Phil Norrey
Chief Executive

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To: The Chair and Members of the Health and Wellbeing Board

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

(see below)

Your ref :
Our ref :

Date : 8 July 2020
Please ask for : Stephanie Lewis 01392 382486

Email: stephanie.lewis@devon.gov.uk

HEALTH AND WELLBEING BOARD

Thursday, 16th July, 2020

A meeting of the Health and Wellbeing Board is to be held on the above date at 2.15 pm to consider the following matters. This will be a virtual meeting, for the joining instructions please contact the Clerk for further details on attendance and / or public participation.

P NORREY
Chief Executive

A G E N D A

PART I - OPEN COMMITTEE

1 Meetings Procedures and Etiquette
The Deputy Democratic Services Manager to present.

2 Election of the Chair

3 Appointment of Vice Chair

4 Welcome from the Chair

5 One Minute's Silence

6 Message of thanks from the Chair

7 Apologies for Absence

8 Minutes (Pages 1 - 8)

Minutes of the meeting held on 16 January 2020.

9 Items Requiring Urgent Attention

Items which in the opinion of the Chair should be considered at the meeting as matters of urgency.

10 Responding to the COVID-19 Pandemic (Pages 9 - 12)

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity outlining the local impact of Covid-19, (attached).

11 Priorities for Recovery

A discussion to be led by the Chief Officer for Communities, Public Health, Environment and Prosperity to include:

- Intelligence from the Joint Strategic Needs Assessment – a brief overview of the impact
- Review of the Joint Health and Wellbeing Strategy – areas include Wellbeing, Mental health, physical activity and Local health inequalities.
- Learning from Response – from all Board Members
- What positives have come out of the emergency – Partnership working, Agile use of the BCF, Hospital discharge arrangements, Community response and wider social capital, Co-production and New approaches to governance through online platforms
- Public Protection Priorities.

12 Local Outbreak Management Plan (Pages 13 - 32)

Report of the Director of Public Health (Chief Officer for Communities, Public Health, Environment and Prosperity) (PH/20/02) giving an update on the Local Outbreak Management Plan and the associated (non-statutory) governance arrangements, attached.

BOARD BUSINESS - MATTERS FOR DECISION

13 Devon Joint Health and Wellbeing Strategy: Priorities and Outcomes Monitoring (Pages 33 - 34)

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity, which reviews progress against the overarching priorities identified in the Joint Health and Wellbeing Strategy for Devon 2020 – 2025.

The appendix is available at https://www.devonhealthandwellbeing.org.uk/strategies/

14 Joint Commissioning in Devon, the Better Care Fund and Governance Arrangements (Pages 35 - 40)

Joint Report of the Associate Director of Commissioning (Care and Health) Devon County Council and NHS Devon CCG on the Better Care Fund (BCF), Quarter Return, Performance Report and Performance Summary on the BCF.

OTHER MATTERS

15 Scrutiny Work Programme

In order to prevent duplication, the Board will review the Council's Scrutiny Committee's Work Programmes. The latest round of Scrutiny Committees confirmed their work programmes and the plan can be accessed at;

http://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/scrutiny-work-programme/

16 Forward Plan (Pages 41 - 42)

To review and agree the Boards Forward Plan.

17 Dates of Future Meetings

Please note that dates of future meetings and conferences will be included in the Devon County Council meetings calendar. All future meetings will take virtually, unless otherwise stated.

Meetings
Thursday 8 Oct 2020 @ 2.15 pm
Thursday 21 Jan 2021 @ 2.15 pm
Thursday 8 Apr 2021 @ 2.15 pm

Members are reminded that Part II Reports contain confidential information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s).
Members are also reminded of the need to dispose of such reports carefully and are therefore invited to return them to the Democratic Services Officer at the conclusion of the meeting for disposal.

Membership

Suzanne Tracey (Chief Executive, RD&E), Councillor Andrew Leadbetter (Devon County Council) (Chair), Councillor Roger Croad (Devon County Council), Councillor James McInnes (Devon County Council), Councillor Barry Parsons (Devon County Council), Dr Virginia Pearson (Chief Officer for Communities, Public Health, Environment and Prosperity), Jennie Stephens (Chief Officer for Adult Care and Health), Jo Olsson (Chief Officer for Childrens Services), Dr Paul Johnson (Devon Clinical Commissioning Group), Jeremy Mann (Environmental Health Officers Group), Diana Crump (Joint Engagement Forum), Phillip Mantay (Devon Partnership NHS Trust), Emma Richards (Probation Service), Councillor Carol Whitton (Devon County Council), Councillor Andrew MacGregor (Teignbridge District Council), Ken Wenman (CEO, South Western Ambulance Service NHS Trust), Adel Jones (Torbay and South Devon NHS Foundation Trust) and Nick Pennell (Health Watch Devon)

Declaration of Interests

Members are reminded that they must declare any interest they may have in any item to be considered at this meeting, prior to any discussion taking place on that item.

Access to Information

Any person wishing to inspect any minutes, reports or lists of background papers relating to any item on this agenda should contact Stephanie Lewis 01392 382486.
Agenda and minutes of the Committee are published on the Council's Website and can also be accessed via the Modern.Gov app, available from the usual stores.

Webcasting, Recording or Reporting of Meetings and Proceedings

The proceedings of this meeting may be recorded for broadcasting live on the internet via the 'Democracy Centre' on the County Council's website. The whole of the meeting may be broadcast apart from any confidential items which may need to be considered in the absence of the press and public. For more information go to: http://www.devoncc.public-i.tv/core/

In addition, anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chair. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting; focusing only on those actively participating in the meeting and having regard also to the wishes of any member of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chair or the Democratic Services Officer in attendance so that all those present may be made aware that is happening.

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Induction loop system available

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SatNav – Postcode EX2 4QD

Walking and Cycling Facilities

County Hall is a pleasant twenty minute walk from Exeter City Centre. Exeter is also one of six National Cycle demonstration towns and has an excellent network of dedicated cycle routes – a map can be found at: https://new.devon.gov.uk/travel/cycle/. Cycle stands are outside County Hall Main Reception and Lucombe House

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Car Sharing

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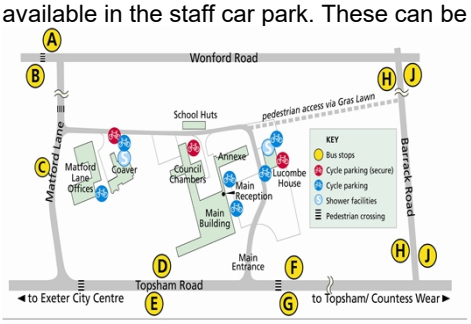

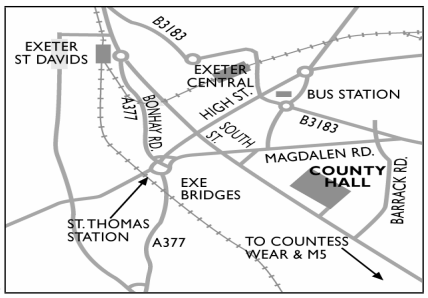

NB A J **Denotes bus stops**

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First Aid

Contact Main Reception (extension 2504) for a trained first aider.

HEALTH AND WELLBEING BOARD

16 January 2020

Present:-

Devon County Council

Councillors A Leadbetter (Chair), R Croad, B Parsons and C Whitton

Dr Virginia Pearson, Chief Officer for Communities, Public Health, Environment and Prosperity
Jennie Stephens, Chief Officer for Adult Care and Health
Jo Olsson, Chief Officer for Children's Services
Chief Superintendent Jim Gale, Devon Commander - Devon and Cornwall Police
Adel Jones, Torbay and South Devon NHS Foundation Trust
Suzanne Tracey, Chief Executive, RD&E
Dr Paul Johnson, Devon Clinical Commissioning Group
David Rogers, Healthwatch Devon
Sarah Hughes, Devon Partnership NHS Trust

Apologies:-

Jeremy Mann, Environmental Health Officers Group
Diana Crump, Joint Engagement Forum
Phillip Mantay, Devon Partnership NHS Trust
Councillor Andrew MacGregor, Teignbridge District Council

* 141 Announcements

The Chair welcomed Mr Hipkin who was attending the meeting in his capacity as a Coopted Member of the Council's Standards Committee to observe and monitor compliance with the Council's ethical governance framework.

* 142 Minutes

RESOLVED that the minutes of the meeting held on 10 October 2019 be signed as a correct record.

* 143 Items Requiring Urgent Attention

There were no items requiring urgent attention.

* 144 Devon Joint Health and Wellbeing Strategy: Priorities and Outcomes Monitoring

The Board considered a Report from the Chief Officer for Communities, Public Health, Environment and Prosperity on the performance for the Board, which monitored the priorities identified in the Joint Health and Wellbeing Strategy for Devon 2020-25.

The Report was themed around the four Joint Health and Wellbeing Strategy 2020-25 priorities and included breakdowns by South West benchmarking, local authority district and local authority comparator group. These priority areas included:

- Create opportunities for all;
- Healthy, safe, strong and sustainable communities;

- Focus on mental health; and
- Maintain good health for all.

The following indicators below had all been identified as being significantly worse compared to the national average at a Devon level:

- Good level of development
- GCSE attainment
- Fuel poverty
- Dwellings with category 1 hazards
- Suicide
- Self-harm admissions
- Alcohol specific admissions in under 18s
- Reablement coverage
- Estimated dementia diagnosis rate

The outcomes report was also available on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk/jsna/health-and-wellbeing-outcomes-report

The Board, in discussion, highlighted and asked questions on;

- The percentage of relating to the Level of Good Development for 2019 had increased to 72.7%, above national average, South West and statistical neighbours;
- The Level of Good Development (Free School Meals) had also increased by 6.3% in 2019;
- The level of GCSE attainment had also improved in 2019 and Devon was achieving better than the national average in English and Maths;
- However, it was noted there was still a gap and challenge relating to pupils with Free School Meals;
- There was still a lot of variations across the County, with North Devon and Torridge noted as being performing lower in most areas, including GCSE attainment, Good Level of Development, Fuel Poverty and dementia diagnosis rates;
- Dementia diagnosis rates were still an area of concern, with difficulties in increasing the rates of early diagnosis and work was ongoing with Primary Care and how to better inform the public about the importance of early diagnosis; and
- The Board noted there was not a large number of Mental Health indicators and that it was difficult to find good quality indicators.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Pearson, and

RESOLVED that the performance report be noted and accepted and the refreshed Health and Wellbeing Outcomes Report, which reflected the priorities in the Joint Health and Wellbeing Strategy 2020-25, be supported by the Board.

* **145** **Child Poverty in Devon**

The Board considered a Report from the Chief Officer for Communities, Public Health, Environment and Prosperity on Child Poverty in Devon. The Report highlighted that the causes of child poverty were broad, and the experience of child poverty varied significantly across Devon's communities. Whilst levels of child poverty had generally declined, there were considerable variations that existed across Devon.

One of the complex and challenging issues with child poverty, as causes were broad and multiple, was that there was no overall lead from a local organisation, meaning that work to resolve the causes and ameliorate the impact of child poverty was usually focused on specific individual causes rather than tackling the issue as a whole. It was therefore important to strengthen collaboration between organisations and strategic partnerships to tackle this issue.

The Board discussed and asked questions on the following;

- Initiatives within Children's Services around school attainment within North Devon and coastal towns which link into child poverty;
- Utilising resources such as the European Social Fund to help reduce child poverty; and
- Devon's Economy Team looking into causes of child poverty including social mobility.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Pearson, and

RESOLVED that the findings of the Child Poverty review be noted and a presentation on strategic economic assessment and development strategy be brought to a future Board meeting.

*** 146 Joint Commissioning in Devon, the Better Care Fund and Governance Arrangements**

The Board considered a joint Report from the Associate Director of Commissioning (Care and Health) and NHS Devon Clinical Commissioning Group (CCG) on the Better Care Fund (BCF), Quarter Return, Performance Report and Performance Summary.

