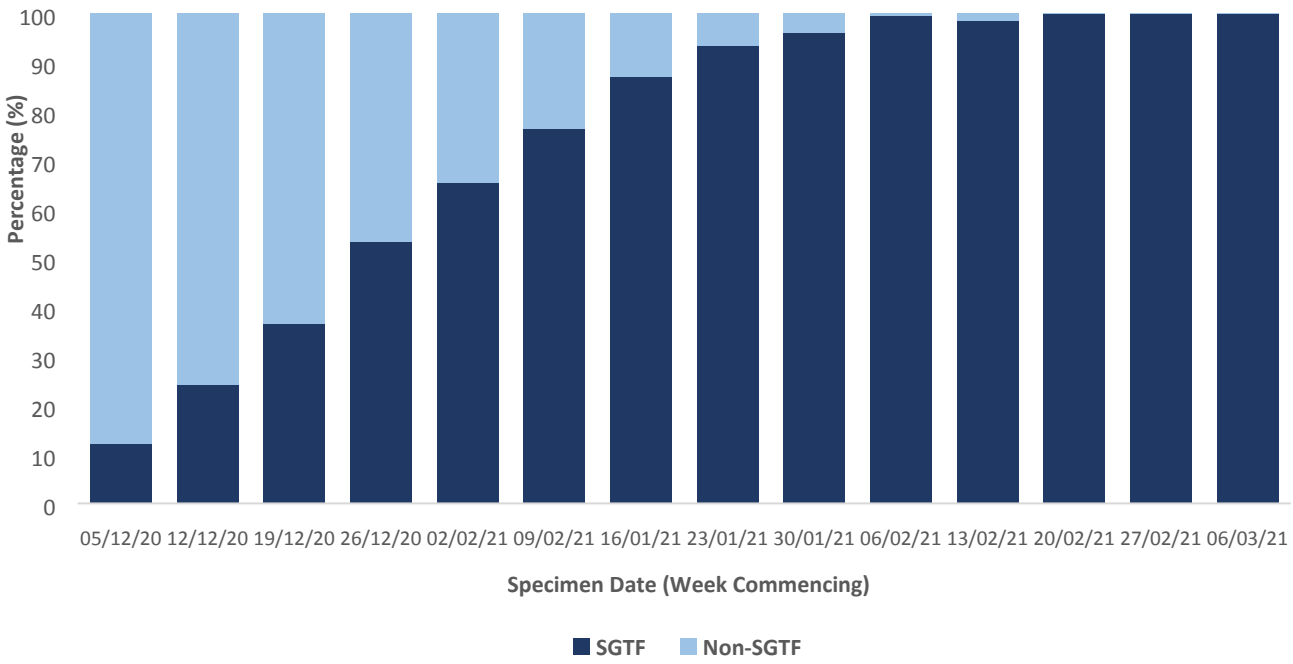


Figure. Proportion of Cases identified with SGTF among those tested in TaqPath Labs between week commencing 05/12/2020 and week commencing 06/03/2021.



National guidance will be followed in relation to the investigation and management of patients who may be infected with a new SARS-CoV-2 VOC or VUI. VOC will be detected through enhanced testing, targeting geographical areas based on intelligence. National discussions are underway for local pharmacies to be involved in the distribution home testing, and this will be deployed for VOC response if available.

Persons at risk include:

- those who have been in or transited through any of the countries listed within the travel ban to the UK and who develop symptoms of COVID-19 within 10 days of departure or transit (or date of sampling for a positive SARS-CoV-2 test if asymptomatic)
- those known to be infected with a VOC or VUI listed in based on sequencing results and regardless of travel history
- contacts of individuals described above

Travel-associated risk alone is sufficient to take action; actions should not be delayed pending sequencing results.

Entry and isolation guidance

Travel measures to protect the UK against new international variants may change over time. The latest information of travel measures is available from the Department for Transport.

Travelers who are permitted to enter the UK from countries listed within the travel ban to the UK are currently required to self-isolate for 10 days on arrival along with their household. Any contacts identified in the UK should also self-isolate for 10 days from the last date of contact after the traveler returns to the UK.

From 15 February 2021, travelers to the UK will be PCR tested for SARS-CoV-2 at Day 2 and Day 8.

General principles relevant to the management of COVID-19 in the context of risk from a new VOC or VUI

Current evidence is that the mechanism of transmission of novel variants is no different to those for SARS-CoV-2 generally. The following principles apply:

- anyone seeking routine or emergency care (whether or not they present with COVID-19 symptoms) should be asked about recent travel to the countries listed in the travel ban and whether they are a contact of a returning traveler from these countries
- all persons at risk in the community should be advised to follow the stay at home guidance if they develop COVID-19 symptoms
- healthcare workers should continue to follow current COVID-19 infection prevention and control (IPC) advice and use the recommended personal protective protection (PPE) for individuals on the high risk pathway
- commonly used PCR assays are expected to be able to detect both VOC and VUI, and should continue to be used for testing patients with possible COVID-19.
- Any person at risk seeking access to non-urgent outpatient, ambulatory or primary care, or elective treatment, should defer their appointment until their 10-day isolation period has ended unless their need is considered urgent (see below).
- Any person at risk who requires urgent care should continue to access emergency NHS services whether for COVD-19 symptoms or for other, non-COVID reasons.
- Information on dates and places of travel, and any contact with possible or confirmed cases of COVID-19 should be recorded. Healthcare staff should ensure systems are in place that enable these cases to be easily flagged and identified.

If a person at risk has a positive test for SARS-CoV-2, discuss further risk assessment and appropriate case-management with the Centre. Hospitals must also contact their local health protection team with the details of these individuals.

North West Contacts

- Alder Hey Children's Hospitals NHS Foundation Trust (Paediatrics (with Liverpool)) 0151 228 4811: ID consultant on call
- Liverpool University Hospitals NHS Foundation Trust (Adults & Paediatrics (with Alder Hey)) 0151 709 0141: ID consultant on call
- Pennine Acute Hospitals NHS Trust (Adults) 07966 621211: ID SpR on call

Development opportunity:

Home Testing early adopter of national rollout narrative – Halton has applied to be a community collect site, and will develop distribution points across Halton, that will be used to support additional testing if required in response to a VOC.

4.3 Action on enduring transmission.

It is clear that long-standing structural inequalities and deprivation have been exacerbated by the pandemic and highlight the need to increase the drive to tackle these at a national level. There are opportunities to address the real and perceived inequalities (including the North-South divide and minority communities) and those facing social or economic inequality.

An analysis by the Joint Biosecurity Centre (JBC) concluded that "unmet financial needs" meant people in poorer areas were less likely to be able to self-isolate because they could not afford to lose income. The analysis by the JBC concluded that "interconnected factors" such as deprivation, poor housing and work conditions, and delays in the test-and-trace system, were all "likely to be significant contributors" to the high coronavirus rates and enduring transmission in some areas. It found evidence that areas with a higher proportion of workers in public-facing roles, such as health and social care, taxi drivers or supermarket workers, were likely to experience high infection rates.

On a local basis, work is underway to determine the inter-relation between the factors of deprivation such as employment, and household composition and how they impact upon local transmission rates. Financial and welfare support is needed to help people to self-isolate and businesses to continue to implement Coivd-19 safe practices. Regular monitoring and the regular review of actions, supported by local epidemiology of Covid-19 is required for the local area.

4.4 Enhanced Contact tracing (in partnership with HPT).

Work is underway locally to determine the role of the Local Authority in offering enhanced contact tracing to complement the NHS Test and Trace Service. Halton will

work closely with colleagues within the area to determine whether a local contact tracing partnership model could be implemented to offer enhanced contract tracing.

The use of mobile phone technology has had an important role in contact tracing. The NHS COVID-19 app provides information on local alert status, venue check-ins and contact tracing and its impact will be considered on a local basis.

Working in partnership with neighboring local authorities, additional testing and genomic sequencing will be considered with regards to targeted areas should variants such as the one first identified in South Africa have been found.

Increased testing will be introduced where required and in addition to existing extensive testing. In combination with the current lockdown rules and following Hands. Face. Space advice, it will help to monitor and suppress the spread of the virus. Positive cases will be sequenced for genomic data to help increase our understanding of COVID-19 variants and their spread within these areas.

Enhanced contact tracing may be used for individuals testing positive with a 'variant of concern'. This is where contact tracers look back across an extended period to determine the route of transmission. People living within targeted areas are strongly encouraged to take a COVID-19 test when offered, whether they are showing symptoms or not. People with symptoms should book a free test online or by phone to get tested at a testing site or have a testing kit sent home. Those without symptoms should visit their local authority website for more information.

The Public Health Evidence and Intelligence team continue to provide week day monitoring of covid data and have access to the common exposures line list and other forms of enhanced data surveillance provided by PHE. The HOST team also have access to soft intelligence from the community obtained through the calls made to positive cases, work done by the Environmental Health team, and feedback from partner organisations, the voluntary sector and direct feedback from the community through local councillors and direct calls and emails received. This provides a detailed set of information that can be compared to test theories and provide additional insight in our local area.

As we enter the next stage of the pandemic, there needs to be a clear conversation with Local Authorities as to what the future structure will look like and what will be managed by PHE and the national and regional systems. If there is an expectation that local areas commence detailed enhanced contact tracing there will need to be sufficient resource and training opportunities made available for local teams to pick this up. There will also need to be clarity on how local systems can better integrate case management systems with the national data systems.

4.5 Ongoing role of Non-Pharmaceutical Interventions (NPIs).

Non-pharmaceutical interventions (NPIs) are strict actions against novel coronavirus disease (COVID-19) which are implemented to interrupt or reduce transmission. They includes various measures like environmental measures, social and physical distancing measures, travel-related measures, and personal protective measures. These measures are intended to reduce the size of epidemic peaks and buy time to prepare the health system to manage demand. There are two strategies under NPIs, namely suppression and mitigation. Suppression aims to decrease the number of cases up to a level where the reproduction number R reaches 1 and human to human transmission is eliminated, whereas mitigation intends to slow the transmission by reducing R (not less than 1) and helping lessen the health impact due to Covid 19.

Non-pharmacological intervention consists of a lot of measures taken in combination to varying degrees according to their feasibility. Personal protective measures include hand hygiene, respiratory protocol, facemask, etc. while environmental standards include regular surface and object cleaning, use of ultraviolet lights, and increased ventilation. Social distancing measures include contact tracing, isolation of sick individuals, quarantine of exposed individuals, school and measures and closures, avoiding crowding. Travel-related measures include travel advisories, entry and exit screening, international travel restriction, and border closures.

Non- pharmacological interventions are robust solutions to fight this ongoing pandemic. In addition to vaccination, countries should continue to adopt such interventions by evaluating the effectiveness and socioeconomic cost to fasten their recovery.

