Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Monday 9 November 2020**

Time **9.30 am**

Venue **Remote Meeting - This meeting is being held remotely via Microsoft Teams**

Business

Part A

Items during which the Press and Public are welcome to attend Members of the public can ask questions with the Chair's agreement, and if registered to speak

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 2 October 2020 (Pages 3 - 18)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. Adult Social Care Overview - Report and presentation by the Head of Adult Care, Durham County Council (Pages 19 - 56)
7. Winter Planning - Report and presentation by Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust and Chair of the Local Accident and Emergency Delivery Board (Pages 57 - 78)
8. Health Impact Assessment for Health Inequalities during the COVID-19 Pandemic - Report and presentation by the Director of Public Health, Durham County Council (Pages 79 - 214)
9. Tees, Esk and Wear Valleys NHS Foundation Trust Updates:- (Pages 215 - 224)

(a) CQC Inspection results and improvement plans

(b) TEWV COVID 19 Pandemic Update – Durham and Darlington Locality Mental Health Services

10. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Helen Lynch
Head of Legal and Democratic Services

County Hall
Durham
30 October 2020

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee**

Councillor J Robinson (Chair)
Councillor J Chaplow (Vice-Chair)

Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, T Henderson, E Huntington, P Jopling, C Kay, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson, O Temple, T Tucker and C Wilson

Co-opted Members: Mrs R Hassoon

Co-opted Employees/Officers: Mr D Logan, Healthwatch County Durham

Contact: Jackie Graham Tel: 03000 269704

DURHAM COUNTY COUNCIL

At a meeting of the **Adults, Wellbeing and Health Overview and Scrutiny Committee** held remotely via Microsoft Teams on **Friday 2 October 2020** at **9.30 am**

Present:

Councillor J Robinson (Chair)

Members of the Committee
Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, T Henderson, E Huntington, P Jopling, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson, O Temple, T Tucker and C Wilson

Co-opted Members
Mrs R Hassoon and Mr D Logan

Other Members
Councillors M Clarke, L Hovvels, I Jewell and A Shield

1. Apologies

Apologies were received from Councillor C Kay

2. Substitute Members

No substitute members were in attendance.

3. Minutes

The minutes of the meeting held on 7 July 2020 were confirmed as a correct record and would be signed by the Chair.

The following matters arising were reported:

Minute No. 6b - The Committee noted additional information requested by the Committee on discharges of County Durham residents from inpatient hospital care from other foundation trusts, and, Covid-19 testing rates in respect of discharges, had been circulated by the Corporate Director of Adult and Health Services.

Minute No. 7 - Further to the discussion at the last meeting in respect of the system response to COVID -19, an overview report and presentation on adult social care will be considered at the Committee's meeting to be held on 9 November 2020.

4. Declarations of Interest

There were no declarations of interest.

5. Items from Co-opted Members or Interested Parties

No items from co-opted members or interested parties were reported.

6. Shotley Bridge Community Hospital Update

The Committee considered an update report presented by Rachel Rooney, Commissioning and Development Manager, NHS County Durham Clinical Commissioning Group, on the Shotley Bridge Community Hospital Programme (for copy see file of minutes).

The Commissioning and Development Manager explained public engagement took place in the spring of 2019 and a proposed model of care had been developed, however, due to the impact of Covid-19 it was necessary to revisit the model in order to reflect recent changes in ways of working such as the increase in the number of virtual appointments and the utilisation of community hospitals throughout the pandemic. The changes will be taken into account and discussed with clinicians, with a view to a proposed public engagement plan being presented to the Committee for comment. Whilst It is hoped that public engagement will take place in November 2020, the Commissioning and Development Manager acknowledged the difficulties in carrying out any public engagement activity at the present time, and she assured the Committee that contingencies will be built into the plan.

The Committee noted that the proposed sites at Leadgate and Blackfyne had been found to be unviable partly due to highways issues. Therefore, the remaining options for consideration are the redevelopment of the current Shotley Bridge Hospital site, and, the site at Puddlers Corner, Genesis Way. Financial assessments will be carried out to inform a business case and to identify a preferred option. The Commissioning and Development Manager outlined the key milestones of the proposed timeline, however, she requested that the Committee bear in mind the high level of uncertainty at the present time.

The Chair thanked the Commissioning and Development Manager for the update and praised the work of all those involved in the project including Councillor Hovvels, local members, and, members of the reference groups. He remarked that the progress of the project was testament to the excellent partnership working that was taking place and he was pleased to report that the Health Secretary, Matt Hancock, had endorsed the project during his recent visit. The Commissioning and Development Manager thanked the Committee for their ongoing input and the challenge they provide.

Councillor T Tucker referred to the current social-distancing restrictions and questioned how a comprehensive public consultation could be undertaken at this time.
The Commissioning and Development Manager explained that the project managers are mindful of the limitations, however, the aim is to ensure the engagement exercise is open, accessible and inclusive to all, including those most vulnerable in the community as they are often in most need. Whilst new methods of engagement are being considered, there is an awareness that not all members of the public have access to / are able to use technology and the Commissioning and Development Manager said that a dedicated telephone line is available for public engagement, where messages can be left and calls are followed-up. It is hoped that existing voluntary sector forums, stakeholders and NHS / care service providers be will be utilised in the consultation exercise, and, suggestions from members on methods of engagement would be welcomed.

Councillor A Shield, local member for Leadgate and Medomsley, informed the Committee on matters discussed at AAP meetings including concerns regarding the highways issues and the anaerobic digester close to the Leadgate site. Referring to the site at Puddlers Corner, Councillor Shield informed members that the Genesis Trust is planning to submit a planning application for an energy recovery facility, which will be subject to approval by the Planning Committee. Councillor Shield also referred to the demise of Derwentside Mind and he added that the reference group had discussed that consideration could be given to Tees and Esk Mental Health Team forming part of the new facility. The Commissioning and Development Manager informed the Committee that the proposed energy facility is being taken into consideration, as the investigation of renewable energy sources forms part of the project.

Councillor O Temple sought assurance that any development of the existing site would not lead to interruption of the existing hospital services. He echoed Councillor T Tucker's comments that the engagement exercise should include telephone engagement, alongside digital methods, commenting that many people, including the elderly, prefer to engage by phone or do not have access to technology. The Commissioning and Development Manager assured Councillor Temple that continuity of care was considered as part of the original options appraisal, and, will feature highly in the future appraisal.

The Principal Overview and Scrutiny Manager stated that, in line with standard practice, it was requested that the proposals for the public engagement be shared with the Committee in due course.

Resolved:

i. That the report be noted.

The Chair of the Adults Wellbeing and Health Overview and Scrutiny Committee proposed the additional recommendation.
It was further:

Resolved:

ii. That the public engagement plan be presented to a future meeting of the Adults Wellbeing and Health Overview and Scrutiny Committee for consideration and comment.

7. Local Outbreak Management Plan

The Corporate Director of Public Health presented the Adults Wellbeing and Health Overview and Scrutiny Committee with a progress update on the Covid-19 local outbreak control plan (for copy see file of minutes).

The Chair gave a warm welcome to Amanda Healy, Director of Public Health and he thanked her, on behalf of the Committee, for the personal commitment she was making to the position, at this unprecedented time.

The Director of Public Health explained that when government relaxed the lockdown rules, it requested all local authorities to develop and publish a local outbreak control plan, with a public facing board being used to communicate openly with the public on the plan. It was agreed that the Health and Wellbeing Board, chaired by Councillor L Hovvels would fulfil this role. The current plan was presented to the Health and Wellbeing Board on 11 September 2020 and it builds upon the existing health protection arrangements in place to protect residents' health from Covid-19, and, to reduce onward transmission.

The Director of Public Health outlined the governance arrangements and the key objectives of the plan which identify seven control settings including care homes, schools and high risk communities and within these setting smaller, focus teams are in place to develop more in-depth plans. The Director of Public Health provided an overview of the work within each of the settings.

With testing and tracing being a key aspect of the plan, the Director of Public Health informed the Committee that work is being undertaken to set up longer term, local testing sites and she acknowledged the challenge some residents have faced when having to travel outside of the county to access testing facilities. In addition, work is being carried out with colleagues in the Contain Team to improve contact tracing rates which currently stand at approximately 60% of people being contacted within a 24 hour period.

In terms of the current position, the Committee noted a rapid rise in the rate of infection since the beginning of September. The Director of Public Heath then

provided information on the number of cases at the time which stood at 95.3 per 100,000, with 372 cases being reported within the previous 7 days. She explained cases were being observed across communities, with small clusters spread throughout the county, within households, schools and workplaces.

Members were advised that up-to-date statistics are available on the Durham Insight website and a link to the website would be circulated to members of the Committee. The Committee noted specific outbreaks in parts of the county had taken place including outbreaks at Stanley, Burnside and Consett. The Director of Public Health informed the Committee that County Durham had joined the LA7 group of local authorities, and the group is looking into additional prevention measures and seeking intervention from government to ensure swift action to slow the spread of the disease. With further restrictions in place from 18 September, a support package had been requested from government, for resources to support these measures, with discussions ongoing.

The Chair thanked the Director of Public Health England for the update and he sought clarification of the role of local members in the local prevention control plan. The Director of Public Health commented on the importance of their role, being the direct link to the community and she encouraged suggestions from members on how they could play a more active role. She added the service aims to keep local members updated through regular briefings and the provision of information with regard to specific outbreaks and widespread community transmission, and, she encouraged members to access the data which is available on the members' dashboard. In addition, a 'Community Champions' initiative is being looked into, which will include volunteers from the Community Hub, AAPs, and, it is hoped local members will also have input. The Director of Public Health then responded to comments and questions from the Committee as follows.

Councillor R Bell, local member for Barnard Castle West, commented that he had been unable to find positive case data at ward level on the Durham Insight website and he requested that granular level data be included. The Director of Public Health agreed to circulate a direct link to the data and to look to provide refined data at ward level but she cautioned that this type of data changed very rapidly. She emphasised the importance of interventions within the community and the continuation of the public messages with regard to hygiene, protection and social distancing.

With respect to funding, Councillor Bell referred to the ongoing discussions on additional funding to resource the recent local restrictions and he asked what funding has been made available, what funding the service would like to see made available, and, what the funding to date, had been used for.

The Director of Public Health replied that a grant of £4.5million had been received initially for the local outbreak control plan, overseen by the Health Protection Assurance Board and the funding had been used to support matters such as additional capacity for a dedicated outbreak control team, enhanced support for environmental health, and, additional capacity in respect of prevention and control for special education. The additional government funding requested would be used to resource test and trace, compliance, enforcement, communication, and, to provide support for businesses and the community sector.

Councillor O Temple, local member for Consett North, expressed concern that with regard to a local outbreak in Consett, he was first made aware of the situation by reading a notice on a community centre door. The Director of Public Health apologised to Councillor Temple for the oversight, adding that community organisations have been a useful tool in enabling messages to be communicated speedily within localities and she assured Councillor Temple that local members will be informed of any further local outbreaks as soon as possible, in the future.

Speaking in relation to care homes, and, recognising that it is essential to control the virus, Councillor Temple said he had received many appeals from local residents who had been unable to visit their relatives in care homes. He requested that the Committee consider how to balance control of the virus with the importance of the basic need for human contact, at the Special Meeting in November. The Corporate Director of Adult and Health Services acknowledged these concerns and suggested that it would be helpful to do a broad presentation around the framework the Council works within, in terms of social care. She said that this question from Councillor Temple would be taken to that meeting and she requested further questions from members to be sent to her, by Friday 9 October, for inclusion in the presentation. The Chair requested that hospital settings also be included, having received similar concerns from those who had been unable to visit relatives in hospitals.

Councillor P Jopling asked what safeguards are in place to ensure that only those who are in need of tests, receive them. The Director of Public Health commented that when the schools returned in September many worried parents whose children had minor illnesses telephoned their GPs fearing they had symptoms of Covid-19. To address this, a flow-chart was developed with colleagues from the NHS, which was circulated to schools to inform parents about symptoms of Covid-19. The service had also responded to intelligence within communities, such as taking steps to raise awareness when it was reported that entire football teams were being encouraged to be tested as a precautionary measure.

The Director of Public Heath responded that the service continues to send a clear message to the community that only those with symptoms should be tested.

Councillor Tucker commended the work of the Public Health team adding she hoped staff were looking after themselves, whilst they were busy keeping the people of County Durham safe. She raised concern about the capacity of testing, saying she was aware of a number of people who had been unable to access tests and, as a result, were isolating as a precaution. She asked if more tests could be made available, and, she enquired as to how accurate the self-tests are. The Director of Public Health encouraged members to inform her of instances when people have been unable to access tests, as the service will continue to press for increased and easier access to testing. She added that an advantage of being part of the LA7 group is to maximise Durham's capacity for testing. With regard to self-tests, the Director of Public Health undertook to provide information on the failure rate of self-testing to a future meeting of the Committee.

Councillor L Brown, extended her thanks to the Public Health Team and commented that, as the local member for Neville's Cross, she had been approached by concerned residents who were apprehensive about going into Durham city and the risk posed by the return of the University students. The Director of Public Health reassured members that the University is going to great lengths to prevent the spread of the virus and that it is taking the return of students very seriously. It is part of a north east group looking at wider plans and it has liaised with local residents and community groups to explore their concerns and to balance those concerns with ensuring the city is welcoming for the students. In addition, Cabinet had visited the University to investigate the plans and to offer support in the event of an outbreak. The Director of Public Health added that she would pass the comments on to the University, at an their up-coming meeting.

Councillor J Stephenson commented, as a school governor, she had been heartened by the support provided to schools to assist them to manage outbreaks effectively. Councillor Stephenson asked whether there had been an increase in non-compliance following the recent additional local measures, and, for information as to how enforcement is dealt with. The Director of Public Health replied that the Licensing Team had carried out approximately 200 visits during the previous weekend and they had reported many good examples of businesses which were Covid-secure. Under the Local Resilience Forum, a compliance cell had been established, with the police and licensing officers, to look at enforcement measures.

Thanking the Director of Public Health for the work, Councillor C Wilson referred to the use of plastic visors and asked if they are safe to use without a mask or should a visor be worn together with a mask.

Councillor Wilson also asked if staff in shops are encouraged to challenge customers who are not wearing masks. The Director of Public Health responded that face coverings are slightly more effective, however, the use of a visor provides a physical barrier. Shop mangers are encouraged to request proof of exemption, if customers refuse to wear face coverings. The Director of Public Health stressed the responsibility for every individual to recognise their social duty and comply with the protective and social distancing measures.

Councillor S Quinn spoke from her experience of working in a care home and agreed with Councillor Temple's concerns regarding the lack of human contact and the impact of this whilst patients are unable to receive visits from relatives. She assured members that care home staff are endeavour to do all they can to provide patients with comfort and support at this time. Speaking as the local member for Shildon, which had recently been identified as a Covid hot-spot, she expressed concern that as more and more pubs close, this may be leading to people travelling from house to house, or, to other towns with fewer restrictions, in order to socialise and she asked if work was being done to dissuade people from this. The Director of Public Health said that the increased rate in Shildon was being actioned, in terms of communication and community engagement, and she would provide an update to Councillor Quinn in due course.

Councillor Bell echoed other members in thanking the Director of Public Health and her team. He commented that having recently checked national statistics, he agreed with Councillor Jopling's comment that the worried-well are accessing tests unnecessarily, as the national statistics indicated that only 1.5% of those tested are testing positive. He commented that if it is the case that most people are asymptomatic, control measures are vitally important. The Director of Public Health advised that the percentage of positive tests locally is higher than the national figure with approximately 6% of those tested being positive.

Councillor Bell then observed that although reports suggest that the hospitality industry is working hard to put measures in place to be compliant, he had observed supermarkets and shops seemed to have relaxed their procedures since the lockdown measures had eased. He also raised concern that as more and more of the hospitality sector is forced to close, an increasing number of people will gather in households to socialise. In acknowledging that the variation of restrictions between locations and settings may be confusing, the Director of Public Health commented that, at present, the rise in transmission is more prevalent in indoor spaces and between households. She remarked on a difficult balancing act to be achieved in keeping the economy going whilst ensuring public safety and she emphasised that it is very much a case of collective responsibility, for all individuals to be as stringent as possible.

Councillor A Reed referred to a public protest planned to take place in Crook and asked what measures would be put in place to protect protestors and members of the public and she asked if local members could assist in any way. The Director of Public Health commented that the planned lawful protest would be managed safely with the police and that she will brief local members to inform them of the plans and liaise on any action they could assist with.

In concluding the discussion, the Chair commented that two themes could be observed throughout, firstly that members would like more information and involvement with regard to their own wards. Secondly the great deal of appreciation members expressed for the Director of Public Health and the Corporate Director of Adults, Wellbeing and Health, and their respective teams, for their ongoing work. The Director of Public Health thanked the Committee for their kind words of support and paid tribute to all the staff within the teams, and, partners, who were working together, across the county.

The Chair then asked Councillor Hovvels to address the Committee on the plans to replace Public Health England with a new organisation. Councillor Hovvels referred to her campaign saying any support from members would be very welcome. She informed members that a joint letter from Health and Wellbeing Chairs was sent to the Health Secretary, however no response had been received. She expressed concerned and disappointed that there had been no communication or consultation with Public Health teams prior to the government announcement. Councillor Hovvels stressed the proposals will have a direct impact and the importance of having an opportunity to shape and influence the new arrangements. The Chair agreed to discuss the matter with Councillor Hovvels and the Principal Overview and Scrutiny Officer in order to look into what support the Adults, Wellbeing and Health Overview and Scrutiny Committee could provide.

Resolved:

That the report be received.

8. Primary Care Update

The Committee considered a report presented by Juliet Carling, Commissioning and Delivery Manager, NHS County Durham Clinical Commissioning Group which provided an overview of the primary care Covid-19 response and subsequent stakeholder engagement. The report also provided information on the national 'Talk Before You Walk' pilot, an update on primary care strategy development, and, information on Peterlee Urgent Treatment Centre (for copy see file of minutes).

Prior to presenting the report, the Commissioning and Delivery Manager explained that the NHS long term plan was for organisations to have integrated care systems in place by 2021. Members were informed that the north east integrated care system has three integrated care partnerships which focus mainly on acute services. The County Durham Care partnership includes health and social care organisations which work collaboratively to ensure joined-up services where possible. Thirteen primary care networks are in place throughout County Durham which are groups of practices that work together on matters such as staffing, finance and estates and they promote easier integration with the wider health and care system.

The Commissioning and Delivery Manager then outlined the report and the response from the primary care service during Covid-19. She provided information on the ways in which primary care had transformed the way it works, including the introduction of 'total triage' and moving to deliver consultations via telephone, online and through e-consult. Work with care homes had been brought forward including GP practice alignment to every care home in County Durham, with the facility to undertake online consultations with a named GP, and, the introduction of NHS emails to ensure the safe transfer of confidential information. There was now a refocus on commissioning priorities in order to incorporate these improvements. Areas of focus for the future include, where appropriate, supporting patients to self-manage, the increase in the use of digital technology, and the possibility of widening the range of health care professionals working within primary care. In conclusion, the Commissioning and Delivery Manager advised that the primary care strategy will be discussed at the January meeting of the Adults, Wellbeing and Health Overview and Scrutiny Committee. She responded to comments and questions from members as follows.

Referring to total triage Councillor Temple spoke of a resident in his ward who had approached him for assistance as she had been unable to access medical advice. She had telephoned her consultant's secretary who had advised her to ring her GP. She had then spent two days repeatedly telephoning the GP surgery to speak her doctor only to be told no telephone slots were available and to ring back the following day. Councillor Temple advised her to call 111, however, the advice from 111 had been to continue calling the GP. Councillor Temple remarked that this effectively reduced the ability to access medical advice to a lottery of telephone connectivity. He requested that total triage be given careful thought prior to its adoption. The Head of Integrated Commissioning, Sarah Burns, requested that Councillor Temple share the details of the case, to enable the service to follow it up. Councillor Temple confirmed he had permission to share the information, that he would do so, and, that he would like two matters to be investigated, triage, and the appointment system.

Councillor Quinn, local member for Shildon, commented that her GP surgery is based in Bishop Auckland however she understood the surgery's health visitors are based in Tees and Esk and travel from as far as Ripon and she queried the practicalities of this. The Commissioning and Delivery Manager responded that she understood the service provider is Tees and Esk, however, she understood the teams were local adding that she would feed Councillor Quinn's comment back.

Rosemary Hassoon expressed concern at the lack of detail regarding mental health in the report and spoke of the importance of continuity of care for those with mental health issues adding that many people suffering with their mental health are unable to work and therefore may not be able to afford equipment to be able to access online services. In addition, she pointed out that although she is a member of the Mental Health Strategic Partnership Board, she had not been invited to a meeting of the Board for a year. The Commissioning and Delivery Manager agreed to pass these concerns to the primary care team to be followed up.

Councillor Jopling pointed out that there are occasions when telephone consultations are not appropriate, for example, she had been contacted by a resident who was suffering from an ear condition who had been offered a consultation, by phone, by the audiology department at her hospital. Councillor Jopling stressed that the method of delivery must be fit for purpose and there are some instances where a physical examination is the most appropriate method.

Councillor Bell agreed swaying although modern technology has its place it also has limitations and he reported that a GP he had spoken to said remote appointments can lead to duplication of work as some patients cannot be diagnosed remotely and ultimately are asked present themselves at the surgery for a face-to-face appointment. He also pointed out that members of the public can be apprehensive about using technology for medical and health matters and whilst technology can be a solution, it is not the only solution. Councillor E Huntington agreed that telephone consultations can be limited, for example where patients have multiple conditions, it may lead to confusion and a delay in getting the correct diagnosis.

The Commissioning and Delivery Manager clarified that total triage involves an initial telephone contact and the patient may be offered a face to face appointment which is a clinical decision taken by a GP or a nurse. She confirmed the service was aware that telephone and video consultations have their limitations and she agreed to feedback members' comments, to ensure all the points discussed are taken into account.

The Head of Integrated Commissioning agreed that telephone consultations do have their place, however, in some cases they are appropriate, especially at the current time with the need to reduce footfall. She added that GPs are reporting similar themes, in that there are times when telephone consultations are appropriate and at other times physical examinations are required. She assured the Committee that the service is carefully working through these new principles and ways of working.

Resolved:

That the report be noted.

9. Overview of Scrutiny Review of GP Services in County Durham

Stephen Gwillym, Principal Overview and Scrutiny Officer, presented the Adults Wellbeing and Health Overview and Scrutiny Committee's review report focusing on GP Services in County Durham (for copy see file of minutes).

The Chair expressed sincere thanks to the Principal Overview and Scrutiny Officer for the support he provided to the Working Group on this piece of work and for his work in supporting the Committee.

By way of background, the Principal Overview and Scrutiny Officer explained that work had taken place during 2018/19 to investigate the review of GP branch services across County Durham and this had informed the decision to undertake a review of the provision of, and, access to GP Services across County Durham.

The Principal Overview and Scrutiny Officer outlined the terms of reference and explained that the review group met on six occasions to examine GP coverage across the county with evidence gathered from colleagues within Public Health, Clinical Commissioning Groups, the North East Ambulance Service and the Care Quality Commission. The Review Group made nine recommendations which aim to improve the sustainability and accessibility of GP services in County Durham. The Principal and Overview and Scrutiny Officer pointed out that references in the report indicate that survey work identified that the use of online and telephony to access services was very low, however, the impact of Covid-19 and its restrictions, was likely to have increased the use of those methods of engagement.

The Committee noted the recommendation to submit the report for consideration by Cabinet at the meeting on 16 December and the Principal Overview and Scrutiny Officer explained that date was a nominal date, and, subject to the Committee agreeing the report, consideration would be given to submitting the report to Cabinet in November.

Subject to Cabinet approval, the report would be shared with the Health and Wellbeing Board and the Clinical Commissioning Group executive body and executive board.

Councillor Tucker requested clarification with regard to the reference at paragraph 12 to a new countywide primary care strategy. The Principal Overview and Scrutiny Officer clarified, at time of the review, there were two separate CCGs both of which had individual primary care strategies. The review report seeks to ensure the findings and recommendations are used to shape and influence the emerging county wide primary care strategy, as referred to in the previous item of business on the primary care update.

Resolved:

i. That the review report and recommendations be agreed.
ii. That the report be submitted for consideration by Cabinet at the earliest opportunity.

10. Quarter One 2020/21 Performance Management Report

The committee considered a report of the Corporate Director of Resources presented by Angela Harrington, Strategy Team Leader, which detailed progress towards achieving the key outcomes of the council's corporate performance framework (for copy see file of minutes).

The Strategy Team Leader explained that the quarter one report covered the period April to June but also included some information relating to the final quarter of 2019-20, due to the impact of the Covid-19 pandemic on the reporting process. Future corporate performance reports will reflect the Covid-19 recovery plan, and, the revised reporting requirements outlined in the Council Plan for 2020-23.

Highlighting some areas of performance, the Strategy Team Leader informed the Committee that a new provider for the stop smoking service had been in place since April and the service had moved to provide telephone-based support in response to Covid-19. This saw an improvement in engagement, particularly with pregnant smokers, with the number of pregnant smokers, accessing the support, doubling on the same period last year. Data for the period also showed a slight improvement with regard to excess weight in adults for County Durham. Data will continue to be monitored in the light of Covid-19 and its impacts on mental and physical health. The increasing demands on adult social care will be analysed and partnership working will continue across the board, to monitor and respond to issues as and when they arise. The Strategy Team Leader informed the Committee that work is being undertaken to improve the way performance data is shared, in order to target support.

Resolved:

That the report be noted.

11. Adult and Health Services Quarter One Forecast of Revenue and Capital Outturn 2020/21

The Committee considered a report and presentation of the Corporate Director of Resources, presented by Andrew Gilmore, Finance Manager for Adult and Health Services, which provided details of the initial forecast outturn budget position for the Adult and Health Service grouping, highlighting major variances in comparison with the budget for the year, based on the position to the end of June 2020 (for copy see file of minutes).

The Finance Manager remarked on the challenge of Covid-19 which had led to significant uncertainty from a budget monitoring perspective and the Committee was asked to note that the forecast presented included a number of assumptions which could be subject to change.

The Finance Manager explained that the council received a headline grant of £38 million in respect of Covid-19 costs pressures, Over £21 million of which was allocated to support pressures in the Adult and Health Services budget. Covid-19 costs included adult social care provider support, supply of personal protective equipment, and, additional staffing. Covid-19 underspends included reduced transport costs, a reduction in contracted placements in care homes, and, a contribution from County Durham Clinical Commissioning Group toward the cost of adult social care provider support.

The Finance Manager referred to the test and trace grant, referred to earlier in the meeting by the Director of Public Health, of approximately £4.5million to develop tailored outbreak control plans.

The Finance Manager also provided details of five main areas of financial support provided to adult social care providers in response to the pandemic, Advance Payment, Sustainability Payments, Stability Payments, Additional Uplift and the Infection Control Fund.

Councillor Tucker thanked the Finance Manager for the comprehensive report, and, referring to infection control, she asked if any of the additional money had been allocated to increase the number of staff in infection control. The Finance Manager explained that some of the money had been used to cover staff double-running costs, however, government guidelines regulate how the finance is utilised by care homes.

Councillor Bell referred to reduced occupancy within care homes, and asked the Finance Manager, what the financial implications will be if the trend continues. The Finance Manager confirmed that there had been an increase in home-care recently, which may be a future trend and monitoring is taking place as to how this will impact care home management in the future.

Resolved:

That the report be noted.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

9 November 2020

Adult Social Care Service Overview

Report of Lee Alexander, Head of Adult Care

Electoral division(s) affected:

All

Purpose of the Report

1 To provide the Adults, Wellbeing and Health Overview and Scrutiny committee with an up-to-date overview of the breadth and activity of the Adult Social Care Service in County Durham and the frameworks within which it operates.

Executive summary

2 The Adult Care Service is one of three closely aligned service areas within the Directorate of Adults and Health – alongside Integrated Commissioning and Public Health.

3 Employing over 1,000 staff, the Adults and Health Service operates within a budget envelope of £313M.

4 The Adult Care and Integrated Commissioning Services work closely together, covering a broad span of service functions, delivering a statutory service to over 19,400 adults with social care needs across the county.

5 The service operates within a complex legislative framework, undertaking statutory duties and powers within the context therein. These frameworks include:

- The Care Act (2014)
- The Mental Capacity Act (2005)
- The Mental Health Act (1983)
- The Human Rights Act (1998)

6 The aims of the services are to:

- support adults to regain or maintain independence
- ensure vulnerable adults who are at risk of abuse, harm or neglect are safeguarded
- improve people's wellbeing and help them achieve outcomes
- prevent unnecessary admissions into hospital or other forms of 24hr/ long term care
- prevent, reduce and delay the demand for formal adult social care support.

7 This is achieved by:

- providing those with lower level needs the advice, information and support to self-manage and retain independence for as long as possible;
- providing those with higher level needs short term services with a focus on enabling the person to regain some independence;
- assessing and meeting longer term needs once the person is at their optimal level of functioning and where all other options have been explored;
- making enquiries and undertaking investigations in situations where potential abuse is suspected.

8 The service is made up of:

- Teams of social workers, social work assistants, care co-ordinators, occupational therapists, occupational therapy assistants, rehab workers, customer service officers and support workers delivering a front-facing service to the public. The teams mainly provide assessment of need, risk management – including safeguarding adults; and the commissioning of appropriate services to meet identified social care needs;
- County Durham Care and Support (CDCS) which is an in-house provider arm delivering care directly to adults with social care needs;
- An integrated commissioning service – made up of staff across Durham County Council (DCC), the Clinical Commissioning Group (CCG) and North of England Commissioning Support Service (NECS). Staff range from strategic managers to admin and support staff to contracts and commissioning officers who review, plan and specify services to meet the health and care needs of people living in the county. The team is also responsible for the quality and performance of commissioned services.
- an operational support function providing workforce development and learning, data and systems support, complaints management, and service improvement.

9 The Adult Care and Integrated Commissioning Service is part of County Durham's Integrated Community Care Partnership which brings together local community health organisations including GP practices, community nursing and therapy services with our social workers supporting older and physically disabled adults. Overseen by the Director of Integrated Community Services, we work closely with colleagues from County Durham and Darlington NHS Foundation Trust, local Primary Care Networks and the Clinical Commissioning Group to ensure that health and social care services in our county are joined up and streamlined wherever possible, and that data and information sharing supports our integrated approach.

10 The service is committed to transformation and service improvement. A programme of Adult Care Transformation is underway, and a bespoke project is also focussing on supporting the care provider market.

Recommendation

11 The Adults, Wellbeing and Health Overview and Scrutiny Committee to note the contents of this report.

Background

12 Adults, Well-Being and Health Overview and Scrutiny Committee in July 2020 expressed an interest in becoming more involved in Adult Social Care issues in County Durham. In order to facilitate this, a request was received to be supported to understand the complexity, diversity and challenges of the sector.

13 This report therefore provides a broad overview of the diverse range of support, services and activity the Adult Social Care service provides and engages in across the county.

14 The report will cover:

- An overview of Adult Social Care and the frameworks it operates within;
- Integrated arrangements;
- The range of services and support provided;
- The numbers of people supported by the service;
- Budgets;
- Performance;
- Challenges;
- Transformation.

General Overview

15 UK Government's Department for Health and Social Care (DHSC) supports and advises government ministers to shape and deliver national policy in relation to health and social care. The department carries out its work through non-governmental organisations including NHS England and Public Health England.

16 Nationally, the profile of Social Care has not historically occupied the same status as NHS and Public Health England, however it has been widely recognised as an extension of key over-arching public health and care service delivery which are essential in supporting people to live as independently and safely as possible.

17 Prior to the COVID-19 pandemic, DHSC were working on a plan in relation to the long-term reform of social care with a parliamentary green paper expected to be published this year. At the time of writing, no further progress has been announced on this plan or the proposed green paper.

18 Local Authorities have statutory responsibilities to deliver social care within national legislative frameworks which are described within this report.

19 In Durham, Adult Social Care is part of the wider directorate of Adults and Health Service which comprises:

- Adult Social Care (955 staff)
- Integrated Commissioning (70 staff)
- Public Health (36 staff).

Strong working arrangements and alignment are in place between the three parts of the directorate and the Adults & Health Service Senior Management Team chaired by the Corporate Director meets regularly.

20 Overseen by the Head of Adult Care and the Head of Integrated Strategic Commissioning, the Adult Care and Integrated Commissioning services work closely together and comprise five discrete Strategic Manager portfolios – outlined in appendix 2.

21 The overarching aim of the service is to:

- support adults to regain or maintain independence;
- to support adults to live in their own homes for as long as possible, and according to their personal lifestyle choices;
- ensure vulnerable adults who are at risk of abuse, harm or neglect are safeguarded;
- improve people's wellbeing and help them achieve outcomes;

- prevent, reduce and delay the demand for formal adult social care support;
- ensure that for those people who do require ongoing social care provision, this is proportionate to meet their needs and keep them safe and is of a good quality.

22 We do this by:

- providing those with lower level needs the advice, information and support to self-manage and retain independence as long as possible;
- providing those with higher level needs short term services with a focus on enabling the person to regain some independence;
- only assessing and meeting longer terms need once the person is at the optimal level of functioning and where all other options have been explored;
- making enquiries and undertaking investigations in situations where potential abuse is suspected;
- achieving a proportionate balance between upholding human rights and – where necessary for their own protection or the protection of others - depriving individuals who lack mental capacity of their liberty under the provisions of the Mental Capacity Act (2005) or the Mental Health Act (1983).

23 The service currently supports over 19,400 adults in the county with social care needs resulting from:

- Age related frailty
- Physical disabilities
- Learning disabilities
- Mental Health
- Substance misuse issues
- Sight or hearing impairment
- Brain injury
- Prisoners with social care needs
- Those who have caring responsibilities for other adults with social care needs.

24 The service also has responsibility for any adult with eligible social care needs who has the status of 'ordinary resident' in County Durham as defined within social care legislation who may be living a care setting within another county.

25 Of the total number of adults currently known to Adult Care 8,400 are provided with ongoing care services to meet their assessed needs. Of these, 5,410 (65%) are supported to live in their own homes or in supported tenancies in the community, and 2,990 (35%) live in a care home setting.

26 A larger cohort of adults known to the service are in receipt of equipment loans, adaptations to their home, assistive technologies, or receive professional support only.

27 Data from Tees, Esk & Wear Valley NHS Mental Health Trust electronic records indicates a further 5000+ adults with mental illness are supported by our integrated mental health teams and of those 550 are in receipt of ongoing social care provision.

Budget

28 Adult and Health Services has an annual budget of circa £313 million, broken down by division of service in the following table:

Service area:	**Annual Budget £000**
Adult Care	213,080
Commissioning	16,093
Public Health	56,533
Central / Other	27,689
Total	313,395

(Nb. 'Central/Other' includes among other things: joint spend with NHS partners, central support costs, accommodation, pension costs and directors costs.)

29 Adult Care has managed within budget for the last 5 years despite operating within challenging and changing statutory frameworks, a shift in complexity relating to social care needs and general austerity measures. This has been achieved by focussing on transformational service development, streamlining processes and management structures, reducing waste, making use of digital technologies, and robustly applying eligibility criteria.

30 Being robust in our application of eligibility criteria ensures that commissioned services are only provided to those with higher levels of need. For those with lower level social care needs, we provide advice and information on how they can access services independently of the local authority. Our online directory

of services - Locate – is designed to enable people to source their own services to meet lower level need and prevent or delay the need for statutory social care provision.

Legislative and Statutory Frameworks

31 Much of the work of the service concerns meeting the local authority's duties, or exercising its powers under these main pieces of legislation:

- The Care Act (2014)
- The Mental Capacity Act (2005)
- The Mental Health Act (1983)
- The Human Rights Act (1998)

32 UK Government's NHS Long Term Plan was published last year which outlined how the national 5-year settlement of £20.5 billion will be targeted at:

- Improving out-of-hospital care
- Ensuring all children get the best start in life (and for adult social care this means that those children with life-long disabilities also get the best support at the point where they transition into adulthood)
- More personalised care for older people to be active citizens in stronger communities
- Mainstreaming digital health services

Our priorities in social care are aligned to these aims. We work collaboratively with our internal partners including Children and Young People's Services and Housing, and external partners such as NHS organisations to join up agendas and services wherever we can to support these priorities.

Integrated Partnership Arrangements

33 The service enjoys strong integrated arrangements with partner organisations.

34 County Durham's Integrated Community Care Partnership brings together local community health organisations including GP practices, community nursing and therapy services with our adult social workers supporting older or physically disabled adults. Working closely with colleagues from County Durham and Darlington NHS Foundation Trust, local Primary Care Networks and the Clinical Commissioning Group, we form multi-disciplinary Teams Around the Patient (TAPs) which aim to:

- provide seamless services to keep people independent and healthy at home
- prevent unnecessary admissions to hospital or long-term care settings.

- support those patients who are most vulnerable and are at risk of deterioration of their health and wellbeing

35 Within our partnership with Tees, Esk and Wear Valley NHS Mental Health Trust, we have co-located and integrated multi-disciplinary teams of practitioners and clinicians supporting the needs of adults with Learning Disabilities & Mental Illness. These services provide assessment and therapy functions within specialist clinical care pathways, developing individualised care plans with service users and their carers. The Integrated Mental Health Service also incorporates a team of Approved Mental Health Professionals who have responsibility for overseeing any compulsory detentions into psychiatric hospital care under the Mental Health Act (1983) and overseeing Community Treatment Orders for mental health patients whose needs are manageable within the community.

36 Our Integrated Commissioning Service utilises market intelligence and works closely with Adult Care, partners, providers and the community to understand demand to stimulate and co-design the market to provide services that best meet people's outcomes and maximise independence and wellbeing. Joint management structures across health and social care enable the service to reduce duplication of work, allow providers opportunity to deliver care across the whole market, and ensure that resources in County Durham are utilised in the most efficient and cost-effective way.

37 The Integrated Commissioning Service oversees over 700 individual contracts with social care service providers.150 of those contracts are with care homes – 96 providing care to older people, and the rest providing specialist care to adults with learning disabilities and mental illness. In addition, individual contracts are in place for a range of non-residential care providers including domiciliary care, day centres and direct payments. The table below shows the budgeted spend for key social care related activity:

Service area:	**Annual Budget £000**
Residential Care	105,507
Supported Living	26,762
Domiciliary Care	24,604
Direct payments	11,278
Day Care	8,668

38 The commissioning team ensures that services are safe, high quality and support improved outcomes for those that access them. All contracts have specifications for standards that services must meet, and data is collected by the commissioning team to support contract monitoring.

39 The team uses a range of locally and nationally collected data and intelligence to inform them of service performance. In addition to this, partners across health and social care regularly share soft intelligence in relation to provision which is discussed during information sharing meetings. This partnership approach has been strengthened during the Covid-19 pandemic.

40 The integrated arrangements between Health and Social Care in Durham provide an opportunity to share best practice and pool resources when monitoring the quality of care providers.

41 A further role of the Integrated Commissioning Service is to commission services required to meet the social care needs of children (aged 0-18). An overlap exists between children and adult's services whilst the young person is transitioning into adulthood which is supported by the service described below. Commissioning colleagues have responsibility to ensure that there are no gaps in service provision.

42 The 14-25 Young People and Adulthood Social Work Service is also closely aligned with Children and Young Peoples Services (CYPS). This service supports younger people with social care needs (typically those with physical or learning disabilities) to 'transition' from children services into adult services where processes, frameworks, legislation and service provision are very different.

Anticipating and Predicting Demand

43 National data indicates that we are an ageing population. People are living longer due to improvements in health care, and those living with long term conditions can manage these much more effectively, meaning that older adults tend not to need support until they are well into the progression of their condition or ageing process. This has led to increased demand on statutory services by older adults with increasingly complex needs.

44 A national increase in the prevalence of mental ill health has also had a significant impact upon adult social care services. 1 in every 4 adults experiences mental health issues at some point.

45 Loneliness and social isolation are also much more prevalent amongst adults with social care needs. National evidence indicates that adults who are socially isolated are at increased risk of heart disease, stroke and dementia, and are also at a higher risk of substance misuse, sleep problems, suicide or early mortality.

46 Durham Insight provides local context and prevalence of a range of health and social care issues which we use together with our Joint Strategic Needs Assessment - which covers 4 themes: Starting Well; Living Well; Ageing Well;

Community Assets – to build a general overview of the current needs of our population. This helps commissioners in strategic decision making about where to prioritise limited resources, and it also informs the Market Position Statement which is used to support social care providers in the county to understand the needs of our population in order to develop sufficient effective and good quality services for the future.

47 At an operational level, we also use Operational Pressures Escalation Levels (OPEL – a joined up tool to consider demand and pressures across the health and social care sector including our provider market) and performance dashboards to understand activity, trends and current demand.

48 Predictive modelling, although useful, can never be an exact science, however we work with partners to share available data which can be used to examine age, dependency and complexity indicators in the context of pressures on the system including policy and practice changes, workforce issues, budget positions and forecasts, occupancy levels and admissions into hospitals and long-term care establishments.

49 By utilising these collective methods of anticipating demand based on the rich sources of data already known to us and shared between our partner agencies, and predictions based on trends and patterns, we have appropriate levels of assurance in meeting demand and need within our local communities.

Range of Services and Support

50 Our model of adult social care in Durham is very much focussed on promoting independence and wellbeing at every stage of our intervention, putting the person (service user) at the centre of the assessment and care planning process to ensure we deliver proportionate and personalised adult social care. See appendix 3.