Regular Reports were provided on the progress of the Devon Better Care Fund Plan to enable monitoring by the Health and Wellbeing Board. Performance and progress was reviewed monthly by the Joint Coordinating Commissioning Group through the high level metrics reports and progress overview.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Pearson, and

RESOLVED that

a) national approval of the Section 75 Framework Agreement and associated Service Specifications for 2019/20, underpinning the Better Care Fund arrangements between the Council and CCG, be noted; and,

b) the Q3 BCF return be submitted to NHS England on 24th January, with delegated approval given to the Chair of the Board to sign the return, due to timeline constraints around the Health and Wellbeing Board meetings.

*** 147 Devon Strategic Partnerships Collaboration Agreement**

The Board considered the Report of the Chief Officer for Communities, Public Health, Environment and Prosperity on the Devon Strategic Partnerships Collaboration Agreement, highlighting the importance of collaborative working and outlining how partnerships would work together to improve health outcomes across Devon.

The Devon Strategic Partnership Collaboration Agreement covered the Devon Health and Wellbeing Board, the Children and Families Partnership, Safeguarding Adults Board, Safer Devon Partnership and the Sustainability and Transformation Partnership. It described the future working relationships between these organisations, setting outcomes to be achieved and the working arrangements that would be established to support this. The Agreement had been signed by the Chairs of the other partners and required final sign off by the Chair of the Health and Wellbeing Board.

RESOLVED that the Devon Strategic Partnerships Collaboration Agreement be formally endorsed by the Board.

*** 148 Prevention Concordat for Better Mental Health**

(Councillors Hall and Scott attended in accordance with Standing Order 25(2) and spoke to this item).

The Board received a Report from the Chief Officer for Communities, Public Health, Environment and Prosperity on the Prevention Concordat for Better Mental Health, developed by Public Health England as a mechanism for promoting good mental health and providing a focus for cross sector action to increase the adoption of public mental health approaches.

The Report highlighted that poor mental health had a considerable impact on the quality of people's lives and was a major contributor to premature death. This was also highlighted in the 'Healthy and Happy Communities', Devon's Joint Health and Wellbeing Strategy 2020-25, which set a priority on mental health and building good emotional health and wellbeing, happiness and resilience.

The Prevention Concordat aimed to:

- galvanise local and national action around the prevention of mental health problems and promotion of good mental health;
- facilitate every local area to put in place effective prevention planning arrangements led by health and wellbeing boards, clinical commissioning groups, and local authorities; and,
- enable every area to use the best data available to plan and commission the right balance of provision to meet local needs, increase equity and reduce health inequalities.

The work covered prevention in the widest sense covering the full range of activity from the promotion of good mental health through to living well with mental health problems.

The Board heard from Councillors Hall and Scott who discussed their own experiences with mental health, the need to remove the stigma around mental health, the importance of Mental Health Champions in the workplace, the link between physical wellbeing and mental health, the vital support provided by local charities and communities and the need for Councils to support these services, and the need to increase mental health services available to children and young adults to reduce the effects of mental health before they become more serious.

Members discussion points included:

- an emphasis required on prevention of mental health, rather than just treatment;
- acknowledging that mental health can affect anyone at any point of their life;
- the need for measurable outcomes when improving mental health services;
- the Devon Deal and need to focus on community assess and resource such as local football clubs and community groups; and,
- links to the STP work programme linking in mental health and cross partnership working to deliver services.

It was **MOVED** by Cllr Leadbetter and **SECONDED** by Dr Pearson and

RESOLVED that the Board supports the work to develop an action plan through constituent organisations and signs up to the Prevention Concordat for Better Mental Health, with an update Report at the next meeting.

*** 149 Healthy Weight Declaration**

The Board considered the Report of the Chief Officer for Communities, Public Health, Environment and Prosperity on the Healthy Weight Declaration, which aimed to achieve local authority commitment to promote healthy weight and improve the health and wellbeing of the

local population, and recognise the need for local authorities to exercise their responsibility to develop and implement policies which promoted healthy weight.

The Report noted that health related factors such as poor diet, physical inactivity and obesity often lead to ill health and premature death, with considerable variation in these risk factors across the county of Devon.

In October 2019, the Council became the first local authority in the South West to sign up to the Healthy Weight Declaration for local authorities developed by Food Active. The Council had committed to a series of pledges that helped improve access to nutritious foods that were low in fat, salt and sugar in places that we each lived, worked and played. Through the declaration there was also an opportunity for local authorities to develop and sign up to any local commitments that were specific to the needs of the local community.

RESOLVED that local work on the Healthy Weight Declaration be noted and future work to promote healthy weight and healthy eating across local organisation be supported by the Board.

* 150 CCG Updates

The Board received the Report of the Chair of the NHS Devon Clinical Commissioning Group which provided an update on CCG business, Devon-wide and national developments within the NHS. It was intended to provide the Board with summary information to ensure Members were kept abreast of important developments affecting the NHS.

The Board noted the updates in relation to:

- the NHS Long Term Plan – which continued to be developed with the final document aimed to be published in early 2020;
- Winter campaign update – including pressures on A&E and the promotion of the NHS 111 service; and
- The development of the Devon Strategy for General Practice.

RESOLVED that the Report be noted.

* 151 References from Committees

Nil

* 152 Scrutiny Work Programme

The Board received a copy of Council's Scrutiny Committee work programme in order that it could review the items being considered and avoid any potential duplications.

* 153 Forward Plan

The Board considered the contents of the Forward Plan, as outlined below (which included the additional items agreed at the meeting).

Date	**Matter for Consideration**
Thursday 9 April 2020 @ 2.15pm	**Morning Session** Dementia Friends Training JSNA Tool Training session **Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC)

	Business / Matters for Decision Better Care Fund Gap in employment rate for those with mental health Strategic Approach to Housing Safer Devon Partnership update Homelessness Reduction Act Report - 12 month update Health Protection Committee Update Strategic Economic Assessment & Development Strategy (Presentation) Mental Health Prevention Concordat Action Plan - update CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 16 July 2020 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC JSNA / Strategy Refresh Population Health Management & and Integrated Care Management (Presentation) CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 8 October 2020 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC Adults Safeguarding annual report CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 21 January 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information

Thursday 8 April 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Annual Reporting	Adults Safeguarding annual report (September / December) Joint Commissioning Strategies – Actions Plans (Annual Report – December) JSNA / Strategy Refresh – (June)
Other Issues	Equality & protected characteristics outcomes framework

RESOLVED that the Forward Plan be approved, including the items approved at the meeting.

* **154** **Briefing Papers, Updates & Matters for Information**

Members of the Board received regular email bulletins directing them to items of interest, including research reports, policy documents, details of national / regional meetings, events, consultations, campaigns and other correspondence. Details were available at; http://www.devonhealthandwellbeing.org.uk/

No items of correspondence had been received since the last meeting.

* **155** **Dates of Future Meetings**

RESOLVED that future meetings and conferences of the Board will be held on:

Meetings
Thursday 9 April 2020 @ 2.15pm
Thursday 16 Jul 2020 @ 2.15 pm
Thursday 8 Oct 2020 @ 2.15 pm
Thursday 21 Jan 2021 @ 2.15 pm
Thursday 8 Apr 2021 @ 2.15 pm

Annual Conference
Thursday 16 Jul 2020 @ 10.00am

***DENOTES DELEGATED MATTER WITH POWER TO ACT**

The Meeting started at 2.15 pm and finished at 4.00 pm

NOTES:
1. Minutes should be read in association with any Reports or documents referred to therein, for a complete record.
2.The Minutes of the Board are published on the County Council's website at http://democracy.devon.gov.uk/ieListMeetings.aspx?CId=166&Year=0
3. A recording of the webcast of this meeting will also available to view for up to six months from the date of the meeting, at http://www.devoncc.public-i.tv/core/portal/home

Health and Wellbeing Board
16 July 2020

COVID-19: A Public Health Overview of the Pandemic

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity

Recommendation: The Health and Wellbeing Board is asked to note the overview report from the Director of Public Health.

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1. Background

1.1 This paper provides an overview of the COVID-19 Pandemic to provide context for the impact on, and responses of, the Health and Care system.

1.2 The rapid international spread of a new coronavirus infection – creating the viral pandemic known as COVID-19 (the virus itself is named 'SARS-CoV-2') – has changed life for millions of people, and many thousands of unexpected deaths.

1.3 Following the initial peak, the United Kingdom is still managing its 'phase 2' response to the pandemic.

1.4 In the absence of an immunisation or an effective treatment, the only management tool for COVID-19 is the prevention of spread of the virus by behaviour – social distancing, hand hygiene and protection from potential spread by isolating oneself from others.

2. Introduction

2.1 On 31st December 2019, the World Health Organisation received reports of cases of pneumonia of unknown cause in China. During early January 2020, more reports were received of a new coronavirus, originating in Wuhan, in Hubei province, the sign of a local outbreak developing into a spreading infection (an epidemic) during January.

2.2 The World Health Organisation declared 'a public health emergency of international concern' on 30th January 2020. The Public Health Devon team convened its first 'response' meeting to prepare for a worsening situation on 31st January 2020.

2.3 On 10th February 2020 the UK Government declared a 'serious and imminent threat to public health'.

2.4 On 25th February 2020 the UK Government advised people returning from affected areas of Italy to self-isolate, with testing and contact tracing. The first Devon case occurred just after this.

2.5 On 3rd March 2020 the UK Government published its 4-phase coronavirus 'action plan'.

2.6 On 11th March 2020 the World Health Organisation designated COVID-19 a pandemic.

2.7 On 12th March the UK moved from the 'containment' phase of the pandemic (and its associated social distancing measures) to the 'delay' phase.

2.8 On 23rd March 2020, following updated modelling by Imperial College, London, the Prime Minister announced more stringent social distancing through the national 'lockdown' measures.

3. Preparation for pandemics through modelling

3.1 To prepare for Pandemic Influenza, modelling is provided to Local Resilience Forums (LRFs) prepared by SAGE (the national Strategic Advisory Group on Emergencies).

3.2 For the COVID-19 Pandemic, initial modelling of COVID-19 was based on Pandemic Influenza (without any population intervention) and this was shared with Local Resilience Forums to enable planning for excess deaths.

3.3 SAGE subsequently used mathematical and behavioural modelling, mainly from Imperial College, London, to assess the impact of changes in the person-to-person transmission rates, as measured by 'R'.
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3.4 In an epidemic, one of the most important numbers is R - the reproduction number. If this is below one, then on average each infected person will infect fewer than one other person and the number of new infections will fall over time.

3.5 When R is 1, each person infects one other person; when R is greater than one, numbers of infected people increase exponentially creating the epidemic. The higher the R number, the faster the virus is spreading in the population. When R is less than one, the epidemic reduces.

3.6 Because COVID-19 has spread at different rates across the country, with the South West (and particularly Devon) being one of the last places to see an upward curve and one of the last to decline, with a much lower peak, the R value will change as lockdown measures are lifted[1].

4. Impact of social distancing measures

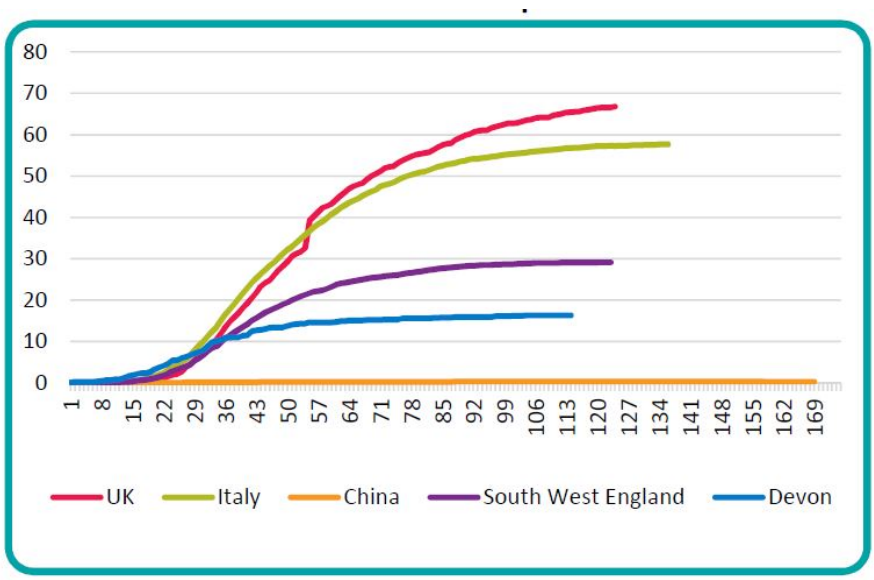
4.1 The impact of different social distancing measures can be measured by the way that R changes. 'Stay at Home' guidance reduces R fastest, but as social distancing measures are relaxed, R rises and - with it - the risk of a resurgence in the spread of COVID-19.

