Essex County Council

Essex Health and Wellbeing Board

10:00	Wednesday, 15 July 2020	Online Meeting

The meeting will be open to the public via telephone or online. Details about this are on the next page. Please do not attend County Hall as no one connected with this meeting will be present.

For information about the meeting please ask for:
Judith Dignum, Democratic Services Officer
Telephone: 033301 34579
Email: democratic.services@essex.gov.uk

Essex County Council and Committees Information

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Members of the public will be able to view and listen to any items on the agenda unless the Committee has resolved to exclude the press and public from the meeting as a result of the likely disclosure of exempt information as defined by Schedule 12A to the Local Government Act 1972.

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Please note that an audio recording may be made of the meeting – at the start of the meeting the Chairman will confirm if all or part of the meeting is being recorded.

		Pages
1	**Membership, Apologies, Substitutions and Declarations of Interest** 10.00am	**6 - 7**
2	**Minutes: 29 January 2020**	**8 - 15**

3	**Public Questions** The Chair to respond to any questions from members of the public which are relevant to the business of the Board and of which advance notice has been given. Questions must be notified by email in advance to the Board Secretary at democratic.services@essex.gov.uk. The deadline for receipt is 10.30am on the third working day before the meeting (i.e. Friday 10 July) and each questioner must provide their name and address. Further information (including the provision for the Chairman to consider requests for urgent questions received by 5pm on the day before the meeting) may be found on the Council's website here.	
4	**Mental Health and Emotional Wellbeing Group (HWB/08/20)** 10.05 - 10.10am For decision - to ratify a recommendation agreed by Members at the last (informal) meeting of the Board on 20 May 2020.	**16 - 22**
5	**Essex Outbreak Plan (HWB/09/20)** 10.10 - 10.30am For decision - to note, discuss and endorse the Draft Outbreak Plan for Essex.	**23 - 57**
6	**Learning from Covid (HWB/10/20)** 10.30 - 11.10am For discussion - to consider the main ways in which better working together has been achieved during the crisis and to discuss how new best practice can be maintained.	**58 - 62**
*****	**BREAK 11.10 - 11.15am**	
7	**Preventing and mitigating the psychosocial impacts caused by the pandemic and economic shocks (HWB/11/20)** 11.15am - 12.10pm For discussion - to support a discussion on the need to anticipate and respond to the psychosocial risks caused by the Covid-19 pandemic and economic shocks.	**63 - 65**

8	**Wider determinants of health (HWB/12/20)** 12.10 - 12.45pm For discussion - to support discussion among Board members of the key issues that will impact on health over the next few years, and, from that, consideration and agreement of priorities for population health.	**66 - 79**
9	**Forward Plan** 12.45pm For discussion - to discuss the latest Forward Plan and consider requests for additional items.	**80 - 80**
10	**Date of next meeting** To note that the next meeting of the Board will take place on Wednesday 16 September 2020 at 10.00am, venue/format to be confirmed.	
11	**Urgent Business** To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.	
12	**Reflections and close** 12.50 - 13.00pm	

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

The following items of business have not been published on the grounds that they involve the likely disclosure of exempt information falling within Part I of Schedule 12A of the Local Government Act 1972. Members are asked to consider whether or not the press and public should be excluded during the consideration of these items. If so it will be necessary for the meeting to pass a formal resolution:

That the press and public are excluded from the meeting during the consideration of the remaining items of business on the grounds that they involve the likely disclosure of exempt information falling within Schedule 12A to the Local Government Act 1972, the specific paragraph(s) of Schedule 12A engaged being set out in the report or appendix relating to that item of business.

13 Urgent Exempt Business

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

Agenda item 1

Committee: Essex Health and Wellbeing Board (EHWB)

Enquiries to: Judith Dignum, Democratic Services Officer
Judith.dignum@essex.gov.uk

Membership, Apologies, Substitutions and Declarations of Interest

Recommendations:

To note

1. Membership as shown below. The following change has occurred since the last meeting:
   - Dr Sunil Gupta has replaced Dr Anand Deshpande as the representative of Mid and South Essex CCG Joint Committee.

   In addition, Dr Jane Halpin is attending her first meeting as Lead Officer for Hertfordshire and West Essex ICS, taking over from Beverley Flowers and Iain Macbeath.

2. Apologies and substitutions

3. Declarations of interest to be made by Members in accordance with the Members' Code of Conduct

Membership
(Quorum:
One quarter of the membership and will include:

- At least one Essex County Council Elected Member
- At least one Clinical Commissioning Group Representative
- Essex County Council either Director of Adult Social Care, Director of Children's Services or Director for Public Health.

Statutory Members

Councillor John Spence	Chairman, EHWB
Dr Hasan Chowhan	North East Essex CCG
Dr Anna Davey	Mid Essex CCG
Sam Glover	Healthwatch Essex
Dr Mike Gogarty	Essex County Council Director of Public Health (DPH)
Dr Sunil Gupta	Castle Point and Rochford CCG
Dr Angus Henderson	West Essex CCG (named substitute: Dr Rob Gerlis)
Helen Lincoln	Essex County Council Director of Children's Services (DCS) (named substitute: Clare Kershaw)
Councillor Louise McKinlay	Essex County Council
Councillor John Moran	Essex County Council

Nick Presmeg	Essex County Council Director of Adult Social Care (DASS)
Dr 'Boye Tayo	Basildon and Brentwood CCG*

Other Members

Georgina Blakemore	Borough/City/District Councils (ECEA rep)
Paul Burstow	Independent Chair, Hertfordshire and West Essex STP/ICS
Councillor Graham Butland	Borough/City/District Councils
Councillor Mark Cory	Borough/City/District Councils
Ian Davidson	Borough/City/District Councils (ECEA Rep)
Cllr Peter Davey	Voluntary Sector - Essex Association of Local Councils (EALC)
Nick Hulme	Essex Acute Hospital Trusts
Lorraine Jarvis	Voluntary Sector – Chelmsford CVS
Brid Johnson	Non-Acute Providers
Gavin Jones	Chief Executive, Essex County Council
Sally Morris	Essex mental health and non-acute providers
Clare Panniker	Essex Acute Hospital Trusts
Will Pope	Independent Chair, Suffolk and North East Essex STP/ICS
Dr Kashif Siddiqui	Mid and South Essex CCG Joint Committee
Trevor Smith	Essex Acute Hospital Trusts
Michael Thorne	Independent Chair, Mid and South Essex STP/ICS
Alison Wilson	Voluntary Sector – Mind in West Essex
Simon Wood	NHS Commissioning Board Essex LAT Director

Non-voting Members

Roger Hirst	Essex Police, Fire and Crime Commissioner
Deborah Stuart-Angus	Independent Chair of the Essex Safeguarding Adults Board
David Archibald	Independent Chair/Facilitator of the Essex Safeguarding Children Board

Minutes of the meeting of the Essex Health and Wellbeing Board, held in Committee Room 1, County Hall, Chelmsford, CM1 1QH at 10:00am on Wednesday November 2019

Present:

Board Members

Cllr John Spence	Essex County Council **(Chairman)**
Lisa Allen	Basildon and Brentwood CCG (substitute for Dr Boye Tayo)
Georgina Blakemore	Borough/City/District Councils (ECEA Rep)
Dr Hasan Chowhan	North East Essex CCG
Cllr Mark Cory	Borough/City/District Councils
Dr Anna Davey	Mid Essex CCG
Cllr Peter Davey	Voluntary Sector – Essex Association of Local Councils
Ian Davidson	Borough/City/District Councils (ECEA Rep)
Sam Glover	Healthwatch Essex
Dr Mike Gogarty	Essex County Council (Director, Wellbeing, Public Health and Communities)
Dr Sunil Gupta	Castle Point and Rochford CCG (substitute for Dr Kashif Siddiqui)
Dr Angus Henderson	West Essex CCG
Lorraine Jarvis	Voluntary Sector (Chelmsford CVS)
Gavin Jones	Essex County Council*
Brid Johnson	Non-Acute Providers
Clare Kershaw	Essex County Council
Nick Presmeg	Essex County Council
Cllr Chris Whitbread	Essex County Council
Charlotte Williams	Acute Hospital Trusts (substitute for Clare Panniker)

Co-opted Members

Roger Hirst	Essex Police, Fire and Crime Commissioner

Other Attendees

Harper Brown	Hertfordshire and West Essex STP (substitute for Beverley Flowers and Iain MacBeath)
Paul Burstow	Independent Chair, Hertfordshire and West Essex STP
Peter Fairley	Essex County Council
Susannah Howard	Suffolk and North East Essex ICS
Caroline Rassell	Mid and South Essex STP
David Sollis	Healthwatch Essex
Judith Dignum	Essex County Council (Board Secretary)

1. Membership, Apologies, Substitutions and Declarations of Interest

The report of Membership, Apologies and Declarations was received.

The Chairman welcomed new members and expressed thanks on behalf of the Board to Jacquie Foile who had stepped down as named substitute for the three Voluntary Sector representatives. Jemma Mindham had now been appointed in her place.

Resolved:

1) To note the following changes in membership:

- Appointment of Councillor Louise McKinlay to represent Essex County Council in place of Councillor Susan Barker
- Appointment of Deborah Stuart-Angus and David Archibald as Chairs respectively of the Essex Safeguarding Adults and Children Boards
- Appointment of Jemma Mindham as named substitute for the Voluntary Sector representatives.

2) To note that apologies for absence had been received from:

Board Members	
Clare Panniker	Acute Hospital Trusts (substitute Charlotte Williams)
Simon Wood	NHS England
Other apologies	
Beverley Flowers	Joint Lead, Hertfordshire and West Essex STP (substitute Harper Brown)
Iain MacBeath	Joint Lead, Hertfordshire and West Essex STP (substitute Harper Brown)
Professor Mike Thorne	Independent Chair, Mid and South Essex STP

3) To note that an interest was declared as follows:
   - Brid Johnson declared an interest in Agenda Item 7 (Mid and South Essex Mental Health Costed Delivery Plan‘) in that she is an employee of one of the service providers (NELFT) (minute 7 below refers).

2. Minutes and Progress Report on Action Arising: 20 November 2019

The minutes of the meeting held Wednesday 20 November 2019 were agreed as a correct record, and the progress report on actions arising since that meeting was noted.

3. Public Questions

None received.

4. Integrated Care System (ICS)/Sustainability and Transformation Partnerships (STPs): verbal updates

The Chairman referred to a recent meeting with the Regional Director of NHS England and NHS Improvement at which local government representatives had raised the frustration caused by NHS ways of working. This was in spite of the best efforts of all concerned. He stressed the importance of finding better ways of working together.

The Board received and **noted** updates on the ICS and STPs as set out below:

- Hertfordshire and West Essex STP: Harper Brown
  It was agreed that Harper Brown and Dr Angus Henderson would arrange a short briefing on commissioning for the County Councillors representing Divisions situated within Harlow district.
- Mid and South Essex STP: Caroline Rassell
- Suffolk and North East Essex ICS: Susannah Howard
  It was agreed that Susannah Howard should be invited to provide a briefing on grants for all County Councillors.

Action:

1) A short briefing on commissioning to be arranged for the County Councillors representing Divisions within Harlow district. (Harper Brown/Dr Angus Henderson)
2) Susannah Howard to be invited to provide a briefing on grants for all County Councillors. (Susannah Howard)

5. Endorsement of the draft five-year plans for NHS Sustainability and Transformation Partnerships (HWB/01/20)

The Board received for endorsement the draft five-year plans of the NHS Integrated Care System (ICS) and two NHS Sustainability and Transformation Partnerships (STPs), noting that they were awaiting final sign-off from NHS England.

Resolved:

That the draft five-year plans for Suffolk and North East Essex ICS, Mid and South Essex Sustainability and Transformation Partnership and Hertfordshire and West Essex Sustainability and Transformation Partnership be endorsed.

6. Livewell Accreditation (HWB/02/20)

The Board considered a report and presentation seeking its endorsement of the new Livewell Development Accreditation developed by Chelmsford City Council. The aim of the scheme was to acknowledge, enable and reward developers of residential-led schemes that positively contribute to lifestyles supportive of good health and wellbeing. It had been agreed by Chelmsford City Council in October 2019.

Arising from discussion, it was noted that around 80% of hospital employees lived within 6 miles of their place of work. In order to encourage healthier modes of travel to work, it would therefore be helpful to investigate opportunities to build in improved public transport, walking and cycling connectivity between hospitals and residential developments. Mike Gogarty and Peter Fairley were requested to progress this piece of work.

The Board welcomed the Accreditation, expressed their support for it and commended it to other local authorities.

Resolved:

1) To endorse the Livewell Development Accreditation developed by Chelmsford City Council and support its roll out across the County.

Action
To investigate the opportunities to build in improved public transport, walking and cycling connectivity between hospitals and residential developments. (Mike Gogarty/Peter Fairley)

7. Mid and South Essex Mental Health Costed Delivery Plan (HWB/03/20)
(Brid Johnson declared an interest in this item – minute 1 above refers.)

The Board considered a report concerning the proposed direction of travel for mental health across the Mid and South Essex STP. Members noted that the proposed transformation would see changing roles across the whole system. As success would be dependent on all parts of the system changing together, it was important for all stakeholders to arrive at a common understanding of the starting position as well as a common vision for the future.

In response to a question, it was noted that sufficient resources were in place to accommodate the planned expansion in the Improving Access to Psychological Therapies programme (IAPT) but there were challenges in terms of integrating the model as part of the whole system.

Resolved:

1) That the following be supported:

    a. Further development of community and primary care-based provision structured around the emerging Primary Care Networks (PCNs) and with significant investment in resources, infrastructure and change management for primary care-based teams and providing required medical or other support to the PCNs.
    b. Delivering NICE-compliant specialist community mental health services for people with eating disorders, complex PD, Early Intervention in psychosis (EIP) or other needs;
    c. Strengthening existing plans on robust community-based crisis response, personality disorders and dementia services;

d. Removing less complex activity from secondary care services, enabling secondary care services to provide higher quality and quantity therapeutic interventions for people who need it the most.; and
e. Developing a strategic approach to estates, workforce, digital and coproduction as key enablers to the delivery of the plan.

8. Ofsted/CQC Inspection Report (HWB/04/19)

The Board received a report presented by setting out the outcome of the recent Ofsted/CQC inspection of the Essex County Council's Special Educational Needs and Disabilities Service (SEND) and the work required to improve services and provision across Essex.

The Board highlighted the following issues:

- The need for a consistent framework for the Education, Health and Care Plan (EHCP) process in Essex
- The current workforce challenges

It was agreed that further updates should be submitted to the July and November 2020 and March 2021 meetings of the Board.

Resolved:

1) That the update be noted.

2) That a report identifying the actions required by Board members in response to the review be submitted to the January 2020 meeting.

Action
Further updates (to include details of any action required from the Board) to be submitted to the July and November 2020 and March 2021 meetings of the Board (Board Secretary/Ralph Holloway)

9. Adult Social Care LGA Peer Review Report (HWB/05/20)

The Board received an update on the Adult Social Care Local Government Association (LGA) Peer Review that took place in October 2019, including findings and recommendations from the LGA Team.

The Board welcomed the report and acknowledged the areas of positive working and relationships identified, as well as the challenges and areas for improvement. A discussion on the findings to be prioritised and actions to be taken would form part of the agenda for the Development Session taking place on the rise of this meeting.

While accepting the importance of Essex County Council's role as an effective system convenor, Members were keen for Board agendas to include items proposed and led by representatives of all the organisations which formed the Board's membership.

Resolved:

1) That the Board's consideration of the Adult Social Care Local Government Association Peer Review final report be as recorded above.
2) That a discussion on the findings to be prioritised and actions to be taken form part of the agenda for the Development Session taking place on the rise of this meeting.

Action
A discussion on the findings from the Adult Social Care LGA Peer Review final report which should be prioritised and the associated actions form part of the agenda for the Development Session taking place on the rise of this meeting (All)

10. Joint Strategic Needs Assessment (JSNA) (HWB/06/20)

The Board considered a report which sought approval for the latest iteration of the Essex Joint Strategic Needs Assessment (JSNA). Members' agreement for, and input to, the continued development of a suite of analytical products that support the JSNA was also requested.

The Board welcomed the proposal to customise the existing Public Health England SHAPE Atlas web platform by the inclusion of geographical and local service data.

