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Portsmouth CITY COUNCIL

NOTICE OF MEETING

CABINET MEMBER FOR HEALTH, WELLBEING & SOCIAL CARE

TUESDAY, 7 JULY 2020 AT 2.00 PM

VIRTUAL REMOTE MEETING - REMOTE

Telephone enquiries to Anna Martyn 023 9283 4870
Email: Anna.Martyn@portsmouthcc.gov.uk

Membership

Cabinet Member for Heatlh, Wellbeing & Social Care
Councillor Matthew Winnington (Cabinet Member)

Group Spokespersons
Councillor Jeanette Smith
Councillor Matthew Atkins
Councillor Graham Heaney

(NB This agenda should be retained for future reference with the minutes of this meeting).

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A written deputation stating which agenda item it refers to must be received by the Local Democracy officer named on the agenda by 12 noon two working days preceding the meeting.

Any written deputation received will be sent to the Members on the relevant decision making body and be referred to and be read out at the meeting.

A G E N D A

1 Apologies for absence

2 Declaration of interests

3 SO58 decision - Allocation of Nitrate Neutrality Credits (Edinburgh House and Longdean Lodge) (Pages 5 - 6)

For information - An urgent Council decision taken by the Chief Executive on 26 March 2020 in response to the above matter in accordance with Standing Order 58 of the council's Procedure Rules. Standing Order 58 requires all such decisions to be reported to the relevant decision making body at its next meeting.

4 Wellbeing Service - Annual Performance Report (Pages 7 - 22)

Purpose
The report is for information only and the purpose is to update the Cabinet Member for Health, Wellbeing & Social Care as to the Wellbeing Service's Annual Performance Report.

5 Update on Residential and Ethical Care Charters (Pages 23 - 34)

Purpose
The report is for information only and the purpose is to update the Cabinet Member for Health, Wellbeing & Social Care as to progress with the implementation of the Residential and Ethical Care Charters.

6 Adult Social Care Charging Arrangements (Pages 35 - 58)

Purpose
To respond to the motion adopted by Full Council on the 14th January 2020, which sought the Cabinet Member for Health, Wellbeing and Social Care to investigate the introduction of a day care cap for all Social Care client groups and to advise councillors of the financial cost of this.

RECOMMENDED that the Cabinet Member

a. Consider and approve one of the following options:

1. **Maintain the current charging arrangements within Adult Social Care, in line with Care Act 2014 and the related charging Regulations; or**
Subject to recommendations (b) and (c) below:
2. **Reinstate a financial cap for Day Care, Community Support and Health & Independence Services; or**
3. **Implement a financial cap across all Adult Social Care services.**

b. Confirm the level of the financial cap to be applied from Monday 06 April 2020, should the implementation of a financial cap be approved as set out in recommendation (a2) or (a3) above.

c. Agree that should the implementation of a financial cap be approved

as set out in recommendation (a2) or (a3) above, it will on a temporary basis, until the publication and implementation of the anticipated government reforms of the financial arrangements for the Adult Social Care sector and how people fund their care and their eligibility for financial support from Local Authorities in the future.

d. Request the Chief of Health & Care Portsmouth to identify and implement alternative income or savings strategies in order to offset any lost income in 2020-21 and future years, and enable Adult Social Care to maintain a balanced budget.

7 Update on Covid 19 - Adult Social Care (Pages 59 - 62)

Report to be published on 6 July so as to reflect the most current situation.

8 Update on Covid 19 - Public Health (Pages 63 - 102)

Report to be published on 6 July so as to reflect the most current situation.

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Note of SO58 urgent decision teleconference with Chief Executive - Health, Wellbeing & Social Care portfolio - Thursday 26 March 2020

Purpose: David Williams, Chief Executive asked that a telephone conference facility be used for him to consult on the urgent decision required on the following agenda item:

Allocation of Nutrient Neutrality Credits for Longdean Lodge and Edinburgh House sites.

Reason for urgency: this item was identified as needing a decision from the cancelled Health, Wellbeing & Social Care Cabinet of 26 March 2020, for which papers had been published, due to the Coronavirus measures meaning public meetings were suspended.

Teleconference attendance:

The Leader of the Council:	Cllr Gerald Vernon-Jackson
Relevant portfolio holder[1]:	Cllr Matthew Winnington
Leader of the Opposition:	Cllr Donna Jones
Group spokespersons:	Cllrs Graham Heaney and Luke Stubbs

Officers: David Williams (Chief Executive), Peter Baulf (City Solicitor) and Innes Richens (Chief of Health & Care Portsmouth).