4.2 The South West had a very different pattern of spread from the rest of England, probably because our first cases occurred 2-3 weeks after the first cases in England. Even within Devon, North Devon was affected 1-2 weeks after initial cases detected in South Devon.

4.3 This later effect within Devon means that the epidemic curve has been 'lower and slower' than in other parts of England such as London and the West Midlands.

4.4 International comparisons are also interesting, which shows how different death rates have been in Devon (figure 1):

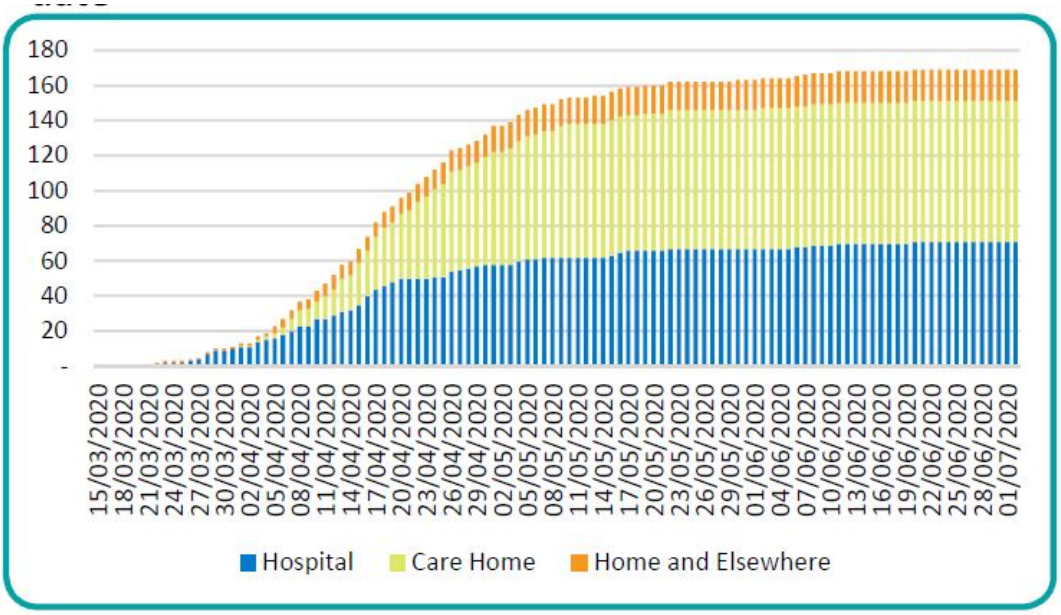
Figure 1: Cumulative COVID-19 deaths per 100,000 population, international comparison.



4.5 Activity in hospitals is the first significant indication of spread, followed by infections in care homes. This is the pattern seen elsewhere across Europe. Activity in NHS hospitals was the first to change, with the NHS acting to discharge patients to create room for a surge in acutely unwell patients. Following this, there was evidence of spread within community settings such as care home, where we saw outbreaks occurring. As a consequence, there was an increasing proportion of deaths in care homes as a total of COVID-19 deaths (figure 2):

[1] https://publichealthmatters.blog.gov.uk/2020/05/15/coronavirus-covid-19-real-time-tracking-of-the-virus/ [accessed 04.06.20].

Figure 2: Local registered cumulative COVID-19 deaths by location (including hospital, care home and other deaths in the community) in Devon, by date.



4.6 As of 03.06.20 there have been 1,094 confirmed cases of COVID. Policy changes around testing will result in fluctuations. Therefore we would expect to see increases in confirmed cases in the coming days and weeks.

4.7 As of 01.06.20 there have been 162 registered COVID deaths

4.8 Deaths across Devon have plateaued, and as of the date of this report we have not seen any recent deaths due to COVID-19 in almost two weeks. Any deaths registered over the last two weeks have related to earlier dates and are less than a count of 5.

4.9 Devon ranks 145 out of 150 upper tier LAs across the country for confirmed cases per 100,000 resident population (rank 1 is the highest rate of cases; rank 150 is the lowest).

5. The future

5.1 To successfully move out of lockdown and relax social distancing measures, there are a number of considerations.

5.2 For Devon, the main factors that need to be taken into consideration are:

- Comparatively low rates of COVID-19 activity and therefore low levels of population exposure (and immunity) to the virus
- An age profile and long-term condition profile of the population that creates more risk from infection
- A potential large influx of visitors in peak holiday periods
- An NHS sector which is already susceptible to seasonal service pressures due to the age and disease profile of the population
- The risks of either a prolonged period of COVID-19 activity or further peaks as lockdown and social distancing measures are relaxed
- The effectiveness of a 'Test and Trace' approach – wider population testing and contact tracing to contain outbreaks, through advice to and isolation of individuals.

5.3 The Government has recently asked Upper Tier and Unitary Local Authorities to establish COVID-19 Health Protection Boards (chaired by their Directors of Public Health) and Local Outbreak Engagement Boards (Chaired by Leaders) to ensure outbreaks of COVID-19 can be managed at local level. The Devon Local Outbreak Management Plan was endorsed by Cabinet on 8th July.

5.4 Devon County Council was selected as a 'Beacon Council' in the South West to develop and share best practice, one of eleven nationally.

6. Financial considerations

6.1 The Government has made a number of financial provisions to mitigate the effect of COVID-19.

7. Legal considerations

7.1 The Director of Public Health for Devon County Council discharges a statutory responsibility for assurance health protection plans under the Health and Social Care Act 2012.

8. Environmental impact considerations

8.1 Contained within the report.

9. Equality considerations

9.1 There have been concerns about the differential impact of COVID-19 on people from Black and Asian Minority Ethnic (BAME) Backgrounds. Public Health England has recently produced a report on disparities in outcomes[2].

10. Risk assessment considerations

10.1 Contained within the report.

11. Recommendation

11.1 Health and Wellbeing Board is asked to receive the report of the Director of Public Health and to note the further work taking place on the development of Local Outbreak Management Plans.

Dr Virginia Pearson
Chief Officer for Communities, Public Health, Environment and Prosperity
Director of Public Health
Devon County Council

Electoral Divisions: **All**

Cabinet Member for Community, Public Health and Transportation and Environmental Services: Councillor Roger Croad

Local Government Act 1972: List of Background Papers

Contact for enquiries: Dr Virginia Pearson

Room No. County Hall, EXETER. EX2 4QD Tel No: 01392) 383000

Background Paper	Date	File Reference
The 2019-20 Public Health Annual Report on 'Planetary and Human Health' makes reference to the risks of novel viruses		www.devonhealthandwellbeing.org.uk/aphr

[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889861/disparities_review.pdf

PH/20/02
Health and Wellbeing Board
16th July 2020

COVID-19: LOCAL OUTBREAK MANAGEMENT PLAN

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity

Recommendation*:* the Board are requested to note the Local Outbreak Management Plan and the associated (non-statutory) governance arrangements.

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1. Background

1.1. On 22nd May 2020 the Government announced new arrangements for local authorities to take a lead role in the management of COVID-19 as lockdown was released.
1.2. Each Upper Tier Local Authority (County Councils and Unitary Authorities) will publish a Local Outbreak Management Plan by 30th June 2020.

2. Introduction

2.1. Upper tier Local Authorities (County Councils and Unitary Authorities) will establish COVID-19 Health Protection Boards. These are multi-agency strategic partnerships, non-statutory, working to detect, manage and contain outbreaks of COVID-19, working under the existing statutory duties of the Director of Public Health. The COVID-19 Health Protection Board will be chaired by the Director of Public Health and its role will be:

a. Overseeing the Local Outbreak Management Plan and resource deployment via tactical and operational management.
b. Data and intelligence (with Joint Biosecurity Centre).
c. Leading the local Public Health response with PHE (and NHS Test and Trace).
d. Assurance and reporting to other groups as required.

2.2 Upper tier Local Authorities (County Councils and Unitary Authorities) will also establish Local Outbreak Engagement Boards which are also non-statutory, and designed to provide:

a. Political oversight of the local delivery of the Local Outbreak Management Plan and the local response.
b. Communicating and engaging with residents and communities.

2.3 The Local Outbreak Engagement Board will be known as 'Team Devon' and will be chaired by the Council Leader Councillor John Hart.

2.4 Local Outbreak Management Plans are dynamic and will be updated according to local need and any change in national requirements.

3. Recommendations

3.1 the Health and Wellbeing Board is asked to note the Local Outbreak Management Plan and the associated governance arrangements, and that these will be developed further as required.
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4. Financial considerations

4.1 The Government has allocated £300 million to Upper Tier Local Authorities in the form of a ring-fenced Local Authority Test and Trace grant to support the additional public health capacity to develop and implement plans. Devon County Council's allocation is £2,618,508.

5. Legal considerations

5.1 The governance arrangements and terms of reference for the new COVID-19 Health Protection Board and the 'Team Devon' Local Outbreak Engagement Board have been prepared by the legal team.

6. Environmental impact considerations

6.1 No direct impacts of the governance arrangements on the environment although there are environmental considerations to the management of the pandemic (including tourism, transport and travel) which will be important for both Boards to consider.

7. Equality considerations

7.1 There has been increasing evidence of the differential impact of the COVID-19 pandemic on certain populations including older people, people from a black and minority ethnic background, and those with learning disability. The emergence of a greater inequality gap in vulnerable groups is of concern as we move into Recovery.

8. Risk assessment considerations

8.1 The development of the new arrangements has involved the County Council's lead manager on risk management, and this is an area that will continue to develop. As these are strategic partnerships, risks will also be held by individual organisations.

Dr Virginia Pearson
CHIEF OFFICER FOR COMMUNITIES, PUBLIC HEALTH, ENVIRONMENT AND PROSPERITY/DIRECTOR OF PUBLIC HEALTH
DEVON COUNTY COUNCIL

Electoral Divisions: All

Cabinet Member for Community, Public Health and Transportation and Environmental Services: Councillor Roger Croad
Council Leader: Councillor John Hart

Background publications

Devon COVID-19 Local Outbreak Management Plan

Public Health Devon

Devon County Council

(version 1 29/06/20)

COVID-19 Local Outbreak Management Plan

1.0 Introduction

1.1 All upper tier Local Authorities have been instructed to produce a Local Outbreak Management Plan (LOMP) by the end of June 2020. Local Authorities have a significant role to play in the identification and management of COVID-19 outbreaks. Directors of Public Health have a crucial leadership role to play ensuring that through the LOMP they have the plans in place and have the necessary capacity and capability to quickly deploy resources to the most critical areas to respond to COVID-19 outbreaks and help prevent the spread of the virus.

1.2 The aim of the LOMP is to provide a clear plan on how local government works with the new NHS Test and Trace Service to ensure a whole system approach to contain and manage local COVID-19 outbreaks. This is a dynamic plan and will be updated as new national guidance is published or legislation changes.

1.3 Containing local outbreaks, while led by the local Director of Public Health, needs to be a co-ordinated effort working with Public Health England local health protection teams, the NHS, Social Care, District Councils, Education, Police, the private sector, employers and the community and voluntary sector. Members of the general public also have a vital role in reducing spread of the virus and preventing outbreaks, both in terms of following national guidance and advice including adherence to the social distancing guidelines and following good hand/respiratory hygiene practices, and if symptomatic having a test but also self-isolating should they be instructed to do so.

2.0 Core Working Principles

2.1 While it is necessary to have a degree of local flexibility it has been agreed that both in the development of the LOMP and the proactive and reactive response to a COVID-19 outbreak it is also important to have a degree of consistency. The South West Regional Directors of Public Health have agreed to adhere to the following key working principles:

1. We will work together as a public health system, building on and utilising the existing close working relationships we have between the local authority public health teams and PHE. We will endeavour to ensure we make best use of the capacity and capability of the regional public health workforce.