4.6 Activities to enable 'living with COVID' (COVID secure).

From 8 March, people in England will see restrictions start to lift and the Government's four-step roadmap offer a route back to a more normal life. The success of the vaccination programme is one factor but by no means the whole story. The public have also risen to the challenge of suppressing COVID-19: by obeying the law; staying at home; getting tested when needed; isolating when required, and following the 'hands, face, space' and 'letting fresh air in' guidance.

While we must all remain vigilant - in particular against the threat from new COVID-19 variants - and continue to protect the NHS, the Government has stated that a safe exit from lockdown can now begin. They have articulated that it will take place in four steps; and at each step, there is a plan to lift restrictions across the whole of England at the same time.

The Government has indicated the following roadmap to support activities to enable local communities to emerge from the pandemic.

STEP 1
8 March **29 March**

STEP 2
No earlier than 12 April

At least 5 weeks after Step 1

EDUCATION

8 MARCH
- Schools and colleges open for all students
- Practical Higher Education courses

EDUCATION

- As previous step

SOCIAL CONTACT

8 MARCH
- Exercise and recreation outdoors with household or one other person
- Household only indoors

29 MARCH
- Rule of 6 or two households outdoors
- Household only indoors

SOCIAL CONTACT

- Rule of 6 or two households outdoors
- Household only indoors

BUSINESS & ACTIVITIES

8 MARCH
- Wraparound care, including sport, for all children

29 MARCH
- Organised outdoor sport (children and adults)
- Outdoor sport and leisure facilities
- All outdoor children's activities
- Outdoor parent & child group (up to 15 parents)

BUSINESS & ACTIVITIES

- All retail
- Personal care
- Libraries & community centres
- Most outdoor attractions
- Indoor leisure inc. gyms (individual use only)
- Self-contained accommodation
- All children's activities
- Outdoor hospitality
- Indoor parent & child groups (up to 15 parents)

TRAVEL

8 MARCH
- Stay at home
- No holidays

29 MARCH
- Minimise travel
- No holidays

TRAVEL

- Domestic overnight stays (household only)
- No international holidays

EVENTS

- Funerals (30)
- Weddings and wakes (6)

EVENTS

- Funerals (30)
- Weddings, wakes, receptions (15)
- Event pilots

STEP 3
No earlier than 17 May

At least 5 weeks after Step 2

EDUCATION
- As previous step

SOCIAL CONTACT
- Maximum 30 people outdoors
- Rule of 6 or two households indoors (subject to review)

BUSINESS & ACTIVITIES
- Indoor hospitality
- Indoor entertainment and attractions
- Organised indoor sport (adult)
- Remaining accommodation
- Remaining outdoor entertainment (including performances)

TRAVEL
- Domestic overnight stays
- International travel (subject to review)

EVENTS
- Most significant life events (30)
- Indoor events: 1,000 or 50%
- Outdoor seated events: 10,000 or 25%
- Outdoor other events: 4,000 or 50%

STEP 4
No earlier than 21 June

At least 5 weeks after Step 3

All subject to review

EDUCATION
- As previous step

SOCIAL CONTACT
- No legal limit

BUSINESS & ACTIVITIES
- Remaining businesses, including nightclubs

TRAVEL
- Domestic overnight stays
- International travel

EVENTS
- No legal limit on life events
- Larger events

In implementing this plan the Government has indicated that it will be guided by data, not dates, so that a surge in infections is avoided and that would put unsustainable pressure on the NHS. For that reason, all the dates in the roadmap are indicative and subject to change. The Government has stated that there will be a minimum of five weeks between each step: four weeks for the scientific data to reflect the changes in restrictions and to be analysed; followed by one week's advance notice of the restrictions that will be eased.

Only when the Government is sure that it is safe to move from one step to the next will the final decision be made. The decision will be based on four tests:

• The vaccine deployment programme continues successfully

• Evidence shows vaccines are sufficiently effective in reducing hospitalisations and deaths in those vaccinated

• Infection rates do not risk a surge in hospitalisations which would put unsustainable pressure on the NHS

•Any assessment of the risks is not fundamentally changed by new Variants of Concern

The Government will continue to protect the public by ensuring local outbreaks are managed quickly and effectively and that new dangerous variants, both within the UK and at the border are detected and combated.

In terms of the local situation, we can make the following assumptions:

- **The virus is still circulating and we are likely to enter into an Endemic phase.**
- **The key priority must be to suppress the virus as much as possible for the foreseeable future.**
- **It is unclear how virus transmission will continue in the short and medium term and we must be prepared for fluctuations in local rates. We need to be ready for this in terms of public trust, confidence and the epidemiological strategies to respond.**
- **We will all be living and working in a covid-endemic environment and we will need to develop multiple strategies and responses to manage during this time.**
- **Variants and of SARS-CoV-2 will continue to cause outbreaks and will likely require vaccine renewal on at least an annual basis.**

As the country moves through each of these phases in the roadmap, we will support the people of Halton to remember that COVID-19 remains a part of our lives. All residents will have to keep living their lives differently to keep themselves and others

safe. Halton must carry on with ‘hands, face, and space’ and comply with the COVID-Secure measures that remain in place. “Meet outdoors where we can and keep letting fresh air in. Get tested when needed. Get vaccinated when offered. If we all continue to play our part, we will be that bit closer to In terms of the local picture, the following future that is more familiar.”

As we learn to live with COVID, we must identify the role that individuals, employers and workplaces must play to reduce risk and create a Covid safe environment and the local system needs to be flexible, knowledgeable and well-resourced to enable people to achieve this.

There is also a need to ensure that the local road map can support the recovery of non-COVID services that have been impacted by the pandemic and play a major role in the lives of local people. These include Mental Health Services, Drug and Alcohol Services and other NHS Services as well as wider social care, business and the voluntary and community sector.

In order to support the local community, the following areas will be a priority for enabling Halton to begin to ‘live with COVID’.

We will:

1. Support the maximum uptake of vaccine especially in those communities facing the greatest burden of disease and ill health.
2. Focus on Inequalities – mitigate against development of ongoing or enduring exposure for those communities facing social or economic inequality.
3. Ensure ‘test and trace’ and ‘self-isolate’ works as part of a whole system approach and is embedded in local structures (where resource permits).
4. Support local people to self-isolate.
5. Promote prevention and ensure every individual has the skills and knowledge to be covid safe.
6. Refresh the local Outbreak Management Plan on a regular basis to ensure the local system meets the needs of the local population and is focused on prevention.
7. Ensure that, with Government support, the local system is agile and responsive to deal with local situations as they arise.
8. Consider the use of new technologies, behavioural and social sciences and other emerging tools to support local people.
9. Ensure that compliance and enforcement are part of a balanced strategy.

We need to look at the impact of COVID on employment, education and wider public services and support local people on their journey out of the pandemic and into a positive and safe future. Responding positively to the impact of the pandemic will only be possible if all partners and the people that we serve work together and play their part in meeting the challenge to tackle COVID together.

5.0 CONCLUSIONS, NEXT STEPS AND REVIEW

Factors that will demonstrate the success of this plan will be:

- **Transmission of the virus needs to be brought, and kept, as low as possible.**
- **Surveillance of transmission and variant emergence must be optimal.**
- **Test, Trace and Isolate needs to work effectively, with a clear testing strategy**
- **A strategy based on high population availability of Rapid Antigen Testing for Public Health purposes**
- **Vaccines must be effective and delivered equitably with high take up.**
- **Reducing viral transmission to the stage where we can exit lockdown.**
- **A well-articulated, careful, and gradual "opening up"**
- **Ongoing monitoring, modelling, surveillance, and adjustment.**
- **Continuing improvements in and adjustments to vaccine and treatment**
- **Ensuring everyone has the skill set to live and work safely in a Covid-endemic environment**
- **Clear and Consistent Communications**

As we learn to live with COVID, we must identify the role that individuals, employers and workplaces must play to reduce risk and create a Covid safe environment and the local system needs to be flexible, knowledgeable and well-resourced to enable people to achieve this.

On a local level we need to make all of the key aspects easy for local residents – testing, self-isolation with clear, proactive guidance and support available for every setting where we may have an outbreak. At each stage of the covid journey there is a need for the local system to come together and regularly review the following to ensure they are fit for purpose. Throughout the community mobilisation of this Local Outbreak Management plan, we will ensure the following documents, plans and strategies are developed in line with evolving national guidance:

- **Local Contain Plan**
- **Schools / Early Years Strategy**
- **Vaccine Uptake Plan**
- **Testing Plan**
- **Contact Tracing Model**

- **High Risk Settings Plans**

COVID-19 is a rapidly evolving situation; guidance is being developed at a fast pace, therefore subject to change with little notice. This plan will be kept under review, and reflect changes to national guidance and other relevant information that will support local outbreak control. The purpose of the Halton COVID-19 Outbreak Management Plan is to set out how we will respond to current and potential future outbreaks of COVID-19 in the borough and coordinate efforts across all stakeholders to keep residents safe.

APPENDIX - Key National Guidance

Social distancing guidance

• Stay at home: guidance for households with possible coronavirus (COVID-19) infection: https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection#ending-isolation

• Guidance on social distancing for everyone in the UK: https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing

• Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

Guidance for contacts

• Guidance for contacts of people with possible or confirmed COVID19: https://www.gov.uk/government/publications/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person

• Guidance for contacts of people with confirmed coronavirus (COVID-19) infection who do not live with the person : https://www.gov.uk/government/publications/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person

Specific guidance for settings / workplaces:

• Guidance to help employers maintain safe workplaces during the COVID-19 epidemic: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19

• Guidance for the construction industry and those working outdoors: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/construction-and-other-outdoor-work

• Guidance for factories, plants and warehouses: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/factories-plants-and-warehouses

• Guidance for labs and research facilities: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/labs-and-research-facilities

• Guidance for offices and contact centres: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/offices-and-contact-centres

• Guidance for people working in, delivering to, or visiting other people's homes: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/homes

Guidance for restaurants offering takeaway or delivery: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/restaurants-offering-takeaway-or-delivery

• Guidance for shops, branches and stores: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/shops-and-branches

• Guidance for people who work in or from vehicles: https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/vehicles

• Guidance for transport operators: https://www.gov.uk/government/publications/coronavirus-covid-19-safer-transport-guidance-for-operators/coronavirus-covid-19-safer-transport-guidance-for-operators
• Guidance for NHS employers about the health, safety and wellbeing of staff: https://www.nhsemployers.org/covid19/health-safety-and-wellbeing
• Guidance for NHS leaders on workforce management: https://www.england.nhs.uk/coronavirus/workforce/
• Guidance for the employers of staff in health and social care settings: https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings
Coronavirus (COVID-19) advice for accommodation providers: https://www.gov.uk/guidance/covid-19-advice-for-accommodation-providers

Testing
• NHS: Testing for coronavirus: https://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/

