SUNDERLAND HEALTH AND WELLBEING BOARD

AGENDA

Meeting to be held remotely on Thursday 25 June 2020 at 9.30am

The meeting will be livestreamed for the public to view on the Council's YouTube channel, 'sunderlandgov' at: - https://youtu.be/lme1axscBOw

For further information and assistance, please contact:

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10. Local Outbreak Control Board 85

Report of the Director of Public Health (attached).

ITEMS FOR INFORMATION

11. Status Update 89

Report of the Senior Manager – Policy (attached).

12. Dates and Times of Future Meetings -

The Board is asked to note the proposed schedule of meetings for 2020/2021: -

Friday 18 September 2020
Friday 11 December 2020
Friday 19 March 2021

All meetings to start at 12noon.

Please note that dates, times and the method of holding meetings may change during the Covid-19 pandemic

ELAINE WAUGH
Assistant Director of Law and Governance

Civic Centre
Sunderland

17 June 2020

Item No. 6

SUNDERLAND HEALTH AND WELLBEING BOARD

Friday 13 December 2019

MINUTES

Present: -

Councillor Geoff Walker (in the Chair)	-	Sunderland City Council
Councillor Kelly Chequer	-	Sunderland City Council
Councillor Louise Farthing	-	Sunderland City Council
Dr John Dean	-	Healthwatch Sunderland
Dave Gallagher	-	Chief Officer, Sunderland CCG
Gillian Gibson	-	Director of Public Health
Lisa Quinn	-	NTW NHS Foundation Trust
Dr Ian Pattison	-	Chair, Sunderland CCG

In Attendance:

Karen Davison	-	Together for Children
Graham King	-	Assistant Director of Adult Services, Sunderland City Council
Colin Shevills	-	Director, Balance – the North East Alcohol Office
Sue Brent	-	University of Sunderland
Laura Cassidy	-	Public Health Practitioner, Sunderland City Council
Wendy Mitchell	-	Public Health Lead, Sunderland City Council
Julie Parker-Walton	-	Registered Public Health Specialist, Sunderland City Council
Lorraine Hughes	-	Public Health Specialist, Sunderland City Council
Jane Hibberd	-	Senior Manager, Policy, Sunderland City Council
Jessica May	-	Senior Manager, Partnerships, Sunderland City Council
Nicola Appleby	-	Senior Policy Officer, Sunderland City Council
Liz Highmore	-	Observer
Chris Binding	-	Local Democracy Reporting Service
Gillian Kelly	-	Governance Services, Sunderland City Council

HW25. Apologies

Apologies for absence were received from Councillor Leadbitter, Ken Bremner, Professor Young, Fiona Brown and Jill Colbert.

HW26. Declarations of Interest

There were no declarations of interest.

HW27. Minutes and Matters Arising

The minutes of the meeting of the Health and Wellbeing Board held on 20 September 2019 and the Action Log were agreed as a correct record subject to an amendment to the second paragraph on page one to show that it was Helen *McArdle* Care which had donated to the nursing school and that this would enable a focus on 'nursing care and research'.

Councillor Farthing referred back to the comments which she had made regarding holding partners to account on early help matters and Karen Davison agreed that there still did not seem to be a natural home for this area of work. This was an action for the Chief Executive of Together for Children, and Dave Gallagher stated that he would pick this up with her at a planned one to one meeting. He said that the prevention element would not be lost and suggested that a task and finish group may be established to look at the recommendations.

Graham King advised that the Better Care Fund submission had been approved by NHS England and MHCLG and the Section 75 Agreement had also been completed and just required a signature from the CCG and local authority.

Dave Gallagher reported that in relation to the Integrated Care System, the Memorandum of Understanding between NHS Partners in the North East and Cumbria was now in place and work would take place with wider partners during the first quarter of the new year. Graham King commented that there had been a useful lead member meeting on this.

It was noted that the completed items had been removed from the Action Log.

HW28. Tobacco Priority Update

The Sunderland Smoke Free Partnership submitted a report setting out the eight key strands of work which would form the basis of action planning for 2019-2024 along with key performance indicators which would be used to measure progress on this priority, and a high-level action plan for the year ahead.

The strands of work were: -

1. Development Infrastructure, Skills and Capacity
2. Reducing Exposure to Second-hand Smoke
3. Helping smokers to stop
4. Media, Communications and Education
5. Reducing the availability and supply of tobacco products; licit and illicit and addressing the supply of tobacco to children
6. Tobacco Regulation

7. Reducing Tobacco Promotion
8. Research, monitoring and evaluation

The Sunderland Smokefree Action Plan would focus on specified groups with high smoking prevalence and would identify areas across the system to maximise opportunities to support local people to stop smoking. A high-level version of the action plan was attached to the report.

The Chair noted that there had been discussions about developing a balanced scorecard approach to the working group programmes and this would be discussed in the April development session.

Councillor Farthing commented that, as a Health Champion, she encouraged people to quit smoking but had been talking to one individual who believed that e-cigarettes were very bad due to media stories which had been circulating and she felt that public bodies were not really counteracting these erroneous messages.

The Chair noted that there had been several press statements from Public Health England on e-cigarettes and safety and Julie Parker-Walton stated that Fresh had produced some media coverage when certain stories had come out of the USA. Julie suggested that she could circulate the press release to the Board Members.

Councillor Farthing said it would be useful to have something which could be shared on social media and Gillian Gibson suggested that Public Health work with the Communications Team on this. She added that regulation of e-cigarettes was different in the United States and the majority of people experiencing health issues had been using e-cigarettes to smoke illegal drugs.

Lisa Quinn referred to the action plan and queried if there were any timescales for partners to implement smoke free policies and for baseline education on tobacco to be delivered in schools. Julie advised that work would have to be done with partners to get those timescales in place and then the extra detail could be developed.

Graham King commented that as Neighbourhood Plans developed, there could be a discussion around complementing the action plan and making a link to certain wards. Dr Pattison added that this was the sort of thing which the Clinical Directors of the Primary Care Networks would like to look at and there may be some early opportunities to link these together.

The Board therefore RESOLVED that: -

(i) the focus of the Sunderland Smokefree Partnership's work being on the eight key strands of work, set out in section 4.2 of the report, be supported;

(ii) the Sunderland Smokefree Partnership action plan be approved; and

(iii) an update be received annually from the Sunderland Smokefree Partnership, including progress on the indicators set out in section 3 of the report and key actions for the year ahead.

HW29. Membership of the Health and Wellbeing Board

The Chair of the Health and Wellbeing Board submitted a report asking Members to consider expanding the membership of the Health and Wellbeing Board.

During the municipal year, Professor Michael Young had been invited to join the Health and Wellbeing Board and it had now been suggested that the Chair of the Sunderland Healthy Workplace Alliance also be invited to become a member of the Board. The current Chair of the Alliance is Ralph Saelzer, Managing Director of Liebherr Works (Sunderland) Ltd.

Councillor Farthing highlighted that 'anchor organisations' had been referred to in previous reports and suggested that there should be representation from those agencies and also place based organisations.

Jane Hibberd advised that the membership of the Board was scheduled for review at the next meeting to coincide with the development of the Healthy City Plan. This would allow the Board to consider whether they would like other partners to become Board Members.

RESOLVED that: -

(i) it be formally agreed that the University of Sunderland be a member of the Board;

(ii) the Chair of the Sunderland Healthy Workplace Alliance to become a member of the Board; and

(iii) the Board notify the Council of its appointments for the Annual Meeting in May 2020.

HW30. Alcohol Harms Priority Update

The Sunderland Alcohol Partnership submitted a report providing a progress update: -

- addressing alcohol harms, one of the Board's seven priorities;
- research on the positive impact of minimum unit price (MUP) on reducing alcohol related deaths, alcohol related crimes and reducing health inequalities; and
- the draft alcohol action plan.

Colin Shevills, Director, Balance was in attendance to talk to the report and reported that in Sunderland, 89 adults died each year due to alcohol consumption and 4,653 hospital admissions were caused by alcohol. The cost of alcohol to the NHS in Sunderland was £20.6m a year.

Minimum Unit Pricing (MUP) was a specifically targeted measure; almost all of the cheapest alcohol was consumed by people drinking at harmful levels (90%) and a 50p MUP locally would prevent 270 deaths over the next 20 years. Half of all deaths

prevented would be in the north of England and consumption in Sunderland would reduce by 9.1%.

MUP had been introduced in Scotland in May 2018 and this had happened smoothly with no evidence of commercial level cross border trading and consumption was down by 3%. Research into purchasing patterns showed that the heaviest drinkers were reducing their consumption the most and there had been reductions in alcoholic liver disease.

MUP was being introduced in Wales on 2 March 2020 and Ireland had introduced a bill for minimum pricing. The Australian Government were looking at a discussion paper on the subject. Organisational bodies were being asked to call upon the Government to introduce MUP at an England level.

Laura Cassidy, Public Health Practitioner delivered a presentation on the Health Related Behaviour Survey. This was a self-reported lifestyle survey carried out with a sample of children and young people in primary and secondary schools across Sunderland and 3,698 young people had been involved in the survey in the 2018/2019 academic year.

In terms of primary school pupils, 2% of Year 6 students said that they had an alcohol drink in the week before the survey. This was a downward trend from 20% in 2006. 90% said that they never drank alcohol, 8% said that their parents always knew if they did and 1% said their parents usually knew.

Turning to the secondary school students, 12% of Year 8 pupils and 26% of Year 10 pupils said that they had drunk alcohol in the last seven days. 9% of both boys and girls in Year 10 said that they had taken an illegal drug and alcohol on the same occasion.

46% of pupils in 2019 said that they did not drink alcohol at all compared with 57% in 2017. 19% in 2019 said that they had an alcoholic drink in the last seven days compared with 13% in 2017. This was considerably lower than the 31% who said this in 2010.

Drinking prevalence in secondary schools was highest in the Coalfields locality and the numbers of pupils drinking 14 units a week or more was also highest in the Coalfields. When asked where they got the alcohol from, the majority of respondents said their parents or carers gave it to them.

A workshop had taken place in the summer, led by Balance, as part of a wider project around a vision for an Alcohol Free Childhood. Eight young people took part in the work and discussed what they thought the key challenges might be and how these could be tackled. A short film had been made on the project and this was shown to the Board Members.

Julie Parker-Walton highlighted that the Alcohol Partnership had held a CLeaR workshop in May 2019 and that this had identified good practice across the city. The draft alcohol action plan had been developed following this and had been discussed at the partnership meeting in October and circulated to key partners for consultation.

The plan would be finalised in the new year and then brought to the Health and Wellbeing Board for approval.

Councillor Chequer commented that she would be happy to lobby the new Government on MUP and enquired whether there had been an impact on commissioned addiction services. There were a number of people in poverty also living with addiction and if they were unable to access services they would continue drinking. She was concerned that people were not pushed further into poverty as a result. Councillor Chequer noted that admissions in Scotland had gone down which she assumed was admissions to acute services but she queried if the numbers of people accessing detox services had been looked at.

Gillian Gibson said it was helpful to see that the greatest reduction in drinking had been seen in the most deprived drinkers and MUP in Scotland had also impacted on the number of children and young people who were drinking. She added that alcohol treatment had been strengthened in substance misuse services

John Dean referred to the number of accident and emergency admissions due to binge drinking which were seen at weekends and whether there had been any impact on this in Scotland.

Colin advised that he had heard nothing from Scotland about increased demand for addiction services but he was due to meet with the Chief Executive of Alcohol Focus Scotland soon and would ask that question. A comprehensive evaluation package was in place in Scotland and the operation of MUP was to be reviewed after five years.

It was known that there were a significant number of children and young people living with adults who had alcohol use disorders and also that individuals drinking over 50 units a week would also be binge drinking, however those statistics had not been separated out.

Councillor Farthing commented that the health related behaviour survey indicated that some adults were allowing children to drink and the Sunderland Safeguarding Children Board had intended to look at some communications on this issue. Strategies needed to be aligned on this and it was suggested that schools in the Coalfields area could be targeted. Councillor Farthing reiterated the need to lobby Government on MUP and the city could not pretend that it did not have a problem with alcohol.

Colin stated that Sunderland and the North East in general had been very active in lobbying but getting the North West and Yorkshire on board would help the position.

Dr Pattison said that as a clinician dealing with alcohol issues every day, he fully supported MUP. He felt that the situation was getting worse, he saw liver disease on a daily basis and wider health conditions such as diabetes, cancer, stroke and blood pressure issues. His only concern was how long it may take to introduce minimum unit pricing.

Councillor Chequer asked if the 50p minimum unit price would rise with inflation in order to maintain the impact. Colin said that a lot of the delay was in getting MUP approved from a political perspective and the view in Scotland had been to agree the principle and then look at the price. A decision would have to be made by Government to tie the MUP to the CPI or RPI. Colin also noted that Balance were communicating with parents through the 'What's the Harm?' campaign in the region. They were also in the process of developing alcohol free schools and alcohol free licensing.

The Health and Wellbeing Board had been asked to support the introduction of the minimum unit price and it was noted that this could be done cohesively as a region but also as individual boards. Dave Gallagher undertook to draft a letter on behalf of the Sunderland Health and Wellbeing Board urging the introduction of MUP in England.

Having thanked Colin and Laura for their presentations, the Board RESOLVED that: -

(i) the update report on the priority addressing alcohol harms be received;

(ii) the introduction of minimum unit price in England be supported and a letter sent to Westminster urging that the minimum unit price is introduced without delay; and

(iii) the Sunderland Alcohol Partnership be asked to finalise the alcohol action plan, with the associated outcome and process KPIs, and to bring the final action plan to the March meeting of the Board for approval.

HW31. Best Start in Life Priority Update

The Best Start in Life Working Group submitted a report providing a progress update on the Board priority including the draft action plan, Best Start in Life area profiles and funding and research opportunities.

Lorraine Hughes, Public Health Specialist was in attendance to deliver a presentation on the Best Start in Life Profiles. A Joint Strategic Needs Assessment (JSNA) had been produced and shared with partners for consultation and final agreement and a draft action plan had been developed, detailing high level actions against ten key priorities: -

- Partners work collaboratively to ensure every child gets the best start in life.
- Make use of data and intelligence to understand local needs
- Promote healthy pregnancy messages
- Improve outcomes for perinatal mental health
- Reduce the prevalence of alcohol consumption in pregnancy
- Reduce the prevalence of smoking in pregnancy
- Promote a culture of breastfeeding
- Promote health eating for infants and young children

- Develop multi-agency approaches to meeting the needs of infants and children whose parents have vulnerabilities
- Ensure every child is supported in their development to be school ready

Public Health had developed Best Start in Life area profiles which had provided data to support an understanding of health outcomes for pregnancy and early childhood at a ward and/or locality level.

The first meeting of the Best Start in Life working group had taken place in September 2019 and a bi-monthly schedule of meetings established with a workshop planned for May. The Board were advised that the local authority had been successful in a bid to participate in the Local Government Association Behavioural Insights Programme to support work on breastfeeding.

Councillor Farthing commented that low rates of breastfeeding in the city had often been highlighted and queried whether there was a link between this and obesity. She suggested that this could also be plotted against the age of the mother at conception. It was also noted that Sunderland had fewer people with higher levels of academic achievement and Councillor Farthing asked whether there might be a correlation between this and age at conception and breastfeeding.

The Chair complimented the working group on the pace which they had set for the work and that this also demonstrated how the work of the task groups overlapped.

Lorraine Hughes said that whilst services were not working separately, it was important to have them working *jointly* together, for example, alcohol and teenage pregnancy.

John Dean noted that it was good to see information getting down to ward level and was pleased to see oral health being one of the indicators. Lorraine highlighted that the community dental service operated across a number of areas and that there were seven mandated health visitor checks in Sunderland – two more than nationally – and one of these was specifically about oral health. Advice on sugar consumption was also included as part of this visit.

Gillian Gibson added that the Health and Wellbeing Scrutiny Committee had been carrying out a review of oral health and would be reporting to the Cabinet in the near future. Councillor Farthing was also pleased to see oral health being targeted and queried if the numbers of children being registered to dentists could be checked.

The Board RESOLVED that: -

(i) the update report on the priority Best Start in Life be received; and

(ii) the Best Start in Life working group be asked to finalise the action plan and to bring this to the March meeting of the Board for approval.

HW32. Director of Public Health's Annual Report

The Director of Public Health submitted a report presenting the findings of her Annual Report to members of the Health and Wellbeing Board.

The full report had not yet been published but would be circulated the following week and the Director of Public Health provided an overview of the key themes within the report which included: -

- inequalities in health outcomes between Sunderland and the rest of the country and within the city itself
- mental wellbeing
- good quality employment and healthy workplaces
- making good food affordable, accessible and appealing.

Matters such as inequalities, prevention and engagement would be picked up in the Healthy City Plan. The 2019 report would be published on the Council website and circulated to key partners.

RESOLVED that the findings of the Director of Public Health's Annual Report be noted.

HW33. Sunderland Winter Plan 2019/2020

The Chief Officer, Sunderland CCG delivered a presentation on the Winter Plan for Sunderland 2019/2020.

It was noted that winter funding would be used to ensure safe and quality patient care was provided at times of high demand and to contribute to the system achieving the ED four hour standard and to test ideas of reform. During September the Surge group proposed winter schemes for consideration and were provided with briefs of expected collaborative projects with a suggested envelope based on costs with initial proposals.

The CCG was providing £2.14m to winter schemes for 2019/20 and there was £300,000 additional capacity during the winter period with £365,791 from All Together Better (ATB) to date. The schemes were overseen via the Surge group and ATB with progress being reported to the A&E Delivery Board.

The summary of the schemes being funded were provided as part of the presentation and the winter schemes had been deployed by the end of November. The Surge plan would be regularly reviewed and schemes adjusted with a view to fully evaluate all schemes to support planning for next year.

System partners recognised that the winter would be difficult but by working together were confident that organisations would get through this period by focusing on safe, quality services.

Having thanked Dave for his presentation, it was: -

RESOLVED that the information be noted.

HW34. Sunderland Safeguarding Children's Board (SSCB) Annual Report 2018/2019

Local Safeguarding Board Independent Chairs were required to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in their local area. The Health and Wellbeing Board received the Sunderland Safeguarding Children's Board (SSCB) Annual Report 2018/2019 as a statutory requirement under Section 14A of the Children Act 2004.

The annual report noted the achievements of the SSCB which included: -

- The implementation of a Neglect Toolkit in conjunction with the Children's Strategic Partnership to ensure that children impacted on by neglect receive assistance to minimise the impact as early as possible.
- More robust systems around Child Sexual Exploitation leading to assurance that the low numbers of young people identified as being at risk are because young people are safe, rather than simply a change of reporting.
- Early help is now well embedded with support from partners increasing and the value of partnership working being valued more and more.

The SSCB had identified a number of areas as service priorities for the coming year which included Vulnerable Adolescents, Neglect and Poverty and Compromised Parenting. These areas presented the greatest risk to the safety of children and young people if process, practice and partnership working were not strengthened.