2. While recognising local sovereignty we will commit to ensuring a common language to describe the local governance arrangements:

    a. **COVID-19 Health Protection Board**
    b. **Local Outbreak Management Plans**
    c. **Local Outbreak Engagement Board**

3. We will ensure that we all work to an agreed common set of quality standards and approaches in the management of local outbreaks, utilising and building upon already agreed approaches such as those defined within the Core Health Protection Functions Memorandum of Understanding

(MoU). The MoU is a document signed by agencies in the South West including Local Authorities, District Councils, Public Health England, Clinical Commissioning Groups and the Port Authority. The document describes a set of key principles on how the agencies will work together to protect the health of the population from the adverse health effects due to infection, contamination and other hazards.

4. We will adopt a continuous learning approach to the planning and response to COVID-19 outbreaks, sharing and learning from one another to ensure we provide the most effective response we can.

5. We will ensure that there is an integrated data and surveillance system established, which alongside a robust evidence-base will enable us to respond effectively to outbreaks. Proposal that a COVID-19 Regional Data and Intelligence Framework is developed which will enable DsPH to have access to the necessary information to lead the COVID-19 Health Protection Board.

6. We will commit to openness and transparency, communicating the most up to date science, evidence and data to colleagues, wider partners and the public.

7. We will ensure that within our planning and response to COVID-19 we will plan and take the necessary actions to mitigate and reduce the impact of COVID-19 on those most vulnerable, including BAME communities.

8. We recognise that DsPH have a system leadership role in chairing the COVID-19 Local Health Protection Board. We commit to actively engaging with key partners, including all levels of government (Upper, lower tier local authorities, towns and parishes and wider partners and communities), key stakeholders including the community and voluntary section to ensure a whole system approach.

9. We accept that we are currently working in a fast-changing, complex environment. DsPH are having to respond dynamically to changing evidence, national guidance, demands and expectations. We will commit to be actioned focused and commit to working to public health first principles (to protect and improve the health of the population)

10. We will ensure that our LOMP includes a strong focus on prevention and early intervention to ensure key settings (e.g. care homes and schools) and high-risk locations and communities identify and prioritise preventative measures to reduce the risk of outbreaks.

3.0 Governance

3.1 Working in partnership is crucial to help prevent the spread of the virus and swiftly respond to local outbreaks. While the response to outbreaks will be led by the local Directors of Public Health success will require a co-ordinated partnership response. This will involve numerous agencies, some of whom are mentioned above, working together. Which agencies are involved will depend somewhat as to the outbreak setting, but it is critical that all organisations understand the plan and the role and actions they are expected to take in a response.

3.2 Managing outbreaks in workplaces, specific settings such as schools and care homes and within the community is not new and is a core function of public

health and environmental health. It is therefore important that the creation of any new arrangements to manage local COVID-19 outbreaks build on existing plans e.g. Care Homes Resilience Plan and link in with existing structures and arrangements such as the Health Protection Sub-Committee of the Health and Wellbeing Board (https://www.devonhealthandwellbeing.org.uk/board/) and the Local Resilience Forum and area able to fulfil any reporting requirements by other bodies.

3.3 The following governance arrangements will support the Local Outbreak Management Plan and are described diagrammatically in appendix 1.

Devon and Torbay Covid-19 Health Protection Board

This Board will be chaired by the Director of Public Health for Devon County Council with the Vice chairs being the Director of Public Health for Torbay Council and DCC Deputy Director of Public Health. This Board is an Executive-level Partnership Board and will have the following key responsibilities:

1. Local Outbreak Management Plan and resource deployment
2. Data and intelligence (with the Joint Biosecurity Centre)
3. Leading the local Public Health response with PHE (and NHS Test and Trace)
4. Assurance and reporting to Local Engagement Outbreak Board and the Local Resilience Forum.

Membership will include:

PHE, Clinical Commissioning Group, Police, Unitary and District Council, (EHO/Housing), Fire and Rescue Service, Public Protection, Social Care, Schools and Colleges, Higher Education, Economy Enterprise and Skills, Business & Tourism, Military Liaison, Prisons, Communities.

* Plus in advisory capacity: Consultant in Public Health/Public Health Intelligence; Communications Lead; DCC Corporate Equality Officer.

Team Devon (Local Outbreak Engagement Board)

This Board will be chaired by the Leader of Devon County Council and will have the following key responsibilities:

1. Political oversight of the local delivery of plan and response
2. Communicating and engaging with residents and communities

Membership will include:

Health and Wellbeing Board Chair, CCG Chair, District Council Leader, Portfolio Holders, Police, Higher Education, Devon Association of Local Councils (Towns and Parish Councils), Voluntary and Community Sector working on a 'hub and spoke' basis with Communities.

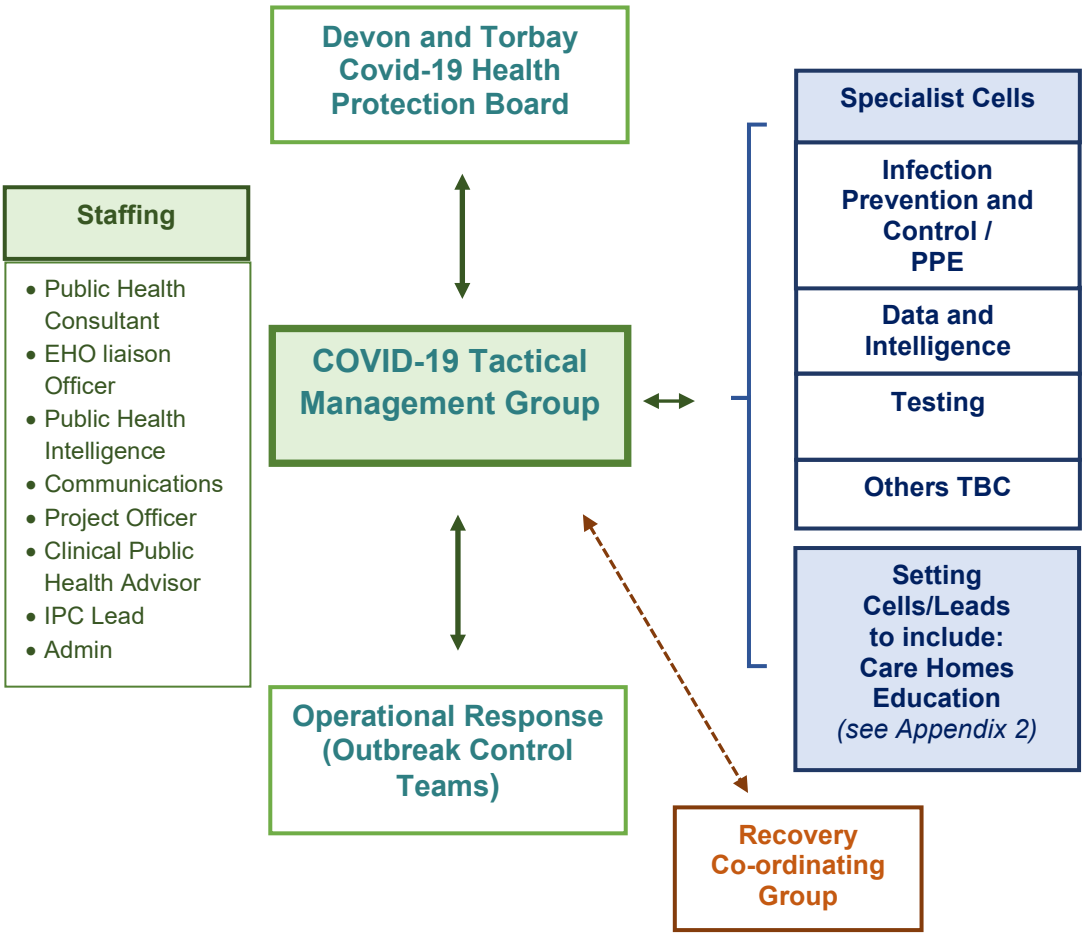
* Plus in advisory capacity: DPH, Communication Lead and Equality Officer.

3.4 The COVID-19 Tactical Management Group (TMG) will receive notifications of suspected or confirmed cases of COVID-19 cases from Public Health England. The role of the group is to carry out a dynamic risk assessment and link with the appropriate setting lead to ensure they are aware of the notification. In collaboration with the setting lead agreement will be reached on the most appropriate person(s) to lead the local response. The locally designated lead,

working with the Local Health Protection Team (PHE) and key local partners (see Appendix 2) will follow the agreed Standard Operating Procedures protocols to take the necessary actions to contain the outbreak. This could include the setting up of an Outbreak Control Team. If an incident or suspected case is raised directly with a Setting Lead this intelligence will be passed onto the Tactical Management Group who will liaise with the Local Health Protection Team to triangulate data and intelligence. Good local relationships often mean service leads/mangers are notified informally before a form notification is made.

3.5 The staffing of COVID-19 Tactical Management Group will vary depending on the number of incidents and while it is expected that additional capacity and capability will be brought into the group as necessary, depending on the scale and complexity of outbreaks, there will be a core group of staff identified to ensure the group can function effectively during the Pandemic.

COVID-19 Tactical Management Group



4.0 Data Integration

4.1 The need for local, timely, high quality data and surveillance is a critical factor in helping the COVID-19 Health Protection Board make the informed decisions. Boards across the South West will work to an agreed dataset which enables transparency and consistency for data analysis, interpretation and comparison purposes. The Department of Health and Social Care National Testing Programme, NHS Digital and NHSX are developing an interactive data dashboard which will be available for local use. This data dashboard,

alongside the data produced by the Joint Biosecurity Centre will provide local Health Protection Boards with national data and intelligence.

4.2 To complement the national data dashboard local data and intelligence, gathered from partners and through local Incident Managements Teams and Outbreak Control Teams will be vital to ensure an effective tactical response to local outbreaks. Timely data and surveillance information will provide the COVID-19 Health Protection Board with the necessary information to help prevent and control the transmission of COVID-19. Team Devon (LOEB) to will also have a key role in communicating data and intelligence with the public, primarily to strengthen the link between evidence and decision making, promoting openness and transparency, as part of the Smarter Devon Smarter Decision-making work (reference working principle 6).

4.3 The establishment of a local COVID-19 data and intelligence group with clear agreement of local data flows, pathways and information sharing protocols is a key priority.

5.0 Prevention and Response Plans for Places and Communities

5.1 While it is important that the plan can be used to respond to all local COVID-19 outbreaks we know from the data and intelligence that there are settings which are more likely to have outbreaks or may be more challenging to manage an outbreak due to the nature of the setting or vulnerability of the cohort concerned. It is therefore prudent to have specific plans in place with pre-agreed actions to respond to outbreaks in these higher risk settings. Standard Operating Procedures (SOPs) will be created to enable a co-ordinated and timely system response to help contain outbreaks. An overview of COVID-19 higher risk setting, including the role of key agencies is included in Appendix 2.

5.2 In addition to settings which maybe at higher risk of COVID-19 outbreaks we know that there are some people and communities who are also at higher risk. These include for example BAME communities, refugees and asylum seekers, people with learning disability and autism, older people and people with underlying health conditions. It is important the Local Outbreak Health Protection Board ensures that the health needs of those most vulnerable people and communities are addressed. The overview in Appendix 2 also includes detail of the relevant Board member lead for these areas.

5.3 As part of the national containment framework 'Action Cards' have been developed for individual settings such as workplaces or institutional settings. The Action Cards provide details of how and who they should contact in the event they suspect they have a COVID-19 outbreak in their setting. The Action Cards also provide clear guidance on how individual settings can help prevent the spread of COVID-19 by applying existing guidance on social distancing, adhering to the risk assessed safe working advice, cleaning hands regularly, disinfecting objects, surfaces and common touch points, cohorting the workforce and minimising contacts outside of the household.

5.4 The Action Cards will be web-based (weblink to be added) and will be produced, updated and promoted nationally and locally for individuals, businesses and organisations to download and use.

5.5 In addition to providing guidance and advice to key settings and general public, both through national and local messaging there is a need for evidence-based preventative measures to be targeted at high risk settings. Training and advice has been, and will continue to be provided by the NHS Community Infection

Prevention and Control Team to those who work in higher risk settings and those working with or caring for the most vulnerable people. High quality and timely Infection Prevention Control (IPC) advice is critical to help prevent and contain the spread of COVID-19.