Resolved:

1) That the Essex-wide summary report and district profiles be approved as the JSNA for Essex in the form appended to the report;
2) That key issues raised within the JSNA be identified and agreed for in-depth consideration at a future Board meeting.
3) That work to develop interactive, online intelligence resources providing a platform for analysts to interrogate this data at various geographical levels, including neighbourhood, Primary Care Network, CCG, STP and various local government geographies be noted; and
4) That work to develop a programme of 'deep-dive' analyses be noted, examining evidence on issues that affect the health and wellbeing of key populations cohorts and communities, and provided a steer on the areas of investigation that should be prioritised within this programme.

11. Essex Hospital Mergers

Charlotte Williams presented an update on the latest position in Mid and South Essex University Hospitals, referring in particular to the Trusts merger, the clinical services reconfiguration and the 'Basildon Hospital as an Anchor' Programme.

In response to a question, it was noted that although the merged Trust would be required to report as a single organisation, reporting at local level would also continue.

The report was **noted.**

Action
Presentation slides to be circulated with the minutes of the meeting (Board Secretary)

12. Falls Prevention (HWB/07/20)

The Board received an update in respect of falls prevention and implementation across Essex, as a basis for discussion and future planning. The following issues arose from consideration of the report:

- The number of falls in Essex was largely in line with the national average, although numbers of fractured femurs were higher.

- The risk of falls was increasing due to lifestyle factors such as obesity and inactivity. Further research was needed to assess whether tackling the root causes of these may offer a means to reducing the risk.

- Given that second and subsequent falls tended to be more severe, early intervention to prevent these was important and work to focus on this was ongoing. A pilot scheme in Mid and South Essex was training community providers and ambulance staff to pick up those who had fallen and to carry out an assessment with a view to preventing further incidences. The project was currently being evaluated.

- The Police and Fire Commissioner advised that the Fire and Rescue Service were well-placed to assist with falls prevention and firefighters were keen to be involved, although there were some challenges associated with this as a potential change to the firefighter job role.

- There was an opportunity to increase prevention through identifying those at risk at an early stage and carrying out adaptations to their home before a fall had occurred. This may represent another opportunity for Fire and Rescue Service involvement.

- It may be helpful to review the prescribing of bone strengthening drugs such as bisphosphonates, given that new methods of administering them had become available. Increased prescribing was likely to lead to long term (5 – 10 years) reductions in the number of falls.

- Charlotte Williams undertook to share the outcome of an audit of avoidable admissions to hospital currently being carried out in Basildon.

Resolved:

That a further report on falls prevention, to include an update on progress, be submitted to the Board in January 2021.

Actions

1) To share the outcome of an audit of avoidable admissions to hospital currently being carried out in Basildon (Charlotte Williams).
2) Update report on Falls Prevention to be added to the Forward Plan for January 2021 and report author advised (Board Secretary)

13. Date of Next Meeting

It was noted that the next meeting of the Board would take place on Wednesday 18 March 2020 at 10.00am in Committee Room 1 at County Hall, Chelmsford.

14. Forward Plan

The Board noted the items planned for consideration at future meetings.

It was agreed that a report on influencing factors for suicides, drawing on findings from the 2018 audit carried out by HM Coroner for Southend, Essex and Thurrock, should be included on the agenda for the May meeting.

Action
Report on influencing factors for suicides to be included on the Forward Plan for May 2020 (Board Secretary)

15. Urgent Business

The Chairman agreed to consideration of the following item of urgent business on the grounds that the issue had arisen since the publication of the agenda for the meeting.

Coronavirus – Latest Position

Dr Mike Gogarty gave an update on the latest position with regard to the outbreak of the Coronavirus, advising that its likely effect on the UK remained unclear.

There being no further business the meeting closed at 12.30pm

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Councillor John Spence
Chairman
18 March 2020

Report title: Establishment of Mental Health and Emotional Wellbeing Group	
Report to: Essex Health and Wellbeing Board	
Report authors: Judith Dignum, Democratic Services Officer	
Date: 15 July 2020	**For:** Decision
Enquiries to: judith.dignum@essex.gov.uk	
County Divisions affected: All Essex	

1 Purpose of Report

1.1 To ratify a recommendation made by Members at the last (informal) meeting of the Board.

2 Recommendation

2.1 That the following recommendation, agreed by Members at the last (informal) meeting of the Board on 20 May 2020, be formally ratified:

2.1.1 To establish a Mental Health and Emotional Wellbeing Group as a Sub-Group of the Board, with draft Terms of Reference set out in the Appendix to this report

3 Background

3.1 When Members of the Board last met, on 20 May 2020, consideration was given to the proposed establishment of a Mental Health and Wellbeing Group as a sub-group of the Board. This was considered desirable in response to the expected need for increased mental health support as a consequence of Covid-19.

3.2 Members expressed their support for the proposal. However, as the meeting was not formally constituted, it was not possible for a decision to be taken on that occasion. Members therefore agreed to recommend the proposal for ratification at the Board's next formally constituted meeting.

Terms of Reference:
Covid-19 Greater Essex Mental Health and Emotional Wellbeing Sub-Group

1. Purpose

The Sub-Group will fulfil an oversight and coordination role in response to the consequences of the Covid-19 emergency on mental health and emotional wellbeing in Greater Essex. This will ensure a comprehensive approach is offered, vulnerable groups and cohorts are identified, capacity is built, duplication is avoided, links are made, and learning is generated and shared widely.

The Sub-Group is mindful of the need for local systems to design responses to meet local need. The operating approach will therefore be 'light touch'; offering input to existing forums as well as support in any escalation as may be required. Where overlaps are identified with other groups being established to coordinate efforts in response to Covid-19 (for example, in mitigating the social and economic consequences of the emergency or improving emotional wellbeing in the community), the Sub-Group will ensure that clarity is achieved on respective remits and purpose.

2. Scope

The primary focus of the Sub-Group will be in agreeing a framework and principles for how the mental health consequences of Covid-19 are mitigated as well as identifying opportunities for enhancement of emotional wellbeing. This role is part of longer-term reset following the peak in virus transmission (for clarity, the initial crisis response is not being overseen via this group). It is anticipated the main function of the Sub-Group is to provide an assurance and guidance role, informed initially by a Humanitarian Impact Assessment (HIA), and over time, the collection of additional intelligence and research.

The Sub-Group will aim to ensure that activity across local systems which may influence the groups or issues created as a consequence of Covid-19 (see appendix 1 for initial list) is coordinated, fully sighted on 'best practice' evidence and is able to exploit the levers and resources at its disposal.

The Sub-Group will have an all-age remit and this will be reflected in its membership and workplan. Regular review points on the scope and function of the Sub-Group will be scheduled in acknowledgement that delivery of responses will take place on different footprints (using existing forums and mechanisms), involving many partners and transfer of function may occur at a future time to support this.

3. Deliverables

The Sub-Group will agree further deliverables as part of a workplan but it will initially include;

- Creation of a Humanitarian Impact Assessment to inform future work; this may look at working practices, communication, barriers to support, system gaps and vulnerable cohorts.
- Development of a framework and recommendations against which existing forums can gauge the strength of their response to the mental health consequences of Covid-19, and any capacity or capability requirements.
- Identification of the levers and mechanisms through which holistic responses can be driven along with a plan for making use of these (for instance, in creation of standard templates for use in commissioning)
- Feed recommendations from the Sub-Group into existing governance for considering funds and resources
- Creation of a central repository for relevant research, literature, evidence and monitoring information on the mental health demand created by the Covid-19 emergency, best practice in working with this, as well as the effectiveness of response.
- Co-production of output with both communities as well as people who are directly experiencing mental ill-health as a consequence of Covid-19.
- Constriction of a system-wide overview/gap analysis of activity being undertaken, ensuring the potential links and overlaps can be flagged to local forums, and resource requirements identified.[1]

4. Membership, roles and structure

The following membership is proposed for the core group. In addition, Task and Finish groups may be initiated to support specific areas of work (for instance, in analysis of need and research).

Roles

In summary, roles within the group are:

Chair – Chair meetings and lead the group; report to SCG/RHAG/ as needed
Vice-Chair – Cover for chair as required
Secretariat - Arrange meetings, manage Microsoft Teams area; keep an email distribution group for stakeholders, prepare agenda, manage action tracker
Core group members:

- Contribute to setting objectives, recommendations and actions
- Represent their theme/area in terms of:
    - Share knowledge to encourage the needs of those affected are understood and addressed
    - Share knowledge about capability/capacity of service provision; outreach; response
    - Share knowledge and expertise for horizon scanning/insight
    - Contribute to and Consider the Humanitarian Impact Assessment
- Feedback, engage and consult to their respective organisations and stakeholders including communities
- Help promote and publicise the Group outcomes
- Encourage effective mechanisms for the sharing of information
- Consider potential innovative approaches encouraging ideas for thinking outside of the box

[1] Page 49 of the Humanitarian Assistance Plan suggests some potential stakeholders

Core membership
(Noted alongside is the forum/themes they're representing. Members are expected to link with organisations within those forums/themes)

Dr Mike Gogarty (chair)[2], Director of Public Health, ECC – Population wellbeing
Moira McGrath, Director of Commissioning, ASC, ECC – Vulnerable Groups
Chris Martin, Director of Commissioning, Children & Families, ECC – Vulnerable Groups
Clare Kershaw, Director of Education – Vulnerable Groups
Andy Brogan, Deputy Chief Executive, EPUT – crisis
NELFT representative - crisis
STP Leads for Mental Health (Toni Coles – Herts and West Essex, Richard Watson – North Essex and Suffolk, Jacqui Lansley – Mid and South Essex)
Steve Evison - Communities and Economic Growth, Housing
Bishop Roger Morris - Bereavement
Dr Sabrina Robinson, ECC wellbeing lead – Workforce
Alistair Gordon – Insight and Intelligence
Thurrock Borough Council – Mental Health lead director
Southend Borough Council – Mental Health lead director

Further key stakeholders (virtual consultations and close contact with core membership via existing forums or any task and finish groups formed)[3].
HPFT representative
Ben Hughes, Public Health and lead on substance misuse and health & justice
Kirsty O'Callaghan, Head of Communities
Vol orgs e.g. Mind and/or rep from the Essex Voluntary Network (EVN) under ERF.
District councils
Police

Officer support:
Secretariat support
Emily Oliver
Maggie Pacini
Matthew Barnett
Sarah Garner, Associate Director and lead commissioner for children's mental health
Emma Dodgson + team (Emergency Planning)
Nominated officers from TBC, SBC and STPs

5. Mechanics

a. Accountability

The Sub-Group will be accountable to Health and Wellbeing Boards, ensuring elected member oversight. Via the Sub-Group chair, the SCG will be informed of

[2] Information about the Local Authority Humanitarian Assistance Lead Officer who would chair the Sub-Group, their responsibilities and initial actions are in the Humanitarian Assistance Plan, page 32
[3] Note, part of the Humanitarian Impact Assessment is to identify appropriate stakeholders (present and future) so this can be considered in through the HIA as well).

the work of the Sub-Group, ensuring coordination, links and escalation can be achieved when needed.

b. Frequency

The Sub-Group will initially meet fortnightly but frequency will be kept under review

c. Review

Terms of Reference will be reviewed every three months, with the first review in July.

At these review points, the Sub-Group will consider whether accountability and coordination responsibility needs to transfer to other forums and organisations, acknowledging that the delivery of solutions is often taking place within local systems and managed by sovereign organisations.

Appendices

1. Initial list of potential consequence areas

The following list contains the areas which may be in-scope for the Sub-Group to consider. Others may be identified in the HIA process.

Area / Theme / Group / Issue	Theme	Existing Delivery Forum
Population self-management including messaging and dissemination of materials from Public Health England and other nationally recognised bodies	Population wellbeing	
Ensuring supported self-management and early intervention responses appropriate to the impact of the Covid-19 emergency	Population wellbeing	
Staff and volunteer resilience and trauma	Workforce	
Workforce development including support and training for non-specialist staff and volunteers (psychological first aid)	Workforce	
Support to those people with pre-existing mental health needs (both adults and young people)	Vulnerable groups	
Support to vulnerable cohorts whose mental health may have deteriorated as a result of the Covid-19 emergency (e.g. autism, sensory impaired)	Vulnerable groups	
Crisis management solutions for mental health	Crisis	
Suicide prevention	Crisis	
Co-morbid drugs and alcohol issues	Vulnerable groups	
Health and Justice Pathways – prisoners, ex-offenders	Vulnerable Groups	
Response for parents and families where the mental wellbeing of a household member(s) has deteriorated, including action relating to rising domestic abuse	Families	
The impact of loss – bereavement, employment and education opportunity, financial certainty, social networks; the required action to mitigate these social determinants.	Loss and social determinants	

Appropriate housing – dealing with the effects of people being placed quickly during the height of crisis or who might have lost accommodation	Housing	
Recovery planning – analysis of the scale and duration of required action	Insight and evidence	
Responses to national consultations and enquiries on behalf of partners	Insight and evidence	
Intelligence (local and national), research and insight repository for the various planning footprints across Greater Essex; Information Sharing to facilitate this activity	Insight and evidence	

Report title: Essex Outbreak Plan	
Report to: Essex Health and Wellbeing Board	
Report author: Dr Mike Gogarty, Director of Wellbeing, Public Health and Communities	
Date: 15 July 2020	**For:** Update and Endorsement
Enquiries to: Mike.gogarty@essex.gov.uk	

1. Purpose of Report

The Board are asked to note, discuss and endorse the Draft Outbreak Plan for Essex

2. Recommendations

2.1. The attached plan is Endorsed by the Board.

3. Context

3.1 The coronavirus Outbreak is receding. This is entirely as a result of people's adherence to lockdown.

3.2 As number of cases reduces, local variations in case rates and discrete outbreaks become relatively more significant. A robust local Outbreak Plan can allow wider national relaxation of measures and a return to normality with economic recovery while helping contain local outbreaks

3.3 This will include ensuring local people maintain social distancing at 2m wherever possible and socially isolate if infected or in contact with somebody who is infected as well as maintaining hand hygiene

3.4 As numbers reduce it becomes possible to identify and robustly manage any local outbreaks. This will be delivered through national and local Test, Tract m, Contain and Enable (TTCE) services.

3.5 In addition to TTCE and local comms initiatives to support social distancing, the Outbreak plan will involve consideration of local lockdowns.

4. Plan and Approach

4.1 People with symptoms are strongly encouraged to have a test. If positive the they will be contacted by a national contact tracing service and their close contacts identified and advised to isolate.

4.2 Where the situation is more complex eg care homes, schools, healthcare, hostels, prisons, businesses and workplaces Public Health England (PHE) will be notifies and will contact the Local Authority who will work with PHE to manage those outbreaks locally

4.3 This has involved development of a local Test and trace service that is provided by Provide and ACE supported by local DC/BC and City EHOs, the Essex Wellbeing Service (EWS), PHE and in-house consultant support. ECC have been given a grant of £5.78m to deliver this service.

4.4 The local TTCE service need strong links with the SCG, education, care home hubs, the NHS, the police and providers of services to vulnerable groups. There are standard operating procedures to allow working with all these partners in a range of settings

4.5 The Outbreak Plan also required careful understanding and processing of data around numbers and patterns of cases locally to identify and explain any local increase in cases to allow timely intervention.

4.6 Governance of the Outbreak system is proscribed with a local officer led Health Protection Board and a member led Outbreak Engagement Board. The membership and terms of reference of these bodies is detailed in the plan. The Health Protection Board will oversee the management of local outbreaks and consider the need for wider actions. The SCG also has a key role in delivering action at a wider system level. The Outbreak Engagement Board will consider and seek action to deliver wider actions locally that will reduce outbreaks including local lockdowns.

5 Consideration

a. Financial implications

The service costs are funded through PH grant and have been agreed.

b. Legal implications

The Plan is a non-statutory document with no direct legal effect. However, it does say how Essex public services would intend to work together in the event of a further outbreak in Essex. It is currently believed that any legal restrictions for a significant local outbreak would be likely to be imposed by central government but the public sector may have existing legal powers to tackle some smaller scale issues

6 Equality and Diversity implications

6.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful
(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.
(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

6.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

6.3 The report is an update of current planning arrangements; each planning group will be responsible for equality impact assessment of any intended plans.