The annual report would be the last in its current form as local safeguarding boards had ceased to exist from 29 September 2019 and the Sunderland Safeguarding Partnership had replaced the SSCB in August. The safeguarding partners were required to publish a report at least once in every twelve month period.

The Board RESOLVED that the content of the report be noted and it be accepted as assurance of the current effectiveness of the local safeguarding children arrangements.

HW35. Sunderland Safeguarding Adults Board (SSAB) Annual Report 2018/2019

The Care Act requires the Independent Chair of the Safeguarding Adults Board to give an annual account of the work of the Board.

The work of the SSAB was focused on four strategic priorities, identified in the Strategic Delivery Plan 2019-2024: -

- Prevention
- Making Safeguarding Personal (MSP)/User Engagement
- Partnership (including regional collaboration)
- Key local areas of risk (self-neglect, mental capacity and exploitation)

The report highlighted significant progress against the Board's strategic priorities and provide detail of the future direction of travel for the Board. It was noted that there really was a multi-agency approach to adult safeguarding in Sunderland and a strong commitment to partnership working to achieve the Board's priorities.

RESOLVED that the Safeguarding Adults Board Annual Report 2018/2019 be received and noted.

HW36. Healthy Economy Priority Update

The Board received an update on the progress being made against the Healthy Economy Priority.

The working group was focused on three work strands: -

1) Workplace Health: employers' role in improving employee's health
2) Healthy labour-force: the health of those in work and seeking work
3) Employment in the health and social care sector: understanding and tackling recruitment issues and wider workforce opportunities.

The report set out the activity taking place in each of the work strands for the information of the Health and Wellbeing Board and provided the draft action plan which had been developed by the Working Group.

RESOLVED that: -

(i) the progress update on the three strands of the Health Economy priority be received; and

(ii) the Healthy Economy Working Group be asked to bring finalised action plans and performance measures to a future meeting of the Board.

HW37. Shaping Sunderland's Future Together – Statement of Intent: Integrated Strategic Commissioning for 0-25 year olds in Sunderland

The Chief Officer, Sunderland CCG and the Chief Executive of Together for Children submitted a report presenting for information the 'Shaping Sunderland's Future Together – Statement of intent: integrated strategic commissioning for 0-25 year olds in Sunderland'.

The children's integrated commissioning function was established in July 2019, initially for twelve months to test out ways of working across Sunderland CCG and

Together for Children. Shaping Sunderland's Future Together sets out a high level plan as to how the two organisations will deliver an integrated commissioning function for 0-25 year olds in Sunderland. The document sets out key terms, principles, aspirations and the current priorities of the Children's Integrated Commissioning Group: mental health; Special Educational Needs and Disabilities (SEND); and individual placements.

The statement of intent reflects the current point in time and it is anticipated that there will be future iterations of the document with a full review in summer 2020.

RESOLVED that: -

(i) the Shaping Sunderland's Future Together – Statement of intent: integrated strategic commissioning for 0-25 year olds in Sunderland; and

(ii) a future report to be presented to the Board on the impact of the pilot.

HW38. 2019/2020 Process to Refresh the Children and Young People's Mental Health and Wellbeing Transformational Plan 2015-2020

The Chief Officer, Sunderland CCG submitted a report setting out the proposed approach to refreshing the Children and Young People's Transformational Plan 2015-2020.

For this year's refresh of the plan, NHS England have announced that they will download a copy of each local plan on 31 March 2020 and they will carry out a review against their Key Lines of Enquiry (KLOE).

Since the plan was now in the final year of its delivery it was proposed that for the refresh, the Executive Summary which had been produced for 2019 refresh be updated and that no changes be made to the main body of the existing plan. The proposed process and the plan would require sign off from the Integrated Commissioning Group, the CCG Executive Committee and the Health and Wellbeing Board.

The proposed process and timescales were set out within the report and it was envisaged that this would be the final refresh of the Children and Young People's Mental Health and Wellbeing Transformational Plan 2015-2020. NHS England had indicated that they would require a new five year plan in 2020.

Councillor Farthing commented that the plan referred to NHS England's concern over waiting times for mental health treatment and that it was important that the local situation was not overridden. Dave Gallagher advised that certain elements had to be within the plan but the local position was reflected too. Partners were aware of the challenges in relation to access to services and waiting times and waiting lists were increasing despite the efforts of all agencies involved. It was noted that an overarching strategic plan on Mental Health and Wellbeing was needed for Sunderland and it was hoped to have this drafted by the end of March 2020.

RESOLVED that the proposed approach to the annual refresh of the Children and Young People's Mental Health and Wellbeing Transformational Plan 2015-2020 as set out in the paper be noted.

HW39. Health and Wellbeing Forward Plan

The Senior Policy Manager submitted a report informing the Board of the Forward Plan of business for 2019/2020.

Members of the Board were encouraged to put forward items for future meetings either at Board meetings or by contacting the Council's policy team.

RESOLVED that the Forward Plan be noted.

HW40. Dates and Time of Next Meetings

The Board noted that the next meeting would take place on Friday 20 March 2020 at 9.30am.

The next Board development session would take place on Monday 3 February 2020 at 12.00pm – 4.00pm.

(Signed) G WALKER
In the Chair

Item No. 7

SUNDERLAND HEALTH AND WELLBEING BOARD **25 June 2020**

COVID-19 HEADLINE REFLECTIONS

1.0 Purpose of the Presentation

1.1 The purpose of the presentation is to provide a general overview of the current situation in relation to COVID-19 in the city and more specific information on how services for adults and children have responded.

1.2 A presentation to the Health and Wellbeing Board will be made by:

Philip Foster, Managing Director, All Together Better Sunderland
reflections from a health and social care system

Jill Colbert, Chief Executive, Together for Children/Director of Children's Services
perspective from services for children and young people

Gillian Gibson, Director of Public Health
summary of the data and key next steps.

2.0 Recommendation

2.1 The Board is recommended to:

- Note the contents of the presentation for information.

Item No. 8

SUNDERLAND HEALTH AND WELLBEING BOARD **25 June 2020**

CARE HOME SUPPORT PROGRAMME

1.0 Purpose of the Presentation

1.1 The purpose of the presentation is to provide an update to the Health and Wellbeing Board on the Care Home Support Programme.

1.2 Sunderland City Council, in partnership with key health and social care partners, has taken a system wide, multi-disciplinary approach to managing and responding to the needs of the care home market during the pandemic.

1.3 The presentation will be made by Graham King, Assistant Director Adult Services / Chief Operating Officer Sunderland Care and Support on work undertaken and future plans.

2.0 Recommendation

2.1 The Board is recommended to:

- Note the contents of the presentation.

Item No. 9

SUNDERLAND HEALTH AND WELLBEING BOARD 25 June 2020

DRAFT SUNDERLAND COVID-19 HEALTH INEQUALITIES STRATEGY

Report of the Director of Public Health

1.0 Purpose of the Report

1.1 The purpose of the report is to consult the Health and Wellbeing Board on the draft Sunderland COVID-19 Health Inequalities Strategy.

2.0 Introduction/ background

2.1 Under the Health and Social Care Act 2012, the Council has responsibility for improving the health of the population in Sunderland and reducing health inequalities.

2.2 People facing the greatest deprivation are experiencing a higher risk of exposure to COVID-19 and existing poor health puts them at risk of more severe outcomes if they contract the virus. According to the ONS data people from the most deprived areas of England and Wales are more likely to die with coronavirus than those in more affluent places. The government and wider societal measures to control the spread of the virus and save lives now (including the lockdown, social distancing and cancellations to routine care) are exacting a heavier social and economic price on those already experiencing inequality.

2.3 The strategy sets out Sunderland's response to COVID-19 and the impact on health inequalities. It builds on previous strategies where health inequalities have been identified including the City Plan, Sunderland Health and Wellbeing Strategy and Director of Public Health Report 2019. The COVID-19 Health Inequalities Strategy aims to:

- Raise awareness of the importance of health inequalities in both the response and recovery to COVID-19
- Follow the key principles set out in the Healthy City Plan and use data, intelligence and evidence to systematically understand the natural and unintended consequences that may have widened health inequalities
- Support local organisations and communities to consider how their work may impact on health inequalities, as described in the Sunderland Prevention and Health Inequalities Framework
- Consider the evidence to ensure that any recommendations will prevent or mitigate health inequalities widening as part of the COVID-19 pandemic.

2.4 There is a danger that in our response to COVID-19 we abandon our community asset-based approach to reducing health inequalities as set out in the Healthy City Plan. It is an opportunity to accelerate the approach by using and responding to local intelligence, building on relationships and resident

experiences gathered as part of the City's immediate response from volunteers (existing and recruited as part of the response), shielded call themes, risk assessments on our vulnerable young people and any other sources of intelligence.

2.5 The strategy details a range of actions the local authority and partners could take to help to mitigate the differential impact of COVID-19 on local communities and outlines a number of strategic objectives, which are:

- To continue to improve health outcomes for our most disadvantaged communities who are at greater risk of COVID-19 by adopting a lifecourse approach which identifies the key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age and into older age.
- To take every opportunity to mitigate the impact that COVID-19 has had on our communities by building on a Health in All Policies (HiAP) approach to policies we systematically and explicitly consider the health implications of the decisions we make with the aim of improving the health of the population.
- To ensure that as we move into recovery we take the opportunity to address health inequalities as part of our plans by using available tools to ensure that health inequalities are considered for every policy and service.

3.0 Public Health England - Disparities in the risk and outcomes from COVID-19

3.1 Since drafting the local strategy, Public Health England have published 'Disparities in the risk and outcomes from COVID-19'. The document confirms the impact of COVID-19 on existing health inequalities and it concludes that in some cases, has increased them. These results improve our understanding of the pandemic and help formulate the future public health response to it.

3.2 They found that the largest disparity was:

- By age - among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40
- The risk of dying among those diagnosed with COVID-19 was higher in males than females - however in the North East females had higher diagnosis rates than in London
- By deprivation - higher in those living in the more deprived areas than those living in the least deprived
- By ethnic group - higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups.

3.3 When compared to previous years, they found a particularly high increase in all cause deaths among those in a range of:

- Caring occupations including social care and nursing auxiliaries and assistants

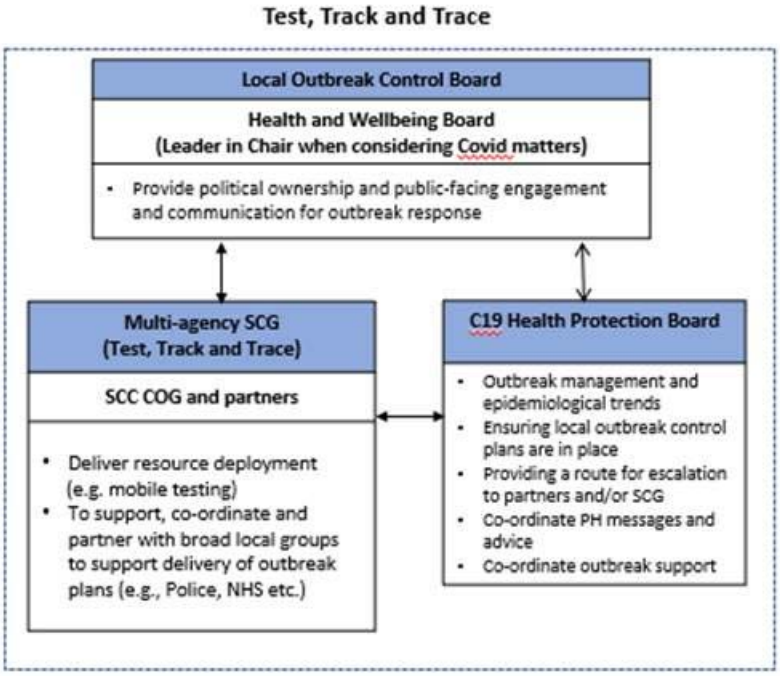
- People who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs
- Those working as security guards and related occupations
- Those in care homes.

3.4 The Public Health England document reinforced what we found when developing our local strategy for Sunderland.

3.5 The draft strategy has been discussed at Cabinet and has been shared with members of the Health and Wellbeing Board.

4.0 Local COVID Control Arrangements

4.1 As the draft strategy collates the evidence and intelligence in to one document this will support the council and partners in understanding the pandemics impact on the key at risk groups. The draft strategy will inform the response from our local COVID control arrangements which will be through the COVID-19 Outbreak Control Board, Multi-agency SCG and COVID-19 Health Protection Board outlined in the governance structure below.



5.0 Recommendations

5.1 The Health and Wellbeing Board is requested to:

- endorse the draft Sunderland COVID-19 Health Inequalities Strategy
- commit to addressing health inequalities in the organisations represented on the Board.

Draft Covid-19 Health Inequalities Strategy

1. Executive Summary

EXECUTIVE SUMMARY

Sunderland City Council

What the strategy sets out?

The strategy sets out Sunderland's response to COVID-19 and the impact it has had on health inequalities. It builds on previous strategies where health inequalities have been identified including the City Plan, Sunderland Health and Wellbeing Strategy, Director of Public Health report 2019 and Draft Public Health Strategy. Covid-19 Health Inequalities Strategy will:

- Raise awareness of the importance of health inequalities in both the response and recovery to Covid-19
- Follow the key principles set out in the Healthy City Plan, and use data, intelligence and evidence to systematically understand the natural and unintended consequences that may have widened health inequalities
- Support local organisations and communities to consider how their work may impact on health inequalities, as described in the Sunderland Prevention and Health Inequalities Framework
- Consider the evidence to ensure that any recommendations will prevent or mitigate health inequalities widening as part of the Covid-19 pandemic

Key facts about Sunderland

What do we want to achieve and why it is important?

There is a danger that in our response to COVID-19 we abandon our community asset-based approach to reducing health inequalities as set out in the Healthy City Plan. It is an opportunity to accelerate the approach by using and responding to local intelligence, building on relationships and resident experiences gathered as part of the City's immediate response from volunteers (existing and recruited as part of the response), shielded call themes, risk assessments on our vulnerable young people and any other sources of intelligence.

A whole system and health in all policies approach that engages the wider council and partners is required to strengthen the recovery response with key at risk populations (appendix four).

Our challenges

At the time of writing there is clear evidence that Covid-19 is impacting on our most deprived communities. Key risk groups include residents of care homes, people with long term conditions, those on low incomes, at risk to domestic abuse, with mental illness, vulnerable children, older people, unemployed, with physical and learning disabilities and ethnic minorities and religious groups, however this may change as we gain more insight of the impact of Covid-19 on our communities.

Deprived communities may experience more direct and indirect impacts because they already have greater vulnerability and are likely to have a compromised ability to respond to the extra impact of COVID-19. ONS data indicates that people from the most deprived areas of England and Wales are more likely to die with coronavirus than those in more affluent areas.

Strategic objectives

Continue to improve health outcomes for our most disadvantaged communities who are at greater risk of Covid-19 by adopting a lifecourse approach which identifies the key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age and into older age.

Take every opportunity to mitigate the impact that Covid-19 has had on our communities by building on a Health in All Policies (HiAP) approach to policies we systematically and explicitly consider the health implications of the decisions we make with the aim of improving the health of the population.

Ensure that as we move into recovery we take the opportunity to address health inequalities as part of our plans by using available tools to ensure that health inequalities are considered for every policy and service.

Key actions

- Develop and use a local tool kit to take in to account any emerging evidence of the impact of Covid-19 on health inequalities which will include evidence-based actions that can be used to address these.
- Embed the Health Inequalities Strategy as part of any response or recovery work in relation to Covid-19
- Build on previous local intelligence, relationships and resident experiences as well as information gathered as part of the City's immediate response from volunteers, people who are shielded, our vulnerable young people and any other sources of community intelligence to inform our approach.
- Consider ways in which new interest in community/mutual aid approaches can be sustained to benefit priority communities and reduce demand on services.
- Review social value secured through existing contracts and explore the potential to divert the social value offer where required for most vulnerable communities.
- To progress the Marmot City principles which have been adopted by Sunderland City Council.

2. Overview

2.1. The coronavirus (COVID-19) pandemic, and the wider governmental and societal response, have brought health inequalities into sharp focus.

2.2. People facing the greatest deprivation are experiencing a higher risk of exposure to COVID-19 and existing poor health puts them at risk of more severe outcomes if they contract the virus. The government and wider societal measures to control the spread of the virus and save lives now (including the lockdown, social distancing and cancellations to routine care) are exacting a heavier social and economic price on those already experiencing inequality. The consequences of this action, and the economic recession that is likely to follow, risk exacerbating health inequalities now and in years to come[1].

2.3. In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, 'Fair Society Healthy Lives', was published in February 2010, and concluded that reducing health inequalities would require action on key six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

2.4. The recent report entitled Health Equity in England: The Marmot Review 10 Years On[2], examines a decade of data to understand the worsening situation of health inequality in the UK and paints a terrifying picture of the health and well-being of the people of the North East of England.

2.5. As the Marmot review 10 years on showed, deprived communities in England have seen vital physical and community assets lost, resources and funding reduced, community and voluntary services eroded and public services cut over the past decade. All of this has damaged health and widened inequalities. Looking ahead to the aftermath of the pandemic, lessons from the past decade of austerity must be learned.

2.6. People can now expect to spend more of their lives in poor health:

[1] https://www.health.org.uk/publications/long-reads/will-covid-19-be-a-watershed-moment-for-health-inequalities#lf-section-59576-anchor

[2] https://www.health.org.uk/funding-and-partnerships/our-partnerships/health-equity-in-england-the-marmot-review-10-years-on

- Improvements to life expectancy have stalled for the first time in over 100 years, and actually declined for the poorest 10% of women;
- The health gap has grown between wealthy and deprived areas;
- That place matters – living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less.

2.7. Speaking at The Stadium of Light in March at the North East Annual Public Health conference, Professor Sir Michael Marmot made three very telling points with regard to the findings of the 10 years on report:

- The actual number of years spent in illness is rising in the whole population;
- As pension age increase to 68 so is the proportion of the population that has a disability leading to a general decline in the quality of life;
- When the 2010 report was produced there was an understanding of the causes of health inequality. In the next 10 years, austerity was clearly a cause of a significant increase of health inequality and this remains the case today.

2.8. Deprived communities may experience more direct and indirect impacts because they already have greater vulnerability and are likely to have a compromised ability to respond to the extra impact of COVID-19. ONS data indicates that people from the most deprived areas of England and Wales are more likely to die with coronavirus than those in more affluent places. The data show there were 55 deaths for every 100,000 people in the poorest parts of England, compared with 25 in the wealthiest areas. More information can be found in appendix two.