The SO58 referral and paper had been circulated to all the required consultees.

Members' Questions and Comments

In response to questions, officers explained that the nutrient neutrality credits from the former Edinburgh House residential care home would be transferred to a the new development at the Longdean Lodge site and the remainder be transferred to the nutrient credit bank.

The council is working on a more strategic approach regarding nutrients and engaging with the Environment Agency and other bodies.

In response to a question, Councillor Winnington explained that Edinburgh House would be used for people with dementia and that a strategy at Solent level is currently being worked on.

Members agreed with the recommendation.

Chief Executive's Decision

David Williams agreed to make the decisions as recommended in the report:

DECISION the Chief Executive delegated authority to the Director Adult Services to instruct the completion of a unilateral undertaking in accordance with section 106 of the Town & Country Planning Act 1990 relating to land at the former Longdean Lodge Site, Hillsley Road, Portsmouth, PO6 4NH and Edinburgh House, Sundridge Close, Portsmouth PO6 3JL.

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Portsmouth CITY COUNCIL

Title of meeting: Cabinet Member for Health, Wellbeing and Social Care

Date of meeting: 7th July 2020

Subject: Annual performance report for the Wellbeing Service

Report by: Director of Public Health

Wards affected: All

Key decision: No

Full Council decision: **No**

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1. Purpose

1.1 To update the Cabinet member for Health, Wellbeing and Social Care on the performance of the Wellbeing Service during 2018/19.

2. Recommendation

2.1 To note the contents of this report.

3. Background Information

3.1 The Wellbeing Service (WBS) commenced in October 2015 to provide support around multiple health risk factors; smoking, unhealthy weight, harmful alcohol consumption, inactivity and emotional wellbeing. The service was redesigned and restructured in autumn 2017. The budget for the WBS for 2017/2018 was £1,206,909 reduced to £616,300 in 2018/2019, and £538,400 for 2019/2020.

3.2 The service provides the following elements of provision:

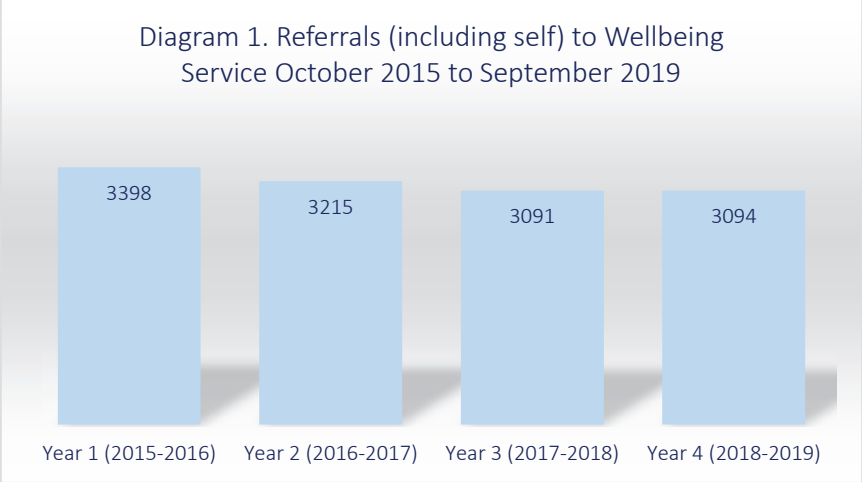
- Smoking cessation support including the facilitation of medication to support cessation, behavioural support and advice in the effective use of e-cigarettes as an aid to cessation.
- Screening all clients to ascertain if alcohol consumption is within safe levels; where clients are found to be consuming at increasing risk or harmful levels, brief advice or extended brief advice or a referral on to the Community Alcohol Support Team (CAST) is made.
- Tier 2 Weight Management is provided to those with BMI >30 (>28 for certain ethnicities). This is provided in either 1:1 sessions or group-based support.
- All clients are screened using Patient Activation Measure (a tool to identify a person's activation level; this relates to the level of knowledge, skills and confidence to maintain good health and wellbeing).

- The WBS is accessible within GP Practices and a range of community settings.
- Training the wider public health workforce including Making Every Contact Count (MECC), Smoking Cessation Practitioner, Connect 5 (Mental Health).