6.0 Protecting and supporting vulnerable people

We know from the number of local people identified within the 'shielding' category as a response to COVID-19 that there are many people and families who need support during this Pandemic. We know that some people and families who are instructed to self-isolate either as a result of having symptoms or being identified as a close contact of a confirmed case will find this difficult and may require additional support in order to self-isolate. The local authority working with key partners and the voluntary and community sector will ensure that people are guided to help and support.

7.0 Testing and contract tracing

7.1 The NHS Test and Trace Service has been set up with three primary goals:

1. To ensure that anyone who develops symptoms of coronavirus can quickly be tested to find out if they have the virus.
2. Provide a targeted asymptomatic testing programme for NHS and social care staff and care home residents.
3. Help trace close recent contacts of anyone who has tested positive for coronavirus.

7.2 The NHS Test and Trace Service (as shown in figure 1) includes four key elements, Test, Trace, Contain and Enable

Testing

Anyone in England who has symptoms of coronavirus (i.e. a high temperature, a new, continuous cough, or a loss or change to sense of smell or taste), whatever their age can access a test by going to the NHS website (https://www.nhs.uk/ask-for-a-coronavirus-test) or by calling 119. People will either be able to book an appointment at a drive-through or walk-through test site or ask for a home test kit.

There is a different testing route for essential workers who have symptoms of coronavirus or for someone who has symptoms and lives with an essential worker. Essential workers include, for example NHS and social care staff, police, transport workers, education and care workers, etc. Test are accessed by the individual via the GOV.UK (https://www.gov.uk/apply-coronavirus-test-essential-workers) or they can be referred by their employer. In addition to these two routes there is a specific national testing route for care homes residents and staff (Whole Care Home Testing) and NHS Trusts can test patients and utilise local capacity to test staff.

Trace

When someone tests positive for coronavirus the NHS Test and Trace Service will trace contacts of the positive case. A 'contact' means a person who has been in close contact with someone who has tested positive for coronavirus and who may or may not live with them. The key timeframe is 48 hours before they developed symptoms and the time since they have developed symptoms.

Close contact means:

- having face-to-face contact with someone (less than 1 metre away)

- spending more than 15 minutes within 2 metres of someone
- travelling in a car or other small vehicle with someone (even on a short journey) or close to them on a plane
- if you work in – or have recently visited – a setting with other people (for example, a GP surgery, a school or a workplace)

The NHS Test and Trace Service will assess and if it is necessary inform the close contact that they must self-isolate at home to help stop the spread of the virus. There are three tiers to the contact tracing operating model with each Tier being bridged by a Team Leader function to ensure information flows and cases are escalated and de-escalated accordingly:

Tier 3: There are approximately 15,000 national call handlers who are trained to make initial contact and provide advice to those testing positive and their contacts.

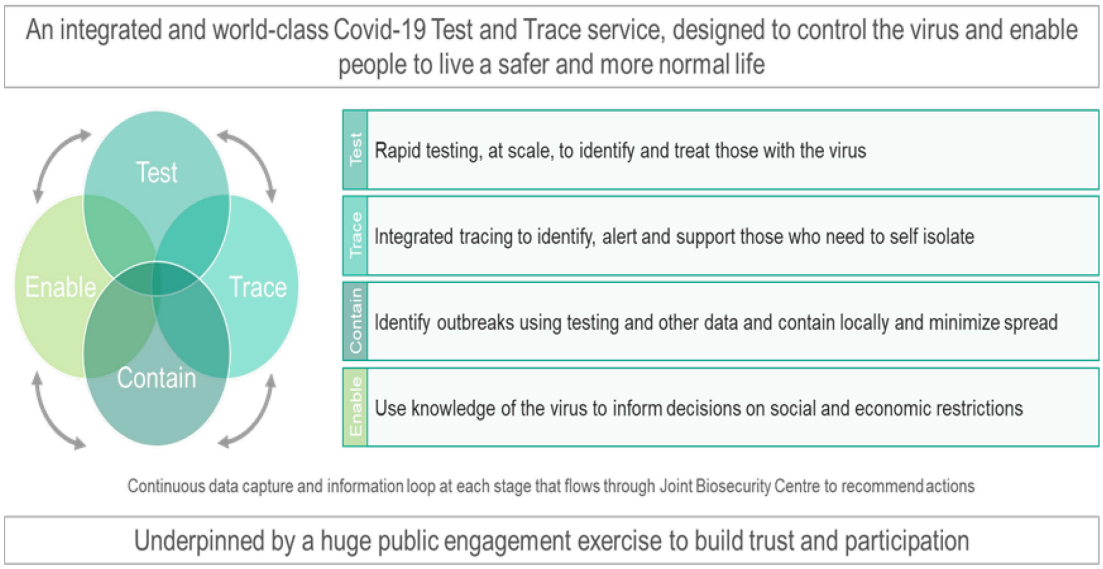
Tier 2: There are approximately 3,000 health care professionals employed nationally who are trained to interview cases and identify contacts.

Tier 1: Where Tier 3 and Tier 2 identify a degree of complexity and a 'context' for concern (e.g. a school, health setting, care home or workplace) they will escalate to Tier 1. At Tier 1 the Local Health Protection Teams (PHE) will work with local partners, including the local authority public health team, to follow up cases and agree actions to contain the outbreak.

7.3 The expectation is that vast majority of people requesting tests and/or being contacted by the NHS Test and Trace Service will not require any local involvement and will be supported through Tier 2 and 3. However, for more complex outbreaks (Tier 1) the knowledge and relationships which local partners have will be invaluable in providing a timely and appropriate response to a local outbreak working in collaboration with PHE. This will include the ability to swiftly mobilise local testing units, to support local intelligence gathering, provide infection control advice and ensure timely communications to the public and their representatives.

7.4 The use of mobile phone technology through the use of the NHS COVID-19 app and a new Google/Apple framework is continuing to be developed. A COVID-19 app will form just one component of the NHS Test and Trace Service and once fully functioning and rolled out, will complement other forms of traditional contact tracing.

NHS Test and Trace Service (figure 1)



Contain

Early identification of an outbreaks, which is generally but not always defined as 'two or more cases connected in time to a specific place' (not a household), is critical to help contain the spread of infection. For complex outbreaks (Tier 1) a local authority will convene an Incident Management Team (IMT). The team will consist of key representative applicable to the setting. In some circumstances it will be necessary to form an Outbreak Control Team (OCT). The OCT will usually be chaired by a member of the Local PHE Health Protection Team or by a Consultant in Public Health from the Local Authority Public Health Team. The membership of the OCT will vary depending on the setting but includes public health expertise, communication leads and the manager or key staff from the outbreak setting. The key aim of the OCT is to contain the outbreak and minimise any risks.

Enable

The gathering of data and intelligence (covered in section 4) and national and international research is critical to inform national policy and local action. The plan will be updated to ensure that as and when new research and policy is produced the plan will be updated accordingly.

8.0 Communication and Engagement

8.1 Providing up-to-date guidance, information and advice to the general public and key stakeholders is a key element of the plan. While much of the guidance and messaging is currently derived from central government and PHE the interpretation and the localisation of the key messaging has often been required. There are existing communication protocols and material in place between PHE and Local Authorities to ensure clarity and consistency of messages in response to an outbreak such as letters to parents following a confirmed case in a school.

8.2 Ensuring there is consistency in messaging from key local organisations is vital to avoid confusion and to build trust and confidence. There are established close working arrangements with key partners in agreeing and communicating proactive, timely COVID-19 messages within the Local Resilience Forum

Warning and Informing Group and under the Team Devon communication channels and connections. DCC has a number of existing communication channels it is using to deliver COVID-19 messages both internally and externally including the ConnectMe e-newsletter, regular messages from the Chief Executive, social media content, a Team Devon newspaper and dedicated webpages. Engaging and involving stakeholders and key individuals in the development and delivery of messages will continue to be a crucial part of the plan. A communication lead will sit on the Local Outbreak Health Protection Board and Local Outbreak Engagement Board to support them in an advisory capacity.

8.3 A communications and engagement strategy will be developed as part of this plan to build trust and confidence within the general public and partners.

9.0 Resources

9.1 The Local Outbreak Management Plan requires the necessary resources, both financial and staffing resources. Nationally £300million has been allocated for local authorities to support the additional public health capacity required to develop and implement the plans to mitigate against and manage local COVID-19 outbreaks. Devon County Council's share of the Local Authority Test and Trace Service Support Grant Determination is £2,618,508.

9.2 While the response to a local outbreak needs to be led by public health, the skills and expertise within the local system are required to effectively manage outbreaks, working as a 'system within the local system'. Public health within the local authority and Public Health England do not have the capacity, skills or expertise alone and so resources and input from key organisations and professional groups such as Environmental Health Officers, Infection Prevention Control specialists, Health and Social Care, NHS, Communications Officers, data and intelligence analysts and Health and Safety Officers will be needed, amongst others.

9.3 The precise additional resource required locally will be dependent upon the number and complexity of COVID-19 outbreaks. There will be a need to increase wider public health capacity to support testing, contact tracing and to provide advice and guidance.

9.4 There will also be additional resources required to support vulnerable people who are instructed to self-isolate. If the local system requires surge capacity to effectively respond to outbreaks this request will be routed through the Local Resilience Forum.

Sign: ……	Sign:……...
Chief Executive: ……	Director of Public Health:……..
Date: ……..	Date: ……..

APPENDIX 1

Governance Arrangements

Devon County Council

Devon, Plymouth, Torbay, Cornwall and Isles of Scilly Health and Wellbeing Boards

Devon and Torbay COVID-19 Health Protection Board

Chair: Director of Public Health, DCC
Vice Chairs: DPH, Torbay; Deputy DPH, DCC
Executive-level Partnership Board
Responsibilities:
1. Local Outbreak Management Plan and resource deployment
2. Data and intelligence (with Joint Biosecurity Centre)
3. Leading the local Public Health response with PHE (and NHS Test and Trace)
4. Assurance and reporting to LOEB/LRF

Members to include:
PHE, CCG, Police, Unitary and District Council, (EHO/Housing), Fire and Rescue Service, Public Protection, Social Care, Schools and Colleges, Higher Education, EES, Business & Tourism, Prisons, Communities, Military Liaison.
* Plus in advisory capacity – Consultant in Public Health (Public Health Intelligence), Communications Leads, DCC Corporate Equality Officer.

Devon, Plymouth, Torbay, Cornwall and Isles of Scilly Health Protection Sub-Committee

Plymouth COVID-19 Health Protection Board

Cornwall and Isles of Scilly COVID-19 Health Protection Board

Team Devon (Local Outbreak Engagement Board)

Chair: Leader, DCC
Responsibilities:
1. Political oversight of the local delivery of plan and response
2. Communicating and engaging with residents and communities

Members to include:
Health and Wellbeing Board Chair, CCG Chair, District Council Leader, Portfolio Holders, Police, Higher Education, Devon Association of Local Councils (Towns and Parish Councils), Voluntary and Community Sector working on a 'hub and spoke' basis with Communities.
* Plus in advisory capacity: DPH, Communication Leads, Equality Officer.

Devon and Cornwall LRF Strategic Co-ordinating Group

Chair: ACC Devon and Cornwall Police
Multi-agency response in the event of a Major Incident

Above linking to all the South West Regional Arrangements

Includes South West Local Authority Leaders, SW Local Authority Chief Executives, SW Directors of Public Heath, SW Health Protection Leads, SW LRFs Response Coordinating Group.