2.9. David Finch, Senior Fellow at the Health Foundation, said: 'The link to deprivation is complex given the virus has spread more in densely populated urban areas that tend to be more deprived. However, there are clearly ways in which existing inequalities mean the crisis is having a disproportionate impact on certain groups. Those facing greater socio-economic disadvantage tend to live in cramped housing conditions and many are now classified as essential workers who don't have the option of working from home, placing them at higher risk of exposure to COVID-19. People living in more deprived areas are also more likely to have one or more long-term health conditions, which means they are at greater risk of suffering severe symptoms from the virus if exposed[3].

2.10. The Office of National Statistics data released on the 1st May 2020 provides important and early insight into how the patterns of death from COVID-19 are corresponding with patterns of deprivation in local areas in the UK. It reveals a clear and worrying trend – that deaths in the most deprived areas are more than double those in the least deprived[4]. More information can be found in appendix two.

[3] https://www.health.org.uk/news-and-comment/news/deaths-from-covid-19-in-the-most-deprived-areas
[4] https://www.ons.gov.uk/deaths/datasets/deathsinvolvingcovid19bylocalareaanddeprivation

2.11. Whilst public health can target those at greatest risk of health inequalities as a result of COVID through its commissioned services, a whole system and health in all policies approach that engages the wider council and partners is required to strengthen the recovery response with key at risk populations. At the time of writing there is clear evidence that Covid-19 is impacting on our most deprived communities. Key risk groups include residents of care homes, people with long term conditions, those on low incomes, at risk to domestic abuse, with mental illness, vulnerable children, older people, unemployed, with physical and learning disabilities and ethnic minorities and religious groups, however this may change as we gain more insight of the impact of Covid-19 on our communities.

2.12. This strategy sets out Sunderland's response to COVID-19 and its impact on health inequalities in Sunderland. It builds on previous strategies where health inequalities have been identified including the Sunderland Health and Wellbeing Strategy, Director of Public Health report 2019[5] and Draft Public Health Strategy[6] and City Plan[7].

2.13. This strategy will focus on all available evidence to date where key health inequalities have been recognised as a result of COVID-19, but it will also consider and respond timely to any emerging evidence as it evolves. This will include the literature review and health inequalities framework currently underway, led by Public Health England.

2.14. Therefore, the Health Inequalities Strategy will:

- Raise awareness of the importance of health inequalities in both the response and recovery to Covid-19
- Follow the key principles set out in the Healthy City Plan, and use data, intelligence and evidence to systematically understand the natural and unintended consequences that may have widened health inequalities
- Support local organisations and communities to consider how their work may impact on health inequalities, as described in the Sunderland Prevention and Health Inequalities Framework
- Consider the evidence to ensure that any recommendations will prevent or mitigate health inequalities widening as part of the Covid-19 pandemic

2.15. There is a danger that in our response to COVID-19 we abandon our community asset-based approach to reducing health inequalities as we have set out in the Health and Wellbeing Strategy, Healthy City Plan and draft Public Health Strategy. However, it is the opportunity to accelerate the approach by using and responding to local intelligence, build on relationships and resident experiences gathered as part of the City's immediate response from volunteers (existing and recruited as part of the response), shielded call themes, risk assessments on our vulnerable young people, any other sources of intelligence.

[5] Director of Public Health report 2019
[6] Draft Sunderland's Public Health Strategy
[7] Healthy City Plan

2.16. There are obvious links to the Council's Social Recovery Group and its functions, which are to:

a. Gain an understanding of the current and future impact of COVID-19 on Sunderland's households and communities;
b. Identify what additional demand for service, if any, may present because of COVID-19 and if the ask will be different to what we are used to;
c. Seek to integrate existing data sets to understand what interventions and prevention measures will be required and what responses will be required by council services more generally.

2.17. The Strategy will follow the key principles and messages set out in the Heathy City plan:

a. Recognition of the stark health inequality across the city
b. Acknowledgement that the social determinants of health (Marmot) are still relevant 10 years on
c. Focus on prevention
d. Focus on closing the disadvantage gap

It is important however to acknowledge the evidence the Strategy will change as we identify and respond to evolving need.

3. What do we know about Health Inequalities?

3.1. As highlighted by 'Health Equity in England: The Marmot review 10 years on' report, health is affected by the environment and community in which we live. The more deprived the area, the shorter the life expectancy and the poorer the state of health within these shorter lives**Error! Bookmark not defined.**.

Diagram one: 'What makes us Healthy?

Director of Public Health Report 2019

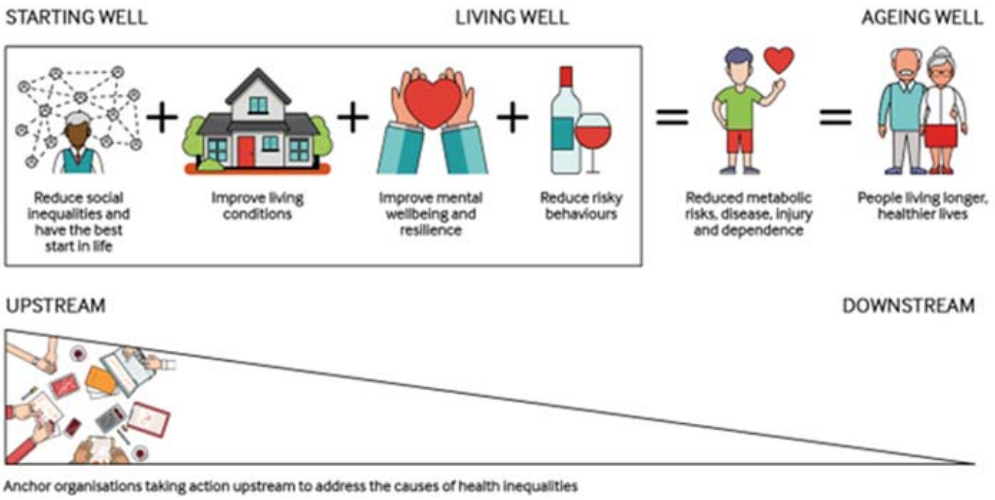
3.2. Sunderland's Director of Public Health Report 2019[8] shares how the health of the city's people continues to be heavily impacted by the economic and social inequalities that individuals and communities experience. We know that 38% of the population are amongst the most disadvantaged in England and one in five of our children live in poverty.

3.3. The report goes on to highlight the stark inequalities in health outcomes both between Sunderland and the rest of the country and within the city itself (diagram three). The causes vary in the way they impact on health and can be thought of as having either an "upstream" or "downstream" effect. Intervening "upstream" means that we are preventing poor health developing, whereas when we focus "downstream" we are less likely to impact on peoples' health in the long term.

Sunderland Health and Wellbeing Board

3.4. Sunderland's Health and Wellbeing Board Framework for reducing health inequalities and preventing poor health demonstrates how we will implement this effectively through an "upstream: downstream" approach. Intervening "upstream" means that we are putting measures in place to prevent poor health developing, whereas when we focus "downstream" we are treating poor health. Often multiple actions are needed to address any single issue. The framework in diagram two is embedded within Sunderland's Healthy City Plan:

Diagram two: Framework for reducing health inequalities and preventing poor health

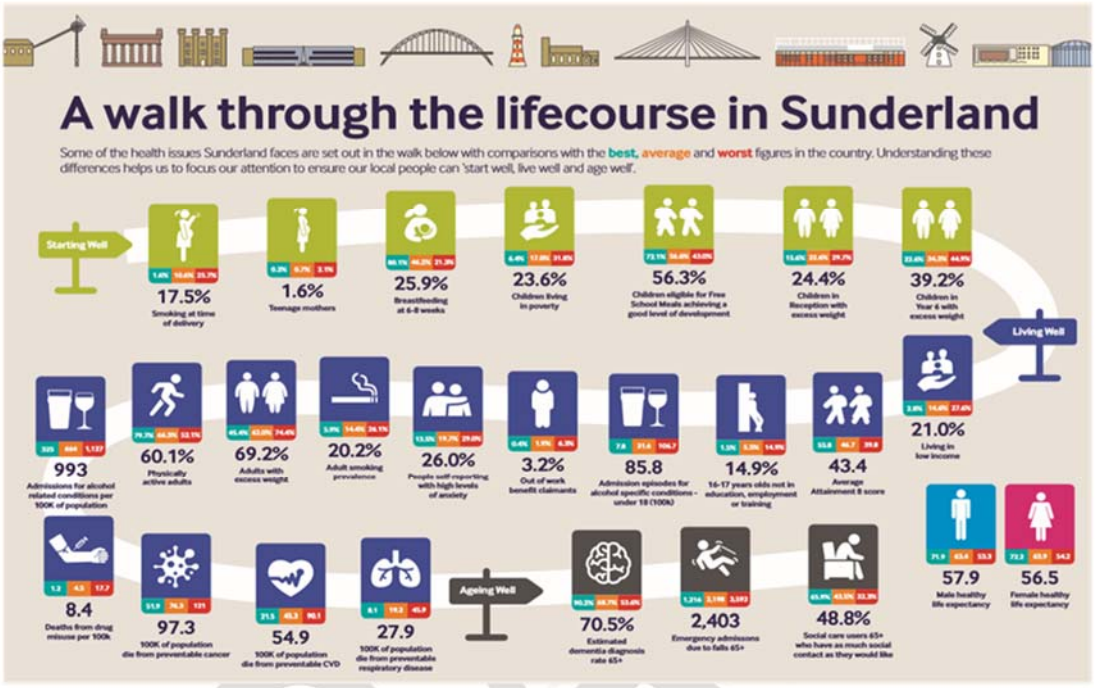


3.5. The Health and Wellbeing Board adopts a life course approach which identifies the key opportunities for minimising risk factors and enhancing

[8] https://www.sunderland.gov.uk/article/13881/Director-of-Public-Health-Annual-Report

protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age and into older age.

Diagram three: Health through the lifecourse in Sunderland



Sunderland City Plan

3.6. Our City Plan with its ambitions to create a Dynamic, Healthy and Vibrant City, will have the greatest impact on people's lives in relation to social determinants. Changes are already happening with modern homes and workplaces being built, access to the city is being improved and historic buildings are being restored and re-imagined for the future. The City Board will oversee these improvements.

4. An evidenced based approach

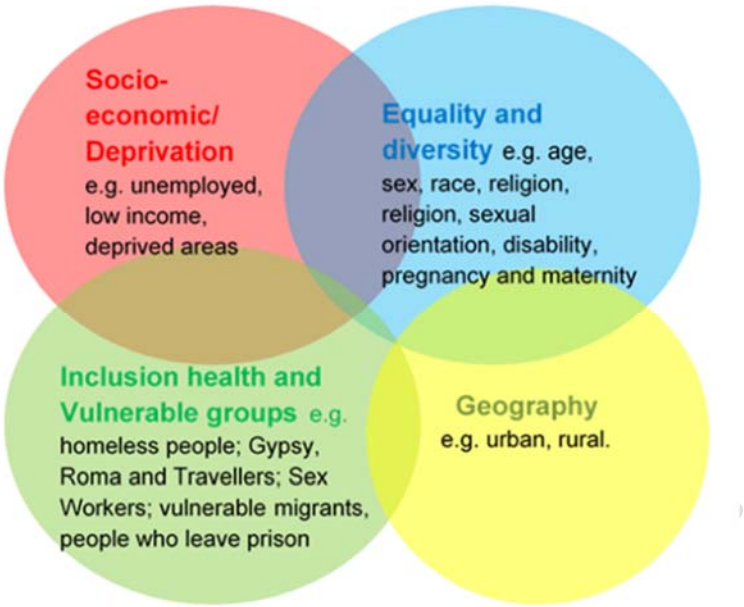
4.1. Recent work carried out by the Royal College of Physicians gathered evidence and examples of how to mitigate the impact of COVID-19 on inequalities[9]. Diagram four below illustrates how some groups within the population may be disproportionately affected by COVID-19. There are clear reasons for giving consideration and support to those groups that experience health inequalities.

4.2. The economic and social response to COVID-19 has the potential to exacerbate these health inequalities. Those in low paid or insecure work, or with existing health conditions or who were already socially isolated, may find it increasingly difficult to afford rent, bills and food and also struggle to

[9] https://www.rcplondon.ac.uk/news/covid-19-and-mitigating-impact-health-inequalities

access the services they need. This is likely to have a significant toll on both their physical and mental health.

Diagram four: Overlapping dimensions of health inequalities



4.3. According to the Joseph Roundtree Foundation people locked in poverty face challenges staying afloat in the face of rising costs and income loss that will come as a result of the Coronavirus outbreak. They are also more likely to be in poor health, disabled, and to be caring for others. In addition, people stuck in poverty are more likely to experience anxiety, depression and other mental health difficulties. The services on which people on low incomes rely on are also at risk of disruption, such as food banks and advice teams.

4.4. Workers trapped in poverty are more likely to have insecure jobs, with fewer rights and employee benefits, and they are less likely to have savings to help cover additional unplanned costs or gaps in income. People on low incomes face additional costs from rising prices in shops and higher bills from staying at home[10].

4.5. Research by the Institute for Fiscal Studies (IFS) has concluded that Britons from black African backgrounds are dying from coronavirus at 3.5 times the rate of white people. Those with black Caribbean or Pakistani heritage are also at significantly greater risk of dying from COVID-19. The IFS study said given demographic and geographic profiles, most minority ethnic groups are dying in "excess" numbers.

4.6. The impact of COVID 19 is likely to further exacerbate health inequalities across Sunderland. Sadly, there are many groups in society who will be hit

[10] https://www.jrf.org.uk/report/talking-about-coronavirus-and-poverty-guide-framing-your-messages

harder by the outbreak: not only older people, those with underlying health conditions and healthcare workers but those who are vulnerable simply because they do not have the same opportunities to stay healthy.

5. Impact of Covid-19

Across the life Course

5.1. The Institute of Fiscal Studies in their report[11] "***We may be in this together, but that doesn't mean we are in this equally***" highlights a wide range of socioeconomic consequences of Covid-19 impacting across the life course (diagram five) including:

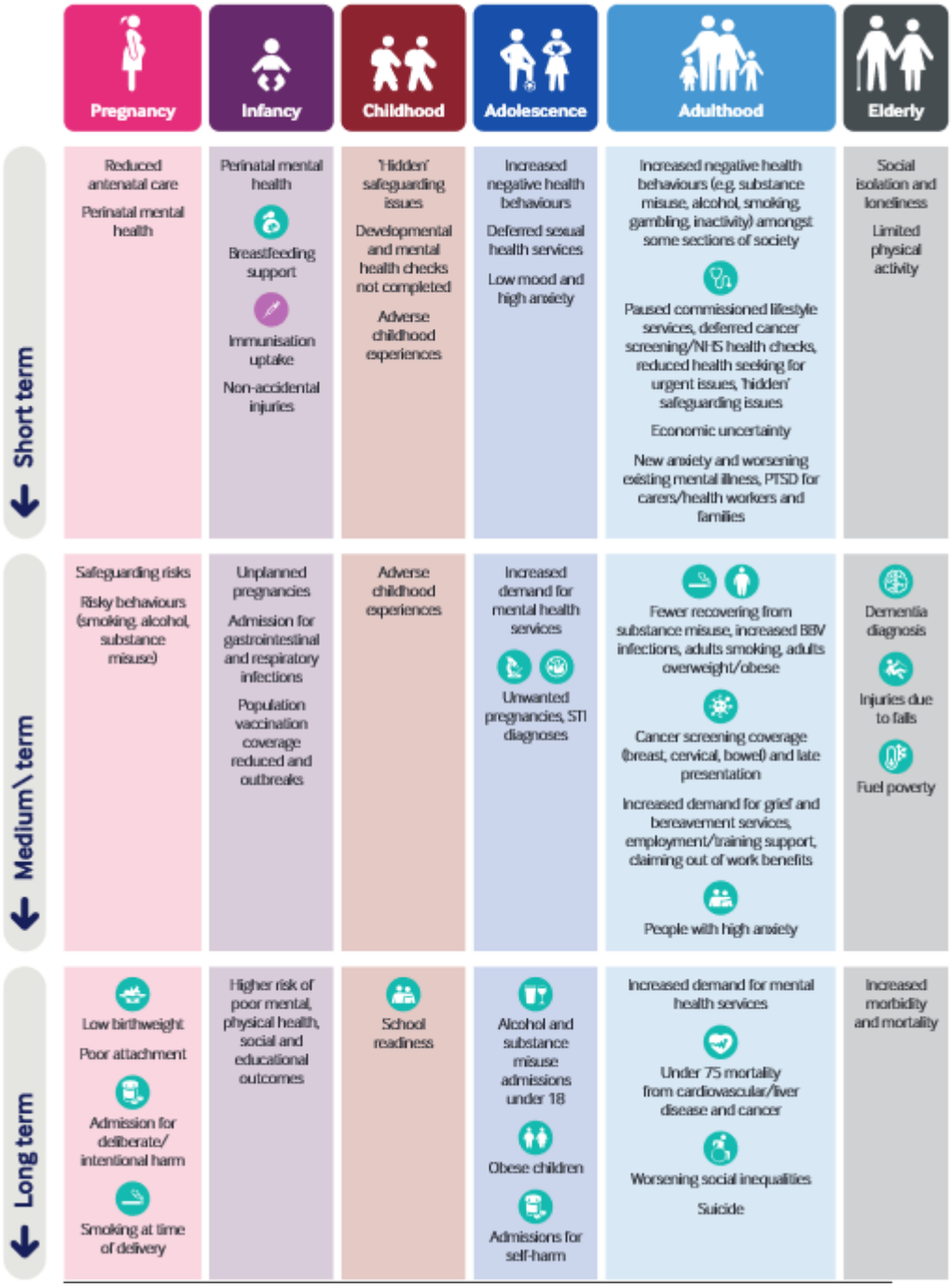
- Young People (workers under 25) – are two and a half times more likely than those over 25-year olds to work in sectors that have closed entirely, or experienced significant impact of Covid-19 such as hospitality and non-food retail;
- Young People (those leaving school or graduating from university this summer) - will be entering the labour market in the middle of a severe recession reducing their employment opportunities;
- Universal Credit claimants – the furlough scheme will protect many workers in the short term, however in the medium to long term many job losses may be experienced by this population group;
- Implications for older people staying healthy;
- Implications for the business and housing sector.

5.2. The measures taken to manage the spread of COVID -19 will have extensive implications for income, job security and social contact and safety. The Health Foundation (2020) describes how these factors will have a powerful influence on people's ability to live healthy lives stating "Without consideration of the long-term health implications of the lockdown and likely economic shock, which stem from necessary measures to protect lives in the short term, the toll on the nation's health risks going well beyond the number of people who will die with COVID-19" .

5.3. As we move into the Covid-19 recovery and response phase sustaining a steady low-level of transmission of the virus is important if we are to effectively manage the avoidance of further outbreaks. This can be achieved by the continuation of effective health protection measures including social distancing (appendix three) which run in parallel with a range of evidence-based interventions during the short- and medium-term recovery and response process.