51 Our model is underpinned by a number of national drivers including:

- DHSC's Hospital Discharge Service: Policy and Operating Model which provides for free reablement and rehabilitation services for anyone leaving hospital with increased levels of need to try to support them to return to their previous level of functioning. There is a strong emphasis on 'discharge to assess' and that assessment of longer-term needs should only be made once a person has reached their optimal level of recovery and once they are outside of the clinical setting.

- the NHS Transforming Care programme for adults with learning disabilities focussing on improving health and care services so that more people can live in the community, with the right support, and close to home.

- the Prevention Concordat for Better Mental Health which is a Public Health England initiative to promote evidence-based planning and commissioning to tackle health inequalities in the field of mental health and wellbeing. It has a focus on prevention and also acknowledges the role played by people with lived experience of mental health problems, individually and through user-led organisations.

52 Durham is in a strong position in terms of how we perform against these drivers. Our operating model is built around the same sound principles:

- that the service user is the expert in their own disabilities and how they affect them as an individual;
- that everyone should have opportunities to be supported to regain independence where appropriate;
- that everyone should have as much choice and control over their care and support as they would like;
- that everyone should be supported to be an active member of their local community;
- that nothing is done to a person without involving the person – regardless of their disabilities, health or cognition;
- health and social care should – wherever possible – be provided in a person's own home or as close to their home as possible.

Front of House Services – resolution; signposting and onward referral

53 Social Care Direct is Adult Care's robust 'front door' providing advice, information and signposting by contact centre staff, which includes qualified social workers and occupational therapy staff.

54 Social Care Direct is co-located with the Integrated Community Services' Care Co-ordination Centre which is the single point of access in the county for referrals into community nursing and therapy services, as well as hospital discharge referrals.

55 Social Care Direct also work closely with the Learning Disabilities Intake Team – an integrated team of practitioners and clinicians who screen for learning disabilities and provide support and advice or an initial assessment prior to transfer for ongoing care co-ordination in the longer-term integrated teams where required.

56 Similarly, access into integrated mental health services is via a central screening hub where practitioners and clinicians can resolve; refer on; provide a short-term intervention; or allocate into longer term community mental health teams for ongoing care co-ordination.

Short term intervention – maximising independence

57 Our Hospital Social Work Teams provide interim assessments of need as soon as someone with social care needs has been deemed medically fit for discharge by hospital clinicians. Wherever possible, they will support the person to return home with a level of care to support their ongoing recuperation which is then reviewed once the person has sufficiently recovered from their medical episode, regained some confidence and re-established their independent living routines. Durham has a low rate of delayed transfers of care from hospital – 3% lower than the national average.

58 Support at home on discharge from hospital is usually provided by our Reablement Service (which is commissioned from an independent care provider). This free service works with people for up to six weeks to support them to regain as much independence as possible or relearn new routines to better manage their condition/ disability. Latest performance figures show that:

- 82.5% of older people in County Durham who are discharged from hospital with a period of reablement or rehabilitation are still living at home 91 days after discharge. The national benchmark for this performance indicator is 82.4%;
- 90.8% of people completing reablement require either no ongoing care, or a reduced care package within the 6-week period;
- 74% have no ongoing care needs following completion of a reablement programme.

59 Where home is not an option immediately on discharge from hospital, intermediate care or ‘time to think’ beds are utilised within local independent care homes or community hospitals giving people further opportunity for rehab and recuperation and to allow for full assessment of longer term needs.

60 For older or physically disabled people at home in the community experiencing a deterioration in their long-term condition or a new medical episode which does not warrant hospital admission, crisis response assessments are undertaken by our trusted assessors from the community nursing services within the TAPs. These nursing colleagues have access to our Short-Term Assistance Service where they can commission urgent home care packages for up to 72 hours to support the person until a social worker or social work assistant can visit to discuss longer term care arrangements. This is also accessible out of office hours.

61 For all other referrals into our locality older people/ physical disabilities teams relating to people who may need support to continue living independently in the community, a reablement period is provided as per point 58 above. This is completed as part of the assessment process so that we can be sure that people receive the correct level of care to meet their needs having had the opportunity to regain some independence or establish different daily routines to accommodate their changing needs.

62 Support and Recovery is a short-term goal orientated intervention provided to adults with mental ill health, substance misuse issues or who self-neglect, with the aim of supporting people to regain or retain independence wherever possible. Interventions are usually 1:1 with a support worker, targeted to achieve outcomes identified by the service user, holistic and time limited. One of the aims of the service is to work with people to strengthen their existing support networks and link them into their local community to reduce social isolation; reduce dependency on statutory services; and avoid hospital admissions/ re-admissions.

63 County Durham Drug and Alcohol Recovery Services are provided in partnership with Humankind – a charity who oversees our joint recovery-focussed approach to working with adults affected by substance misuse. The recovery centres offer psychosocial interventions; substitute prescribing; practical help and advice with housing and benefits; as well as structured recovery programmes.

64 Most of our short-term interventions are provided free of charge.

Longer term support – maintaining independence & protecting quality of life

65 Only when someone has been supported to achieve their maximum potential for independence will we work with them to plan how their longer-term needs will be met.

66 We do this by assessing their care and support needs and determining their eligibility for ongoing support services using the national eligibility framework within the Care Act (2014). See Figure 1 below. Eligibility is not determined by how ill or disabled a person is, how chronic their condition is or how old they are. Everyone is affected differently by their health or social care needs and therefore eligibility focusses on how their ability to achieve basic outcomes related to independent living is affected and to what extent this impacts upon their individual wellbeing.

67 Robustly applying eligibility criteria not only ensures we do not create unnecessary dependency, but ensures a high degree of consistency in the effective management of our finite resources which we can target at meeting eligible needs which cannot otherwise be met from within the individual's existing support networks. Every individual's personal circumstances are different according to their personal resilience levels or their lifestyle choices, therefore in figure 1 below, not all of the listed outcomes we use to determine eligibility for services will be applicable to everyone. Our assessments of need focus on *desired* outcomes *relevant* to the person's individual circumstances.

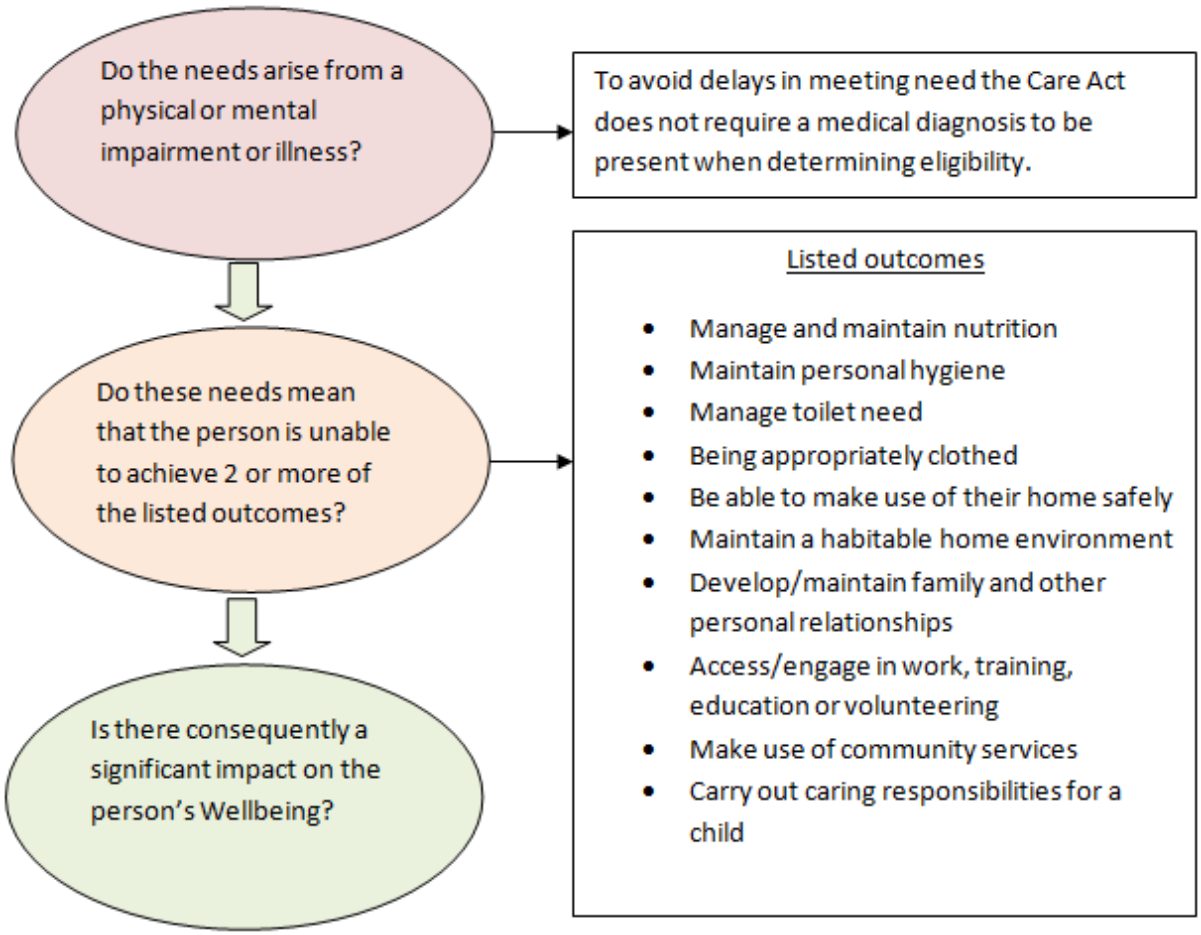


Figure 1

68 The most flexible way to receive longer term care and support services at home is via Direct Payments. This is where the council makes money available to the service user to be spent on services to meet their care and support needs. It allows the service user to have more choice and control over their care provision, and some people choose to employ their own support worker directly.

69 For people who prefer the council to arrange care and support services on their behalf, or for those who need permanent residential care our Commissioning Service procure a range of local domiciliary care providers, day centres, care homes, supported living, Shared Lives and extra care housing schemes, assistive technologies, as well as other bespoke services. These providers are contracted to deliver services on behalf of the council. Quality assurance and contractual compliance is very carefully managed by commissioning colleagues. We also have a dedicated team of Practice Improvement Officers. Working closely with Adult Protection Lead Officers, their role includes working directly into care homes and other care provision establishments to drive up standards, share good practice, and offer advice on how to improve the quality of care practices – particularly where there have been concerns raised within safeguarding adults processes.

70 A small number of day opportunities, outreach services, extra care schemes and respite placements are provided directly by our in-house provider County Durham Care & Support.

71 Longer-term care provision at home or in a care home is chargeable, and charges are means-tested against a person's income with their assets being taken into account only if they need to move into a care home permanently.

72 Permanent admission into a care home is a last resort option, and one of our service aims is to keep as many people as possible supported within their own homes and own communities.

73 Health care in the UK is, of course, free at the point of delivery and it is therefore very important that we work closely with our health colleagues to ensure that any care which is provided to meet health needs – as opposed to social care needs – is considered jointly to ensure that people are not charged for elements of their care which should be free. We do this by working within the DHSC's National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care.

74 Individuals' care needs change as their condition progresses, or as they develop new ways to manage their needs, and we aim to engage service users in receipt of longer-term care provision in a review of their care and support plan at least annually. 94% of service users have had a review of their care plan in the last 12 months.

Service Transformation

75 We have a positive culture of service transformation in Adult Care, responding to national and local drivers which we share with our partners, and also to the changing financial picture in adult social care.

76 We commenced our current programme of Adult Care Transformation in 2019. We recognised that a number of societal, cultural and statutory and legislative changes had occurred over recent years but that we had made no major changes to practice or processes since the implementation of the Care Act in 2014.

77 Senior managers and leaders within the service recognised that:

- There was an increased demand upon the service due to

  a) people living well for longer

  b) our front-of-house service offering robust advice and support to prevent or delay the need for statutory services, and our robust application of national eligibility criteria meant that adults only came to us when their needs were at a comparatively higher level than previously

c) more cases being referred to the Court of Protection due to the emergence of changing caselaw within the Mental Capacity Act (2005).

- Austerity had impacted so much on the service that reduced staffing levels were struggling to cope with the increased demand as described above. Staff wellbeing was becoming an issue as a result.

- Our assessments of people's needs were deficit-based, focussing on 'fixing' perceived problems, rather than working with people to use their existing strengths and assets to create opportunities for them to have autonomous choice and control in the management of their condition and how it impacts upon their quality of life in their local community.

- There was more we could do to make sure that people's wellbeing – as well as their physical and mental health – was supported by our interventions.

- More positive outcomes could be achieved for our service users by maximising our multi-agency integrated working.

78 We set out with the following objectives – which mirrored those of the corporate transformation programme:

79 Our service transformation programme is centred around 5 key themes of work:

80 Our aim is to reshape our frontline social care practice to become a more modern, stream-lined service achieving improved outcomes for our service users, maximising choice, control and independence; embracing digital technologies where there is a benefit to our staff and service users; and achieving improved efficiencies and cost effectiveness.

81 Our Commissioning Service is also committed to supporting the provider market. A programme of work is underway to enhance, maintain and support workforce training, recruitment, retention and development in a number of adult service sectors across provider markets, such as domiciliary/ community-based care, residential /nursing care, day services and the voluntary sector.

82 Funded through the Improved Better Care Fund (a government grant aimed at improving outcomes in adult social care) this initiative is designed to be transformative, with an emphasis on new ways of working including utilising new technology to support improvement. Achievements to date include:

- Development of the Care Academy – a workforce development resource which includes free training to people already working in the social care sector, or those hoping to develop a career in the care industry – guaranteeing interviews with providers after 'graduating' from the Care Academy. So far, the Care Academy has supported over 40 people into social care jobs, and a further 80+ are currently undergoing training. A fast-track recruitment process has been developed to respond to the workforce needs of the sector during the pandemic;

- Roll out of Health Call's Digital Care Home across our care home community for older adults. This has enabled greater use of digital technologies to facilitate communication between social care providers and local health care professionals to ensure that appropriate advice

and treatment is received in a timely manner – particularly important during the pandemic when face-to-face visits were reduced.

Challenges

83 A current challenge for the service is to review local hospital discharge arrangements in line with DHSC's Hospital Discharge Service: Policy and Operating Model. Increasing pressures on acute hospitals to improve patient flow, reduce length of stay and discharge to assess invariably impact upon social care. The service has begun to work with health partners to look at reviewing existing resources to address not only the annual winter pressures across the integrated health and care system, but also the impending changes expected by March 2021 to the current Policy and Operating model.

84 The increase in prevalence of mental ill health has already begun to impact operationally upon the service. Our integrated partnership arrangements with TEWV are well established and the service is currently undergoing a structural review to better shape response to need and service delivery around the anticipated needs of this client group. Work is also underway focussing on mental health prevention and improving wellbeing. The key to managing the mental health needs of the population in the future needs to be as much about prevention and self-resilience as crisis response. This requires a cross sector approach including working with voluntary and community groups.

85 Like other local authorities across the region, Adult Care in Durham has experienced increased complexity in the needs of the client group it serves (as described in points 43-45). There has also been an exponential increase in legal requirements impacting upon professional practice within the sector and social care provision.

86 One such example of changing legal requirements impacting upon the service is the implementation of Liberty Protection Safeguards which will replace existing Deprivation of Liberty Safeguards once amendments to the Mental Capacity Act (2005) come into force in March 2022. These safeguards provide for legal authorisation when a mentally incapacitated person's liberty must be restricted for their own protection. This is likely to require adjustment to and reconfiguration of social work resources, a robust training programme and a review of the relevant practice procedures for front line staff.

87 Partnership working over a sustained period in the context of austerity presents a number of challenges, including different organisational cultures and leadership models; real understanding of each other's business; and professional trust where responsibilities, duties and risks are shared. However, partnership arrangements also present us with opportunity to transform our services together – achieving increased efficiencies and value for money from the public purse, pooling resources, knowledge and expertise to improve outcomes for users of our services.

Conclusion

88 The Adult Care Service provides a range of statutory functions and support offers to adults in County Durham with a range of social needs. Supporting over 19,400 individual service users and carers the service is committed to improving outcomes for those adults who use our services.

89 This is achieved by working closely with Commissioning and Public Health colleagues making up the Adults and Health Service, and by maximising collaboration and use of resources within our partnership arrangements with health colleagues, Housing Solutions and Children and Young Peoples Services.

90 Consistently the service has demonstrated the effective use and management of resources whilst delivering positive outcomes for local people.

91 The service is also committed to continuous improvement programmes, and in the development of a robust, skilled and resilient workforce. Strategies are in place for further development required to meet anticipated future need.

92 Working in partnership is fundamental to the delivery of support, by doing so the service is in a strong position to adapt to challenges likely to impact upon service delivery and performance.

Background papers

- None

Other useful documents

- None

Contact: Karen Barnes Tel: 07825 938443

Appendix 1: Implications

Legal Implications

The service works within the main legislative frameworks of The Care Act (2014), The Mental Capacity Act (2005), The Mental Health Act (1983), The Human Rights Act (1998).

Finance

AHS has a total budget of £313M, has come within budget for the last five years, and continues to review and shape it's services in response to austerity and budget pressures.

Consultation

None

Equality and Diversity / Public Sector Equality Duty

Registered social workers and occupational therapists work within professional ethical frameworks including anti-oppressive practice and equality.

Human Rights

The Human Rights Act (1998) underpins social care and the wider legislative framework it operates within.

Crime and Disorder

The service works closely with police and other criminal justice agencies in respect of safeguarding vulnerable adults from abuse, tackling anti-social behaviour which arises as a result of learning disabilities, mental illness or brain injury, and forensic interventions.

Staffing

AHS employ over 1000 staff.

Accommodation

The service is currently working closely with transformation and partnership colleagues to work towards corporate accommodation strategies.

Risk

The service contributes to the corporate risk register which is reviewed regularly. Appropriate Business Continuity plans are regularly reviewed. An annual audit schedule is signed off by senior managers who receive regular feedback on levels of assurance.

Procurement

None

Appendix 2: Service Make up

Appendix 2
SERVICE MAKE UP.d

Appendix 3: Service delivery model

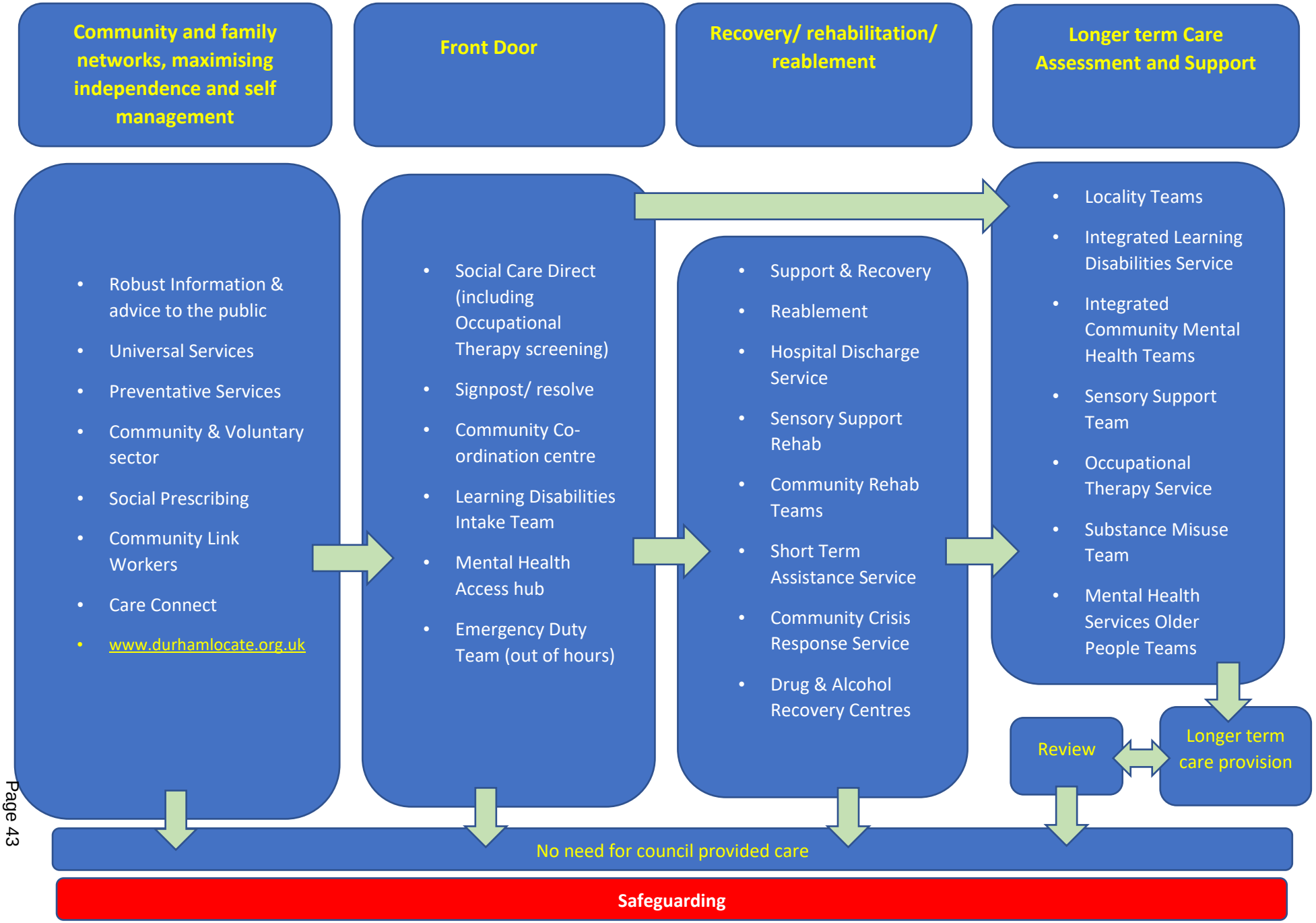
appendix 3.docx

SERVICE MAKE UP

Older Persons/ Physical Disabilities/ In-house Provider Service	Learning Disabilities/ Mental Health/ Substance Misuse	Safeguarding, Access, Practice Development & Direct Payments	Operational Support	Commissioning
5 x Locality Social Work Teams for Older People/ Physical Disabilities	3 x Integrated Learning Disabilities Team 1 x LD Intake Team 1 x 14-25 Young People and Adulthood Service	Adult Protection Service	Development and Learning Service	Adults Care Commissioning Adults Health Commissioning Supporting the Provider Market
Countywide Occupational Therapy Service (covering North, South and East)	3 x Mental Health Psychosis Teams 5 x Mental Health Affective Disorders Teams Countywide MH Crisis Service 2 x Early Intervention Psychosis Teams 1 x core team of Approved Mental Health Professionals	Practice Development Service	Data and Systems Team	Children & Young People Commissioning MH/LD Commissioning (with the MHLD Partnership) Public Health Commissioning
3 x Hospital Discharge Social Work Teams (North, South and East)	1 x countywide Substance Misuse Social Work Service	Practice Improvement Service	Complaints management	Provider Performance & Quality
Countywide Sensory Support Social Work and Rehabilitation Team		Deprivation of Liberty Safeguards Best Interest Assessors Team	Service Improvement	Engagement
		Social Care Direct (front of house single point of access)		
In-house Provider Service:		Direct Payments		

7 x Extra Care Housing Schemes for 280 x over 55s with care needs 5 x Pathways Hubs (providing day opportunities to 121 adults with higher dependency/ therapeutic needs) + 1 outreach service for 5 x adults with autism who have behaviours which challenge. 1 x Shared Lives Service (supports 103 adults with Learning Disabilities by providing permanent or respite placements with 63 families/ individuals in the family's own home) 1 x Support and Recovery Service (supports 223 adults mainly with complex Mental Health needs to regain/ maintain their independence in the community) 1 x residential respite unit for higher dependency adults with Learning Disabilities				

Appendix 3


Community and family networks, maximising independence and self management
Front Door
Recovery/ rehabilitation/ reablement
Longer term Care Assessment and Support
Robust Information & advice to the public
Universal Services
Preventative Services
Community & Voluntary sector
Social Prescribing
Community Link Workers
Care Connect
www.durhamlocate.org.uk
Social Care Direct (including Occupational Therapy screening)
Signpost/ resolve
Community Co-ordination centre
Learning Disabilities Intake Team
Mental Health Access hub
Emergency Duty Team (out of hours)
Support & Recovery
Reablement
Hospital Discharge Service
Sensory Support Rehab
Community Rehab Teams
Short Term Assistance Service
Community Crisis Response Service
Drug & Alcohol Recovery Centres
Locality Teams
Integrated Learning Disabilities Service
Integrated Community Mental Health Teams
Sensory Support Team
Occupational Therapy Service
Substance Misuse Team
Mental Health Services Older People Teams
Review
Longer term care provision
No need for council provided care
Safeguarding

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Adults, Wellbeing and Health Overview and Scrutiny

Adult Social Care: An overview

9 November 2020

Altogether better

Durham County Council

Governance

Altogether better

Main Legislative Frameworks

Care Act (2014)

Mental Capacity Act (2005)

Mental Health Act (1983)

Human Rights Act (1998)

Altogether better

Durham County Council

Integrated Partnership arrangements

County Durham Care Partnership

NHS County Durham Clinical Commissioning Group

NHS County Durham and Darlington NHS Foundation Trust

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

NHS North of England Commissioning Support Unit

Altogether better

Durham County Council

People we support

Currently supporting 19,400 adults in County Durham with a wide range of social care needs:

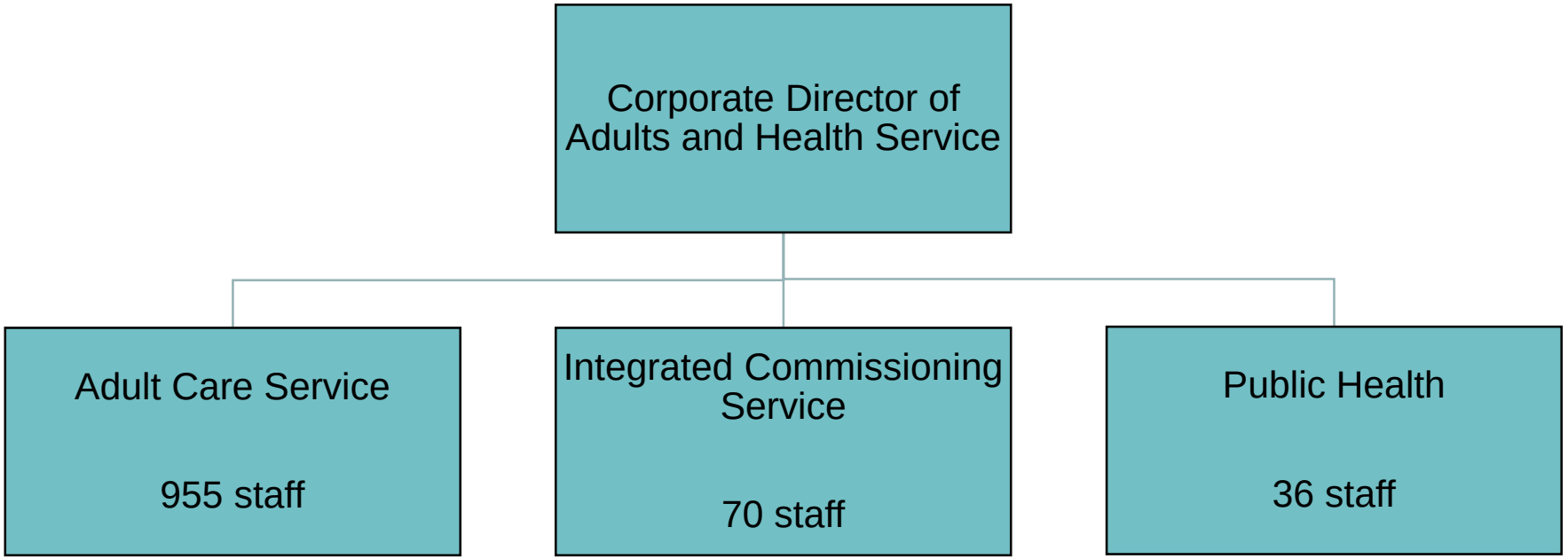
- Age related frailty
- Physical disabilities
- Learning disabilities
- Mental Health
- Substance misuse issues
- Sight or hearing impairment
- Brain injury
- Prisoners with social care needs
- Those who have caring responsibilities for other adults with social care needs.

8,400 adults are in receipt of a formal ongoing care service provision

65% of those in their own homes in the community

35% in residential care

Service Structure



Altogether better

Durham County Council

Range of services and support

Front of House Services – resolution, signposting and onward referral

Short term intervention – maximising independence

Longer term support – maintaining independence & protecting quality of life

‘Ann’: older woman with age related frailty

2 yrs ago

Present day

- Initial referral to Social Care Direct. Signposted to voluntary community activities. No further action.
- Hospital admission. Discharged with Reablement. Regained independence. No further action.
- Health & care needs increase. Integrated Team Around the Patient multi-disciplinary meeting. Further reablement episode.
- Diagnosed with dementia by consultant in integrated team
- Needs care x 2 per day after reablement
- Dementia progresses. Begins to ‘wander’. Care increased. Telecare installed
- Aggression & forgetfulness. Multiple falls. Multi-agency meeting with police and Fire Community Safety
- Loses mental capacity to make decisions about care & support needs & where she should live
- Best Interests decision: 24 hour dementia care. Deprivation of Liberty Safeguards application.
- Objects to living in care home. Referral to Court of Protection.

Altogether better

Durham County Council

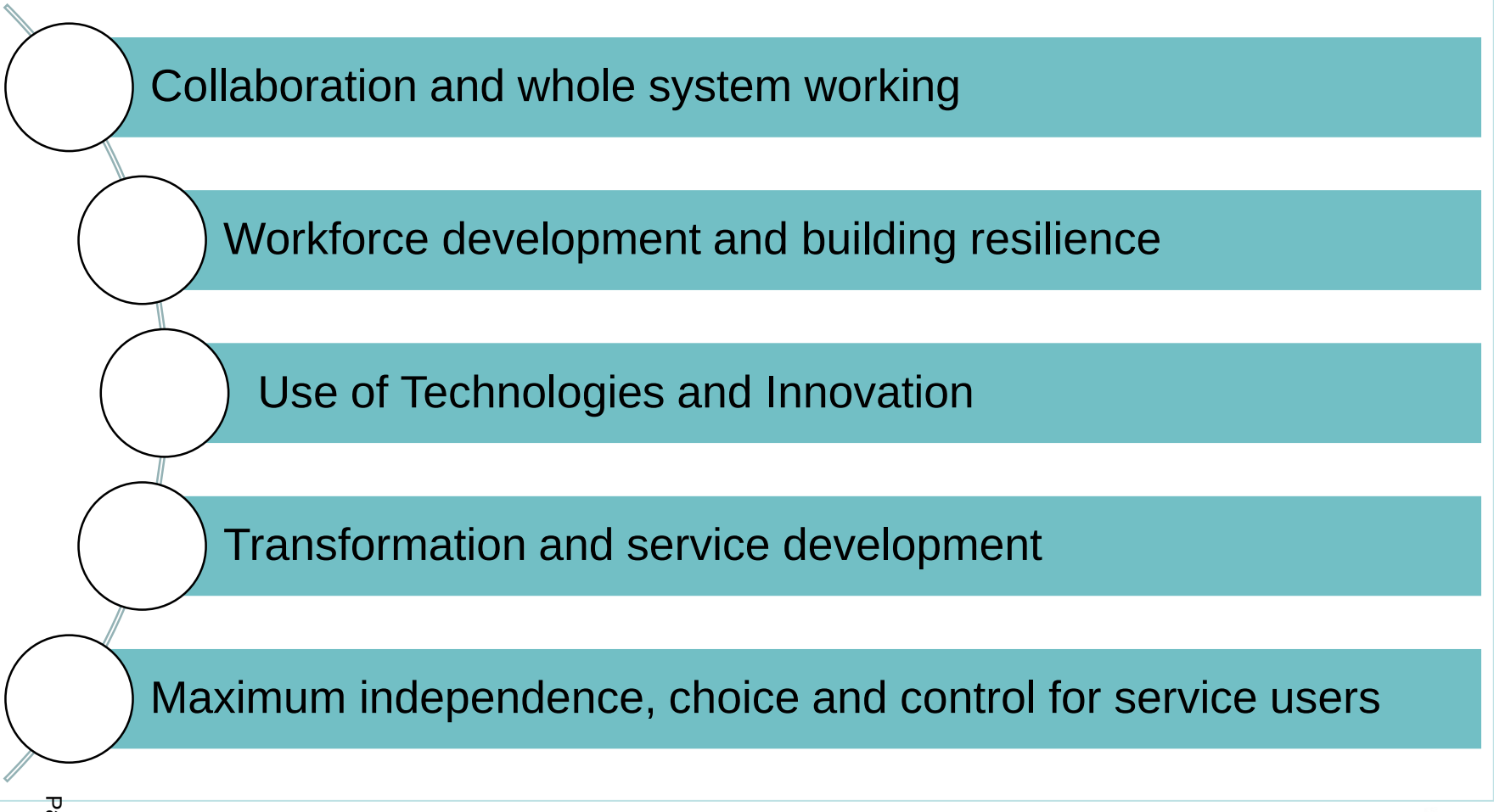
‘Tom’: man with learning disabilities

2 yrs ago

Present day

- Lives at home with elderly mum (main carer) who is becoming frail. Can’t do as much as she used to. Tom Struggling to cope with changing situation.
- Care Act assessments for both. Mum referred to Carers Service. Tom referred to day centre to give mum a break.
- Mum becomes ill. Needs operation. Worried about who will look after Tom. Multi-disciplinary team plan mum’s health interventions around arrangements for Tom’s social care needs.
- Tom stays with Shared Lives respite providers while mum in hospital. He continues to attend day centre so the familiar staff there can monitor his behaviours.
- Mum discharged home with short term reablement support. Workers try to help Tom too but he won’t let them.
- Direct Payment set up. Mum employs family friend to care for both Tom and herself. Free training provided by Care Academy.
- Mum’s health deteriorates. Now needs end-of-life care. Tom referred to an advocate to support decision-making.
- Tom moves into a Supported Living unit with 3 other adults with similar needs. Staff support with some independent living skills.

Transformation



Altogether better

Durham County Council

Challenges

- Increased prevalence of mental health
- Local response to changes to national hospital discharge policy and operating model
- Increased complexity of adult social care needs
- Changes to legislative frameworks
- Social care reform

Adults Wellbeing and Health Overview and Scrutiny Committee

9 November 2020

County Durham and Darlington System Winter Plan 2020/21

Report of Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust and Chair of the Local Accident and Emergency Board (LADB)

Electoral division(s) affected:

Countywide

Purpose of the Report

1 The purpose of this report is to update members of the Adults Wellbeing and Health Overview and Scrutiny Committee on the System's Winter Plan 2020/21

Executive summary

2 Over the last few month's members of County Durham and Darlington LADB have been working on compiling the System Winter Plan for 2020/21.

3 The plan is based on each organisation's recovery and reset plans following the first wave of COVID-19, which take into account the need to continue with the full restoration of services, whilst managing winter pressures and the risk of a second COVID surge and/or local outbreaks.

4 The plan contains a combination of mitigations to be able to continue to provide safe levels of service provision against the plan risks which are amplified this year by COVID.

5 There are tried and tested internal processes in place across all partner organisations to keep the position throughout winter under review on a daily and weekly basis, with clear routes of escalation to the LADB to be able to rapidly take action to address any exceptional circumstances or issues that may arise.

6 Work is still ongoing to develop further mitigations and mutual aid responses across the ICP and ICS footprints, working with NHS England and the North East Commissioning Support Unit.

7 Additional guidance also continues to be released which will be incorporated in the plan.

Recommendation(s)

8 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are recommended to:

(a) Receive the plan for assurance that a System Winter Plan has been put in place to protect services over the winter period and that there is robust daily oversight.

(b) To note the increased levels of risk in relation to the winter period, given the combination of winter pressures and COVID.

(c) To note that work is still ongoing to agree mutual aid responses across the North East and Cumbria Integrated Care System (ICS), and LADB partners continue to be rapidly respond to new guidance being released.

Background

9 The System's Winter Plan is refreshed every year, building on learning from previous years and taking into account new requirements, services, developments and opportunities.

10 This year's refresh has been quite different, having to take account of COVID-19 and the requirement to put in additional plans and mitigations to protect the system from both winter, and the ongoing pandemic.

11 All organisations, following the first wave of the pandemic, have incorporated winter into their reset programmes.

12 A number of system wide planning sessions across County Durham and Darlington, and the rest of the North East region, has brought those plans together and partners have jointly addressed identified risks and gaps in the overall plan.

13 There is now a system wide plan in place, and work is ongoing to develop mutual aid responses at ICP and ICS levels.

Key objectives

14 The objectives of the winter plan aim to:

- Ensure the system is able to effectively respond to winter and COVID-19 pressures.
- Optimise all available system capacity, enhancing community service and primary care provision and care home support.
- Maintain the highest standards of patient safety and patient experience.
- Sustain high levels of performance in Urgent and Emergency Care Services, similar to those that have been experienced during the Pandemic ie >90% of patients seen within 4 hours.
- Implement the Hospital Discharge Service Policy (new guidance from September 2020).
- Minimise ambulance handover delays.
- Enhance mental health support for patients and local populations.
- Protect elective care as far as possible given the accumulation of appointment delays and high number of patients waiting for their operation following COVID-19 wave 1.
- Continue to provide essential support to all key workers.

- Promote and ensure high levels of uptake of the Influenza vaccination.
- Maintain COVID-19 testing capacity.

Summary of plans

15 There are a number of initiatives as part of the plan that will help manage and mitigate anticipated system pressure over the next six months.

- Optimising capacity
  - Ongoing offering of extended access in primary care
  - 'Hot clinics' ready to be stepped up if required. These are for any symptomatic patient presenting /relating to COVID-19 care to enable other sites to continue to see routine patients.
  - Launch of Talk Before You Walk (TBYW) on 19 October 2020, encouraging patients to contact NHS 111 to be directed to the most appropriate service which may not be the Emergency Departments.
  - Community extended services.
  - Additional re-ablement packages.
  - Rapid response domiciliary care.
  - Development of the Care Home Capacity Tracker providing good visibility of capacity and pressure, with daily check in calls with all homes.
  - Additional G&A beds to cope with increased demand, and to allow a sustained protection of elective beds.

    There is an expectation that systems put plans in place throughout winter to continue the restoration of all services, including the elective care position, as set in the Phase 3 Planning Guidance issued by NHSEI.

    The Independent Sector in the region continues to contribute to this programme of work, dedicating outpatient and operating capacity to the NHS until end March 2021.
  - Enhanced provision of Same Day Emergency Care (SDEC).
  - Step up plan for additional crisis or liaison capacity.
- Optimising uptake of flu vaccination.
- A Task and Finish Group is up and running to roll out the latest discharge practice guidance, aiming to avoid any delays to patients being transferred to their next destination regardless of where that is.

- There is a myriad of support packages and services in place
  - 24/7 mental health support line
  - The development of a standard, regional self-monitoring tool for wellbeing for use across our whole population. The aim will be to normalise responses and match care and treatment, when required, with the appropriate level of need.
  - Cancer Services Helpline established during wave 1, which can be increased if needed.
  - Various employee resilience and support programmes such as provision of psychological support to staff, creation of a Wellbeing Hub to support and encourage self-help and to provide tools, interventions and advice to staff, through staff reviews and appraisal processes all staff receive a wellbeing conversation.

16 The plan has been developed in the context of being able to continue to safely provide optimum levels of elective care and diagnostic activity in line with NHSEI Phase 3 Planning guidance and in support of recovery.

17 It has also been essential to plan in parallel a range of actions in response to the pandemic across all sectors, such as:

- access to appropriate levels of PPE, equipment and other consumables
- increased isolation capacity within Critical Care
- embedding of new processes, such as segmented management of patients based on clinical risk and priorities.

18 Durham and Darlington Local Resilience Forum (LRF) continues to be integral to winter/COVID Pandemic planning, and tracking and forecasting activity.

COVID planning

19 Specifically in relation to the ongoing management of the COVID incident a number of actions were initiated/ put in place during Wave 1. These will remain and include:

20 A number of regional developments were put in place during the first wave, including:

- The stepping up of the well-established regional Critical Care Network to provide daily intelligence and hold regional oversight to ensure there was sufficient capacity to cope with demand.
- The Nightingale Hospital was also established during Wave 1, situated in Sunderland, with a Managing Director appointed. The

facility is readily available should demand require it, subject to deployment of a workforce.

21 More recently the Lighthouse Lab is being developed to support increased testing capacity for the region.

Main implications

22 The plan has been developed on the basis that winter pressures are likely to be amplified this year, presenting a higher level of risk than in previous years. The key risks include:

- Increased levels of staff absence, due to COVID, Test and Trace, seasonal flu and the pressures of work, directly impacting on all health and social care service provision.
- 2nd and 3rd Waves of COVID driving up demand above anticipated levels, directly impacting on emergency and urgent care performance and the elective care programme.
- Increased incidence of mental health arising from the impact of COVID and lockdown.
- Reduced capacity in care homes, care sector due to COVID.
- Reduced transport capacity due to social distancing to support hospital discharging.
- Reduced bed capacity due to:
  - the requirement to safely isolate and cohort patients presenting with infectious diseases including COVID, Norovirus, VRE, which results in the temporary closure beds.
  - long turn-around times to obtain COVID test results to support the transfer of patients from assessment areas to a relevant base wards/ cubicles.