7 List of appendices

Outbreak Plan

8 List of background papers

None

Essex COVID-19 Local Outbreak Control Plan

Essex County Council

Table of Contents

1. Introduction

1.1. Background

On the 22nd May 2020 the Government announced that as part of its national strategy to reduce infection from SARS-CoV-2 it would expect every area in England to create a COVID-19 Local Outbreak Control Plan by the end of June 2020. The plans are to lead by the Directors of Public Health in Local Authorities.

This Local Outbreak Control Plans were required to cover seven themes:

1. Planning for outbreaks in care homes and schools.
2. Identifying and managing outbreaks in high risk places, locations and communities.
3. Identifying methods for local testing capacity.
4. Contact tracing in complex settings.
5. National and local data integration.
6. Supporting vulnerable people to get help to self-isolate
7. Establishing local governance structures.

1.2. Objectives

This document outlines the plan for local outbreaks of COVID-19 in the Essex County Council (ECC) area and how this works with regional and national systems for COVID-19 control.

The key objective of the Local Outbreak Control Plan is to protect the health of the population of Essex by:

- Prevention of the spread of COVID-19 and associated disease
- Pro-active management of high - risk settings. These are settings which would be complex and problematic if an outbreak were to occur.
- Early identification and proactive management of local outbreaks to reduce risk to life.
- Co-ordination of capabilities across partner authorities, agencies, and stakeholders.
- Assuring the public and stakeholders that this is being effectively delivered.
- Enable economic recovery through controlled relaxation of ‘lockdown’, underpinned by a robust and effective infection control strategy.

2. Governance

2.1. Context

The legal context for managing outbreaks of communicable disease which present a risk to the health of the public requiring urgent investigation and management sits:

- With Public Health England under the Health and Social Care Act 2012
- With Directors of Public Health under the Health and Social Care Act 2012
- With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
- With NHS Clinical Commissioning Groups[1] to collaborate with Directors of Public Health and Public Health England to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
- With other responder's specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004

In the context of COVID-19 there is also the Coronavirus Act 2020.

This underpinning context gives Local Authorities (Public Health and Environmental Health) and Public Health England (PHE) the primary responsibility for public health actions to be taken in relation to outbreaks of communicable disease through the local Health Protection Partnerships (sometimes these are Local Health Resilience Partnerships) and local Memoranda of Understanding. These arrangements are clarified in the 2013 guidance Health Protection in Local Government.

2.2. Structure

SUBJECT TO ESSEX COUNTY COUNCIL APPROVAL

Governance processes in Essex will fit in to the overall central government strategy To support the delivery of the Local Outbreak Plan two new committees are being formed with distinct roles and responsibilities, alongside the use of the existing strategic co-ordinating group.

Local Outbreak Engagement Board- To receive decisions and/or recommendations from the Health Protection Board, providing democratic oversight and shaping the approach to public-facing engagement and communication for outbreak response and endorsing any request to exercise any legal power to close premises or make regulations.

[1] And NHS England in the case of Prisons and custodial institutions

Covid 19 Health Protection Board - Responsible for the development and overseeing the implementation of local outbreak control plans by the Director of Public Health. It will oversee the set-up of incident management teams to control potential significant outbreaks and receive their updates and reports. It will also receive and analysis data to understand the transmission of the SARS-CoV-2 virus in the community. This will include data from the test and trace service, hospital data and testing.

Strategic Co-ordinating Group - Gold emergency planning group to support, co-ordinate and partner with broad local groups to support delivery of outbreak plans (e.g., Police, SIRE, NHS etc)

2.3. Information Governance and Data

The test and trace system both nationally and locally and outbreak control more generally rely on the sharing of person identifiable data. The public must have trust that their personal information will be safeguarded and only used for the purpose of controlling or preventing covid-19 infections. Data sharing agreements are in place with Public Health England, district, unitary and county tiers of local government, the NHS providers operationalising the Essex and Southend Contract Tracing Service and the Clinical Commissioning Groups in Essex. The Caldicott guardians in each stakeholder organisation have reviewed and signed of the information governance arrangement for outbreak management and the local contract tracing service.

2.4 Risks and Issues

Issues & Risks Logs will be maintained and reviewed by the Project Manager and significant entries will be escalated to the Health Protection Board for further action or escalation as required. Key risks at the start of the project will be agreed by the Chair of the Health Protection Board and added to the logs with proposed mitigations.

The key risks and mitigations of 29 June 2020 are:

Risk	Mitigations
Major outbreak identified prior to Essex model being mature enough to implement an	Team meetings set up twice weekly to monitor progress across all key workstreams. And model on track to be in place by the 29th June. Other Local Authority progress/planning being monitored to inform Essex planning.

effective response.	Public health professionals are relatively comfortable that in the interim outbreak could be managed prior to the full model being in place
Unknown capacity requirements could impact ability to deal with large outbreaks.	Process being put in place to quickly increase/decrease resource availability. Including the use of partner agencies and staff from other District Authorities.

3. Operations

3.1. Prevention

Prevention must come first and is a pillar of the communications strategy. We will support individuals to protect themselves and others through the promotion of:

- hand washing and respiratory hygiene,
- maintenance of social distancing and related measures,
- the appropriate use of Personal Protective Equipment (PPE).

Reducing the amount of viral transmission occurring in the community helps prevent outbreaks by reducing the number of infectious people. For this reason, our communication strategy aims to:

- embolden people to self-isolate if they or members of their household have symptoms and advise them how to get support if they need it,
- encourage those with symptoms to get tested for the virus (see section 3),
- work with the test and trace service to identify contacts of those who have tested positive and break viral transmission.

In addition, the need for individuals who have travelled into the UK from abroad to follow the latest Government requirements on self-isolation will be promoted.

3.2. Processes

Outbreaks will be managed in two ways. For small outbreaks, the test and trace system, both nationally and locally will be adequate. An example might be a single office worker has tested positive and did not adequately socially distance at work while in the infectious period. By tracing his or her workplace contacts and getting them to self-isolate an outbreak is stopped before it has begun.

In some situations, simple contact tracing of individuals testing positive will not be enough to control an outbreak. Examples would include several cases associated with a workplace or increase in cases despite apparent adequate self-isolation of contacts. In situations like these an Incident Management Team (IMT) would be established to control the outbreak.

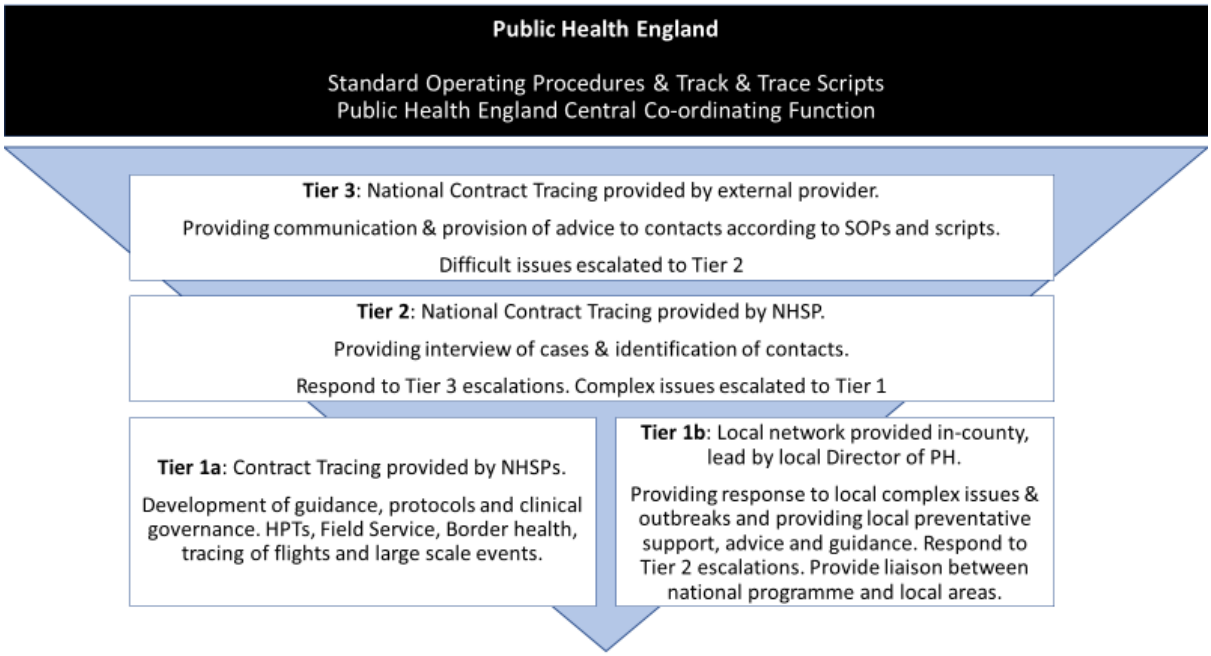
3.2.1. Test and Trace

The contact tracing processes in Essex will integrate with the wider strategic regional contract tracing approach for the East of England, overseen by Public Health

England (PHE). This will be through the implementation of a three-tier model (Figure 3.1) with clear escalation routes between tiers.

The Essex Outbreak control plan will address the roles required for staff in Tier 1b of this model.

Figure 3.2.1 Three Tier Model



A common high-level process, shown in Figure 3.2, will be used in the management of potential local outbreaks in Essex County Council and Southend District Authority. This process will ensure consistency in approach, and that appropriate quality control and governance measures can be robustly applied.

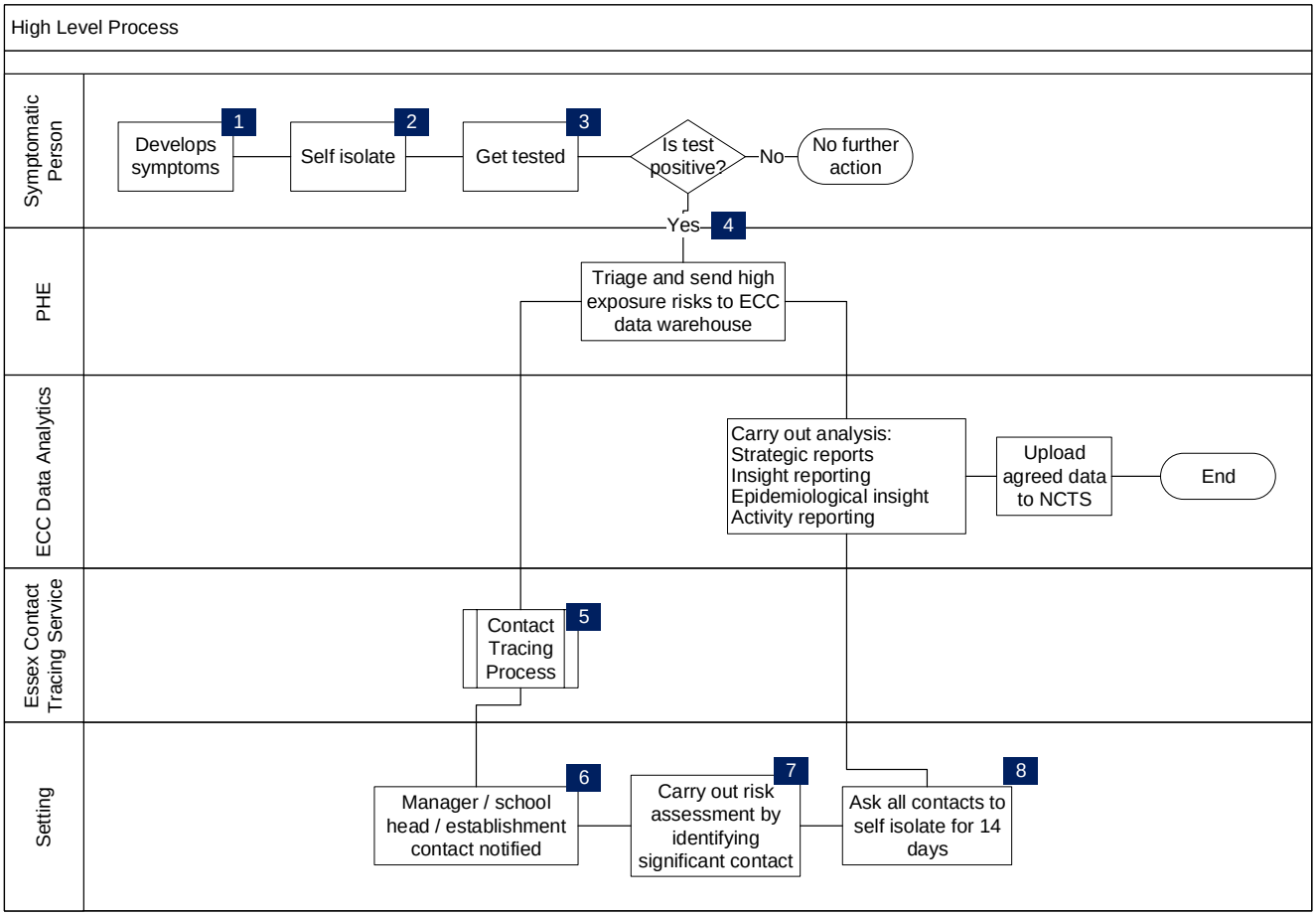
Where settings require specific outbreak control plans these will be informed by the common high-level process outlined here. Outbreak control plans will be developed for the following specific settings:

- Schools.
- Care homes.
- Workplaces.
- Vulnerable groups.
- High-risk settings or communities.

High Level Process

It is not anticipated that the high-level process will address all potential outbreak scenarios. Rather it is intended to provide a consistent model within which professional judgement can be applied.

Figure 3.2 High level outbreak control process for Essex



1. Development of symptoms of COVID-19

A symptomatic person will be defined as a possible case as per the current PHE case definition.

As of the 29th June 2020 this includes:

- A new continuous cough

or

- A high temperature

or

- A loss of, or change in, normal sense of taste or smell (anosmia)

2. Self-isolation

Current guidance on self-isolation can be found on the UK Government website.

As of the 29th June key guidance includes:

- If an individual has symptoms of coronavirus (COVID-19), however mild, **or** they have received a positive coronavirus (COVID-19) test result, must immediately self-isolate at home for at least 7 days from when symptoms started
- Individuals should consider alerting the people that they have had close contact within the last 48 hours to let them know you have symptoms
- Individuals should arrange to have a test to see if they have COVID-19

3. Getting tested

Tests can be arranged online. Guidance on how to self-administer a home test is available on the testing website.

Access to testing

While there is high demand for tests it cannot be guaranteed that tests will be available. If a test is not available an individual with symptoms of COVID-19 must self-isolate for 7 days, or longer. If the person still has symptoms other than cough or loss of sense of smell/taste, they must continue to self-isolate until they feel better.

Surveillance testing of some settings may occur.

People unable to test for COVID-19

There will be situations in which a person who is symptomatic cannot or will not be tested. Examples may include a parent unable or willing to have their child tested or if testing capacity is not available.

In such cases the individual needs to self-isolate for seven days but those they may have infected will not be contacted. It is expected that such cases will be rare enough not too significantly hinder infection prevention.

4. Testing positive

Following a positive test result, the person who has tested positive will receive a request by text, email or phone to log into the NHS Test and Trace service website and provide information about recent close contacts. They will also be advised to self-isolate, following government guidance.

People who test positive for COVID-19 are advised to continue to self-isolate after seven days or longer if they still have symptoms other than cough or loss of sense of smell/taste. They must continue to self-isolate until they feel better.