3.3 Following a Vanguard systems thinking review in 2017/2018 the service was redesigned leading to a radical change in approach, focusing on what the client wants support with. To support this, robust data capture and management has been introduced including the implementation of a new I.T. system, QuitManager (May 2017) supported with further analysis to gain insight into the breadth of support provided. This has further been supported with the creation of a 'data dashboard' providing analysis in relatively real time for monitoring purposes. The reporting year 1st October 2018 to 30th September 2019 is the first year of comprehensive data available for evaluation.

4. Performance

4.1 Demand for support from the WBS has remained relatively constant (diagram 1) despite the reduction in staffing levels following the restructure in 2017.



4.2 Primary care (35.26%) and self referrals (33.48%) represent the majority of referrals into the WBS (appendix 1), this is consistent with previous years, however, there has been a slight increase in referrals from secondary care (15.61%) due to performance incentives at Queen Alexadra Hospital. Midwifery referrals represent 10.63%, with the remainder of services making up 5% (appendix 2).

4.3 The demographic profile of clients (appendix 3) in 18/19 is consistent on previous years; 64% of clients are female and 54% of clients are aged between 34-64.

4.4 All clients were asked about existing medical conditions, to which 1367 responded positively to (appendix 4).

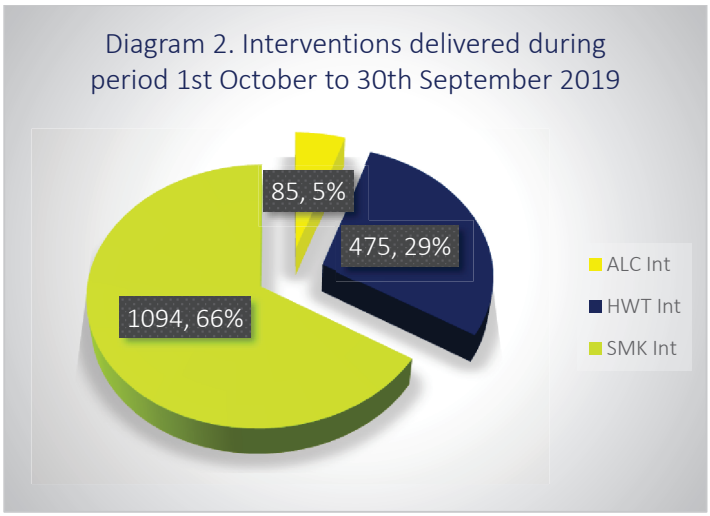
4.5 Closure or end of provision – a system for coding exit from the service was introduced in the reporting year. 'T' codes classify reason for client closure occurring at referral/triage and C codes classify closure post entry into service (detailed list of closure reasons can be found in appendix 5).

4.6 Of all referrals 29% (no. 1066) did not come into the service (appendix 6). Of concern is the level of referrals that the WBS is unable to contact, 17.81%. The remainder comprise clients who either decline support, are not suitable for the WBS or are already making changes. Evaluation is currently being undertaken to fully understand the reasons for this; interim measures have been implemented to address this, including expansion of triage hours into evenings to capture those individuals not available during working hours. There is significant resource placed in attempting to make contact and it is imperative that improvement is achieved in this area.

4.7 The WBS is well cited across the city; over 98% of interventions took place in community settings such as Tesco Fratton, Buckland CC or Paulsgrove CC (58.41%) or GP Practices (39.81%).

5.0 Outcomes

5.1 Of the 3094 referrals, 2028 individuals took up support. The WBS provided 1654 interventions (diagram 2) for smoking, weight and alcohol. Smoking cessation support represents 66% of all activity.



5.2 Clients also received support in the form of an intervention or brief advice in response to other risk factors (appendix 7). This was most predominant in supporting clients around alcohol.

5.3 Other support recorded included onward referral, signposting, joint working with other services and the provision of topic specific information. During the reporting period the WBS achieved:

- 49 onward referrals
- 30 joint working with other services
- 1017 signposts to other services (or back to primary/secondary care)
- Self- help information (printed resources) was provided, based on topic, on 2545 occasions.

5.4 In total 1094 clients set a quit date to cease smoking; of this 523 (47.81%) successful quit at 4 weeks, compared to National figure of 52%[i]. The WBS routinely follow up successful quitters at 12 weeks; of the 1094 setting a quit date, contact was made with 1003 (91.68%) clients, and of the 1094 clients setting a quit date, the success rate at 12 weeks was 28.98%. This is in line with national data.