[11] https://www.ifs.org.uk/publications/14821

Diagram five: Impacts of Covid-19 pandemic through the lifecourse



Groups identified as vulnerable as a result of Covid-19

5.5 Public Health England suggests several groups have been identified as vulnerable as a result of COVID -19 and the measures put in place to manage the pandemic.

Low income families
Workers in poverty are more likely to have insecure jobs with fewer rights, and less savings to help them bridge any gaps in income. Currently 21% of the city's population have low income.

People may experience loss of income from social distancing in several ways. For example, those in public facing roles or workplace closures or those who cannot go back to work due to school closures. There are large numbers of the population who are vulnerable to the economic effects as they do not get sick pay, are on zero hours contracts, or are self-employed.

People on low incomes face additional costs from rising prices in shops and higher bills from staying at home.

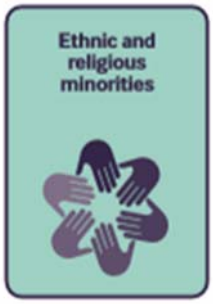
They are more likely to be in poor health, disabled, and/or caring for others, and services they rely on, such as food banks and advice teams, are also at risk of disruption.

Domestic abuse victims
The emergency response to the COVID-19 pandemic may exacerbate and escalate domestic abuse. The isolation of families could exacerbate domestic abuse, as perpetrators will be more likely to be at home with the victim, and the traditional routes to help and support such as schools, GPs and workplaces may be closed. There will also be new domestic abuse cases during this period. Isolation will also mean there are less opportunities to identify the early warning signs of abuse as new domestic abuse cases emerge.(ref: https://www.local.gov.uk/tackling-domestic-abuse-during-covid-19-pandemic)

The UK's Domestic Abuse line reported a 25% increase in online requests and phone calls since lockdown began. In mid-April, the Victims' commissioner for England and Wales indicated that there had been 16 domestic homicides, including those of children, in the first three weeks of lockdown, the highest it's been for 11 years.

People in prisons and secure settings, prison leavers
People facing greater socio-economic disadvantage risk greater exposure to COVID-19, for example, key workers working often in large institutions such as secure settings or prisons. Those living in large urban conurbations or crowded housing conditions.

These groups are also more likely to experience poverty and poorer health such as respiratory conditions or heart disease and therefore more likely to experience severe symptoms and hospitalisation.



Ethnic and religious minorities

Ethnic inequalities can develop in two main ways, through exposure to infection and health risks and though low paid employment and exposure to loss of income. The impacts of the COVID-19 crisis are unlikely to be equal across ethnic groups and aggregating all sub groups together will miss important differences. Understanding why these differences exist will be crucial for thinking about the role policy can play in addressing ethnic inequalities. (Ref: www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/)

Occupation may partially explain disproportionate deaths for some ethnic groups, health and social care key workers are at higher risk of infection. More than two in ten black African women of working age are employed in the health and social care sector. Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors. (Ref: www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/)

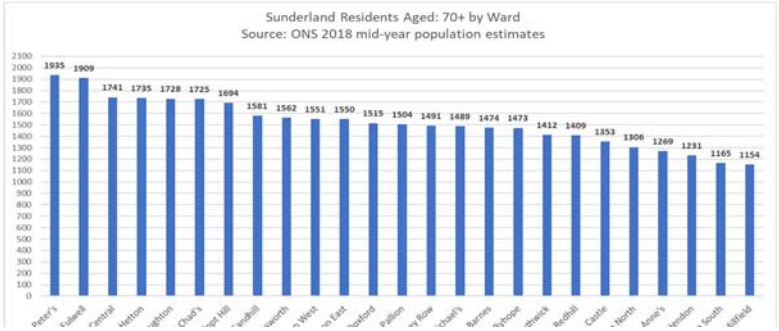
People aged 70+ and clinically vulnerable groups

30.6% of Sunderland's overall population are at increased risk of COVID-19, this includes 37,956 over the age of 70 years of age [see below graph one for the ward breakdown] and 44,651 of all age deemed in a clinical at risk group.

The older adult population are at increased risk of COVID- 19 and severe disease or death following infection, resulting in significant implications for the health and social care sector. Older people are not just struggling with greater health risks but are also likely to be less capable of supporting themselves in isolation

We need to understand emerging and exacerbated needs for vulnerable adults, both from a safeguarding and health perspective, and the issue of support as we move forward to manage demand and support need.

Graph one: Breakdown of Sunderland residents aged 70 and over by ward



People living in care homes
Care home residents and staff are particularly vulnerable to COVID-19 as a consequence of the setting and client's complex health conditions.

It is projected that approximately 400,000 older people in the UK live in care homes this is a bed base three times that of the acute hospital sector in England.

Sunderland like other areas has experienced the devastating consequences of outbreaks in care homes. As at week ending 22nd May 2020, 31 out of 47 care homes have been affected by COVID-19 (66%).

People experiencing mental illness
Evidence shows that having someone to rely on in times of trouble is the top driver of a high-wellbeing nation. Already evidence showing that 5% of the UK population feel chronically lonely, and the overlap between loneliness and those at risk of low wellbeing. (Ref: Emotional wellbeing issues - Paul Litchfield, Chair, What Works Centre for Wellbeing) COVID-19 lockdown measures have been found to create or increase existing feelings of anxiety, isolation and low mood. The ONS personal wellbeing indicators indicate 32.3% people had high levels of anxiety.

Advising or compelling people to self-isolate at home risks serious social and psychological harm. The effects are exacerbated by prolonged isolation, fear of the infection, frustration, boredom, inadequate supplies and information, financial loss, and stigma.

People who are socioeconomically disadvantaged or in poor physical or mental health are at higher risk. Online and telephone support needs to be provided for vulnerable groups, especially those living alone.

Staff on the front line of health and social care services will experience varying levels of stress and distress due to Covid-19. It is essential that organisations take every effort to support the physical and mental wellbeing of the workforce, to enable staff to stay healthy and protect themselves, colleagues, patients and families as we continue to deliver services through this challenging period.

Vulnerable Children
The North East Child Poverty Commission (2020) highlights the impact of the Covid-19 on children and young people already being raised by North East MPs, including in relation to financial support for families and additional resources for schools to support the most disadvantaged pupils.

In terms of the impact of Covid-19 on childhood development and risk to widening health inequalities, the Sutton Trust highlights that differences in parental engagement and the home learning environment are key for children from all socio-economic backgrounds, suggesting "the home learning environment and parental engagement is more important than ever[1]."

Paediatric services have had reduced availability of staff due to self-isolation, or paediatric staff redeployed to adult services. All these changes may have an impact on the safety and quality of services for children.
(Ref: www.hsj.co.uk/acute-care/some-hospitals-left-quiet-as-covid-19-sparks-huge-fall-in-attendances/7027244.article)

Unemployed
There is likely to be an increase in the number of people claiming welfare benefits, as people become out of work either on a temporary or permanent basis. Between Jan 2019 – Dec 2019, 6.5% (8,600) of the Economically Active residents of Sunderland 74.5% (133,100) were unemployed pre COVID-19.
According to NOMIS April 2020, Universal Credit claimant counts (requirement to seek work), shows a significant rise in number (more than the NE and England).
Claimants as a proportion of residents aged 16-64 years increased from March 20 to April 20

- Sunderland increased from 5.1% to 7.6%
- North East increased from 4.6% to 6.9%
- England increased from 3.0 to 5.0%

Hendon, Southwick and Washington North currently have the higher proportion of claimants aged 16-64 yrs.

People with disabilities or LTC
The Institute of Fiscal Studies (2020) suggests a 50% drop in accident and emergency attendances highlighting that normally Accident & Emergency admission rates are 80 per cent higher among residents of the most-deprived areas than among those living in the most-affluent neighbourhoods further exacerbating existing health inequalities

People missing vital appointments or not attending emergency departments, with both the service and public so focused on covid-19. Bigger effect on heart disease and stroke patients heart disease related conditions patients, for example. Attendances relating to myocardial infarction at emergency departments have dropped right down, whereas ambulance calls in relation to chest pain have increased.

Individuals and their carer's who live with autism spectrum disorder and learning difficulties are being identified as a group at higher risk for complications from COVID-19. This group also experience additional behavioural challenges which can impact on their ability to cope with disruptions to their daily lives and thus require additional consideration in relation to measures put in place to manage COVID-19 such as social distancing and test and trace plans.

Inclusion groups
The British Medical Journal (BMJ, 2020) highlights the health benefits of social distancing measures in terms of slowing the spread of infection, however it also highlights some groups are more susceptible to the effects social distancing measures have on their health such as homeless, rough sleepers those with a physical or learning disability and those experiencing mental health issues. Specific at-risk population groups will need to be considered through our recovery and response including test and trace roll out.

Risk factors for mortality

5.6 In Sunderland around 59% of the life expectancy gap (calculated by looking at the causes of excess deaths) between Sunderland and England is due to higher rates of death from cardiovascular diseases (mainly coronary heart disease), cancers (mainly lung cancer) and respiratory diseases (particularly chronic obstructive airways disease, COPD); making some of the Sunderland population at higher risk to COVID 19[12].

5.7 A paper published by the Local Government Association[13] set out the estimated percentage of the population at increased risk of severe illness from Covid-19 (table one).

Table one: Estimated percentage of the population at increased risk of severe illness from Covid-19

	Estimated number of people aged 70+ years (with or without clinical risk factors)	Estimated number of people in clinical risk group (based on flu vaccine risk group data) age ,70 years	Estimated number of women currently pregnant (and not incl. In clinical risk factor group)	Total number of people at increased risk of severe illness from Covid-19	% of total population at increased risk of severe illness from Covid-19	Total area all-age population (ONS mid-2018)
England	7,356,660	7,510,182	611,185	15,478,027	27.7%	55,977,178
North East	372,002	386,236	24,692	782,930	29.5%	2,657,909
Sunderland	37,956	44,651	2,277	84,884	30.6%	277,417

5.8 A more recent study undertaken by NHS England (2020)[14] identified further risk factors for Covid-19 mortality including:

- male
- older age
- deprivation
- diabetes
- asthma
- black or Asian ethnicity

5.9 This followed an earlier study[15] which reviewed data for 16,749 UK hospitalised patients with Covid-19 which found that there was a higher risk of death for patients with:

- Cardiovascular disease
- Pulmonary
- kidney disease
- malignancy
- dementia
- obesity

[12] https://fingertips.phe.org.uk/indicator-list/view/7DVXEB34E2
[13] https://lginform.local.gov.uk/reports/view/lga-research/covid-19-case-tracker-area
[14] https://doi.org/10.1101/2020.05.06.20092999
[15] https://www.medrxiv.org/

5.10 Data from NHS England[16] shows that 95% of patients who have died in hospitals in England and had tested positive for Covid-19 at time of death had an underlying condition, including:

- 26% with diabetes
- 18% with dementia
- 15% with COPD
- 14% with chronic kidney disease
- 10% with ischaemic heart disease
- 7% with asthma

5.11 Taking this evidence into account, the life expectancy gap for Sunderland and the findings from recent studies in relation to underlying health conditions and risk factors for mortality it would suggest the potential for increased susceptibility to COVID -19 within the Sunderland's population.

Cardiovascular disease
Cardiovascular disease is the second commonest cause of premature death in Sunderland with a death rate of 84.7 per 100,000 persons aged under 75 in 2016-2018. The rate of premature mortality from cardiovascular disease considered preventable is 54.9 per 100,000 persons aged under 75 for the same period. Both rates are significantly higher than the England average, but not significantly different from the regional average.

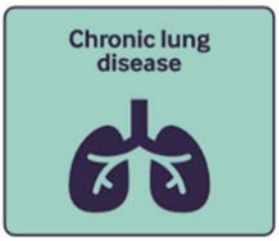
For coronary heart disease, recorded prevalence in Sunderland is 4.7% in 2018/19 (around 13,281 persons) compared to a prevalence of 3.1% in England. There are also concerns reported by WHO around medication and susceptibility to the virus for hypertension and other cardiovascular conditions. (Ref: https://www.who.int/news-room/commentaries/detail/covid-19-and-the-use-of-angiotensin-converting-enzyme-inhibitors-and-receptor-blockers)

[16] https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/

Immunosuppressed
When people are immunocompromised they have a reduced ability to fight infection this may include a range of auto immune conditions and those on treatment or medication to manage their illness which has the effect of suppressing the immune system such as certain cancer treatments.

Within Sunderland, cancer remains a significant cause of premature death and health inequalities. Cancer is the commonest cause of premature death in Sunderland with a death rate of 162.9 per 100,000 persons aged under 75 in 2016-2018.
A study carried out by University College London (UCL) and DATA-CAN, the Health Data Research Hub for Cancer has suggested that around 18,000 people could die from cancer over the next year in England due to the impact of Covid-19.

This is due to delays in diagnosing new cancers and getting treatment for those already diagnosed with cancer could adversely impact survival. Analysis of real-time weekly hospital data for urgent cancer referrals and chemotherapy attendances during the pandemic showed that the majority of patients with cancer or suspected cancer are not accessing health services. (Ref:https://britishlivertrust.org.uk/almost-18000-more-people-could-die-from-cancer-due-to-covid-19-impact/)



Chronic lung disease
Respiratory disease makes a disproportionate contribution to the health inequalities gap in Sunderland. “The incidence and death rates for people with lung diseases in England are higher in poorer groups and areas of social deprivation, where there are often higher levels of cigarette smoking and exposure to air pollution, as well as poorer housing conditions and exposure to occupational pollutants.” Primary symptoms of COVID-19 are respiratory.
(Ref: https://www.england.nhs.uk/blog/tackling-lung-disease-can-help-reduce-health-inequality/)

NHS, QOF data from Fingertips shows that Sunderland already has a high prevalence of respiratory disease:

- For COPD, recorded prevalence in Sunderland is 3.5% compared to a prevalence of 1.9% in 2018/19 in England;
- For asthma (all ages), recorded prevalence in Sunderland is 6.2% compared to a prevalence of 6% in 2018/19 in England;

Sunderland is in the worst 99.8% for:

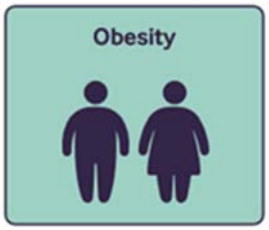
- Rates of hospital admissions for asthma (under 19 years) (crude rate of 334 per 100,00 per data from 2018-19) and;
- Mortality from COPD (83.6 per 100,000 population). (2015-17)

Chronic kidney and liver disease
Chronic kidney and liver disease have been identified as a risk factor in COVID-19. In terms of Chronic Kidney Disease (QOF) prevalence (18+) (2018/19) shows Sunderland at 4.8% compared to 4.1% in England.

The Liver disease profile for Sunderland is significantly worse than England. This is often linked a wide range of factors often associated with increased deprivation such as drug and alcohol use and associated cardiovascular disease risks.

Diabetes
Diabetes (Types 1&2) has been identified as a risk factor in COVID-19 however its relationship at this time is unclear. In Sunderland the estimated prevalence of diabetes- diagnosed and undiagnosed (2017) was 8.7% for Sunderland compared to 8.5% for England.

The percentage of people with type2 diabetes aged 65-79 is 39.3% for Sunderland these individuals are amenable to modifiable risk factors such as physical activity and obesity interventions.



Obesity
Recent reports have suggested that obesity is one of the underlying health conditions that can cause a more severe reaction to COVID-19. This is significant given that for most Local Authorities the majority of adults are either overweight or obese. The prevalence of overweight and obesity in adults appears to be linked to higher levels of deprivation and is a contributing factor to a range of underlying health conditions such as diabetes and cardiovascular disease.

Obesity is clearly a complex issue influenced by environmental factors including access to healthy food options, for some people COVID 19 will have impacted on access to healthy food particularly for those with existing long-term conditions who are identified. as “shielded” and for those experiencing food poverty and may be reliant of food bank and other provision.

5.12 There are a range of other risk taking and lifestyle behaviours identified below which further contribute to “risk factors for mortality” including:

Physical activity
Reduction in levels of physical activity, and potential for changes in dietary behaviour impacts on health and wellbeing. This includes immediate impacts such as weight gain, stress, mental health and social isolation; plus, medium and longer-term impacts such as the management of a health condition, maintaining physical capacity and risk of frailty and falling. This is a particular risk for people who have limited access to their usual opportunities. (Ref: https://www.sportengland.org/news/new-exercise-habits-forming-during-coronavirus-crisis)

Smoking
According to the World Health Organisation (WHO), smokers and tobacco users are at higher risk of COVID-19 infection. Emerging evidence based on 1.5 million people from all over the UK from the COVID Symptom trackers suggests smoking significantly increases the risk of self-diagnosed Covid-19based on the classical symptoms (fever and persistent cough) by about 26%. (Ref: https://covid.joinzoe.com/post/smoking-and-covid-19)

Other studies indicate the risk of severe disease is probably higher and suggests smokers in hospital who have Covid-19are at a higher risk than non-smokers of severe illness impacting further on recovery.(Ref: http://www.tobaccoinduceddiseases.org/COVID-19-and-smoking)

In 2018/19 the Sunderland prevalence of smoking among adults over 18 years was 20.2%, compared to a North East average of 16.0% and a national average of 14.4%. (Ref: https://fingertips.phe.org.uk/profile/tobacco-control/) In terms of Smoking at Time of Delivery in 2018/19 the prevalence stood at 17.5%, compared to a North East average of 13.8% and a national average of 10.6%.

When considering some of the impact of smoking on the population there were 3036, smoking attributable hospital admissions for 2018/19 compared to a North East average of 2346 and a national average of 1612. As such smoking is a significant contributor to health inequalities and poorer family health outcomes in Sunderland, which will be further impacted on by Covid-19.

Alcohol
The potential public health effects of long-term isolation on alcohol use and misuse are unknown. The period of isolation might lead to a spike in alcohol misuse, relapse, and potentially, development of alcohol use disorder in at-risk individuals, therefore placing further strain on addiction and drug and alcohol services, and the health service in general, during and after the pandemic. (Ref: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30088-8/fulltext) Retail sales across the UK have fallen at a record pace under the lockdown, but demand for alcohol has soared. New ONS data has shown alcohol sales increasing by 31.4% against a record fall in overall monthly sales of 5.1% in March 2020.

New research from Alcohol Change UK (Ref: https://alcoholchange.org.uk/blog/2020/covid19-drinking-during-lockdown-headline-findings) suggests that drinking habits of people in the North East and nationally have changed during the lockdown, with over 450,000 adults in the North East and 8.6 million adults in the UK drinking more frequently since lockdown. However, over 650,000 NE adults and 14 million nationally are drinking less often or have stopped drinking entirely. More than four out of ten drinkers (or people who drank before the lockdown) appear to be taking active steps to try to manage drinking, suggesting that people are conscious that lockdown might lead us to drink more frequently or heavily.