Infection Prevention and Control (IPC)
• IPC for healthcare settings: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
• PPE: https://www.gov.uk/government/collections/coronavirus-covid-19-personal-protective-equipment-ppe
• COVID-19: putting on and removing PPE – a guide for care homes (video):
• COVID-19: management of exposed healthcare workers and patients in hospital settings:
• 5 moments for hand hygiene: with how to hand rub and how to hand wash. Posters: https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/
• Catch it. Bin it. Kill it. Poster: https://campaignresources.phe.gov.uk/resources/campaigns/34/resources/2665

Cleaning and waste management
• Safe management of healthcare waste: https://www.gov.uk/government/publications/guidance-on-the-safe-management-of-healthcare-wasteand-social-care
• COVID-19: cleaning in non-healthcare settings: https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings

Coronavirus Resource Centre posters
• https://coronavirusresources.phe.gov.uk/

APPPENDIX - Key contacts

HOST	Public.health@halton.gov.uk	0151 511 5200
Environmental Health	Environmental.Protection@halton.gov.uk	0151 511 5200
0-19 Team	bchft.0-19phcovidsupport@nhs.net	01928 593 056
Infection Control	3boroughs.infectioncontrol@sthelensccg.nhs.uk	01744 457314
Cheshire and Merseyside Hub / PHE North West	cmcthub@phe.gov.uk/ icc.northwest@phe.gov.uk.	Health Protection Team: 0344 225 0562

REPORT TO:	Health and Wellbeing Board
DATE:	24th March 2021
REPORTING OFFICER:	Director of Public Health & Chief Commissioner Halton CCG
PORTFOLIO:	Public Health
SUBJECT:	Covid-19 vaccination programme
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The report presents an update on the progress of the local Covid-19 vaccination programme for the Borough

2.0 RECOMMENDATION: That

1. **The Health and Wellbeing Board note the content report; and**

2. **The positive rapid escalation of plans and system wide response is recognised and praised.**

3.0 SUPPORTING INFORMATION

3.1 **What Vaccines are available?**

There are currently 2 vaccines that have been approved by the UKs MHRA (Medicines and Health Care products Regulatory Agency) and currently available. Pfizer- BioNTech vaccine and AstraZeneca (Oxford) vaccine. Both have been approved as effective and safe and supply is available and being rolled out across the UK. These vaccines differ slightly in their production and make up and so delivery systems are slightly different for these vaccines. If you are offered a vaccine, you will not be given a choice, unless you have a medical reason why one vaccine may be unsuitable.

A 3rd Vaccine, Moderna, has been approved by the MHRA but supplies are not yet available in the UK but are anticipated within the next few months.

3.2 **How is the vaccine rolled out?**

The vaccine roll out is being coordinated nationally with a number of sites identified and becoming live in a series of waves. Initially some NHS Vaccine hubs were identified to serve as vaccine centers and facilitate local coordination and vaccine storage. This enables a series of Primary Care delivered sites to come on stream in a series of waves over December and Early January, with Widnes and Runcorn sites being designated to Waves 1 and 2.

Additional capacity was included as a number of Mass Vaccination Sites across the Country, with the nearest current mass vaccination sites to Halton being the Totally Wicked Stadium in St Helens and the Etihad Stadium in Manchester.

A series of pharmacies are also identified to deliver the vaccine to the eligible populations. New or different approaches to delivery may be developed over time as vaccine availability and supply increases.

The vaccine is provided by an national Enhanced agreement which provides the template for the mechanism for delivery, support and remuneration for vaccine delivery to primary care and relevant sites, including the rules by which the sites can operate under.

Delivery Model

1) There are four main vaccine delivery site models within the system for Halton:

    - **Local Vaccination Sites:**
        - Two in Halton – the Brindley Theatre in Runcorn and the DCBL Stadium in Widnes
    - **Hospital Hub** at Warrington and Halton Teaching Hospitals NHS Foundation Trust & St Helens & Knowsley Trust
    - **Pharmacies:**
        - Appleton Village Pharmacy in Widnes
    - **Mass Vaccination Site** at The Totally Wicked Stadium (St Helens)

2) In addition, Bridgewater Community Healthcare NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust have been delivering vaccines to their own staff (and inpatients at North West Boroughs Healthcare NHS Foundation Trust).

To support system vaccine delivery across Halton a Steering Group meets twice a week, chaired by Leigh Thompson (COVID-19 Senior Responsible Officer for Halton and Warrington). The Steering Group includes representation from all key interested parties from across the system, including partners from the borough council, NHS providers, public health, commissioners and the volunatary sector.

3.3 **Who can have the vaccine?**

The UK JCVI (Joint Committee on Vaccination and Immunisation) has identified that the first priority for vaccination to prevent mortality from Covid-19 and to protect the health and social care staff and systems.[1]

Current evidence strongly indicates that the single greatest risk for mortality from Covid-19 is increased age and the risk of death increases exponentially with age. The JCVI have predominantly recommended an age based approach to vaccination with the oldest age groups given the highest priority.

There is also strong evidence that those living in a care home for older adults are disproportionately affected, given the increased risk of outbreaks in closed settings. Adults and workers in such settings are amongst the highest priority to protect the most vulnerable and prevent severe illness and death.

Also a high priority are those people who are working at the front line of health and care are at greater personal risk when working in areas of high rates of Covid and at greater risk of transmitting the virus to vulnerable people. Health and care workers are also considered a top priority.

Based on all available evidence and considering the risks of specific population groups, the JCVI have identified a priority grouping for the roll out of vaccines. There can be no variation within these groups and the vaccine must only be made available to each group, in priority order when most individuals in the previous groups has been offered the vaccine.

The JCVI priority groups, as advised on 30th December 2020 are:

1	Residents in a care home for older adults and their carers
2	All those 80 years of age and over Frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over Clinically extremely vulnerable individuals*
5	All those 65 years of age and over
6	All individuals aged 16 years** to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality***
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over
*	Clinically extremely vulnerable individuals are described here. This

[1] https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020

	advice on vaccination does not include all pregnant women or those under the age of 16 years (see above)
**	The Pfizer-BioNTech vaccine is authorised in those aged 16 years and over. The AstraZeneca vaccine is only authorised for use in those aged 18 years of age and over
***	This also includes those who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill

The JCVI have recently announced that there will be a phase 2 of vaccine delivery which will ensure that all adults aged 18 and over have received at least a first dose of vaccine by the end of July 2021:

10	All those 40-49 years of age
11	All those 30 to 39 years of age
12	All those 18-29 years of age

There has been a very recent announcement that the Enhanced Services for the delivery of the vaccination in primary care will be extended as an opt out system. Discussions are currently under way as to the continuation of delivery approaches for Halton.

3.4 **Vaccine uptake**

Response to the vaccination has been phenomenal with exceptionally high uptake in all current cohorts.

All Cohorts 1-4 were required to be completed by 15th February 2021. Locally we ensured a 100% offer of vaccination with an uptake of over 80% at that point.

Other cohorts have since been added to the current vaccination list in a phased approach and delivery of vaccines continues at a great rate. The uptake amongst these cohorts is constantly developing and the presentation will provide the most recent update of data as it stands, including updates on the current issues and achievements to date.

4.0 POLICY IMPLICATIONS

4.1 The vaccination programme is a national requirement and a key element of the fight against Covid-19.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There will be financial implications in the implementation though much is

remunerated through national mechanisms.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Reducing the risk of transmission of Covid-19 to protect the most vulnerable children.

Children under 16 are not licenced to receive the vaccine except under exceptions clinical circumstances

6.2 Employment, Learning & Skills in Halton

Maximising uptake to provide better outcomes for at risk individuals and ensure a faster return to normal conditions and reduce disruption to daily life.

6.3 A Healthy Halton

Maximising uptake to provide better outcomes for at risk individuals and ensure a faster return to normal conditions and reduce disruption to daily life.

6.4 A Safer Halton

Keeping Halton's population safe from all threats is a key consideration and more important currently with the added difficulties posed by the pandemic.

6.5 Halton's Urban Renewal

Maximise opportunities for Halton's regeneration and development approaches by maximising the return to normal.

7.0 RISK ANALYSIS

7.1 *Failing to adequately implement the vaccination programme and protect our community puts the population at significant risk of outbreaks and increased incidence of a serious, preventable infection, increasing mortality and morbidity and adding to the significant burden on health and social care services as well significant detriment to the local economy and local communities*

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 *The strategy is developed in line with all equality and diversity issues within Halton.*

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None within the meaning of the Act.

REPORT TO:	Health & Wellbeing Board
DATE:	24th March 2021
REPORTING OFFICER:	Chief Commissioner Halton CCG; Director of Strategy and Partnerships Warrington & Halton Teaching Hospitals NHS FT
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Presentation on pre-consultation engagement outcomes around the creation of a 'Health Hub' delivering some outpatient Hospital Services from Runcorn Shopping City
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), in partnership with Halton Borough Council and Liverpool City Region, has developed a plan to utilise unused retail space in Runcorn Shopping City to deliver a number of clinical services. The following presentation describes the pre-consultation engagement work to date, including response rates and themed outcomes.

2.0 RECOMMENDATION: That

1) **the report be noted; and**
2) **the Board receives the proposal to begin formal consultation proceedings following local elections in May.**

3.0 SUPPORTING INFORMATION

Supporting information to be delivered via a presentation to the Board.

4.0 POLICY IMPLICATIONS

None

5.0 FINANCIAL IMPLICATIONS

All physical and pathway changes will be funded via the LCR bid and through capital funding secured via WHH's capital programme. Additional revenue funding has been secured from the Trust to offset the ongoing revenue requirements of the scheme.

The costs to run this consultation will be funded via the LCR bid funding.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Provision of health services for Children and Young People from a community location such as Shopping City, with increased transport links and free parking has potential to make access easier. This will be tested through the feedback from the consultation.

6.2 Employment, Learning and Skills in Halton

Potential for increased volunteering opportunities through offering of additional location for health care delivery. By providing health and care services within a community location, it raises the profile of employment opportunities within health and care.

6.3 A Healthy Halton

There is a potential for improved access to clinical services, including an expanded ophthalmology service, which might reduce any requirement for patients to travel out of Borough for healthcare. This will be tested via the consultation.

6.4 A Safer Halton

None

6.5 Halton's Urban Renewal

There is potential for increased footfall within Runcorn Shopping City, for example there could be up to 200 patients per week who are accessing ophthalmic services.

7.0 RISK ANALYSIS

The project is governed in line with Warrington and Halton Teaching Hospitals risk controls. A detailed risk log is available, and mitigations are in place as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

All design and construction of health assets within Runcorn Shopping City as a result of this project will be accompanied by a detailed Equality Impact Assessment, should the outcome of the consultation support these plans.

Additionally, the new potential location would offer improved access and accessibility than the current service delivery location within Phase 1 of Halton General Hospital, including reduced travel from the car park to the service.