APPENDIX 2

Overview of organisational involvement and role in the prevention and management of outbreaks by setting

Category	Setting	Health Protection Board Lead	Key agencies involved and role			
			PHE	**LA**	**NHS**	**Other**
Health and Care Setting	Hospital	CCG AO	**LHPT** *(Advice / Guidance)*	**DPH** *(notified)*	**Implement Hospital Outbreak Plan**	
	Mental Health	CCG AO	**LHPT** *(Advice / Guidance)*	**DPH** *(notified)*	**System mental health lead** **Implement Hospital Outbreak Plan**	
	Primary care	CCG AO	**LHPT** *(Advice / Guidance)*	**DPH** *(notified)*	**Primary Care lead**	
	Community Services	CCG AO	**LHPT** *(Advice / Guidance)*	**DPH** *(notified)*	**ASC MDT lead** **CCG** ***Community Infection Control Team*** *If required*	
	Care Homes	DASS x2	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**ASC/QAIT** *(notification, support, advice, comm's)* **PH Lead** *(support LHPT)*	**CCG** ***Community Infection Control Team*** *If required*	**PPE Cell** *(if emergency supplies required)*
	Domiciliary Care	DASS x2	**LHPT** *(Advice / Guidance)*	**ASC/QAIT**	**CCG** ***Community Infection Control Team*** *If required*	
Educational Setting	Preschool	Deputy Chief Officer/ Education Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's*	**Education** *(notification, support)* **PH Lead**	**CCG** ***Community Infection Control Team*** *If required*	**DCC Health & Safety Team** *(Risk Assessment & Advice)*

				(notification, Advice, support LHPT) **LA Comm's team**		
	Schools	Deputy Chief Officer/ Education Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Education** *(notification, support)* **PH Lead** *(notification, Advice, support LHPT)*	**Mental Health Support Teams** **CCG** ***Community Infection Control Team*** *If required*	**School Principal** **DCC Health & Safety Team** *(Risk Assessment & Advice)*
	Boarding Schools	Deputy Chief Officer/ Education Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Education** *(notification, support)* **PH Lead** *(notification, Advice, support LHPT)*	**CCG** ***Community Infection Control Team*** *If required*	**Boarding School Principal**
	Universities and colleges (Including private)	University Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Education** *(notification, support)* **PH Lead** *(notification, Advice, support LHPT)*	**CCG** ***Community Infection Control Team*** *If required*	**University Lead** **District Council's**
Workplace Settings	Institutional *e.g.* *Prisons.*	HMP Cluster Governor	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*	**NHSE/I**	**PHE/MoJ Prison Lead** **PHE led Prison Outbreak Control Group**
	Public Transport	Head of TCS	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Head of TCS** **PH Lead** *(notification, Advice, support LHPT)*	**CCG** ***Community Infection Control Team*** *If required*	**Network rail and private travel providers**
	Industrial sites *e.g.* *Manufacturing.* *Construction.* *Outdoor working.*	Head of EES Business Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Head of EES** **PH Lead** *(notification, Advice, support LHPT)*	**CCG** ***Community Infection Control Team*** *If required*	**DSEHM and sub-groups** (*e.g. licensing, food and health and safety*) **HSE**

	Commercial *e.g.* *Offices* *Contact centres*	Head of EES Business Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Head of EES** **PH Lead** *(notification, Advice, support LHPT)*		**DSEHM and sub-groups** **HSE**
	Consumer *e.g.* *Food and Drink establishments.* *Shops.*	Head of EES Business Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Head of EES** **PH Lead** *(notification, Advice, support LHPT)*		**DSEHM and sub-groups**
	Social *e.g.* *Caravan/camping sites.* *Hotels.* *Holiday lets/ B&B's.* *Cinemas.* *Leisure centres.* *Libraries.*	Head of EES Business Lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**Head of ESS** **PH Lead** *(notification, Advice, support LHPT)* **LA Communities Team**		**Libraries unlimited** **Tourism** **DSEHM - Licensing District Councils**
Travel and Movement	Mass Transportation *e.g.* *Airports.* *Ferry Ports.* *Trains*	Port Health	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*		**DSEHM and sub-groups** **PHE Port Health Group**
	Large gathering (>500 people) *e.g.* *sports grounds.* *Theatres.*	EH lead (licensing) Police	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)* **Communications Lead**		**DSEHM and licensing sub-group** **SDP/OPiC**

	Tourist attractions. will					
	Small gathering (<500 people) *e.g.* *Cinemas.* *Parks.* *Place of worship.*	EH lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)* **Communications Lead**		**DSEHM and licensing sub-group** **SDP/OPIC** **Diocese (places of worship)** **District Councils(parks)**
Vulnerable Individuals and groups	Homelessness *Inc: Hostels*	Housing lead	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*	**CCG** ***Community Infection Control Team*** *If required*	**District Councils** *(Housing Leads)*
	Vulnerability & /or complexity including Domestic abuse & substance *Inc: Hostels/refuges*	Head of Communities	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*		**District Councils** *(Housing Leads)*
	Refugees and Asylum seekers	Head of Communities	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*		**District Councils** *(Housing Leads)*
	Gypsy, Traveller and Roma	Head of Communities	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*		
	Disabled people and carers	DASS	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**DASS** **PH Lead** *(notification, Advice, support LHPT)*	**ASC/CCG lead**	

	People with LD and autism	DASS	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**DASS** *(Notified)*	**ASC/CCG lead**	
	Mental Health Service users	CCG/DASS	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**DASS** *(Notified)*	**Mental Health Lead**	
	Older People	CCG/DASS	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**DASS** *(Notified)*	**CCG lead**	
	People with underlying health conditions	CCG	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*		**CCG lead**	
	Health and Care Staff	CCG/DASS	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**DASS** *(Notified)*		
High risk communities and neighbourhoods	BAME Communities	Head of Communities	**LHPT** *(Test notification, risk assessment, IPC advice, comm's)*	**PH Lead** *(notification, Advice, support LHPT)*		**Equality and Diversity leads in organisations**
Public Protection	Business Lead	Police (X2) Head Trading Standards (Devon/ Somerset/ Torbay shared Service)				
Military Liaison	Planning	Military Lead				

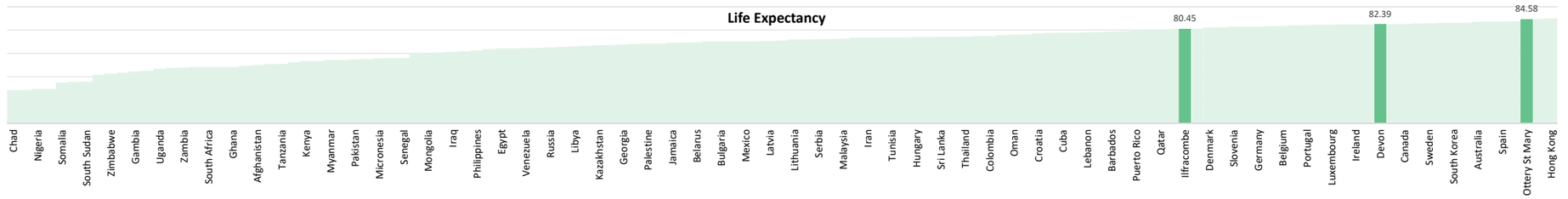
Key:

AO: Accountable Officer
ASC: Adult Social Care
CCG Lead: Clinical Commissioning Group

DASS:	Director of Adult Social Services
DPH:	Director of Public Health
DSEHM:	Devon Strategic Environmental Health Management Group
EES:	Economy, Enterprise and Skills
HSE:	Health and Safety Executive
LHPT:	Local Health Protection Team (Public Health England)
LRF:	Local Resilience Forum
MDT:	Multi-Disciplinary Team SDP
NHSE/I:	NHS England and NHS Improvement
OPiC:	Operational Incident Cell (LRF)
PHE:	Public Health England
PH Lead:	Local Authority Public Health Team Lead
SDP:	Safer Devon Partnership
TCS:	Transport Coordination Services
QAIT:	Quality Assurance Improvement Team

HEALTH AND WELLBEING OUTCOMES REPORT 2020-25

Vision - Health outcomes and health equality in Devon will be amongst the best in the world, and will be achieved by Devon's communities, businesses and organisations working in partnership



Priority and Indicator	Time Period	Devon	SW	Eng	Devon Trend	East Devon	Exeter	Mid Devon	North Devon	South Hams	Teignbridge	Torridge	West Devon	Deprivation MD <-------> LD	Value	Guide
1. Create opportunities for all																
GCSE Attainment (Free School Meals)	2018	18.2%	17.7%	21.7%	-	28.2%	21.1%	25.0%	17.9%	26.2%	17.5%	13.2%	16.7%		%	Higher is better
GCSE Attainment	2018	41.0%	43.2%	43.5%	-	48.0%	41.9%	45.3%	36.7%	45.2%	36.1%	28.0%	41.2%		%	Higher is better
Good Level of Development (Free School Meals)	2018/19	54.7%	53.0%	56.5%		58.1%	53.7%	55.7%	53.4%	59.5%	56.8%	49.0%	52.5%		%	Higher is better
Good Level of Development	2018/19	72.7%	72.0%	71.8%		73.5%	71.7%	70.3%	72.5%	77.7%	73.3%	68.8%	74.2%		%	Higher is better
% with NVQ4+ (aged 16-64)	2018	40.1%	38.7%	39.0%		35.8%	40.6%	40.3%	30.5%	45.7%	46.4%	33.6%	50.0%		%	Higher is better
% with no qualifications (NVQ) (aged 16-64)	2018	5.1%	5.3%	7.6%		6.5%	4.4%	5.4%	9.2%	2.4%	5.1%	-	5.5%		%	Lower is better
Child Poverty	2016	12.5%	14.0%	17.0%		11.2%	13.4%	11.6%	13.4%	10.5%	12.8%	16.0%	12.3%		%	Lower is better
Not in Education, Employment or Training	2019	6.3%	6.7%	6.0%	-	5.9%	8.5%	6.0%	6.8%	4.8%	6.0%	6.0%	5.7%		%	Lower is better
Gross Value Added - Per Head (Output)	2016	£ 20,843	£ 23,091	£ 27,108		£17,246	£ 31,446	£ 16,663	£ 20,929	£ 23,847	£ 18,583	£ 16,094	£ 17,371	-	£	Higher is better
2. Healthy, safe strong and sustainable communities																
Fuel Poverty	2017	11.6%	10.8%	10.9%		10.3%	12.4%	11.2%	12.6%	11.2%	10.9%	13.2%	12.6%		%	Lower is better
Rough Sleeping	2018	1.5	1.9	2.0	-	0.8	3.2	0.9	2.9	1.8	1.2	0.9	0.0	-	Rate per 10,000	Lower is better
Dwellings with category one hazards	2014/15	15.4%	15.6%	10.4%		14.7%	9.4%	17.3%	17.7%	15.8%	13.4%	26.2%	13.8%	-	%	Lower is better
Private sector dwellings made free of hazards	2014/15	1.0%	1.0%	1.2%		1.1%	1.7%	1.1%	1.9%	0.4%	1.5%	0.1%	0.5%	-	%	Higher is better
People who use services who feel safe	2018/19	69.2%	70.0%	70.1%		78.7%	63.7%	68.5%	70.2%	66.7%	72.2%	60.8%	66.7%		%	Higher is better
Proportion of people with poor access to healthy assets	2017	26.5%	18.1%	21.1%	-	37.4%	-	30.7%	23.8%	38.4%	15.7%	44.6%	44.0%		%	Higher is better
Overall rate of crime	2018/19	57.1	67.1	67.3		44.0	84.0	45.0	60.0	41.0	52.0	43.0	40.0		Rate per 1,000	Lower is better
3. Focus on mental health																
Suicide Rate	2016-18	11.2	11.1	9.6		7.0	15.0	12.9	13.0	6.7	13.7	12.8	8.9		DASR per 100,000	Lower is better
Emergency Hospital Admissions for Intentional Self-Harm	2018/19	210.4	272.8	193.4		187.6	216.8	158.9	309.6	176.9	232.3	273.5	128.4		DASR per 100,000	Lower is better
Self-Reported Wellbeing (low happiness score %)	2018/19	5.7%	7.3%	7.8%		-	-	-	-	-	-	-	-	-	%	Lower is better
Social Contentedness	2018/19	44.7%	46.6%	45.9%	-	-	-	-	-	-	-	-	-	-	%	Lower is better
Access to psychological therapies	2017	17.5%	-	18.3%	-	16.8%	20.1%	16.1%	18.8%	13.3%	18.9%	17.3%	15.3%	-	%	Higher is better
4. Maintain good health for all																
Adults Excess Weight*	2018/19	60.7%	61.3%	62.3%		55.7%	59.9%	67.9%	65.2%	61.6%	59.7%	62.7%	56.8%		%	Lower is better
Proportion of Physically Active Adults*	2018/19	74.8%	71.8%	67.2%		78.8%	75.1%	73.9%	72.1%	75.2%	72.9%	71.5%	77.5%		%	Higher is better
Alcohol-Related Admissions	2018/19	547.0	680.0	664.0	-	461.0	590.0	479.0	703.0	459.0	593.0	654.0	456.0		DASR per 100,000	Lower is better
Alcohol-Specific Admissions in Under 18s	2016-19	46.1	44.1	31.6	-	45.8	37.5	30.0	63.2	54.4	62.2	26.8	50.1		Rate per 100,000	Lower is better
Fruit and Vegetable Consumption (5-a-day)*	2018/19	63.4%	59.5%	54.6%		68.1%	61.4%	64.1%	61.3%	62.9%	62.3%	58.6%	68.0%		%	Higher is better
Mortality Rate from Preventable Causes	2016-18	159.9	167.2	180.8		136.8	193.1	154.8	183.6	137.4	157.5	175.4	157.6		DASR per 100,000	Lower is better
Cancer Diagnosed at Stage 1 or 2	2017	56.1%	53.3%	52.2%		58.5%	59.9%	56.0%	49.3%	57.4%	54.2%	57.1%	56.6%		%	Higher is better
Overall satisfaction of carers with social services	2018/19	38.3%	38.5%	38.6%	-	43.9%	47.1%	50.0%	32.4%	28.6%	36.0%	33.3%	30.0%		%	Higher is better
Feel Supported to Manage Own Condition	2019	84.2%	81.8%	78.4%	-	87.2%	83.5%	83.8%	83.6%	84.3%	82.7%	80.0%	88.4%	-	%	Higher is better
Re-ablement Services (Effectiveness)	2017/18	82.6%	80.2%	82.9%		77.5%	79.5%	79.5%	76.1%	97.8%	81.9%	87.1%	94.6%		%	Higher is better
Re-ablement Services (Coverage)	2017/18	1.8%	2.6%	2.9%		-	-	-	-	-	-	-	-	-	%	Higher is better
Injuries Due to Falls	2018/19	1785.0	2113.0	2198.0		1681.0	1862.0	1831.0	1866.0	1812.0	1900.0	1733.0	1550.0		DASR per 100,000	Lower is better
Adult Smoking Prevalence	2018	13.4%	13.9%	14.4%		8.6%	17.2%	13.3%	14.4%	17.3%	14.1%	7.1%	14.3%		%	Lower is better
Estimated Dementia Diagnosis Rate (65+)	2019	59.8%	62.4%	68.7%		64.8%	71.9%	52.1%	61.0%	41.4%	59.1%	58.5%	58.8%	-	%	Higher is better