Change to coping behaviours – increase in alcohol consumption, drug misuse and smoking prevalence:

- Increasing demand, and reduced provision of services for alcohol misuse and smoking cessation in the community.
- Increase demand for Tier 3 secondary care services for alcoholism.
- Increase in longer-term consequences of smoking and alcohol misuse leading to longer-term impact on services

6. How will we address health inequalities?

6.1 Appendix five details a range of actions the local authority and partners could take to help to mitigate the differential impact of COVID-19 on local communities. The consequences of disruption in relation to Covid-19 is likely to impact more on some groups, communities and places than others and result in further increases in health inequalities and focused targeted action needs to take place at a local level.

6.2 Health inequalities should be considered in all recovery plans. Some changes to services may have unintended consequences, therefore when developing any recovery plan, we will consider if any health inequalities are widened and how we will address these in the short-term (acute current phase) we will identify what services have been stopped or adapted, capture potential risks and mitigations and identify who are the high risk/ vulnerable populations who will have been impacted by COVID19. In the medium-term (adapting with COVID 19, some restrictions lifted) we will identify which services can resume and when, what are the risks and mitigations and the potential impacts on identified vulnerable populations.

6.3 Building on a Health in All Policies (HiAP) approach to policies we systematically and explicitly consider the health implications of the decisions we make, target key social determinants of health and the work we do with partners and tries to avoid causing harm with the aim of improving the health of the population and reducing inequity.

6.4 As part of recovery we will ensure that use available tools to ensure that health inequalities are considered for every policy and service. A local tool kit will be developed that will be continuously updated to take in to account any emerging evidence of the impact of Covid-19 on health inequalities which will include evidence-based actions that can be used to address these.

7. Strategic objectives

7.1 Continue to improve health outcomes for our most disadvantaged communities who are at greater risk of Covid-19 by adopting a lifecourse approach which identifies the key opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age and into older age.

7.2 Take every opportunity to mitigate the impact that Covid-19 has had on our communities by building on a Health in All Policies (HiAP) approach to policies we systematically and explicitly consider the health implications of the decisions we make with the aim of improving the health of the population.

7.3 Ensure that as we move into recovery we take the opportunity to address health inequalities as part of our plans by using available tools to ensure that health inequalities are considered for every policy and service.

8. Key actions

8.1 Develop and use a local tool kit to take in to account any emerging evidence of the impact of Covid-19 on health inequalities which will include evidence-based actions that can be used to address these.

8.2 Embed the Health Inequalities Strategy as part of any response or recovery work in relation to Covid-19

8.3 Build on previous local intelligence, relationships and resident experiences as well as information gathered as part of the City's immediate response from volunteers, people who are shielded, our vulnerable young people and any other sources of community intelligence to inform our approach.

8.4 Consider ways in which new interest in community /mutual aid approaches can be sustained to benefit priority communities and reduce demand on services.

8.5 Review social value secured through existing contracts and explore the potential to divert the social value offer where required for most vulnerable communities.

8.6 To progress the Marmot City principles which have been adopted by Sunderland City Council.

Appendix One: Further information

The Local Government Association have collated and also produced a number of useful resources for councils on novel coronavirus (COVID-19), these can be found at www.local.gov.uk/our-support/lga-covid-19-support-offer

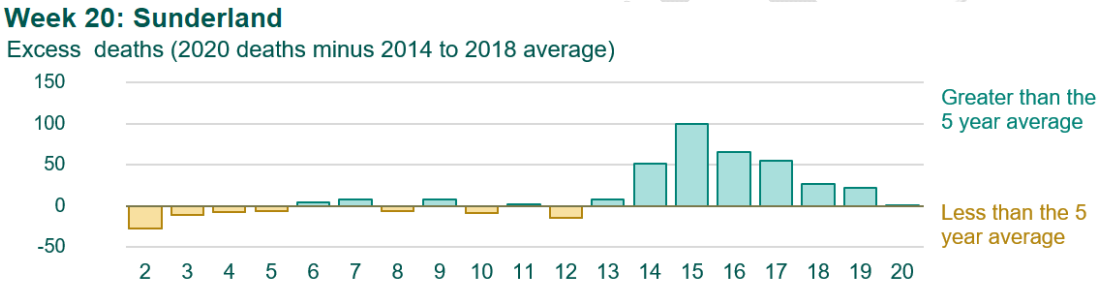
Appendix two: Local Impact Implications of COVID locally

The source of the data below comes from the ONS Death registration and occurrence by local authority and health board Office for Statistics, licensed under the Open Government Licence.

Excess death

Graphs 1 shows registered deaths by week for 2020, compared to the average registered deaths count, by week, for the year 2015 to 2019. This excess by week is also compared to the number of deaths where coronavirus (COVID-19) was mentioned on the death certificate.

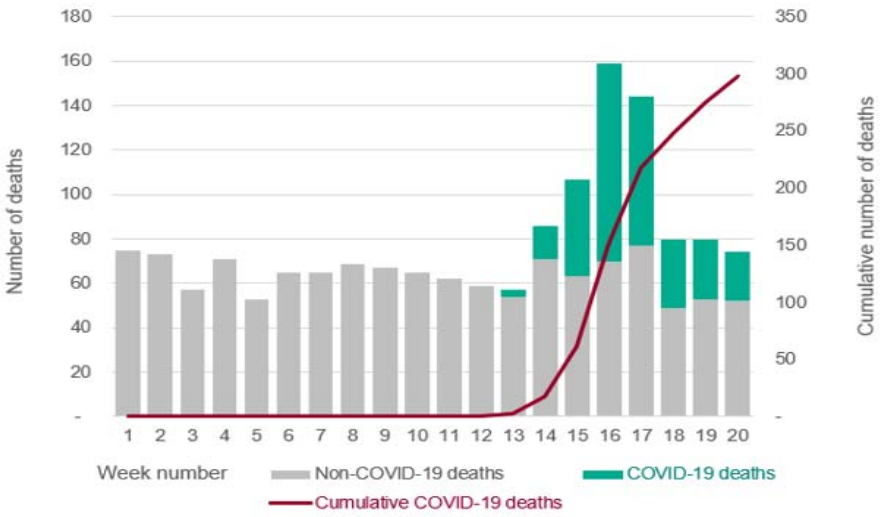
Graph 1 - Weekly provisional figures on deaths occurring, minus the weekly average occurrence 2014 to 2018, with proportion where coronavirus (COVID-19) was mentioned on the death certificate



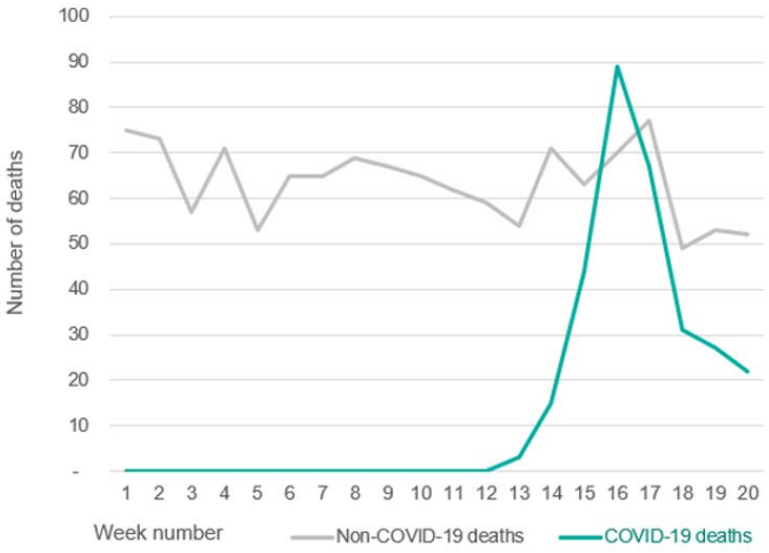
Trends and places of deaths

Graphs 2 and 3 use the ONS Death registrations and occurrences by local authority to look at the weekly trends for all causes mortality and where coronavirus (COVID-19). They show cumulative deaths for COVID-19.

Graph 2 - Deaths by cause of death (weekly numbers and cumulative), for deaths registered up to 15 May 2020 by week, Sunderland



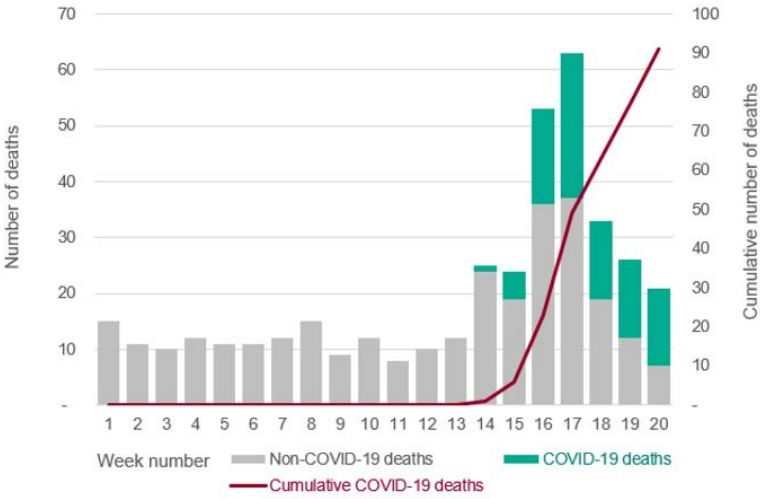
Graph 3 - Deaths by cause of death (numbers), for deaths registered up to 15 May 2020 by week, Sunderland



Trends – care homes

Graph 4 show similar trends to 'trends – all registrations and all occurrences' but where place of death was recorded as 'care homes'.

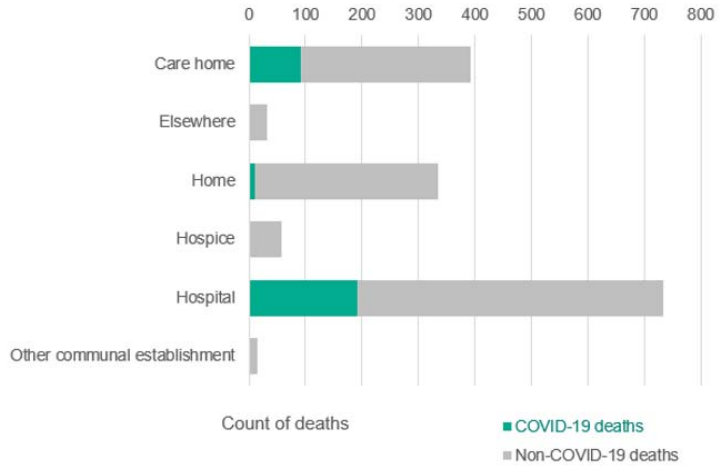
Graph 4 -Trends in numbers of deaths by cause and cumulative COVID-19 deaths, deaths registered up to 15 May 2020 by week, where place of death was recorded as 'care homes', Sunderland



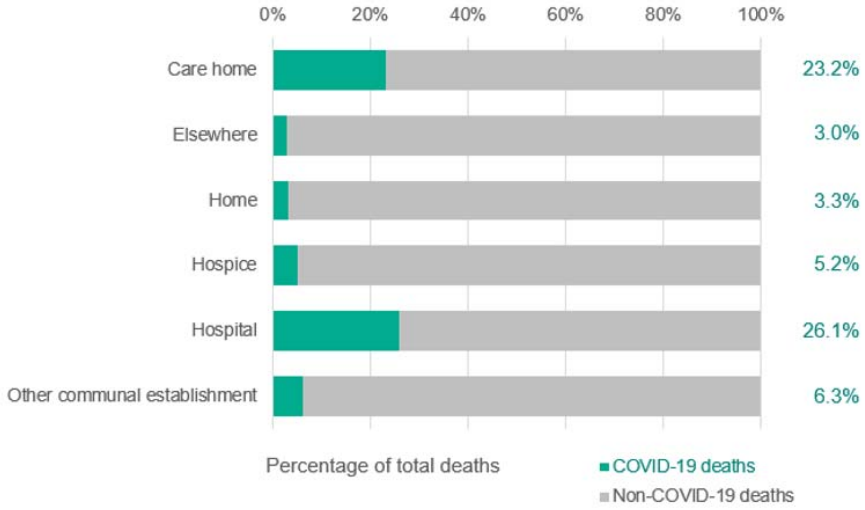
Place of death - registrations and occurrences

Graph 5 and 6 look at the proportion of COVID-19 and non-COVID-19 deaths, split by location for Care home, home, hospital, hospice, other communal

Graph 5 -2020 deaths by place of death (cumulative numbers), for deaths registered up to 15 May 2020 by place of occurrence, cumulative, Sunderland



Graph 6 -2020 deaths by place of death (cumulative numbers), for deaths registered up to 15 May 2020 by place of occurrence, Sunderland

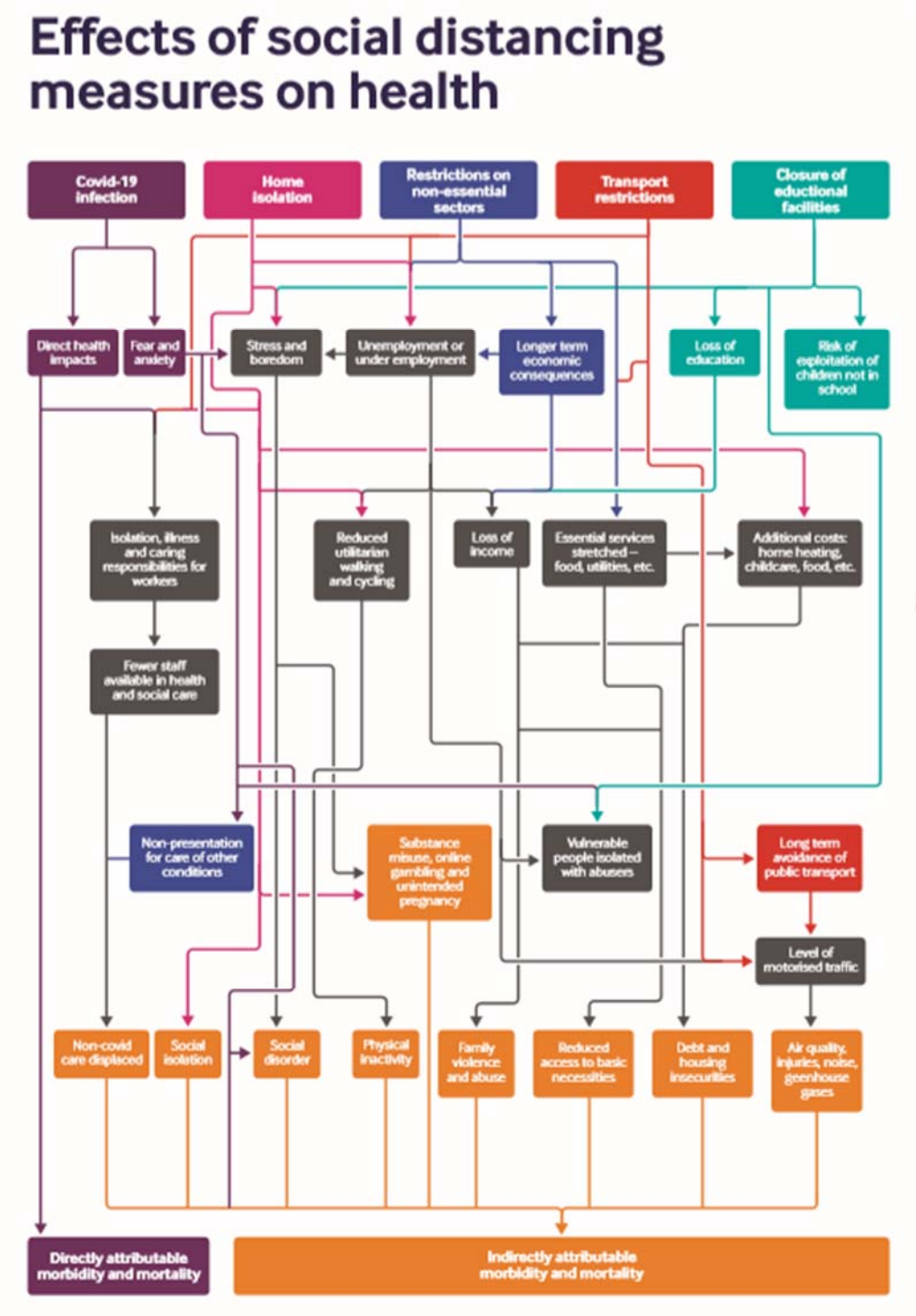


The data is set against all-cause mortality, which for Sunderland is historically higher than both the England and North East figures. In relation to COVID-19, this pattern continues.

Summary of the 320 deaths in Sunderland as of 11th May:

- 147 (46%) were males and 173 (54%) were females
- Ages ranged from 26-103, with a mean age of around 80 years and a median age of 82 years. The distribution of deaths by age has been fairly consistent throughout

Appendix three: **Diagram x Effects of Social Distancing on Health**
Ref: https://www.bmj.com/content/369/bmj.m1557



Appendix four: **Diagram x Groups at particular risk from responses to Covid-19**

Appendix five: COVID-19 Suggestions for mitigating the impact on health inequalities at a local level[17]

Area	Issue	Impact	Potential Action
1. Community Resilience and Social Isolation	**1.1 Marginalised and disadvantaged communities** are at risk of poorer outcomes associated with COVID-19 and are least likely to access mainstream support	An emergency can stimulate lots of local community action and support. However not everyone is likely to benefit or be able to contribute. Some communities will be disadvantaged already which will impact on capability to maintain community resilience and social networks.	Implement actions outlined in the national Community Resilience Development Framework. In particular: a. Use local data and intelligence to understand community resilience e.g. single person households, volunteers, community groups. b. Target activity to support communities in priority areas. c. Encourage and enable informal volunteer networks in areas where these are less likely to be established by communities themselves. d. Provide a means for key volunteers to identify they are undertaking mutual aid e.g. shopping for other people. e. Co-ordinate volunteering efforts with the NHS volunteer programme. f. Identify critical volunteering functions outside of NHS to inform prioritisation and support. g. Maintain and adapt community development, resilience and cohesion infrastructures (including buildings where relevant) and strengthen links with community facing groups and consider them and their volunteers as key workers where appropriate. h. Support the VCS in their role as employers and providers. i. Adapt community engagement/ participation methods to maintain two-way communications between services and communities e.g. using online methods. j. Raise awareness of everyone's responsibility in safeguarding to keep people safe. k. •Ensure community groups, including new online support groups are communicating the most up to date information. l. Consider adding new community groups to your community mapping, or carrying this out if not already in existence. m. Consider how to stay in touch with those who are otherwise digitally excluded. n. Link with other organisations working with priority communities and identify what action they are taking.