23 The plan aims to mitigate the risks described and should any of these materialise at unprecedented levels, escalation will firstly be made to the Local A&E Deliver Board (LADB) and then subsequently to the Central/ South ICP to secure additional actions and mutual aid.

24 Regional system oversight as in previous years will be provided by NHSEI and the regional surge team (NECS) operating as a triumvirate in a single virtual winter room. They will undertake a daily performance function and manage all regional correspondence. The LADB will maintain local system oversight and the LRF will continue to remain an integral partner in the ongoing incident response.

Conclusion

25 The most optimal plan has been developed using the physical and workforce resources that are available to ensure as safe as a provision of services as possible throughout the winter period. The system has been developed iteratively and was approved by the LADB in October.

26 Whilst the plan puts the system in a strong a position as possible to cope, it is unknown how COVID demand will impact, and this remains the sole significant risk to the overall plan.

27 Internal processes are in place across all partner organisation on a daily and weekly basis to keep the position throughout winter under review and for action to be taken in a timely manner to address any exceptional circumstances or issues that may arise.

28 It will remain the responsibility of the LADB to keep appropriate levels of oversight of the system and if necessary activate appropriate escalation to respond to circumstances beyond the capacity of the local system to deal with.

Background papers

- Implementing phase 3 of the NHS response to the COVID-19 pandemic, 7 August 2020, Publications approval reference: 001559

Other useful documents

- Other documents are embedded within the Winter Plan, Power Point document attached at ***Appendix 2***.

Author

Nichola Kenny, Director of Performance, CDDFT on behalf of County Durham and Darlington LADB

Appendix 1: Implications

Legal Implications

N/a

Finance

Winter financial planning is aligned to each partner organisations own plans.

Consultation

N/a.

Equality and Diversity / Public Sector Equality Duty

Social and Health Inequalities is a key feature of organisational reset plans.

Climate Change

N/a

Human Rights

N/a

Crime and Disorder

N/a.

Staffing

The plan is inclusive of organisation staffing plans and associated risks.

Accommodation

N/a

Risk

The plan is inclusive of key risks

Procurement

N/a

Appendix 2: Winter System Plan and Flu Update

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The County Durham and Darlington Flu Prevention Board is co-chaired by a Medical Director from County Durham CCG and a Consultant in Public Health from DCC.

The Board seeks assurance that the local health system is working to deliver a safe, effective and equitable flu vaccination programme.

It includes membership from commissioners and providers of the flu vaccination programme and primary and secondary care, including NHS England, CDDFT, TEWV, HDFT, and pharmacy.

The Board has met fortnightly during in 2020 to maintain energy and focus on delivering flu vaccinations in the context of COVID-19.

It has established a separate communications workstream to ensure a well-coordinated local campaign that aligns with the local plans of commissioners and providers.

The Board has overseen key activities to support the safe, effective and equitable delivery of flu vaccinations including:

- DCC corporate management agreeing flu vaccination for all staff.
- GP increasing their current adult flu vaccine order by an additional 10%, with any associated losses to be covered by the CCG.
- The CCG also agreed to underwrite 10% unused flu vaccine stock for pharmacies that had placed additional orders early.
- Total estimated vaccine capacity (within GP practices and pharmacy) in County Durham to vaccinate 87-88% of the eligible population aged 18 and above.
- Mapping of care homes to practices, to ensure full coverage of residents in care homes between practice and community nursing teams, and to minimise the number of people entering the homes.
- Commissioners to monitor uptake of flu vaccination amongst care home staff.
- Joint letter signed by the Director of Public Health and Chief Clinical Officer of County Durham CCG encouraging eligible patients in the local population to take up their vaccination (dependent on individual GP practices providing consent to share patient data).
- Comprehensive set of FAQs developed for use by partners in local communications.
- Development of a more streamlined referral pathway for housebound eligible patients into Community Nursing Teams.
- Development of a dedicated Learning Disability plan delivered in conjunction with TEWV.
- Collaboration to promote vaccination to and engage with vulnerable groups such as Gypsy, Roma and Traveller communities and people who are homeless.
- Midwives trained to provide the vaccine, with fridges to stock the vaccine, and administering vaccinations at CDDFT clinics as well as community clinics.
- Collective understanding shared on use of PPE in administration of flu vaccine.
- NHSE exploring the possibility of commissioning PharmOutcomes as the tool for informing GP practices of vaccine administration by pharmacies.
- Successful delivery of flu clinics in COVID-secure settings, not requiring support for large venues brokered through partner organisations.

At the time of writing, it is early in the delivery of flu vaccinations. Initial demand appears to be high, with community pharmacies in the North East already having vaccinated 40% of the eligible NHS patients that came forward for a pharmacy vaccination during the whole of last year's campaign. Some community pharmacy chains have announced that they are no longer taking further bookings for Flu vaccines, particularly for private flu vaccinations.

At the time of writing, no reports were available through PHE's ImmForm portal to show uptake amongst eligible groups.

There remain some matters to be resolved during the current season. Two key issues are the size and availability of NHS stock, and whether vaccines are going to be available for people aged 50 to 64, and if so how the programme would be delivered.

The intermittent availability of Pneumococcal vaccine remains an ongoing concern for both the prevention of respiratory disease, and on a practical level as many practices usually vaccinate at the same time.

Winter Planning 2020/2021

County Durham & Darlington Local A&E Delivery Board (CD&D LADB)

v1.9

What is in place?

CDDFT – ACUTE

- ED segregated pathways supported by Snr FoH decision making (COVID and Multi-specialty Area (MSA))
- Segregated COVID hospital pathways
- Senior Nurse 7 day matron model
- SDEC
- Protection of elective programme - Cancer Care Surgical Hub and ongoing collaborative working, ongoing use of Independent Sector up until Dec and potentially to March 2021
- Vocera live in UHND ED
- Overseas recruitment
- Enhanced on call support

CDDFT - COMMUNITY

- 7 day services
- First contact physio
- DN team support until midnight
- Community extended services; Crises, community wards, IC beds, Discharge Management

PUBLIC HEALTH

- Joint flu programme
- Cold Weather Plan

NEAS

- REAP Framework/Escalation policy
- Winter Plan
- Demand Management Plan
- On call arrangements in place
- Adverse weather plan
- Managed outbreak plans

OTHER JOINT WORKING

- Discharge Management Teams established system wide through teams, evidenced as good mechanism in managing discharge
- Discharge Pathways successfully implemented
- Trusted Assessor model now in place
- EHiCH Steering Group
- Daily calls to care homes
- Operational support for accelerated discharge across Care homes

ADULT AND SOCIAL CARE

DARLINGTON

- Flexed use of Reablement Spot Beds
- Rapid Response Dom Care – 70hrs per week commissioned with a 2hr response & some night capacity
- Extra Reablement Packages
- Continued effective use of resources, moving staff to respond to pressure points
- Home from hospital - Care Connect
- 7 day social work assessment Weekend/Bank Holiday working over Xmas
- Increased Occupational Therapy support
- Continue to use Assistive Technology to reduce unnecessary admissions to hospital as well as supporting discharge
- Daily contact with all care home providers to identify any key issues
- Use of capacity tracker data to inform system wide position
- Local Staff deployment arrangements for Care Homes
- Regional Care Home Deployment Hub

DURHAM

- Continued effective use of resources, moving staff to respond to pressure points
- Communication to all DBC, ASC staff in ensuring pathway flow. All hospital/ community hospital discharges are a priority.
- DBC Adult Social Care, Social work interface at DMH, supporting communication between hospital and community colleagues
- Spot reablement community beds accessible across weekends /Bank Holidays, by Health and Social care as part of Trusted assessor.
- Assistive Technology – Lifeline
- Care Connect
- Rapid Response Dom Care - 7 days
- Re-ablement: Improved 7 days pathway
- Exploring increased ASC social work/OT availability
- Enhanced Health Care in Care Homes system wide strategic steering group
- Durham Care Academy have been actively recruiting staff for registered care providers since the start of the pandemic, with over 200 applications to date. Staff are available for employment by providers, inc care homes
- http://www.durham.gov.uk/media/33110/County-Durham-Covid-19-Local-Outbreak-Control-

PRIMARY CARE

- Reporting of daily OPEL levels
- Direct booking for NHS111 appointments
- GP improved access provided 365 days per year, extended access

TEWV

- Daily monitoring of demand for acute liaison services with capacity to flex as needed
- Daily monitoring of demand for crisis services with capacity to flex as needed
- Proactive monitoring of community team caseloads across all specialties
- Trust wide flu vaccination programme well planned with vaccination offered to all staff. Take up rates increasing year on year
- Good staff management plans in place to ensure all teams have adequate cover through rosters
- 24/7 Crisis Service with hub and spoke model in place, leading to greater call handling capacity
- Single crisis number for whole Trust
- Acute Liaison services in place 24/7 with ability to flex capacity across acute sites depending on demand
- Daily monitoring of acute liaison KPIs (1 hour response time for A&Es) – currently performing well
- Close liaison between acute liaison and crisis services to minimise delays and re-work where admission to a TEWV bed from A&E may be required or where intensive home treatment may be helpful to prevent admission
- Close working with VCS to develop range of offers across wider crisis pathways
- Mechanisms in place to monitor any surge in COVID specific demand
- Mechanisms in place to re-establish business continuity arrangements as required for any further COVID waves

Plans for Winter

Ongoing developments linked to Reset Programmes - living with COVID

Acute and Community

- Increase in G&A Bed Capacity c28% (Expansion of specialty frailty pathway into Bishop Auckland Hospital)
- Critical Care Bed escalation, cubicle development
- Expansion of Same Day Emergency Care (SDEC) activity, reducing admissions
- Frailty Care, front door assessment (DMH)
- Embedding of 7 day integrated discharge management (commenced during COVID)
- Further transition to a sustained 7 day working model
- Step up options into Community Hospital beds
- Additional diagnostic equipment ie CT scanner to support flow through ED
- 7 day specialist palliative nursing care
- Flu vaccination – more housebound delivery

NEAS

- Talk before you Walk (North pilot)
- Plans for improving flu vaccinations
- trained Health Advisors working within alternative roles (i.e. support services) will be called upon to assist
- Senior Health Advisors, who, during periods of pressure, can take 999 and 111 calls
- Clinicians are also trained across NHS 111, 999 and Primary Care telephone assessment, this clinical workforce can be flexed across support for ambulance dispatch safety management,

PRIMARY CARE

- Working with CCGs - plan to improve increase in flu vaccination uptake
- From 31st July each Care Home will be aligned to a Primary Care Network (PCN)
- To access "enhanced care" residents in the care home have to re-register with the aligned PCN
- PCNs will work as part of MDT with community services, pharmacy, mental Health and LA
- Structured medication reviews
- Social prescribing link workers
- Care navigation
- DVT pathway
- paramedic clinical support

TEWV

- Improved processes for access prior to COVID has led to reduced waiting times – exploring how this can be extended and sustained including development of Access +/PCN level capacity
- Significant learning within IAPT re different ways to manage capacity to minimise waits – will be critical to sustain with predicted increases in demand
- Backlog management – modelling underway to help local planning/contingency management
- System-wide – revisiting RCRP initiatives; working with PCNs, VCS, wider system to prioritise early intervention and improved pathways
- LRF HIA analysis and TEWV modelling – predicting activity
- New ways of working – embedding learning from lockdown
- Implementation on track for 24/7 mental health support line across Durham and Darlington (commissioned prior to the pandemic). Builds on the mental health support line in place through NEAS from April. Recruitment should be complete by end of July
- Ability to step up additional crisis or liaison capacity, but this may risk drawing from community services. Contingencies being discussed internally

Plans to manage surge in activity

DARLINGTON

- Exploring increased ASC social work/OT availability
- The Darlington Rapid Response is a service that is able to operate flexibly and respond to a surge in domiciliary care discharges over and above (if required) the available hours of 70 per week.
- Residential and Nursing Care Home occupancy levels and vacancies are closely monitored on a weekly basis– any significant reduction in capacity over the bank holiday weekend will be escalated to senior management.
- Establish processes and protocols now in place, as evidenced during the covid pandemic, allowing, among others areas, redeployment of staff into key areas
- EHiCH
- Infection Control Fund support

DURHAM

- 3x per week data collection from all front-line social care providers – managed by Integrated Commissioning Service
- OPEL Tool for RAG rating providers
- Financial Support package for providers, covering occupancy and additional COVID19 costs
- Significant system input into registered social care providers, particularly care homes – Commissioning, IPCT, care home liaison team, DN's, Practice Improvement etc
- Advice, guidance and support package

TEWV

- Implementation on track for 24/7 mental health support line across Durham and Darlington (commissioned prior to the pandemic). Builds on the mental health support line in place through NEAS from April. Recruitment should be complete by end of July
- Ability to step up additional crisis or liaison capacity, but this may risk drawing from community services. Contingencies being discussed internally
- Daily lean management in place in all services to allow timely responses and decision making across service areas
- **Internally**
- Daily Lean Management and regular report outs – timely and rapid escalation of any issues
- Emergency Planning/Business continuity arrangements being reviewed to capture learning from COVID
- Key theme is ability to quickly step back up activity and different ways of working if needed
- **Externally**
- Lessons from COVID – importance of triangulation of multi agency intelligence to pre-empt possible issues
- Making best use of system wide structures and comms flows

CDDFT

- Elective pacing
- OPEL
- Major incident –emergency planning
- Opening of identified escalation wards (BAH & Community)
- Talk before you Walk (subject to pilot and funding)

LADB Escalation Plans

- Escalation plans are in place to provide operational, tactical and strategic responses.

Microsoft Word Document

Escalation Plans – specific to COVID

Primary Care

- Designated "hot clinics" ready to be stepped back up in primary care if required, any symptomatic patient/patient presenting relating COVID related care would attend here and free up other sites to see routine appointments
- COVID Virtual ward
- County Durham Primary Care Pandemic Plan developed at PCN level – this sets out clear contingency plans should some sites need to close due to staffing levels across the PCN
- Ongoing review of current OPEL Framework

LAs

- Mutual Aid from staff in wider system in place for providers in crisis (most likely care homes) – dom care, day services staff. Nursing cover has been arranged via CDDFT in emergency situation only
- Financial Support package for providers, covering occupancy and additional COVID19 costs
- Significant system input into registered social care providers, particularly care homes – Commissioning, IPCT, care home liaison team, DN's, Practice Improvement etc
- Advice, guidance and support package

TEWV

- Detailed forecasting and modelling work complete within Trust, linking to HIA, which will help us plan for any surge in advance of winter.
- Cohorting arrangements for wards across all specialties in place and can be stepped up/down
- Embedded processes re PPE
- Community team RAG rating of caseloads to allow more segmented management of clinical risk established
- Site management arrangements across 7 days can be stepped up/down as required
- Specific support to care homes and the wider system in terms of managing mental health demand but also supporting staff

Acute & Community

- Stepped increased of COVID wards/beds within segregated pathways
- Critical Care Expansion plan in support of increased isolation areas.
- Sustained two ED pathways – COVID and non-COVID
- Step down of routine activity (pending volumes) ie elective surgery, outpatients, step up of enhanced respiratory and critical care teams and wider ward teams
- Opening up of resilience wards in BAH and in the community

NEAS

- An FFP3 respirator should be worn by frontline staff when carrying out a potentially infectious aerosol-generating procedure. Where a patient is known/suspected to have an infection spread via the aerosol route or when caring for patients known/suspected to be infected with a newly identified respiratory virus.

Plans for Winter 2020/21

Plan risks

Risk	Current mitigation	Residual Risk
Activity peaks to/above pre-covid levels	Communications campaign to use UEC services appropriately Extended primary care access All available physical bed capacity has been identified and every effort being made to recruit staff to support these. Elective pacing OPEL Major incident –emergency planning Opening of identified escalation wards (BAH) Talk before you Walk (subject to pilot and funding)	H
Second/ third Wave of COVID 19	Pandemic plan (See COVID headline related surge actions) Step up use of community beds usage and bring into action identified escalation wards (BAH) to support additional segregated pathways	H
Risk of insufficient staffing /staff burnout during the winter pressures and increased staff absence due to work pressures/flu /COVID (also leading to loss of bed capacity)	Health and well-being programmes actively promoted and made available Rolling recruitment of Qualified Workforce throughout the year, including overseas recruitment. Working to 1:8 ratio (nursing) Daily assessment of safe staffing and prospective view of staffing. Maximum number of additional beds to be opened to minimise impact on workforce. Resilience training and team support Robust flu vaccination programme	H

Plans for Winter 2020/21

Plan risks

Risk	Current mitigation	Residual Risk
Delay of funding to support capital schemes in relation to critical projects including ward and ITU expansion, Elective Surgical Units, SDEC, Endoscopy and CT scanner	Developments critical to reset programme Key schemes prioritised to secure funding (both capital and revenue) Robust project management of all schemes Timely recruitment in support of scheme go live dates	M
Increased incidence of mental illness arising from impact of COVID-19	TEWV undertaking modelling exercise to evaluate impact. Work just being completed now (end of June) through internal modelling and via the D&D Health Impact Assessment to understand the COVID-specific impact on mental health services and mental health demand. Plans for winter may need to be adapted to reflect anything that arises from that work.	tbc
Unknown Flu volumes	Planning for flu activity in line with last three years average.	M
Ongoing reduced capacity of discharge transport to maintain social distancing	Temporary transport solution in place to transfer HRW patients Reduced need for transport in outpatients due to move to a %age of e-consultations in support of switching to discharge activity.	H
Risk of transfer of patients to Care home due to COVID	Build confident in testing Capacity tracker shows isolation capability and capacity. Daily calls with Care Homes.	M

Plans for Winter 2020/21

Testing of plans – strengthening of plans for multiple care home failre

Risk	Current mitigation
Care home failure	1 Commissioning Capacity Tracker and daily contact with care homes to identify potentially vulnerable care homes so that early action can be taken and will support them in gaining access to agency/bank staff Further review of the Contingency Plan previously submitted to the ICB to take account of multiple failures to avoid patient harm and admissions to acute sites The Contingency Plan to cover i) containment ii) support from Integrated Commissioning, IPC and PH Teams iii) workforce support iv) temporary moves to other care homes v) use of Community Hospitals Action Cards setting out contacts and the escalation and response process will be produced for and communicated to Emergency Duty, Patient Flow and On Call Teams 2 Workforce Process of deployment support of CDDFT registered workforce into care homes A list of adult social care staff list based on skills and experience to be deployed to support care homes Wider pool of support being identified by partners who could offer support e.g. GPs, TEWV

Detailed documents for reference

CDDFT	Public Health Cold Weather Plan	Primary Care OPEL Framework	Adult and Social Care Durham	LADB OPEL	ICP OPEL
	Cold weather plan deadline for sign off is 11 October Adobe Acrobat Document	Microsoft Word Document	Included in the cold weather plan	Document under review Microsoft Word Document	Work in progress
NEAS	**Communications**	**Darlington PCN Flu Contingency**	**Adult and Social Care Darlington**	**Regional Flu Progamme**	**TEWV summer/ winter preparedness plan**
Microsoft verPoint Presentat	**TBYW to be added** Microsoft verPoint Presentat	Microsoft Word Document	Microsoft Word 7 - 2003 Documen		Adobe Acrobat Document

Adults Wellbeing and Health Overview and Scrutiny Committee

9 November 2020

Health Impact assessment for Health Inequalities During COVID-19

Report of Amanda Healy, Director of Public Health, Durham County Council

Electoral divisions affected:

Countywide

Purpose of the Report

1 The purpose of this report is to give the Adults Wellbeing and Health Overview and Scrutiny Committee an overview of the findings and recommendations taken from a Health Impact Assessment (HIA) on health inequalities conducted in response to the COVID-19 pandemic. The Health Impact assessment for Health Inequalities During COVID-19 in attached at Appendix 2.

Executive summary

2 The response to the COVID-19 pandemic has been developed over time to help contain the spread of the virus through local communities. On 23rd March 2020, the government introduced measures to help protect the public from COVID-19 by introducing Staying at Home and social distancing policies; staying at home is commonly referred to as 'lockdown'.

3 Evidence suggests the consequence of lockdown restrictions are likely to increase inequalities in our most deprived communities. This is due to the prolonged and predicted socio-economic impact of COVID-19 on individuals, families, communities and businesses.

4 The lockdown measures implemented have led to a range of new policies being developed to mitigate the spread of the virus. Areas impacted by lockdown have included health, social care, education, housing, criminal justice, communities, the environment, business and the economy.

5 In response, the County Durham and Darlington Health, Welfare and Communities Recovery Group initiated a rapid Health Impact

Assessment (HIA) to provide a ‘snapshot’ insight into the impact of COVID-19 lockdown on inequalities during the recovery and restoration phase of the pandemic.

6 From the HIA screening and prioritisation process undertaken, the priority high impact areas identified by the HIA requiring further action to mitigate against health inequalities are:

- Socio-economic factors - poverty reduction
- Mental health and emotional wellbeing
- Community assets and community mobilisation
- Inclusion of vulnerable groups integrated into the key priorities.

7 Areas of policy screened out the HIA prioritisation process remain significant and will continue to be monitored for outcomes within current delivery mechanisms e.g. the pause in housing evictions. This will help with the ongoing assessment of any changes in impacts occurring over the COVID-19 recovery timeframe These areas include:

- Education and skills
- Housing and homelessness
- Criminal justice
- Domestic abuse
- Healthcare
- Tobacco control
- Alcohol and drug harms

8. At the time of writing the HIA, the full impact of reduced access to health care for physical needs due to COVID-19 was not fully quantified (May - June 2020). Evidence emerging from Europe regarding mental health highlighted growing concerns. Subsequently, the 5-Year System Plan OGIM’s have been developed referencing the HIA to help frame each plans’ response to reducing inequalities across County Durham.

9. The findings and recommendations from the HIA will be developed into a system-wide Recovery Plan for Health Inequalities which will be integrated into key strategic partnership plans such as the Joint Health and Wellbeing Strategy and the County Durham System Plan.

Recommendations

10 The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to:

(a) Endorse the actions identified in the HIA to mitigate negative impacts and enhance positive impacts of the COVID-19 recovery response using a system wide approach.

(b) Promote the key priorities identified in the HIA with all partners to enable their integration into all strategies and polices as a contribution to reducing inequalities.

(c) Prioritise and promote the recommendations made in the HIA (see Appendix 3).

(d) Monitor data in priority areas to measure impact of future actions undertaken at a local level.

(e) Work with partners to build on learning and support preparations for any second wave or local outbreak situations.

Background

COVID-19 and Inequalities

11 There is clear evidence that the COVID-19 virus does not affect all population groups equally. Public Health England (PHE) indicate those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness due to COVID-19 (PHE, June 2020).

12 Many analyses have shown that older age, ethnicity, male sex, obesity and geographical area, for example, are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death.

13 The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. (PHE, June 2020).

14 Risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups.

15 In County Durham, the Gypsy, Roma, Traveller communities present the largest minority ethnic group, but are not systematically highlighted in BAME definitions.

16 The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure (PHE, 2020).

17 In March 2020, the Government Scientific Advisory Group for Emergencies (SAGE) advised that a combination of individual home isolation of symptomatic cases, household isolation and social distancing could have a positive effect on reducing the number of cases of COVID-19 (SAGE, 3rd March 2020).

18 On 16th March 2020, the UK Government introduced a shielding policy for the most vulnerable of our society and restrictions on non-essential contact and travel.

19 Evidence suggests the consequence of lockdown restrictions are also likely to increase inequalities in our most deprived communities. This is

due to the prolonged and predicted socio-economic impact of COVID-19 on individuals, families, communities and businesses.

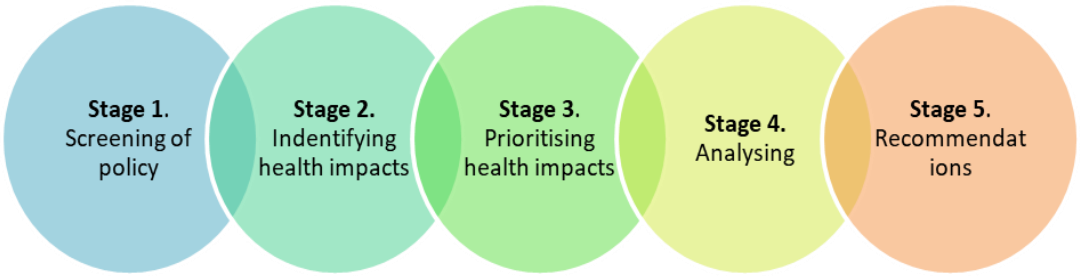
20 The lockdown measures implemented have led to a range of new policies being developed to mitigate the spread of the virus. Areas impacted by lockdown have included health, social care, education, housing, criminal justice, local communities, the environment, business and the economy.

21 The County Durham and Darlington Health, Welfare and Communities Recovery Group initiated a rapid HIA to provide a 'snapshot' insight into the impact of COVID-19 lockdown on inequalities during the recovery and restoration phase of the pandemic.

22 The HIA process was undertaken to inform a system-wide approach to mitigate against negative impacts of COVID-19 on inequalities and build on positive findings as part of the recovery response.

Health Impact Assessment

23 A HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of the population and the distribution of those effects within the population. The 5-stages of an HIA include:



24 The HIA developed by the Health Welfare and Communities Recovery Group focuses on the key determinants impacting on the direct and indirect consequences of physical health, mental health and emotional wellbeing, social and economic factors over Marmots' Life course (Marmot, 2010).

25 The engagement of the views of individuals, families, communities and businesses is key to providing the narrative from those directly experiencing the impact of the pandemic.

26 The HIA provides a system-wide focus on specific population groups impacted by COVID-19 and encourages the development of a place-based approach to reduce inequalities.

27 As part of the HIA screening process, local policies and approaches developed to reduce health inequalities have been screened and prioritised for impact. The screening matrix of the HIA highlighted positives and negatives of lockdown restrictions and timelines of short, medium and longer-term impact (see Appendix 4).

28 The screening enabled the ranking of key policy areas to help inform the progression into the assessment phase of the HIA which would ultimately inform the recommendations for action.

29 Those areas identified as high priority, but not taken forward as a priority for the HIA will continue to be monitored for impact and progressed through existing partnership forums as business as usual.

30 From the HIA screening and prioritisation process undertaken, the priority high impact areas identified by the HIA that require further action to mitigate against health inequalities are:

a) Socio-economic factors - poverty reduction

b) Mental health and emotional wellbeing

c) Community assets and community mobilisation

d) Inclusion of vulnerable groups integrated into the key priorities.

31 Areas of policy screened out the HIA prioritisation process remain significant and will continue to be monitored for outcomes within current delivery mechanisms. This will help with the ongoing assessment of any changes in impacts occurring over the COVID-19 recovery timeframe. These areas include:

- Education and skills
- Housing and homelessness
- Criminal justice
- Domestic abuse
- Health care
- Tobacco control
- Alcohol and Drug harms

32 The findings and recommendations from this HIA will be developed into a system-wide Recovery Plan for Health Inequalities in September 2020, which will be monitored for outcomes in 2020, 2021 and 2022.

Area Action Partnership Data Sets

33 During the HIA process, data relating to local residents has been assessed to determine the inequalities within County Durham communities. This data will be monitored on an ongoing basis over a short, medium and long-term timeframe (2020, 2021 and 2022), bolstered by COVID related data published by Public Health England (WICH data, PHE, publication date to be confirmed).

34 Local authorities have received a shielded NHS patient list, which provides dynamic information on individuals who have specific medical conditions. This puts those people at higher risk of severe illness should they contract COVID-19. There are currently, 25,909 people across County Durham included on this list.

35 The information contained in the shielding data set has been used to analyse need at a county wide level through the lens of poverty reduction, mental wellbeing community assets and BAME communities.

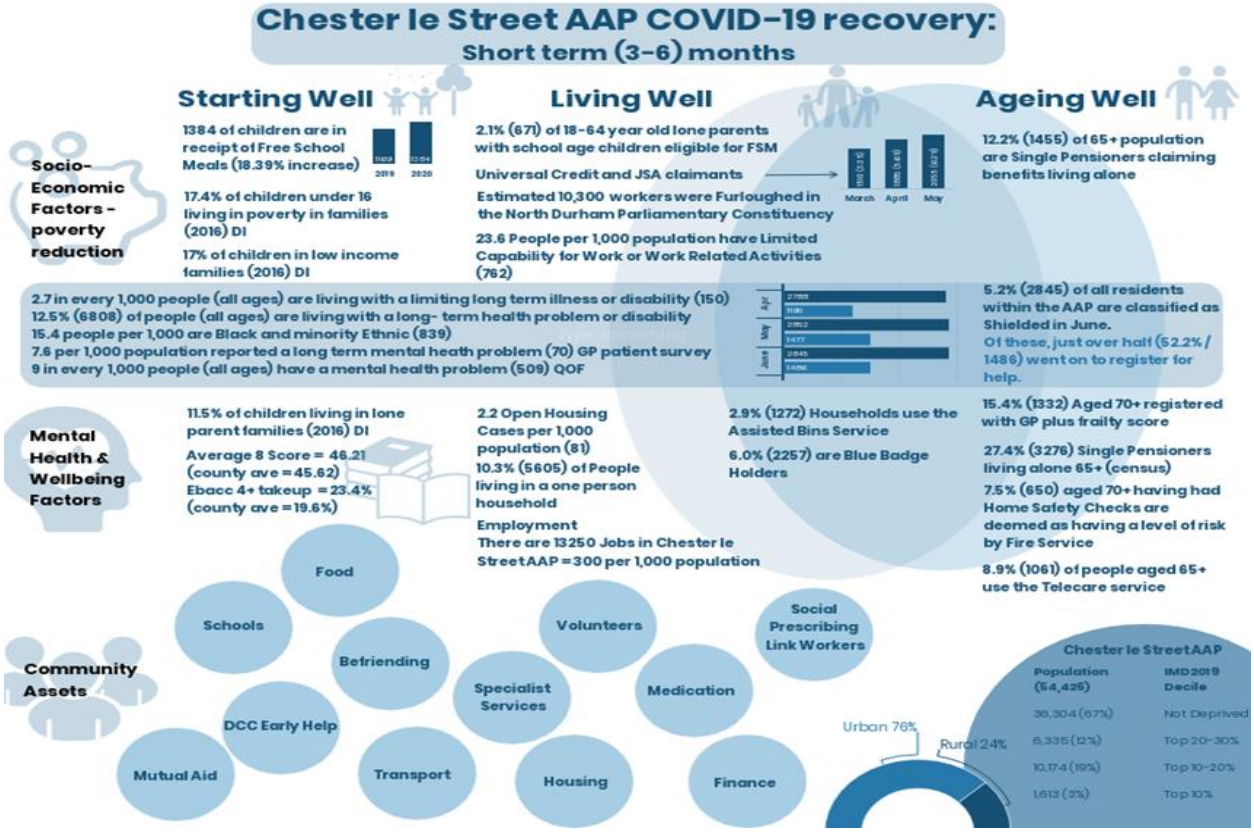
36 The data has then been segmented for each Area Action Partnership to help them understand the impact of COVID-19 on their communities and help in the planning process during each stage of recovery.

37 Data relating to Primary Care Networks boundaries is also being considered.

38 The monitoring process for the priorities warranting further assessment, as determined through the screening process require, where possible, ‘real time’ data to provide ongoing insight into any change in the needs of local communities.

39 The data sets will also provide the ongoing narrative underpinning the evidence base on the outcomes of the recovery and its impact on inequalities.

Figure 1. Example of AAP Infogram Chester leStreet



Recommendations from HIA

40 The key priorities identified by the HIA have been developed into a set of recommendations to address the findings on the HIA process (see Appendix 3).

41 The ask of all partners based within the health, welfare and community's system is to identify their contribution to reducing inequalities linked to the priority areas of socio-economic factors – poverty reduction, mental health and emotional wellbeing, building community assets and targeting the inclusion of minority ethnic groups.

42 This action can be achieved by reviewing all strategies and polices with an inequalities lens and contributing to the recommendation of the HIA. The County Durham 5-Year System Plan 2020-2025 (OGIM's), has been a positive example of this work being undertaken.

Conclusion

43 The response to the COVID-19 pandemic will continue to develop over time as the local communities in County Durham learn to live with the virus.

44 As a consequence of the pandemic and governmental policies, health inequalities are expected to rise in our most deprived communities. This will be due to the prolonged socio-economic impact of COVID-19 lockdown on residents, their families, the communities and local businesses.

45 The recovery phase to the pandemic instigated by health, social care, education, housing, criminal justice, communities, environment, business and the economy all need to adapt to the changes.

46 The Health Impact assessment for Health Inequalities during COVID-19 initiated by the County Durham and Darlington Health, Welfare and Communities Recovery Group has provided a 'snapshot' insight into the impact of COVID-19 lockdown using a place-based approach.

47 The focus on socio-economic factors impacting on levels of financial resilience, mental health and emotional wellbeing and the use of community assets and networks can now move into the action phase as part of the recovery process.

48 The requirement to ensure vulnerable, shielded and minority groups are targeted for consideration and has also been highlighted as a core function of helping to reduce inequalities especially as we aim to prevent a second wave and mitigate the risks of a local lockdown from occurring.

49 This includes ensuring early help, safeguarding, risk management and inclusion processes are implemented for the most deprived communities and proactive community engagement with communities least likely to engage with mainstream messaging to prevent the spread of the virus.

50 The recommendations made by the HIA present opportunities for all partners to work together to address the impacts of COVID-19 on health inequalities during 2020, 2021 and 2022.

Author

Jane Sunter, Public Health Strategic Manager Tel: 07825938455

Appendix 1: Implications

Legal Implications - The finding of the HIA do not incur any legal implications.

Finance - Multiple funding packages have been disseminated by HM Government to the local authority in response to COVID-19. No specific funding has been allocated to implement the recommendations of the HIA. All areas of work will be undertaken withing core funding allocated to the system and/or value added by COVID-19 monies.

Consultation - The HIA has developed by using partnership agencies to provide information on the impact of COVID-19 on specific community groups. The findings from the consultation process has been factored into the report. The Health, Welfare and Communities Recovery Group are currently considering further community engagement strategies to provide insight from local residents and vulnerable groups identified.

Equality and Diversity / Public Sector Equality Duty - Equity and the engagement of vulnerable and marginalised communities are highlighted within key findings and the recommendations of the HIA report. The effectiveness of the system to identify the needs of these communities during the pandemic will be monitored and part of the implementation of the HIA Action Plan (September 2020).

Climate Change - The impact of a reduced carbon footprint during COVID-19 has been identified within the HIA. This area for consideration will highlighted within the development of a local obesity strategy which will encourage the further development of a future obesogenic environment across the county by encouraging increases in green travel plans.

Human Rights - The World Health Organization has stated that stay-at-home measures for slowing down the pandemic must not be done at the expense of human rights, but there are risks that the impact of COVID-19 could have implications for increased stigmatisation, discrimination, racism and xenophobia. Impact on human right may also be may also be compromised by border controls and quarantine measures. At a local level there may be implications for an individual’s right to health and right to privacy.

Crime and Disorder - During the initial stages of COVID-19 lockdown there has been a reduction in crime and disorder issues being reported to Durham Constabulary. The HIA has identified crime and order as an area consideration requiring further monitoring as the lockdown restrictions are eased, and/or reintroduced over time.

Staffing - There are no staffing implications for the implementation of the HIA recommendations.

Accommodation - There are no implications on accommodation for the implementation of the HIA recommendations.

Risk - COVID-19 brings multiple risks to local residents in relation to increases in morbidity and mortality rates, socio-economic factors, increases in mental ill health, social isolation, community disengagement, stigma and discrimination. The risks have been identified as negative implications of COVID-19 lockdown within the HIA and have been addressed within the recommendations contained within the report.

Procurement - There are no implication for procurement for the implementation of the HIA recommendations at this current time.

Appendix 2: Health Impact assessment for Health Inequalities During COVID-19

The Executive Summary is attached as a separate document.

A full version of the document can be requested by emailing Jane.Sunter@durham.gov.uk

Appendix 3: HIA Recommendations

Using a system-wide approach	**Organisation**	**Timeline** **2020, 2021, 2022**
1. Ensure findings from this HIA are shared with regional partnerships such as the integrated care system and LA7 strategy group to work to reduce health inequalities across the NE	LA, NHS, VCSE, Businesses	Short term
2. Key findings and recommendations from HIA become embedded into existing local plans for recovery such as the refreshed joint health and wellbeing strategy	LA, NHS, VCSE, Businesses	Short term
3. Utilise the data and intelligence drawn from the HIA into all refreshed strategies to inform planning.	LA, NHS, VCSE, Businesses	Short term
4. Develop communication mechanisms to engage with the voice of children, young people and adults to ensure recovery is undertaken WITH our communities and not done to them	LA, NHS VCSE	Short, medium and long term
5. Develop and Ageing Well Strategy to inform future policy and service delivery across the system	LA, NHS VCSE	Short term
6. Focus targeted work on vulnerable and marginalised groups as part of COVID-19 recovery to reduce preventable inequalities	LA, NHS, VCSE, Businesses	Short, medium and long
7. Link to the County Durham Poverty Reduction Strategy and Poverty Reduction Action Plan to:		

i) Prioritise the reduction of food poverty through school-based and wider community approaches. ii) Improve all partner pathways to ensure understanding of how to access statutory and VCSE support iii) Train whole-system workforce to raise awareness of welfare support and impact money worries can have on health and wellbeing iv) Undertake a specific review to understand the impact on older people and poverty linked to an ageing well strategy.	Schools and VCSE LA, NHS LA, NHS, VCSE LA, NHS, VCSE, Businesses LA, NHS	Short, medium and long Short term Medium and long-term Medium and long-term
8. Link to the County Durham Mental Health Strategic Partnership to: i. Increase access to low level early mental health support pathways for children and young people within educational and community settings – graded response and trauma informed. Consideration given for most vulnerable populations such as LGBTQ+. ii. Using population health management approaches and forecasting across the system, consider how to support prevention and early intervention to mitigate as far as possible any increased demand to secondary care iii. Develop and implement a streamlined information resource to provide access for communities and individuals to support for mental health and emotional wellbeing iv. Train system-wide workforces to address mental health and emotional wellbeing in local communities. – mental health champions and MECC	LA, educational settings NHS, VCSE LA, NHS, VCSE, Businesses	Short, medium, long term Short, medium, long term

v.	Develop system response and offer to support the workforce (key workers) with a mental health and emotional wellbeing needs/moral injury that have developed as a result of COVID-19, eg through development of a resilience hub	MHSP	Medium and long term
vi.	Provide targeted support for COVID survivors and their families – CDDFT, TEWV, VCSE, Primary Care	LA, NHS, VCSE, Businesses	Medium, Long term
vii.	Undertake consultation with older people and carers as part of a developing ageing well strategy	TEWV, CDDFT, VCSE, Primary Care	Short, medium, long term
		TEWV, CDDFT, VCSE, Primary Care	Short, medium and long term
		LA, NHS, VCSE	Medium and long term
9.	**Build resilience in community assets and community networks to:**		
i.	Maintain and further develop the Community Hub to continue engagement with vulnerable and shielded populations ensuring system interface	LA, NHS	Short, medium
ii.	Map and add to Locate community assets to provide ongoing support for local residents utilising a place-based approach.		
iii.	Improve service user pathways to access statutory and VCSE support mechanisms as standard.		
iv.	Support the VCSE by providing sustained funding and measure outcomes to beneficiaries.	LA	Short, medium

v.	Maintain support for volunteers and increase options to recruit more.	LA, NHS	Short, medium
vi.	Progress Alliance contracting model to build community resilience.	LA, VCSE	Short, medium and long
vii.	Adopt the wellbeing approach across County Durham		Medium and long
viii.	Ensure the community is prepared to respond to a second wave and local outbreaks	LA, VCSE	Medium and long
		LA, VCSE	Short, medium and long
		LA, NHS, VCSE, Businesses	Short, medium and long
		LA, NHS, VCSE, Businesses	

Appendix 4: Results from HIA Impact Prioritising Process

Policy/area of approach	Impact ranking	Positive and negative impacts	Timeframe
Socio-economic factors and Poverty Employment Income	**High Impact** - due to financial implications for universal populations and vulnerable groups. Inequalities to be increased highly likely **Outcome: Screened In** Due to lasting legacy of rise in unemployment, financial resilience, housing, mental ill health, relationship breakdown and community cohesion – warrants further assessment of health inequalities.	**Negatives**: impact may increase over time as recession hits. implications for those losing their jobs as financial packages are withdrawn. **Positives:** opportunities to innovate, find new ways of working, increase efficiency and local investment to help stimulate the economy	Short, medium and long term – especially linked to mental health and emotional wellbeing.
Education and Skills	**Medium Impact** – universal populations and vulnerable groups. **Outcome: Screened out** as national government direction is for all schools,	**Negatives**: Depends on how long social distancing in educational settings is maintained. May be some legacy for	Medium and long term depending on duration of lockdown restrictions in

	colleges, universities to return to the new normal in September 2020. The mental health impact on CYP is considered separately rather than as part standalone education health impact and so does not warrant further assessment as stand-alone policy area	impact on certain age groups. Lack of access to IT equipment is a barrier to learning. Impact on young people in general having school disruption and reduced social contact is predicted to impact on mental wellbeing over years to come as well as potential for disruption educational attainment	educational setting.
		Positives: home schooling has enabled young people to reconnect with families, local CYP report increased levels of mental wellbeing by not being at school (see local voice section).	