Key Symbols
- \- Data not available
- # Value missing due to small sample size
- ^ Change in methodology
- ^^ National method for calculating Confidence Intervals are being revised

Most deprived <---------> Least deprived

* Updated indicator

Significance compared to England figure
- Significantly worse
- Not significantly different
- Significantly better

Trend
- Worsening trend
- Static trend
- Improving trend
- \- Not enough data

Health and Wellbeing — Devon County Council

Committed to promoting health equality

Indicator	Description	Detailed specification
1. Create Opportunities for All		
GCSE Attainment (Free School Meals)	Percentage of pupils achieving five or more GCSEs at grades 9 to 5 including English and Maths that are part of the Free School Meal 6 status.	Number of pupils at end of Key Stage 4 in schools maintained by the local education authority (includes special schools and pupil referral units) achieving five or more GCSEs at grades A* to C or equivalent, including English and maths GCSE as a percentage of all pupils at end of Key Stage 4.
GCSE Attainment	Percentage of overall pupils achieving five or more GCSEs at grades 9 to 5 including English and Maths.	Number of pupils at end of Key Stage 4 in schools maintained by the local education authority (includes special schools and pupil referral units) achieving five or more GCSEs at grades A* to C or equivalent, including English and maths GCSE as a percentage of all pupils at end of Key Stage 4.
Good Level of Development (Free School Meals)	The percentage of children with free school meal status achieving a good level of development at the end of reception	All children defined as having reached a good level of development at the end of the EYFS by local authority. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.
Good Level of Development	The percentage of children achieving a good level of development at the end of reception	All children defined as having reached a good level of development at the end of the EYFS by local authority. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.
% with NVQ4+ (aged 16-64)	Percentage of people aged 16-64 with and NVQ4+ qualification	The number of people with NVQ 4 equivalent and above, e.g. HND, Degree and Higher Degree level qualifications or equivalent divided by the total population age 16-64.
% with no qualifications (NVQ) (aged 16-64)	Percentage of people aged 16-64 with no qualifications (%)	The number of people with no formal qualifications divided by the total population aged 16-64.
Child Poverty	Percentage of children (aged 0 to 15) living in households dependent on benefits or tax credits.	Children living in families in receipt of Child Tax Credit (CTC) whose reported income is less than 60 per cent of the median income or are in receipt of income support (IS) or Income-Based Jobseeker's Allowance (JSA), as a proportion of the total number of children in the area.
Not in Education, Employment or Training	16-19 year olds not in education, employment or training (NEET) or whose activity is not known	The estimated number of 16-19 year olds not in education, employment or training or whose activity is not known. The England and South West figure represents the estimated proportion of 16-17 year olds not in education, employment or training or whose activity is not known.
Gross Value Added - Per Head (Output)	The value generated by any unit engaged in the production of goods and services.	A measure of the increase in the value of the economy due to the production of goods and services. It is measured at current basic prices, which includes the effect of inflation, excluding taxes (less subsidies) on products. GVA plus taxes (less subsidies) on products is equivalent to gross domestic product (GDP).
2. Healthy, Safe, Strong and Sustainable Communities		
Fuel Poverty	The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology	Under the "Low Income, High Cost" measure, households are considered to be fuel poor where: 1.They have required fuel costs that are above average (the national median level) 2.Were they to spend that amount, they would be left with a residual income below the official fuel poverty line. The key elements in determining whether a household is fuel poor or not are income, fuel prices, and fuel consumption (which is dependent on the dwelling characteristics and the lifestyle of the household)
Rough Sleeping	The number of rough sleepers counted or estimated by the local authority as a rate per 1,000 households	These annual rough sleeping counts and estimates are carried out in October or November. Each local authority district either conducts a street count or provides an estimate. A count is a single night snapshot of the number of rough sleepers in a local authority area. Counts are independently verified by Homeless Link. An estimate is the number of people thought to be sleeping rough in a local authority area on any one night in a chosen week. Local authorities decide annually whether to provide a count or an estimate in light of their local circumstances. Counts and estimates may underestimate the true extent of rough sleeping.
Dwellings with category one hazards	Percentage of total dwellings with hazards rated as serious (category one) under the housing health and safety rating system (HHSRS)	The housing health and safety rating system (HHSRS) is a risk-based evaluation tool introduced under the Housing Act 2004, which identifies 29 hazards including damp, excess cold, excess heat, the presence of pollutants (including Asbestos), space, security, light, noise, hygiene, sanitation, water supply, and risk of accidental injury. Risks rated as category one pose a serious risk to health and safety. The numerator is the total number of dwellings identified as having category one hazards present (f6a). The denominator is the total number of dwellings from Live Table 100 (dwelling stocks by local authority).
Private sector dwellings made free of hazards	Percentage of private sector dwellings identified as having hazards rated as serious (category one) under the housing health and safety rating system (HHSRS) which were made free of these hazards in the previous financial year	The housing health and safety rating system (HHSRS) is a risk-based evaluation tool introduced under the Housing Act 2004, which identifies 29 hazards including damp, excess cold, excess heat, the presence of pollutants (including Asbestos), space, security, light, noise, hygiene, sanitation, water supply, and risk of accidental injury. Risks rated as category one pose a serious risk to health and safety. The numerator is the total number of private sector dwellings made free of category one hazards through local authority intervention. The denominator is the total number of private sector dwellings identified as having category one hazards present.
People who use services who feel safe	The measure is defined by determining the percentage of all those responding who choose the answer “I feel as safe as I want” from the Adult Social Care Survey.	This measures one component of the overarching ‘social care-related quality of life’ measure. It provides an overarching measure for this domain.
Proportion of people with poor access to healthy assets	Access to Healthy Assets & Hazards Index	Percentage of the population who live in LSOAs which score in the poorest performing 20% on the Access to Healthy Assets & Hazards (AHAH) index. The AHAH index is comprised of four domains: access to retail services (fast food outlets, gambling outlets, pubs/bars/nightclubs, off licences, tobacconists), access to health services (GP surgeries, A&E hospitals, pharmacies, dentists and leisure centres), the physical environment (access to green spaces, and three air pollutants: NO2 level, PM10 level, SO2 level) and air pollution (NO2 level, PM10 level, SO2 level).
Overall rate of crime	The rate of crimes, crude rate per 1,000	Numerator is the number of crime incidents recorded by the police. Denominator is the rounded mid-year population of the area. Rate is numerator divided by denominator multiplied by 1,000.
3. Focus on Mental Health		
Suicide Rate	Direct age-standardised mortality rate (DASR) from suicide and injury of undetermined intent per 100,000 population	Number of deaths from suicide and injury of undetermined intent (classified by underlying cause of death recorded as ICD10 codes X60-X84 (all ages), Y10-Y34 (ages 15+ only) registered in the respective calendar years, aggregated into quinary age bands, with corresponding mid-year population totals. Age specific rates are calculated and multiplied by the standard population for each age group and aggregated to give the age adjusted count of deaths for the area, and divided by the total standard population and multiplied by 100,000 to give the age standardised mortality rate for the area. New 2013 European Standard population used.
Emergency Hospital Admissions for Intentional Self-Harm	Direct Age Standardised Rate of finished admission episodes for self-harm per 100,000 population aged 10 to 24 years	Numerator is number of finished admission episodes in children aged between 10 and 24 years where the main recorded cause is between ‘X60’ and ‘X84’ (Intentional self-harm). Population for people aged 10 to 24, aggregated into quinary age bands. Age specific rates are calculated and multiplied by the standard population for each age group and aggregated to give the age adjusted count of deaths for the area, and divided by the total standard population and multiplied by 100,000 to give the age standardised mortality rate for the area. The 2013 revision to the European Standard Population has been used.
Self-Reported Wellbeing (low happiness score %)	Self-reported well-being - percentage of people with a low happiness score	The percentage of respondents who answered 0-4 to the question "Overall, how happy did you feel yesterday?"ONS are currently measuring individual/subjective well-being based on four questions included on the Integrated Household Survey. Responses are given on a scale of 0-10 (where 0 is “not at all happy” and 10 is “completely happy”)The first full year data from these questions was published by ONS in July 2012 and are being treated as experimental statistics. In the ONS report, the percentage of people scoring 0-6 and 7-10 have been calculated for this indicator.
Social Contentedness	Proportion of people who use services who reported that they had as much social contact as they would like.	The percentage of users responding "I have as much contact as I want with people I like" and carers choosing "I have as much contact as I want" to questions based on their social situation in the Adult Social Care Survey and Carers Survey. Currently just measuring social care users. Measures for users and carers will be presented separately
Access to psychological therapies	Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/depression	The number of people entering IAPT services as a proportion of those estimated to have anxiety and/or depression.
4. Maintain good health for all		
Adults Excess Weight	Percentage of adults classified as overweight or obese.	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2. Denominator is number of adults ages 18+ with valid height and weight recorded.Height and weight is self-reported but is adjusted by age and sex using Health Survey for England data to adjust for differences between self-reports and actual BMI. Prevalences are weighted to be representative of the whole population at each level of geography and have been age-standardised.
Proportion of Physically Active Adults	Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity.	The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16. This includes physical activity as a mode of transportation to work, as well as direct leisure activities.
Alcohol-Related Admissions (Narrow)	Direct age-standarised rate of hospital admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population.	Admissions to hospital involving an alcohol-related primary diagnosis or an alcohol-related external cause. Admissions of children under 16 were only included if they had an alcohol-specific diagnosis i.e. where the attributable fraction = 1, meaning that the admission is treated as being wholly attributable to alcohol. For other conditions, estimates of the alcohol-attributable fraction were not available for children.
Alcohol-Specific Admissions in under 18s	Hospital admissions for alcohol-specific causes in persons aged under 18 per 100,000 population	Persons aged less than 18 years admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific condition for three financial years pooled. In addition, individuals admitted are only counted once per financial year. Denominator is ONS mid-year population estimates for 0-17 year olds. Three years are pooled. Rate is a crude rate per 100,000 population. See LAPE user guide for further details - http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
Fruit and Vegetable Consumption (5-a-day)	Proportion of the population who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on a usual day.	Proportion of the population who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on the previous day. Respondents to the Active Lives Survey who answered both of the following questions were included: 1) How many portions of fruit did you eat yesterday? Please include all fruit, including fresh, frozen, dried or tinned fruit, stewed fruit or fruit juices and smoothies. Fruit juice only counts as one portion no matter how much you drink. 2) How many portions of vegetables did you eat yesterday? Please include fresh, frozen, raw or tinned vegetables, but do not include any potatoes you ate. Beans and pulses only count as one portion no matter how much of them you eat.
Mortality Rate from Preventable Causes	Direct age-standardised mortality rate from causes considered preventable per 100,000 population	Numerator is number of deaths that are considered preventable (classified by underlying cause of death recorded as ICD codes A15-A19, B17.1, B18.2, B20-B24, B90, C00-C16, C18-C22, C33-C34, C43, C45, C50, C53, E10-E14, F10-F16, F18-F19, G31.2, G62.1, I20-I26, I42.6, I71, I80.1-I80.3, I80.9, I82.9, J09-J11, J40-J44, K29.2, K70, K73-K74 (excl. K74.3-K74.5), K86.0, U50.9, V01-Y34, Y60-Y69, Y83-Y84) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 80-84, 85+). The 2013 revision to the European Standard Population has been used for this measure.
Cancer Diagnosed at Stage 1 or 2	Proportion of cancers diagnosed at an early stage	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin). This indicator is labelled as experimental statistics because of the variation in data quality: the indicator values primarily represent variation in completeness of staging information.
Overall satisfaction of carers with social services	The measure is defined by determining the percentage of all those responding who identify strong satisfaction, by choosing the answer “I am extremely satisfied” or the answer “I am very satisfied” from the Adult Social Care Survey.	This measures the satisfaction with services of carers of people using adult social care, which is directly linked to a positive experience of care and support. Analysis of user surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.
Feel Supported to Manage Own Condition	Weighted percentage of people feeling supported to manage their condition.	Numerator: For people who answer yes to the Question 30 “Do you have a longstanding health condition”, the numerator is the total number of ‘Yes, definitely’ or ‘Yes, to some extent’ answers to GPPS Question 32: In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)? Please think about all services and organisations, not just health services • Yes, definitely • Yes, to some extent • No • I have not needed such support • Don’t know/can’t say. Responses weighted according to the following 0-100 scale: “No” = 0 “Yes, to some extent” = 50 “Yes, definitely” = 100.
Re-ablement Services (Effectiveness)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
Re-ablement Services (Coverage)	Proportion of older people (65 and over) offered reablement services following discharge from hospital.	The number of older people (65 and over) offered reablement services as a proportion of the total number of older people discharged from hospitals based on Hospital Episode Statitstics (HES)
Injuries Due to Falls	Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age-sex standardised rate per 100,000.	Emergency admissions for falls injuries classified by primary diagnosis code (ICD10 code S00-T98) and external cause (ICD10 code W00-W19) and an emergency admission code. Age at admission 65 and over.Counted by first finished consultant episode (excluding regular and day attenders) in financial year in which episode ended, by local authority and region of residence from the HES data. Population based on Local Authority estimates of resident population produced by ONS. Analysis uses the quinary age bands 65-69, 70-74, 75-79, 80-84 and 85+, by sex. Calculated using the 2013 European Standard Population.
Adult Smoking Prevalence	Percentage of adults aged 18 and over who smoke	The number of persons aged 18+ who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response. Denominator is Total number of respondents (with valid recorded smoking status) aged 18+ in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Estimated Dementia Diagnosis Rate (65+)	Number of persons recorded on a GP Dementia Disease Register as a % of those in the area estimated to have dementia (using age and sex based estimates)	Numerator is the number of people on a GP practice dementia disease register at the end of the given period and reported through the Quality and Outcomes Framework. Numbers predicted to have dementia in individual GP practice population in quinary age bands to age and sex specific dementia prevalence rates from the 2007 Dementia UK prevalence study. Rate divides the number on the QOF register by the predicted number with dementia to give the percentage diagnosed. GP practice numerators and denominators are aggregated to areas based on location of practice.