[17] Ref: https://www.local.gov.uk/sites/default/files/documents/COVID-19%20Suggestions%20for%20mitigating%20the%20impact%20on%20health%20inequalities%20at%20a%20local%20level%20%282%29.pdf

		Supply shortages (food, pharmaceuticals and other key goods) are likely to have a bigger impact on those in areas of high deprivation, for example due to increased costs, and disruption to factories and logistics. Some communities such as those that are physically isolated or remote may find it more difficult to access food, pharmaceuticals and other key goods.	a. Target response to any emerging shortage to the needs of priority communities, considering the ability of those communities to mobilise; preferred communication methods and styles; and suitable alternatives where routine or general population approaches are assessed as not likely to be effective. b. Consider the needs of those vulnerable people who have been advised to "shield" and encourage them to continue to register on gov.uk to support access to food parcels. c. Identify ways to address access issues for remote and isolated communities. d. Given the potential duration of the outbreak it is important that was far as possible people are supported to maintain a diet in line with the Eatwell Guide.
	1.2 Small Charities and Voluntary Groups	There are considerable risks that small organisations supporting vulnerable groups may struggle to continue their services due to a lack of income or staff shortages.	a. Review updates from national VCS infrastructure organisations and support dissemination to small community groups. b. Link existing organisations to emerging community led responses. c. Inform/utilise emergency grants distributed via the National Emergencies Trust. d. Make local voluntary organisations aware of the £370m for smaller local charities to be distributed via organisations like the National Lottery Community Fund. e. Work with infrastructure / community anchor organisations to identify voluntary organisations critical to addressing health inequalities gaps and consider how/whether support can be targeted to these groups.
2. Life Course	**2.1 People living with dementia**	Communication may not be targeted to people living with dementia. Some people with dementia may have difficulty understanding complex instructions, for example about self-isolation or handwashing. People with dementia may lack awareness of and be less able to report symptoms because of communication difficulties.	a. Ensure information provided is accessible and repeatable b. Encourage all to be alert to the presence of signs and symptoms of the virus for people living with dementia ("look beyond words").

		People with dementia in their own homes may already feel isolated and if they need to further self-isolate, additional assistance and support may be needed to mitigate the practical and emotional impact of separation. Relatives and friends not being allowed to see a person in a care home could have a detrimental effect on residents with dementia	c. Consider encouraging volunteer community groups, with appropriate expertise, to provide support for carers and people with dementia, particularly those living alone. d. Ensure care plans reflect the impact of self-isolation, including updated Lasting Power of Attorney documentation and advance directives. e. Promote the use of technology to help improve communication between families both at home and in care homes.
	2.2 Older people	People aged 70+ are strongly advised to social distance for an extended period. This may lead to an increase in social isolation and impact on physical activity levels, it may also affect mental health, physical capacity and, increased risk of falls as well as overall health and wellbeing. Considering how communication is delivered is important, to ensure the most vulnerable older adults are reached, including those who may not have internet access.	a. Promote ways of ensuring that physical distances do not mean losing all social contact especially for those who may not have access to the internet. For example, promote telephone contact and alternative ways of providing traditional befriending services. b. Signpost advice on how people can help themselves and others to manage feelings of loneliness, and sources of support through the #Let's Talk Loneliness campaign. c. Consider the potential to offer access to online services and resources for example postal print/audio books. d. Promote access to free e-books including audiobooks and newspapers/magazines for example through libraries online and free resources from online retailers. e. Encourage people to make use of interactive entertainment such as visiting art galleries and museums online. f. Provide clear and practical advice about structuring the day and keeping mentally as well as physically active. This might include making time for hobbies or learning new skills. g. Ensure consistent messaging for older people to drink plenty of fluids to stay hydrated.

			h. Promote importance of physical activity including strength and balance exercises, for maintaining physical function and good mental health. i. Target resources for physical activity to the needs of the most vulnerable older people, including those who may be at risk of falls to keep muscles, bones and joints strong. j. Encourage a healthy balanced diet based on the Eatwell guide. k. Target resources for older people at risk of malnutrition with a focus on not restricting calorie intake. l. Highlight risks of increased alcohol intake: memory problems, dizziness and injuries such as falling over. Drinking whilst on some medications can also be dangerous and stop certain medications from working and cause side-effects. m. Maintain support for older people who cannot access essential supplies (groceries, prescriptions). n. Remind people that health services can still be accessed when needed. o. Provide appropriate bereavement and grief support as the impact at this time is likely to be worse. p. Encourage contingency planning in case of an emergency.
	2.3 Children and Young People: Early Years	Families with children in early years may find it more difficult to access resources, services and support to enable early childhood development, and may be more at risk of loneliness and social isolation.	a. Health professionals should signpost parents to informative resources such as ICON which are particularly helpful at a time of high stress in the home and outside. b. Ensure continuation of national immunisation schedule for children and young people. Refer to the role of the health visitor for support. c. Refer to and highlight the role of health visitors to support children and families' health development and wellbeing during COVID-19.
	2.4 Children and Young People: Impact on educational outcomes	Evidence suggests that for disadvantaged children school closures may have a differential impact on families in deprived communities or on a low income. Action may be needed to ensure that the gap in educational outcomes for children is not exacerbated by any lengthy break from school/educational settings.	a. Prioritise the needs of those at risk of poorer educational outcomes in arrangements for home learning or where accessing school provision for priority groups that remain open. b. Consider the feasibility of schools reaching out to families in challenging circumstances to see how they are coping. c. Promote home learning environment resources to families, including activities that require limited equipment. d. Consider differential and increased home learning support for those most at risk and least likely to have resources. e. Deliver/promote virtual groups for families to join in with.

			f. Promote resources and support to known vulnerable families through health visiting and school nurse services (via existing targeted caseloads). g. Consider forward planning to mitigate against widening of the education attainment gap h. Consider specific support for SEN children and young people and their parents or carers, including more short breaks / respite care and the need for support with at home education, including connectivity, devices and training. i. Consider complementary work with schools on provision of support to families and carers of those SEND children and young people, particularly when risk assessment judges children's needs are best met if they remain at home.
	2.5 Children and Young People: Impact of greater risk of safeguarding issues	Children in need may have limited and reduced visibility of, and access to health professionals (e.g. health visitors, school nurses, social workers). Increased number of families will be at risk due to financial pressure/stress of being at home.	a. Consider reviewing methods of access to services to maintain safeguarding service levels. b. Consider action which can be taken to increase access to support for children at risk of abuse. c. Explore use of digital technology to be used to keep in touch with children and young people and their families without physical face-to-face contact, in line with NHS guidance. d. Maintain resources to deliver statutory safeguarding duties when re-deploying staff. e. Encourage children to use the internet safely to stay informed, educational purposes and to connect with friends and family. f. Consider the role of the VCSE youth sector and assets.
	2.6 Children and Young People: Access to learning resources	The gap in access to computers and internet at home between the poorest and richest households may hamper young people's ability to complete schoolwork and maintain peer relationships in the context of remote learning (Education Policy Institute, 2018).	a. Encourage local authorities and schools to take up the offer of free devices and connectivity for certain groups of disadvantaged and vulnerable children. b. Encourage schools to set up a cloud-based education platform to deliver education remotely. c. Consider the potential to loan school equipment for home learning.

		This may be compounded in larger families where learning resources are usually shared. For some disabled children access to learning is supported through adaptations in school e.g. differentiated IT and learning resources or adapted material for children with dyslexia, and these may not be available at home.	d. Consider ways to enable priority families to access free internet access. e. Consider making available learning packages which include the supply of resources e.g. paper/pens. f. Make adapted learning available at home to support disabled children.
	2.7 Children and Young People: Physical activity	Children are likely to undertake less physical activity during social distancing, this may be more marked in families where parents are not active themselves. People from lower socio-economic groups may lack resources (physical and technological) to participate in physical activity. Access to play spaces may be more of an issue for those without private outdoor areas whilst play grounds are closed.	a. Ensure care settings that remain open for critical workers incorporate physical activity within their offer. b. Promote access to free online resources and equipment. c. Provide guidance to priority communities on appropriate and safe physical activity in line with daily physical activity guidance.
	2.8 Children and Young People: Mental health and wellbeing	Removal of the protective role that schools and youth services play is likely to have a disproportionate impact on disadvantaged CYP. For example, they may be more isolated or have less access to home entertainment and technology and may be more likely to access mental health and wellbeing	a. Provide advice to schools on how they can support CYP to remotely access existing school based mental health support. b. Promote access to free entertainment designed to support people to remain positive c. Connect young people to peer support networks and digital activities. d. Connect young people to digital youth services (e.g. youth worker support or counselling online).

		support in schools and drop-in centres and families may not be aware of the online support available.	e. Coordinate helpline capacity and promote what's available but also consider prioritising resources to increase capacity at the helplines [subject to ability to train up volunteers in time].
3. Socio-economic, disadvantage and deprivation	**3.1** Deprived communities may experience more direct and indirect impacts from COVID -19. Because they already have greater vulnerability and are likely to have a compromised ability to respond to the extra impact of COVID-19.	People in deprived communities may be: more likely to work in occupations where social distancing is more difficult to observe e.g. manual occupations, key workers - less likely to be able to mobilise community support quickly because of a lack of resources - more likely to have existing health problems - more likely to live in overcrowded housing - less likely to have reliable and affordable access to the internet and online services - less likely to be able to navigate remote access to services - less likely to seek early help for existing or emerging health problems - be less able to access affordable food because of increased cost/ reduced public transport	a. Identify deprived communities using available data and local insight. b. Consider how to provide more intensive and focussed support for COVID-19 to those areas at sufficient scale for likely level of need. c. Consider how to provide alternative communication methods that are acceptable to communities who might traditionally rely more on face to face access. d. Identify ways of providing additional resources to grow community support. e. Focus communication to encourage people to continue to access essential health and care services on communities with the least health seeking behaviour. f. Consider ways of making available affordable and reliable internet access for deprived communities and increase digital literacy. g. Utilise expert citizens or similar approaches to engage and value the contribution of marginalised communities.
	3.2 Welfare benefits There is likely to be an increase in the number of people claiming**,** as people become out of work either	It is likely that the most vulnerable may be the most exposed to changes in financial circumstances. Some people will have more difficulty than others in navigating the welfare benefits system and may need additional support to	a. Target housing/financial information and support to the needs of the most vulnerable groups and those new to the system. b. Target more intensive forms of help towards those least likely to be able to navigate the claims process alone. c. Ensure there are strong links with DWP advice services. d. Plan for additional demand in housing benefit services (where existing claimants may need to amend their circumstances as income levels change (e.g. self- employed) throughout the course/different phases of the pandemic.

	on a temporary or permanent basis	adapt to changes in their financial circumstances, or access support. Changing financial situations can impact both as a cause and effect of mental health problems.	e. Provide information directly to targeted employers to pass on to their staff, including on the potential impact on mental health of changing financial situations.
	3.3 Low income micro businesses	Lower resilience to economic shock in low income small /micro businesses and sole traders.	a. Provide information to small businesses and sole traders/self-employed on ways of maintaining an income stream/ supporting local small business (in advance of access to Government help) Target information on managing mental health to small/low income businesses.
	3.4 Good quality work	Good and fulfilling work is important for health and wellbeing.	a. Target opportunities to link people into volunteering opportunities b. Provide support for individuals needing to claim Universal Credit, alongside support packages such as the Job Retention Scheme offered by the Treasury/HMRC. c. Encourage sectors who are currently recruiting to priority roles (e.g. health and social care roles, agriculture) to advertise their roles on DWP's Find A Job website. d. Work with Job Centres and other partners to link people quickly with priority employment opportunities that may arise e.g. - care sector, food retail and the NHS in support roles. e. Consider the feasibility of rapid online training working with local college staff (who may be working from home). f. Promote the new "Jobs Help" and "Employer Help", websites, which directly link to "Find a Job". g. Work alongside Mayoral Combined Authorities and Local Enterprise Partnerships to shape regional offers.
	3.5 People who are unemployed	People who are unemployed may face additional challenges as a result of COVID-19.	a. Target linking people from groups and communities who may feel that they do not have skills to contribute with volunteering opportunities that arise. This recognises their skills potential to contribute as well as being recipients of help ensuring individuals or communities are not left behind. b. Link people up quickly with any employment opportunities that may arise, in particular in the key sectors, for example key worker roles c. Provide access to online access to skills and training via local colleges and universities to enable meaningful use of time.

	3.6 Social value	Social value matters now more than ever as a means for supporting those who are most vulnerable in society, and most likely to be disproportionately affected.	a. Continue to have a focus on social value and strengthen this where possible, drawing on on-line expertise. b. Review social value secured through existing contracts and explore the potential to divert the social value offer where required for most vulnerable communities.
	3.7 Relationship with community businesses, social enterprises & VCSE at local level	There are potential issues with resilience/capacity of local organisations to continue to provide services. Potential reduced capacity to provide support where appropriate to third sector providers. Community spaces e.g. community centres may not be used during this time resulting in, issues around up-keep, cost and future safe running. Seek to ensure community spaces are not lost during the pandemic due to lack of resources to keep them viable whilst not in use.	a. Review and refocus some third sector activity (within their terms of reference/articles), to meet the needs of COVID-19 response. b. Maintain regular contact with providers, and other local business considering the impact of these businesses on priority communities. (for example, using on-line forum). c. Review current usage, rent breaks, repurposing community facilities in the short-term to ensure sustainability. d. Focus efforts in areas most vulnerable to losing facilities e.g. deprived areas and isolated areas. e. Explore alternative ways of delivering services which do not rely on face to face. Consider supporting smaller VCS organisations to access equipment to enable them to maintain client contact such as mobile phone, ipads etc.
	3.8 Utilising learning to identify future action to reduce health inequalities	Opportunity to learn from new ways of working e.g. reduced traffic flows, public transport, potential for mutual aid, growing resilient communities etc.	a. Create a repository of information that can be used later to inform learning. b. Consider ways in which new interest in community /mutual aid approaches can be sustained after the outbreak to benefit priority communities and reduce demand on services. c. Explore opportunities to engage academic communities to support process for example by reviewing existing contracts and contacts to support this work. d. Create opportunities for joint learning within and across public institutions at a later date.

4. Geography and Surroundings	**4.1 Housing**	There are a number of health inequality risks associated with housing. This includes: - An unhealthy home: cold, damp or otherwise hazardous - An unsuitable home: overcrowded or not meeting residents' needs - An unstable home: precarious living circumstances Some groups such as GRTB communities may have specific housing needs.	a. Follow guidance to be published by MHCLG. b. Local areas can use the community hubs being set up by government to help people in poor housing situations. c. Local areas can promote information on help available more widely, including information on help to heat your home, through: 1. community and mutual aid groups 2. support from energy suppliers 3. - information on the role of landlords in supporting tenants 4. care & repair including consideration of extending any care and repair schemes to other vulnerable groups See GRTB section
	4.2 Households who are self-isolating/ shielding	Reduction in levels of physical activity, and potential for changes in dietary behaviour impacts on health and wellbeing. This includes immediate impacts such as weight gain, stress, mental health and social isolation; plus medium and longer-term impacts such as the management of a health condition, maintaining physical capacity and risk of frailty and falling. This is a particular risk for people who have limited access to their usual opportunities People experiencing socio economic deprivation/reduced access to usual income source etc who are self-isolating but who fall outside of vulnerable groups for government directed support e.g.	a. Promote home based physical activity including activity appropriate for different groups e.g. those with more limited mobility, at risk of falls, more active but vulnerable, including promoting safe outdoor time (e.g. in own garden where available). b. Support people to maintain a healthy balanced diet in line with the Eatwell Guide, where possible. c. Highlight that food items with a longer shelf life such as dried, canned, ultra-heat treated (UHT) and frozen options are healthy alternatives to fresh produce. d. Encourage people to follow appropriate dietary advice if they have reduced appetite because they are unwell e.g. eating little and often and staying hydrated. e. See also potential for impact on mental health in mental health section and the domestic abuse section of this document. f. Work with food retailers, community support groups/food banks etc to target support to low income groups who are self-isolating/shielding g. Consider the cultural needs of these groups in providing support. h. Promote information on when it is appropriate to undertake home repairs to maintain health and wellbeing during isolation. i. Consider the potential for those on low incomes to have insufficient income to afford to make urgent repairs.

		food parcels may have limited access to affordable food.	j. Support voluntary/community activities that help local residents during the outbreak. k. Encourage people to use the internet safely to stay informed and connect with family and friends
	4.3 People living in overcrowded conditions or HMOs	People living in overcrowded housing conditions or in HMOs more generally may be at greater risk of exposure to the virus because they may be less able to control their home environment.	a. Provide information and myth busting to landlords and tenants on the steps they could take to minimise the risks associated with living in shared spaces e.g. cleaning and disinfection, laundry and hygiene practices.
	4.4 Indoor air quality	People who are self-isolating/shielding and/or spending prolonged periods indoors may be more at risk of impact on health of poor indoor air quality.	a. Stop smoking services should target support and advice to smokers who are self-isolating/shielding and are not able to go outside to smoke, including offering information on alternatives such as Nicotine Replacement Therapy (NRT) or e-cigarettes to protect the people around them from harm. b. Smokers who do not want to quit should take steps to protect others from second-hand smoke exposure as this could also exacerbate the symptoms of COVID-19. This includes using other sources of nicotine and taking their smoke completely outside where this is possible. c. Raise awareness about maintaining good ventilation by opening one or more windows (even just a little, and only where it's safe to do so) or opening vents during the daytime. This is particularly important if there are several people/animals in the household, and when showering/having a bath, cooking, drying clothes or hair, using cleaning products, doing DIY or smoking.
	4.5 Fuel poverty	People on low or reduced incomes may be less likely to heat their home/water sufficiently during extended periods in the home because of cost.	a. Provide targeted information on help available to heat homes during COVID-19. b. Consider the needs of people in particular circumstances for example, not on mains gas. c. Encourage people to make use of financial assistance for home energy replacements as appropriate.
	4.6 Overheating	If the period of social distancing runs for a prolonged period into the spring and summer, there is a challenge of some homes	a. Refer and reinforce key messages in the Heatwave Plan for England as and when there are heatwaves.

		overheating. Some groups of people are especially vulnerable to overheating in homes.	
	4.7 Public realm	An emergency can exacerbate the already challenging conditions under which some of our most vulnerable population live. For example, areas with high air pollution can impact on those contracting respiratory diseases. It can make it even harder for those living with no gardens of their own, or easy access to green spaces to get outdoor exercise in accordance with government guidelines – and make it more difficult to remain socially distanced. Some areas already suffer from a lack of services and shops, for example food deserts where it is difficult to easily access healthier food.	a. Local authorities will know those areas experiencing multiple deprivation and can take action to identify and support the most vulnerable (as identified elsewhere in this table). b. Local Authorities can consider action to support those with more limited access to green spaces, parks and recreation grounds to follow government guidance on daily exercise e.g. consider closing off streets temporarily to allow safe corridors to people to get outside and take physical activity as recommended. c. Local Authority Environmental Health teams could advise on areas which suffer from lack of services or 'food deserts' and target support and community activities appropriately so that vulnerable areas are not further disadvantaged further by the rules on social distancing and restrictions on travel. d. Local authorities could identify where critical workers are travelling to and from areas with limited connectivity and identify ways of supporting such workers travelling to work safely.
5. Inclusion health and vulnerable groups	**5.1 Unpaid Carers**	Carers might be worried about how care can be provided if they or the person they care for develops symptoms of COVID-19. Some carers might also find that their caring duties increase as a result of the current circumstances.	a. Encourage and support carers to develop contingency plans, if they become unable to provide care. b. Provide clear messages to carers about how they can access additional support if it is required c. Promote to carers the importance of looking after mental and physical health and wellbeing. d. Promote information on financial support available for carers.
	5.2 People experiencing domestic abuse	Hidden Harms and potential physical and mental impacts on individuals and families.	a. Increase awareness of the issue and that support is available– including still calling 999 in emergency, local helplines, national helplines etc.