Housing and homelessness	**Medium Impact** – universal and vulnerable groups **Outcome: screened out** for health inequality impacts at this current stage due to capacity meeting demand but requires monitoring into the longer term. Health impact will be explored through the poverty / welfare policy area instead of housing as stand alone	**Negatives**: Impact may increase as potential unemployment levels rise and/or recession hits. Full extent on future demand is unknown. **Positive:** Capacity has met demand. Potential homelessness has been managed during lockdown.	Medium and long term - especially linked to impacts of socio-economic status and predicted changes
Inclusion BAME GRT Refugees LGBT+ LD and Autism Carers	**High Impact –** due to vulnerabilities, low socio-economic status, poor housing, poor health status., specialist needs, higher risk of COVID-19 **Outcome: Screened in -** to be integrated in other of other areas around poverty, mental health and community networks and mobilisation and warrants further assessment	**Negatives:** inequalities in vulnerabilities to COVID-19. Lack of access to specialist support. Low socio-economic status for some groups, social isolation. **Positives:** opportunity for further investigation in to needs for	Short and medium depending on timescales for lockdown

		some vulnerable groups.	
Mental Health and Emotional Wellbeing CYP LTP Suicide Prevention – including bereavement support. Crisis care Dementia Resilient Communities	**High Impact** – increasing in general population over time and within vulnerable groups. **Outcome: Screened In –** due to long term implications of impacts on mental wellbeing and requires further assessment to understand impact	**Negatives -** Will be ongoing as the predicted impact on socio-economic growth, unemployment, poverty levels may be affected. Impact CYP and ACE's. Impact on VSCE may also reduce access to wellbeing support and wider mental health services. reports on impacts on confidence returning to the new normal. . **Positives –** reports of reconnecting with families. Reduction in external	Short, medium and long term – especially linked to impacts of socio-economic impacts.

		stressors e.g. schools. Slower pace of life	
Criminal Justice	**Medium impact** – due to current lower levels of reporting crime, but could increase over time. **Outcome – Screened out** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the longer term.	**Negatives -** Impact levels may increase as crime resumes, incidence of poverty and poor mental health increases. **Positives** – current capacity has met demand for criminal justice pathways and support	Medium to long term – linked to socio-economic factors and mental wellbeing.
Domestic Abuse	**Medium impact** – which could minimise during the lift of lockdown, or increase as socio-economic hardship increases. **Outcome: Screened Out -** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term. Being	**Negatives** – reports of hidden harm on the increase with the inability to report during short term stage of lockdown. Will add to impact of CYP and ACE's	Short, medium and long term - linked to socio-economic factors and mental wellbeing.

	considered within existing infrastructures of DASVEG	**Positives -** Service provision has been increased 24/7. Uplift from government support has also been given during COVID. Requires close monitoring as recovery develops.	
Safeguarding CYP Vulnerable adults	**High Impact** – which could minimise during the lift of lockdown,or increase as socio-economic hardship increases. requires on-going monitoring Outcome - Screened Out - for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term. Being considered within existing infrastructures SAB and DSCP	**Negative** full extent of hidden harm not yet known with the inability to report during short term stage of lockdown. ACE's for CYP may increase. **Positives** – robust mechanisms in place to maintain monitoring of safeguarding concerns via SAB and DSCP	Short, medium and long term - linked to socio-economic factors and mental wellbeing.

Community networks and mobilisation through Community Hub and VCSE	**High Impact** – due to capacity of VCSE. Impact of funding, staffing and accessibility into services. targeted approaches to the shielded and most vulnerable and so inequalities in access may widen **Outcome: Screened In –** due to the potential demand on services required to respond to growing needs on the community to mitigate health inequalities	**Negatives -** Full impact is still unknown as lockdown lifts, COVID-19 funding for VCSE runs out at the end of July. Demand on services may increase whilst VCSE capacity contracts. **Positives** – many residents report high levels of resilience for self-management of needs. Success of community Hub, high level of activity for VCSE, especially in mutual aid.	Short, medium and long term – depending on timing of lifting of lockdown and financial resilience of the sector.
Healthcare - 5-Year System Plan Access Screening LTC	**High impact** – depending on the ability of CCG's/PCN's,CDDFT/TEWV to be able to respond to need. **Outcome: Screened out** - Requires connection into	**Negatives** – potential for services to become over burdened with demand. Reduction in those most in need accessing	Medium and long term as residents begin to access healthcare

	NHS system planning group to monitor service delivery to meet demand and manage inequalities during recovery.	services including imms and vacs, treatment for acute and long- term conditions. **Positives** - Acceleration of integration agenda in response to COVID-19 between partner organisations	
Tobacco Control	**Medium/Low Impact** – prevalence of smoking and any increase unknown at the current time **Outcome:** Screened Out – monitored via existing channels. Full COVID-19 action plan delivered within short term timeframe - completed	**Negative** – lack of perceived access to stop smoking services. Smoking prevalence may increase during increase in challenging socio-economic times **Positives** - Stopping smoking is key to improving life chances Service has been maintained during	Short, medium, long term - linked to socio-economic factors and mental wellbeing.

		lockdown. Wider tobacco control work has been adapted to maintain functions.	
Alcohol and Drug Harm Reduction	**Medium/low** Impact – regional reports suggest alcohol intake may have increased in the most vulnerable. Drug use is maintained at current levels. This may increase due to socio-economic factors and requires monitoring. **Outcome: Screened out -** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term.	**Negatives** - May increase as recovery progresses due to socio-economic factors. **Positives** - County Durham Drug and Alcohol Recovery Service has had an increase in clients accessing the service and current clients remain stable**.**	Medium to long term - linked to socio-economic factors and mental wellbeing.
Environment – Urban and rural	**Current low-medium impact** – impact reduced as lockdown has lifted	**Negatives** – social isolation may increase, especially for vulnerable and shielded populations.	Short to Medium – depending on ability to access to the outside environment

	Outcome: Screened Out – due to the easing of lockdown restrictions.	**Positives -** Physical activity levels have reported to have increased. Climate change has benefitted from less carbon emissions due to less traffic.	

County Durham

Health Impact Assessment on Health Inequalities in Response to the COVID-19 Pandemic

June 2020

Acknowledgements

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Jane Sunter
Public Health Strategic Manager – Living and Ageing Well
County Durham Council
Jane.Sunter@durham.gov.uk

Contents

Executive Summary

1. The response to the COVID-19 pandemic has been developed over time to help contain the spread of the virus through local communities. On 23rd March the government introduced measures to help protect the public by introducing Staying at Home and social distancing policies; staying at home commonly referred to as 'lockdown'.

2. There is growing evidence suggesting the consequence of lockdown restrictions are likely to increase inequalities in our most deprived communities. This is due to the prolonged socio-economic impact of COVID-19 on individuals, families, communities and businesses.

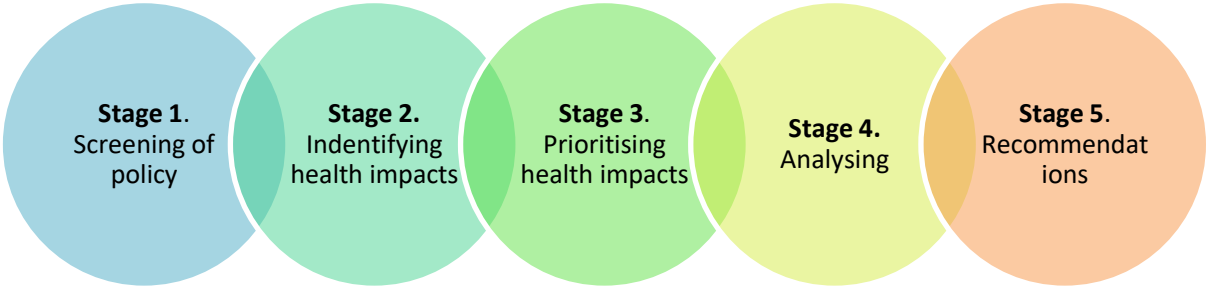
3. The recovery phase to the pandemic is an evolving process and the evidence-base continually growing. The lockdown measures implemented have led to a range of new policies being developed to mitigate the spread of the virus. Areas of impact have included health, social care, education, housing, criminal justice, communities, environment, business and the economy.

4. The County Durham and Darlington Health, Welfare and Communities Recovery Group have initiated a rapid Health Impact Assessment (HIA) on health inequalities to provide a 'snapshot' insight into the impact of COVID-19 lockdown during the recovery and restoration phase of the pandemic.

5. The findings and recommendations from this HIA will be developed into a system-wide Recovery Plan for Health Inequalities. This can then be used by all partners to ensure the recommendations are integrated into their own policies and approaches, helping to mitigate against the impact on health inequalities during COVID-19 recovery.

What is a Health Impact Assessment?

6. A HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of the population and the distribution of those effects within the population. The stages of an HIA include:



7. The HIA process provides an appraisal of the assets that can be built upon to help reduce health inequalities and work towards minimising risks within identified populations.

8. Indicators will be developed as part of the HIA process to measure the actual impact of COVID-19 across the system on a short, medium and long-term basis. This will be within 2020, 2021 and 2022.

9. This HIA focuses on the key determinants impacting on the direct and indirect consequences of physical health, mental health and emotional wellbeing, social and economic factors over the life course.

10. The engagement of the views of individuals, families, communities and businesses has also been key, helping to provide the narrative from those directly experiencing the impact of the pandemic. Due to the speed of completing this rapid HIA this has been limited but ongoing dialogue is planned.

11. Due to the fast pace nature of the pandemic, this HIA has been conducted as a rapid process to enable the Health, Welfare and Communities group to identify both positive and negatives impacts of the COVID-19 lockdown restrictions and work accordingly to mitigate against identified risks.

12. Findings from the impact assessment can be used by decision makers to:

- Identify actions to mitigate negative impacts and enhance positive impacts of the COVID-19 recovery response using a system wide approach.
- Integrate the key priorities identified by the HIA into all strategies and polices to contribute to a reduction in inequalities.
- Contribute to the recommendations made.
- Monitor data in priority areas to measure impact of future actions undertaken at a local level.
- Build on learning and support preparations for any second wave or local outbreak situations

COVID-19 and Health Inequalities

13. The Government Scientific Advisory Group for Emergencies (SAGE) advised that a combination of individual home isolation of symptomatic cases, household isolation and social distancing could have a positive effect on reducing the number of cases of COVID-19 (SAGE, 3rd March 2020).

14. On 16th March 2020, the UK Government introduced a shielding policy for the most vulnerable of our society and restrictions on non-essential contact and travel.

15. There is clear evidence that COVID-19 does not affect all population groups equally. Public Health England (PHE) indicate those with underlying medical

problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness due to COVID-19 (PHE, June 2020).

16. Many analyses have shown that older age, ethnicity, male sex and geographical area, for example, are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death.

17. The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. Genetics were not included in the scope of the review (PHE, June 2020).

18. Risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups.

19. The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure (PHE, 2020).

HIA Screening

20. The HIA provides a system-wide focus on specific population groups impacted by COVID-19 and encourages the development of a place-based approach to reduce inequalities.

21. Local policies and approaches developed to reduce health inequalities have been screened and prioritised for impact. The screening matrix of the HIA highlighted positives and negatives of lockdown restrictions and timelines of short, medium and longer-term impact.

22. The screening enabled the ranking of key policy areas to help inform the progression into the assessment phase of the HIA which would ultimately inform the recommendations for action.

23. This stage helped partners focus on key areas of highest concern and what would be in and out of scope for this rapid HIA. The areas of highest concern would be screened in-scope to warrant further exploration at the assessment phase.

24. Those areas identified as high priority, but not taken forward as a priority for the HIA will continue to be monitored for impact and progressed through existing partnership forums as business as usual.

Table 1. Results from the HIA Screening process to Identify Priorities.

Policy/area of approach	Impact ranking	Positive and negative impacts	Timeframe
Socio-economic factors and Poverty Employment Income	**High Impact** - due to financial implications for universal populations and vulnerable groups. Inequalities to be increased highly likely **Outcome: Screened In** Due to lasting legacy of rise in unemployment, financial resilience, housing, mental ill health, relationship breakdown and community cohesion – warrants further assessment of health inequalities.	**Negatives**: impact may increase over time as recession hits. implications for those losing their jobs as financial packages are withdrawn. **Positives:** opportunities to innovate, find new ways of working, increase efficiency and local investment to help stimulate the economy	Short, medium and long term – especially linked to mental health and emotional wellbeing.
Education and Skills	**Medium Impact** – universal populations and vulnerable groups. **Outcome: Screened out** as national government direction is for all schools, colleges, universities to return to the new normal in September 2020. The mental health impact on CYP is considered separately rather than as part standalone education health impact and so does not warrant further assessment as stand alone policy area	**Negatives**: Depends on how long social distancing in educational settings is maintained. May be some legacy for impact on certain age groups. Lack of access to IT equipment is a barrier to learning. Impact on young people in general having school disruption and reduced social contact is predicted to impact on mental wellbeing over years to come as well as potential for disruption educational attainment **Positives:** home schooling has enabled young people to reconnect with families, local CYP report increased levels of mental wellbeing by not being at school (see local voice section).	Medium and long term depending on duration of lockdown restrictions in educational setting.
Housing and homelessness	**Medium Impact** – universal and vulnerable groups **Outcome: screened out** for health inequality impacts at this current stage due to capacity meeting demand but requires monitoring into the longer term. Health impact will be explored through the poverty / welfare policy area instead of housing as stand alone	**Negatives**: Impact may increase as potential unemployment levels rise and/or recession hits. Full extent on future demand is unknown. **Positive:** Capacity has met demand. Potential homelessness has been managed during lockdown.	Medium and long term -especially linked to impacts of socio-economic status and predicted changes
Inclusion BAME GRT Refugees LGBT+	**High Impact –** due to vulnerabilities, low socio-economic status, poor housing, poor health status., specialist needs, higher risk of COVID-19	**Negatives:** inequalities in vulnerabilities to COVID-19. Lack of access to specialist support. Low socio-economic	Short and medium depending on timescales for lockdown

LD and Autism Carers	**Outcome: Screened in -** to be integrated in other of other areas around poverty, mental health and community networks and mobilisation and warrants further assessment	status for some groups, social isolation. **Positives:** opportunity for further investigation in to needs for some vulnerable groups.	
Mental Health and Emotional Wellbeing CYP LTP Suicide Prevention – including bereavement support. Crisis care Dementia Resilient Communities	**High Impact** – increasing in general population over time and within vulnerable groups. **Outcome: Screened In –** due to long term implications of impacts on mental wellbeing and requires further assessment to understand impact	**Negatives -** Will be ongoing as the predicted impact on socio-economic growth, unemployment, poverty levels may be affected. Impact CYP and ACE's. Impact on VSCE may also reduce access to wellbeing support and wider mental health services. reports on impacts on confidence returning to the new normal. . **Positives –** reports of reconnecting with families. Reduction in external stressors e.g. schools. Slower pace of life	Short, medium and long term – especially linked to impacts of socio-economic impacts.
Criminal Justice	**Medium impact** – due to current lower levels of reporting crime, but could increase over time. **Outcome – Screened out** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the longer term.	**Negatives -** Impact levels may increase as crime resumes, incidence of poverty and poor mental health increases. **Positives** – current capacity has met demand for criminal justice pathways and support	Medium to long term – linked to socio-economic factors and mental wellbeing.
Domestic Abuse	**Medium impact** – which could minimise during the lift of lockdown, or increase as socio-economic hardship increases. **Outcome: Screened Out -** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term. Being considered within existing infrastructures of DASVEG	**Negatives** – reports of hidden harm on the increase with the inability to report during short term stage of lockdown. Will add to impact of CYP and ACE's **Positives -** Service provision has been increased 24/7. Uplift from government support has also been given during COVID. Requires close monitoring as recovery develops.	Short, medium and long term - linked to socio-economic factors and mental wellbeing.

Safeguarding CYP Vulnerable adults	**High Impact** – which could minimise during the lift of lockdown,or increase as socio-economic hardship increases. requires on-going monitoring Outcome - Screened Out - for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term. Being considered within existing infrastructures SAB and DSCP	**Negative** full extent of hidden harm not yet known with the inability to report during short term stage of lockdown. ACE's for CYP may increase. **Positives** – robust mechanisms in place to maintain monitoring of safeguarding concerns via SAB and DSCP	Short, medium and long term - linked to socio-economic factors and mental wellbeing.
Community networks and mobilisation through Community Hub and VCSE	**High Impact** – due to capacity of VCSE. Impact of funding, staffing and accessibility into services. targeted approaches to the shielded and most vulnerable and so inequalities in access may widen **Outcome: Screened In –** due to the potential demand on services required to respond to growing needs on the community to mitigate health inequalities	**Negatives -** Full impact is still unknown as lockdown lifts, COVID-19 funding for VCSE runs out at the end of July. Demand on services may increase whilst VCSE capacity contracts. **Positives** – many residents report high levels of resilience for self-management of needs. Success of community Hub, high level of activity for VCSE, especially in mutual aid.	Short, medium and long term – depending on timing of lifting of lockdown and financial resilience of the sector.
Healthcare - 5-Year System Plan Access Screening LTC	**High impact** – depending on the ability of CCG's/PCN's,CDDFT/TEWV to be able to respond to need. **Outcome: Screened out** - Requires connection into NHS system planning group to monitor service delivery to meet demand and manage inequalities during recovery.	**Negatives** – potential for services to become over burdened with demand. Reduction in those most in need accessing services including imms and vacs, treatment for acute and long-term conditions. **Positives** - Acceleration of integration agenda in response to COVID-19 between partner organisations	Medium and long term as residents begin to access healthcare
Tobacco Control	**Medium/Low Impact** – prevalence of smoking and any increase unknown at the current time **Outcome:** Screened Out – monitored via existing channels. Full COVID-19 action plan delivered within short term timeframe - completed	**Negative** – lack of perceived access to stop smoking services. Smoking prevalence may increase during increase in challenging socio-economic times **Positives** - Stopping smoking is key to improving life chances Service has been maintained during lockdown. Wider tobacco control work has been adapted to maintain functions.	Short, medium, long term - linked to socio-economic factors and mental wellbeing.

Alcohol and Drug Harm Reduction	**Medium/low** Impact – regional reports suggest alcohol intake may have increased in the most vulnerable. Drug use is maintained at current levels. This may increase due to socio-economic factors and requires monitoring. **Outcome: Screened out -** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term.	**Negatives** - May increase as recovery progresses due to socio-economic factors. **Positives** - County Durham Drug and Alcohol Recovery Service has had an increase in clients accessing the service and current clients remain stable**.**	Medium to long term - linked to socio-economic factors and mental wellbeing.
Environment – Urban and rural	**Current low-medium impact** – impact reduced as lockdown has lifted **Outcome: Screened Out –** due to the easing of lockdown restrictions.	**Negatives** – social isolation may increase, especially for vulnerable and shielded populations. **Positives -** Physical activity levels have reported to have increased. Climate change has benefitted from less carbon emissions due to less traffic.	Short to Medium – depending on ability to access to the outside environment

25. From the screening and prioritisation process undertaken, the priority high impact areas identified by the HIA that require further action to mitigate against health inequalities are:

- Socio-economic factors - poverty reduction
- Mental health and emotional wellbeing
- Community assets and community mobilisation
- Inclusion of vulnerable groups integrated into the key priorities.

26. Safeguarding and risk management processes will continue to be an integrated throughout the priority workstreams by everyone in the system. Governance for activity in the areas highlighted will be recognised as normal practice in County Durham by the Local Children's Safeguarding Partnership and the Adult Safeguarding Board as part of mandatory functions.

27. It is important to note that the areas screened out during the HIA prioritisation process remain significant and will continue to be monitored for outcomes within current delivery mechanisms. This will help with the ongoing assessment of any changes in impacts occurring over the COVID-19 recovery timeframe. These areas include:

- Education and skills
- Housing and homelessness
- Criminal justice
- Domestic abuse
- Health care
- Tobacco control
- Alcohol and Drug harms

- Environment – urban and rural, obesity, food, active travel and carbon emissions

Monitoring and Data Sets - Assessment of Need

28. To understand the impact of lockdown, data relating to local residents has been assessed to determine the inequalities within County Durham communities which can then be monitored over a short, medium and long-term timeframe.

29. Local authorities have received a shielded NHS patient list, which has been used as an overarching, ongoing data set. The list is dynamic, providing information on individuals who have specific medical conditions, putting them at higher risk of severe illness should they contract COVID-19. There are currently, 25,909 people across County Durham included on this list.

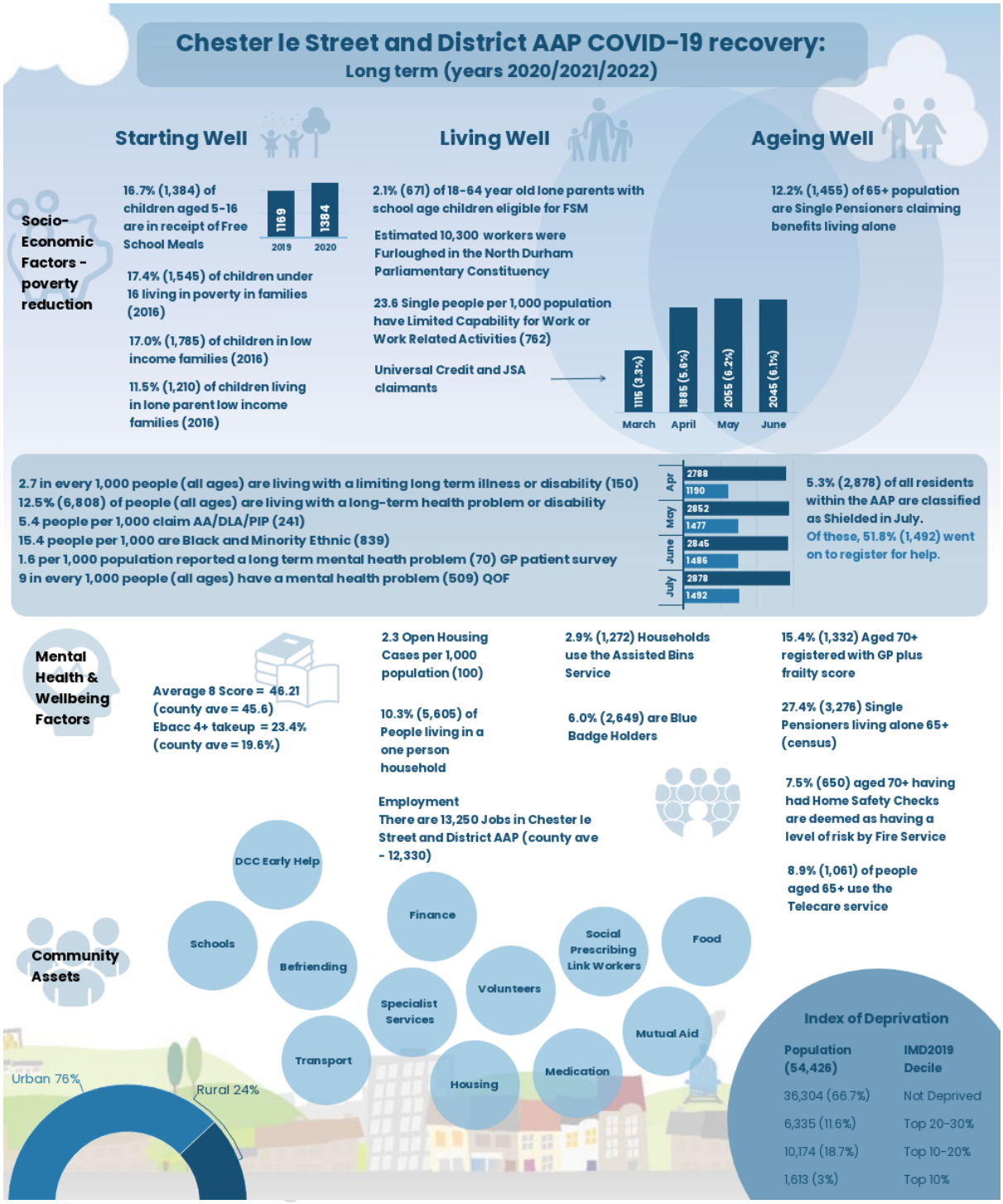
30. The information contained in the shielding data set can be used to analyse need at a county wide level through the lens of poverty reduction, mental wellbeing and community assets. This data can then be segmented into Area Action Partnership level to help understand the impact of COVID-19 during each stage of recovery.

31. Data relating to Primary Care Networks boundaries can also be provided as COVID-19 recovery progresses.

32. The monitoring process for the priorities warranting further assessment, as determined through the screening process require, where possible, 'real time' data to provide ongoing insight into any change in the needs of local communities.

33. The data sets will also provide the ongoing narrative underpinning the evidence base on the outcomes of the recovery and its impact on inequalities.

Diagram 1. Example of Area Action Partnership Infogram highlighting data sets linked to inequalities in priority areas across the life course.



Conclusion

34. The response to the COVID-19 pandemic will continue to develop over time as communities learn to live with the virus until a vaccine can be sourced. Until that time, measures to protect the public including varying policies for social distancing will be maintained.

35. The recovery phase to the pandemic including health, social care, education, housing, criminal justice, communities, environment, business and the

economy will need to adapt to the changes once the restrictions are lifted and the economy reopens, and inequalities are closely monitored.

36. There is recognition that the pandemic has brought many negative areas of impact to people's lives, but also some positives. The ability to innovate the delivery of care and share common practice has accelerated the pace of change for new ways of working to reduce health inequalities. These developments can be maximised to move system-wide approaches into the 'new' normal.

37. The areas prioritised by the HIA including socio-economic factors, mental health and emotional wellbeing, the use of community assets and inclusion can now inform the action phase of recovery for health, welfare and local communities.

Recommendations.

Using a system-wide approach	**Organisation**	**Timeline 2020, 2021 and 2022**
1. Ensure findings from this HIA are shared with regional partnerships such as the integrated care system and LA7 strategy group to work to reduce health inequalities across the NE	LA, NHS, VCSE, Businesses	Short term
2. Key findings and recommendations from HIA become embedded into existing local plans for recovery such as the refreshed joint health and wellbeing strategy	LA, NHS, VCSE, Businesses	Short term
3. Utilise the data and intelligence drawn from the HIA into all refreshed strategies to inform planning.	LA, NHS, VCSE, Businesses	Short term
4. Develop communication mechanisms to engage with the voice of children, young people and adults to ensure recovery is undertaken WITH our communities and not done to them	LA, NHS VCSE	Short, medium and long term
5. Develop and Ageing Well Strategy to inform future policy and service delivery across the system	LA, NHS VCSE	Short term
6. Focus targeted work on vulnerable and marginalised groups as part of COVID-19 recovery to reduce preventable inequalities	LA, NHS, VCSE, Businesses	Short, medium and long
7. Link to the County Durham Poverty Reduction Strategy and Poverty Reduction Action Plan to:		

i)	Prioritise the reduction of food poverty through school-based and wider community approaches.	Schools and VCSE LA, NHS	Short, medium and long
ii)	Improve all partner pathways to ensure understanding of how to access statutory and VCSE support	LA, NHS, VCSE	Short term
iii)	Train whole-system workforce to raise awareness of welfare support and impact money worries can have on health and wellbeing	LA, NHS, VCSE, Businesses	Medium and long-term
iv)	Undertake a specific review to understand the impact on older people and poverty linked to an ageing well strategy.	LA, NHS	Medium and long-term
8.	**Link to the County Durham Mental Health Strategic Partnership to:**		
i.	Increase access to low level early mental health support pathways for children and young people within educational and community settings – graded response and trauma informed. Consideration given for most vulnerable populations such as LGBTQ+.	LA, educational settings NHS, VCSE	Short, medium, long term
ii.	Using population health management approaches and forecasting across the system, consider how to support prevention and early intervention to mitigate as far as possible any increased demand to secondary care	LA, NHS, VCSE, Businesses	Short, medium, long term
iii.	Develop and implement a streamlined information resource to provide access for communities and individuals to support for mental health and emotional wellbeing	MHSP	Medium and long term
iv.	Train system-wide workforces to address mental health and emotional wellbeing in local communities. – mental health champions and MECC	LA, NHS, VCSE, Businesses	Medium, Long term
v.	Develop system response and offer to support the workforce (key workers) with a mental health and emotional wellbeing needs/moral injury that have developed as a result of COVID-19, eg through development of a resilience hub	TEWV, CDDFT, VCSE, Primary Care	Short, medium, long term
vi.	Provide targeted support for COVID survivors and their families – CDDFT, TEWV, VCSE, Primary Care	TEWV, CDDFT, VCSE, Primary Care LA, NHS, VCSE	Short, medium and long term

vii.	Undertake consultation with older people and carers as part of a developing ageing well strategy		Medium and long term
9.	**Build resilience in community assets and community networks to:**		
i.	Maintain and further develop the Community Hub to continue engagement with vulnerable and shielded populations ensuring system interface	LA, NHS	Short, medium
ii.	Map and add to Locate community assets to provide ongoing support for local residents utilising a place-based approach.	LA	Short, medium
iii.	Improve service user pathways to access statutory and VCSE support mechanisms as standard.	LA, NHS	Short, medium
iv.	Support the VCSE by providing sustained funding and measure outcomes to beneficiaries.	LA, VCSE	Short, medium and long
v.	Maintain support for volunteers and increase options to recruit more.	LA, VCSE	Medium and long
vi.	Progress Alliance contracting model to build community resilience.	LA, VCSE	Medium and long
vii.	Adopt the wellbeing approach across County Durham	LA, NHS, VCSE, Businesses	Short, medium and long
viii.	Ensure the community is prepared to respond to a second wave and local outbreaks	LA, NHS, VCSE, Businesses	Short, medium and long

Introduction

35. The first cases of COVID-19 in the UK were reported on the 31st January 2020. As the infection rate increased the government responded by publishing health protection regulations on 19th February 2020.

36. The introduction of the Coronavirus Act on the 19th March granted the government emergency powers over the NHS, local authorities, schools, funerals, police, Border Force and courts to build on strategies for containment and isolation, hoping to stop the spread of the virus.

37. On 23rd March the government announced restrictions on movement for the population in the form of Stay at Home policies and social distancing

measures, commonly referred to as ‘lockdown’. These measures included going outside only for:

- Shopping for essential supplies only and as infrequently as possible
- One form of exercise a day - for example a walk, run or cycle with members of your household only
- Fulfilling a care need for medication or to support a vulnerable person
- Travelling to and from work, but only where necessary and working could not be done from home.

38. As the pandemic has unfolded, growing evidence suggests the consequence of lockdown restrictions and social distancing are likely to increase inequalities in our most deprived communities. This will be due to the prolonged socio-economic impact of COVID-19 lockdown.

39. This Health Impact Assessment (HIA) will consider the impact of the restriction measures implemented to help slow the transmission of the virus and make recommendations contributing to reducing health inequalities in County Durham.

40. The findings of the HIA will be reviewed by the Health, Welfare and Communities Recovery Group and presented at the Recovery Group and Local Resilience Forum before progressing to the Health and Wellbeing Board.

41. Once agreed, the recommendations will be shared with wider partners to help influence the integration of a COVID-19 recovery into local strategies, policies plans.

42. This action will help mitigate against a rise in health inequalities during the recovery stages of the pandemic.

What is a Health Impact Assessment?

43. A HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of the population and the distribution of those effects within the population.

44. The proposed HIA on COVID-19 will enable County Durham to assess the impact of policies and guidance measures developed to manage the response to the pandemic.

45. The assessment will also provide an appraisal of the assets that can be built upon to help reduce health inequalities and work towards minimising risks within the identified populations.

46. This HIA will work across the life course to address need at a local level. The engagement of the views of those directly experiencing the pandemic will also be incorporated into the findings.

47. Indicators will be developed as part of the HIA process to measure the actual impact of COVID-19 across the system on a short, medium and long-term basis.

48. Outcomes relating to wider determinants, including poverty, housing, education, environment, volunteering, community assets and connections will be considered for further assessment.

49. The HIA will be undertaken using the principles taken from the Health Welfare and Communities Group which endorses an approach of:

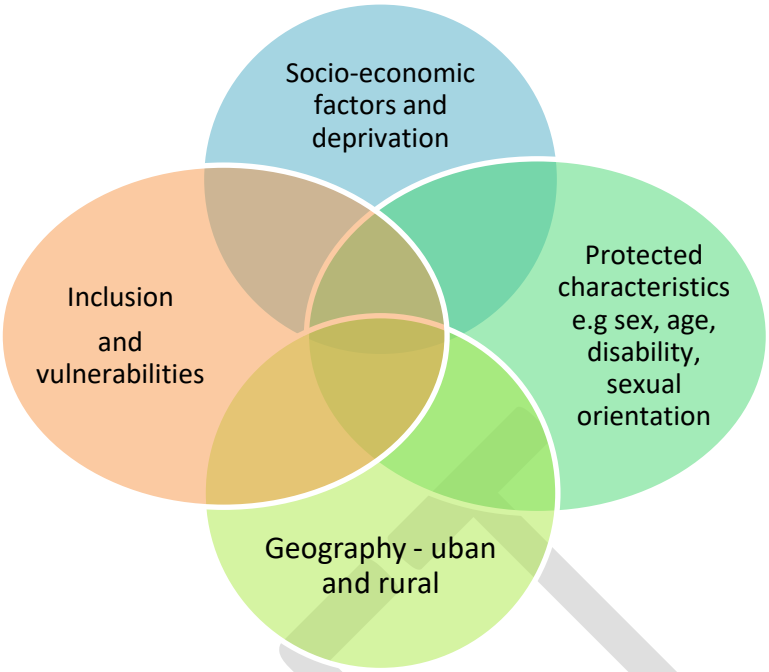
- Tackling inequalities across the life course and settings.
- Working at the level of pace that is most meaningful to communities (and people)
- Co-production with our communities to build on an asset-based approach for recovery
- Appreciating the interdependencies across organisations and departments using existing structures and governance where possible.
- Avoidance of inadvertently shunting pressures or risks to other parts of the system

50. The HIA recommendations will also be framed within the new Approach to Wellbeing being developed in County Durham and be intelligence led. This approach uses set criteria to ensure health and wellbeing is integrated into a range of recovery policies and settings as part of everyday practice.

What are health Inequalities?

51. Health inequalities are the preventable differences in health status between individuals and populations arising from inequities in economic resilience, protected characteristics, social circumstance and environmental conditions. These factors influence the ability of populations to prevent ill health, improve their quality of life and gain equitable access to healthcare (PHE, 2020).

Figure 1. Dimensions of Health Inequalities



Taken from: COVID-19 Place-based approach to reducing health inequalities (PHE and LGA, May 2020)

52. During COVID-19, it is important to understand the impact of policies and approaches implemented to manage the pandemic and their impact on health inequalities across County Durham.

53. The Office of National Statistics report: Personal and economic well-being in Great Britain: June 2020 (ONS, June 2020), estimates 12.5 million people say their households have been affected financially by the impacts of the coronavirus (COVID-19), a similar share to the beginning of lockdown.

54. The share of employees and self-employed actively working fell in the first two weeks of lockdown and remained comparable up to 7th June 2020, at 67.0% and 79.9% respectively (ONS, June 2020).

55. The data also suggests there are some signs of increasing economic inequality, with more people on lower personal incomes reporting reduced income in the household. The lockdown has resulted in people working fewer hours, with less ability to save for the future. Fewer people with higher incomes have been impacted financially (ONS, June 2020).

56. Parents and those who do not feel safe at home or people who are lonely are more likely to be impacted financially and to feel more anxious. These groups are less likely to be able to save in the year ahead and less than half able to cover a large necessary expense. Those people were more likely to have been furloughed than adults without children in the house, with over 20% finding childcare impacting their work (ONS, June 2020).

57. Since the easing of some restrictions, average life satisfaction worsened for those with a health condition before bouncing back to the level comparable

with those without a health condition in the latest period up to 7th June (ONS, June 2020).

58. Within the HIA process the identification of those at greatest risk from poor health outcomes will enable partners to develop responsive action to help build on the social and economic resilience of people and their families, community and local businesses.

59. The use of Marmots life course approach will provide a mechanism for considering impact across the life course, including the life chances for children, young people, adults of working age and older people (Marmot 2012).

60. Recommendations from the HIA will highlight impacts at the level of population health, rather than just focusing on individual needs (Marmot, 2012).

61. At a local level, there are several dimensions in which COVID-19 will impact on health inequalities, especially in those populations who display multiple vulnerabilities and are socially and economically disadvantaged.

62. It is recognised these groups of the population may also be least equipped to manage the socio-economic impacts of shielding and social distancing measures during the COVID-19 response and should, therefore, be given specific consideration to help address their needs.

Pre COVID-19 Indices of Deprivation for County Durham

63. The Indices of Deprivation are used to measure a broad concept of multiple issues relating to various socioeconomic inequalities in specific areas. They also indicate areas of unmet need.

64. These indices are used to describe the conditions in which people are born, grow up, live, work and age. These conditions influence a person's opportunity to be healthy, risk of illness and life expectancy as well as a host of other socioeconomic outcomes.

65. The Index of Multiple Deprivation (IMD) 2019 is the official measure of relative deprivation for small areas (or neighbourhoods) in England. The Index of Multiple Deprivation ranks every small area (Lower Super Output Area - LSOA) in England from 1 (most deprived area) to 32,844 (least deprived area) (Durham Insights, 2020).

66. Pre COVID-19, County Durham is ranked in the top 40% most deprived upper-tier authorities across England, (48th out of 151; ID2015 – 59th out of 152 and in the top 40% most deprived), which means that large numbers of County Durham residents live in areas that have significant issues (Durham Insights, 2020).

67. County Durham has 39 LSOAs (12% of 324 LSOAs) ranked in the top 10 percent most deprived areas in England. Within the top 30% most deprived there are 158 LSOAs (48.8% of 324 LSOAs).

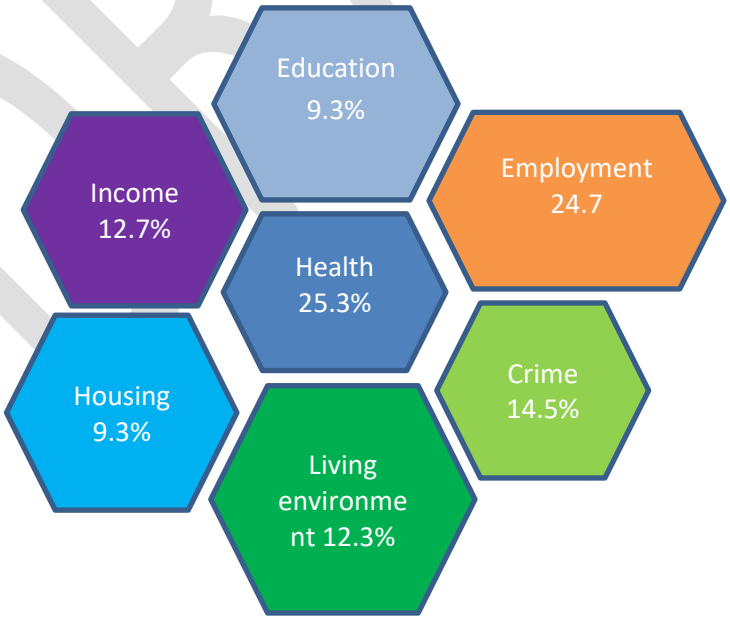
68. These 39 LSOAs cover an area representing 10.8% of the county's population with 47.3% of the county's population living in areas in the top 30% most deprived nationally.

Figure 2. Deprivation in County Durham IMD 2019

12%	Of our LSOA's (n=39) in the most deprived 10% nationally
10%	Of our populations live in these areas
49%	Of our LSOA's (n=158) in the most deprived nationally
47%	Of our population live in these areas
54%	Of children (0-15) live in the most deprived 30% LSOA's nationally (IDACI)
35%	Of older people (65+) live in the most deprived 30% of LSOA's nationally (IDAOPI)

69. Highlighting these multiple measures pre-COVID-19 create a baseline from which the impact of COVID-19 can be assessed for any negative increases in the domains for deprivation and life expectancy. The domains pertaining to health outcomes include education, employment status, income, crime, housing and living environment (Durham Insights, 2020).

Figure 3. % of County Durham LSOA's in the 10% most deprived nationally, by domain.



70. Life Expectancy before the pandemic for men and women has been improving in County Durham over time. However, life expectancy remains worse than

the England average and health inequalities remain persistent and pervasive across the multiple domains.

For Men life expectancy:

- 74.9 years - 2001/03
- 78.3 years - 2015/17 (England: 79.6)

For Women life expectancy:

- 79.2 years - 2001/03.
- 74 years - 2015/17 (England: 83.1)

71. Evidence from the Public Health England Segmentation Tool (PHE, 2018-19) shows the main contributors to the lower life expectancy in the more deprived areas of County Durham, compared to the less deprived areas (the gap between the most deprived quintile [20%]) of the selected local authority. The data collated illustrates that:

For men:

- Around one-quarter (27.3%) of the gap between the most and least deprived communities in County Durham is caused by higher rates of circulatory disease.
- Cancer mortality is the second biggest contributor to the gap between the least and most deprived in County Durham for men (19.4%) followed by respiratory disease (12.9%).

For women:

- One quarter (25%) of the gap between the most and least deprived communities in County Durham is caused by higher rates of cancer mortality.
- Respiratory disease is the second biggest contributor to the gap between the least and most deprived in County Durham (24%) followed by circulatory (18.9%).

(Taken from Durham Insights, 2020)

72. The information above creates a baseline which enables impact of COVID-19 on health inequalities to be considered. However, the outcome for these measures will not be available on an immediate basis or reflect real-time changes in health inequality during the COVID-19 recovery response.