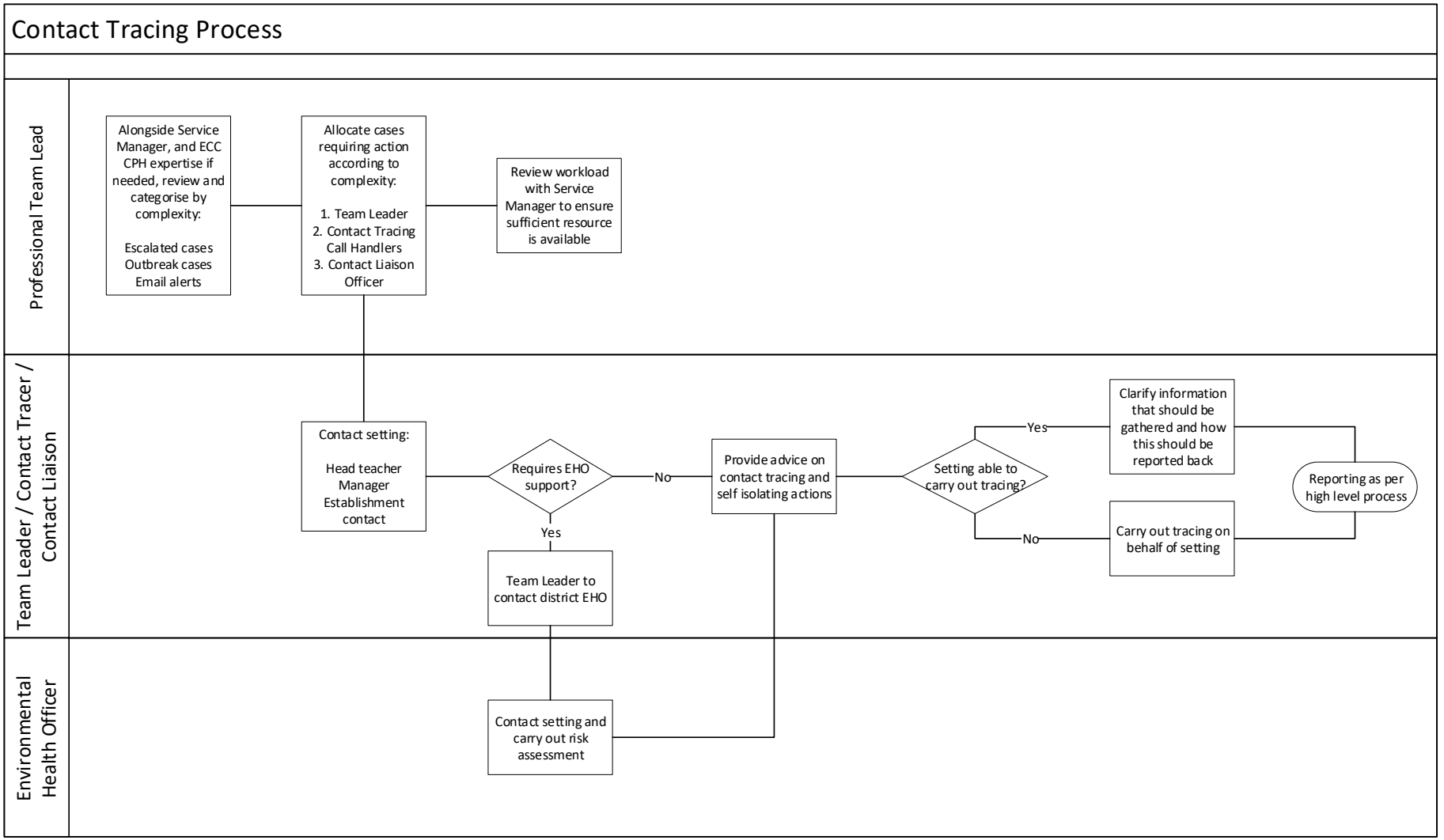
People who test positive do not need to continue to self-isolate after seven days if they only have a cough or loss of sense of smell/taste, as these symptoms can last for several weeks after the infection has gone. Information on ending isolation is available.

Self-isolation of household members should occur when any one member of the household is symptomatic, following the guidance illustrated in the explanatory diagram.

Additional support can be sought if the individual cannot cope with their symptoms at home, if their condition gets worse, or if symptoms do not get better after seven days. Support can be accessed by using the NHS 111 online coronavirus (COVID-19) service or calling NHS 111. For any medical emergency 999 should be contacted.

If people develop new coronavirus COVID-19 symptoms at any point after ending the first period of isolation (self or household) then they must follow the same guidance on self-isolation again.

5. Essex and Southend Contact tracing



Local contact tracing will be a joint responsibility between the PHE health protection team and upper tier local authorities. PHE will contact cases directly where there is lower risk of an outbreak developing (with ECC or other local involvement if needed) Where there is higher risk of outbreak developing, case information will be passed to Essex data insight function. Please see 3.4 for Memorandums of Understanding.

The caseload dataset requested from PHE will include name, contact phone number, address full postcode, occupation, workplace address. Essex data insight function are constructing the Essex data warehouse to which Essex and Southend Contact Tracing Service will have direct and timely access to data passed down by PHE, as soon as information governance has been completed.

The Service will assess cases and pass to a setting or contact tracing lead in the Essex and Southend Contact Tracing Service. A Consultant in Communicable Disease control will be available to support contact tracing if required. There will also be strong ongoing links with PHE.

Detailed protocols may be different according to setting. See settings 3.2. With time and learning it might be possible for the assignment of contact tracing without involving senior staff. This will be reviewed as needed.

6. Manager / School head / Establishment Contact

Identifying those at significant risk of infection and removing them from a setting can stop outbreaks developing. By acting, transmission in the setting is prevented.

A senior member of the contact tracing team will contact the manager of the organisation (the workplace, health setting, care home or school) to assess who is at risk (see 7 risk assessment below). They will be able to offer:

- Generic leaflets and text that explain why a person is considered at risk, that they should self-isolate, what this means and why it is important. This will have links to the relevant guidance and Essex Welfare Services.
- Generic communications templates will be available from ECC if requested.
- Support in understanding the guidance.
- Advise on the principles of social distancing to minimise recurrence.

While it is expected that most establishment contacts will be able to follow guidance circumstances will arise where this is impacted by communication or process challenges. In these circumstances, cases will need to be passed on to senior contact tracers for a decision on what action to take; Local Consultant in Communicable Disease Control support will be available for advice if required as well as access to PHE advice and support.

7. Risk assessment: who is a significant risk?

The risk assessment will try to identify all those who may have had a significant risk of infection. To be at significant risk of infection an individual must have had contact with the person who tested positive during the infectious period and the contact must have been significant. The infectious period and significant contact are defined as follows:

> **Infectious period:** from 48 hours before the onset of symptoms (or the date the test was taken if they did not have symptoms) until seven days after onset of symptoms (or the date the test was taken if they did not have symptoms).
>
> **Significant contact:**
>
> - had face-to-face contact of any duration (less than one metre away)
> Or
> - were coughed or sneezed on
> Or
> - spent more than 15 minutes within two metres of each other
> Or
> - travelled in a car or other small vehicle (even on a short journey)

All those having significant contact during the infectious period must be advised to self-isolate. They will be encouraged to apply for a COVID-19 test if they develop symptoms.

It is not necessary for those in the same household as the person self-isolating to self-isolate. This would only be needed if symptoms develop and is explained in the national guidance.

8. All contacts asked to self-isolate (14 days)

Full guidance on self-isolation is available.

Support for people who are self-isolating

Contact tracers will be able to pass on the details of the Essex Welfare Service (EWS) to individuals who are asked to self-isolate. EWS can provide support to individuals while in self isolation, as well as supporting individuals who do not otherwise have access to resources or help. Appendix 3

Details of EWS can be found on the service website or by calling the service on 0300 303 9988.

3.3. Settings

Setting	Detail	Process Link
Schools	In cases in which transmission may occur in schools the contact tracers will contact the school's head teacher.	Schools
Care Homes	In cases where transmission occurs contact tracers will contact care home management.	Care Homes
Workplaces including restaurants and shops	In cases where transmission occurs in a workplace it contact tracers will contact workplace management.	Workplaces
Healthcare and Emergency Services • NHS Trusts • Primary Care • Emergency Services	Cases involved in NHS settings, hospitals, community trusts and mental health providers will be passed over to the relevant Trust incident management team inbox which is monitored out of hours, with the Director of Infection Prevention and Control copied in. In primary care settings (for example dental surgeries, general medical practices, opticians) or other settings where there is not a Director of Infection Prevention and Control, a senior level contact tracer will contact the management of the service. For emergency services (excluding Ambulance Trust which is managed as NHS above), the relevant organisation will be notified via their control rooms.	Healthcare and Emergency Services
Under-served groups and justice	In cases involving vulnerable groups, such as the homeless, this will be a through a bespoke process that will involve support workers from Peabody or from Environmental Health Officers.	Under-served groups and justice
Traveller Communities	Outbreak management and contact tracing on a Traveller site is likely to benefit from specialist Traveller advice on how best to engage site residents. The Essex Countywide Traveller Unit (ECTU) team, hosted by ECC can assist with this. ECC own some of the Traveller sites in Essex, but many more Travellers live on private sites or caravan pitches. However, ECTU can assist by either directly or indirectly facilitating access to sites. For traveler communities where a site is known but precise contact details are not, contact tracing will be liaison with the ECTU to use their expertise to contact trace.	-
Cross border cases	It is inevitable that there will be outbreaks/incidents where the setting is in one local authority area, with cases or contacts in a different area(s). In such situations the overall management responsibilities will reside with the health protection team and lead local authority where the setting is located. Other local authorities should be informed of any associated cases or contacts, invited to	-

	participate in any incident management teams and take responsibility for local actions, when and if appropriate	

3.3.1. Incident Management Teams

Identification of the need for an Incident Management Team (IMT)

The suspicion of an outbreak may come in several ways. It may come from contact tracing hearing of multiple people with symptoms in a setting or that contract tracing in a setting or location is rising. It may also be from analysis of the wider data. Once the question is raised the decision to form an IMT will be taken by a Director of Public Health, CCDC or a Consultant in Public Health working in an upper tier local authority.

IMT Membership

IMTs will in most cases be chaired by the Director of Public Health from Essex or a CCDC employed by the local authority. The membership of the IMT will depend on nature of the incident but would be expected to draw from the following:

- PHE Consultant in Communicable Disease Control
- Environmental Health Officer from a District Local Authority
- contact tracer from the Essex and Southend Contract Tracing service
- specialist who works with a community group relevant to the incident (for example the Essex travellers' unit or the Peabody for the homeless)
- communication lead
- local authority Consultant in Communicable Disease Control
- local authority Public Health Consultant

IMT Actions

The IMT will follow the standard as set out in the Template East of England Joint Communicable Disease Incident/ Outbreak Management Plan. This will include the following:

- establish that a problem exists
- instigate immediate control measures
- undertake case finding
- construct descriptive epidemiology
- consider analytical epidemiology (in most cases this will not be needed)
- consider further control measures
- communicate to stakeholders and the public as needed
- declare when an outbreak is over
- report on progress and produce a final outbreak report

The reports form the IMT will go to the Covid-19 Health Protection Board and where appropriate from there to the Local Outbreak Engagement Board and the Strategic Co-ordinating Group.

3.4. Essex & Southend Contact Tracing Service

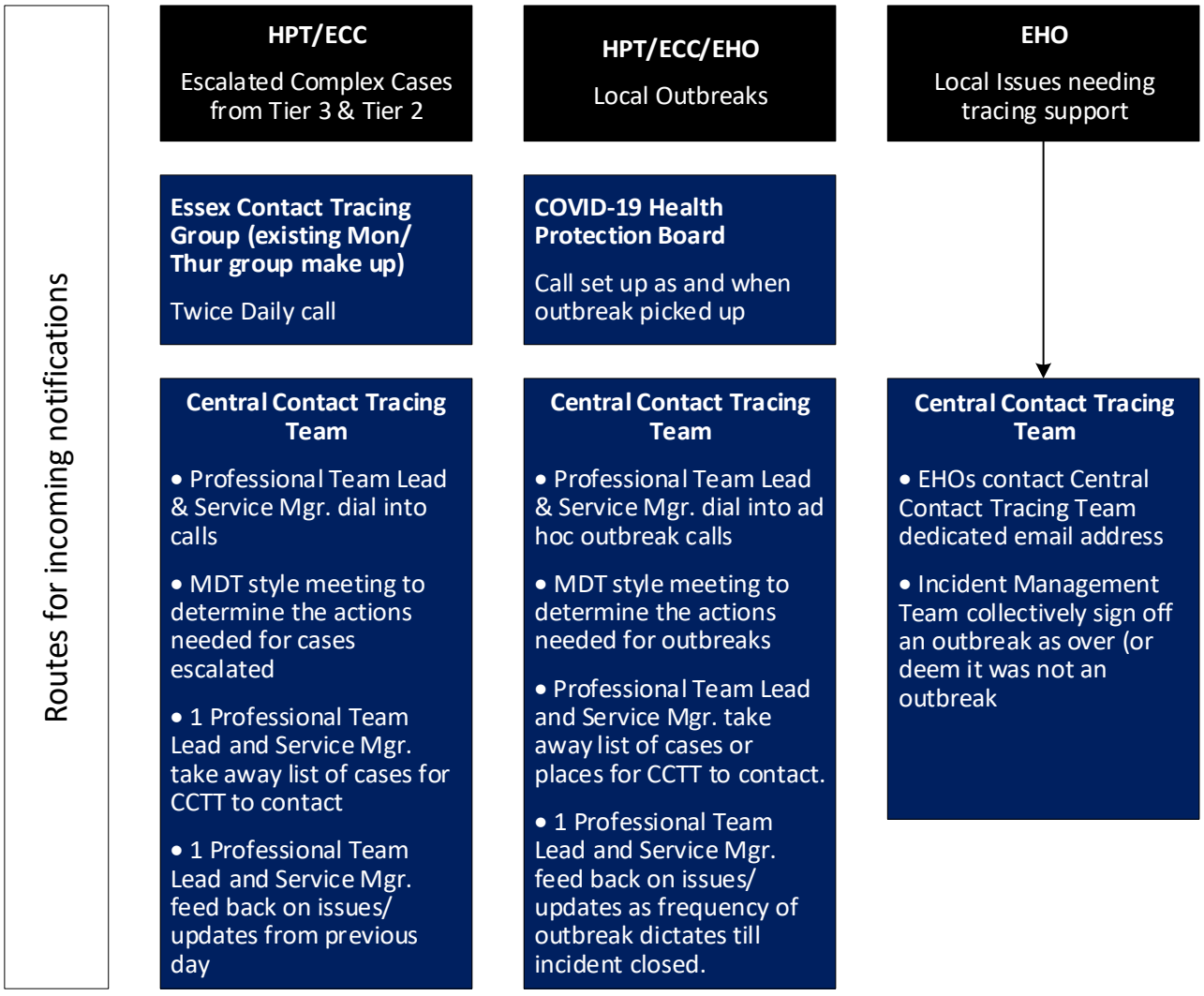
Essex will be delivering a local contact tracing service with Southend Unitary Authority named the Essex and Southend Contract Tracing Service. The host for the service, will be two of current providers of Essex sexual health service and community services, ACE and PROVIDE.

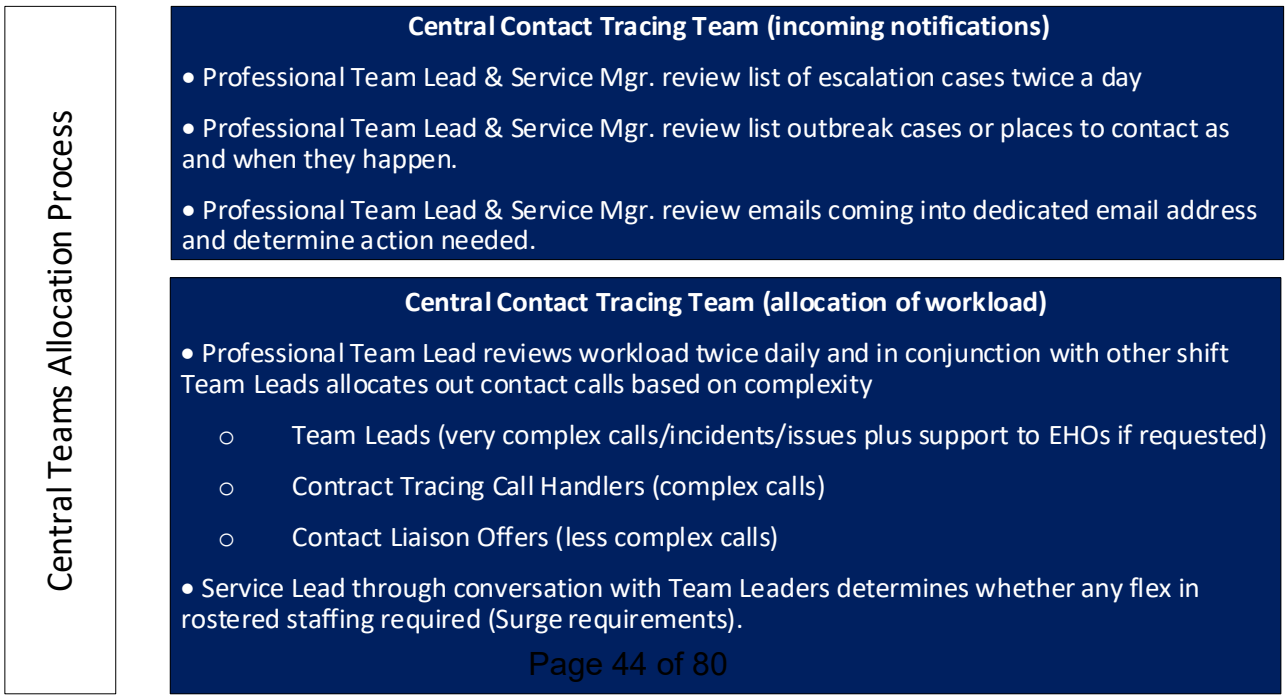
The current need identified is for additional capacity of approximately 50 staff. Initially two thirds of the staff compliment will be specialists such as Environmental Health Officers (EHO) and / or Trading Standards Officers (TSO). Access to an interpretation service is in place to support the team.