		There may be an increase in new cases of domestic abuse (DA). Families living together are under additional stress and may be drinking more at home to manage this. This could also exacerbate existing abuse within relationships. Reduced ability to call helplines for support if at home with perpetrator during lockdown. People experiencing DA may think that the police won't respond during COVID-19 to DA calls so don't call for help. There may be reduced capacity in services to deal with DA due to demands of COVID-19. People experiencing domestic abuse may feel that they are not able to seek support / may have less opportunities to seek support. There may be a decrease in opportunities to identify possible victims/survivors. Potential perpetrators of domestic abuse may feel they are not able to seek support.	b. Increase awareness that while women are twice as likely to experience domestic abuse as men, men can also be victims of domestic abuse. Intersectionalities to further consider are; parents and elders, LGB and trans people. c. Raise awareness of #YouAreNotAlone government awareness campaign and safe spaces in pharmacies etc. d. Consider ways to address the impact on children of DA e.g. signposting to support such as Childline. e. Maintain awareness of local support offer and capacity in services (including availability of refuge spaces) and of normal police service for DA incidents. f. Communicate to those currently receiving support how to access that support/alternative arrangements. Provide clear messaging that support is available, and people can leave their homes if living with abuse to go to places of safety. g. Seek ways to maintain contact with those already known to be at risk in a safe and appropriate way. h. Maintain statutory safeguarding and MARACs in safe way (e.g. remote working where possible). i. Continue multi-agency working e.g. with the police to collaborate on DVPOs and COVID-19 bill powers to ensure safety of family from domestic abuse and COVID-19. j. Continue to provide messaging on where people who fear they may perpetrate can access support (e.g. respect helpline). k. Raise awareness of what support is available in line with national guidance, including the availability of Sexual Assault Referral Centres (SARC) and safe accommodation. l. Consider how the public/neighbours/volunteers/ can help to identify and reporting people at risk of domestic abuse. m. Consider how perpetrators can be supported to change their behaviour.in the context of COVID-19 restrictions.
	5.3 People with distressed	Relate research from 2016 estimated that 18% of couples (and	a. Promote information and advice on managing relationships during COVID-19.

	relationships in their household.	others who live together) were in distressed relationships. Self-isolation, social distancing and other concerns may place relationships under them under added pressure impacting on health and wellbeing.	
	5.4 Vulnerable Migrants including asylum seekers, refugees and undocumented migrants.	Vulnerable migrants may be unclear about how the healthcare system works, their entitlements to healthcare access and whether they are eligible for government support. Other barriers to healthcare access include the fear of being charged and fear of data sharing with other authorities. Some vulnerable migrants will face additional barriers in accessing public information e.g. because of language barriers and access to technology etc. There is potential for some groups to access information from unreliable sources or from countries that speak their first language where information may not be relevant here.	a. Where possible, make guidance available in multiple languages, and promote awareness of rights of access to healthcare services. b. Where an individual has a visa or leave to remain expiring between 24 January 2020 and 30 May 2020 raise awareness that migrants can receive a letter of extension of their leave from the Home Office, which would allow them to continue to work if their previous leave conditions enabled them to do so. c. Raise awareness of resources for health professionals and community hubs to support migrant patients and clarifying the entitlements to free and chargeable NHS services. d. NHS services provided for the investigation, diagnosis and treatment for COVID-19 are free of charge, irrespective of immigration status. e. As well as translated guidance, videos with spoken guidance can help where there are issues with illiteracy in first languages as some languages are primarily oral e.g Sylheti. Audio-only guidance can be shared easily among communities. f. Engage faith and community leaders who may be seen as trusted sources of information in their communities.
	5.5 Sex Workers	There are multiple pressures on sex workers during the response including a reduction in income,	a. The National Police Chiefs Council has sent a message to police forces reinforcing that the approach to sex work should focus on

		lack of eligibility for government support and greater risk of exposure and potentially exploitation.	engaging, explaining and encouraging, using enforcement as a last resort. b. Local sex worker organisations have developed local guidance to protect this group – check with your local sex worker organisation and support the key messages for this group. c. The police are still pursuing high risk modern slavery cases where there is a risk of harm to the individual. If you have concerns about victims of sexual exploitation you can refer to the modern slavery section for further information on support.
	5.6 Modern Slavery Victims	Victims of modern slavery often have medical needs arising from their exploitation. A significant proportion of victims have insecure immigration status and can struggle to access necessary health services as a result. During COVID-19 victims are at increased risk of social isolation as many rely on contact with support workers or community organisations that may not be operating. As modern slavery is a hidden crime, victims may not be identified through the usual channels and come into contact with different frontline services during the crisis.	a. First Responders have been provided with guidance on assessing symptoms prior to referral into support to ensure a safe transition. b. Ensure Local Authority staff are aware of how to identify the signs of modern slavery and refer someone into support through the National Referral Mechanism. c. Frontline staff at other services should receive a copy of the Spotting the Signs flyer (available on the COVID-19 Modern Slavery resources page) in case victims access services through other routes d. Healthcare providers should ensure they are aware that victims of modern slavery can access treatment (see 15.47 - 15.63 of the statutory guidance). e. Sign-up for regular COVID-19 Modern Slavery updates here.
	5.7 People who experience homelessness and rough sleeping	People who experience homelessness and rough sleeping may be at greater risk due to the difficulties around self-isolating and may be affected by closure of homeless services due to an outbreak or lack of staff as support workers become ill.	a. Local authorities are responding to the request by Government to provide emergency accommodation for people who are sleeping rough or in emergency accommodation. b. Pathways has published clinical advice and guidance on delivering a health-led, multi-agency approach to reducing the risk of infection and severe illness among the homeless population. This has been the basis of many areas' health response to delivering care for people experiencing rough sleeping. c. • NHSE/I have a dedicated collaborative workspace for colleagues working across health and care on the homeless health response to COVID-19 hosted on the Future NHS collaborative platform. You can

			register to join by emailing HomelessHealthCOVID19-manager@future.nhs.uk.
	5.8 Gypsy, Roma, Traveller, and Boater Communities	People who live on Traveller sites, in vehicles or living on canal boats may experience additional difficulties with implementing social distancing and social isolation due to a number of factors, including lack of access to basic amenities including water and sanitation, overcrowded living conditions, access to support and low literacy and language barriers. There is potential for some Roma groups to access information from unreliable sources, or from countries where their first language is spoken, but where information may not be relevant.	a. Local authorities should ensure communities have access to water, sanitation and waste collections. b. Some Gypsy and Traveller communities, especially those living on unauthorised sites and lacking basic amenities, may require alternative places to stop where access to facilities such as water pipes and water bowsers and portable toilets is provided, or can be made temporarily available. c. Consider offering support beyond essentials such as medication and food. This could include refilling gas bottles and/or fuel and refilling water butts and advice on refuse collection. d. Caravan sites and Campsites should remain open to allow people to remain if they would otherwise be homeless. e. Local authorities to consider identifying a lead on support to Gypsy, Roma and Traveller communities.
	5.9 People who smoke/ who are stopping smoking	The CMO has highlighted that smokers are at increased risk if they develop COVID-19. Smoking may increase complications from coronaviruses. The best way to quit is through using an alternative source of nicotine (such as NRT or e-cigarettes), other medications (such as Champix) and behavioural support. There is a risk is that people want to quit smoking but cannot access support.	a. Smokers should be advised to quit or temporarily abstain to reduce the risks of complications from COVID-19 and other health problems. b. Smokers who do not want to quit should take steps to protect others from second-hand smoke exposure as this could also exacerbate the symptoms of COVID-19. This includes using other sources of nicotine and taking their smoke completely outside where this is possible. c. Identify ways of continuing to offer stop smoking support e.g. through online and telephone support

			d. Consider ways of maintaining access to quitting aids such as NRT and vaping products. e. Provide advice for smokers who are self-isolating and are not able to go outside to smoke e.g. on seeking alternatives such as Nicotine Replacement Therapy (NRT) or e-cigarettes to protect the people around them from harm.
	5.10 Gambling Harms	While overall gambling levels have dropped with the closure of all land-based gambling venues and the cancellation of sport and racing, there is evidence that play is increasing on some online products such as casino games. Some individuals, especially those with existing gambling problems, may be vulnerable to increased harm while spending more time at home during lockdown. Operators have been warned to be particularly responsible on monitoring play and intervening to prevent harm, and on advertising. The National Problem Gambling Clinic is reallocating resource to more acute mental health issues yet continues to maintain a reduced service offer. Gambleaware commissioned treatment providers are having to adjust to online support services only.	a. The National Problem Gambling Helpline is still open to provide information and support, as well as some online treatment and support series. Those requiring support should call the helpline for further information about the best source of support for them. b. Those requiring support with problem gambling are still able to access GAMSTOP, a free service that enables individuals to put controls in place to help restrict online gambling activities. Many banks also continue to offer gambling transaction blocking tools. c. Gam-anon meetings have moved online and there is an online meeting nightly (except Saturday night) from 19:00-21:00. d. Concerns about the behaviour of an operator can be logged with the Gambling Commission by phone or email. e. Some organisations such as The Gordon Moody Association (who offer residential care) has switched to proactively contacting ex residents remotely to offer support.
	5.11 People who misuse or are dependent on drugs or alcohol	Drug and alcohol services are under increased pressure due to social distancing requirements necessitating new ways of working,	a. Take steps to maintain access to and availability of drug and alcohol treatment services as a priority. For example, by considering deferring any retendering processes, and reducing. contract/performance management demands to focus on key aspects of service delivery, for

		and additional strains on staff and service users during the COVID-19 outbreak. A significant proportion of the estimated alcohol dependent population are not actively engaged in alcohol treatment. These are often people with multiple needs/comorbidities such as poor physical and mental health. There is a risk of physical complications from COVID-19 in a population already experiencing poor physical health. Many alcohol and drug users have underlying health conditions. There may be challenges in providing supervised consumption of methadone and buprenorphine, and there may be supply interruptions with medicines and injecting equipment. People dependent on drugs and alcohol may be unable to obtain (sufficient) supplies and may go into withdrawal (greater danger with alcohol).	example opioid substitution therapy; medically assisted withdrawal for alcohol dependence for those assessed as in priority need. b. Raise awareness with the public and health and care professionals of the risk of unmanaged alcohol withdrawal and need for medically assisted withdrawal if indicated wherever possible; gradual cutting down with clinical oversight based on clinical assessment, and assessment and management of acute withdrawal. c. Pathways/arrangements in place in secondary care to detoxify alcohol dependent patients admitted to hospital with COVID-19. d. Pathways to community-based treatment provision and advice to dependent drinkers about how to access this during outbreak to ensure continuity of care. e. There is an opportunity for health and care professionals to encourage drug and alcohol dependent people presenting with COVID-19 symptoms, but not in contact with, the treatment system to establish links to treatment. f. COVID-19 guidance for drug and alcohol services published by PHE should be followed by commissioners and service providers. g. Provide links to mutual aid online meetings and other helplines and online resources.

		People in recovery will not be able to attend mutual aid meetings in person (though meetings are available online) and may be at risk of relapse Because of reduced supply, drug dealers may sell contaminated or adulterated drugs, or other dangerous alternatives. There is an increased risk of acute alcohol withdrawal to the alcohol dependent population during the COVID outbreak, because of potential changes in alcohol availability, unexpected changes in income and people being unable to have appointments with clinicians to monitor their treatment need. Social isolation could exacerbate drinking behaviour and potentially increase the risk of harm to self or others (through DA, child neglect).	h. Support drug and alcohol service providers to work with Local Resilience Forums, Local Pharmaceutical Committee's and pharmacies to make alternative arrangements for ongoing prescribing and dispensing. i. Encourage drug and alcohol services to provide advice to people who use drugs and alcohol on ways clients can manage reduced access. This includes managing supplies and avoiding significant withdrawal symptoms in line with harm reduction advice published by PHE and NHSE. j. Work with local drug information systems to ensure assessment and alert is taking place as appropriate.
	5.12 People being released early from prison	People will continue to be released from prison and some will be released earlier than expected under special arrangements. These people are often the most socially excluded and many will find themselves homeless after being released. Prison populations have complex multiple health needs including substance misuse, mental health	a. Local authorities should agree protocols with the prison and probation services to provide care, support and housing for people leaving prison, including residential placements for social care if required. b. All local authorities should be familiar with the rules about determining the ordinary residence of someone on returning to the community from custody. c. Collaborate across local authority boundaries where relevant to ensure outcomes are delivered quickly for this group.

		and physical health problems. People are released from multiple prisons to each local authority area.	
	5.13 Critical workers	Critical workers who are required to continue working in the community will be at greater risk. This includes not only health workers but also those who will continue to work in some forms of retail, delivery services and other public response personnel.	a. Create ways for all critical workers to travel to work in a safe environment to limit exposure (e.g. relaxing parking restrictions or to support active travel through measures such as emergency bike lanes). b. Promote mental well-being in staff who may be overworked or are worried about the impact of the virus. Ensure that all staff are aware of mental health services to support their well-being.
	5.14 People with mental health problems or recovering from mental health problems.	Prolonged periods of social isolation and social distancing are likely to impact on the mental health and wellbeing of vulnerable groups in general, as well as those who already have mental health conditions, ranging from anxiety to depression to more severe conditions. Social distancing and self-isolation measures during the coronavirus lockdown are likely to increase feelings of loneliness, which has wider impacts on mental and physical health.	a. Target support for mental wellbeing and resilience to vulnerable communities. b. Consider ways in which vulnerable groups can be supported to act upon COVID-19 mental wellbeing guidance (this includes mental health advice for people who are pregnant, people with learning disabilities, people with autism, people living with dementia and older people). c. Consider how you can boost national communications on wellbeing and mental health locally. d. Support library services to ensure their bibliotherapy books and information are available online. e. Ensure support and resources can be accessed through non-digital formats.
	5.15 People with serious mental illness	Potential risk to wellbeing if community groups and social prescribing activities cease. Potential risk if people are isolating, or if there is a significant change in the structure of their day due to home working, that people may be	a. Utilise national resources e.g. through the national. social prescribing academy. b. Promote physical activity to help structure the day and manage stress. c. Support VCS organisations tackling loneliness, including through the funding and volunteering support announced in the Government's action plan for tackling loneliness during the coronavirus lockdown.

		less likely to undertake activity which supports mental health. Potential risks associated with not being able to access treatment and other stressors such as unemployment, changes to home environment, bereavement, exposure to trauma, lack of physical exercise etc. More likely to have underlying physical health conditions. There is a greater prevalence of behavioural risks such as smoking, unhealthy eating and lack of physical activity which are associated with poorer health outcomes.	d. Signpost advice on how people can help themselves and others to manage feelings of loneliness, and sources of support through the #Let's Talk Loneliness campaign. e. Consider ways of promoting resilience during social isolation. Link with local NHS MH providers to establish what measures they are taking to switch treatments such as IAPT to digital, and when their 24/7 MH crisis line will be active for you to promote. f. Link in with your local VCS sector and signpost to the support they can provide – DHSC is giving a £5M grant to MIND to distribute locally to boost VCS sector efforts to support mental health. g. Utilise the LA coronavirus hub to signpost and promote mental health and wellbeing, as well as making use of volunteering schemes to help vulnerable groups deal with anxiety and other mental health issues that might arise about access to food and medication and social contact. h. Consider ways to support access to help with finance, debt, essential services, employment, housing and the welfare system. i. Identify and address ways to support people in collecting medication. j. Consider ways to provide access to lifestyle support if needed, e.g. smoking cessation, alcohol and drug misuse.
	5.16 People with autism	People with autism may experience a change to their usual support arrangements, for example due to the need for them or those who support them to self-isolate.	a. Provide communication support e.g. visual aids, plain English, and easy read. b. Local areas could consider the capacity and resilience of support systems. c. Consideration should be given to making contingency plans and maintaining consistency of support and routines as much as possible and supporting people to understand change and transition when it occurs. d. Those supporting people with autism should continue to advocate for their human rights and equal access to health care throughout the outbreak.

			e. Raise awareness of the letter from NHSE regarding DNACPR.
	5.17 People who have a learning disability	People who have a learning disability may experience changes to their care and support and may lack capacity to understand the Coronavirus outbreak.	a. Local areas should consider the capacity and resilience of support systems. b. People should be supported to make plans involving family or paid carers about what will happen if those who usually support them are not able to. c. Accessible information should be provided to support their understanding of Coronavirus and the changes everyone needs to make as a result of it. Such as easy read guidance on; how to stop the spread, handwashing, keeping your mind and body well, shielding, keeping away from other people and advice about staying at home. d. Those supporting people with learning disabilities should continue to advocate for their human rights and equal access to health care through the outbreak. e. Raise awareness of the letter from NHSE regarding DNACPR.
	5.18 People with a sensory impairment	Communication may not be targeted to the needs of people with hearing, speech or visual impairments. People who need to touch things to be able to get around may be more exposed because they are less likely to be able to avoid touching surfaces which may be more contaminated. This group may also be less likely to be able to identify places to wash their hands / identify available hand gel so easily.	a. Consider developing/making available specific communications such as providing information in easy read, British sign-language or braille format. b. Support organisations supporting such groups to identify advice and information relevant to the specific needs of this group. E.g. carrying and frequently using hand gel where possible.
6. Protected Characteristics	**6.1 Pregnant women and early years**	Pregnant women (and new mothers) may be more at risk from the potential dis-benefits of social distancing (for example loneliness, reduced access to services and information, reduced physical activity and access to a balanced	a. Link with NHS/maternity/antenatal services to enable different models of service provision during COVID-19. b. Link with NHS Maternity services to support messaging to pregnant women to continue to attend their antenatal appointments and to contact maternity services if they have any concerns (e.g. reduced foetal movements).