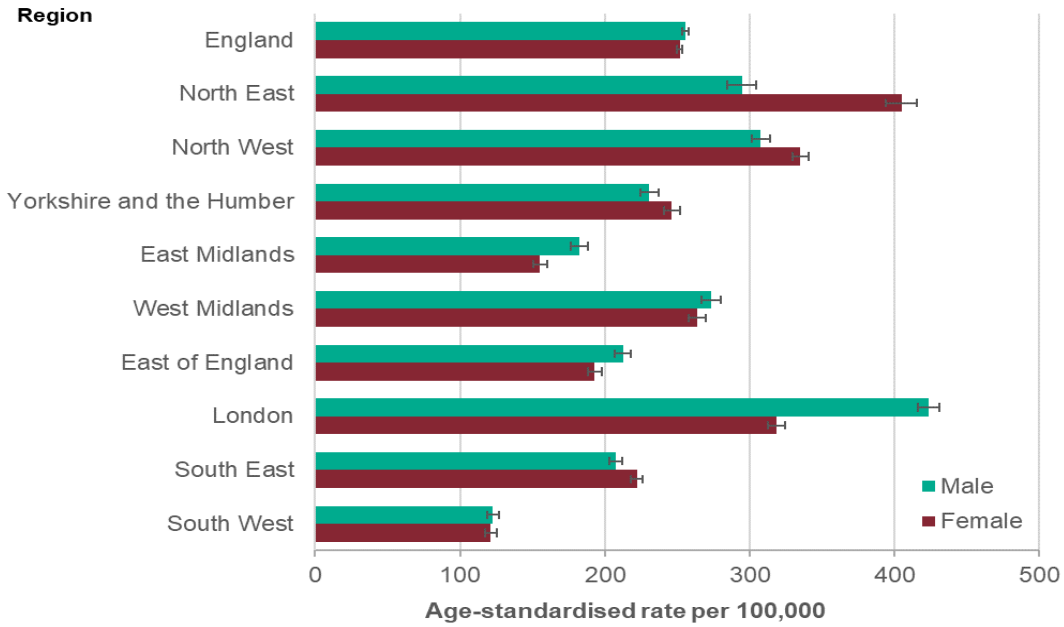
73. It is, therefore, important that other outcome data used in the HIA monitoring process will be used to assess the short and medium-term outcomes for inequalities in direct response to the COVID-19 outbreak.

Health Inequality Outcomes During COVID-19

74. The Disparities in the Risk and Outcomes of COVID-19 report (PHE, June 2020), confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them (PHE, 2020).

75. On a national basis the largest disparity found was by age. Among people already diagnosed with COVID-19, the ratio between men and women have been found to differ across regions. (Table 1).

Table1. Age standardised diagnosis rates by region and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.



Note: The diagnosis rate in women in the North East is higher than men and both sexes for many regional areas, however there is an indication that the variation in diagnosis rates will be partly influenced by variation in testing practices between areas (PHE, June 2020).

76. Nationally, the risk of dying among those diagnosed with COVID-19 was also higher in males than females. People who were 80 or older were seventy times more likely to die than those under 40 (PHE, June 2020).

77. Death rates higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups (PHE, June 2020).

78. These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups.

79. The Disparity Report analysis takes into account age, sex, deprivation, region and ethnicity, but it does not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences (PHE, June 2020).

80. The trend in the number of diagnosed cases of COVID-19 by deprivation quintile shows that cases in the least deprived group peaked earlier and lower than other groups and at 13th May, the cumulative number of cases and diagnosis rate was highest in the most deprived quintile.

81. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females. This is greater than the ratio for all-cause mortality between 2014 to 2018 indicating greater inequality in death rates from COVID-19 than all causes.

82. Survival among confirmed cases, after adjusting for sex, age group, ethnicity and region was lower in the most deprived areas, particularly among those of working age where the risk of death was almost double the least deprived areas.

83. In summary, people in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas.

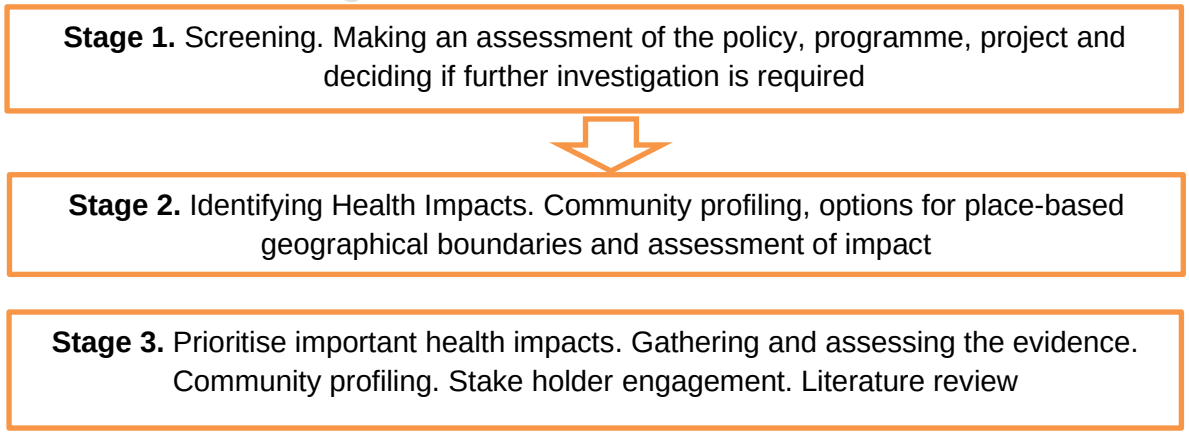
84. High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation.

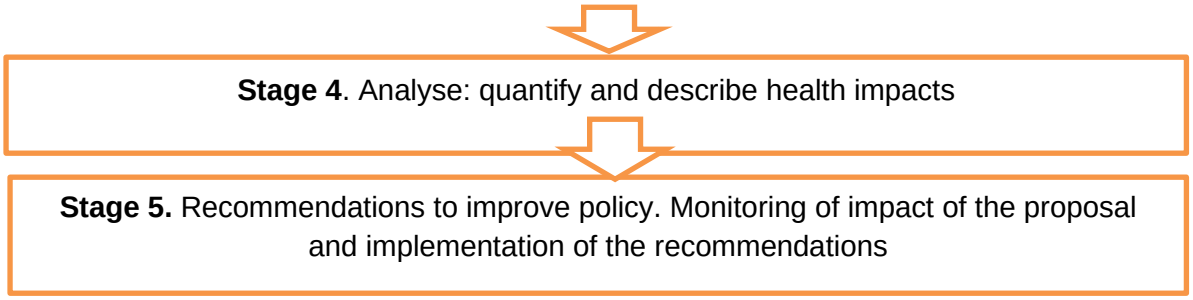
85. The findings from PHE will also provide insight into wider themes that can be considered at a local level for action in relation to the impact from the virus itself.

The Health Impact Assessment Process

86. A HIA usually requires a 6-9-month process to complete a 5-stage approach. Due to the fast pace nature of the pandemic, this HIA will be conducted as a rapid process to enable the Health, Welfare and Communities group to identify both positive and negatives impacts of the COVID-19 lockdown restrictions.

Figure 2. Stages of a Health Impact Assessment





87. The HIA process provides an evidence-based audit trail for the assessment of priority themes found to be impacting on health and well-being during the lockdown. From the findings of the assessment, the development of mitigating actions can be taken forward to help reduce the health inequalities during the staged phases of recovery.

Objectives for the HIA

88. The objectives for conducting the HIA include:

- Developing a shared, coherent understanding of the impact of COVID-19 lockdown restrictions on health and social inequalities throughout the life course. This includes the impact on populations of children and young people, adults of working age and older people.
- Ensure a system-wide response to COVID-19 recovery is implemented. This will include partners from local working groups, economic, environmental and safety partnerships, NHS, housing, local voluntary, community and business sectors, all working together on a common goal of reducing the impact of health inequalities using a place-based approach.
- Re-focusing efforts to co-produce new and improved approaches to reducing health and social inequalities during the response and recovery processes of COVID-19.
- Creating a baseline measure on which to monitor data relating to the impact of COVID-19 restrictions on those most vulnerable and at risk within a short, medium and long-term timeframe.

89. These objectives will be achieved by disseminating relevant COVID-19 guidance, encouraging community engagement, cross-sector working, joint commissioning processes and innovative service delivery.

90. These mechanisms will help to maximise people's ability to respond positively to the relaxation and lifting of lockdown restrictions using a staged approach and being able to respond flexibly to needs and requirements as they emerge.

91. Real challenges also remain in predicting the outcomes of lifting lock down restrictions that may result in a second peak of infections. This development might overwhelm service provision and impact further on the country's economy. Therefore, all opportunities to learn from the early stages of

lockdown should be taken to help safeguard future outcomes, should they be required.

Stage 1. Screening

92. Protecting and restoring people's livelihoods and improving people's physical and mental wellbeing provides a key to reducing the impact of COVID-19 in the long term.

93. The government have published significant amounts of COVID-19 guidance to support the management of the pandemic including:

- Stay at Home guidance
- Lockdown measures

94. The Government Scientific Advisory Group for Emergencies (SAGE) advised that a combination of individual home isolation of symptomatic cases, household isolation and social distancing of the over 70s could have a positive effect on: reducing the number of cases of COVID-19 during the pandemic (SAGE, 3rd March 2020).

95. On 16th March 2020, the UK Government introduced a shielding policy for the most vulnerable of our society and restrictions on non-essential contact and travel.

96. A further series of responsive announcements resulted in the closure of schools, hospitality, leisure and indoor leisure venues, all designed to help contain the outbreak. Stay at Home guidance was published in the same month.

97. There is wide-spread recognition that the effect of social distancing may increase vulnerabilities within society. Long term school closures could have an impact on long-term educational attainment of children and young people, especially early years and for those about to take exams.

98. Social distancing may also impact on people's mental health and emotional wellbeing, the ability to care for loved ones, create feelings of social and physical isolation and increase rates of domestic abuse and unhealthy behaviours.

99. Coupled with this, the longer the impact of COVID-19 and its associated lockdown restrictions affects individuals, families and communities, the greater the risks of long-term reduced economic activity.

100. The increase in rates of unemployment, reduction in financial security and instability in the housing market are all likely to impact on physical and mental health outcomes. These factors may also increase in the prevalence of chronic disease and disability (PHE, 2020).

101. The postponement of some public health preventative programmes and non-urgent medical care may result in unintended consequences such as people deciding not to seek treatment when needed. This may also prove to have significant impact on medium to long-term health outcomes.

102. The HIA will also provide a system-wide focus on specific population groups impacted by COVID-19 and enable the development of a place-based approach to reduce inequalities as the local area moves out of lockdown and into the recovery phase for health, welfare and communities.

103. The HIA screening process enables an assessment of any policy, programme or project to be made to decide if further investigation is required. The screening assessment tool asks questions to help identify if the policy has a direct impact on health or any socio-economic factors experienced by the local population.

104. For this HIA, Table 1. highlights the process undertaken to screening the Stay at Home policy and lockdown restrictions. This process helps to assess if the HIA should be taken forward, based on the answer to a number of screening questions posed to examine the impact of the government policy.

Table 1. HIA Screening Questions for COVID-19 Lockdown Policies.

Policy: Stay at Home and Lockdown Restrictions during COVID-19		
ASSOCIATED POLICY DOCUMENT		
Screening Question	**No health impact identified**	**Yes, health impact identified**
1. Will the policy have a direct impact on health, mental health and emotional wellbeing e.g. Does it cause ill-health, inclusion, independence any socioeconomic or equalities groups affected?	N/A	Yes, the new lockdown measures will have a major impact on the universal population, vulnerable and shielded groups. These may increase as lockdown is eased.
2. **Will the policy have an impact on social, economic and environmental living conditions that would directly affect health**. e.g. child development, education, employment, housing, green space. Will any particular vulnerable groups be affected?	N/A	Yes, the inability to access schools, shops, workplaces and family members from outside the home can directly affect the physical health and mental health and wellbeing of individuals and families. Long term lockdown may lead to unemployment, unstable housing, financial instability, poverty, social isolation and inability to access health care.
3. Will the policy affect individuals ability to improve their own health and wellbeing e.g. will it affect ability to be physically active, impact on health behaviours e.g. smoking. drinking, healthy diet?	N/A	Yes, lack of personal control over the pandemic and the inability to access support through family networks, support services, leisure facilities and the environment will all affect health and wellbeing outcomes

		and may increase unhealthy behaviours.
4. Will there be a change in demand for access into health and social care services? e.g. NHS, local authority, VCSE.	N/A	Yes, if the lockdown restrictions continue there may be more demand for health and social care services, however service delivery will also change due to social distancing measures. This may impact on the most vulnerable and shielded populations.

105. The outcome of using the screening tool indicates the Stay at Home measures and lockdown restrictions do warrant further investigation to fully identify the health impact of the policy directives. This is due to the level of potential negative impacts that could occur as individuals, families, communities and businesses are unable to access local infrastructure and usual support mechanisms.

106. The screening process also identifies that the measures may also increase over time, which in this case will progress as lockdown is eased during the recovery phase of the pandemic. This will warrant ongoing monitoring to assess any change in trends over time.

107. Once it is recognised the policy does impact on health, the HIA moves to stage 2 to begin to identify those impacts on wider policy areas. In this case, the HIA will consider policy areas impacting health inequalities.

Stage 2. Identifying the Health Impacts

108. As a second stage, an identification screening matrix has been utilised to review the impact of the lockdown measures on key health, welfare and community policy areas and approaches. These areas are all linked to the wider determinants of health. This helps to provide a standardised approach to consider the far-reaching risks which may result in widening the health gap.

109. The screening process also enables deliberation to take place to measure the scale of the issue, i.e. will the impact occur at population-wide level, or within targeted groups.

110. Some areas recognised as having a high level of impact from lockdown measures will be addressed by other partnership arrangements across County Durham. This reduces the need for further consideration as part of the identification process and provides an audit trail for the separate governance arrangements.

111. The policy areas considered as part of the identification process for the HIA were those which will influence on health inequalities across County Durham.

112. Policy areas considered as part of this process were:

1. Socio-economic factors and poverty reduction

- County Durham Poverty Strategy and Action Plan
- County Durham Prevention Strategy
- County Durham SEND Strategy

2. Inclusion and vulnerabilities

- Mental Health Strategic Partnership Strategy - including Children's and Young People's Mental Health and Emotional Wellbeing Strategic Plan, Suicide Prevention Alliance Action Plan, Crisis Care Concordat, Dementia Strategy and Resilient Communities Action Plan.
- County Durham Housing and Homelessness Policies
- County Durham Gypsy and Roma Traveller Delivery Plan
- Safe Durham Partnership Plan
- County Durham Domestic Abuse Plan on a Page
- County Durham Safeguarding Adults Board (Strategy/POP)
- Durham Safeguarding Children's Partnership
- County Durham Learning Disabilities Commissioning Strategy

3. Health Care and Early Intervention/Health behaviours/LTC

- 5 Year System Plan - access to health care, including screening and management of long-term conditions.
- County Durham Tobacco Control Alliance Action Plan
- County Durham Alcohol and Drugs Harm Reduction Strategy

4. Environment – Urban and Rural

- County Durham Sustainable and Healthy Food Policy

113. Appendix 1. provides the outcome of the identification screening matrix process for the HIA. Consideration has been made to the impact on the local population, the ability to resolve the impact, proposed timescales for outcomes, impacts on public perception and any positive or negative effects.

Stage 3. Prioritising Health Impacts

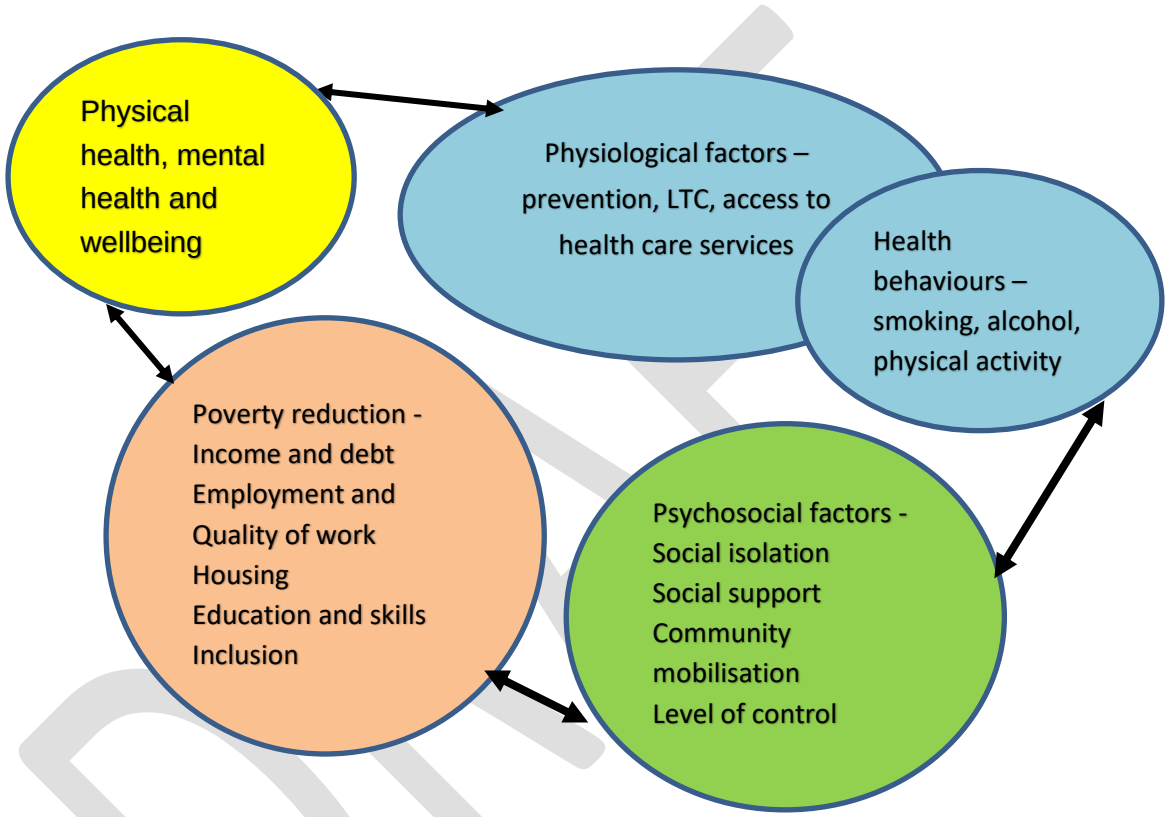
114. In order to begin to consider what action can be taken to help reduce health inequalities during lockdown restrictions, joined up processes are required to help prioritise areas of policy work that will impact on the lives of our local residents, families, communities and businesses.

115. The HIA identification process has highlighted a number of themes for consideration relating to COVID-19 lockdown. Many of these areas will result in increasing health inequalities across County Durham in the long-term. Many of the causes affiliate with increasing health inequalities may be multiple and

complex when considering the needs of our most vulnerable and shielded in our communities.

116. Areas requiring prioritisation being given further consideration in relation to their impact on the causes of health inequalities using the Labonte Model (1992), as highlighted in government evidence-based guidance for conducting HIA's published in response to the pandemic (PHE, 2020).

Figure 5. Systems Map of the Causes of Inequalities (Adapted from Labonte model (1992)



Socio-economic Impact and Poverty Reduction

117. Estimates alone suggest the impact of COVID-19 will have a profound and prolonged impact on widening social determinants between populations during lock down. Socio-economic factors relating to levels of poverty will impact on the wider determinants for health across County Durham (PHE, 2020).

118. Poverty impacts across the life course including Starting Well - children, young people; Living and Ageing Well - adults of working age and older people.

Child Poverty

119. The reduction in household income during the COVID-19 response will have a significant impact on the estimated four million children and young people already living in poverty in the UK (JRF, 2019).

120. In-work child poverty rates are closely linked to the number of adults in work in the family and their hours of work. Child poverty rates are very low for children in families where two parents are in work, with at least one in full-time work. Families with a single earner or with only part-time workers experience much higher poverty rates (JRF, 2019).

121. Child poverty in County Durham continues to rise, with 21.4% of children under the age of 16 living in low-income families. Financial instability is becoming ever more prominent due to the COVID-19 crisis. Low-income families and those living in poverty who are already unable to budget for unexpected expenses and have limited disposable income will be hit the hardest (PHE, Fingertips 2018-19).

122. Whilst the closure of school's is an important intervention to stop the spread of COVID-19, this could place additional strain on families who rely on the current support schools provide, both financially and socially. For example, families with children not receiving free school meals are likely to struggle with the additional food costs, leading to an increase in families using foodbanks and food insecurity.

123. Children and young people not being able to access educational settings could result in increased social isolation and mental health problems and an overall decrease in educational attainment. Although schools are providing alternative ways for young people to learn, such as online teaching, children whose families cannot afford access to laptops, phones or the internet are at a disadvantage and could potentially miss out on vital learning.

124. In addition, increased childcare responsibilities for parents while children are not in school are also likely to put additional financial strain on families as they can no longer rely on wider family networks to support with childcare.

125. COVID-19 has the potential to cause a double burden of deprivation. Where job security is an issue such as zero-hour contracts and self-employed, parents may lose their main source of income. Coupled with this there is an inevitable rise in the cost of living due to children and parents being at home, both in terms of increased utility bills and increased levels of food consumption.

126. These pressures could have long term impacts on families not being able to meet the basic needs of their children. It is likely that the pandemic will expose and extend existing inequalities, creating significant new forms of vulnerabilities and hardship for children and young people.

Poverty - Adults and Older People

127. Within the Indices of Deprivation, the income domain measures the number of working age people in receipt of unemployment and worklessness related benefits including Jobseekers Allowance, Employment and Support Allowance, Incapacity Benefit, Severe Disablement Allowance, Carer's Allowance and Claimants of Universal Credit in the 'Searching for work' and 'No work requirements' conditionality groups (Durham Insights, 2020).

128. County Durham is in the top 20% most employment deprived upper-tier authorities across England, (26th out of 151; ID2015 – 26th out of 152 and in the top 20% most deprived). Over half (59.4%) of the county's working age population live in areas with high levels of employment deprivation (top 30%), (a decrease from 60.9% in the ID2015 and from 64.9% in the ID2010) (PHE Fingertips, 2019).

129. During the first phase of social distancing measures, there was unprecedented national action taken to support people and businesses through the crisis to minimise deep and long-lasting impacts on the economy. As a result of this action on 3rd May 2020, 800,000 employers had applied to the Coronavirus Job Retention Scheme to help pay the wages of 6.3m jobs (HM Government, April 2020).

130. Despite this action, reports already suggest unemployment is beginning to rise nationally with 1.8m households making claims during lockdown for Universal Credit (HM Government, 16th March and 28th April 2020).

131. Ongoing modelling suggests if the current measures stay in place until June 2020 and are then eased over the next three months, unemployment could rise by more than 2 million people in the second quarter of 2020. (HM Government, April 2020). This will have significant impact for many already deprived communities with reduced income and employment levels in County Durham.

132. First indications suggest, workers in those sectors most affected, including tourism, hospitality and retail, are more likely to be low paid, younger and female. Younger households are also likely to be disproportionately hit in the longer term, as evidence suggests that, following recessions, lost future earnings potential is greater for young people. (HM Government, April 2020).

133. The Ipsos Mori 'Life Under Lockdown' survey confirmed the perception by the public that lockdown restrictions would have financial implications, with 22% of respondents stating they would be likely to experience difficulty in affording food essentials and housing costs (Ipsos Mori and Kings College London, 2020).

134. These findings may be corroborated locally by surge of cases into the County Durham Community Hub, requesting information on financial support and access to foodbanks (Durham County Council, May 2020).

135. At the outbreak of the COVID-19 pandemic, and particularly following imposition of Government measures to control onward transmission of the virus, many businesses in County Durham closed. Certain businesses within the manufacturing industry remained open – mainly those correlated around essential services, i.e. those that produced products supplying healthcare and those within the energy industry. A good proportion of organisations within the manufacturing industry operated at 30% staff capacity (with the remaining 70% furloughed).

136. Whilst Government issued financial support packages (SME cash grants, tax deferrals, rates relief, etc) were taken up by a large proportion of businesses in County Durham, they were not available to the whole business estate. This has brought inevitable financial pressures to those who did not qualify. For some businesses that did benefit from support, the packages may only have mitigated the financial pressures to a certain extent.

137. The furlough scheme has been well received and has enabled businesses to maintain jobs and skilled workers during the pandemic. It is felt, however, that furlough is likely to mask the true levels of potential redundancies that may follow, not only upon business owners, but also staff working for them.

138. Businesses operating in retail, hospitality and leisure are highly likely to continue to be affected as we move into recovery. Many retail units, particularly those with a small footprint (i.e. in town and city centres) may encounter difficulties operating under current measures to reduce virus transmission, i.e. 2 metre social distance rules.

139. Whilst many businesses, and SME owners in particular, will now be considering strategies that will enable them to build the resilience of their business, COVID-19 will inevitably impact upon their own personal resilience and mental health and wellbeing, as well as that of their employees.

140. For further consideration, the Treasury Committee published the ‘Gap’s in Support’ report (HM Government, June 2020), urging the Government to help over a million people who have lost livelihoods while being locked down and locked out of support. They argued the Government schemes resulted in “some hard edges in policy design and some critical gaps in provision”.

141. The inquiry identified the key concerns in regard to people unable to qualify for Government financial support and the impact on the individuals and families as the recovery phase unfolds. The gaps in provision include:

- Those newly in employment: people are suffering financial hardship due to unfortunate timing in starting a new job or their employer’s choice of timing in submitting paperwork to HMRC.
- Those newly self-employed: Many people starting a business in the last year do not qualify for support from the SEISS as they cannot fulfil the eligibility criteria.

- Those self-employed with annual trading profits in excess of £50,000: are suffering hardship because of the arbitrary £50,000 cut-off in the SEISS.
- Directors of limited companies who take a large part of their income in dividends.
- Freelancers or those on short term contracts: In industries such as television and theatre, where short-term PAYE contracts are the norm, many workers are not entitled to support under the CJRS or SEISS.

142. The impact of poverty increases with age (UN, May 2020). The pandemic may significantly lower an older persons' income and living standards. Many older people rely on multiple income sources including paid work, savings and reliance on families and pensions.

143. The ability of older people to access their social security maybe reduced due to their vulnerable or shielded status and a lockdown on their ability to move around and access supportive networks. Those most at risk of disadvantage are older women and those with a disability.

144. Whilst the true impact of COVID-19 lockdown is not truly quantifiable in economic terms for its effect on employment and income. The ability to reduce poverty has been identified as an underpinning factor that will improve the health and welfare of local communities across County Durham.

Summary of Considerations: Socio-economic impact and poverty:

Starting well

- Child poverty in County Durham pre- COVID continues to rise, with 21.4% of children under the age of 16 living in low-income families
- School closure place additional strain on families who rely on the current support schools provide, both financially and socially.
- Families with children not receiving free school meals are likely to struggle with the additional food costs, leading to an increase in food insecurity
- Young people and women are most at risk of unemployment.
- May increase levels of vulnerably and safeguarding concerns.

Living and Ageing Well

- County Durham is in the top 20% most employment deprived upper-tier authorities across England.
- Over half (59.4%) of the county's working age population live in areas with high levels of employment deprivation.
- Unemployment is rising on a national basis and so are claimant for benefits
- Job opportunities maybe reduced as lock down is released, but social distancing is retained.
- Individuals and families express concern at meeting household bills.
- Many individuals do not quality for government financial support packages.
- Older people are of significant risk.

Status: High Priority Impact
Population: Universal Impact on socio-economic for all – increasing with new claimants and those in low paid employment and those already accessing welfare support. Impacts across the life course for children and young people, adults and older people.
Likelihood of Impact: Confirmed by current local and national data.

Outcome: Screened In - Due to lasting legacy of any rise in unemployment, lack of financial resilience, impact on housing, mental ill health, relationship breakdown and community cohesion.

Education and Skills

145. There is extensive social policy and research in relation to the benefits of formal education across the life course. In 2014, the Economic and Social Research Council outlined the wellbeing effect of education. They outlined that education has become one of the clearest indicators of life outcomes such as employment, income and social status, and is a strong predictor of attitudes and wellbeing (ESRC, 2014).

146. The closure of schools and education settings as part of COVID-19 lockdown restrictions have many cross-cutting issues impacting on children, young people and their families. School closures will exacerbate food insecurity. For many students living in poverty, schools are not only a place for learning but also for eating healthily.

147. Research highlighted in the Lancet (2020), shows that school lunch is associated with improvements in academic performance, whereas food insecurity (including irregular or unhealthy diets) is associated with low educational attainment and substantial risks to the physical health and mental wellbeing of children (Schwartz and Rothbart, 2019).

148. The number of children facing food insecurity is substantial. According to Eurostat, 6·6% of households with children in the European Union—5·5% in the UK—cannot afford a meal with meat, fish, or a vegetarian equivalent every second day. This will be exacerbated during the COVID-19 response (Flora Southby, April 2020).

149. Research also suggests that non-school factors are a primary source of inequalities in educational outcomes. The gap in mathematical and literacy skills between children from lower and higher socioeconomic backgrounds often widens during school holiday periods (Alexander and Entwisle, 2007).

150. The summer holiday in most American schools is estimated to contribute to a loss in academic achievement equivalent to one month of education for children with low socioeconomic status; however, this effect is not observed for children with higher socioeconomic status (Alexander and Entwisle, 2007).

151. Although the current school closures due to COVID-19 differ from summer holidays in that learning is expected to continue digitally, the closures are

likely to widen the learning gap between children from lower-income and higher-income families. Children from low-income households live in conditions that make home schooling difficult. Online learning environments usually require computers and a reliable internet connection.

152. Although not directly comparable to the impact of COVID on school attendance, the long-term implications of sustained school absence remains relevant. In 2011 the Department of Education highlighted the implications of persistent absence. They identified that much of the work children miss when they are absent from school is never made up, leaving pupils at a considerable disadvantage for the remainder of their school career. There is also clear evidence of a link between poor attendance at school and low levels of achievement:

- Of pupils who miss more than 50 per cent of school, only three per cent manage to achieve five A* to Cs including English and maths.
- Of pupils who miss between 10 per cent and 20 per cent of school, only 35 per cent manage to achieve five A* to C GCSEs including English and maths.
- Of pupils who miss less than five per cent of school, 73 per cent achieve five A* to Cs including English and maths.

(DoE, 2011)

153. The Government's Green Paper on Transforming Children and Young Peoples Mental Health along with the report of the Health and Social Care Select Committee highlight the key role schools and education settings have in supporting the mental health and wellbeing of children and young people.

154. Their report found that schools and colleges have a "frontline role in promoting and protecting children and young people's mental health and wellbeing". Schools and education settings are ideally placed to act as a conduit to support and guidance in relation to mental health and emotional wellbeing recovery. (DoH, DfE, 2017).

155. This population has a higher prevalence of long-term conditions and mental health problems. There is also evidence that people with autism are at increased risk of anxiety, phobia, OCD and social anxiety disorders.

156. Those children and young people with cognitive difference in learning disabilities and autism may also suffer during COVID-19 lockdown. This may manifest itself in increased symptoms of anxiety, challenging behaviour and stress. This can change in routines and daily activities, less understanding of rules, communication challenges and reduced social interaction/loss of support networks (PHE, COVID-19 Support Packs, June 2020).

157. There is a risk of diagnostic overshadowing, which means that mental health issues associated with or exacerbated by COVID-19 may not be picked up. In other countries, individuals with autism spectrum disorder are being identified as part of a group at higher risk for complications.

158. Some schools have remained open for vulnerable groups and for the children and young people of key workers. Universities and colleges have retained their delivery functions through virtual methods.

159. The Opinion and Lifestyle Survey for June 25th-June 28th 2020, states of adults with children of school age, 4 in 10 (40%) reported that they had been asked to send their children back to school, with almost 7 in 10 (68%) of these saying that their children were now attending school some or all of the time (HM Government, July 2020).

160. Of those who have home-schooled their children during this week, over 6 in 10 adults (62%) said their children were struggling to continue their education at home - a similar level to last week (60%). Lack of motivation, lack of guidance and support, and limited parent or carer time to support were the most common reasons for children to be struggling (HM Government, July 2020).

Summary of Considerations: Education and Skills

Starting Well

- Education is recognised as a key indicator of life outcomes such as employment, income, social status and wellbeing.
- Time away from the educational settings impacts on educational attainment for students.
- Educational setting improve access to regular meals and healthy foods.
- Schools and educational settings have a key role in supporting the mental health, wellbeing and vulnerabilities of children and young people.
- Time away from school may only be temporary until lockdown restrictions are lifted and social distancing measures are put in place.
- CYP reporting increases in mental wellbeing due to not having to attend school.

Status: Moderate impact – depending on extended timeframe of lockdown restrictions.
Population: Universal, with some targeted populations of vulnerability.
Likelihood of impact – possible if the lockdown restrictions are extended past 4th July.

Outcome: Screened Out as schools, colleges, universities return to the new normal in September 2020 and the mental wellbeing issues can be picked up in the mental health section and the food poverty issues picked up in the welfare section

Housing and Homelessness

161. During the lockdown restrictions, the Government has also introduced a number of schemes intended to support people in the private rented sector,

including halting evictions for 3 months and raising the Local Housing Allowance rate.

162. National directives were also given for local authorities to house people living on the streets or registered as homeless during the lockdown.

163. This was responded to positively, however there remains national concerns about the short and long-term impact of these strategies. These include questions about the quality of accommodation offered and access to amenities. Homeless people in temporary accommodation will also require a planned exit strategy when social distancing measures are reduced.

164. County Durham Council introduced a Ready to Let scheme, where landlords approach with available properties, these are inspected and those in temporary accommodation or in some cases, rough sleepers are matched against properties. This and proactive work with social providers have ensured 62 positive moves for those in housing need under COVID-19.

165. Concerns have also been raised about people in the private rented sector who may build up rent arrears over the coming months and still face eviction when the three-month ban expires. DCC is looking to introduce a Stop b4u Serve scheme to support landlords and tenants through the eviction process. The scheme, marketing materials and dedicated webpage are being developed by the Private Rented Team #iamhomelessaware and has been updated with a COVID section and was launched to DCC staff at the end of June.

166. Guidance for landlords and the private rental sector has been issued by the Government to maintain safety standards in properties (HM Government 31st May, 2020). It is important local authorities work closely with landlords and tenants to ensure standards in rented properties are maintained.

167. Local authorities are being advised to consider contacting landlords and using communications and marketing to emphasise the importance of keeping properties free from hazardous conditions, but also reassure them that a pragmatic, risk-based and common-sense approach will be used when enforcement decisions are taken.

168. Private Rented Initiative Officers have continued to work through COVID, to ensure where possible conditions are adhered to and COVID restrictions maintained.

169. Where it has not been possible to complete works due to restrictions these have been logged and will be followed up when business returns to normal.

170. On a national basis, between 2nd March – 8th May 2020, there were 54 men and 13 women diagnosed with COVID-19 with no fixed abode, likely to be rough sleepers. This is estimated to represents 2% and 1.5% of the known population of women and men who experienced rough sleeping in 2019.

171. There have been 31 rough sleepers accommodated in County Durham since the Government announcement, placed in a variety of accommodation across the county.

172. As the pandemic progresses there are concerns for an increase in numbers requiring housing support due to job losses and the inability of households to maintain their mortgage payments. This may increase the demand on housing services to source suitable housing for a new population of families becoming homeless.

Summary of Considerations: Housing and Homelessness Strategies

- Introduction of a number of schemes intended to support people in the private rented sector, including halting evictions for 3 months and raising the Local Housing Allowance rate.
- National directives given to local authorities to house people living on the streets or registered as homeless during the lockdown.
- Concerns about the short and long-term impact of these strategies. and quality of housing available.
- 62 positive moves for those in housing need under COVID-19 undertaken in County Durham
- 31 rough sleepers accommodated in County Durham
- An increase in homeless families are predicted as levels of unemployment increase.

Status: Medium Impact due to proactive work undertaken by housing solutions, but this could change as unemployment levels increase.
Population: Universal and Vulnerable, but current demand is being addressed within current capacity.
Likelihood of Impact: moderate to high as unemployment rises and financial implications of COVID-19 are fully understood.

Outcome: Screened Out - at this current stage due to capacity meeting demand but requires monitoring into the more long-term. The underlying root cause of housing issues is poverty and income and as such will be considered within the poverty review.

Inclusion

Black, Asian and Minority Ethnic Groups

173. On a national basis, people from Black, Asian and Minority Ethnic (BAME) groups are most likely to be diagnosed with COVID-19 (PHE, June 2020). Death rates from COVID-19 are highest among people of Black and Asian ethnic groups. The disparity in COVID-19 mortality between ethnic groups is the opposite of that seen in previous years as mortality rates have started to reduce. (PHE, 2020).

174. An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, shows that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity.

175. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British, However, the recent analyses of the impact of COVID-19 on BAME communities did not account for the effect of occupation, comorbidities or obesity.

176. The impact of COVID-19 on BAME communities also needs to be considered as part of the impact of on health inequalities and wider determinants.

177. In the PHE report Beyond the Data: Understanding the impact of COVID-19 on BAME groups, recommendations cite COVID-19 recovery strategies actively focus on reducing inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised (PHE, 17th June 2020).

178. In County Durham, Gypsy and Roma Traveller communities have the poorest outcomes of any ethnic group, but are not always recognised within the BAME definition. Poor outcomes for GRT communities traditionally impact on education, health, employment, criminal justice and hate crime.

179. This remains a persistent challenge for both national and local policy-makers to tackle in any sustained way, but is especially relevant during the COVID-19 lockdown restrictions.

180. County Durham has the second highest number of pitches for GRT of all English authorities and a third of all pitches for GRT in the North East.

181. Most GRT communities live in housing, but a sizable population live on 6 council sites and a number of authorised private sites across the county. This council also provide10-Temporary Stop Over Areas (TSOA), which are made available predominantly to support for seasonal migration. There are also 3 Showperson's Yards.

182. Social distancing support has reportedly been maintained by the GRT Communities on authorised sites during the COVID-19 response. TSOA's have been closed during lockdown. The full impact of lockdown restrictions on GRT community used to traveling is currently unknown and be explored further.

Asylum Seekers and Refugees

183. An asylum seeker is someone who comes to the UK; often fleeing persecution

torture or war; and applies for refugee status. Until refugee status is granted, such a person remains an asylum seeker. Asylum seekers often encounter homelessness and face difficulty in obtaining accommodation.

184. County Durham is currently supporting more than fifty refugee families (approximately 250 individuals) to resettle in the UK under the government's resettlement schemes. The focus of the Vulnerable Person's Resettlement Scheme is on those most at risk and refugees are resettled from border camps and nations neighbouring Syria, including Egypt, Jordan, Lebanon, Iraq and Turkey.

185. A small number of vulnerable children and their families forced to flee their homes from the Middle East and North Africa (MENA) are also being supported under the Vulnerable Children's Resettlement Programme.

186. Refugees have been welcomed to the county in two phases each year and resettled in several areas of County Durham. Families are at different stages of resettlement, with the first refugees arriving in spring 2016 and the county's more recent arrivals being welcomed in late 2019. Most families have had little or no access to healthcare for several years whilst living in border camps/countries and therefore tend to have greater healthcare needs.

187. All families will, to some extent, experience challenges when accessing health services, as a result of language and communication barriers. Many individuals have limited English language and therefore accessing alternative methods of healthcare, e.g. online or telephone consultations, is difficult. Some families are illiterate and therefore the provision of translated material is inadequate and would require the services of an interpreter.

188. Lockdown restrictions have had a negative impact on health consultations, as the majority of non-urgent health appointments have either been postponed or delayed.

189. Recently-arrived families have relied upon resettlement support workers to assist in rearranging health appointments and ensuring that an interpreter is requested to facilitate telephone appointments; whilst some appointments, such as vaccination sessions for children, have been conducted without an interpreter present.

190. Restrictions have had a significant impact on access to dental treatment. Families had only been in the UK for four months prior to lockdown and many individuals required follow-up dental treatment, having been without access to a dentist for several years, but have had no access to a dentist during the lockdown.

191. For those families resettled in the County for more than 12 months lockdown restrictions have had a similarly negative impact on healthcare appointments, such as delays and cancellations, although some families advised that they could call and book their own appointments and ask for telephone interpreters. Some families have chosen to cancel or rearrange their own

appointments, either because they were categorised as high risk, or were concerned about a risk to their health during this period.

192. There have been positive reports from families in response to the council providing loan laptops for families arriving in the county during the twelve months preceding lockdown to enable families and individuals to continue English language tuition and support and to allow children to continue their education, including English language development.

193. Families reported this had a positive impact on mental health, as they have been able to continue this support, as well as access social media and international news updates in Arabic.

LGBTQ+

194. Stonewall suggests some lesbian, bi, gay, trans and questioning (LGBTQ+) people are harder hit than others during the response to COVID-19 due to lockdown measures. Many individuals return home with an undisclosed identity leading to feelings of anxiety and social isolation. Equality is an essential domain for reducing the impact of health inequalities and promoting everyone's safety, health and wellbeing.

195. Almost a quarter of young people at risk of homelessness are LGBT, due to the potential for family rejection and relationship breakdown. More than one in ten LGBT people have faced domestic abuse from a partner, rising to 19 per cent for trans people (Stonewall, April 2020).

196. LGBT Traveller Pride, a community-led LGBT Traveller collective in the UK say this is a particularly difficult time for Gypsy, Roma and Traveller (GRT) communities.