It is recognised that additionally there will need to be access to Consultant in Communicable Disease Control (CCDC) advice and support. There will be 1 WTE CCDC bespoke support for the service. The in house CCDC support will reduce pressure on PHE but also ensure their involvement where appropriate.

3.5. Essex & Southend Contact Tracing Service Processes

Essex Contact Tracing Team





Central Team Contact and Tracing Process

Central Contact Tracing Team (contact tracing)

- **Team Leads**
  - Oversee and manage workload of team in conjunction with other Team Leads and Service Manager.
  - Take lead in management of outbreak incidents within central team
  - Liaise with District EHOs where their support needed in a particular locality
  - Take referrals from District EHOs where the EHOs need support (allocate response out to team where appropriate)
  - Make contact with other EHOs in other Districts if surge capacity needed. Notify XXXXX if this is needed.
  - Make contact (from XXXX number) and undertake contact tracing process for very complex cases
  - If resultant contacts less complex allocate out to rest of team as appropriate.
  - Undertake public health risk assessment, including escalation of issues or concerns to HPT/PHE for advice.
  - Document information obtained from cases/incidents and outcomes.
  - Ensure escalations are actioned and closed appropriately.
  - Liaise with contacts in border areas where cases/incidents straddle
  - Liaise with border forces and ports as appropriate and under guidance from HPT

- **Contract Tracing Call Handlers**
  - Make contact with cases/organisations/locations following PHE protocol and scripts
  - Undertake public health risk assessments
  - Ascertain contacts (where these are considered to not be complex, complete documentation for T3/T2 to pick up calls)
  - Call contacts (utilising the Contact Tracing Liaison Officers if appropriate)
  - Provide public health advice were appropriate including advice relating to complex incidents/outbreaks
  - Document information obtained and outcomes in XXXXX system.
  - Escalate any difficult issues or difficult non-compliance or concerns to a Team Lead.
  - Pick up cases escalated from the Contact Tracing Liaison Officers
  - Ensure escalations are actioned and closed appropriately.
  - Flag workload capacity issues to a Team Lead.
  - Flag to Team Lead if District EHO support required for geographical expertise.

- **Contact Tracing Liaison Officers**
  - Make contact with cases following national PHE protocol and scripts
  - Document information and outcomes in XXXXX system
  - Escalate issues or non-compliance to Contact Tracing Call Handlers

3.6. Memorandums of Understanding and Standard Operating Procedures

The following Memorandums of Understanding (MOU) and Standard Operating Procedures (SOPs) will support the working processes and relationships between other organisations required in this Local Outbreak Control Plan. If you would like a copy of the documents referenced below please email public.health@essex.gov.uk

Setting	Last updated	Document
Schools and early year settings MOU	Awaiting final document	
Care Homes SOP	22 May	FINAL Template PHE-LA Care Home S(
Workplaces MOU	Awaiting final document	
Border Health Guidance	5 June	BorderMeasures-AviationIndustryOperatior BorderMeasuresFAQs-AviationSectorV2.0(19COVID-19PHEFAQs-AirportsV4.1.pdf COVID-19PHEFAQs-MaritimeSectorV6.00.
Socially excluded groups MOU	Awaiting final document	

3.7. Local Testing Capacity

Most of the testing for those who have symptoms of covid-19 will be done through the national testing routes. Individuals assess this themselves either through the NHS website or calling 111. The options will be to go to a drive-through test centre or have a test delivered to be taken at home and returned. There are drive-through test centres at Stansted and Ipswich as well as a mobile unit whose location each day. The list of dates and sites is available on the Essex County Council website.

There are additional testing options for key workers in Essex, details of which can be found on the relevant Essex County Council webpage. Care home managers can also ask for testing of their residents or staff from the national portal, or via the health protection team of Public Health England if they think they have an outbreak. The testing in cases of suspected care home outbreaks is undertaken by Commiseo Primary Care Solutions.

Testing of patients admitted to hospital or attending the emergency department is arranged by the hospitals. Hospitals will also test patients being discharged in to care homes even if they are not symptomatic.

All the above must cover most of the testing that is needed in Essex. There will be situations in which these arrangements are inadequate. For example, a person in temporary accommodation without a phone, internet access or transport. For these rare occasions we can employ Commisseo Primary Care Solutions. They will undertake the testing but need a definite safe location to undertake the testing, for example an individual's room in a house of multiple occupation. This will be undertaken on a fee for service basic depending on the number of tests that needed to be done in a location and the distance that needed to be travelled to that location.

4. Data Integration

4.1. Data sharing

Agencies will assume they are required to adopt a proactive approach to sharing information by default, in line with the Instructions of the Secretary of State, the Statement of the Information Commissioner on COVID-19 and the Civil Contingencies Act (CCA).

The Secretary of State has issued four notices under the Health Service Control of Patient Information Regulations 2002 requiring the following organisations to process information: NHS Digital, NHS England and Improvement, health organisations, arm's length bodies, Local Authorities, General Practitioners. These notices require that data is shared for purposes of COVID-19 and give health organisations and local authorities the security and confidence to share the data they need to respond to COVID-19. These can be found here.

The data sharing permissions under the Civil Contingencies Act 2004 and the statement of the Information Commissioner all apply. Under the Civil Contingencies Act 2004 (CCA) and the Contingency Planning Regulations, Category 1 and 2 responders have a duty to share information with other Category 1 and 2 responders. This is required for those responders to fulfil their duties under the CCA.

4.2. Proposed Test and Trace Tier 1 escalation routes

There is a need to understand these three data flows and management processes. This includes:

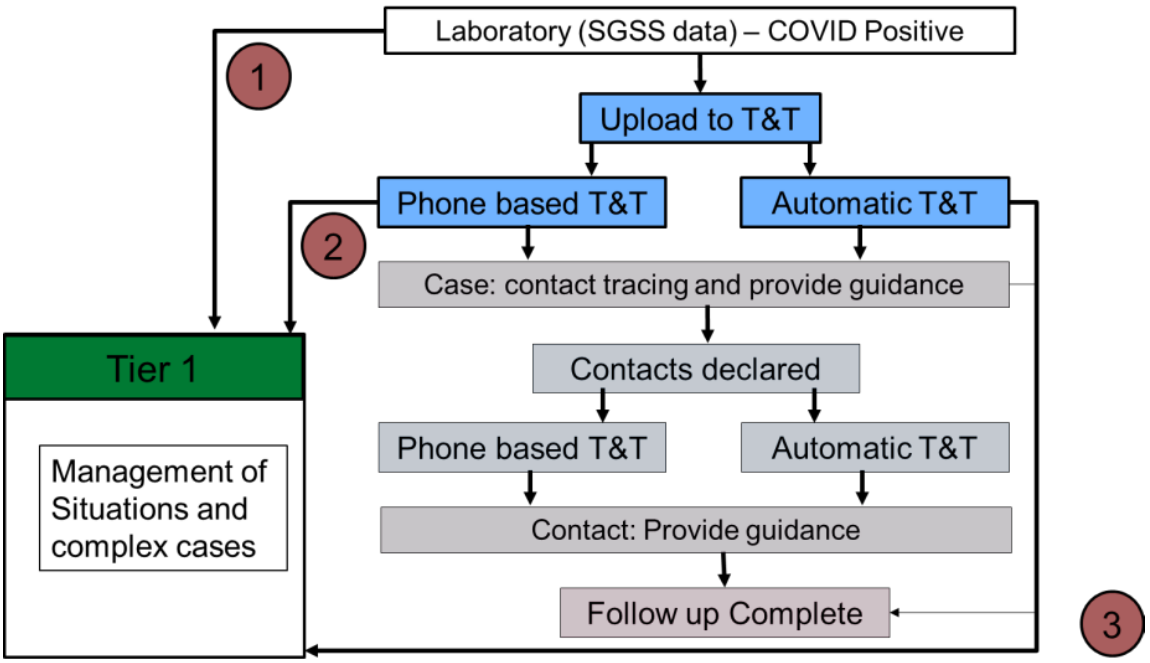
- Data types and format
- Intended IG guidelines and compliance needs
- Frequency
- Feedback reporting

Three routes to Tier 1 escalation from the national test and trace team are captured in Figure 4.1. These are:

1. **Direct allocation:** records automatically allocated to Tier One due to their status. For example, a care home resident is followed-up without progressing through national test and trace (no questionnaire completed).
2. **Call handler escalation:** if a person provides information not captured by test and trace questions that requires escalation. For example, if a person has concerns over disclosure or is unwilling to provide information.
3. **Through review of data** the national test and trace team will identify any records or events that need escalation and have not been captured above. For example, school settings not escalated by call handlers or postcode co-incidences.

A fourth route to escalation, not captured in the diagram, will be **automatic escalation:** If a person provides certain responses to questions. For example, if a case identifies as "working in a healthcare setting". The case will be escalated after completion of the questionnaire.

Figure 4.1 Essex & Southend Test and Trace escalation routes



3 routes to Tier 1 escalation

SGSS: Central system and database that stores and manages data on laboratory isolates and notifications. Captures all positive COVID-19 tests from laboratories across England. Stored in a central database within PHE

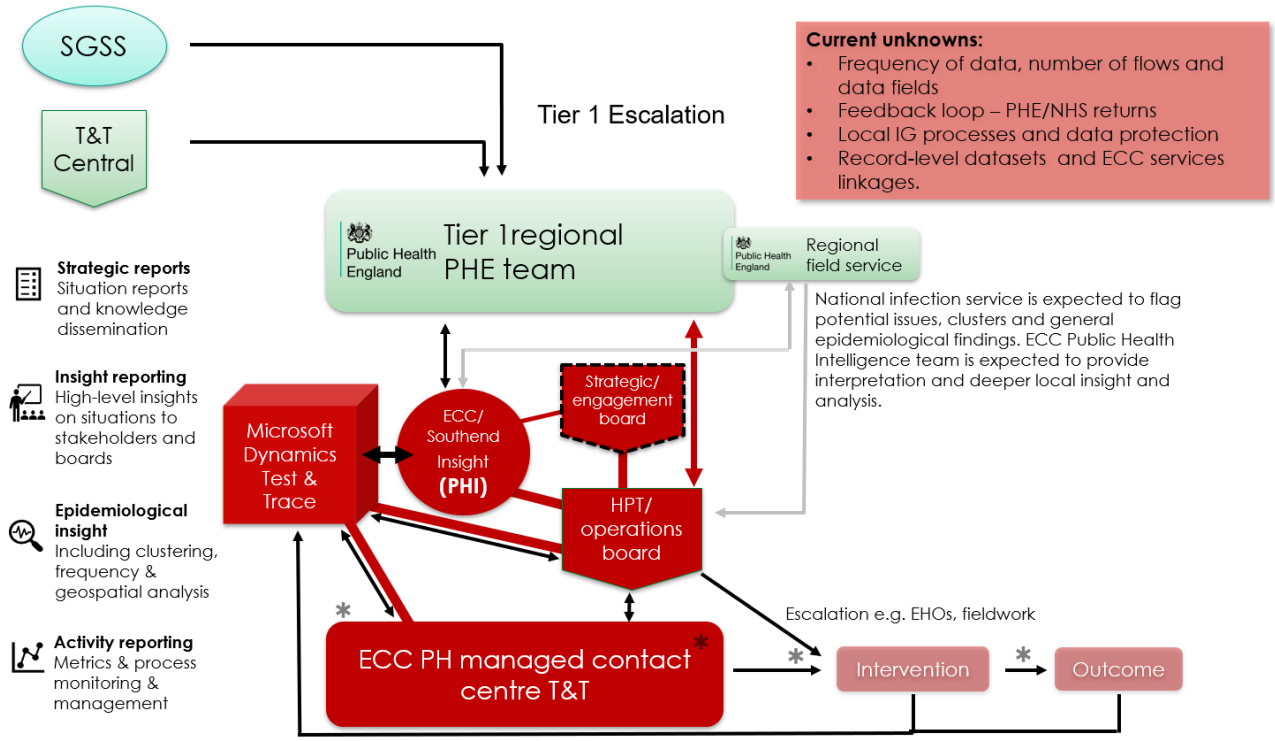
4.2.1. Information flow & management processes

For analysis of data the National infection service is expected to flag potential issues, clusters and general epidemiological findings. The ECC Public Health Intelligence team is expected to provide interpretation and deeper local insight and analysis.

Local flows and current unknowns are shown in Figure 4.2.

Figure 4.2 Local information flows and processes

.

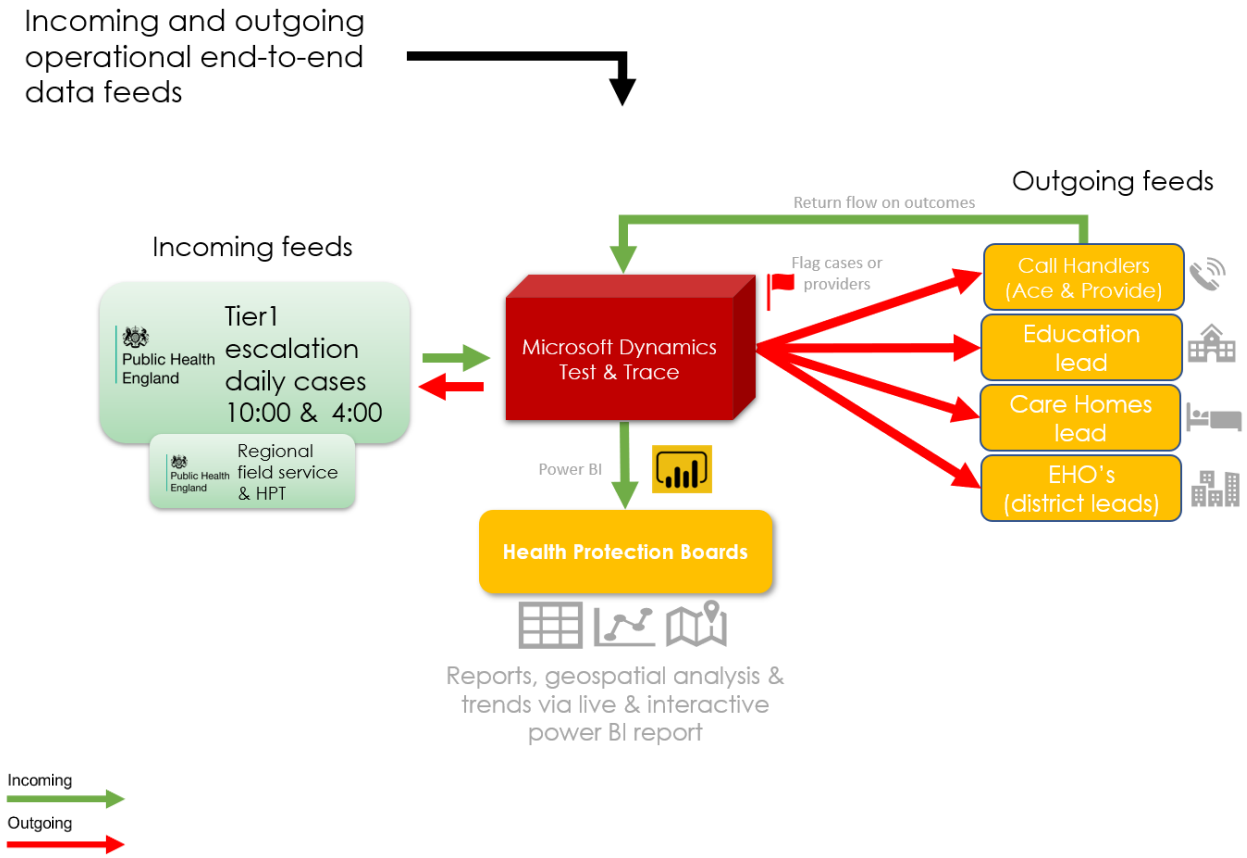


*Activity recording and reporting

4.2.2. Proposed detailed data flows

Proposed detailed data flows are captured in Figure 4.3 below.