The new location will reduce the requirement for patients having to travel out of Borough to receive care.

There is a reduced risk of entering a hospital site during the covid-19 pandemic, especially for BAME residents, vulnerable residents, and residents with long-term conditions.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

'**None under the meaning of the Act.**'

REPORT TO: Health & Wellbeing Board

DATE: 24th March 2021

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Children, Education and Social Care

SUBJECT: Principal Social Worker Progress Report

WARD(S) Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide a progress report on the Principal Social Work Role and Responsibilities.

2.0 RECOMMENDATION

i) That Members of the Health and Wellbeing Board note the report.

3.0 SUPPORTING INFORMATION

3.1 Background

Marie Lynch has now held the role of Principal Social Worker for over five years since it was first introduced for Adult Services in Halton. The national guidance on the role has evolved and been updated and clarified over recent years.

The role was first instigated from July 2012, by the Care and Support White Paper, *Caring for our future: reforming care and support* (HM Government, 2012) which set out a commitment to establishing the role of Principal Social Worker (PSW) within adult services to mirror the developments in Children and Family Services instigated by the Munro Review (Munro, 2011).

The Care and Support Statutory Guidance provided an update in May 2016 offering further clarification about the Principal Social Worker role for adults. The Guidance states that the Principal Social Worker should be visible across the organization, from Elected Members and Senior Management, through to frontline Social workers and people who use services and their carers. Principal Social Workers should also have a broad knowledge base on safeguarding and 'Making Safeguarding Personal'. It also states that local authorities should make arrangements to have a qualified and registered social work professional practice lead in place to:

- Function at the strategic level of the Professional Capabilities Framework (PCF)
- Lead and oversee excellent social work practice
- Support and develop arrangements for excellent practice
- Lead the development of excellent Social Workers
- Support effective social work supervision and decision making
- Oversee quality assurance and improvement of social work practice
- Advice the Director of Adult Social Services (DASS) and/or wider Council in complex or controversial cases and on case or other law relating to social work practice

3.2 The role was clarified again to develop a national understanding in July 2019, introducing, “PSW Role and Responsibilities: Adult Principal Social Worker (APSW)” guidance”, produced in collaboration with the Principal Social Worker Adults (PSA) network and ADASS. Alongside this runs the new, “Capability Statement for Principal Social Workers in Adult Services”, issued by the Department of Health and Social Care.

3.3 In her role as Principal Social Worker, Marie has maintained her professional registration through the new regulatory body social work England, which came into force in Dec 2019. There is now a new requirement to upload evidence of meeting all professional standards of a professional capability framework (PCF). She has supported our social work staff in renewing their registration and completing their PCF, in November 2020.

3.4 Whilst discussing her progress, in this role, she has begun by acknowledging the challenges and priorities arising from the COVID-19 pandemic, in respect of social workers. Throughout the pandemic, they have adapted well to new ways of working required. Both nationally and locally, we have observed, higher than usual levels of sickness, stress and anxiety, which has contributed to issues of capacity, staff recruitment and retention. We have seen increased service demand, complexity of casework and safeguarding’s. As such, staff mental health and wellbeing is an ongoing priority. Our social work teams make best use of “Mindfulness” Training sessions, which prove really helpful.

The teams were initially required to reconfigure to a Single point of Access Team (SPA) working over a seven day period with extended hours for a substantive part of last year. They lived up to the challenge of becoming redeployed to meet needs, support hospital discharges and working in a more joined-up way with other services.

Although social workers are now working from home, face to face visits have continued where necessary. Much work has been completed digitally using IT tools such as skype, FaceTime, Microsoft teams and Zoom.

The biggest challenges as a PSW when we move into the post-COVID-19 ‘recovery’ phase* are likely to be around, supporting workforce

development, the mental health and well-being of staff, and harnessing working in different ways with people who use services.

3.5 It is also stated, "The PSW role straddles the strategic and operational interface and Principal Social Workers need to be able to challenge the organisation in its delivery and development of social work practice. Specific tasks for Principal Social Workers include:

I. Ensuring the employer standards are implemented
II. Ensuring the organisational health check is completed each year
III. Improving practice supervision arrangements
IV. Ensuring reflective practice supervision is taking place across the authority

The role is about leading beyond authority and developing a circle of influence, and to do this the Principal Social Worker must have practice credibility with frontline social work staff, but also the status and authority, gravitas to lead and time to carry this out".

3.6 **Progress**

I. Employee standards

What are the Standards? The Local Government Association states *"they set out the shared core expectations of employers which will enable social workers in all employment settings to work effectively and safely. These expectations can be used within self-regulation and improvement frameworks for public services and by service regulators. All employers providing a social work service should establish a monitoring system by which they can assess their organisation's performance against this framework, set a process for review and, where necessary, outline their plans for improvement."* There are eight standards under each standard there is a list of things that employers should do in order to meet that standard. Full details can be found on the LGA's website: (https://www.local.gov.uk/standards-employers-social-workers-england-0)

Marie has established a steering group and completed our own self-assessment against the standards, In summary, the self-assessment exercise revealed that the working group agreed that Halton's performance was generally good in relation to the Standards with most areas being identified as 'fully met'.

II. Organisational Health Check

One of the requirements under Standard 1 is for employers to "ensure that mechanisms are in place to listen to and respond to the views of practitioners on a regular basis, including undertaking an annual health check to ensure the organisation remains a place where the right environment and conditions exist to support best social work practice"

The Health Check survey issued in December 2020, by the Local

Government Association, asked social workers about the eight standards and five other areas – COVID, employee contribution, tensions, overall satisfaction and desire to stay.

We have now received an initial Health Check report, with a more detail report to follow later. The working group will re-convene to review the results and compare them to the outcome of the self-assessment exercise. An action plan will then be agreed in order to determine what needs to be done to ensure that Halton is meeting all areas of the Standards.

III. Improving Practice Supervision Arrangements

The Supervision Policy for Halton Borough Council's adult social care services was reviewed in December 2020. This comprehensive document sets the standard for supporting staff across services and provides a framework for conducting regular supervision. Used in conjunction with the Workload Management Policy and the Adult Social Work Progression Policy (both also recently reviewed) the processes set out to aid social work professionals in managing caseload, exploring Continue Professional Development (CPD) options, reflecting on fieldwork practice and give scope to consider service user feedback. Having a structured supervision procedure ensures that all aspect of working life are considered and outcomes recording, from wellbeing and support needs through to workload scheduling. The stipulations for having two-way conversations, between supervisor and supervisee, ensure equity of access to ongoing support and advocate a consultative approach to managing the challenges of the role of a social worker.

Operational teams play a valuable role in the review of policies in Halton enabling them to be effective working documents that fit the needs of the workplace. In these most recent reviews engagement with social work and assessment teams has been extensive to ensure that the resulting processes give them a clear voice in shaping social work practice in Halton.

IV. Ensuring reflective practice supervision is taking place across the authority

Marie runs a Social Work Matters forum which focuses on updating social workers of what's happening regionally, nationally, new legislation or guidance and enables social workers to share their best practice, learning and issues or concerns. During the height of the pandemic we have substituted these with newsletters, before reinstating meetings through Microsoft teams, see an example attached.

The social workers have their own regular Journal Clubs and Action learning sets, where they share good practice and reading materials. We are signed up to RIPFA which provides up to date research, guidance and training.

4.0 **POLICY IMPLICATIONS**

4.1 None

5.0 **FINANCIAL/RESOURCE IMPLICATIONS**

5.1 None identified.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

None

6.2 **Employment, Learning & Skills in Halton**

None

6.3 **A Healthy Halton**

None

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 Not required

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Not at this time

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None.

Social Work Matters Newsletter

Issue 8 – January 2021

Service User Feedback

It's fair to say that everyone is pushed to the limits currently, once again managing a further lockdown and the increased pressures this brings. That's why it's more important than ever that we look to capture feedback on our interactions with service users. If we're feeling the pinch it's certain that they are too and we need to consider their experiences of their interactions with social care in order to maintain service standards.

Our Service User Feedback forms, situated on the Adult Social Care Policy Library, can be used, where appropriate, at initial stages of assessment or following a gap in contact e.g. annual review.

They form part of our Care Act duties to consult with service users and gauge their views on the accessibility of adult social care.

They also provide an opportunity for individual workers to reflect on their own practice skills, knowledge and competence.

The questions asked cover just a single page in its written format and a pictorial 'easy read' version is also available. Service users can alternatively opt to complete the questions online and the data is captured and reported back to management team on a quarterly basis.

If anyone is having difficult in fulfilling this process please speak to your line manage in the first instance.

Management and Employee Module Series

The corporate Organisational Development team are running a series of learning modules to support people's continued training needs during the pandemic.

Titles include:

- Remote Change Management during COVID 19 Pandemic
- Conflict Resolution in a Remote Working Environment
- Ensuring High Performance Remotely
- Behavioural Science and How it Can Support Remote Working

Each title involves a series of 90-minute modules held on-line over consecutive week.

To find out more visit:
http://intranet/EventsinHalton/Organisational%20Development%20%20Management%20and%20Employee%20Module%20Series.aspx

Community DoLS – Lessons Learned

Deprivation of Liberty Safeguards, as enshrined into the Mental Capacity Act in 2007, apply to those adults under the care of a 'Managing Authority' – a residential or nursing care home or hospital setting. However, case law in 2014 broadened the need to scrutinise other care settings where adults receiving care and treatment, including those living in the community.

'Community DoLS' has become an additional and aligned requirement of mental capacity and deprivation of liberty considerations and Halton has a Deprivation of Liberty – Community Settings policy to look at this.

In the wake of increased numbers of Community DoLS the Integrated Adult Safeguarding Unit have been gathering 'lessons learned' information on their application and the care planning processes that sit around this.

To find out more click into the document: DoLS in a community setting.docx

This information needs to be reflected in current practice but of course this will all change once the Mental Capacity (Amendments) Act 2019 comes into force and the new Liberty Protection Safeguards are rolled out. With the amended timeline for this taking account of the pandemic it is anticipated that this will apply from April 2022. Halton has a working group looking at the change management requirements around these variations.

Professional Curiosity in Safeguarding Adults

RiPfA's latest strategic briefing centres on professional curiosity in safeguarding adults.

The concept of professional curiosity has been recognised as important in the area of safeguarding children for many years. More recently, Safeguarding Adult Reviews (SARs) have highlighted a similar need for professional curiosity in safeguarding adults with care and support needs. Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns and make connections to enable a greater understanding of the person's situation.

This Strategic Briefing draws from research and Safeguarding Adults Reviews to examine the nature of professional curiosity, some of the barriers that inhibit professionally curious practice, and the enablers that can put in place to create the conditions for a culture of curiosity in their organisations. It offers an opportunity to consider actions required to embed the approach and asks reflective questions throughout the resource.