197. The impact of COVID-19 Stay at Home measures and lockdown restrictions on LGBT communities at a local level is as yet unknown and requires further exploration at a local level.

Learning Disabilities and Autism

198. The Learning Disability Mortality Review Programme (LeDeR) indicates people with learning disability die up to 30 years sooner, than the general population, of preventable causes. People with a learning disability are in a clinically at-risk group with mortality from constipation, pneumonia and aspiration pneumonia, sepsis, epilepsy, dementia, ischaemic heart disease being cited as causes of death (LeDeR, 2020).

199. Reduced access to health and social care support during the lockdown may have had an impact on people with learning disabilities. Annual health checks and cancer screening are usually available to everyone with a learning disability age 14+ and help to identify illnesses or health issues.

200. During lockdown health checks stopped but GP practices are starting to invite people for their annual health checks, which are likely to be a mix of face to face and virtual consultations. However, there are likely to be challenges related to people with learning disabilities having access to digital technology, consent and capacity, communication, PPE and a fear of accessing health settings.

201. The specialist health team have been monitoring those at greater risk and have continued to support access to health checks. They are working with practices now to make sure those that didn't happened can be picked up within reasonable timescales. There's also been some national guidance released to support primary care which all practices are using – includes easy read information.

202. The Scottish Commission for Learning Disabilities conducted two surveys, one for people with learning/intellectual disabilities and one for their parents, carers and supporters to help understand the impact of COVID-19 lockdown on this specific group (SCLD, June 2020).

203. The survey results reveal some key insights about how many people were concerned about the reduction or removal of support since the beginning of lockdown; amongst people with learning disabilities increased social isolation was reported. This was compounded by digital exclusion, and the mental health impact this is having on people with learning/intellectual disabilities.

204. People also felt that there was increased pressure on family carers, because of reductions in support from care providers or fears of accepting support due to the risks of COVID-19; and pressure on paid carers, due to staff shortages, and changes to how support is given were also key issues.

205. The Care Quality Commission, which regulates services caring for people with LD in England, found that 386 people died between April 10 and May 15. This was 134 percent higher than the same period last year, when the total was 165. Almost all of the extra deaths were accounted for by COVID-19, with some 206 of those people died with confirmed or suspected COVID-19 (CQC, 2020)

206. Autism is a complex condition that can have a profound impact on many areas of an individual's life but many individuals share similar characteristics such as sensory sensitivity, social and communicative differences, and a preference for routine and certain interests.

207. These characteristics can make life during the pandemic particularly challenging. The lockdown has put a stop to normal schedules and activities. For people with autism, this may be particularly distressing as routines are relied upon to make the world predictable and comforting (Larson, 2006).

208. Additionally, there are pressing anxieties in relation to the possibility of infection. As people with autism are significantly more likely to have clinical levels of anxiety and experience OCD related symptoms, the fear of infection

and an increased emphasis on handwashing and social distancing can compound existing stressors (Van Steensel et al., 2011).

209. Social isolation may be particularly isolating for those on the spectrum. Research suggests that many adults with autism already experience higher levels of loneliness and may have less social contact than those without autism (Mazurek, 2014). They're also more likely to have clinical depression (Ghaziuddin et al., 2002).

210. School closures may also be particularly difficult for children with autism, as research shows they in particular benefit from social inclusion during instruction and extracurricular activities where they can learn socially from other children (Harper et al., 2008).

211. The government have produced guidance to address concerns the impact of the COVID-19 on the use of the Mental Health Act (MHA) and supporting systems to safeguard the legal rights of people receiving mental health, learning disability (LD) and autism services, including specialised commissioned services (HM Government, 2020).

212. The guidance has been produced to enable assessments to be made to identify potential equality impacts of the COVID-19 pandemic on people with mental health needs and learning disabilities and/or autism. It is acknowledged that people with mental health needs, LD or autism, who contract COVID-19, may require reasonable adjustments to protect their mental health and wellbeing (HM Government, 2020).

Carers

213. Carers provide unpaid support and care for family members, friends and even neighbours. They play a pivotal role in the lives of others.

213. Durham County Council's commissioned services have continued to provide support to unpaid carers throughout the Coronavirus outbreak, through Durham County Carers Support and Family Action -The Bridge Young Carers Service.

214. The services have supported carers through video calls, financially via Carers Break funding, as well as health and well-being sessions.

215. COVID-19 has had a significant impact on unpaid carers including a reduced support network, increased anxieties, impact of lockdown on mental health for both carer and cared for and particularly for those who have been shielding.

216. Carers UK have recently published findings of a survey "Caring Behind Closed Doors 2020" that captured some of the additional stress and physical challenges that Carers have experienced during the pandemic. Responses have included:

- 35% of Carers are providing at least 10 additional hours of caring each week
- 69% providing more help with emotional support, motivation and checking in on the cared for person
- 72% spending more money on food
- 38% are worried about finances
- 55% agree with the statement “I feel overwhelmed and I am worried that I am going to burnout in the coming weeks”
- 87% agree with the statement “I am worried about what will happen to the people I care for if I have to self-isolate or become ill”.

Young Carers

217. The impact of COVID-19 virus will have far-reaching implications for the estimated 700,000 young carers in the UK (1,659 young carers aged between 5 and 17 years of age living in County Durham, an increase of 7.2% since 2001 (Source: Census 2011)). While it appears that children and young people are less likely to experience significant physical effects from the virus itself, the indirect impact of attempts to counter the spread of it are likely to have a major impact on their psychological well-being.

218. Statutory and non-services are reporting they are having to put new systems in place to support and safeguard young carers and their families to meet their needs. This includes restrictions on in-person contact and travel outside the home. This presents substantial barriers to children who provide care for vulnerable family members.

219. With a potential increase in caring responsibilities during COVID-19, and a restricted access to pre-existing networks that may have provided young carers with respite and support, such as school and peer group friendships, home visits and home care, have been reduced or drawn to a sudden end.

220. The Bridge Young Carers Service has continued to take referrals throughout the COVID-19 pandemic and offers support to around 90 young carers at any one time. Whilst the service only works with young people who have been referred, they offer training to organisations and schools for those young carers who do not need one to one level support.

221. For young carers in County Durham registered with The Bridge, one-to-one support has continued through the COVID-19 pandemic in various forms, with the aim of improving resilience and reducing negative impacts of caring. Practitioners have also been carrying out doorstep visits to deliver resilience packs to young carers. A grant from Family Action has allowed the service to support some families financially, who were struggling to cover increased food and utility costs during the pandemic. Practitioners have created bespoke wellbeing packs for each family they are supporting.

Adult Carers

222. Adult carers may find themselves in similar circumstances, coupled with worry and anxiety about the toll COVID-19 may take on their vulnerable or shielded family member. Feelings of social isolation impacting on mental health and wellbeing as well as the physical ability to access to food, medication and the ability to access support will all increase the capability to cope.

223. As a consequence of COVID-19 the care and help for carers has had to change including the reduction of, e.g. Respite Care, Day Care etc. Carers will have spent more time in the immediate company of the person they care for than they usually would, and the challenges for carers presented by someone with, e.g. a learning disability or autism where normal routines are important, can and will have been difficult to manage.

224. The government has published specific guidance for carers of friends or family during the COVID-19 outbreak. The measures highlight taking extra precautionary measures by only providing essential care and promoting the NHS hygiene advice for people at higher risk. Whilst this may help, the responsibility for reducing the infection risk to their family member and for elderly carers themselves, places further burdens on an already challenging situation.

225. According to carersuk.org, it is estimated that 1 in 8 adults are carers in the UK (around 6.5m people), 1.3m carers provide more than 50 hours of care / week and 1.0m provide care for more than 1 person.

226. Census results for 2011 show that there were approximately 59,000 adult carers living in County Durham of which nearly 17,000 are providing 50 hours or more of care a week. Durham County Carers Support have over 20,000 unpaid carers registered with needs ranging from receiving a regular newsletter to assessment in their own right and regular face-to-face support. They receive between 300 and 400 new referrals each month.

227. The service has operated as normal throughout the pandemic apart from face to face visits. Carers can, however, connect to the service via phone, email, social media, Zoom and their web chat service called Tawk, which operates during office hours. Additional newsletters have been produced with additional focus on receipt by those without IT.

228. A counselling service is operating via phone and Zoom, with 30 sessions per week. A virtual support group continues to be held every fortnight for those caring for someone with a learning disability. There is also a virtual support group for carers of adults with autism.

229. Following a successful bid for COVID-19 funding DCCS have implemented a “Keeping in Touch with Carers” service for an initial six-month period which will focus on making contact by telephone with as many carers as possible based on a priority system. Intended outcomes include preventing carer breakdown and reducing isolation.

Summary of Consideration: Inclusion

- BAME communities are disproportionally affected by health outcomes directly related to the COVID-19 virus.
- GRT Communities are a minority ethnic group not recognised within BAME profiles, their views require further exploration.
- Asylum seekers and refugees have reported language barriers when accessing health care and challenges in accessing dentists. IT and Educational support has been welcomed.
- LGBTQ+ communities are reported to be at risk from impacts relating to COVID-19 Stay at Home guidance and lockdown restrictions. Further insight is required for this community.
- LD and Autism – lack of ability to maintain routine, access support and fear of health implications.
- Carers – both adult and young carers are responsibility for reducing infection transmission to their vulnerable family members creating worry and anxiety and may suffer from social isolation.
- Criminal Justice may rise due to financial implications of COVID-19 lockdown plus increase in substance misuse and mental health issues.
- Further investigation and evidence needs to be acquired to quantify the impact of COVID-19 restrictions on these communities at a local level.

Status: Impact high, with some areas requiring further inquiry
Population: vulnerable and targeted
Likelihood of Impact: Moderate/major depending on the group and impact of lockdown.

Outcome: Screened in – increasing overtime and creates an inequalities gap. Integrated within other areas of priority including poverty, mental health and community assets and networks.

Psycho-social factors

Mental Health and Emotional Wellbeing

230. Understanding the risk and protective factors for mental health, and baseline levels of existing mental ill-health across County Durham is key to enabling the identification of those most at risk of a deterioration in their mental wellbeing during the pandemic lockdown restrictions and beyond.

231. Reports from Italy speak of an, ‘Emergency within an emergency’, for the mental health impact of COVID-19 on their citizens. Even people with stable families and secure jobs anticipate significant psychological and societal changes due to lockdown restriction, such as social distancing, which may impact on their populations for months.

i) Pre-natal Mental health

232. On 5th June 2020, only 19 women nationally have been reported to have been affected by COVID-19 during pregnancy and have delivered 20 infants all within 13 days of onset of illness. All women had viral changes apparent on CT chest imaging and there were no maternal deaths (Mullins et al, 5th June, 2020).

233. Due to the underlying factors that affect perinatal mental health it is likely that COVID-19 will increase the prevalence of this condition and an increase in concerns and anxiety displayed by pregnant women and their families. This may be exacerbated by worries in accessing ante-natal appointments during lockdown restrictions.

i) Children and Young People

234. As the UK COVID-19 response progresses it is hard to predict the effects on the mental and social development of children and young people who have abruptly had a dramatic change of their normal life.

235. Children and young people are likely to be experiencing worry, anxiety and fear, and this can include the types of fears that are very similar to those experienced by adults. These can include fear of the unknown, fear of dying, a fear of relatives dying and lack of access to their usual support networks.

236. The 'Life Under Lockdown' survey found that nearly half of participants had felt more anxious or depressed than normal as a result of COVID. Younger people were more likely to find it very difficult to cope, with 42% of 16-24 year-olds stating they were finding it extremely difficult to cope. (Ipsos Mori and Kings College London, 2020).

237. The partial closure of schools for many children and young people in the UK, may mean they no longer have a sense of structure and stimulation that is provided by school environment.

238. Children and young people also now have less opportunity to be with their friends to get the social support that is essential to maintaining positive mental health and emotional well-being. Educational settings are also places for safety for any safeguarding concerns occurring in the home.

239. The impact on years about to take exams or go to college and university also creates anxiety in terms of an unknown future.

240. As schools re-open (and the pandemic is managed in advance of a long-term solution) it is likely that young people's lives will continue to be significantly disrupted. For some this will mean their wellbeing will be chronically and at times acutely impacted.

241. A number of factors characterise the particular problems associated with maintaining wellbeing in this context:

- Disruption to the normal routine
- Reduction in experiences that are known to underpin good mental health (5 ways to wellbeing)
- Direct impact of loss of friends and family members
- Indirect impact of Covid 19 in terms of family relationships and financial strain
- Intensification of risk associated with trauma and abuse, and difficulty in providing the usual range of specialist family interventions

242. Children and young people may want to be closer to their parents and make more demands on them, resulting in an increased pressure on the parents or caregivers may be already be suffering the impact of COVID-19 (WHO, March 2020).

243. There may also be an impact on children of key workers who worry about seeing parents still working within dangerous conditions and seeing emotional impact on those parents.

244. Being at home can place some children at increased risk, or exposure to child protection incidents. They may witness interpersonal violence and not consider their home as a safe place. Parents trapped indoors need to be supported in managing their own stressors, so that they can be role models for their children to help deal with their own mental health and emotional wellbeing needs (WHO, March 2020).

245. Safeguarding mechanisms remain in place for children and young people to address any concerns raised for families at risk.

ii) Adults

246. In Italy, requests for psychological support are on the rise, especially among adults in their thirties. The Italians describe the population as having been exposed to intense psychological trauma, both individually and collectively, caused not only by the direct consequences of the pandemic, including unexpected, social isolation and loss of support systems.

247. The Italians also cite indirect consequences such as job loss, burnout, post-traumatic stress and quarantine stress having an impact (Sani et al. April, 2020).

248. For those on the frontline the impact of COVID-19 can be especially challenging on mental health and emotional wellbeing. Liu et al. recently identified rates of stress-related symptoms in 73.4% of 15363 medical staff in China, with 50.7% suffering from depression, 44.7% anxiety 36.1% reporting insomnia (Lui et al. 2020). In the Italian situation, the risks of acute stress

disorder, burnout syndrome, and full psychiatric disorders are currently very high in health-care professionals.

iii) Older people

249. For older people and those with underlying health conditions, having been identified as more vulnerable to COVID-19 can be fear-inducing. The psychological impacts for older populations can include anxiety and feeling stressed or angry. Its impacts can be particularly difficult for older people who may be experiencing cognitive decline or dementia. Some older people may already be socially isolated and experiencing loneliness which can worsen mental health (WHO, April 2020).

250. Age UK have reported they have seen a range of issues raised through their welfare calls. Themes include:
    - People who have been shielding have been worried and have not even gone into their gardens
    - Increased anxiety about lockdown and about re-joining society
    - Increase in low mood
    - A range of concerns about coming out of lockdown
    - Unsure about physical health status during lockdown

251. Support for older people, their families and their caregivers is an essential part of the countries' comprehensive response to the pandemic. During times of social isolation, older people need safe access to nutritious food, basic supplies, money, medicine to support their physical health, domiciliary support and social care.

252. Addressing this need has been coordinated by the Community Hub provision within County Durham working alongside the herculean efforts of the voluntary and community sector. Dissemination of accurate information is critical to ensuring that older people have clear messages and resources on how to stay physically and mentally healthy during the pandemic and what to do if they should fall ill with COVID-19, or other medical conditions during lockdown.

253. Homes et.al have suggested the likely consequences of COVID-19 would be an increase in social isolation and loneliness (Holmes et al, 2020). These symptoms of poor mental health are themselves strongly associated with other common mental health problems including anxiety, depression, self-harm and death by suicide.

iv) Mental ill health as a direct result of COVID-19

254. Evidence from previous epidemics shows that, those who have been infected have experienced post-illness mental health problems such as PTSD (32%), anxiety (15%) and depression (15%) (PHE, COVID-19 Support Packs. June 2020).

255. There are also potential direct neuropsychiatric effects of coronavirus infection; which have been identified in previous coronavirus epidemics. Emerging evidence suggests a possible increased risk of stroke and encephalopathy in COVID-19 survivors.

256. In previous epidemics, those who have been infected have experienced stigma and discrimination that can impact on mental health; as well as other mental health problems such as depression following the illness.

257. There are also reported risks of an increase in post-traumatic stress disorder (PTSD) post ITU admission and emerging evidence of increased risk of PTSD post isolation / quarantine (PHE, COVID-19 Support Packs. June 2020).

v) Bereavement

258. The number of people bereaved has increased due to the pandemic with 10-20% of those bereaved usually experiencing complicated grief. It is likely that these rates will increase during COVID-19 with the restrictions on visits to care homes/hospitals and funerals adding to a lack of closure on the death.

259. Groups at higher risk of requiring additional bereavement support during the pandemic include:

- those with higher risk of mortality from COVID-19 e.g. BAME communities, the elderly, those living in deprived areas
- those disproportionately affected by the lockdown e.g. those living alone, those in vulnerable groups and those shielding
- those who already face risks in bereavement or barriers to accessing support e.g. those with learning disabilities and dementia.

Potential Demand on System-wide Services for Mental Health

260. Tees Esk and Wear Valley NHS Hospital Trust (TEWV) have estimated how large the surge of extra “C-19 generated” demand for primary / secondary mental health services is going to be and which segments of the population are going to be most affected. This will be added to an increase trend for demand on services currently being experienced.

261. Modelling has suggested there will be a significant volume of additional needs presenting which will challenge all systems over the next 5 years. These estimates at both a primary and secondary care level with a diagnosable mental health condition who require help will be:

- The equivalent of 52% of children and young people (some of this estimate is made up of individuals with multiple episodes so the actual percentage of individuals needing intervention is lower)
- The equivalent of 23% of working age adults (as above)
- The equivalent of 22% of older people (65+) (as above)

(TEWV would like to place a caveat in their 5-year modelling predictions highlighting they are based on areas of research gaps, unknown research quality and the application based on other 'similar' past events).

262. Safeguarding mechanisms remain in place for adults to address any concerns raised for individuals and families at risk during the pandemic response.

Considerations: Mental Health and Emotional Wellbeing

Starting Well

- Mental health and emotional wellbeing across the life course can be severely impacted by COVID-19 Stay at Home restrictions and lockdown.
- Children and young people can be affected due to lack of support from schools and social networks.
- Increases in safeguarding concerns can escalate for CYP in the home leading to Adverse Childhood Experiences (ACE's)

Living and Ageing Well

- Adults can be can impacted due to stress anxiety, fear of the unknown, lack of access to family support mechanisms and services.
- People experiencing bereavement can also suffer from metal ill health.
- Those on the front line dealing with the pandemic can suffer from PTSD and other mental health conditions.
- Individuals who have had COVID-19 can suffer neurological impairment and PTSD.
- Older people can experience fear anxiety and stress by being one of the vulnerable and shielded populations and fear of illness and death.
- TEWV modelling suggest increases in demand on services to support mental ill health across the system over 5-years.

Status: High Impact
Population: Universal and targeted within vulnerable groups.
Likelihood of Impact: Major as mental health and emotional wellbeing is a key factor in maintaining capacity and ability for self-management and community connection.

Outcome: Screened in due to long term implications of impacts on mental wellbeing across the life course

Criminal Justice

263. On a national basis, COVID-19 pandemic has impacted crime and illicit economies such as organised crime, terrorism, street crime, online crime, illegal markets and smuggling, human and wildlife trafficking, slavery, robberies and burglaries.

264. The Global Initiative Against Transnational Organized Crime has stated in a that whilst the impact of pandemic in the short term indicates a decrease in

some organized-criminal activities, the lockdown has provided new opportunities for crime in other areas, causing a change in the "organized-criminal economy" that may be more long term (GIATOC, 2020).

265. Following an increase in movement restrictions within the UK, there are fewer people on the streets, causing a decrease in street crime. With a larger population staying indoors at home, thefts and residential burglaries have decreased.

266. However, there have been increases in counterfeiting and fraud directly related to the COVID-19 pandemic and more reports of cybercrime, domestic abuse, and hate crimes. All aspects of crime increase the fear of crime within local communities, especially during times of crisis. National reports suggest increases in fraud especially targeting elderly vulnerable people (Action Fraud, 2020).

267. The lockdown can especially impact on women with existing vulnerabilities such as poverty, homelessness, poor mental health and past experiences of trauma, and who are victims of sexual abuse and sexual violence (Changing Lives, 2020).

268. This issue can be related to, but is often distinct from, domestic abuse – also a significant and pressing concern – affecting women including those who are being systematically targeted for sexual exploitation.

269. There is also a risk that without the right support, women leaving prison are particularly vulnerable to becoming involved in selling sex where they are targeted by pimps and perpetrators on release.

270. However, Durham Constabulary force data show that mental health related incidents have remained relatively stable throughout COVID-19, and the same can be said for incidents to Durham police which are related to domestic abuse (Durham Constabulary, May 2020).

271. Work is currently being undertaken to address significant court backlog and how local agencies can start to address the issues relating to social distancing to enable cases to continue through the courts.

272. Prison releases have been delayed to ensure all individuals are suitably housed on returning to their local area. This action has helped reduce the numbers who are homeless and living on the streets.

273. Digital mechanisms are currently being utilised to engage those engaged by the National Probation Service. This may cause inequalities in some clients being able to access health and social care support due to a lack of access to suitable equipment.

Considerations: Criminal Justice

Living and ageing well, Starting Well for vulnerable populations.

Status: Medium Impact – potential for high impact as lockdown lifts

- Crime profiles are changing during COVID-19.
- Vulnerable and infirm maybe targets of new types of crime, especially scams and fraud during lockdown.
- Women are especially vulnerable.
- Demands on the police are reported to be down during the initial stage of lockdown.
- Virtual methods of engagement may cause inequalities in ability to access wider health and social care support in the short term.

Population: Targeted within vulnerable groups.
Likelihood of Impact: Moderate, but may increase as unemployment rises and financial impact is known

Outcome: Screened out – at the current time but may require further investigation for health impact on the most vulnerable as recovery progresses.

Domestic Abuse

274. Domestic abuse affects over 1.8 million people in England and Wales each year. The Stay at Home order put in place to save lives and protect the NHS will cause anxiety for those who are experiencing or feel at risk of domestic abuse.

275. Incidents of domestic abuse often increase when households and/or relationships are under additional pressure (DASVEG, March 2020). This may result in long-term impacts on children and young people experiencing domestic abuse within the household leading to adverse childhood experiences (ACE's).

276. Government action has included an increase in funding to protect survivors of domestic abuse during the current pandemic and beyond recognising the potential increase for abuse during lockdown. This has included:

    - Over £16 million to 75 projects to help fund domestic abuse refuge services for victims and their children;
    - £25 million for support services for victims of domestic abuse and sexual violence in the community during the coronavirus outbreak, plus £3 million to fund Independent Sexual Violence Advisers until 2022;
    - A new campaign, under the hashtag #YouAreNotAlone, highlighting that those at risk of, or experiencing, domestic abuse can still leave and seek refuge and publicising support available.

277. Whilst it is difficult to quantify levels of domestic abuse at a local level due to its hidden nature, local evidence provided by Harbour Support Services, County Durham's specialist domestic abuse service, highlighted a concerning reduction in numbers of individuals and families accessing specialist domestic abuse support services since social distancing and further lockdown measures, introduced by the government throughout March 2020.

278. Alongside this, whilst Durham Constabulary report levels of domestic abuse incidents remain similar to previous years, safeguarding officers have highlighted a decrease in incidents that are graded as high risk by responding officers. This is thought to indicate the hidden nature of the impacts from lockdown restrictions.

279. Information provided by Harbour Support Services released on Tuesday 14th April 2020 shows an increase in referral of over 50% following the targeted, partnership approach to awareness raising communications supported by national government announcements.

Consideration: Domestic Abuse
Starting well

- Impacts on CYP and can manifest as ACE's
- Presents as a hidden harm.

Living and Ageing Well

- Presents as a hidden harm.
- Victims are unable to come forward to due close proximity with perpetrator in the home.
- Social distancing requires remote working to access support leading to inability to access services.
- Increase in Domestic abuse can be linked to financial instability

Status: High Impact, but potential for reduction as lockdown is lifted, or an increase as potential recession hits
Population: Vulnerable populations, also wider impact of children and young people when happening within the home.
Likelihood of Impact – Moderate, if lockdown is extended and/or unemployment rises and financial implications are known.

Outcome: Screened Out, but requires monitoring for any increases over medium and long term recovery due to unemployment and financial disability.

Safeguarding

280. Safeguarding adults and children and young people continues to remain a statutory function and as such partners to work together to ensure the safety of those most vulnerable in our communities.

281. The local Safeguarding Adults Board (SAB) Business Unit continue to provide updates to partners, in response to COVID-19 response and the daily challenges being faced by those key agencies and front-line activity, work from home in line with government guidance.

282. The Durham Safeguarding Children's Partnership (DSCP) also maintains its statutory function during lockdown linking with the Multi Agency Safeguarding Hub (MASH) as a central point for the screening, gathering, sharing and analysing of information about children in County Durham who may be at risk of harm or who may need support services.

283. Safeguarding has been screened as having a high impact on children, young people and vulnerable adults. This impact could increase as the lockdown restrictions lift due to financial insecurity, unemployment, instability in the housing market, relationship breakdown and mental ill-health.

284. Safeguarding has been screened out of the HIA prioritisation, due to the ability of the SAB and DSCP to manage safeguarding concerns through standardised processes. This status will be monitored on an ongoing basis throughout the recovery timeframe.

Consideration: Safeguarding

- Concern for an increase in safeguarding of children, young people and vulnerable adults.
- Local strategies have been retained for children, young people and vulnerable adults.
- Referrals remain within manageable levels but concerns for hidden harm remain as recovery response progresses.
- Monitoring of referrals into First contact and Social Care direct are being maintained for increase in occurrence as lockdown eases.

Status: High Impact, but potential for reduction as lockdown is lifted, or an increase as potential recession hits.
Population: Universal and vulnerable

Outcome: Screened Out, but monitoring will be maintained via SAB and DSCP

Community Assets and Community Mobilisation

Community Hub

285. In the week commencing March 23rd 2020, The County Durham and Darlington Community Support Cell was tasked to establish the community hub to protect those both clinically vulnerable to COVID-19 (shielded) and those who had become socially vulnerable due to the Stay at Home and lockdown measures put in place to prevent the spread of COVID-19.

286. The Community Hub was established to coordinate food provision, social contact, welfare support, volunteering and be the central coordination function for the voluntary and community sector (VCS).

287. The Hub went live on 27th March 2020 and offers support and guidance to County Durham residents who are shielded, vulnerable and have needs related to COVID-19, linking them to existing local services where possible and supporting with essential aid where necessary.

The County Durham Hub has two client pathways:

a. Proactive pathway – outgoing calls made by CDDFT NHS Wellbeing For Life from NHS lists to those residents who meet all below criteria:

i. Identified by NHS (letter to home) as clinically vulnerable to Covid 19;
ii. As instructed in this letter, self-registered on the Government 'clinically vulnerable' website;
iii. When registering stated that they do not have support with essential supplies.

b. Reactive pathway – incoming contacts received via a dedicated online form, or contact centre phoneline from residents who self-identify or are referred by third parties (e.g. family, neighbours, TEWV, Adult Health Services, Housing Organisations, Probation) as needing support around issues linked to COVID-19.

288. At the outset of the pandemic, most Hub enquiries were around food. However, when contacted, many local residents reported they had used existing family, or community networks to support their needs.

289. This indicates a level of personal and community resilience and active use of existing, local assets during the response phase of the pandemic. This should be investigated further and built upon to maximise opportunities for further community engagement and mobilisation.

290. A key component for the Hub staff was to link clients (both new to and known by) to specialist providers and services via established, co-produced referral pathways where necessary.

291. County Durham has 25,909 people on the shielded list, which increases on a daily basis. These are individuals classed as having specific medical conditions putting them at higher risk of severe illness should they contract COVID-19 and therefore guidance suggests they should remain socially distanced from others.

292. As of the 24th May 2020, after 8 weeks of delivery, the Hub has supported 6517 clients:

- 3392 clients via the proactive pathway
- 3125 clients via the reactive pathway

293. Whilst volume of demand into the Hub has decreased recently, client vulnerability has become apparent. Clients now engaging with the Hub have multiple and often complex needs linked to social isolation, emotional and mental wellbeing and wider financial hardship/resilience.

294. The Hub provision has provided a much-needed response during the immediate response phase of the pandemic and will be reviewed as the COVID-19 recovery phase progresses. The initiation of the Community Hub has helped qualify the numbers of the most vulnerable and shielded groups in County Durham, but has also highlighted the levels of potential unmet needs.

295. There are opportunities to now consider the future model of the Community Hub and its role as an engagement tool for vulnerable local residents placed within a wider concept of integration and the connectivity with the VCSE.

296. When reflecting on the delivery of the Community Hub, consideration needs to be made about how much the wider VCSE have also provided in terms of support to vulnerable and shielded individuals. This has not been quantified to provide an overarching profile for numbers supported during the early response to the pandemic.

Considerations: The Community Hub

Starting well, Living and Ageing Well

- Initiated to provide immediate support for the vulnerable and shielded populations in County Durham and Darlington.
- Many people had already engaged in their own family and community networks to provide support.
- Hub highlights levels of potential unmet need when considering prevalence with numbers of engagement.
- Levels of complexity now being reported as increasing as lockdown restrictions are slowly lifted.
- Further consideration needs to be made to quantify support given to vulnerable and shielded groups as part of a bigger profile in conjunction with VCSE.

Status: High Impact
Population: Shielded and Vulnerable – potential for high levels of unmet need. Connectivity for people know to the community Hub into VCSE enables residents to engage support at a place-based level.
Likelihood of Impact: Major to provide connectivity into VCSE to respond to need from vulnerable and shielded populations.

Outcome: Screened In – to ensure residents and local communities continue to be supported during the ongoing nature of the pandemic and linked to wider VCS infrastructure

Voluntary, Community and Social Enterprise (VSCE) Sector

297. The Voluntary, Community and Social Enterprise (VSCE) Sector is the term used to describe the range of organisations which are neither state nor the private sector. This sector includes small local community organisations, and large, established, national and international voluntary or charitable organisations (see appendix 3).

298. Some VCSE organisations rely solely on the efforts of volunteers; others employ paid professional staff and have management structures and processes similar to those of businesses, large or small; many are registered charities whilst others operate as co-operatives, “social enterprises” or companies limited by guarantee (Bourne, 2005).

299. During COVID-19, the VCSE have played a significant part in mobilising community networks and assets to provide an immediate response supporting the vulnerable in need during the lockdown.

300. The Voluntary Organisations’ Network North East (VONNE), conducted an Impact Assessment on the VCSE across the North East during COVID-19 (VONNE, April 2020). Responses from 404 organisations of varying sizes suggest a third of VCSE organisations surveyed suggested they expect to lose more than 50 per cent of their income in the quarter April to June 2020.

301. An overwhelming 82 per cent of respondents to the VONNE survey stated that social distancing measures have had a significant impact on their ability to deliver services. Of those, 39 per cent have not been able to operate at all.

302. The outcome of the impacts on the VCSE due to COVID-19 suggest almost 400k beneficiaries are receiving a significantly reduced service, or no service at all which is of serious concern.

303. The groups with the highest levels of currently unmet need are reported to be children and young people, older people, and people with disabilities, including learning disabilities. These are also the groups most likely to be unable to access services either online or by telephone.

304. It is important to note that despite 31 per cent of organisations anticipating a significant (more than 50 per cent) drop in income between April and June, and 40 per cent having less than three months running costs in reserve, only 13 per cent of respondents consider it likely or very likely that their organisation will close as a result of the pandemic (VONNE, April 2002).

305. The reason for this positive projection could be attributed to the expectation of COVID-19 being short-lived, and/or that organisations will bounce back once lockdown restrictions begin to be eased. In addition, previous Third Sector Trends studies have recognised the 'optimistic' nature of sector organisations when forward planning and forecasting (Community Foundation serving Tyne & Wear and Northumberland, May 2020).

306. At a local level, small grant payments have helped to support an immediate response to the COVID-19 lockdown and bridged the shortfall in income generation losses for some. However, the future for any sustained funding for the VCSE on a more longer-term footing remains unknown.

307. In the VONNE survey, 72 of the 404 organisations who responded, currently operated within the boundaries of County Durham.

308. Durham Community Action conducted a County Durham VCSE Sector COVID-19 Impact Survey (DCA, May 2020), building on the VONNE survey and in consultation with Volunteer Coordinators Forum & Better Together, Anchor Organisations and Mutual Aid Groups. The outcome of the survey suggested four key themes in regard to organisational concerns for the impact of COVID-19 on the local VCSE. These include:

- Worries about keeping charities/groups afloat to engage local communities
- Coping with remote working to engage clients
- Supporting staff safety and wellbeing
- Supporting beneficiary safety and wellbeing

309. All of these factors need to be considered when reflecting on methods of engagement by VCSE with local communities to enable shielded and vulnerable groups to come out of lockdown when restrictions are lifted.

310. Ways of quantifying outputs and outcomes from the VCSE during this time should also be studied.

311. VCSE organisations report they are continuing on a pathway of transition from crisis, through recovery and towards rebuilding during the COVID-19 response. There is a recognition this is a changing situation. The potential of a second wave of the virus, further lockdowns, the forecasted recession and changes in public expectations, behaviours and needs may all have negative impacts.

312. The DCA survey suggests that the current position statement on the response of the VCSE services will not remain stable or consistent and requires a long term plan for rebuilding the sector post-COVID-19.

313. DCA suggests the sector can work with the engagement and levels of cooperation shared across County Durham to develop an evolving and mutually supportive model which can flex to respond to needs and new opportunities (DCA, May 2020).

Volunteering

314. The VCSE sector's capacity in the North East is reported to be severely limited at the current time, with 53 per cent of the workforce not operational and 75 per cent of volunteers unable to support their organisations. Many volunteers were themselves part of the shielded population and were unable to leave their home to help provide support.

315. The national recruitment of volunteers did provide support for food and medication which was utilised at a local level, however many of these volunteers have returned back to their own places of work.

316. In County Durham, 27 business made offers to provide volunteering support, with 20 businesses still reporting capacity to help. There have been 10 successful matches of request for support with business offers directly through the Volunteer Unit some additional matches for AAP projects.

Considerations: Response from the VCSE

Starting Well and Living and Ageing Well.

- Some VCSE rely solely on the efforts of volunteers; others employ paid professional staff and management structures to delivery their services.
- The COVID-19 lockdown restrictions have impacted on the capacity of those organisations to income generate and deliver services to their local communities.
- VONNE suggest almost 400k beneficiaries in the NE are receiving a significantly reduced service, or no service at all which is of serious concern.
- Local VCSE report their concerns for the future once COVID-19 funding runs out. Sustainable funding is essential
- Outputs and outcomes from VCSE work should also be quantified and considered.
- Volunteering options should be maximised to help enhance the capacity within the VCSE sector as the recovery progresses.

Status: High Impact
Population: Local populations using a place-based approach.
Likelihood of Impact: Major – due to need for communities to be self-sustaining and able to respond to any economic recession during recovery by maintaining community connections.

Outcome: Screened in – to ensure communities are able to access local community assets and empower themselves to maintain their own health and wellbeing at a local level.

Physiological factors and access to health care

317. WHO indicate over 95% of deaths that have occurred across the world during the COVID-19 pandemic are in those older than 60 years. More than 50% of all fatalities involved people aged 80 years or older. Reports show that 8 out of 10 deaths are occurring in individuals with at least one comorbidity, in particular those with cardiovascular disease, hypertension and diabetes, but also with a range of other chronic underlying conditions (WHO, April 2020).

318. Further investigation into the number of excess community deaths far exceeding the number of deaths currently directly attributed to COVID-19 is required. It will take months, perhaps years, to make sense of how this will affect long term population health outcomes.

319. It is still too soon to have conclusive evidence able to unpick the complex health impacts of both coronavirus itself and those of lockdown in the UK.

320. Guidance was issued through the BMA and RCGP to advise community practices to consider postponing non-urgent clinics during the pandemic; this included pausing low risk smears, NHS health checks, Over 75 health checks and medication reviews.

321. There are some early signs as referrals for suspected cancer reduced by around 75% over the first few weeks of lockdown, and screening programmes were effectively paused.

322. Hospital trusts have been given permission to pause all non-urgent elective work at the early stages of the pandemic. The attendance at A+E departments for April 2020 was 56% lower than the same month in 2019. The decision about when and what to stop has appeared more straightforward than when and how to restart this work, and how delivery methods need to adapt to meet demand.

323. The COVID-19 pandemic has brought rapid and dramatic change in how people access health services. Prior to the pandemic around 80% of primary care appointments were face-to-face contacts and this changed in a matter of weeks to the majority being telephone, video or online consultations in order to support social distancing measures.

324. The risk of further peaks of the virus means that remote consultations in both primary and secondary care are likely to continue. Where face-to-face contact is needed, for example in certain diagnostics and treatments, in order to maintain adequate social distancing and other infection control measures the allocated time and space needs to be considered.

325. If an appointment takes double the time because of such measures then only half the number of patients will be able to be seen in the same length clinic. Add to this the expected backlog of referrals, with a potential for waiting lists to soar.

326. Increasing remote access to GP services has been a policy priority for a number of years prior to the pandemic, but uptake had previously made slow progress with little in the way of evidence for how this might impact on patients. Concerns had been raised about any shift potentially increasing health inequalities by online methods increasing access and demand from those with the fewest health needs.

327. There are also concerns about the lack of human contact reducing the opportunities to pick up clues around safeguarding and domestic abuse. However, with the need to maintain social distancing within healthcare environments set to continue even when more general lockdown measures are eased, this shift in how healthcare services are accessed may be maintained in the longer term, with some quarters keen to avoid going back to the traditional model.

328. When considering remote consulting, this process relies on internet connectivity. According to the ONS 93% of households have broadband internet access, but only 84% of adults access the internet ‘on the go’ (i.e. on a mobile, laptop or tablet). Nearly a quarter of adults over the age of 65 have not used the internet at all in the last 3 months, with mobile device use lower in older age groups.

329. Complex co-morbidity generally evolves as people age. Figures add some credence to the concern that promotion of video and online consultations may be to the detriment of those with highest level of health ‘need’. There are also confidentiality concerns where devices are shared between family members or where a consultation takes place with the patient in a busy household; this can be a barrier to honest questioning about sensitive issues that may play out differently were the conversation in a private consultation room.

330. However, there are also potential benefits. Telephone triage can improve on the day access to a clinician, remote consultations can be time efficient and convenient for both patient and clinician. Going forward, the evidence available have suggests that the demography of patients using telephone consultations differs very little from those who traditionally accessed surgeries face to face.

331. Younger, more affluent patients tend to take up online consultation options but there is a general low level of use even when promoted by practices so the impact of this may not be as great as feared.

332. Ultimately there remains a scarcity of evidence to know exactly what this change will mean in terms of health inequalities. However, its potential to disadvantage those without internet access or who struggle with remote access for other reasons (perhaps due to disability, language or privacy barriers) needs careful monitoring.

333. Despite a potential for increased pressures, there may also be positive health outcomes cause by COVID-19. Immunisations have continued to be made

available with plans to reschedule any missed that are normally given in education settings.

334. There is expected to be increased take-up of flu vaccination with County Durham CCG requesting that local practices increase their adult influenza vaccination order by 10%.

335. The knowledge that diabetes, obesity and heart disease increase the risk of complications from Covid-19 may provide motivation for some patients to engage in managing these conditions more proactively.

336. A presumed reduction in casual sexual encounters alongside the use of postal STI testing kits has the potential to significantly reduce the chain of transmission for sexually transmitted diseases.

337. The role of the Social Prescribing Link Workers based in the Primary Care Networks will be pivotal to linking the patients to local support provided by the VCSE to help sustain community connections at a place-based level.

338. The required response of Clinical Commissioning Groups to the NHS 5-System Year Plan will provide opportunities to integrate the recovery response into the affiliated Outcomes, Goals and Integration Measure plans (OGIM's).

339. This process highlights key health care areas requiring action to improve health outcomes and will be pivotal to producing a cross reference towards mitigating against the impacts identified for healthcare services.

Considerations: Health Care Services

Starting Well, Living and Ageing Well.

- Stay at Home and Lockdown restrictions have reduced the numbers of patients accessing GP services for CYP and adult services.
- Some patients are unable to access healthcare services with a gap in skills, or access to virtual means.
- Patients are reluctant to access NHS services due to fear of infection meaning many are not addressing health concerns at an early stage.
- Long term conditions may remain untreated.
- Scheduled operations have been put on hold.
- COVID-19 may encourage positive engagement in screening programmes and vaccinations.
- Social Prescribing Link Workers will provide a link for local communities into the VCSE
- The CCG's and Primary Care Networks will be reviewing access measures
- OGIM's will provide opportunities to cross reference outcomes for the recovery response on a system-wide basis.

Status: Medium/high Impact due to current management by Trusts, CCG's and PCN's

Population: Universal with targeting for vulnerable and shielded groups. Likelihood of Impact – moderate, but may increase on a more long term basis.

Outcome: Screened out – The 5-Year System Plan needs to highlight areas of future activity in relation to the recovery from Covid-19.

Tobacco Control

340. The Cochrane Library have produced a Tobacco Control Special Collection's for the evidence base around tobacco control and its impact in relation to COVID-19. There is a recognition that tobacco smoking is known to be a risk factor for acute respiratory infections.

341. In addition, second-hand smoke increases the risk of acute respiratory infections. The World Health Organization urges people to stop smoking tobacco to minimize the risks associated with the current coronavirus pandemic in both people who smoke and those exposed to second-hand smoke in the home.