		diet /healthy food, peer support, increased instances of domestic abuse during pregnancy and beyond). Pregnant women have been told to self-isolate and may delay seeking help from maternity services when they should not delay.	c. Link with NHS, employers and other services to provide support to priority groups of pregnant women to access any virtual support during pregnancy. d. Raise awareness of right for full pay suspension if work places cannot provide a safe environment. e. Consider providing guidance on what to do with younger children who are off school to enable access to medical appointments if needed. f. Consider providing access to guidance for pregnant women on seeking help from maternity services during COVID-19. g. Encourage women to speak with their midwives to tweak birth plans considering COVID-19. h. Women should continue to be supported to access specialist stop-smoking support. Consider how any changes to local provision can continue to support pregnant women. i. Promote information to pregnant women on the dangers if other people in the household smoke. j. Ensure guidance includes advice and signposting around domestic abuse using sensitive and appropriate language. Refer to the role of the health visitor for support. k. Ensure women are aware of possibility of telephone counselling appointments. Signpost to the Tommy's wellbeing tool. l. Promote importance of physical activity for pregnant and post-partum women and for early years children (following social distancing guidance).
	6.2 Race, ethnicity, BAME groups	Available information on COVID-19 may be seen to be less culturally appropriate for some groups. Information may not be available in community languages; oral and easier read formats; or may not fully account for different domestic arrangements, multi-generational households and acceptable norms such as greetings.	a. Provide information in a range of community languages. b. Provide access to information which addresses the challenges of COVID- 19 for different domestic arrangements and cultural norms. c. Focus on key elements: 1. What to do if someone is unwell, how to get support, social distancing. 2. Develop a wider range of mechanisms for engagement with BAME communities and groups.
	6.3 Religion or Belief	Faith and belief groups may be in contact with vulnerable groups.	a. Some faith groups e.g. Sikh, Muslim, Christian, have developed messages including about safe volunteering targeted to their communities which are being distributed through social media and by

		Faith and belief groups may need additional information about how to undertake practices safely at this time (I.e. information on whether to fast during Ramadan with COVID-19 symptoms). Available information on COVID-19 may be seen to be less culturally appropriate for some groups. Information may not be available in community languages; oral and easier read formats; or may not fully account for different domestic arrangements, multi-generational households and acceptable norms such as greetings. Faith and belief groups may take part in rituals around death and conduct funerals.	organisations themselves. Some organisations are offering support and outreach for vulnerable people. b. Linking with faith and belief organisations can provide insight into the needs of these groups and identify actions already in place to assist them. c. Develop a wider range of mechanisms for engagement with faith and belief groups. d. Provide information in a range of community languages. e. Provide access to information which addresses the challenges of COVID-19 for different domestic arrangements and cultural norms. f. Work with funeral directors and faith groups to ensure there is proper understanding of the guidance on funerals and safe care of the deceased by professionals and, as far as possible, consistency of application. g. Work with funeral directors to ensure there is access to Personal Protective Equipment (PPE) and trained professionals for funerals, and where there is a requirement to take part in rituals or practices which bring individuals into close contact with the body of the deceased, such as washing, preparing or dressing the body. h. Produce specific guidance, where appropriate, to make sure that faith practices can be undertaken safely in the context of COVID-19 (where they can be practiced at home/permitted by the law).
	6.4 Lesbian, gay, bisexual and trans (LGBT) communities	Communication from mainstream services that is targeted at LGBT people may be more limited. These communities may be less visible in health and social care settings. Certain factors may put some members of LGBT communities at greater risk of being affected by COVID-19. LGBT people are more likely to smoke, and certain LGBT groups are more likely to be living with HIV. There is also evidence to	a. Engage with local LGBT organisations for insight into how best to support LGBT communities. b. Health and care providers can signpost people to LGBT organisations and mutual aid services operating in their area. c. Share COVID-19 LGBT specific information via public sector communication channels. A range of LGBT organisation such as Stonewall and LGBT Foundation provide advice and support to LGBT communities via social media. d. Ensure there is adequate local provision of sexual health services during COVID-19 particularly for key vulnerable groups and good communication of how to access any online/remote provision.

		suggest that LGBT people may delay accessing healthcare due to fears of encountering discrimination. Trans people may have difficulty in gaining access to cross-sex hormones and gay and bisexual men may have lack of access to PrEP. LGBT people may be more likely to be negatively affected by social isolation measures. LGBT people are more likely to have poor mental health, problems with substance misuse, be affected by domestic abuse, some LGBT young people may be isolating with family members who are LGBT-phobic, and evidence suggests that older LGB people are more likely to live alone and less likely to see biological family on a regular basis. Any disruption of adult Gender Identity Services as a result of COVID-19 response is likely to have a negative impact on trans and non-binary people.	

Item No. 10

SUNDERLAND HEALTH AND WELLBEING BOARD **25 June 2020**

LOCAL OUTBREAK CONTROL BOARD

Report of the Director of Public Health

1.0 Purpose of this report

1.1 This report details the proposed arrangements for the Sunderland Local Outbreak Control Board for agreement by the Sunderland Health & Wellbeing Board.

2.0 Background

2.1 On 22 May 2020 the UK national government announced that as part of the next phase of the response to the COVID-19 Pandemic, alongside the NHS Test and Trace Service, there is a need for a co-ordinated effort from national and local government, the NHS, GPs, businesses and employers, voluntary organisations and other community partners as well as the general public to control the rate of reproduction of the virus, reduce the spread of infection and so help return life to normal for as many people as possible in a way that is safe.

2.2 Upper tier local authorities have been tasked with developing local outbreak control plans due to their statutory responsibility for public health. In developing the plan they will need to work with Public Health England's local health protection teams, the NHS and other relevant organisations through a local COVID-19 Health Protection Board. The COVID-19 Local Outbreak Control Plan will focus on preventing, rapidly identifying and swiftly responding to complex cases in high-risk places, locations and communities. This allows the response to be targeted and tailored to local circumstances and supports the move towards recovery from the pandemic. The aim is once again to contain the virus.

2.3 The development of the plan is the responsibility of the Director of Public Health working through a local COVID-19 Health Protection Board. There are seven key themes that need to be addressed by the Plan as follows:

- Managing local outbreaks in care homes and schools;
- Managing high risk places, locations and communities of interest;
- Prioritising and managing deployment of testing capacity;
- Ensuring capacity for contact tracing in complex settings;
- Integrating national and local data to support decision making and action;
- Supporting vulnerable people;
- Establishing governance arrangements.

2.4 The plan will be completed by the end of June 2020.The local response set out in the Plan will build on existing health protection good practice and will involve working collaboratively with a range of partners, such as PHE, NHS, care homes, educational establishments, private businesses and the voluntary sector.

3.0 Establishing governance arrangements

3.1 While we continue to live in unprecedented times, much of what we are required to do in response to this new phase of the pandemic is known and will, therefore, be built on existing processes, relationships and structures.

3.2 National guidance identified three critical roles and the relationship between them. The public health response will, therefore, operate within local governance arrangements that include three approaches for multi-agency working as depicted in figure 1.

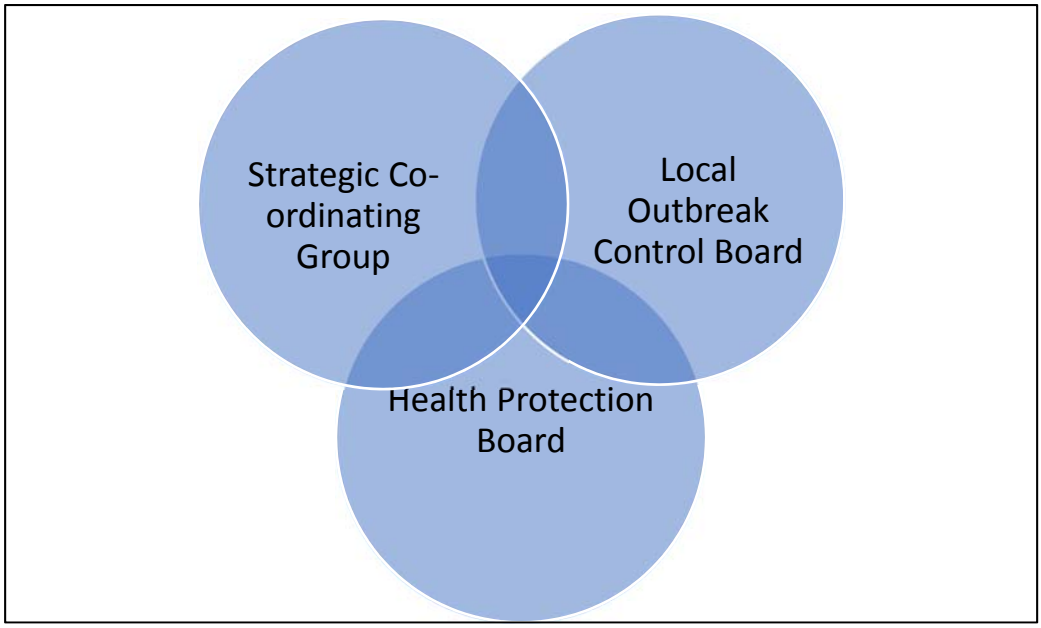


Figure 1: Three critical local roles in test and trace.

3.3 The COVID-19 Health Protection Board will support the development and delivery of the Plan and provide expert health protection and infection control advice to incident management and outbreak control teams, as well as giving assurance and advice to the Local Outbreak Control Board and the Strategic Co-ordinating Group. This will build on and strengthen the current processes that are in place for managing outbreaks of infectious disease and will have a direct link to regional PHE teams.

3.4 The Local Outbreak Control Board will facilitate political ownership and support public facing engagement and communication for the local outbreak response. It will also act as liaison to Ministers as needed. This will build on existing place-based relationships.

3.5 The Strategic Co-ordinating Group will support delivery of the outbreak plan through co-ordinating and working with partners to ensure swift resource deployment. This group will link with the Joint Biosecurity Centre, Whitehall and COBR.

4.0 Proposal for the Local Outbreak Control Board

4.1 One of the key objectives for the next phase of the response to COVID-19 is to enable individuals and organisations to safely return to as close to normal as possible. To achieve this, it is imperative that we work with our local communities to ensure that together we continue to behave in a way that keeps ourselves and others safe.

4.2 Local authorities are required to create a Local Outbreak Control Board which provides political ownership, communication and engagement between key stakeholders and with communities. This is key in preventing local outbreaks and ensuring coordinated local action should they occur. The Board will have oversight of all aspects of managing the COVID-19 epidemic including local decisions on opening and closing venues and settings, subject to national government rules and guidance, and recovery and restoration of services. It will also agree any additional control measures required for which there are currently no local powers and therefore needs the agreement of Ministers.

4.3 The Health and Wellbeing Board, with its joint political, health and care system leadership, currently has a function to ensure that more people in Sunderland live healthier longer lives and so it makes sense that it undertakes this important new function. It is, therefore, proposed that the Health and Wellbeing Board should take on the role of the Local Outbreak Control Board. This will ensure that new responsibilities build on existing functions and relationships and that there is clarity of responsibilities and avoidance of duplication of effort.

4.4 National guidance recommends that the Local Outbreak Control Board is chaired by the Leader of the Council. It is therefore proposed that when matters relating to COVID-19 are being discussed the Leader of the Council takes the Chair. If the Leader is unavailable then the Deputy Leader of the Council will take the Chair.

4.5 It is important that the Local Outbreak Control Board is flexible in its approach so that it can respond to rapidly moving events. As a result, it may be that the Board will need to meet urgently. Members are, therefore, asked to be as responsive as possible on these occasions.

5.0 Recommendation

5.1 The Health and Wellbeing Board is asked to:

- Note the contents of this report;
- Agree to fulfil the role of Local Outbreak Control Board;
- Agree that for that part of any meeting when matters relating to COVID-19 are being discussed, the Leader of the Council will chair the meeting.

Item No. 11

SUNDERLAND HEALTH AND WELLBEING BOARD 25 June 2020

STATUS UPDATE – MARCH AGENDA

Report of Senior Manager - Policy

1.0 Purpose of the Report

1.1 The purpose of the report is to update the Health and Wellbeing Board on the status of decision/discussion agenda items from the meeting of 20 March 2020, which was cancelled.

2.0 Background

2.1 On 16 March 2020, the Government advised that people should limit the amount of contact we have with others, to cancel all non-essential travel and to work from home wherever possible to prevent the spread of Coronavirus. On the basis of this advice the Health and Wellbeing Board, scheduled for 20 March 2020 was cancelled.

2.2 Below is an update of those agenda items that were due for decision or discussion.

3.0 Status update – 20 March 2020 agenda

3.1 Pharmaceutical Needs Assessment (PNA)

A renewed PNA was due to be published by the Board in April 2021 and a report was included in the 20 March 2020 Board papers to agree the process for renewing the assessment. In light of COVID-19, the Department of Health and Social Care has announced that the requirement to publish renewed PNAs will be suspended until April 2022 and a report in relation to this will be presented to the Board at a later date. Health and Wellbeing Boards retain the ability to issue supplementary statements to respond to local changes and pharmaceutical needs during this time.

3.2 Best Start in Life

Oversight of the action plan of the Best Start in Life Working Group has continued, although the group has not met recently due to the COVID-19 pandemic. Progress on the action plan was reviewed in March and an update was shared with the working group in May, describing service changes in response to COVID-19.

Most service delivery for young children and families has transitioned to alternative delivery models in order to keep face to face contact to a minimum using telephone contacts and consultations, video calls, and virtual sessions. For example, Children's Centres are posting Time for Rhyme videos online,

and the 0-19 Public Health Service has launched a virtual breastfeeding clinic. Where there is a clinical need or vulnerability in families, face to face contact is still provided, with the appropriate use of PPE. The 0-19 Public Health Service has maintained all mandatory contacts, with New Birth Visits and those with a safeguarding concern being delivered face to face where possible; all other contacts have been provided virtually. From June, all FNP visits and visits for those on the enhanced parenting pathway recommenced on a face to face basis, and it is intended that other mandated contacts will resume on a face to face basis over a period of three months, in accordance with the *'restoration of health services for children and young people'* shared on 3rd June 2020.

The Infant Feeding Research Project is complete, and findings have been shared with the BSIL working group. The summary report will be made available online alongside the JSNA. The Behavioural Insights project, which is focused on breastfeeding, is now underway with the intervention due to begin this summer. Members of the Group have been invited to be involved in a project led by Adfam, to support the families of children with Foetal Alcohol Spectrum Disorder (FASD).

Data for smoking at time of delivery for the first three quarters of 2019/20 indicate a downward trend for Sunderland, with quarter 3 being 15.1%. However, recent local data from the CCG indicates a significant increase in monthly data during quarter 4. Whilst this data has not yet been validated and published nationally it is of concern and may have a negative impact on the annual rate. Commissioners are working together with services to address these concerns, and it should be acknowledged that due to the small number of people in the data cohort monthly figures can fluctuate a great deal. We do not yet know the impact COVID-19 has had on rates of smoking, but due to emerging evidence suggesting that smokers who contract COVID-19 have more severe symptoms and the fact that pregnant women have been identified as clinically vulnerable, it may encourage more pregnant women to seek support to quit. Local promotion of the national Quit4COVID campaign is also taking place.

Recent data shows that Sunderland performs well in children achieving a Good Level of Development at the end of Reception. Around two-thirds of children eligible for free school meals (FSM) achieved a good level of development in 2018/19 compared to three-quarters of non-FSM children. This is significantly higher than the national rate of 56.5%, and a significant improvement from the previous year. As a result the achievement gap in the city has reduced to 12 percentage points from almost 20 percentage points the previous year.

3.3 Alcohol Harms

Sunderland Alcohol Partnership

The group has not met since March however the Partnership continues to get regular updates via email from Public Health and Balance.

Wear Recovery - Adult Substance Misuse
Due to the COVID-19 outbreak, it was deemed too risky to implement a new contract for the adult substance misuse service due to the vulnerable client group the service works with. The council agreed to extend the current substance misuse contract with CNTW, Humankind and Changing Lives for one year until 30th June 2021.

The council recognises that until the new contract could be fully mobilised in July 2021 there may be some gaps in relation to the alcohol tier two offer. Public health received a request from NERAF to support the increase in demand their service was facing due to COVID-19 and alcohol in Sunderland. The draft COVID-19 Health Inequalities Strategy has highlighted the impact of this disease on the increase of drinking alcohol in certain groups. It was felt that by supporting NERAF with a short term grant we could help local people to access tier two alcohol support in a more timely way.

Youth Drug and Alcohol Project (YDAP)
YDAP has developed a new protocol in partnership with South Tyneside and Sunderland Foundation Trust A&E Department for young people who present at hospital under the influence of drug and/or alcohol. This has now gone live. YDAP has also developed a campaign to share with local services to raise YDAPs profile with parents, carers and young people during the lockdown. The graphic has been developed and shared so it can be promoted via social media.

Minimum Unit Price
We continue to keep the partnership updated with emerging evidence around MUP from Scotland and Australia. A letter was sent from the Sunderland HWB to the Prime Minister calling for the introduction of MUP without delay.

Public health information and campaigns
In May/ June the Council has:

- Launched a new local alcohol campaign for people to cut down on their drinking during drinking through social media and via the Workplace Alliance
- Worked with Together for Children to promote the FRANK website for young people around drugs and alcohol
- Developed a crisis support leaflet to include in food bank parcels, information on Healthy start vitamin, stop smoking and reducing alcohol intake information is also included
- Supported a number of Balance campaigns via social media and partners.

3.4 Healthy Economy

Progress made across the three workstreams being pursued by the Healthy Economy Working Group has continued, albeit at a slower pace due to officers and partners being required to work on COVID-19 critical business. The action plan agreed by this Board for the 'Workplace Health' workstream will be reviewed in light of COVID-19 impacts. Alongside this, draft action plans for the other two workstreams, 'Healthy Labour Force' and

'Employment in the Health and Social Care Sector', will be presented at the September 2020 Board meeting.

3.5 Children and Young People's Mental Health and Wellbeing Transformational Plan

The deadline for the Children and Young People's Mental Health and Wellbeing Transformational Plan (originally 31 March 2020) was deferred by NHS England due to COVID-19, as this work was not considered business critical. It has been agreed to delegate this decision (i.e. the recommendations within the report), to the appropriate chief officer – in this case the Director of Children's Services – who will confer with the Chief Officer of the CCG in advance of seeking endorsement of the plan and its associated recommendations with the Chair of the Health and Wellbeing Board. As assurance to the Board, work continues on the priorities set out in the plan and regular progress updates will be provided to the Board.

3.6 Draft Healthy City Plan

The Healthy City Plan presentation, which was due to be presented in March, was shared with Board members for information. The development of the plan has continued, with inputs needed to firm up the priorities (key areas for improvement and confirming what will be different). Priority working groups will need to consider the impact of COVID-19.

3.7 Community Fluoridation Programme

As making progress regarding the Community Water Fluoridation Scheme was determined to be a non-critical function during the COVID-19 pandemic, the work was paused. This was agreed with neighbouring local authorities and took into account the difficulties of conducting detailed engagement activities whilst restrictions regarding public gatherings and requirements for strict social distancing were in place. The activities to gather views to inform the public consultation will be re-programmed at a time when public health teams can move back into more business as usual activities. A report will be presented to the Board once this is possible.

4.0 Recommendation

4.1 The Board is recommended to:

- Receive the report for information.