ASC Workforce Development Strategy

The new Halton Adult Social Care Workforce Development Strategy 2021-23 sets out the Council's continued commitment to learning and development across adult social care.

At a time when staff face amplified challenges and changes on a daily basis it's more important than ever to pledge the Council's steadfast position in investing time and resource in its staffing body in order for them to deliver against their role and remit.

The new strategy replaces the one covering the period 2016-18, looks at the achievements (Section 5) since this point. It gives a new set of deliverables which will be monitored through the quarterly ASC Workforce Development Group, chaired by Marie Lynch.

A particular area of interest for social work teams is the diagram in Section 3.1 which looks at what constitutes learning and development. This recognises that this is now widely regarded as a much broader endeavour than simply buying-in training provision. It give scope to consider continued professional development needs through an extensive breadth of opportunities which can be further discussed as part of supervision processes.

Principal Social Worker's across England give their views

Skills for Care have recently published a report following responses to a Principal Social Workers annual survey and the results show that the role is having a positive impact on the profession.

The Survey of Principal Social Workers 2020 sets out how the role works, how it has been embedded into organisational structures, what difference it has made, and specifically how social work has been shaped by recent global events.

As well as the full report an infographic overview of key findings of the survey has been produced: PSW Annual Report 2020.

Social Work Week 2021

Social Work England has launched a major new event on the social work calendar.

Social Work Week, which will take place from 8-12 March 2021, will encourage social workers and those with an interest in social work, including people with lived experience, to reflect on the significant events, challenges and successes of the profession in 2020.

Social Work England are encouraging people to put the date in their diaries now and start considering their own responses to the initiative.

The social work week aims to complement the annual World Social Work Day which takes place on 16 March 2021.

Social Work Week in Halton Borough Council

While we had planned to have a virtual Forum to start planning towards this the current lockdown has taken precedence. Marie Lynch, as Principal Social Worker for Adult Social Care in Halton, is keen to mark the occasion and requests that ideas are sent to her for further discussion.

Cheshire and Merseyside Teaching Partnership

Halton's Social Workers can access the activities being put on for Social Work Week by Cheshire and Merseyside Teaching Partnership. Please see the attached flyer for more details:

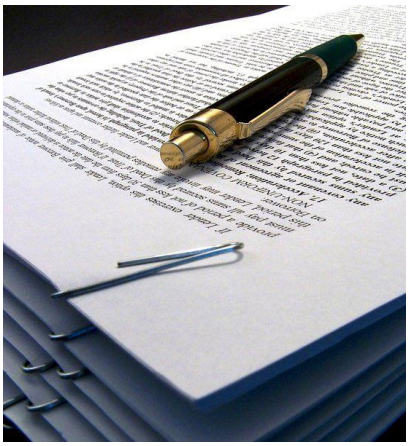
SW week Flyer .docx

New domestic abuse codeword scheme

The Home Office has launched a domestic abuse codeword scheme in thousands of pharmacies across the UK. The Ask for ANI codeword scheme allows those at risk or suffering from domestic abuse to discreetly signal to pharmacy staff that they need help accessing support.

In response to an alert trained pharmacy workers will offer a private space where they can understand if the victim needs to speak to the police or would like help to access support services, such as a national or local domestic abuse helpline.

Social Work England CPD Sampling



Following professional re-registration at the back end of last year, and our first with Social Work England, a programme of Continued Professional Development (CPD) sampling is taking place.

A number of social workers in adults' services have been identified in the sample and it is our understanding is that no action is required at this time but feedback will be given on CPD submissions that don't fulfil the criteria. Where this is the case social worker will be re-sampled next time around to check they have met the standards.

If you have any queries about your submission, registration or have received additional notice from Social Work England please discuss this with your line manager in the first instance.

Skills for Care – Covid-19 Updates for Social Workers

Continued refresh of the Covid-19 Updates for Social Workers is being made to support practice during the current lockdown.

The materials offer practical help, such as 'getting the most out of video calling applications', through the legal guidance on the 'Care Act Easements'. There is information on the site for supporting 'student placements' at this time as well as looking at how to manage your own 'emotional resilience and wellbeing' needs.

Please do take a look and reflect on what you need right now to support your work. Where that's not covered in these pages please speak to your line manager in the first instance.

-ENDS-

REPORT TO: Health and Wellbeing Board

DATE: 24 March 2021

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Pharmaceutical Needs Assessment 2021-2024

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To appraise the members of the Board to the risks associated with development and subsequent publication of the next required Pharmaceutical Needs Assessment (PNA) covering 2021-2024, due to the ongoing coronavirus pandemic local system response.

2.0 **RECOMMENDATION: That: the Board write to the Local Government Association detailing their concerns about the requirement to start the PNA process and ask that they lobby the Department for Health and Social Care for a further postponement.**

3. SUPPORTING INFORMATION

3.1 The pharmaceutical needs assessment (PNA) is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. First detailed in the NHS Act 2006 where PCTs were divested with the responsibility for producing the PNA, since 1 April 2013 this responsibility now sits with Health & Wellbeing Boards.

3.2 Background to the PNA

A PNA details the current pharmaceutical service provision available in the area and where there may need to be changes to this in the future because of changes to the health needs or geographical location of the local population. It covers a 3-year period. Any changes to community pharmacy provision within the lifetime of the PNA can be detailed in supplementary statements to keep the document up-to-date.

The PNA enables all commissioners of community pharmacy services to make sure that any new contracts granted and pharmaceutical services commissioned are based on the information provided in the document. It means that anyone wishing to open a new pharmacy in the area needs to include in their application their plans to meet the needs of local people as identified in the PNA.

Halton's current PNA covers between 1 April 2018 to 31 March 2021. There have been a number of supplementary statements issued alongside the PNA covering minor changes to community pharmaceutical provision.

Locally the Director of Public Health is the HWB sponsor for the PNA, with a PNA steering group, chaired by a Consultant in Public Health, tasked with producing the PNA. The process is managed by the Public Health Evidence & Intelligence who also write the PNA document. It requires significant input from Community Pharmacy.

3.3 **Suspension of the current development process for next Pharmaceutical Needs Assessment – was due for publishing in April 2021**

Local Health and Wellbeing Boards and Local Authority leads had started working towards new Pharmaceutical Needs Assessments that were due to be renewed and published by Local Health and Wellbeing Boards no later than 1 April 2021.

The Department of Health and Social Care announced on 21st May 2020 that, due to current pressures across all sectors in response to the coronavirus (COVID-19) pandemic, the requirement to publish renewed Pharmaceutical Need Assessments has been suspended until 1 April 2022.

Local Health and Well Being Boards retain the ability to issue supplementary statements to respond to local changes and pharmaceutical needs during this time.

The suspension of publishing PNAs from April 2021 until April 2022 was confirmed to free up time and capacity given other priorities during the COVID-19 pandemic. If additional information is required ahead of the extended deadline then Supplementary Statements can still be issued.

The decision took account that updating the PNA brings a considerable amount of work, in particular to local authority public health intelligence teams, local pharmaceutical committees and their member pharmacies.

The NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013 were subsequently updated.

Thus instead of having to work on the PNA during 2020 with publication due 1 April 2021 it was confirmed the current PNA findings could remain valid, with any minor changes detailed in supplementary statements.

3.4 **Locally and across Cheshire & Merseyside**

Typically, in previous years, the PNA has taken 12-15 months to complete, taking in to account the need to follow the regulated process and significant new data collection required.

In December 2019-March 2020 we had already started planning the pharmacy survey as a collaborative effort across Cheshire & Merseyside, with NHS England and the Local Pharmaceutical Committees.

This survey requires 100% of pharmacies to complete to gather necessary information for inclusion in local PNAs and enable cross border issues to be identified and dealt with in each local PNA.

In March 2020 we asked the health and wellbeing board to stand up the PNA steering group to oversee development of the PNA and allow them to continue writing supplementary statements as required. This was approved.

However, with the start of the coronavirus pandemic and notification from DHSC this work was suspended.

3.6 **Current position**

All public services have worked exceptionally hard to react to, and mitigate the pressures created by the pandemic. The 3rd wave of the pandemic, commencing November 2020, has seen capacity stretched beyond our experience to date. Public services are under intense pressure and the mass testing and vaccination programmes are also taking significant resource. Community Pharmacy is similarly stretched.

Delaying the PNA another year will not cause the same disruption that would be caused by attempting to undertake a new PNA at the time of a local, national and international crisis.

- Since March 2020 the local public health intelligence team responsible for co-ordinating the PNA development and writing the updated version have been working on coronavirus surveillance
- This position is likely to continue during 2021.
- Even if the team are able to re-start a limited amount of non-coronavirus surveillance and needs assessment work, given that the PNA must draw on a the local JSNA it is unlikely there will be sufficient capacity to do both
- This is especially so given that the PNA is bound up in strict regulations on content and development process, meaning it is a lengthy and involved endeavour.
- The PNA relies heavily also on a substantial amount of data gathering from each pharmacy in the form of a survey. Again, with capacity in pharmacies needing to continue to support coronavirus measures including vaccination, it is unlikely there would be sufficient engagement and would draw on human resources in the pharmacies needed for direct patient care.
- As the Cheshire & Merseyside collaborative approach has been suspended, if Halton where to 'go it alone' additional capacity, over and above that needed previously would be required.

3.8 **Proposed next steps**

- Communications with both the Cheshire & Merseyside NHS England pharmacy contracts lead and a contact in the Local Government Association (LGA) have suggested there are conversations at a national level to determine if the PNA, amongst other activities, should be suspended a further year. However, this is far from definite. A strong voice from local HWBs would greatly assist in this decision-making process

- When DHSC were consulting in 2019 on local HWB views as to potential changes to the PNA regulations, they did this through the LGA.
- **As such it is recommended that the HWB write to the LGA apprising them of their views. That in this letter they ask that the LGA act on our behalf to request DHSC grant another postponement of the PNA.**

- A specimen letter has been produced which could be used as the basis of the communication between the HWB and the LGA (attached)

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA should be used to develop the PNA.

The JSNA provides a robust and detailed assessment of need and priorities across Halton borough. As such is should continue to be used in the development of other policies, strategies and commissioning plans and reviews such as those of Halton Clinical Commissioning Group.

However, because of the coronavirus pandemic, the team responsible to co-ordinating the JSNA have been working exclusively on coronavirus surveillance.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the Health & Wellbeing Board up to Judicial Review. This can have significant financial implications.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this should be reflected in the PNA, detailing service provision that is appropriate to this age group.

6.2 **Employment, Learning & Skills in Halton**
Not applicable

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
Not applicable

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Pharmacies provide a vital primary health care service to residents across the borough, are located within the heart of communities and offer open access to trained health professionals for advice on a wide range of issues.