342. For many people quitting is not easy; however, there are a number of reviews evaluating interventions to help people to stop smoking. Evidence suggests that people who smoke should use a combination of 'stop smoking medicines' and behavioural support to give them the best chances of success.

343. Options for quitting smoking may be more limited during lockdown restrictions than usual at the current time, however there are still evidence-based ways available to help people succeed. These include medication; behavioural support; and gradual quitting.

344. Interventions that mimic the act of smoking, notably e-cigarettes, have been excluded from the Cochrane collection as the risks associated with their use in relation to the current pandemic are not clear.

345. The COVID-19 pandemic is unprecedented and stressful, and it may not seem achievable to make big behavioural changes during this time. For people who cannot attempt stopping smoking immediately, an option is to reduce the number of cigarettes smoked before quitting.

346. There is evidence to suggest that people who reduce their smoking before stopping altogether may be just as likely to successfully stop as those who quit abruptly.

347. However, in the current situation it would be beneficial to quit soon to reduce the risks associated with COVID-19 as much as possible. Quitting smoking also helps to increase financial resilience.

Consideration: Tobacco Control

Starting Well

- Smoking has an impact on health outcomes from the virus across the life course.
- Second hand smoke and smoking in the home will increase impacts of the virus.

Living and Ageing Well

- Access to Stop Smoking Service Support maybe perceived as being reduced.
- Smoking prevalence could rise as negative socio-economic impacts of COVID-19 are understood, which will impact on mental wellbeing.

Status: Low to medium Impact
Likelihood of Impact: possible
Population: Smokers and home environment due to second-hand smoke

Outcome: Screened out – but to be reviewed and monitored by the County Durham Tobacco Control Alliance

Alcohol and Drug Related Harm

Covid-19 Lockdown and Alcohol Consumption

348. Research has found that consumption of alcohol increased across the country during the COVID-19 crisis. The Global Drug Survey found UK drinkers started drinking earlier in the day, having more drinking days and found more evidence of binge drinking (Global Drugs Survey, April 2020).

349. Kings College London has carried out its second survey during the crisis showing 29% drinking more than usual, up from 19% in April.

350. YouGov find over half of Brits are spending less money than usual – but spending on alcohol for home consumption is up 34%.

351. As the UK and most other countries went into lockdown, the need to save lives from COVID-19 has been a priority over longer term health concerns. Many people stocked up on alcohol to drink at home. In the week to 21 March, alcohol sales were up 67%, compared to a 43% increase in overall supermarket sales.

352. The impact of increased alcohol consumption is an increase in disease burden causes by alcohol. PHE published Alcohol- attributable fractions for England: An update on 12th June 2020. This found that in comparison to the previously published AAFs, 64% of estimated AAFs for chronic conditions have decreased in magnitude, while 3% have remained constant and 33% have increased (PHE, June 2020).

353. The North East survey of 513 people from Balance is part of a representative survey of more than 2,000 people across the UK commissioned by charity Alcohol Change UK. The survey suggests that lockdown is changing the way that the UK drinks at both ends of the scale, with one in 20 (5%) of people who previously drank alcohol having stopped completely during the lockdown (Alcohol Change UK, 2020).

354. These figures suggest that over 450,000 adults in the North East and 8.6 million adults in the UK are drinking more frequently since lockdown, while over 650,000 NE adults and 14 million nationally are drinking less often or have stopped drinking entirely (Alcohol Change UK, 2020).

355. 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. In the North East:

- 20% of drinkers are now taking drink free days
- 11% are being careful with the amount of alcohol they buy
- 5% are stopping drinking completely for the lockdown
- Seeking advice online (3%)
- Attending remote support groups (1%)
- Receiving remote 1-1 counselling (1%)
- Using apps to monitor their drinking (1%)

356. The context of these changes needs to be considered as the people who were already drinking the least often who have cut down in the greatest number. Almost half (46%) of people who drank weekly or less have cut down or stopped drinking completely, compared to 25% of people who drank four to six times a week, and no daily drinkers (Alcohol Change UK, 2020).

357. Worryingly, 11% of daily drinkers (who are already more likely to be drinking above the Chief Medical Officer's low risk guidelines of no more than 14 units a week) have further increased the amount they drink.

Drug and Alcohol Recovery Services

358. The illicit heroin market is reported to be reasonably stable nationally; although some areas are reporting long waiting times and reduced quality. Whilst crack and cocaine purity appears stable in the majority of regions (PHE, 2020).

359. There is continuing speculation that following easing of the lockdown, many regions will be flooded by high-purity, low-cost drugs as dealers try to shift stock which could lead to an increase in overdoses. It is anticipated that supply issues could affect the drug market more acutely later in the year.

360. There have been reports of increased county lines activity from across the country and increasing drug market competition and violence.

361. In late May, a ‘large’ number of ‘blue pills’ (believed to be benzodiazepines but this is unconfirmed) were seized in the East of England and have been linked to local violence, A&E attendances and to 1 death. However, this isn’t something seen in County Durham (PHE, 2020).

362. For Drug and Alcohol Recovery Services, during the first phase of the pandemic the aim was to reflect the pressures on services (including pharmacies) and to protect staff and service users by reducing some face-to-face interactions (e.g. supervised consumption) and increasing harm reduction (e.g. NSP, naloxone, alcohol reduction advice).

363. Following this an assessment of the impact of service adjustments on people and the risks generated, particularly in relation to isolation, mental health, safeguarding, domestic abuse and the accessibility of services including to new referrals is being developed.

364. In the initial stages, positively, County Durham has seen consistent numbers in treatment services and no increase in substance misuse related deaths (Durham County Council, 2020).

365. The next phase of the pandemic will focus needs to be on how provision can now be safely enhanced. Including bringing services back gradually where it is safe and appropriate to do so, being sure to remain compliant with COVID-19 safety guidance (distancing, PPE, isolation, etc).

Consideration: Alcohol and Drug Related Harm

Starting Well, Living and Ageing Well

- In the week to 21 March, alcohol sales were up 67%, compared to a 43% increase in overall supermarket sales.
- Over 450,000 adults in the North East are drinking more frequently since lockdown.
- Over 650,000 are drinking less often or have stopped drinking entirely.
- 11% of daily drinkers (who are already more likely to be drinking above the Chief Medical Officer’s low risk guidelines of no more than 14 units a week) have further increased the amount they drink.
- DARS report the maintenance of those in treatment

Status: Medium to low Impact
Population: People who use alcohol and substances
Likelihood of Impact: possible.

Outcome: Screened out – to be reviewed and monitored by the County Durham Alcohol and Drug Harm Reduction Strategy Group

Environment – urban and rural spaces

366. The Government has issued guidance which sets out the key principles of enjoying the benefits of being outside, whilst protecting yourself and others from the virus. The risk from COVID-19 being passed on to others outdoors is considered to be low on condition that people maintain the primary recommendation social distancing at 2-metres apart. A new 1-metre rule is being initiated on 4th July if the 2-metre is not viable.

367. The government have issued guidance on accessing green spaces safely. Within this a key message to the public is to respect other people and protect the natural environment.

368. Exercise and physical activity and spending time outdoors for recreation in line with government guidelines has been a key component of the Stay at Home measures instigated during the lockdown phase. However, for those from shielded populations extended confinement has been recommended.

369. From 1st June 2020, an opening of access to the environment this has been extended to include people within with households or in groups of up to six people from outside the household. Shielding restrictions have also been lifted (HM Government, 31st May 2020).

370. In England, people have been encouraged to spend time outdoors and take part in other outdoor sports and activities, including walking, running and cycling. As lock down restrictions have lifted the ability to drive to outdoor open spaces, including beaches and beauty spots has been loosened.

371. From 1st June, irrespective of distance, members of the public can drive to outdoor open spaces, including beaches and beauty spots, gardens, nature reserves and parkland to spend time outdoors, although access may be limited to members or those with tickets to ensure social distancing.

372. However, guidance has been retained for avoiding public transport other than for essential journeys, which could disadvantage those unable to afford private vehicles. With the current closure of leisure centres, swimming pools and sports clubs, people accessing outdoor space during the lockdown has been very important too for physical and mental health benefits.

373. The ability to maintain connectivity to the environment and encouragement to keep up physical activity is seen as a positive measure. Other European countries during the pandemic have used police enforcement in some areas to prevent the public form venturing outside during the peak of the infection.

374. Evidence from earlier economic recessions in the UK, suggested that they may have led to an improvement in physical health, possibly due to reduced work-related stress and the relative unaffordability of unhealthy behaviours such as smoking, excessive drinking and drink driving (Vanoross, 27th April 2020).

375. Evidence considering more recent crises have been measurably damaging for physical health. Recent studies found a decrease in fruit intake and an increase in obesity and the likelihood of suffering from diabetes in England following the great recession of the late 2000s.

376. In the case of the post-COVID-19 recession, the negative health impacts of the recession will be given a head start by the lockdown. The lockdown is necessary to prevent the spread of Covid-19, but it may have spill over effects. It has the potential to widen health inequalities between the most affluent communities and the most deprived communities in a number of factors such as obesity, cardiovascular disease and physical activity prevalence.

377. Being less active can lead to higher levels of obesity, which is associated with numerous diseases including coronary heart disease, diabetes and cancer (Vanoross, 27th April 2020). Early studies from France, the US and UK, figures suggest that patients who are classified as are at significantly greater risk. In New York City, a study of 4,000 Covid-19 patients found that obesity is the second strongest predictor, after their age, of whether someone over 60 will require critical hospital care.

378. Evidence from the US has found that patients under 60, they are twice as likely to need intensive care if they have a body mass index over 30, and over three times more likely to need critical care with a BMI over 35.

379. However, the quarantine may have some positive impact if the population are able to maintain new behaviours and build upon the fact that physical activity levels were on the rise and inactivity was falling prior to the COVID-19 outbreak, according to Sport England's Active Lives Adult Survey. The survey showed that there were approximately 159,500 fewer inactive people in England (Nov 2018- Nov 2019) meaning more adults were doing at least 30 minutes of moderate intensity physical activity a week.

380. We may see fewer car crashes, improved air quality due to reduced carbon emissions and increased perception of safety of commuters if there is a permanent switch to working from home and less commuting.

381. If more people choose to commute via walking, cycling or running then evidence has been attributed to both physical and mental health benefits. For example, active travel has shown a reduction in cardiovascular events such as heart attacks.

382. Related to mental health, active travelling via walking and cycling has been shown to improve mental health. particularly for active travel to and from work compared with passive commuting. Pollution is a serious health risk factor that claims about 40,000 deaths a year in the UK, while over 1,700 people lose their lives per year in car crashes.

383. Reports that smokers are more likely to experience severe symptoms of COVID-19 may, in combination with the curtailment of opportunities to socialise, are contributing to lower smoking rates.

384. The pandemic has brought added pressures for residents based in the rural areas of County Durham. This impacts specifically on the agricultural sector as many of the measures to control transmission were implemented in the midst of the spring programme, where farmers are very busy with tasks such as lambing and planting.

385. As well as worrying about the potential impact of COVID-19 on the supply chain generally (reduction in demand for farm produce, delayed deliveries and pick-up), farmers are a relatively older population compared to the average UK workforce.

386. Remote farming communities and less frequent travel may provide a natural social distancing for rural communities; however this can bring challenges unique to rural residents. Access to schools and services via digital media, can prove challenging for those who do not have access to the internet/broadband. These issues can result in residents feeling more isolated and less able to access help if needed.

387. Upper Teesdale Agricultural Support Services (UTASS) has over 400 farming businesses on its database. Its staff and volunteers have been helping those within our Dales communities by providing practical advice and support services to those who have contacted the organisation directly or via its social media platforms.

Considerations: Environment – urban and rural

Starting Well, Living and Ageing Well.

- Stay at home guidance and lockdown measures have impacted on the reduction of access to the outside environment.
- For those from shielded populations extended confinement has been recommended.
- People have been encouraged to spend time outdoors and take part in other outdoor sports and activities, including walking, running and cycling.
- The closure of leisure centres, swimming pools and sports clubs may impact on the physical and mental health benefits they supply.
- Being less active can lead to higher levels of obesity, associated with numerous diseases including coronary heart disease, diabetes and cancer.
- Sport England's Active Lives Adult Survey. The survey showed that there were approximately 159,500 fewer inactive people in England.
- Positive reduction on carbon emissions and traffic.
- The farming community should engage directly to reduce social isolation and accessibility issues.

Status: Low/Medium Impact as the lockdown measures are lifted.
Population: Universal and vulnerable

Likelihood of Impact - possible negative impacts on obesity, and social isolation, but may lift as lockdown is eased. Moderate on positive impacts on carbon emissions and traffic levels.

Outcome: Screened Out as positive outcomes may increase when lockdown lifts.

388. In considering the potential of impacts of Stay at Home measures and lockdown restrictions during the COVID-19 response, the prioritisation process for the HIA has highlighted the key areas requiring further consideration in order to reduce the pandemic's impact on health inequalities (see appendix 1).

389. The impact scoring for the policy areas of poverty reduction, mental health and emotional wellbeing and Community mobilisation through the Community Hub and the VCSE have been identified as areas for further analysis and action at a place-based level.

The Local Voice

390. To ensure all activity proposed for the recovery phase of COVID-19 designed to address inequalities remain relevant, the involvement of local voices is an essential part of the HIA process.

391. Since the advent of COVID-19, there have been many questionnaires, surveys and qualitative processes developed to help identify the impact the pandemic is having on individuals, families, communities, localities and various sectors of the VCS and business communities.

392. The use of qualitative feedback allows for an assessment of the possible health impacts as highlighted by the community themselves. This qualitative information will add depth to the HIA as it represents community experience, and perceptions of our local residents and stakeholders with 'expert' knowledge. This may be especially important when assessing social factors which may be difficult to portray in a traditional health profile.

393. The HIA creates an opportunity for the views and opinions from both a strategic and operational level to be fed-in to the process. Local insight can be added into the HIA on an ongoing basis reflecting the dynamic nature of the pandemic response.

394. Communication processes have been developed to engage the voices of:

- Children and Young people via the Time to Change Hub
- Young Offenders via Youth Justice service.
- Adults – currently in development.

Children and Young People

395. Investing in Children CIC were asked to support engagement with children and young people to consult on their experience during COVID-19. 14 young people aged 16-21 took part in 3 small discussions represented by the eXtreme Group (young people with Special Educational Needs and Disabilities) and two Young Adult Support Café groups (emotional wellbeing peer support projects.

396. The young people reported it was very difficult to understand the situation as the Government guidance has been very unclear. Their perception was there was a lot of inaccurate information and scare mongering on social media. This makes families feel anxious and uncertain about the future. The need for routine was highlighted as an important factor to staying well.

397. Families reported having very different opinions over social distancing and shielding measures causing conflict at home. However, some families reported becoming closer spending more quality time together. There were also positive reports of feeling less pressure to complete work (school and college), which was enhanced by the flexibility of working from home. the young people also reported time for reflection on what they want to do in the future.

398. When asked about the easing of lockdown restrictions, the young people questioned reported levels of frustration as they perceived some people had already been abusing social distancing regulations. They were also in favour of a slow return to normal to prevent the experience of feeling overwhelmed.

399. For some young people who currently access mental health services the lack of face to face support was not helpful. Young people and families also reported feeling socially isolated by being unable to see friends and family, which impacted on their condition.

400. The respondents felt very anxious about going to places and having to socially distance. They also reported a breakdown in relationships during this period has affected people's mental health. Some young people had been hospitalised due to a deterioration in their mental health. The young people also reported self-harming again due to pressures at home.

Youth Justice Service

401. The Youth Justice Service have asked for feedback from the young people engaged with their service. For young people who have offended the response is generally that lockdown has not impacted on them negatively. When explored further, the main reason for this is that lock-down restrictions have been largely ignored. In some cases, this was reported to be a family-wide approach and common within their local community.

402. Some young people have reported enjoying not having any pressure to attend educational settings, especially young people who had been bullied at school.

403. The Youth Justice Substance Misuse Workers have said that some young people have successfully managed to reduce/stop their substance misuse. This has been partly out of necessity – drugs are more difficult to source, and the prices have risen.

404. The young victims of crime involved with the service seem to have struggled more, verbalising increased issues with mental health and self-harm. Family conflict and boredom being issues. Difficulty in communicating over the phone or virtually seems also to have impacted on young offenders. These young people are missing the more personal face to face support.

405. Young people with SEND - aged 15-18, stated they were struggling and missing friends and family, however some young people who are due to transition from year 11 to further education expressed they felt far more relaxed about their upcoming transition, despite a lot of uncertainties. The pressure of not doing their GCSE's meant they felt far better about the current circumstances.

Adults

406. The engagement of the adult voice is currently in development as part of the Health, Welfare and Communities Recovery Group Plan and is an essential component of the HIA process.

407. The ability to build in a robust consultation process during the COVID-19 response will help the health and social care system understand the impact of the pandemic and enhance the development of future actions. This activity will also increase the confidence of communities to begin to return to the new COVID-normality.

408. Building on the principles of the Wellbeing Approach, communities need to be engaged to co-produce the on-going development of current services and future designs. Communities can also become part of the monitoring process in order to assess the effectiveness of those services in meeting their needs.

409. Methods to engage the community on their perceptions of the COVID-19 recovery currently being considered are:

- Using established engagement mechanisms (interest or geographical areas), where they exist, to gather views. Identify gaps and undertake targeted work to ensure voices are heard.
- Online and telephone surveys to establish attitudes and behaviours. Survey's can also be used to dig deeper on specific areas of interest.
- Creative dialogue - pulling together a representative Citizens Jury made up of participants who work with the council or who may have been recruited through a specific process. This method of community engagement would allow dialogue to occur over a specified timeframe during COVID-19 recovery.

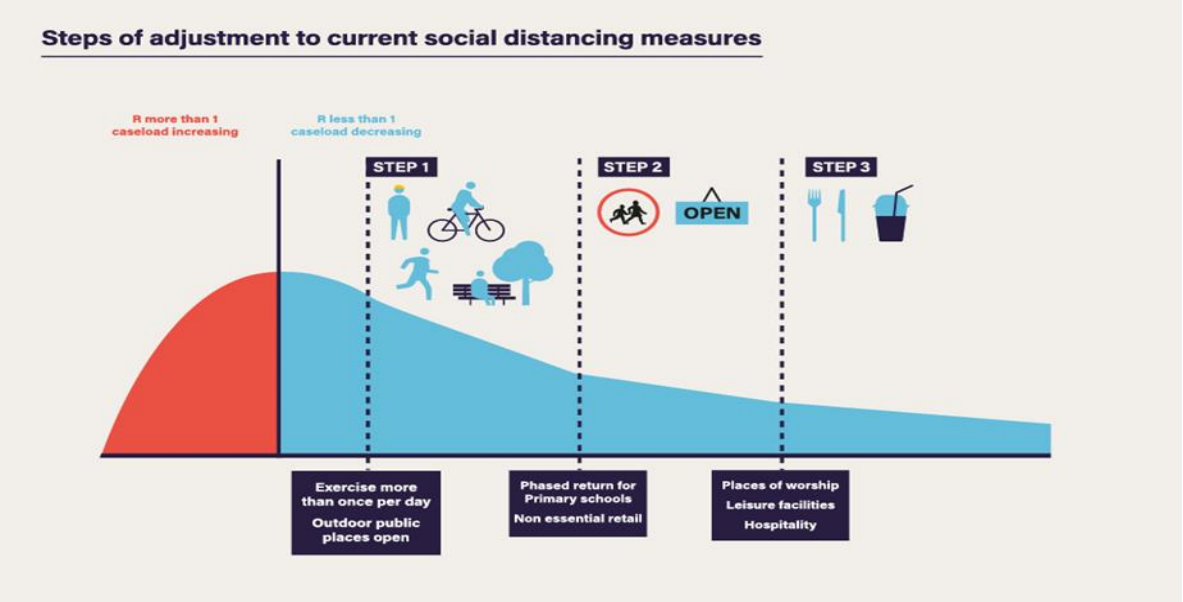
410. Decisions for the methods for community engagement will be made by the Health, Welfare and Communities Group.

Stage 4. Analysis

411. The full impact of the pandemic on local communities will not be fully understood until all COVID-19 restrictions are lifted and the new normal emerges as part of the recovery and restoration phases.

412. As the response to COVID-19 develops and the recovery phase progresses there will be a need to develop system-wide responses to react to changes within the stepped timeline. This will enable partners to adapt their approaches to respond to local needs during the stages of lockdown easing.

Figure 6. Steps of adjustment to current social distancing measures.



413. As well as being negative aspects of the lockdown restrictions the pandemic has brought many positives. This has included enhancing integration across the health and social care system. The restrictions have accelerated innovative ways of working to protect the more vulnerable in our society.

414. There has been successful action to place those who are homeless in accommodation within County Durham. The rapid initiation of the Community Hub and an active response by the VCSE has brought support to those residents who are shielded and vulnerable. The Drug and Alcohol Recovery Service report a new stability in some opiate clients and alcohol consumption has reduced in some population groups. The crime rates have also reduced.

415. There has been a rapid increase in use of digital technology and social media, which has helped people to stay connected with their loved ones as well as providing opportunity to retain contact with educational settings, NHS provision, support services and workplaces.

416. Home working has reported to have provided greater flexibility for some individuals, enabling a better work-life balance.

417. There has been an overall reduction in car use and traffic, along with improved air quality and reduced emissions. For some of the population, physical activity levels have increased as people explored their own local environment during their hours of lockdown exercise.

418. The use of the screening matrix of the HIA has enabled the negative impacts of the lockdown restrictions to be understood and prioritised.

419. The review of local strategies and approaches has highlighted key areas which need to be progressed into the action phase of the recovery process.

420. This will help raise awareness with partners of areas of concern and enable them to mitigate against risks impacting on health inequalities (Table 2).

Table 2. Results from HIA Impact Prioritising Process

Policy/area of approach	Impact ranking	Positive and negative impacts	Timeframe
Socio-economic factors and Poverty Employment Income	**High Impact** - due to financial implications for universal populations and vulnerable groups. Inequalities to be increased highly likely **Outcome: Screened In** Due to lasting legacy of rise in unemployment, financial resilience, housing, mental ill health, relationship breakdown and community cohesion – warrants further assessment of health inequalities.	**Negatives**: impact may increase over time as recession hits. implications for those losing their jobs as financial packages are withdrawn. **Positives:** opportunities to innovate, find new ways of working, increase efficiency and local investment to help stimulate the economy	Short, medium and long term – especially linked to mental health and emotional wellbeing.
Education and Skills	**Medium Impact** – universal populations and vulnerable groups. **Outcome: Screened out** as national government direction is for all schools, colleges, universities to return to the new normal in September 2020. The mental health impact on CYP is considered separately rather than as part standalone education health impact and so does not warrant further assessment as stand-alone policy area	**Negatives**: Depends on how long social distancing in educational settings is maintained. May be some legacy for impact on certain age groups. Lack of access to IT equipment is a barrier to learning. Impact on young people in general having school disruption and reduced social contact is predicted to impact on mental wellbeing over years to come as well as potential for disruption educational attainment	Medium and long term depending on duration of lockdown restrictions in educational setting.

		Positives: home schooling has enabled young people to reconnect with families, local CYP report increased levels of mental wellbeing by not being at school (see local voice section).	
Housing and homelessness	**Medium Impact** – universal and vulnerable groups **Outcome: screened out** for health inequality impacts at this current stage due to capacity meeting demand but requires monitoring into the longer term. Health impact will be explored through the poverty / welfare policy area instead of housing as stand alone	**Negatives**: Impact may increase as potential unemployment levels rise and/or recession hits. Full extent on future demand is unknown. **Positive:** Capacity has met demand. Potential homelessness has been managed during lockdown.	Medium and long term -especially linked to impacts of socio-economic status and predicted changes
Inclusion BAME GRT Refugees LGBT+ LD and Autism Carers	**High Impact –** due to vulnerabilities, low socio-economic status, poor housing, poor health status., specialist needs, higher risk of COVID-19 **Outcome: Screened in -** to be integrated in other of other areas around poverty, mental health and community networks and mobilisation and warrants further assessment	**Negatives:** inequalities in vulnerabilities to COVID-19. Lack of access to specialist support. Low socio-economic status for some groups, social isolation. **Positives:** opportunity for further investigation in to needs for some vulnerable groups.	Short and medium depending on timescales for lockdown
Mental Health and Emotional Wellbeing CYP LTP Suicide Prevention – including bereavement support. Crisis care Dementia Resilient Communities	**High Impact** – increasing in general population over time and within vulnerable groups. **Outcome: Screened In –** due to long term implications of impacts on mental wellbeing and requires further assessment to understand impact	**Negatives -** Will be ongoing as the predicted impact on socio-economic growth, unemployment, poverty levels may be affected. Impact CYP and ACE's. Impact on VSCE may also reduce access to wellbeing support and wider mental health services. reports on impacts on confidence returning to the new normal. . **Positives –** reports of reconnecting with families. Reduction in external stressors e.g. schools. Slower pace of life	Short, medium and long term – especially linked to impacts of socio-economic impacts.
Criminal Justice	**Medium impact** – due to current lower levels of reporting crime, but could increase over time. **Outcome – Screened out** for health impacts at this current stage due to	**Negatives -** Impact levels may increase as crime resumes, incidence of poverty and poor mental health increases.	Medium to long term – linked to socio-economic factors and mental wellbeing.

	capacity meeting demand, but requires monitoring into the longer term.	**Positives** – current capacity has met demand for criminal justice pathways and support	
Domestic Abuse	**Medium impact** – which could minimise during the lift of lockdown, or increase as socio-economic hardship increases. **Outcome: Screened Out -** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term. Being considered within existing infrastructures of DASVEG	**Negatives** – reports of hidden harm on the increase with the inability to report during short term stage of lockdown. Will add to impact of CYP and ACE's **Positives -** Service provision has been increased 24/7. Uplift from government support has also been given during COVID. Requires close monitoring as recovery develops.	Short, medium and long term - linked to socio-economic factors and mental wellbeing.
Safeguarding CYP Vulnerable adults	**High Impact** – which could minimise during the lift of lockdown,or increase as socio-economic hardship increases. requires on-going monitoring Outcome - Screened Out - for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term. Being considered within existing infrastructures SAB and DSCP	**Negative** full extent of hidden harm not yet known with the inability to report during short term stage of lockdown. ACE's for CYP may increase. **Positives** – robust mechanisms in place to maintain monitoring of safeguarding concerns via SAB and DSCP	Short, medium and long term - linked to socio-economic factors and mental wellbeing.
Community networks and mobilisation through Community Hub and VCSE	**High Impact** – due to capacity of VCSE. Impact of funding, staffing and accessibility into services. targeted approaches to the shielded and most vulnerable and so inequalities in access may widen **Outcome: Screened In –** due to the potential demand on services required to respond to growing needs on the community to mitigate health inequalities	**Negatives -** Full impact is still unknown as lockdown lifts, COVID-19 funding for VCSE runs out at the end of July. Demand on services may increase whilst VCSE capacity contracts. **Positives** – many residents report high levels of resilience for self-management of needs. Success of community Hub, high level of activity for VCSE, especially in mutual aid.	Short, medium and long term – depending on timing of lifting of lockdown and financial resilience of the sector.
Healthcare - 5-Year System Plan Access Screening LTC	**High impact** – depending on the ability of CCG's/PCN's,CDDFT/TEWV to be able to respond to need. **Outcome: Screened out** - Requires connection into NHS system planning group to monitor service delivery to	**Negatives** – potential for services to become over burdened with demand. Reduction in those most in need accessing services including imms and vacs, treatment for acute and long-term conditions.	Medium and long term as residents begin to access healthcare

	meet demand and manage inequalities during recovery.	**Positives** - Acceleration of integration agenda in response to COVID-19 between partner organisations	
Tobacco Control	**Medium/Low Impact** – prevalence of smoking and any increase unknown at the current time **Outcome:** Screened Out – monitored via existing channels. Full COVID-19 action plan delivered within short term timeframe - completed	**Negative** – lack of perceived access to stop smoking services. Smoking prevalence may increase during increase in challenging socio-economic times **Positives** - Stopping smoking is key to improving life chances Service has been maintained during lockdown. Wider tobacco control work has been adapted to maintain functions.	Short, medium, long term - linked to socio-economic factors and mental wellbeing.
Alcohol and Drug Harm Reduction	**Medium/low** Impact – regional reports suggest alcohol intake may have increased in the most vulnerable. Drug use is maintained at current levels. This may increase due to socio-economic factors and requires monitoring. **Outcome: Screened out -** for health impacts at this current stage due to capacity meeting demand, but requires monitoring into the more long term.	**Negatives** - May increase as recovery progresses due to socio-economic factors. **Positives** - County Durham Drug and Alcohol Recovery Service has had an increase in clients accessing the service and current clients remain stable**.**	Medium to long term - linked to socio-economic factors and mental wellbeing.
Environment – Urban and rural	**Current low-medium impact** – impact reduced as lockdown has lifted **Outcome: Screened Out –** due to the easing of lockdown restrictions.	**Negatives** – social isolation may increase, especially for vulnerable and shielded populations. **Positives -** Physical activity levels have reported to have increased. Climate change has benefitted from less carbon emissions due to less traffic.	Short to Medium – depending on ability to access to the outside environment

421. The priority high impact areas identified by the HIA for action are:

- Socio-economic and poverty reduction
- Mental health and emotional wellbeing
- Community assets and community mobilisation
- Inclusion of vulnerable groups integrated into the key priorities.

422. It is important to note other areas screened out during the HIA prioritisation process remain significant and will continue to be monitored for outcomes within current partner delivery mechanisms. This will help with the ongoing

assessment of any changes in impacts occurring over the COVID-19 recovery timeframe.

Analysis of Key Priorities

Socio-economic Factors and Poverty Reduction

423. The HIA has confirmed COVID-19 restrictions will have a profound and prolonged impact on widening social determinants during the short, medium and long-term timeframe. Socio-economic recovery and the impact of poverty underpin all major factors impacting on the wider determinants for health across County Durham.

424. With County Durham being in the top 20% most employment deprived upper-tier authorities across England, the lockdown restriction will have a significant impact on the county's working age population, who already live in areas with high levels of employment deprivation. This will only increase with time as the virus lingers and the threat of recession becomes a reality.

425. Impacts will be greatest on low paid, younger female workers and young people, many who are employed by small businesses hospitality, leisure and the travel sector. This will all increase the impact on child poverty as families struggle to pay their rent and manage their bills.

426. The COVID-19 alert level moved from Level 4 to Level 3 on 19th June 2020, even a loosening the two-metre distancing rule may still have implications for reduced profit margins for some businesses who may not be able to be sustained.

427. The wider poverty reduction agenda will be managed through the County Durham Poverty Action Strategy. The COVID-19 Poverty Action Plan on a Page (2020-2021) highlights the strategic aims and key priorities for reducing the socio-economic impact of lockdown on residents, businesses and communities.

428. The plan includes measures to:

- improve understanding of immediate financial hardship and long-term poverty, and the impacts on County Durham's residents
- To foster employability, personal wellbeing and sense of worth for residents experiencing immediate hardship and/or poverty
- Residents receive the best advice and support available concerning all areas of their financial situation
- Children and families have access to specific resources in response to the measures in place to combat COVID-19

429. All measures highlighted in the Poverty Reduction Strategy should integrate the priority areas within the HIA including a cross reference with mental health and emotional wellbeing as part of the process.

430. Knowledge and accessibility to local community assets and pathways into community networks should also be utilised to ensure the socio-economic support given to local residents to address their needs before they reach crisis.

431. The inclusion of groups including BAME, GRT, LGBTQ+, refugees, LD and autism and those within the criminal justice system should receive specialist support and measures tailored to redress inequalities for those who are most deprived.

Analysis of Key Priorities: Mental Health and Emotional Wellbeing

432. The experience of other European countries suggests the impact of lockdown restrictions on mental health and wellbeing will escalate over time. This includes those living in stable circumstances and with secure jobs.

433. Children and young people are likely to experience similar anxieties caused by COVID-19 lockdown as in adults. The inability to access school, normal routines, friends and relatives may have negative implications for early years, those transitioning to schools, colleges and universities and those taking exams.

434. Inaccurate information, mixed messages and scare mongering on social media has made both adults and young people feel anxious and uncertain about the future.

435. Some impacts on mental wellbeing for both young people and adults should resolve over time once lockdown eases and the new normal emerges. However, TEWV modelling suggests that at system level (including primary and secondary care) over 5 years the number of people with a diagnosable MH condition who need help from any part of “the system” could equate to up to 52% of CYP, 23% of working age adults and 22% of older people.

436. The potential for ongoing negative socio-economic impacts of the pandemic requires ongoing dialogue with local communities to assess longer-term mental health consequences. This can be achieved by developing a communication and engagement tool to consult with local voices over a prolonged timeframe, which is currently progressing.

437. This will be especially relevant for older people and those as identified as being vulnerable. The psychological impacts of the pandemic can impact negatively on those who may already be socially isolated. New ways of providing preventative befriending services whilst still social distancing will need to be developed to reduce the potential surge in demand for mental health services from older people.

438. For those on the frontline working during the COVID-19 to keep the NHS, social care and essential services running has taken its toll mental health and emotional wellbeing.

439. For those people hospitalised with COVID-19, there may also be the manifestation of psychological damage, which is as yet not fully understood. These areas of specialism are currently being reviewed by TEWV to address future demand.

440. Whilst the negative impacts of COVID-19 restrictions are recognised, people have also expressed positives impacts of lockdown. These include having more time to spend with their families and a reduction in the exposure to external stressors including school and the workplace.

441. Members of the local community have also indicated a new sense of kindness and community cohesion as people pull together to support each other during the lockdown restrictions. Many people hope this will remain long after the lockdown restrictions have lifted.

442. Many new mutual aid groups in the community have developed during the crisis response to provide support to the most shielded and vulnerable helping to reduce social isolation.

443. These support mechanisms can be built on to provide ongoing connectivity within local communities and help people access local VCSE services. This will add value the prevention and early intervention initiatives developed to ensure low-level mental health issues do not escalate into crisis.

444. The numbers of potential deaths by suicide occurring in County Durham during March-June 2020 during the lockdown restrictions have remained lower during the same time period in the previous year. This may challenge initial perceptions of the negative impact of COVID-19 on mental health but should be monitored for any increasing trends on a longer-term basis.

445. A recent snap-shot review of cases entering mental health services undertaken by Tees Esk and Wear Valley NHS Trust (TEWV) in May-June 2020, indicate 40% of new clients had never accessed mental health services prior to COVID-19 lockdown. This may indicate a potential surge in mental ill health within the general population as the recovery progresses. This may be set to increase if the country enters into economic recession.

446. TEWV also report an increase in community patients known to services who are struggling as lockdown eases. There is an issue re people not accessing any service over the past few months. Primary care are starting to see an increased demand for mental health related issues. 63% of all contacts with the NEAS 111 support line through lockdown were not known to mental health services.

447. In County Durham the Mental Health Strategic Partnership continues to provide the strategic framework for the COVID-19 response for mental health

and emotional wellbeing across the county, linking in with the wider response of the Integrated Care System (ICS) and Integrated Care Partnership.

448. The sub-groups for Children and Young People (via the Children and Young People Local Transformation and Resilience Plan - LTP), Suicide Prevention, Crisis Care Concordat, Dementia and the Resilient Communities Group continue to provide governance for all work currently being delivered.

449. The framework and governance of the MHSP can help to integrate the COVID-19 recovery response for mental health and emotional wellbeing into other key areas of priority highlighted in the HIA.

450. This will help to ensure mental wellbeing is firmly embedded into all partnership work undertaken to reduce the socio-economic impact of COVID-19 and increase the efficacy of the VCSE in engaging with their communities to address identified need.

451. The inclusion of target groups including BAME, GRT, LGBTQ+, refugees, LD and autism and those within the criminal justice system should also be taken into consideration within measures to address mental wellbeing to redress inequalities for those who are most deprived.

Analysis of key priorities: Community Assets and Community Networks

452. The development of the Community Hub in County Durham ensured contact with the 25,909 people registered on the shielded list. Once contacted to assess their needs for essential supplies, medication and social isolation, it became apparent the majority of local residents reported they had used existing family, or community networks to support their needs which indicates there is a level of personal and community resilience within local communities and an active use of existing, local assets during the response phase of the pandemic. This should be investigated further and built upon to maximise opportunities for further community engagement and mobilisation.

453. Whilst volume of demand into the Hub has decreased over time, client vulnerability has become apparent. Clients now engaging with the Hub have multiple and often complex needs linked to social isolation, emotional and mental wellbeing and ability to maintain financial resilience.

454. The Community Hub has provided support to a relatively small number of residents when considering the size of the population in County Durham. This indicates the wider VCSE may have provided significant support to local residents during the early response to the pandemic.

455. This level of community mobilisation and use of VCSE community assets accelerated by the response to COVID-19 lockdown has helped to accelerate the vision of ‘County Durham Together.’

456. The new Approach to Wellbeing provides an important set of criteria helping to nurture community resilience during the recovery period. The criteria can be

adopted by organisations as a guide to integrating health and wellbeing into their everyday practice. This approach can provide a collective approach to reduce inequalities. Organisations can do this by considering ways to:

- Make person centred health and care interventions available to all, ensuring they are empowering rather than stigmatising in approach;
- Working *with* communities to supporting their development and empowerment rather than doing *to* them;
- Acknowledge the differing needs of communities as well as the potential of their assets;
- Focus activities to support the most disadvantaged and vulnerable, helping to build their resilience;
- Align all related strategies, policies and services to reduce duplication and ensure greater impact;
- Develop and deliver services and assets in a way that encourages co-design and co-production with the people who need services and for those who provide support.

457. VONNE have indicated a third of VCSE organisations surveyed suggested they expect to lose more than 50 per cent of their income in the quarter April to June 2020.

458. The result of this may mean the VCSE sector's capacity may be severely limited during lockdown. Many volunteers will be unable to support their organisations on an ongoing basis. Organisations are expecting an average drop in VCSE staffing capacity of a third because of reduced income levels.

459. The outcome on the impacts on the VCSE may result in beneficiaries receiving a significantly reduced service, or no service at all. This may continue into the recovery phase of the pandemic due to the inability to fund raise whilst social distancing measures remain.

460. To respond to this the commissioning strategies for both adult and children's services in County Durham should continue to progress towards place-based approach to test the potential for Alliance contacting model for providers, including the VCSE.

461. The initial intention to progress the model with Community Mental Health contracts should be reviewed in light of COVID-19. The Durham Together provides an ideal opportunity to revisit the model and explore further options for expanding this approach which will help support the VCSE in the long term.

462. AAPs have allocated almost £1 Million of newly identified council funding to almost 200 projects across the county that have been established during the COVID-19 response. Significant amounts of short-term funding have also been made available to VCSE organisations over the last 2 months.

463. County Durham Community Foundation (CDCF) has also awarded £1m of COVID-19 Emergency Funding to date. £443,000 of this was to 99 projects in County Durham specifically.

464. Mitigation on the impact of COVID-19 restrictions on the sector should focus on plans protect community assets in the long term once the short-term funding has been spent. This could be as soon as September 2020.

465. In the meantime, the fragile VCSE sector should be given sustained support using a system-wide approach to maintain its buoyancy during the ongoing period of recovery. This action will help maintain the engagement of those vulnerable residents who find themselves in the most disadvantaged groups.

Monitoring and data sets

466. In order to help to understand the impact of lockdown on the priority areas identified by the HIA, data relating to local residents will enable an assess of the breakdown in need which can then be monitored over a short, medium and long-term timeframe.

467. Local authorities have received a shielded patient list, which is being used as an overarching, ongoing data set for each area. The list is dynamic, providing information on individuals who have specific medical conditions, putting them at higher risk of severe illness should they contract COVID-19.

468. Currently, 25,909 people across County Durham included on this list. They have all received a letter advising them to 'shield', i.e. protect themselves by staying at home and avoiding any face-to-face contact until 30 June (date is regularly reviewed).

469. To date, 13,732 people across County Durham have registered and, of these, 4,184 have highlighted their need for additional support (3,153 related to essential supplies, 261 to basic care and 770 to both).

470. To date, almost 5,713 food packages have been delivered through this route. In addition to centrally sourced data sets, the authority has a cross-referenced households with local datasets that could also indicate vulnerability. This identified a further 72,000 households which have residents who could be clinically, socially or economically vulnerable (taken from the population health management list).