Figure 4.3 Proposed detailed data flows



4.2.3. Responding to potential issues arising from the data

It is essential that the system can identify and appropriately respond to what is happening locally. This needs to be through twice weekly meeting including Analyst lead, Consultant in Public Health or Consultant in Communicable Disease Control, Public Health England and Director of Public health to understand in detail local data trends.

This will involve consideration of local outbreaks as well as more crucially any emerging underlying trends in the wider community. Data considered may include:

- Increased numbers asking for testing as they have symptoms
- Increased number of positive tests
- Increased school absence as pupils are in households with symptomatic household members
- Increased number of small possible outbreaks in settings without a clear mode of transmission
- No large outbreaks big enough to make a significant contribution to an increase in the number of positive cases
- An increase in the number of hospital admission testing positive (this one have a 7 to 10 day lag after increased transmission)
- An increase in COVID-19 positive intensive care unit patients (after an additional lag)
- An increase in the number of COVID-19 positive deaths (again after a lag)

This group would need to consider any implications and potential action required around this to be discussed at the Health Protection Board and if required the Engagement Board.

5. Communications approach

The Government will be providing lots of information and resources to support local authorities to communicate with residents about Test and Trace. Our approach will be to take that content, localise it where needed, and then share through every channel available to us. Of importance will be using the data available to us to identify communities we need to target (both geographical, demographic etc), and how best to tailor this messaging. This insight will be crucial to ensure we are targeting where we are seeing emerging issues and areas that are not adhering to social distancing measures. (Appendix – Communications Strategy)

Communications approaches will be tailored to different audiences and centre around four key pillars:

1. **Prevention** -Our strategy to prevent the spread of the virus and encourage them to use track and trace. For this activity we should use PHE assets as much as possible and localise if required. Widespread “push” messages should be disseminated out across all owned channels, both from ECC and partners. We will also look at opportunities for “earned” content through, for example, media opportunities, partnerships, paid for opportunities. This will be supplemented by targeted activity which will be determined through insight and data.

2. **Management of Outbreaks** – Our strategy when an outbreak occurs. For this activity communications will be two-fold – firstly direct and targeted communications to support the outbreak. This will align to the process/protocols put in place by Public Health colleagues for each scenario. Much like the process/protocol, there will be a generic approach which will be tailored to the relevant audience. It is anticipated that template guidance for communication will be issued by PHE which we should follow and adapt where appropriate (schools protocol being issued w/c 8th June which will include template letters for staff/parents for example). In these instances the setting will be provided with these templates and supported with finalising and issuing these via established channels. The second element would be any wider communications required in relation to local outbreaks, for example managing public/media interest and scrutiny around local outbreaks.

3. **Local action in response to outbreaks/R number/additional insight** – Our strategy for implementing local action to further prevent the spread of infection. Activity will focus on communicating clearly the process around how decisions are made around local action, and communicating what decisions are made and impact of these.

4. **Support** – Our strategy for people who need to isolate. Activity will focus on providing those who need to isolate with effective support and guidance of how best to support themselves during a period of isolation (including financial support/guidance around sick pay), including, where appropriate, directing to Essex Welfare Service.

For each above scenario, a separate plan has been created which will allow for detailed scenario planning and templates to be developed. (Appendix – Awaiting Plans).

6. Lockdown

It is likely that as cases reduce local infection rates will vary more. This may require consideration of options to take local action in reducing transmission. It is recognised that lockdown has been the single effective measure in the UK to date. While the key purpose of this plan is to ensure local test and trace systems effectively contain Outbreaks there may be a need to consider and action wider lockdown arrangements

The options will need to be developed by the Health Protection Board with strong input from PHE both Regionally and likely nationally.

The SCG will need to be fully engaged with particularly the Chief Constable aware and in agreement with any areas requiring police intervention.

The Engagement Board will need to consider recommendations and decide on agreed action as well as communicate this.

Action might include:

- Urging local people to return to lockdown
- Asking businesses to close in each area for example the High street
- Advising/delivering Closure of all schools in an area
- Working with Regional and National leads around the need for more enforced lockdown

Draft guidance on legal powers to add enforcement if needed are in Appendix 10.

7. Appendices

	Title	Last updated	Document
1	ERF Covid-19 Supporting Framework v3	4 June 2020	See appendices folder
2	TORs and membership lists for Boards	12 June 2020	See appendices folder
3	Essex Welfare Service	19 June 2020	See appendices folder
4	Setting specific flow charts	18 June 2020	7.1
5	Directory of contacts	18 June 2020	See appendices folder
6	Scripts	Not yet confirmed	
7	Template East of England Joint Communicable Disease Incident/ Outbreak Management Plan	25 June 2020	See appendices folder
8	Communications Strategy	18 June 2020	See appendices folder
9	Scenario specific comms plans	To follow	To follow
10	Control Powers for Lockdown	29 June 2020	See appendices folder

7.1. Setting specific flow charts

If you would like a copy of the documents referenced below please email public.health@essex.gov.uk

Schools.

Children, Families and Education Proce

Care homes.

Care Homes and Conact Tracing.pdf

Workplaces.

Workplaces Health Process.pdf

Healthcare and Emergency Services

Healthcare & Emergency Services P

Vulnerable groups (Under-served Groups and Health and Justice Allocation).

Under-served Process Flow T&T.pdf

Report title: Learning from Covid	
Report to: Essex Health and Wellbeing Board	
Report author: Peter Fairley, Director for Strategy and Integration	
Date: 15 July 2020	**For:** Discussion
Enquiries to: peter.fairley@essex.gov.uk	
County Divisions affected: All Essex	

1 Purpose of Report

1.1 To consider the main ways in which better working together has been achieved during the crisis and to discuss how new best practice can be maintained

2 Recommendations

2.1 Ask Sustainability and Partnerships (STPs) work to identify and build-on what has worked well within local alliances and at an Essex and Sustainability and Transformation Partnership level

2.2 Ask the Essex Tactical Co-ordination Group for Health and Care to share learnings across STPs and identify any priority areas for progressing together at a pan-Essex level

3 Summary of issue

3.1 The Covid-19 pandemic is an unprecedented event in health and care and in society. It has had a significant impact on services and has been the biggest impact on British society and the economy since the Second World War.

3.2 Covid led to a rapid and necessary change in some priorities and processes. It also necessitated close co-operation and collaboration between the public, private and voluntary sectors in order to meet the challenges posed.

3.3 Health and care systems (via Sustainability and Transformation Partnerships) are undergoing processes to identify learnings and what has worked well so we can build on and maintain new best practice. This paper sets out some early reflections to share with STPs.

4. Developments during Covid-19

4.1 There have been several areas of positive joint-working during the Covid crisis and the below is just a summary of some of the key examples.

A. Hospital discharges

New national guidance was implemented quickly and there was a move to 7-day working for social care. All Essex hospitals were able to lower their occupancy levels to around 50-60% by mid-April, freeing-up bed capacity for Covid-19 patients. This was crucial because at the height of the crisis, Essex hospitals were operating at around 3 times the normal level of people in intensive care as they struggled with rising Covid demand.

The new process has been more joined-up and has helped implement a new 3 hour discharge process, effectively eliminating delays and significantly reducing average length of stay in hospitals. There has also been positive work in the North East system to track discharge outcomes and to ensure that people are supported to live as independently as possible, ensuring that a higher proportion of discharges are supported by short-term care and reablement services rather than require (avoidable) long-term or permanent stays in residential care homes.

However, there is also evidence that in some areas faster discharge is leading to an increase in the proportion of people heading into long-term residential care. While this could be due to higher levels of need (post Covid), it also indicates there is further work to do between partners to embed the principle of “Home First” and to support and promote independence.

There also remains uncertainty about what will happen when the current funding arrangements end and there will need to be close partnership working between local authorities and the NHS on the succession / transition arrangements.

B. Local care home hubs and Infection Control Plan

Partners developed five multi-agency local care home hubs across Essex (involving social care, NHS, public health, Care Quality Commission) to provide advice and support to care homes to assist them with infection control and the management of any outbreaks. Each home has a named contact. Local hubs identify the homes that need to be prioritised for testing of all staff and residents. All homes are currently risk assessed weekly and contacted regularly - with daily contact for those considered most at risk. This work has helped to successfully prevent the further spread of Covid in Essex care homes and these have significantly reduced since they peaked in mid-April and helped ensure that care homes in Essex have been less affected by outbreaks than in some neighbouring areas.

C. Essex Welfare (now Wellbeing) Service and Operation Shield

Essex County Council worked with Provide (an NHS community interest company) to launch the Essex Welfare Service (EWS) to facilitate the provision of shopping and medicines to shield those unable to access direct support from central government, family, friends or local community groups. This was achieved through community pharmacies, Red Cross and a new bank of shield volunteers, attached to a county wide network of community hubs that were mobilised through Borough and District councils. This service

provides a single point of contact for residents who are unable to get the help they need to keep safe. So far over 9,000 people have been supported by the service.

Twelve community hubs were established to provide shielding services, resourced by district and borough councils and through existing Community Voluntary Sector (CVS) partnerships. EWS referred requests for support onward to the community hubs who then assigned these tasks to be fulfilled by their local bank of DBS--checked volunteers. From April, the hubs have also been tasked to contact over 60,000 additional Category A (most vulnerable) residents as identified by NHS England, to confirm their shielding needs and carry out welfare checks. This has been a considerable undertaking by the local teams with limited resource and has been a testament to effective partnership working.

Partners need to consider how to build-on what has worked and develop a sustainable model, strengthening links with primary care networks.

D. Digital and care technology

There has been rapid introduction of 'digital first' approach across the NHS and public services and a much-expanded use of video and telephone based clinical contacts with both patients and primary care. This has also supported a significant reduction in attendances at hospitals.

Essex County Council took an urgent decision to work with Alcove and ReThink Partners to roll-out up to 2,000 care tech phones to vulnerable people to give them new means of staying connected to their care support and to their loved ones. The roll-out has been done in conjunction with key system partners.

Essex County Council has also worked with Sports for Confidence (who provide sports activities for those with physical disabilities and learning disabilities) to introduce a new *Stay Connected Service*, ensuring that people can still access these services remotely.

For many people during lockdown, technology has been absolutely critical to their mental and physical wellbeing. The crisis has increased the importance of ensuring that we are technology and digitally-mature.

E. Service user insights

System partners are working to gather insights from service users and patients about the impact of Covid and the lockdown.

Some initial insights suggest that the impact has often been mixed. For some people, not being able to access key services has been damaging and stressful. It was predicted early-on in the crisis that lockdown would likely lead to an increase in mental health problems and the early evidence suggests that has been the case. Demand for assessments under the Mental Health Act have increased as a result of Covid. We are still working on data but believe this could be a 15 – 20% increase from this time last year.

By contrast, we have heard and seen that some of our service users / vulnerable groups have flourished more during lockdown and have been less stressed. While some adults with learning disabilities have missed seeing their friends during the necessary closure of day centres, others have enjoyed the greater freedom and choices that providers have made available to them to fill the void. This is an area where technology seems to have opened-up new opportunities for people.

In short, it is crucial that we seek people's views and don't assume that the way we operated pre-Covid was fit-for-purpose.

F. Data and analytics/system capacity

System partners have prioritised the collection and use of data and analytics to help respond to the crisis and inform future planning. This has included sharing operational capacity challenges and constraints (beds, workforce, personal protective equipment supplies etc) and working together jointly on future forecasts for demand for different types of health and care services. This can strengthen our future approach to system resilience and winter planning.

Essex local authorities and CCGs have also established a new Tactical Co-ordination Group with the NHS, public health, and with Southend and Thurrock councils to oversee community care capacity planning. This group is overseeing future forecasting of demand for services (NHS, residential, homecare etc), as well as supporting mutual aid approaches between the councils. This co-ordination group has proved beneficial at ensuring greater collaboration and co-operation between councils and the NHS and between the 3 STP systems and will continue going forward as an informal liaison group between councils and the NHS / STPs.

It will be important to build on and push for further improvements in management information and data-sharing, not only locally but also with regional and national bodies where relevant.

G. Local alliances

The North East Essex Alliance (bringing together NHS, local authority and voluntary and community sector organisations) worked on a number of partnership initiatives including:

- Investment in all three Suffolk and North East Essex hospices to coordinate all End of Life out of hospital care including 24/7 advice lines
- EPUT and NSFT launched new 24/7 mental health lines in both Essex and Suffolk for all ages to provide support to local residents
- Planned and mobilised range of VCS support offers for children, young people and their families

5. Next steps and recommendations

5.1 Agree that Sustainability and Partnerships (STPs) work to identify and build-on what has worked well within local alliances and at an Essex and Sustainability and Transformation Partnership level

4.2 Agree that the Essex Tactical Co-ordination Group for Health and Care is asked to share learnings across STPs and identify any priority areas for progressing together at a pan-Essex level

Report title: Preventing and mitigating the psychosocial impacts caused by the pandemic and economic shocks	
Report to: Essex Health and Wellbeing Board	
Report author: Paul Burstow, Independent Chair, Hertfordshire and West Essex ICS	
Date: 15 July 2020	**For:** Discussion
Enquiries to: paul.burstow@nhs.net	
County Divisions affected: All Essex	

1 Purpose of Report

1.1 To support a discussion on the need to anticipate and respond to the cascade of compounding psychosocial risks triggered by the Covid-19 pandemic and economic shocks.

2 Recommendation

2.1 For consideration and discussion

3 Summary of Issue

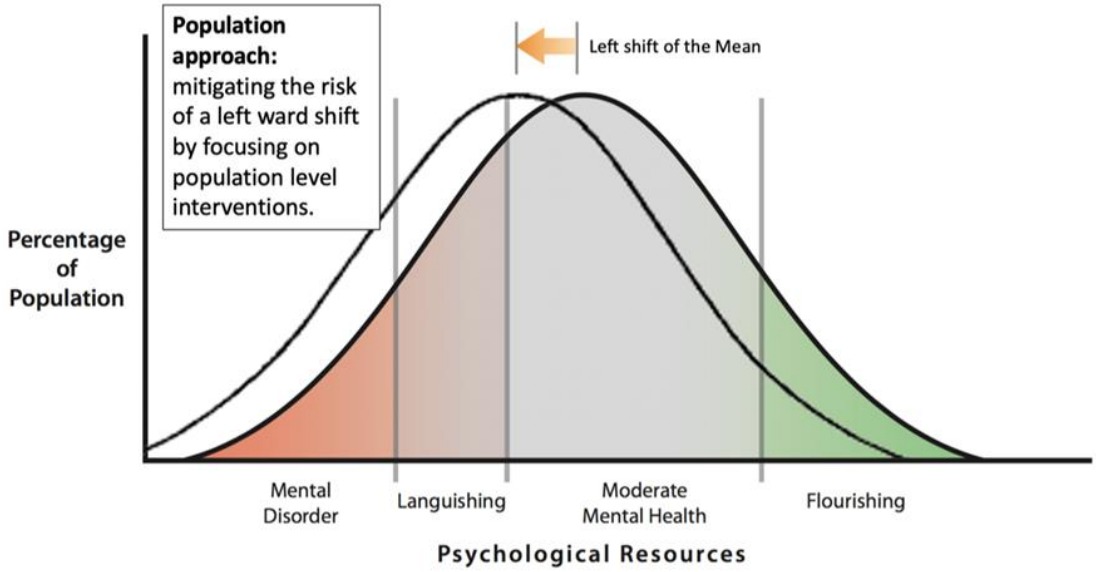
3.1 Included below is the text of an email from Paul Burstow to the Chairmen of the Essex and Hertfordshire Health and Wellbeing Boards. It is intended to form the basis of a discussion on the need to anticipate and respond to the cascade of compounding psychosocial risks triggered by the Covid-19 pandemic and economic shock.