7.0 RISK ANALYSIS

7.1 There is a legal duty under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 to complete a PNA every three years. Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by NHS England over their application to open new premises based on information contained in the PNA.

7.2 There is a risk of challenge to the Health & Wellbeing Board who produced that PNA, and

Boards are recommended add the PNA to the risk register. Legal challenges to decisions based on the information in the PNA may be open to judicial review. However to date there have been no legal challenges nationally.

There is an increased risk of being unable to produce a PNA by 1 April 2022 due to additional pressures brought about by the coronavirus pandemic.

7.3 This increase in risk should be logged though Halton Borough Council's risk assessment and register process

Achieving a postponement of the PNA for an additional year would mitigate the risks identified above.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None within the meaning of the Act

Paul Ogden
Senior Adviser
Local Government Association
Smith Square
London
SW1P 3HZ

Dear Paul,

RE: Pharmaceutical Needs Assessment (PNA) postponement

I am writing to you regarding the impending start of the already delayed Pharmaceutical Needs Assessment (PNA) and Halton Health and Wellbeing Boards' concerns that this is now not the time to be undertaking such as assessment with system-wide capacity and demand at breaking point.

The PNA is a requirement under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and as such requires repeating every three years to provide the next generation of its local PNA, which is a legal, comprehensive, assessment of the current and future needs of local people for community pharmacy services..

At the start of the Coronavirus pandemic last March 2020 concerns were raised that it was not the right time to have to start developing the next PNA. This resulted in the Department of Health and Social Care announcing on 21st May to postpone the completion of a new PNA due to current pressures across all sectors in response to the coronavirus (COVID-19) pandemic, with the requirement to publish renewed Pharmaceutical Need Assessments being suspended until April 2022. This was recognition across the NHS and Local Government that the focus needed to be on patients and residents.

We believe this situation remains the same and as such we do not see the work to complete a new PNA as time best spent serving the public, nor does it use the scarce and overburdened public services.

Halton Health & Wellbeing Board request that you speak with Department for Health and Social Care on our behalf and convey our concerns and make them aware of the unnecessary but real demands a new PNA process would make on staff already stretched to the limit. Another year will not cause the same disruption that would be caused by attempting to undertake a new PNA at the time of a national and international crisis.

REPORT TO:	Health and Wellbeing Board
DATE:	24th March 2021
REPORTING OFFICER:	David Parr Chief Executive, Halton Borough Council and Place Lead (One Halton)
PORTFOLIO:	Health
SUBJECT:	White Paper – Integration and Innovation: Working together to improve health and social care for all.
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 To provide a summary update on the key elements outlined in the Government White Paper "Integration and Innovation: working together to improve health and social care for all" February 2021.

2.0 RECOMMENDATION: That the contents of the report are noted.

3.0 SUPPORTING INFORMATION

3.1 BACKGROUND

3.2 The Department of Health and Social Care (DHSC) has published a White Paper that sets out legislative proposals for a Health and Care Bill. Entitled 'Integration and innovation: working together to improve health and social care for all', the paper details proposals for NHS and social care reform, with a focus on integrated care and services adding value for end-users.

3.3 The legislative proposals are due to be implemented in 2022.

3.4 The White Paper recognises that the response to Covid-19 is the current priority; however, as the system emerges from the pandemic the legislative measures aim to assist with the recovery by bringing organisations together, removing the barriers and enabling change and innovations.

3.5 The legislation is themed under the following headings:

A. Working together and supporting integration
B. Reducing bureaucracy
C. Improving accountability and enhancing public confidence
D. Additional proposals grouped as Social Care, Public Health and Safety and Quality.

3.6 **A) WORKING TOGETHER AND SUPPORTING INTEGRATION**

3.7 There are a number of proposals included in the white paper to enable different parts of the health and care system to work effectively. These include creating statutory **Integrated Care Systems,** a **duty to collaborate** across the health and care system and a **triple aim** duty on health bodies.

3.8 C**ollaborative commissioning** will enable "double delegation" back to Place supported by **joint committees** and **joint appointments.**

3.9 Other measures include: additional safeguard for financial sustainability; a power to impose **capital spending limits on Foundation Trusts**, in line with NHS England's recommendation is proposed. **Patient Choice** will be preserved and strengthened within systems. Legislation will also ensure more effective **data sharing** across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.

3.10 **Integrated Care Systems**

Every part of England will be covered by an Integrated Care System (ICS). ICSs will be accountable for outcomes of the health of the population, therefore they will work closely with local Health and Wellbeing Boards which have the experience as 'place-based' planners.

3.11 The ICS will be made up of a statutory ICS NHS Body **and** a separate statutory ICS Health and Care Partnership, bringing together the NHS, local government and partners.

3.12 **The ICS NHS Body will be responsible for:** developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography and securing the provision of health services to meet the needs of the system population.

3.13 The ICS NHS Body will merge some of the functions currently being fulfilled by STPs/ICSs with the functions of a CCG. It will have a unitary board and be directly accountable for NHS spend and performance within the system. The board will, as a minimum, include a chair, CEO, and representatives from NHS trusts, general practice, local authorities, and others determined locally, for example community health services (CHS) trusts and mental health trusts, and non-executives. Further guidance will be published by NHS England.

3.14 **ICS Health and Care Partnership will be responsible for:** developing a plan that addresses the wider health, public health, and social care needs of the system, as well as promoting partnership arrangements.

3.15 There is no intention to specify membership or detailed functions for the ICS Health and Care Partnership and local areas can appoint members and delegate functions as they think is appropriate.

3.16 The proposals around ICSs **do not change the provider landscape**, NHS Trusts and Foundation Trusts will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a **new duty** to compel providers to have regard to the system financial objectives.

3.17 **B) REDUCING BUREAUCRACY**

3.18 The White Paper includes a number of measures aimed at reducing bureaucracy, such as changes to **competition rules for healthcare services**; a simpler **national tariff**; new measures for creating **new trusts** and removing **Local Education Training Boards** (LETBs). The aim is to remove barriers that prevent organisations working together and enable them to provide joined up care in the interest of the patient/user.

3.19 Where procurement processes can add value they will continue, but changes to the competition rules for healthcare will **eliminate the need for competitive tendering where it adds limited or no value**. The proposed removal of Local Education Training Boards will give Health Education England more flexibility to adapt its regional operating model.

3.20 **C) IMPROVING ACCOUNTABILITY AND ENHANCING PUBLIC CONFIDENCE**

3.21 Several measures to improve accountability, empower organisations and provide public confidence are being proposed. This includes the **formal merger for NHS England and NHS Improvement** and **enhanced powers of direction for the government**. Measures include **reforms to the mandate** to NHS England to allow for more flexibility of timing; the power **to transfer functions between Arm's Length Bodies**, the **removal of time limits on Special Health Authorities** and new responsibilities for workforce planning.

3.22 An improved level of accountability will also be introduced within social care, **with a new assurance framework allowing greater oversight of local authority delivery of care,** and improved data collection.

3.23 There will be **increased powers for the Secretary of State** for Health and Social Care to enhance the accountability. This includes intervention powers and ability to set objectives for NHS England; ability to intervene in local service reconfiguration; obtain data from all registered adult social care providers about all services they provide, whether funded by the local authority or privately and the ability to make payments directly to adult social care providers. These powers do not allow the Secretary of State to direct local NHS organisations or intervene in individual clinical decisions.

3.24 **D) ADDITIONAL PROPOSALS GROUPED AS SOCIAL CARE, PUBLIC HEALTH AND SAFETY AND QUALITY**

3.25 The measures set out the Government's intention to modernise the legal framework that underpins the health and care system as well as putting in place targeted improvements for the delivery of public health and social care.

3.26 **SOCIAL CARE**
Whilst the legislation is not the vehicle for wholescale social care or public health reform, the Government has sought to use it to address specific problems where legislative change could be beneficial. The Government has indicated that **Social Care reforms remain a manifesto commitment** and the Government intends to bring forward **separate proposals on social care reforms later this year**.

3.27 **ICS and Adult Social Care**
ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Wellbeing Boards, the Better Care Fund and pooled budget arrangements.
There will be published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the Adult Social Care sector.

3.28 There will be a more clearly defined role for local authorities within the structure of an NHS ICS Body. It is hoped this will give Adult Social Care a greater voice in NHS planning and allocation.

3.29 **Quality and Availability of Data**
The proposal includes collection of additional data for social care services provided to those who self-fund care, linking client level data to health data on hours of care, services provided and their cost per person, together with data on financial flows, it will show how money flows to providers and workforce.

3.30 Improved data and data flows are needed. Changes to the data collected and frequency will need to be made, not just for central government assurance and oversight, but so that providers and consumers can access the data they need while minimising the burden on data providers.

3.31 Building on improvements made by existing tools, such as the capacity tracker, during the pandemic and an increased ability to gather data from social care providers (for Local Authority and private funded care) it will remedy gaps in available data to help understand capacity and risk in the system. The legislation is needed to ensure a continued high response rate that will provide high quality provider data collection. Long

standing gaps in coverage in data on social care, both from Local Authorities and from care providers, have prevented making evidence based case for system change (with key gaps on self-funders, hours of care provided and cost per person) together with data on financial flows to providers and workforce mentioned.

3.32 With more and better data, it will enable improved future planning for the care of our population. There is a potential to generate significant health benefits such as increased independence, improved quality of care and higher patient satisfaction.

3.33 **New Assurance Framework**
The document proposes to introduce, through the Health and Care Bill, a new duty for the Care Quality Commission (CQC) to assess local authorities' delivery of their adult social care duties. It also adds that it wants to introduce a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties.

3.34 The initial focus will be to improve the quality, timeliness and accessibility of adult social care data, with the assessment and intervention elements to be introduced over time as the final element of the assurance framework.

3.35 **Discharge to Assess – Model Changes**
The government is looking to bring forward measures to update approaches to this process to help facilitate smooth discharge, by putting in place a legal framework for a Discharge to Assess model, whereby NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care.
This will replace the existing legal requirement for all assessments to take place prior to discharge. At this stage it is not clear what the funding arrangements for this will be.

3.36 **A Standalone Power for the Better Care Fund**
Legislation will be amending the process for setting the NHS mandate so that it is no longer set on a rolling annual basis. As such, there will be a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process. This will be a technical change, and will not have any impact on the function, purpose or policy intention for the fund.

3.37 **SOCIAL CARE SUMMARY**

3.38 There appears to be a stronger role for Local Authorities within the ICS; but waiting for further guidance. Additionally reforms relating to Adult Social Care are also expected later this year.

3.39 The main focus within the paper is around a centralised data collection from social care providers. However it is not clear how this links with the current plans to refresh the Adult Social Care Outcomes framework and develop an outcomes and performance framework.
It is essential that Local Authorities ensure co-production/co-design; using the making it real principles (using the current capacity tracker will only focus on available capacity and risks to services; there is a danger of losing the focus on people and outcomes)

3.40 Integrated data flows are essential to ensure the system of care and support is fully understood. Historically this data and intelligence has sat with Local Authorities. Adult Social Care understands the capacity and risks in our provider system. The implementation of the National Tracker did duplicate existing systems and approaches in Local Authorities. In addition, there are a number of data accuracy and interpretation issues with the National tracker.