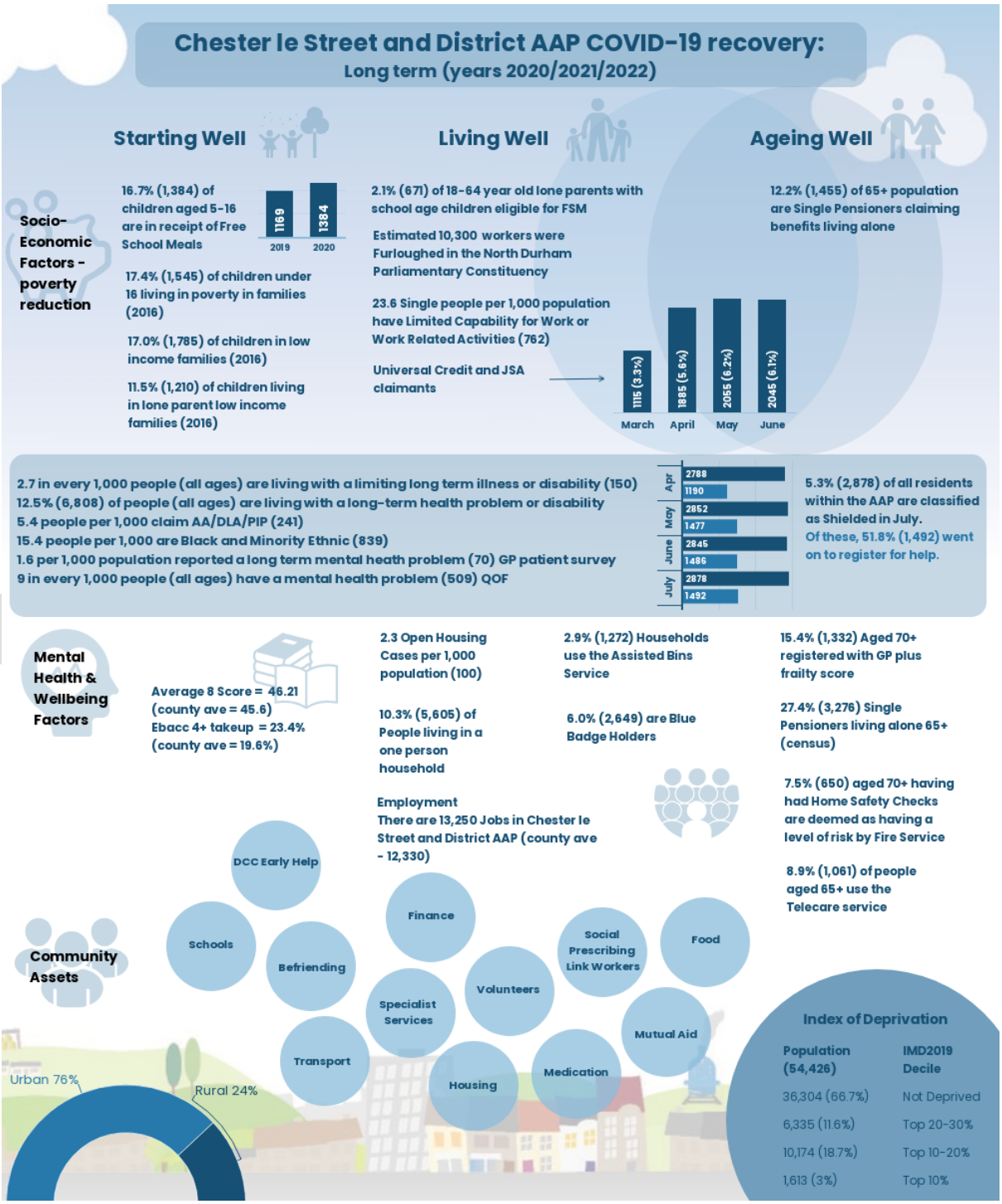
471. The information contained in the ongoing data sets can be used to analyse need at a county wide level through the lens of poverty reduction, mental wellbeing and community assets. This data can then be segmented into Area Action Partnership level to help understand the impact of COVID-19 in each area during each stage of recovery.

472. Data relating to Primary Care Networks boundaries can also be provided as COVID-19 recovery progresses.

473. The monitoring process for the priorities highlighted by the HIA will need to include ‘real time’ data reviewed over a designated timeframe (12, 24 and 36-months) to provide ongoing insight into any change in the needs of local communities

474. The data sets will also provide the ongoing narrative underpinning the evidence base on the outcomes of the recovery and its impact on inequalities.

Figure 7. Example Infographic highlighting HIA datasets for Chester-le-Street AAP.



475. Data sets will be provided for each of the 14 AAP areas to enable local communities to understand factors impacting on health at a place-based level

Conclusion

476. The response to the COVID-19 pandemic will continue to develop over time as the local communities in County Durham learn to live the virus until such a time as a vaccine can be found. Until that time, measures to help protect the public including varying policies for social distancing and lockdown will be maintained as the recovery moves to managing local outbreak situations.

477. As a consequence of the pandemic and governmental policies, health inequalities are expected to rise in our most deprived communities. This will be due to the prolonged socio-economic impact of COVID-19 lockdown on residents, their families, the communities in which they live and local businesses.

478. The recovery phase to the pandemic instigated by health, social care, education, housing, criminal justice, communities, environment, business and the economy all need to adapt to the changes once the restrictions are lifted and the economy reopens.

479. The pandemic has brought many negative areas of impact to people's lives, but also some positive. The ability to innovate and integrate approaches to the delivery of care through digital methods and shared practice has accelerate the pace of change for new ways of working. These developments can be maximised to move system-wide approaches into the new normal.

480. This rapid Health Impact Assessment (HIA) on health inequalities initiated by the County Durham and Darlington Health, Welfare and Communities Recovery Group has provided a 'snapshot' insight into the impact of COVID-19 lockdown using a place-based approach.

481. The focus on socio-economic factors impacting on levels of financial resilience, mental health and emotional wellbeing and the use of community assets and networks can now move into the action phase as part of the recovery process.

482. The requirement to ensure vulnerable, shielded and minority groups are targeted for consideration and has also been highlighted as a core function of helping to reduce inequalities.

483. This includes ensuring early help, safeguarding, risk management and inclusion processes are implemented for the most deprived communities.

484. The recommendations made by the HIA present opportunities for all partners to work together to address the pending impacts of COVID-19 on health inequalities.

485. Data produced at a place-based level will enable those partners to assess the impact of their activities on inequalities over time.

Recommendations.

Using a system-wide approach	**Organisation**	**Timeline 2020, 2021, 2022**
10. Ensure findings from this HIA are shared with regional partnerships such as the integrated care system and LA7 strategy group to work to reduce health inequalities across the NE	LA, NHS, VCSE, Businesses	Short term
11. Key findings and recommendations from HIA become embedded into existing local plans for recovery such as the refreshed joint health and wellbeing strategy	LA, NHS, VCSE, Businesses	Short term
12. Utilise the data and intelligence drawn from the HIA into all refreshed strategies to inform planning.	LA, NHS, VCSE, Businesses	Short term
13. Develop communication mechanisms to engage with the voice of children, young people and adults to ensure recovery is undertaken WITH our communities and not done to them	LA, NHS VCSE	Short, medium and long term
14. Develop and Ageing Well Strategy to inform future policy and service delivery across the system	LA, NHS VCSE	Short term
15. Focus targeted work on vulnerable and marginalised groups as part of COVID-19 recovery to reduce preventable inequalities	LA, NHS, VCSE, Businesses	Short, medium and long
16. Link to the County Durham Poverty Reduction Strategy and Poverty Reduction Action Plan to: v) Prioritise the reduction of food poverty through school-based and wider community approaches. vi) Improve all partner pathways to ensure understanding of how to access statutory and VCSE support vii) Train whole-system workforce to raise awareness of welfare support and impact money worries can have on health and wellbeing	 Schools and VCSE LA, NHS LA, NHS, VCSE LA, NHS, VCSE, Businesses	 Short, medium and long Short term Medium and long-term

viii)	Undertake a specific review to understand the impact on older people and poverty linked to an ageing well strategy.	LA, NHS	Medium and long-term
17.	Link to the County Durham Mental Health Strategic Partnership to:		
viii.	Increase access to low level early mental health support pathways for children and young people within educational and community settings – graded response and trauma informed. Consideration given for most vulnerable populations such as LGBTQ+.	LA, educational settings NHS, VCSE	Short, medium, long term
ix.	Using population health management approaches and forecasting across the system, consider how to support prevention and early intervention to mitigate as far as possible any increased demand to secondary care	LA, NHS, VCSE, Businesses	Short, medium, long term
x.	Develop and implement a streamlined information resource to provide access for communities and individuals to support for mental health and emotional wellbeing	MHSP	Medium and long term
xi.	Train system-wide workforces to address mental health and emotional wellbeing in local communities. – mental health champions and MECC	LA, NHS, VCSE, Businesses	Medium, Long term
xii.	Develop system response and offer to support the workforce (key workers) with a mental health and emotional wellbeing needs/moral injury that have developed as a result of COVID-19, eg through development of a resilience hub	TEWV, CDDFT, VCSE, Primary Care	Short, medium, long term
xiii.	Provide targeted support for COVID survivors and their families – CDDFT, TEWV, VCSE, Primary Care	TEWV, CDDFT, VCSE, Primary Care	Short, medium and long term
xiv.	Undertake consultation with older people and carers as part of a developing ageing well strategy	LA, NHS, VCSE	Medium and long term
18.	Build resilience in community assets and community networks to:		
ix.	Maintain and further develop the Community Hub to continue engagement with vulnerable and shielded populations ensuring system interface	LA, NHS	Short, medium
x.	Map and add to Locate community assets to provide ongoing support for local residents utilising a place-based approach.	LA	Short, medium

xi.	Improve service user pathways to access statutory and VCSE support mechanisms as standard.	LA, NHS	Short, medium
xii.	Support the VCSE by providing sustained funding and measure outcomes to beneficiaries.	LA, VCSE	Short, medium and long
xiii.	Maintain support for volunteers and increase options to recruit more.	LA, VCSE	Medium and long
xiv.	Progress Alliance contracting model to build community resilience.	LA, VCSE	Medium and long
xv.	Adopt the wellbeing approach across County Durham	LA, NHS, VCSE, Businesses	Short, medium and long
xvi.	Ensure the community is prepared to respond to a second wave and local outbreaks	LA, NHS, VCSE, Businesses	Short, medium and long

Describe health impact area	Will health impact affect whole population, or targeted groups	Will the health impact be difficult to resolve, or have irreversible impact	Will health impact be medium to long-term	Are the health impacts likely to generate public concern	Are health impacts likely to generate cumulative impact	Will the health impact have positive, or negative impacts	Scoping outcome for action
Poverty Reduction	Whole population and targeted group	Difficult to resolve during lockdown for deprived groups	Medium and long term	Yes	Yes as pandemic progresses	Negative	High Impact
Education and Skills	Whole population and targeted groups	Ongoing	long term	Yes	Yes until schools re open	Negative and positive reports for CYP not going to school	Low/Medium Impact
Housing	Targeted group	Can be resolved depending on capacity	Medium and long term	Yes	Yes as pandemic progresses	Negative	Medium impact
Homelessness	Targeted group	Has been resolved during lockdown	Medium and long term	Yes	Yes as pandemic progresses	Negative	Low/Medium Impact
BAME	Targeted groups	Ongoing	Medium and long term	Yes	Yes as pandemic progresses	Negative	Requires further enquiry
GRT	Targeted group	Required further investigation	Medium and long term	Yes, but potentially limited due to stigmatised nature of the group	Yes as pandemic progresses, but will reduce after lockdown	Negative	Requires further enquiry
Refugees	Target group	Can be resolved after lockdown	Medium term	In some areas	Yes as pandemic progresses, but will reduce after lockdown	Negative – with some positive stories in County Durham	Requires further enquiry
LGBTQ+	Target group	Can be resolved after lockdown	Medium term	In some areas	Yes as pandemic progresses, but will reduce after lockdown	Negative but will reduce after lockdown	Medium impact during lockdown Requires further enquiry
Learning Disabilities and Autism	Target group	Can be resolved after lockdown	Medium term	Yes	Yes as pandemic progresses	Negative	Medium Impact during lockdown
Carers	Target group	Can be resolved after lockdown	Medium to long term	Yes	Yes as pandemic progresses	Negative	Medium/High impact during lockdown
Mental Health and Wellbeing		Can be resolved after lockdown but may have long term impacts	Medium to long term	Yes	Yes as pandemic progresses	Negative, but also some positive benefits for CYP not going to school. Reduction in stress whilst in lockdown. increasing family connections.	High Impact
Criminal Justice	Target group	May increase after lockdown is lifted	Medium to long term	Yes	Yes as pandemic progresses	Negative	Medium increasing to high as lockdown lifts
Domestic Abuse	Universal and target group	Can be resolved after lockdown but may	Medium term	Yes	Yes as pandemic progresses, but will	Negative	High impact

		have long term impacts			reduce after lockdown		
Safeguarding	Universal and vulnerable groups	On going	Medium to long term	Yes	Yes as pandemic progresses	Negative	High Impact reducing after lockdown
Community Networks and mobilisation	Universal and target groups	Can be resolved after lockdown but may have long term impacts	Medium and long term	Yes	Yes as pandemic progresses	Negative, but positive for community mobilisation	High Impact reducing after lockdown
5-Year NHS Plan – access, Screening and LTC	Universal	Can be resolved after lockdown but may have long term impacts	Medium and long term	Yes	Yes as pandemic progresses, but will reduce after lockdown	Negative for access, screening, scheduled operations, LTC	High impact reducing after lockdown
Tobacco Control	Targeted group	Ongoing	Medium and long term	Yes	Yes as pandemic progresses, but will reduce after lockdown	Negative	Medium/Low Impact
Alcohol and Drug Harm Reduction	Whole population and targeted group	Substance misuse may increase due to lockdown	Medium and long term	Yes	Yes as pandemic progresses, but will reduce after lockdown	Negative	Medium/Low Impact
Environment – Urban and rural	Whole population and targeted group	Ongoing developments	Medium and long term	Yes	Yes as pandemic progresses, but will reduce after lockdown	Negative	Low/Medium Impact

Appendix 2.

Clinically extremely vulnerable groups

Taken from Government Guidance 31st May 2020

Expert doctors in England have identified specific medical conditions that, based on what we know about the virus so far, place some people at greatest risk of severe illness from coronavirus. Disease severity, history or treatment levels will also affect who is in this group.

Clinically extremely vulnerable people may include:

1. Solid organ transplant recipients.
2. People with specific cancers:

- people with cancer who are undergoing active chemotherapy
- people with lung cancer who are undergoing radical radiotherapy
- people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
- people having immunotherapy or other continuing antibody treatments for cancer
- people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs

3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD).
4. People with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.
7. Other people have also been classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions.

Appendix 3. Definition of VCSE

National Audit Office uses the following definition to distinguish between the differing levels of TSO's, commonly referred to as Voluntary, Community Sector and Enterprise (VCSE).

Voluntary and Community Sector
Includes registered charities, as well as non-charitable non-profit organisations, associations, self-help groups and community groups. Most involve some aspect of voluntary activity, though many are also professional organisations with paid staff. 'Community organisations' tend to be focused on localities or groups within the community; many are dependent entirely or almost entirely on voluntary activity.

General charities
Charities registered with the Charity Commission except those considered part of the government apparatus, such as universities, and those financial institutions considered part of the corporate sector.

Social enterprises (and community businesses)
A business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or community, rather than being driven by the need to maximise profit for shareholders and owners.

Mutual Aid and Co-operatives
Membership-based organisations run on a democratic basis for the benefit of their members. Members may be their employees or their consumers or be drawn from the wider community. Some employee co-operatives may be essentially private businesses but many mutuals and co-operatives consider themselves part of the social enterprise sector.

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Rapid Health Impact Assessment of Health Inequalities during COVID-19

Jane Sunter
Public Health Strategic Manager,
Living and Ageing Well

Altogether better

Durham County Council

Impact of COVID-19 on Local Residents

Higher impact on older age (70+) due to vulnerabilities and long term conditions

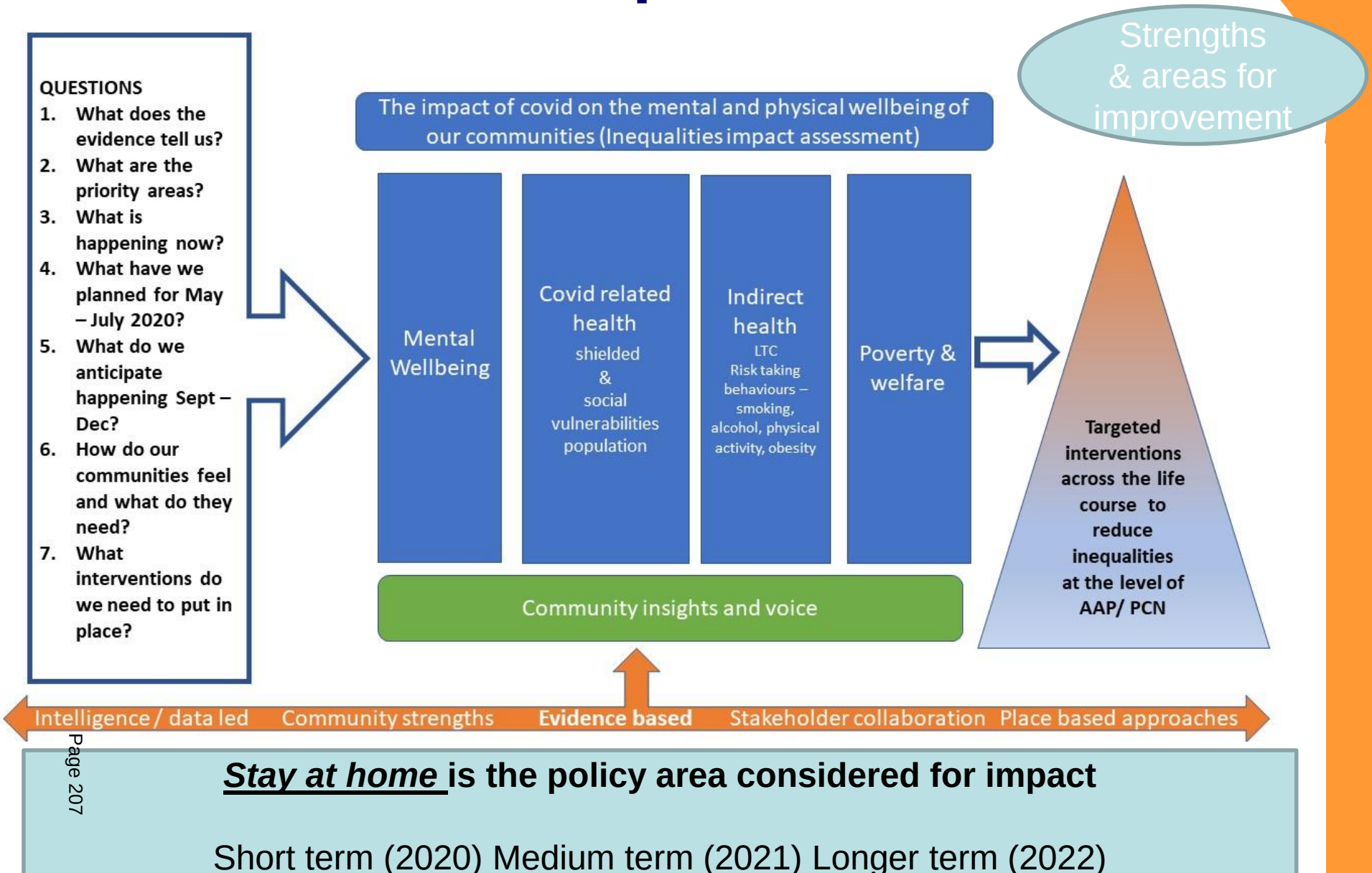
Virus has higher impact on men, but lockdown has a higher impact on mental health of women

High impact on residents within certain geographical areas experiencing higher levels of inequalities

Higher impact on BAME communities. In County Durham impact on GRT requires further investigation

High Impact on child poverty, educational attainment and future employment opportunities for young people

RAPID Health Impact Assessment



Stay at home **is the policy area considered for impact**

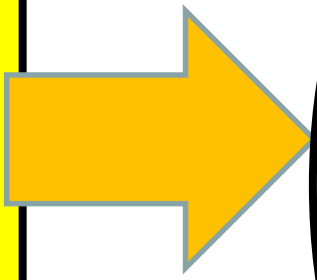
Short term (2020) Medium term (2021) Longer term (2022)

Key Priorities Identified

1. Socio-economic factors - poverty reduction
2. Mental health and emotional wellbeing
3. Community assets and community mobilisation
4. Inclusion of vulnerable groups integrated into the key priorities.

Other Priorities Identified (Still imp)

Education and skills
Housing, homelessness
Criminal justice
Domestic abuse
Safeguarding
5-Year System Plan
Tobacco control
Alcohol and drug harms
Environment – obesity, food and carbon footprint



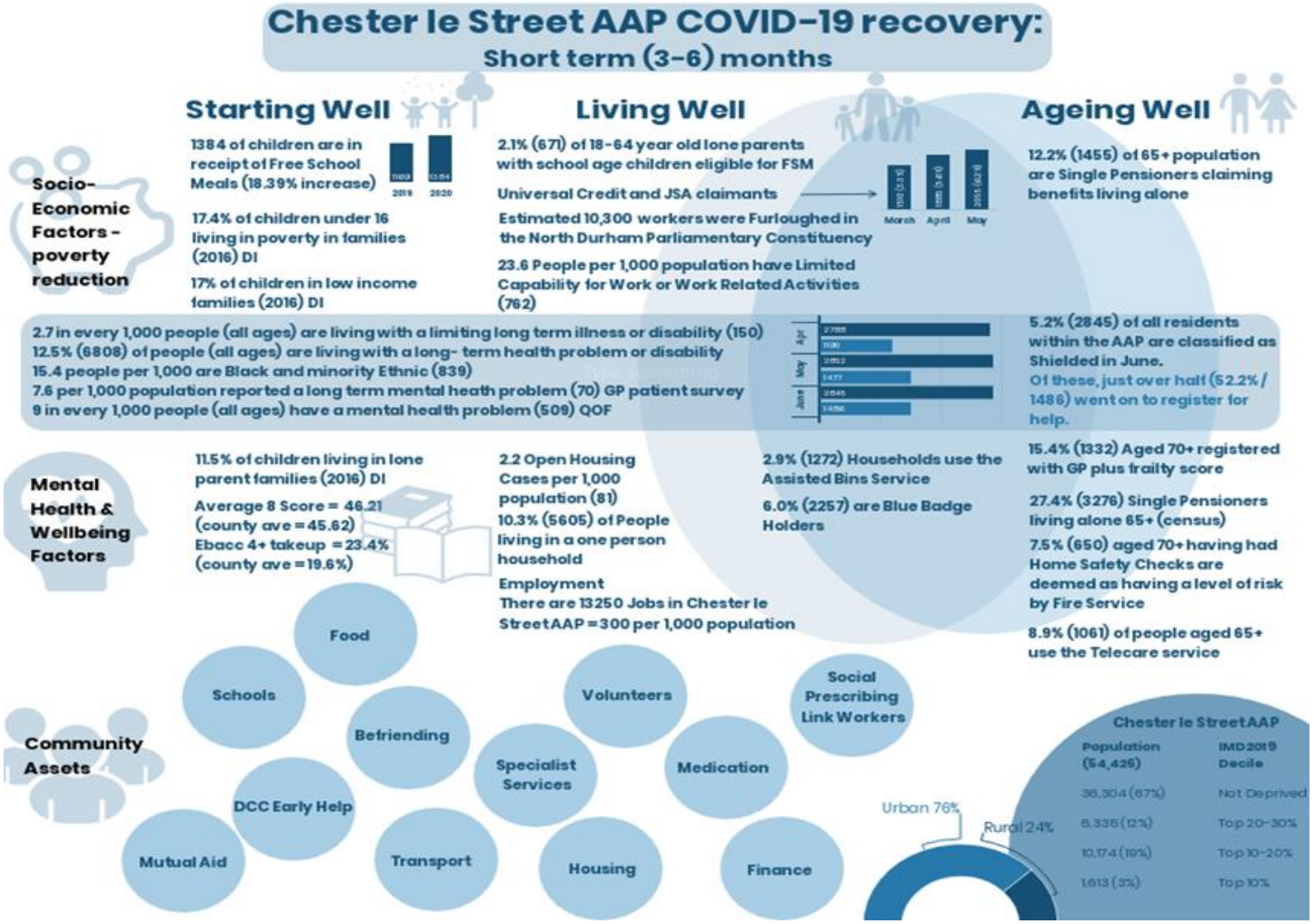
Managed through other partnership arrangements

Monitor and review over short, medium and long term

Altogether better

Durham County Council

Example Infographic highlighting HIA datasets for Chester-le-Street AAP



What's the ask for partners?

- Identify actions to ***mitigate negative impacts and enhance positive impacts*** of the COVID-19 recovery response using a system wide approach.
- ***Integrate the key priorities*** identified by the HIA into all strategies and polices to contribute to a reduction in inequalities.
- Contribute to the ***recommendations***
- ***Monitor data*** in priority areas to measure impact of future actions undertaken.
- ***Build on learning*** and support preparations for any second wave or local outbreak situations

Examples of Recommendations

Using a system-wide approach		Organisation	Timeline
1.	Ensure findings from this HIA are shared with regional partnerships such as the integrated care system and LA7 strategy group to work to reduce health inequalities across the NE	All	Short term
2.	Key findings and recommendations from HIA become embedded into existing local plans for recovery such as the refreshed joint health and wellbeing strategy	All	Short term
3.	Utilise the data and intelligence drawn from the HIA into all refreshed strategies to inform planning	All	Short term
6	Focus targeted work on vulnerable and marginalised groups as part of COVID-19 recovery to reduce preventable inequalities	All	Short medium and long term

Examples of Recommendations

7.	**Link to the County Durham Poverty Reduction Strategy and Poverty Reduction Action Plan to:**	Partners	Timeline
iii)	Train whole-system workforce to raise awareness of welfare support and impact money worries can have on health and wellbeing	All	Medium and long term

8. Link to the County Durham Mental Health Strategic Partnership to:		**Organisation**	**Timeline**
•	iv) Train system-wide workforces to address mental health and emotional wellbeing in local communities. – mental health champions and MECC	All	Medium, Long term
9. Build resilience in community assets and community networks to:			Short term
	viii) Ensure the community is prepared to respond to a second wave and local outbreaks	All	Short term

Next Steps

- Disseminate HIA to relevant partnerships
- Develop HIA Action Plan (complete)
- Complete and disseminate data packs
- Monitor partnership implementation of 4 key priority areas and contribution to recommendations.
- Monitor data over a 12, 24 and 36-month timeframes

Tees, Esk and Wear Valleys
NHS Foundation Trust

CQC Inspection/Action Plan Update

The purpose of this report is to provide an update on the CQC action plan developed in response to the Trust CQC Inspection undertaken September to November 2019 (published March 2020).

The resulting CQC report rated the Trust overall as 'requires improvement' and the ratings for the five individual domains are as follows:

Safe	Requires Improvement	
Effective	Good	
Caring	Good	
Responsive	Requires Improvement	
Well-led	Good	

Specific core services were rated as follows:

Acute wards for adults of working age and psychiatric ITU	
Specialist Eating Disorder services	
Long stay or Rehabilitation wards for working age adults	
Mental health crisis services and health based places of safety	
Wards for older people with mental health problems	
Wards for people with a Learning Disability or autism	
Specialist community mental health services for children	
Forensic inpatient or secure wards	
Community based mental health services for older people	
Child and adolescent mental health wards	
Community based mental health services for adults	
Community based mental health services for LD & autism	

Actions in response to each of the findings from the inspection have been agreed in collaboration with the Executive Management Team, Operational Management Team and other Senior Leads from the organisation.

The action plan is subject to rigorous monitoring to ensure achievement of the plan to given timescales. As at 27/10/20; 6 of the 19 actions are complete, 2 are complete and require submission of supporting evidence to facilitate sign off, 7 actions are in progress within timescale and 4 actions are reporting as behind schedule (see following page).

Of the 4 actions that are behind schedule only 2 are relevant to Durham. They both relate to mental health services for older people and are related to correctly recording information within patients electronic care records. The Durham locality leadership team monitors progress against our actions on a monthly basis.

The link to the full report can be found here for information:

https://api.cqc.org.uk/public/v1/reports/a6a9c607-f22b-434e-98c5-dcfedf9e0d52?20200302132407

Jennifer Illingworth

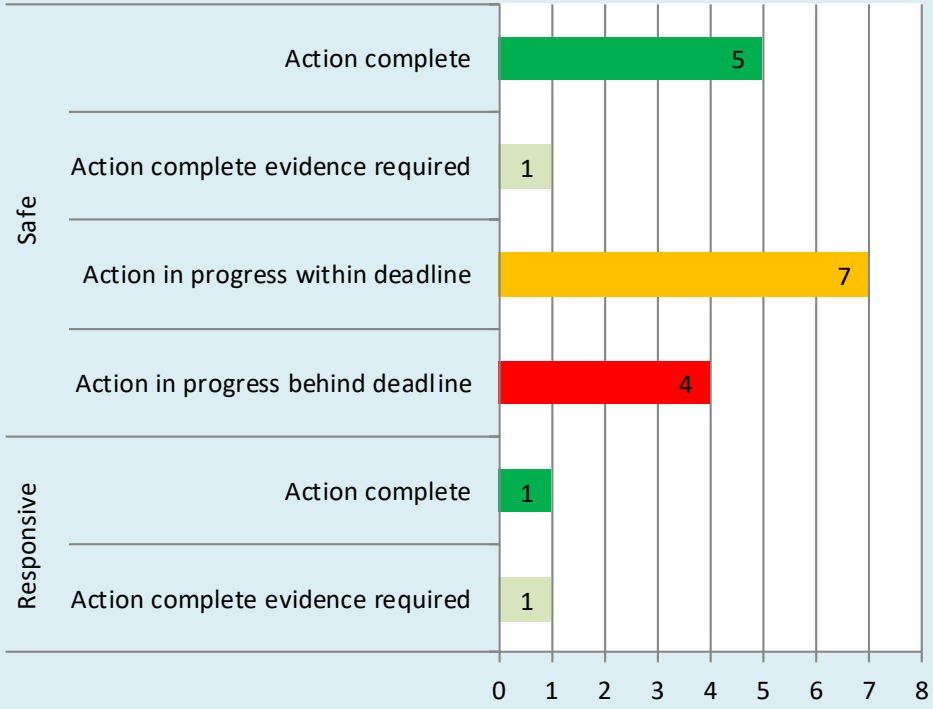
Director of Operations, Durham & Darlington

Tees, Esk and Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust
CQC Action Plan (Must Do) Status

Date: 27/10/2020

Status of each 'Must Do' Action by Domain



Overall Status of all 'Must Do' Actions

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Durham & Darlington Mental Health Services update

Current position in Durham (as at 28th October 2020)

During the second wave of the pandemic inpatient acuity and demand remains exceptionally high, with a continued trend in seeing a large number of people previously unknown to services. This is especially concerning with the increase in COVID within the community and forthcoming anticipated winter pressures

Crisis teams also remain very busy. There is some local and regional work ongoing to consider how we might make mental health support lines established through COVID sustainable in the longer term for non-crisis issues, however locally a mental health support line has been put in place for lower level needs which is available 24/7 this month via the Freephone Crisis number.

We have cared for a few patients with Covid-19 on the Lanchester Road site and have 1 Covid-19+ve patient at the time of writing this report. Several staff have also been affected by the virus to date. We are vigilant and have strict procedures for PPE adherence for staff in both our in-patient and community settings. We have risk assessment processes in place for any visitors to our sites.

Referral activity in all services dropped significantly in the spring but has now been restored to pre-pandemic levels if not higher in some cases.

Understanding the long term Mental Health Impact of COVID

From work being completed through the LRF recovery cell and internally within TEWV, it is clear that TEWV and the wider system should expect a surge of additional mental health demand over the coming months and years. Broadly speaking this will come from:

- **New covid19 related demand -** Mental health support for covid19 survivors; mental health impact of lockdown on vulnerable groups ; moral injury amongst frontline staff (*all* key workers)
- **Backlog of clinical activity -** Backlog of clinical activity not possible to be done due to restrictions (eg autism assessments, dementia assessments); increased referrals and demand as a result of referring agencies getting back to normality (schools, GPs, social care etc); delayed diagnosis and access to treatment for more routine/non urgent cases resulting in increasing complexity of case loads
- **Exacerbation and relapse of mental health conditions -** Relapse due to impact of Covid19 on mental health, continuity of care, bereavement, changes to social conditions,
- **Long term impact of the socioeconomic consequences -** Impact of unemployment, reduced finances, ‘austerity’ , relationship breakdown

TEWV has been able to produce a set of indicative figures, by area, of anticipated additional mental health demand over the next 5 years. These figures for the Durham population are shown below. Although not an exact science, these numbers have been built up through research and evidence from elsewhere, as well as expert clinical judgement. Similar to national predictions, we are anticipating significant volume of additional needs which will challenge systems and TEWV over the next 5 years.

	CYPS		AMH		MHSOP		All	
	Aged 0-17		Aged 18-64		Aged 65+		Total	
Local population:	111,432		333,044		113,217		557,693	
	MH system need	**Secondary care need**	**MH system need**	**Secondary care need**	**MH system need**	**Secondary care need**	**MH system need**	**Secondary care need**
Expected increase in service users (over next 5yrs)	58,190	20,366	77,066	20,191	24,589	6,442	159,845	47,000
Yearly increase in service users	11,638	4,073	15,413	4,038	4,918	1,288	31,969	9,400
Monthly increase in service users	970	339	1,284	337	410	107	2,664	783
Weekly increase in service users	224	78	296	78	95	25	615	181

NB – forecasts are based knowledge/research to date and experience from other 'similar' past events, so are indicative estimates to aid planning and development work post-COVID

The figures in the table above are based on current (2019/20) referral patterns, and approximate proportion who may need specific support at either "system" level or from specialist services within TEWV. At system level (including primary and secondary care) over 5 years the number of people with a diagnosable MH condition who might need help from any part of "the system" are estimated to be up to 52% of CYP (some of this is made up of individuals with multiple episodes so actual % of individuals needing intervention is lower), 23% of working age adults and 22% of older people. The "new normal" for referrals to secondary care are predicted to be 61% above the 19/20 level for CAMHS; 43% above the 19/20 level for Adult Mental Health secondary care services (e.g. CMHTs, IHT, Crisis); 19% above the 19/20 level for Older People's services (e.g. OP CMHTs; liaison teams). This is based on TEWV still seeing 35% of CYP and 26% of adult and older people's system demand.

Key Issues for Durham System Working

Care Homes

Care Homes have been a particular focus for support over the past 6 months and much of this work is being fed into our recovery planning. Our plans, both within TEWV and working with partners, include:

- Continued support directly into Older People's Care Homes (in particular those with EMI provision) to give bespoke support to individual residents and staff
- Continued work with DCC and health commissioners to provide similar bespoke input to specialist (MH/LD) Care Homes, for both residents and staff
- Continuing to build on our offer to care home staff which currently includes
  - Computerised CBT via Talking Changes
  - One off anonymised support over the phone via CNTW
  - 1-1 or other bespoke support for any care home staff via Care Home Liaison Team

- Self-guided support through the Recovery College
- New PHE e-learning on Psychological First Aid during COVID-19

We have recently had confirmation of an expansion plan for our care home liaison team (focusing on older people's homes). This plan will see an increase in specialist nursing capacity as well as Occupational Therapy and Psychology, to deliver increased and more intensive support for behaviours that challenge, and develop expertise within care homes to support people living with dementia who are experiencing acute mental health problems and associated distress. The team will support the development of a network of Dementia Champions in each home to help embed training into practice through on-going supervision and coaching through learning networks.

We also are currently considering how we might be able to align specialist MH/LD staff to specialist care homes to better support aligned practices and GPs.

Supporting System Activity

The mental health pathway that has been developed to support community hubs will continue to support partners in the system appropriately signpost any mental health need to services. We now also have some dedicated sessional mental health capacity working into the community hub to support staff with supervision, guided reflection and to assist manage/signpost more complex cases.

We have updated information for referrers and the public about what services are currently available and how to access them (including where self-referrals are possible).

The Recovery College Online continues to introduce new modules and courses/ offers as feedback is shared with what the system would find most helpful. There has been positive feedback about this, substantiated by a significant number of increased 'hits' (total of over 13,500 additional hits during just 1 month with almost 12,000 new users).

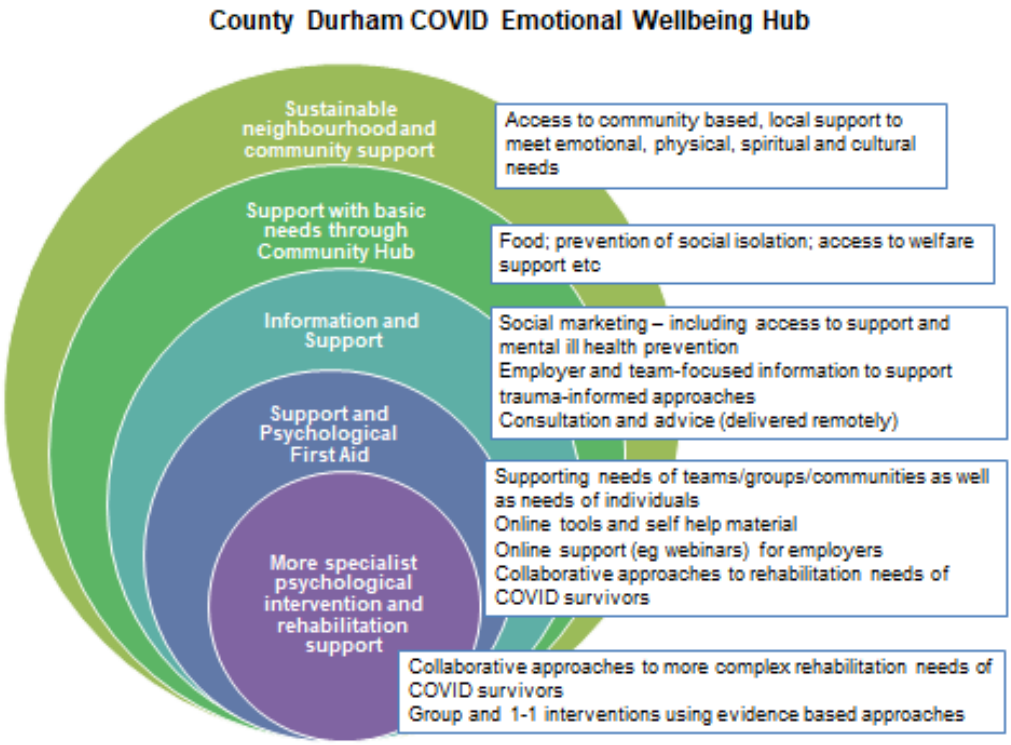
Workforce Support

A small multi-agency working group has been set up to rapidly consider how best as a system we can support the key worker workforce in particular over the coming months through a 'resilience hub' or similar. This build on the resources put in place through lockdown period (such as the care home support outlined above

Community/Population Support

There has been a lot of work at a system level to develop our capacity and approaches to supporting people's mental health more strategically. However, the existing system is not equipped or able to meet the totality of COVID-specific need that we are anticipating. We have learned a lot about what has worked and what hasn't since March, and parallel work to understand more specific impacts on the community (via DCC) and workforce (via Public Health) will add important detail to this.

We have, in response to recommendations from the LRF Health Impact Assessment and in response to organisation-specific requests to consider the concept of 'resilience hubs' developed a multi-agency model for a County Durham COVID Emotional Wellbeing Hub. The model builds on system strengths and existing provision, and provides a more collaborative approach which is non stigmatising. It provides a COVID lens to systemic pathway developments and seeks to offer a similar approach to that already delivered in Lancashire and South Cumbria. The infographic below summarises the proposed service model, which will be complementary to support via the ICS for health and social care staff (additional detail for each level is shown at appendix 1):



There are a number of key differences between this proposal and the current situation, including:

- More systemic, collaborative approach to managing COVID-specific need
- Greater integration across physical and mental health care
- Clearer stepped approach to maximise use of community resources and provide a clearer focus where more specialist care is needed

This model will be specifically applicable to people with COVID-specific needs, ie mental health support for covid19 survivors; mental health impact of lockdown on vulnerable groups; moral injury amongst frontline staff (*all* key workers, not just health and social care staff). All other needs will continue to be supported through existing services. Learning from this approach will be used to directly influence and help shape our response to the Community Mental Health Framework more generally.

Additional Resources

We have been successful in securing additional funding (some recurrent, some non-recurrent) from the MHLDP for a range of services, many of which are in line with pressure areas identified previously by PCNs and practices. These include:

- Enhanced primary care service: staff to work alongside the access service and practice based mental health workers to provide a range of low level interventions such as 12 week group work, DBT skills, medicines titration etc. This links to a proposal developed with Sedgefield and Easington PCNs in 2019/20 to complement existing provision. The additional resource should provide stabilisation support to individuals whilst waiting for other interventions (eg Talking Changes) and provide short term, community based intervention following assessment through access for people who do not require secondary care but do need a level of additional support. Should be operational December 2020/January 2021
- Dedicated capacity to better support people with personality and relational issues, using structured clinical management approaches
- Community based befriending and peer support offers being developed the Resilient Communities Group. This very much stems from ideas generated in 2019 from practices, PCNs and partners/service users in relation to developments that would make the biggest difference. Further information will be shared with PCNs as implementation progresses to make sure the development appropriately meets need and supports practices
- Early work to test options for ARRS roles prior to national resources being available from April 2021, eg for 'first contact' type roles and more targeted roles to support specific groups, eg those with dual mental health and substance misuse needs
- COVID related investment and change including the County Durham Together Hub and associated Emotional Wellbeing Resilience Hub
- Development of a virtual "one stop shop" for information about mental health services and support

Moral Injury/Impact of COVID on Frontline and Essential Workers

Frontline and essential workers may have come across difficult situations in the pandemic and be troubled by their own, or others', actions that they feel go against good practice. As part of a multiagency group we have designed a quick survey to identify these situations and anything staff feel would help nationally or locally. This survey has been widely shared across the whole system, including statutory, voluntary and local business sectors. The results of this are currently being analysed and can be shared with the AWOSC at a future meeting.

Jennifer Illingworth
Director of Operations – Durham & Darlington
Tees, Esk and Wear Valleys NHS Foundation Trust

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