Health and Wellbeing Board
16 July 2020

BETTER CARE FUND PLAN 2019/20 - QUARTER 4 REPORT

Report of the Associate Director of Commissioning (Care and Health), Devon County Council and NHS Devon Clinical Commissioning Group.

Please note that the following recommendations are subject to consideration and determination by the Committee before taking effect

Recommendation:

The Board note:

That the Quarter 4 BCF return will be submitted to NHS England in accordance with its timescales (yet to be confirmed); the Health and Wellbeing Board is asked to approve the Quarter 4 submission.

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1. Background/Introduction

1.1 The Better Care Fund is the only mandatory policy to facilitate integration, providing a framework for joint Health and Social Care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant and funding paid to local government for adult social care services. The Health and Wellbeing Board is required to complete a BCF plan each year for endorsement by NHS England alongside the Section 75 agreement which details the agreement for how the fund be utilised and operated between the Council and CCG.

2. Compliance with national conditions

2.1 We will confirm that we have met each of the national conditions required of the submission:

NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**
	PR2	**A clear narrative for the integration of health and social care**
	PR3	**A strategic, joined up plan for DFG spending**
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**
NC4: Implementation of the High Impact Change Model for	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**
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Managing Transfers of Care		
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**
	PR8	**Indication of outputs for specified scheme types**
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**

3.0 High Impact Change Model

3.1 We are required to assess our progress against each of the metrics outlined in the High Impact Change Model – a set of best practice recommendations for tackling delayed transfers of care.

3.2 We have reached maturity within all but one of the domains: seven-day services. Community based health and social care teams have been progressing towards 6 day working, and during the Covid-19 pandemic teams have been asked to cover 7 days a week to better support the national discharge guidance. This has provided teams with the opportunity to test the 7-day model and help understand how we might embed this further.

	Current position of maturity
Early discharge planning	Mature
Systems to monitor patient flow	Mature
Multi-disciplinary/Multi-agency discharge teams	Mature
Home first / discharge to assess	Mature
Seven-day service	Established
Trusted assessors	Mature
Focus on choice	Mature
Enhancing health in care homes	Mature

4.0 Metrics

4.1 We are required to outline our 19/20 target and plan around 4 key metrics. Below is a summary of performance and plans for each area:

Total number of specific acute non-elective spells per 100,000 population

4.2 Performance has been challenging in this area, but we remain around 5.53% below our 2019/20 plan, with 36791 non-elective admissions against a system target of 38947. We saw a significant drop in non-elective admissions in the last two weeks in March.

4.3 Our plan focused on:

- Population Health Management capability to be embedded at neighbourhood and place which enables the delivery of proactive care.
- A 'One Team' model blurring organisational boundaries at place that is agile and adaptable to population need.
- Maturing Primary Care Networks delivering integrated care to meet population needs and working as part of that one team
- Continued investment in core approaches such as clinical triage at emergency departments, extending primary care and therapy support to care homes and developing voluntary sector capacity

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)

4.4 Delayed transfers of care (DTOC) are monitored daily across each of Devon's acute trusts, with A&E Delivery Boards taking ownership locally. Prior to Covid-19 DTOC performance had continued to be a challenge, particularly within the Eastern locality. The reasons for delay vary by organisation, but in general delays were mostly around:

1. Care Packages in own home
2. Patients waiting for further non-acute NHS care
3. Patients awaiting residential care home placements

4.5 A Covid-19 Discharge Cell was established to support compliance with the national discharge guidance and has been monitoring acute and community hospital discharge daily. In the latter part of Q4 we have seen a significant reduction in DTOC, particularly within the Eastern system, which went from 50 (March) to 11 (April). We are capturing the learning as part of the restoration and recovery process in order to maintain this performance improvement.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

4.6 Whilst we continue to place fewer older people in residential/nursing care relative to population than comparator and national averages, we have seen an upward trend in admission to long-term care. This is linked to our older population, with a prevalence of dementia and behaviours that challenge which makes this a continued area of focus for us.

4.7 Our aim is to ensure we have sufficient and robust alternatives to long term care, supporting people to remain living as independently as possible in their own homes. This includes our integrated care model and a continuation of community based intermediate care solutions, such as Rapid Response, Social Care Reablement and regulated personal care. Alongside this we are continuing to develop a range of alternatives including Extra Care Housing and Supported Living.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

4.8 This metric is designed to measure how well our reablement and rehabilitation services are working to help people recover after a spell in hospital. As we support more and more people with these services (i.e. increase the reach), we do expect the performance against this measure to reduce – as we are supporting people with very complex needs who may well need repeated hospital care, rather than simply those who only need a small amount of support.

4.9 Coordination of care and support and multi-disciplinary team working helps us to support more people to remain at home, and Primary Care Networks are key to the development of enhanced integrated health and social care teams. In quarter four we have seen the accelerated development of this 'One Team' approach in response to Covid-19 and in particular through joint working to support shielding patients and care homes.

5.0 Integration highlight

5.1 We are required to highlight one area which demonstrates our integrated working this quarter, and we chose to highlight our progress with the Enhanced Health in Care Homes Framework.

5.2 We have established weekly forums for care home providers via the Provider Engagement Network, as well as webinars to facilitate support to homes including testing, PPE, infection control, staffing and advanced care planning. This has facilitated the development of joined up care home support plans with local authority, community, acute and primary care colleagues and strengthened our engagement with the sector.

5.3 We have also established a bed bureau, through the Arranging Support Teams in each locality, as a means of managing and tracking care home vacancies across the county, using the national tracker, to have a more accurate and up to date picture of capacity and demand.

6.0 Winter Pressures

6.1 The Q4 return includes a brief narrative on how we have spent the £3.5 million social care winter funding. Investment of this money has meant more people cared for at home with wraparound support that helps prevent emergency admissions to hospital.

6.2 Our submission will state that the has indeed been invested to strengthen acute admission prevention schemes, including:

- targeted care home support
- early care home visiting for medical reviews
- prescribing and medication reviews for patients who are 65+

7.0 End of year report

The return confirms that we already have longstanding joint working arrangements, but the BCF funding has helped consolidate those through the joint development of workstreams to address shared challenges within the remit of the funding. The reflection of our key successes for integration this year have been strong system-wide governance and systems leadership, building on the joint working arrangements already in place.

Tim Golby
Associate Director of Commissioning (Care and Health), DCC and NHS Devon CCG

Electoral Divisions: All

Cabinet Member for Adult Care and Health: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS
Contact for Enquiries:
Rebecca Harty, Head of Integrated Care Model Northern and Eastern
Tel No: 01392 675344
Room: 2nd Floor, The Annexe, County Hall

BACKGROUND PAPER	DATE	FILE REFERENCE
Nil		

HEALTH AND WELLBEING BOARD – FORWARD PLAN

Date	Matter for Consideration
Thursday 8 October 2020 @ 2.15pm	**Morning Session** Dementia Friends Training JSNA Tool Training session **Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund Adults Safeguarding annual report Gap in employment rate for those with mental health Strategic Approach to Housing Safer Devon Partnership update Homelessness Reduction Act Report - 12 month update Health Protection Committee Update Strategic Economic Assessment & Development Strategy (Presentation) Mental Health Prevention Concordat Action Plan - update CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 21 January 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC JSNA / Strategy Refresh Children's Social Care Services OFSTED update (look at report) Population Health Management & and Integrated Care Management (Presentation) CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Annual Reporting	Adults Safeguarding annual report (September / December) Joint Commissioning Strategies – Actions Plans (Annual Report – December) JSNA / Strategy Refresh – (June)
Other Issues	Equality & protected characteristics outcomes framework