3.41 A local integrated data system is the preferred approach; to really enable focus on place based care and support, delivering good outcomes to individuals.

3.42 Integrated care systems; system wide assurance verses sector assurances and selection of the right metrics needs to be considered. This could result in burden on Local Authorities and providers

3.43 CQC to inspect Adult Social Care again; with a clear role for Secretary of State if assessed as “failing”. CQC previously undertook Adult Social Care performance many years ago, which was very time consuming and overly bureaucratic. This system was replaced with sector led improvement which has demonstrated a number of successes over the years. There are concerns this could be a backward step.

3.44 There needs to be a balance between national system of assurance and sector led improvement. Consideration of existing tools; Peer reviews, Local Accounts, regional and national benchmarking.

3.45 There needs to be an opportunity for ADASS to co-design methodology with CQC to ensure ratings that inspire and motivate improvement not create fear and apportion blame.

3.46 Overall it appears that this a general move towards centralised control and assurance, similar to the NHS.

3.47 **PUBLIC HEALTH:**
Alongside the Government’s proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England, a range of targeted proposals in primary legislation relating to public health are proposed. They include:

- Making it easier for the Secretary of State to direct NHS England to **discharge public health functions** alongside the existing section 7A provisions.
- Help tackle **obesity** by introducing further restrictions on the advertising of high fat, salt and sugar foods, as well as a new power for ministers to alter certain food labelling requirements.
- The process for the **fluoridation of water** in England will be streamlined by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government.

3.48 These public health measures will complement and augment the efforts of ICSs to make real inroads in improving population health in their areas, helping to tackle inequalities and 'level-up' across communities.

3.49 Building on the Government's **obesity strategy**, Tackling obesity: empowering adults and children to live healthier lives, the Government wants to help people make better-informed food choices and to help them improve their own health. The new powers will enable the swift introduction of key obesity strategy policies such as changes to our front-of-pack nutrition labelling scheme and mandatory alcohol calorie labelling, following consultation.

3.50 **Water Fluoridation** is clinically proven to improve oral health and reduce oral health inequalities. Since 2013, Local Authorities have had the power to propose, and consult on new fluoridation schemes, variations to existing schemes, and to terminate existing schemes and have however reported several difficulties with this process. In light of these challenges, the paper proposes **giving the Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes**. This removes the burden from Local Authorities and will allow the Department to streamline processes and take responsibility for proposing any new fluoridation schemes. Central Government will also become responsible for the associated work, such as the cost of consultations, feasibility studies, and the capital and revenue costs associated with any new and existing schemes.

3.51 The Government suggests that the proposals will strengthen local public health systems, improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, strengthen the NHS's public health responsibilities, strengthen the role of the Department of Health and Social Care in health improvement, and drive more joint working across Government on prevention.

3.52 **SAFETY AND QUALITY**

Measures included in the White Paper include:

i. Healthcare Safety Investigation Branch (HSIB) will be put on a statutory footing; to improve the current regulatory landscape for healthcare professionals as needed;

ii. To establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved,

iii. Allow the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries to provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

iv. Measures to enable the Secretary of State to set requirements in relation to hospital food.

v. Implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.

4.0 NHS SUMMARY

4.1 The White Paper proposed a significant number of changes relating to the NHS as described earlier, relating to working together and supporting integration, reducing bureaucracy, improving accountability and enhancing public confidence. The changes focus on the commissioning landscape and new governance arrangements with the creation of statutory ICSs.

4.2 Alongside the White Paper, on the same day, NHS England issued **"Legislating for Integrated Care Systems: five recommendations to Government and Parliament"** which is detailed in Appendix 1.

4.3 The broad aim of the recommendations are a duty to collaborate across the health and care system and a triple aim duty on health bodies, which require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

4.4 CCG functions and some NHS England functions will transfer to the new ICS NHS body; this means CCGs across England will cease to exist when the legislation comes into effect.

4.5 To ensure a smooth transition process an "employment commitment" for NHS staff (below board level) has been outlined and staff will be employed by the NHS ICS body.

4.6 ICSs will be different organisations to CCGs by bringing in perspectives and skills from a wider range of partners from Providers and Local Authorities.

4.7 There is still a requirement for strong place-based working within the NHS ICS body.

4.8 The NHS Provider landscape is not formally changing.

4.9 There is a commitment to working with patients in ensuring that patient care is not affected by any of the changes.

4.10 There is a continued commitment to national contractual arrangements across the primary care contractor professions and also to the primary and community services funding guarantee. However, there has been no specific detail provided in relation to Primary Care Networks.

4.11 Mental Health investment identified in the NHS Long Term Plan is guaranteed.

4.12 There are a number of areas that remain ambiguous and currently further guidance is awaited from NHS England as to next steps and actions required.

5.0 IMPACT ON PLACE (ONE HALTON)

5.1 Place level commissioning will align geographically to a local authority boundary and the Better Care Fund (BCF) will provide a tool for agreeing priorities.

5.2 There are no legislative provisions about arrangements at place level; the expectation is NHS England will work with ICS NHS bodies on different models for place-based arrangements.

5.3 Specifically the White Paper states, *"Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues*."

5.4 It is expected that the ICS NHS Body will delegate significantly to Place. The exact division of roles and responsibilities between place and the ICS are still to be agreed.

5.5 There is a commitment for Health and Wellbeing Boards to remain in place and continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

5.6 Local authorities are recognised as an integral partner, including housing, leisure, employment services in addition to public health and social care.

5.7 One Halton already reports into the Health and Wellbeing Board. Further work will be needed to strengthen the governance process and refresh the Health and Wellbeing Strategy, which is due to be refreshed in 2022.

5.8 It is anticipated there will be a requirement for a Place Based Plan each year. Although the specific requirements remain unknown until further guidance is received from NHS England or the ICS. In the meantime, progress can be made to strengthen current governance arrangements for One Halton.

5.9 NEXT STEPS

5.10 One Halton will continue to work with Cheshire and Merseyside Health and Care Partnership as further guidance and information is shared in relation to the legislative proposals and NHS England recommendations. These will be reported and shared formally with the Health and Wellbeing Board, as well as Health PPB, CCG Governing Body and other organisational boards as appropriate.

5.11 A One Halton Strategy Workshop is planned for 14th April with regard to reviewing priorities and strengthening the governance process. It is anticipated further guidance will have been received by then and the Workshop will act as an enabler to ensure Halton is best placed to contribute to the development of the ICS in Cheshire and Merseyside.

6.0 POLICY IMPLICATIONS

6.1 The Local Authority has a statutory responsibility to provide social care and to improve the health and well-being of the local population through the delivery of specialist public health advice and the continued access to health improvement services for residents in Halton. Changes to the legislation will require significant local and national policy change.

7.0 FINANCIAL IMPLICATIONS

7.1 The changes proposed in the White Paper will result in a systematic redesign of how local functions are designed, developed and deployed. Financial and resource implications are unknown at this moment but will form part of the consultation process and the local implementation of any changes required by the implementation of new legislation. Subject to its passage through Parliament, it is indicated that a new Bill will result in the introduction of these measures in 2022.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 **Children and Young People in Halton**

The White Paper has limited detail relating to children, with the exception of childhood obesity, which is included within the Health and Wellbeing Strategy.

8.2 **Employment, Learning and Skills in Halton**
Employment, Learning and Skills are a key determinant of health and wellbeing and will therefore be a key consideration when developing strategies to address health inequalities.

8.3 **A Healthy Halton**
The proposals contained within the White Paper will shape and inform the council's delivery of the Health and Wellbeing strategy and will contribute to the achievement of the council's outcomes, including population health and reducing health inequalities as outlined in the priorities contained in the Joint Strategic Needs Assessment (JSNA).

8.4 **A Safer Halton**
None

8.5 **Halton's Urban Renewal**
None

9.0 RISK ANALYSIS

9.1 As part of the development and implementation of the proposals outlined in the White Paper there is the potential for significant disruption to local system for the provision of health and wellbeing services for the local population. As any programme of implementation is developed a full risk analysis will need to be implemented and monitored.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 An Equality Impact Assessment (EIA) will be required as part of any significant change to the provision of local services or structures.

11.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

11.1 "Integration and Innovation: working together to improve health and social care for all" – White Paper on Health and Social Care, HM Government. February 2021
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960549/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-print-version.pdf

11.2 Legislating for Integrated Care Systems: five recommendations to Government and Parliament, NHS England and NHS Improvement. February 2021.
https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/

Appendix 1:

Alongside the white paper, NHS England also issued "Legislating for Integrated Care Systems: five recommendations to Government and Parliament"

The five recommendations are:

1. The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

2. ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

3. The NHS ICS statutory body should be supported by a wider statutory health and care stakeholder partnership. Explicit provision should also be made for requirements about transparency.

4. There should be maximum local flexibility as to how the ICS health and care stakeholder partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well. The composition of the board of the NHS ICS statutory body itself must however be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance.

5. Provisions should enable the transfer of responsibility for primary medical, dental, ophthalmic and community pharmacy services by NHS England to the NHS ICS statutory body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

REPORT TO:	Health and Wellbeing Board
DATE:	24th March 2021
REPORTING OFFICER:	Chief Executive Officer
PORTFOLIO:	Health & Wellbeing Children, Education & Social Care
SUBJECT:	Health Reforms
WARD(S):	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To advise the Board of the current developments on Integrated Care Systems for Cheshire and Merseyside and Halton.

2.0 **RECOMMENDATION: That the Board :**

1) Note the current developments on Integrated Care Systems in the attached presentation.
2) Support the development of One Halton as the Integrated Care Partnership for Halton
3) Agree that the
    a. Halton Health & Well Being Board should set the outcomes for Halton
    b. Halton Health PPB provide scrutiny of the work of the HWBB, its officers and partners and the C&M Health Care Partnership
    c. Halton Council CEO be nominated the 'Place Lead' for Halton
4) Delegate to the CEO responsibility to engage with the Partnership and One Halton partners, to develop:
    a. A shared Vision and Plan for reducing inequalities and improving health outcomes for Halton, based on a revised JSNA
    b. Defined neighbourhood footprints and arrangements for the delivery of integrated health and care 'at Place', (recognising the importance of clinically-led PCNs working, with adult and children social care, community, mental health, public health and voluntary / community groups)
    c. Arrangements for the delivery of acute and specialist provision 'at Scale'
    d. Operating arrangements
    e. Structures
    f. Governance
5) Support a programme of public and stakeholder engagement.