Dear Richard and John,

I am writing to you both to raise with you the need to anticipate and respond to the cascade of compounding psychosocial risks triggered by the pandemic and economic shock.

I had a very helpful call with Jane Halpin, Jim McManus and Peter Fairley to share my thoughts and seek their advice. I agreed as a result of the call to write to you as the Chairs of the Essex and Hertfordshire Health and Wellbeing Boards to share my thoughts.

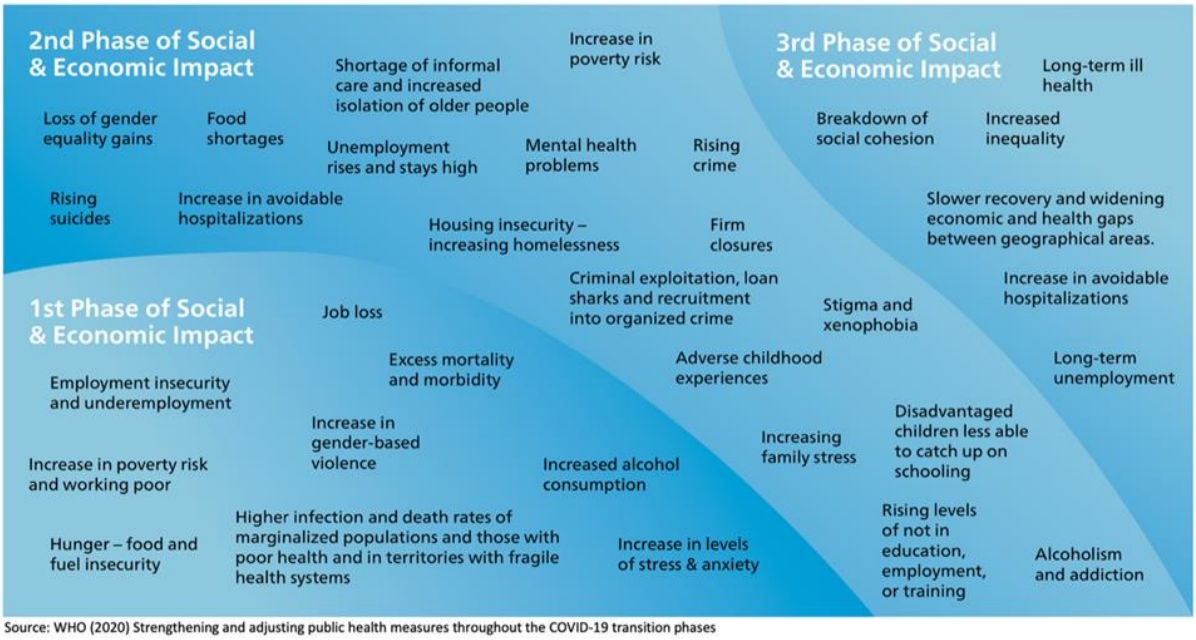
There is a growing recognition that Covid19 and the economic and social shockwaves that it has triggered is having significant psychosocial impacts. It is likely that the global impact will be to shift the wellbeing status of whole populations in a negative direction (see figure below) with a resultant increase in the full spectrum of mental health needs from the natural reactions to a traumatic experience to clinical disorders.



Based on a figures in Huppert et al. (Eds). The Science of Well-being

The response to this has to be more than a healthcare response, I would call this an everything and response. It requires actors in Government (national and local), civil society and business to understand the risk, be guided by the evidence and have the signposts and supports necessary to minimise the size of the adverse shift in population wellbeing and mitigate the consequences of the shift.

The UN has issued a briefing on the mental health impacts of Covid, although this does not address the likely impacts of the recession triggered by the pandemic. New Zealand has published a strategy and Australia have published plan. The UK has taken a number of measures that would form part of a strategy but as yet has not publicly acknowledged the need for such a strategy. The chart below from a very recent WHO report, sets out the sorts of impacts that might be expected.



Source: WHO (2020) Strengthening and adjusting public health measures throughout the COVID-19 transition phases

My strong view is that there is no need to wait for national strategy to begin to act. There is clearly no single 'magic bullet' that will flatten the curve of the 4th wave but a sharing of insights, actions and resources would be a good place to start. It will need multiple actors to play their part and feel empowered to do so. There is already within your public health teams the knowledge of the risk and protective factors behind mental health and wellbeing. For most of the population the response won't be about a service or treatment it will be about the social scaffolding and making the resources and tools widely available to help people to cope, maintain and build resilience.

So I wanted to ask how we might work together to

1. engage with partner organisations - civil society, business, voluntary sectors - to put in place the necessary scaffolding;
2. learn lessons from how our different agencies have supported people already on our books and what this might mean for responding to emerging need;
3. anticipate which places and populations are at greatest risk, and how the pandemic may have changed this;
4. agree how the idea of anchor institutions might be applied to meeting this challenge; and
4. agree some common pubic mental health messages.

As a next step a discussion on these issues at your Board would be very helpful to get a wider view and give these issues greater prominence. I would also like to suggest that we organise a Prevention Summit(s) (webinars) to get the word out.

With best wishes

Paul

Rt Hon Paul Burstow
Independent Chair
Hertfordshire and West Essex ICS

Agenda Item 8
HWB/12/20

Report title: Wider determinants of health: to consider priorities in population health	
Report to: Essex Health and Wellbeing Board	
Report author: Dr Mike Gogarty, Director of Wellbeing, Public Health and Communities	
Date: 15 July 2020	**For:** Discussion
Enquiries to: Mike Gogarty , Director Wellbeing, Public Health and Communities, Essex County Council. Mike.gogarty@essex.gov.uk	

1. Purpose of Report

1.1 To support discussion among Board members of the key issues that will impact on health over the next few years, and, from that, consideration and agreement of priorities for population health. Board members are referred to the more detailed report in the appendix to help their considerations.

2. Recommendations

2.1 That the Board note the wider impacts of Covid on Essex and its implications for public health and the wider determinants – as outlined below and in appendix A

2.2 That the Board agree a set of priorities for the Essex system

2.3 That the Board consider its role in both the short and medium term in ensuring the key agreed priorities can be tackled by the wider system.

2.4 That, on the basis of the above recommendations, the Board reflect on whether the existing Joint Health and Wellbeing Strategy remains fit for purpose.

2.5 That the Board note that we are likely to suffer a recurrence of Covid with a need for further preventative measures at the end of this calendar year.

2.6 The Board note that greater insight is required to understand Covid-19's impact on health inequalities and support a partnership approach to developing this work.

3. Background

3.1 The Board are very aware there is a social gradient to life expectancy and people's health is adversely impacted by a range of wider determinants There is a large and growing gap between the most and least deprived districts in Essex; more

than 123,000 people in areas which are amongst England most deprived, which has more than doubled over the last ten years.

3.2 The Board are well versed in the importance of wider determinants of health. These include socioeconomic factors including material wealth, education, employment and loneliness which account for around 40% of health impacts. Another 30% are driven by lifestyle choices including diet, exercise, tobacco, alcohol and substance misuse. The next 20% relates to access to healthcare and services.

3.3 Covid is likely to have a profound and long-lasting impact on the health and wellbeing of the people of Essex. The Board have clear existing priorities and strategy with focus on mental health, wider determinates, lifestyles and older people and people with disabilities underlined by and all age approach. It is suggested that these priorities remain apposite, but the range of actions requires under the Board to deliver agreed improvements may need to be revised, and as we move through the different stages of recovery, a greater commitment and oversight by the Board to collectively shape and measure the impact of these actions on health and life expectancy.

3.4 While the impacts of the virus on communities has been profound everywhere, the impacts in terms of wider determinants are likely to be worst felt in areas of existing deprivation with loss of work and less access to useful home education. There will also be high levels of poor mental health following the outbreak as a result of the socioeconomic impacts of the disease.

3.5 In addition to historical areas of need we must also be aware of areas dependant on industries hit hard by the outbreak. These will include the airline industry around Stansted.

3.6 The coronavirus outbreak has had unprecedented impacts on health and society. The impact on health across the population, and in local systems is complex and not yet fully clear. It is important to note we remain in the grip of the virus and a future scenario with a return to higher levels of infection with rigorous lockdown remains.

3.7 The likely proportion of people who have had the virus nationally has been between 3 and 15% by region. In Essex the figure would be between 5 and 10% likely increasing from north to south.

3.8 Whilst the future disruptions from COVID-19 are still unknown, the likelihood is that the pandemic will continue to have a devastating impact on the lives of many. The likely impact on deaths is complex, but could include:

i) Increase in deaths as a direct result virus infection in short term which could increase again

ii) Increase in deaths in short to medium term through people presenting late to services or not undergoing required interventions.

iii) Long term increase in deaths through negative impact of wider determinates of health. These will tend to fall most heavily on already deprived populations.

iv) There may also be a short-term reduction in deaths in frail older people as a result of coronavirus infection having hastened demise in this group.

3.9 Key areas where indirect coronavirus impacts need to be considered therefore include:

a. Material wealth and employment
b. Best start in life and education
c. Mental health and isolation
d. Lifestyle choices

These are detailed in the Appendix

4. Issues for consideration

a. Financial implications

As this is a discussion piece there are no direct financial implications arising from this report.

b. Legal implications

There are no known legal implications arising from this report

5. Equality and Diversity implications

5.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful
(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.
(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

5.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that ‘marriage and civil partnership’ is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

5.3 The report is an update of current planning arrangements; each planning group will be responsible for equality impact assessment of any intended plans.

Appendix: Wider determinants of health; to consider priorities in population health

1. Specific Areas for Consideration

1.1 The wider impacts of Covid on Essex and its implications for wider determinants (section 3)

1.2 Support for local communities around the impacts on material wealth through role as anchors as previously discussed (section 4)

1.3 Securing the best start in life and educational opportunities including work with schools and FE and around apprenticeships (section 5)

1.4 Ensuring a holistic approach to improved mental health with a focus on support around underlying drivers including debt, employment, loneliness, loss and housing (section 6)

1.5 Consideration of lifestyle choices during, and in the aftermath of, Covid, with the impact on issues such as physical activity, diet, drug and alcohol abuse and smoking (section 7).

1.5 With all of the above, consideration that we are likely to suffer a recurrence of Covid with a need for further preventative measures at the end of this calendar year.

2 Context before Coronavirus

2.1 Developments in Public Health and healthcare have had a significant impact on the population's health; people are living longer lives. However, these improvements are beginning to slow and on average over 20% of years lived are expected to be in poor health.[1]

2.2 The risk of developing long term conditions increase as people age; the latest figures for disability free life expectancy are 62 years for women and 63 for men.[2] Long term conditions, such as dementia, are key challenges for population health and in sustaining independence.

2.3 Whilst these issues are risks for the whole population there is a social gradient to life expectancy and people's health is adversely impacted by the place in which they live.[3] There are growing areas of society facing entrenched poverty and deprivation which impact adversely on people's health.

[1] Department of Health and Social Care, *Advancing our health: prevention in the 2020s* (Prevention Green Paper), July 2019
[2] The King's Fund, *What is happening to life expectancy in the UK?*, October 2019
[3] The King's Fund, *What is happening to life expectancy in the UK?*, October 2019

2.4 There is a large and growing gap between the most and least deprived districts in Essex; more than 123,000 people in areas which are amongst England most deprived, which has more than doubled over the last ten years. There is a consistent and marked decline in areas such as Tendring, which is falling faster and further behind the rest of the country.[4]

2.5 The Board are well versed in the importance of wider determinates of health. These include socioeconomic factors including material wealth, education, employment. They are especially important in the early years of life. Social networks are also important. This group account for around 40% of health impacts. Another 30% are driven by lifestyle choices including diet, exercise, tobacco, alcohol and substance misuse. The next 20% relates to access to healthcare and services

3 Coronavirus and health impacts

3.1 COVID-19 is likely to have a profound and long-lasting impact on the health and wellbeing of the people of Essex. The Board have clear existing priorities and strategy with focus on mental health, wider determinates, lifestyles and older people and people with disabilities underlined by and all age approach. It is suggested that these priorities remain apposite, but the range of actions requires under the Board to deliver agreed improvements may need to be revised, and as we move through the different stages of recovery, a greater commitment and oversight by the Board to collectively shape and measure the impact of these actions on health and life expectancy.

3.2 Age is the single biggest risk factor of serious illness from COVID-19, but we know the existing inequalities prevalent before COVID have been amplified.

3.3 COVID-19 deaths disproportionately occur in the elderly, male, and BAME populations. Ethnicity is unlikely to be the sole cause for these deaths. Ethnicity has strong links to the wider determinants of health – employment & the types of work available, quality of housing, and financial security. These socioeconomic factors may have an influence in driving the higher number of BAME deaths

3.4 COVID-19 has had a proportionally higher impact on the countries most deprived areas vs the least deprived. The age-standardised mortality rate of deaths involving COVID-19 in the most deprived areas of England was 55.1 deaths per 100,000 population compared with 25.3 deaths per 100,000 population in the least deprived areas. On average, there are 36.2 deaths involving COVID-19 per 100,000 people in England and Wales.

3.5 As more people become unemployed the economic effects will transmit from vulnerable businesses to vulnerable households and have a further knock-on effect on public services and people's health and wellbeing. Considering the

[4] Essex County Council (Data & Analytics, Research & Insight), *Changes in the Index of Multiple Deprivation for Essex: IMD 2019*, November 2019

most significant structural factors affecting deprivation before COVID-19 was income and employment, the potential for further decline is substantial.[5]

3.6 The coronavirus outbreak has had unprecedented impacts on health and society. The impact on health across the population, and in local systems is complex and not yet fully clear. It is important to note we remain in the grip of the virus and a future scenario with a return to higher levels of infection with rigorous lockdown remains.

3.7. There are a wide number of scenarios around coronavirus in the near future~

1. The disease goes away – there are examples historically in which diseases have gone away for reasons that were unclear. This is highly improbable here. Of note the Antipodes are seeing very little seasonal flu as the prevention measures for coronavirus also stop flu
2. Winter peak – the rate of transmission will be low and stay low (hovering below 1) through summer and early autumn period, before a peak or surge of COVID-19 cases over winter. This is the most likely scenario.
3. Further waves – if there is a second wave travelling around the world, it is more likely to hit the northern hemisphere over the winter months
4. We lose control – this will happen if we release the social distancing measures too fast**.** This could trigger a pandemic wave

It is important the Board note we have **not** been exposed to a pandemic wave. This would happen if the disease had swept through the population attacking 80% of people as initially proposed. This would have led to half a million deaths but rendered survivors immune to subsequent waves.

The likely proportion of people who have had the virus nationally has been between 3 and 15% by region. In Essex the figure would be between 5 and 10% likely increasing from North to South.

3.8 Against this background we need to determine impacts on health and services. The coronavirus will be with us for some time and will inevitably impact widely on health, wellbeing and have wider implications for independence. In the short to medium there will be people who are vulnerable because of their presenting health or social care need, but those who will be at risk from becoming vulnerable because of the impact from COVID 19, this is likely to change over time and the danger is that it will deteriorate. Systems need to understand the sectors, places and people who are most likely to be impacted by the evolving COVID-19 to target resources effectively

3.9 Whilst the future disruptions states from COVID-19 are still unknown, the likelihood is that the pandemic will continue to have a devastating impact on the lives of many. The likely impact on deaths is complex:

a) Increase in deaths as a direct result virus infection in short term which could increase again

[5] https://www.birmingham.ac.uk/news/thebirminghambrief/items/2020/03/contagion-the-economic-and-social-Impacts-of-COVID-19-on-our-region.aspx

b) Increase in deaths in short to medium term through people presenting late to services or not undergoing required interventions.

c) Long term increase in deaths through negative impact of wider determinates of health. These will tend to fall most heavily on already deprived populations.

There may also be a short-term reduction in deaths in frail older people as a result of coronavirus infection having hastened demise in this group.

3.10 Key areas where indirect coronavirus impacts need to be considered include~

- Material wealth and employment
- Best start in life and education
- Mental health and isolation
- Lifestyle choices

4 Material wealth and employment

4.1 This is both the key driver of health and wellbeing and the area most impacted on by coronavirus. It is also clear that those at highest risk of the disease itself including those in deprived communities and from BAME groups are often those most likely to be additionally exposed to increased financial pressure and uncertain employment. This is very difficult to manage and balance and the governments approach to the pace of relaxation of lockdown and its approach to social distance is informed by the need to start to reduce the wider impact on these groups.