3.0 **SUPPORTING INFORMATION – see presentation Appendix A**

Background

National – Integrating Care: Next steps to building strong and effective integrated care systems across England – published by NHSE/I

3.1 The NHS has been on a journey with partners since 2016 (with the creation of System Transformation Partnerships (STPs)) to establish system wide integrated and collaborative working aimed at improving population health, reducing inequalities, and managing resources effectively.

3.2 The NHS Long Term Plan, published in 2019, further set out the direction for health and care to join up locally to meet population needs and for greater collaborative working and for all STPs to work towards being formally approved by NHSE as an ICS (Integrated Care System).

3.3 In December 2020, NHSE/I produced a paper entitled the **National – Integrating Care: Next steps to building strong and effective integrated care systems across England** which set out proposals for significant legislative reform that would give ICSs statutory functions and change Clinical Commissioning Group (CCGs) and the way NHS providers work together. The consultation on this paper has now concluded and a White Paper produced.

3.4 The Health and Social Care Act 2012 resulted in the creation of CCGs and also an overt separation in the NHS between the commissioning and the provision of services. However, in recent years there has been a growing recognition that integration and collaboration are more effective at driving improved population health and reducing inequalities than competition and division. There is also evidence demonstrating the benefits of health and social care working together with other key partners such as housing, schools, businesses, and voluntary sector to support individuals and communities to be more independent and resilient.

3.5 Therefore, since 2016 the NHS has been on a journey to embed system wide integration and collaboration and to support local (Place/Borough) areas to bring together key partners to have a collective approach on improving outcomes for local people. There has been a drive to have integrated health and social care commissioning at a local level and to work with all relevant partners on improving outcomes locally and reducing inequalities. In Halton, this has been driven by ONE HALTON.

3.6 In Cheshire and Merseyside, the Health and Care Partnership (C&MHCP) is working, as directed by NHSE/I, towards formal designation as an ICS by April 2021. As part of this process the C&MHCP have produced a Memorandum of Understanding (MOU)

3.7 Each of the Local Authorities have been designated “Place” within Cheshire and Merseyside and collectively the nine places make up the Cheshire and Merseyside Health & Care Partnership.

3.8 An ICS is a system where: NHS bodies (commissioners and providers), local authorities and third-sector providers each take collective responsibility for the management of resources, delivering NHS standards and improving the health of the population they serve.

3.9 The national research shows that when different organisations work together in this way, local services can provide better and more joined-up care for patients. ‘Systems’ can

better understand data about local people's health, allowing them to provide care that is tailored to the needs of local communities and individuals. For staff, the improved collaboration can help to make it easier to work with colleagues from other organisations.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this stage.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Not Applicable.

6.2 **Employment, Learning & Skills in Halton**
Not Applicable.

6.3 **A Healthy Halton**
The need to have effective and efficient commissioning and delivery of health and social care provision in Halton is directly linked to this priority.

6.4 **A Safer Halton**
Not Applicable.

6.5 **Halton's Urban Renewal**
Not Applicable.

7.0 RISK ANALYSIS

7.1 A detailed risk analysis has not yet been carried out, however as part of the consultation response, a number of issues have been highlighted. For example, the proposal to put ICSs on a statutory footing from 2022 means there is a danger of reducing or replacing established place based leadership, best placed to achieve greater investment in prevention and community-based health and wellbeing services by addressing the wider determinants of health.

7.2 Further work on associated risks will need to be undertaken at the appropriate time.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officers
Integrating Care: Next steps to	https://www.england.nhs.uk/wp-	David Parr

building strong and effective integrated care systems across England	content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf	David.parr@halton.gov.uk Milorad Vasic Milorad.Vasic@halton.gov.uk

Establishing Integrated Care Partnerships - Definitions

Cheshire and Merseyside Health and Care Partnership

Integrated Care Systems (ICS): Bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health & care outcomes. All areas will covered by an ICS by April 2021 and on a statutory footing by 2022. Cheshire & Merseyside is an ICS area.

Place: a defined area within an ICS, typically aligned with local authority boundaries. In C&M there are 9 places aligned with the Local Authorities.

Neighbourhood: a defined area within a Place that is typically co-terminus with a Primary Care Network or other recognised local community footprint.

Integrated Care Partnerships (ICP): term used to describe **place-based** joint working between NHS, local government, community services and other partners. Each Place will determine how it organises itself as an ICP and how these arrangements relate to the Health & Wellbeing Board (HWB). HWB continue to have statutory role for improving health and wellbeing of local population, using JSNA to set local priorities. HWBs are a key component of the ICS and a key role for the ICS is to support place-based working and the development of ICP arrangements.

What is Purpose of an ICP? ICPs will deliver the local priorities set by the HWB and system priorities set by the ICS, by organising how local services and partners can work better together. ICPs will drive improved outcomes and address the inequalities identified by the HWB. They can use enablers such as integrated commissioning, BCF, population health data and improved digital technology to enable this work.

Establishing Integrated Care Partnerships

Core features:

1) **Integrated Care Partnership (ICP) Governance:** clearly defined formal arrangements for place partners to meet and work together to deliver outcomes set by the Health & Wellbeing Board (HWB) and ICS.

2) **ICP nominated 'Place Lead'** with remit for integrated working who will connect with ICS

3) **Shared vision and plan for reducing inequalities and improving outcomes** of local people approved by HWB (underpinned by local population health and socio-economic intelligence)

4) **Agreed ICP development plan**

5) **Defined footprints (e.g. neighbourhoods) for delivery of integrated care**, clinically led by PCNs working with social care, community, mental health, public health and other community groups.

6) **Programme of ongoing public and wider stakeholder engagement** at place

Places will be expected to develop an integrated approach to commissioning between health and local authority (such as shared posts, joint teams and pooled budgets) to underpin and support the work of the ICP

1. ICP Governance

Cheshire and Merseyside Health and Care Partnership

a. Arrangements for ICPs must outline how link with local HWB who retain statutory role for local population health and are key to the ICS. Some Places may want the Health and Wellbeing Board to be the nominated 'ICP Board' other Places may want to establish an 'ICP Board / Committee' as a sub group of the HWB.

b. ICPs should include a breadth of place partners extending beyond health & social care, e.g. housing, voluntary sector, police

c. ICPs will have a governance framework that sets out:
   - core members represented on the Partnership Groups,
   - the organisations and services that are part of the wider partnership, and
   - how the ICP will work with and alongside existing partnership structures (e.g. safeguarding boards, community safety partnerships, Local Enterprise Partnerships etc) to deliver on the aims of improving the quality of life and reducing inequalities.
   - ICPs should consider developing formal 'place agreements / MOUs' that each partner signs with agreed objectives / outcomes
   - ICPs should bring together statutory and non-statutory organisations & communities
   - ICPs will need to link to ICS (how will be determined as ICS evolves)

d. An ICP should be able to describe and present it's governance arrangements and it should be agreed by all partners

2. ICP nominated 'Place Lead'

a. The Place lead should be endorsed by members of the ICP and be able to represent Place within the ICS.

b. The Place lead will be a main point of contact for the ICS executive team and will sit on a Place Collaborative Forum and may be asked to represent Place on other ICS forum as system architecture and governance is developed further.

3. Shared vision and plan for reducing inequalities and improving outcomes of local people

Cheshire and Merseyside Health and Care Partnership

a. The ICP will need a shared vision and plans / strategies aimed at reducing inequalities & improving outcomes, these plans may already exist eg H&WBB and 5 year Place Plans. In addition, the work of the ICP is also likely to contribute to wider Place plans that support broader social and economic development.

b. This will be underpinned by local population health and socio-economic intelligence

c. Using their JSNA, ICPs will have a sound understanding of the characteristics of their population and the local drivers of inequality. There will be a requirement to use 'real time' population health data (supported by case finding and risk stratification) at Place to determine how to best deliver services and address local needs on a personal, neighbourhood & whole Place level.

d. Plans and strategies will be created using robust engagement with local people – including minority groups and those whose voices are seldom heard.

4. Agreed ICP development plan

a. The ICS will develop an ICP assurance / maturity framework, ICPs will need development plans to support their progress against this framework.

b. An ‘Organisational Development plan’ will be required that sets out how staff from all of the ICPs partners (working at all levels) will be engaged in the vision of the Place and supported to work in an integrated collaborative culture that embeds cross system partnership working.

c. As staff are asked to start working differently there will need to be a structured and significant programme of development in place to support implementation at each stage.

5. Defined footprints for delivery of integrated care, clinically led by PCNs working with social care, community, mental health, public health and other community groups.

a) Each Place should have agreed 'neighbourhood' footprints (ideally based on recognised local communities) where there will be partnerships between voluntary sector and other community groups (eg faith groups), schools and other local agencies who can influence health and wellbeing. There should be strong partnership working between these neighbourhood services / groups and PCNs, in many areas there will be coterminosity with PCNs and established community footprints.

b) PCNs will provide 'clinical' leadership for their registered population and work with social care, community, mental health and voluntary sector on the design and delivery of integrated health and care services at a neighbourhood level linking this to wider place agendas such as economic growth, community safety and education.

6. Programme of ongoing public and wider stakeholder engagement at place

a. Communications teams from each partner in the ICP need to be working closely together to deliver a programme of comms and engagement that is based on common messages and the shared ICP vision. There should be one nominated communications link from each ICP to work with the ICS comms team on how ICP and ICS messages can be coordinated across Cheshire and Merseyside.

b. The local population should be able to influence and co-produce local services to best meet their needs.

c. Each ICP will need an infrastructure to ensure there is ongoing and wide stakeholder and public engagement and a joint ICP engagement plan. This plan will address how to include seldom heard and minority voices.

7. Places will be expected to develop an integrated approach to commissioning between health and local authority (such as shared posts, joint teams and pooled budgets) to underpin and support the work of the ICP

a) As legislative reform is clarified, Places (CCGs & LAs) need to work with ICS on the transition of commissioning functions and development of new operating models. A move towards shared leadership of health & care commissioning, joint posts and pooled budgets at Place would be welcomed.

b) 'Commissioning' at Place should be an **enabler** for the ICP to transform local services, improve outcomes and address inequalities. Integrated commissioning teams should be part of the ICP arrangements and work to support provider collaboration and service re-design

ICP Development - supporting background resources

Cheshire and Merseyside
Health and Care Partnership

Governance and Structures

- Central Lancs ICP-Gov
- Durham ICP-gov
- Tameside Governance
- Rochdale - gov structure

Memorandum of Understanding & Agreements

- Bassetlaw-ICP-MoU
- Thurrock Care Alliance-MoU
- MLCO - ırtnering Agreeme
- Rochdale-Partneri ng Agreement
- Wigan Alliance Agreement
- St Helens Collaboration Agreement

Stakeholder forum examples

- VCFSE & ICP Checklist - draft
- Inequalities Group-ToR-example
- Primary Care Council - ToR-example