4.2 Action in this area is key to improving future health. While many people have been negatively impacted economically, it is clear that those areas with higher levels of exiting deprivation are harder hit. It is also clear that the true impact and course of the economic depression can not yet be estimated and may get considerably worse over the medium term

4.3 The Board will wish to consider how it can ensure progress in this area. Key areas would include strong corporate focus in all public sector bodies in developing their role as Anchor Organisations with focus on~

- Increasing local employment including work with targeted schools and a clear approach to skills, apprenticeships and training
- Local procurement
- Social value in procurement including focus on suppliers in turn commissioning locally and providers support for key vulnerable groups in the workplace.

4.4 The Board will wish to consider its role in this and how we can ensure strong progress

4.5 There is also a need to ensure strong financial support to those who find themselves in increased hardship. This will be in part driven by the voluntary

sector. The board will wish to ensure that there is a wide range of accessible support to local communities.

4.6 This will include ensuring accessible quality advice on debt and finances through organisations such as CAB, role out of the Healthier Wealthier Children approach and enabling development of community initiatives including uniform banks and foodbank and holiday hunger initiatives

4.7 The Board will wish to ensure strong links between member organisations and training partners including Adult Community Learning to develop, with focus on areas of most need, specific projects to improve skills and access to public sector opportunities. The proposed Clacton Health and Care Campus should be a priority.

4.8 The Board will recognise the higher health needs in deprived groups and the need to ensure high quality and appropriate capacity of accessible health and care service are available. This will involve best matching of resources to need with a particular focus on primary care to address any “inverse care law”. This may involve conscious reallocation of resource.

5 Best Start in Life and Education

5.1 Support during pregnancy, new birth and early years has remained generally consistent with pre covid activity thanks to a good service response to covid by the Essex Child and Family Wellbeing Service (ECFWS), working in conjunction with other partners such as the Clinical Commissioning Groups. Antenatal visits, new birth visits and other mandated health visitor checks have remained consistently above target levels, albeit with some of it being undertaken virtually rather than face to face in line with national guidance.

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5.2 Before covid the universal Healthy Child Programme activities undertaken by ECFWS had identified priority groups at risk of not achieving health and wellbeing outcomes and were targeting these. Many of these groups are those at increased risk of covid as referred to in 5.2 above and will continue to be targeted as those in relatively greater need. However, identifying newly created covid need remains a challenge, and requires a co-ordinated approach across agencies in Essex dealing with covid..

5.3 The Education directorate are currently supporting providers whom are responsible for immunisations to access large volumes of children outside of schools as social distancing is making it very difficult to continue the programme within school buildings – there is a likelihood of some children have missed their immunisations including sexual health preventions

5.4 At the start of the lockdown period, approx. 85% of early years and childcare settings closed. This will have led to children’s routines and early learning experiences being disrupted. However, the majority of settings have done a

good job at keeping in touch with their families even when they were closed and supporting parents to continue with their children's early learning in the home environment. Some children of critical workers have needed to access a new setting to enable their parents to work, due to their usual setting closing and remaining closed. Most have made this adjustment well, but this has been very stressful for some children despite the childcare practitioners' best endeavours to make the transition as easy as possible.

5.5 It is highly likely that a number of the Essex Early Years and Childcare settings will either not re-open after covid 19, or will quickly become financially unviable and will close. This may lead to a shortage of early learning places for the under 5s and before, after and school holiday childcare in the coming months, which could also impact on parents ability to work

5.6 Proportionate universalism, whereby everyone gets some support, but those in greater need get greater support must continue. This is because a universal service, such as the Essex Child and family Wellbeing Service as the "first line response" It is imperative that front line practitioners continue to be responsive to need through universal service delivery as a safety net by which to identify those in the population who were not vulnerable pre covid but have become so. It will also be important to anticipate and predict where those with greater need are – it is anticipated that this cohort will grow due to redundancies ext. Some significant work going on in the JAMs world to understand this and to make sure holiday provision are in place during the summer holidays

5.7 Two different types of information to define need must be co-ordinated going forward – firstly information on new presenting need from front line practitioners, particularly where that new need is amongst groups not normally defined as vulnerable, and secondly information from desk top research on groups known to be vulnerable for whom need is likely exacerbated through covid. This applies across the whole Essex population, but is particularly important in terms of early intervention and prevention of problems for children and families starting out in life. Our school partnership network is important with this – as schools will already know who these children and young people are and supporting schools to support these children could mean we are in there before these children become known to frontline services

5.8 Schools have implemented a hierarchy of protective measures but the risk cannot be entirely mitigated. They have the support and advice from the ECC and Public Health teams to prevent/ contain any outbreaks within schools. 2 schools in Essex are also taking part in the national study into the prevalence of covid within primary schools, which should provide some insight into the role of children/schools in the transmission of the virus.

5.9 An implication of school closure has been a reduction in quality and access to healthy meals . The Free School Meals voucher scheme assisted with access to funds but supermarket vouchers may not necessarily have been spent on healthy food (or any food!). The Free Fruit and Veg scheme also ceased over the covid response period and there is no news on this for the Autumn term. These factors, along with a majority of children being out of school and not

necessarily being active could contribute to a rise in childhood obesity. The Free School Meal voucher scheme has now been extended to cover the summer holiday and Active Essex are planning to run summer programmes.

5.10 The impact of school closures is going to be a major issue going forward. We are currently canvassing schools to understand what their approach is going to be to make sure children 'catch up'. We already know that those disadvantage children would not have had access to technology to access the full curriculum on offer. The government provided us with some laptops that had now been distributed to children in schools. However the Further Education providers made it clear are young people in FE colleges which would not have qualified for this scheme and therefore still do not have the means to access the curriculum on offer. We also know young people in colleges will be adversely affected by not having access to the work market and therefore this could lead to the increase in our NEET numbers with all the added complications this entails. Additionally children in groups where parents less value education are less likely to have been encouraged and supported around home schooling with likely widening of inequality of opportunity.

5.11 It is also worth noting those children who are in our alternative provision – they are already disadvantaged by not being on a full time timetable and in this time having to find provision which meets their individual needs will become increasingly difficult – although we have systems in place to check these children and young people are safe their access to education might have been seriously compromised

5.12 This year's curriculum has been impacted and so some schools may have struggled to do certain subjects remotely, such as sexual health, which may have increased risk of teenage pregnancy and also reduced access to pastoral support around this issue. Schools were due to implement a new Relationships, Sex and Health Education (RSHE) curriculum from Sept but have now been given flexibility about how and when they do this which may have a further impact, particularly when combined with School Nurse drop ins being less available during school closures, even though School Nurses have continued with virtual support.

5.13 Emotional Wellbeing as a result of covid is a significant concern for schools. The ECC education team have provided a lot of support, training and guidance to schools about MH and wellbeing through the 'Let's Talk Recovery' package. There may also be an element of developmental delay caused by a significant period of time out of school and away from peers and teachers, with an associated knock on impact to the statutory SEND system if more CYP are identified with moderate learning needs. This is a current focus of the SEND improvement work following the recent Ofsted inspection

We are also worried about the emotional wellbeing of the teachers and head teachers. The education workforce have been dealing with the trauma of the children and their communities whilst trying to put things in place to ensure children are safe and provision continue – Education workforce fatigue (also emotionally) should be considered when thinking of the impact of Covid 19

5.14 Children and young people may have missed their usual therapeutic provision,
speech and language therapy, OT and physiotherapy. Knock on impact of this is not yet known. This is a focus of the Reasonable Endeavours work. There may also have been a reduction in children/ young people accessing A&E which could have a knock on impact if families were fearful of accessing A&E because of the perceived risk of COVID19 and as such have missed opportunities to access necessary health care. Messages have been promoted through the children and young people system on the importance of continuing to access the health care they need when they need to .

5.15 It is worth considering what comprehensive support can continue to be in place to support schools through this – it is mentioned elsewhere that some schools are involved in research and the education and public health team are supporting schools now. This may have to be in place for a long time to come – the interpretation and localising of national policy takes most of the education teams time – supporting head teachers to think things through and providing supportive challenge to those who are not able to provide the provision has become the day job of our teams. Children with SEND needs are not going away either and the ECC SEND teams still have statutory requirements and timescales to adhere to – if the partnership (Health and Social Care) are not able to support these SEND teams need to meet statutory requirements then the inspection due in less than 18 months will be less good

6 Mental health and isolation

6.1 Academic research from previous emergencies suggests that the height of demand for mental health support occurs after the immediate crisis abates, with some evidence suggesting that this peak can be anticipated in between 2- and 36-months' time.

The root cause in many cases will be loss; of routine, employment, financial stability, relationships (including within the family home), loved ones and as a result of prolonged isolation, opportunity. Many of those suffering will not previously required support

There will also be a cumulative effect on people with pre-existing conditions, as recovery and support will have been unsettled, causing further trauma to those who are already vulnerable.

6.2 Specialist mental health services will face these challenges with a workforce physically and psychologically drained from working through the peak of the pandemic.

6.3 However, the Covid-19 emergency has served to further highlight some of the assets and opportunities that might be mobilised as part of solution(s) to these issues. Amongst these are:

- The utilisation of community volunteers and neighbourhood-based support offers
- The use of technology for efficient remote working
- The focus of partners and providers on strong collaboration to achieve common goals, including through links to the Humanitarian Assistance Plan and associated structures.
- The ability of non-specialists to support with root-cause issues which may cause mental ill-health or emotional distress (debt, subsistence, housing).
- Routes and channels for strong population self-care messaging

6.4 There will need to be systems in place to offer support to people with mental health issues who would not historically contacted services as well as practical support and advice to help with underlying precipitating factors eg debt support.

6.5 Helping people with mental health issues to remain at work is a key element of the new Service as well as helping people back to work. This work will be especially critical

6.6 The Board is asked to note the proposal to extend the Covid-19 Mental Health & Wellbeing Forum arrangements to encompass a wider remit on prevention and wider determinants of mental health with this extended part to be chaired by the Director of Public Health.

7 Lifestyle choices

7.1 It is hard as yet to understand the implications of coronavirus and lockdown on people's lifestyle choices and impacts may be inconsistent.

7.2 In some instances working from home or furlough has enabled people more time to undertake physical activity and indeed exercise has been encouraged. The data from the State of Life and the Sport England suggests that while those in more affluent areas have been more physically active, deprived communities have struggled to maintain previous levels and have not benefit in to the same extent. It seems that positive action in this area has been more common in less deprived groups. It is not clear the impact of leisure centre and gym closures as some users would have been motivated to seek alternatives. Walking, running and cycling have all increased as a result.

7.3 In other cases restrictions and closures have reduced physical activity eg mother who would walk children to nursery or school. Similarly it is likely many children will not have benefitted from either recommended level of exercise through schools nor specific initiatives such as the daily mile.

7.4 Active Essex have worked to support a range of activities to encourage physical activity in lockdown. This has supported the national focus in this area, via

Sport England and statements from the CMO around importance of physical activity. There has been a strong focus on behaviour change in this messaging that can be built upon and grown, locally in Essex.

LDP Pilot early learnings show the impact of behaviour change, social movements and the benefits of online communities/ Covid facebook group as an example. Programmes and initiatives will need to be locally targeted, working with communities, adopting proportionate universalism principals. Asset Based Community Development is are proving effective during Covid response and can be upscaled. The Board is asked to support this as a priority. More on line activity (eg - Joe Wickes Body coach and Keeping Essex Active Youtube channel) will be appropriate in future with more flexible and home working. The future of the traditional health and fitness sector is uncertain currently. Active Essex colleagues are supporting this reset/ reopening with Sport England. We will need to step up initiatives such as the Daily Mile when schools return although school priorities may have changed.

7.5 It is possible that people may have been eating more in lockdown and there will have been less opportunity for mutual weight loss support as well as less direct Tier 2 opportunities. We will need to assess the likely impact, certainly our activity in supporting weight loss has declined considerably. Additionally the lifestyle service availability has reduced and this, together with fewer face to face and lifestyle focussed GP consultations has impacted on efforts to increase Primary care referrals to the service who are overweight and erefore at risk of diabetes

7.6 ECC PH will need to step up community weight loss services now that community halls have opened and strengthen on line offer. Diabetes prevention will be considered by the Board at the next meeting as part of a wider approach to diabetes.

7.7 The impact of Coronavirus and lockdown on alcohol use is not yet clear. Services moved on line effectively for those misusing substances but anecdote suggests an increase in referrals to services around alcohol misuse. It may be necessary to increase service capacity should need have increased. Once lockdown is relaxed drug markets will free up, availability will “improve” and people will party. We could see a spike in both Drug Related Deaths and occasional/problematic use.

7.8 While demand for smoking cessation services have declined hugely during the pandemic, smoking prevalence remains on a downward trajectory overall and the impact cessation services to overall performance is not clear. There may have been some difficulty in nicotine users accessing vape products as high street vape shops closed but the impact of this on tobacco use is not clear. It is not likely any specific additional focus will be required in this area.
Smoking cessation support in Essex moved to on line and telephone support since the end of March. It experienced an increase in self referrals during April no doubt due to concerns around respiratory issues. It would appear that whilst some people are using the pandemic as an opportunity to focus on their health

and quit habits like smoking, however there are undoubtedly some who have turned to smoking in order to cope. YouGov's COVID-19 tracker suggests 2.2 million people across the UK are smoking more than they were before lockdown.

By maintaining on line and telephone support clinics we can sustain capacity and are using social media campaigns such as #quitforcovid to emphasis the benefits of quitting particularly at this time. Consideration should also be given to the effects of COVID on those who suffer with mental ill health given they are much more likely to smoke than the general population

7.9 We are yet unclear as to the effect of Covid -19 social distancing on STI rates. Whilst the opportunity for close contact was reduced, so was the opportunity for those that were infected to be tested and treated. Many Essex residents attend large London hospitals for STi screening whilst working in London and we await both attendance and STI data from PHE.

The COVID pandemic necessitated a reprioritising of clinical delivery with a refocused response on critical services. Many sexual health services across the country stopped or significantly reduced. The Essex Sexual Health Service rapidly adapted its centralised access, electronic records and telephone triage process to maintain and expand all online services, adapt to safer medicine collection systems and provide direct contact for those who required it

Triage will be enhanced through virtual consultation and assessment, resulting in a far greater focus on clinical need before any direct contact, did not attend rates (Historically poor in sexual health) will be improved and therefore service efficiency We are also exploring a range of remote imaging and diagnostic software and systems to support the development of further virtual work

Health and Wellbeing Board Forward Plan 2020-21

September	**Item No**	**Agenda Item**	**Lead Officer**	**Summary/Comments**
Wednesday 16 September	**1a**	Suffolk and NE Essex ICS	Susannah Howard	
	1b	West Essex and Hertfordshire ICS	Dr Jane Halpin	
	1c	Mid &South Essex HCP	tbc	
	2	Diabetes: prevention and Mid and South Essex HCP Framework	Mike Gogarty / Tricia D'Orsi	Deferred from March
	3	Prevention – review the role of the Prevention Group (in accordance with the desire not to have too many bodies)	Mike Gogarty	September 2020 (18 months from March 2019, as requested by Board at 20 March 2019 meeting)
November	**Item No**	**Agenda Item**	**Lead Officer**	**Summary/Comments**
	Joint Health and Wellbeing Strategy Area of Focus:			
8 November	**1a**	Mid &South Essex HCP	tbc	
	1b	Suffolk and NE Essex ICS	Susannah Howard	
	1c	West Essex and Hertfordshire ICS	Dr Jane Halpin	
	2	Learning Disabilities Mortality Review (LeDeR): Southend, Essex and Thurrock End of Year Report 2019-20	Rebekah Bailie, Commissioning Manager, ECC	Annual Report – last submitted July 2019
	3	HWB Scorecard Q4 2019/20	Sean Maguire	Regular report – March, July & November
Jan 2021	**Item No**	**Agenda Item**	**Lead Officer**	**Summary/Comments**
January 2021	**1a**	West Essex and Hertfordshire ICS	Dr Jane Halpin	
	1b	Mid &South Essex HCP	tbc	
	1c	Suffolk and NE Essex ICS	Susannah Howard	
	2	Falls Prevention	Maggie Pacini	Update based on report to January 2020 meeting (requested 29 January 2020)