5.5 Screening for alcohol was achieved in 2010 clients; 68% identified as no or low risk, 18% at increasing risk and 14% at harmful levels. Significant improvement has been made this year in ensuing an Audit-C is conducted at entry with an 80% increase in the number of audit C screens carried out. Re-screen is routinely conducted at 4th week (or session) and was achieved 29.5% (no. 593 clients) which showing some improvement with 70% identifying as low risk, 20% at increasing risk and 10% at harmful levels.

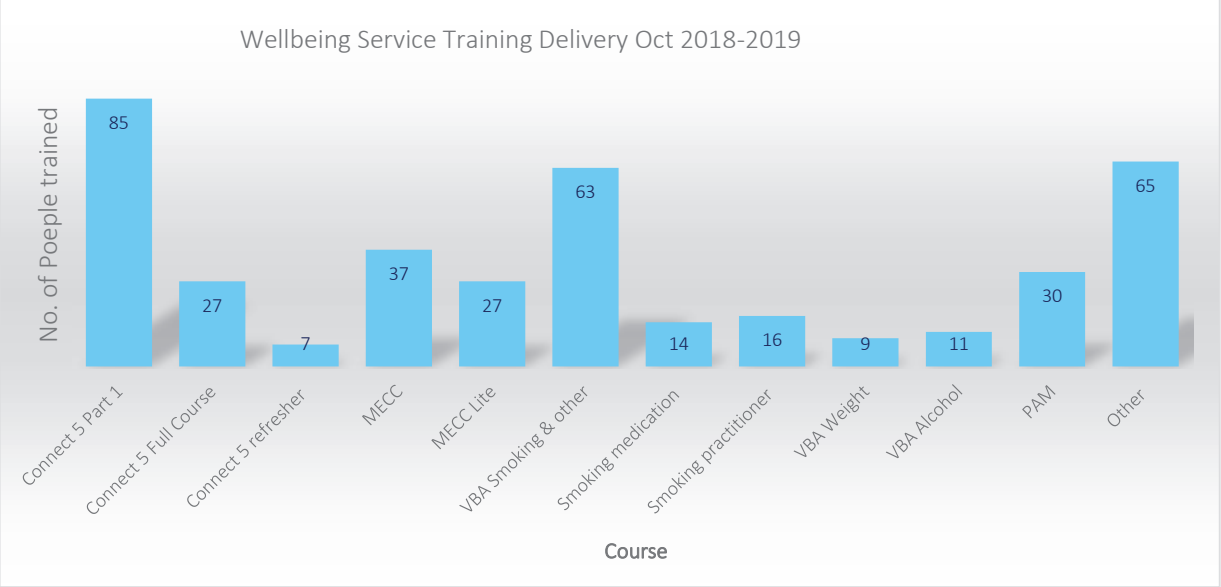
5.6 The WBS provided 475 weight management interventions during the year; however, BMI at entry point into the WBS was recorded in 515 clients; for evaluation purposes, the last recorded weight was used as the end weight and this data was available in 314 clients at exit from the service. The overall change was:

Average Start Weight Kilo's	Average End Weight	Best Weight Change	Worst Weight Change	Average Weight Change Kilo's
108.43	106.42	-24.30	+7.70	-2.01

Average Start BMI	Average End BMI	Best BMI Change	Worst BMI Change	Average BMI Change
39.28	38.46	-7.10	+4.80	-0.83

Weight management remains resource intense with only significant reduction in the minority of clients; currently new approaches are being piloted in a series of 'Living Well' workshops broadening the range of topics typically covered in weight management programs.

5.7 Training Activity. In 2018/19 the WBS provided training to 481 attendees; all allied health care professionals working within PO1-PO6. Upskilling the wider health care workforce adds value to the range of support provided by the WBS as well as fully utilising the skilled workforce. Given this skill base the WBS has been able to develop bespoke courses to support such services as Midwifery and Health Visiting in topics such as 'difficult conversations' and very brief advice.



5.8 Additional activities the WBS has been involved in includes the QA Hospital going 'Smoke Free'; this created the opportunity to train a team of 'SmokeFree Ambassadors' within QA staff to support the SmokeFree initiative.

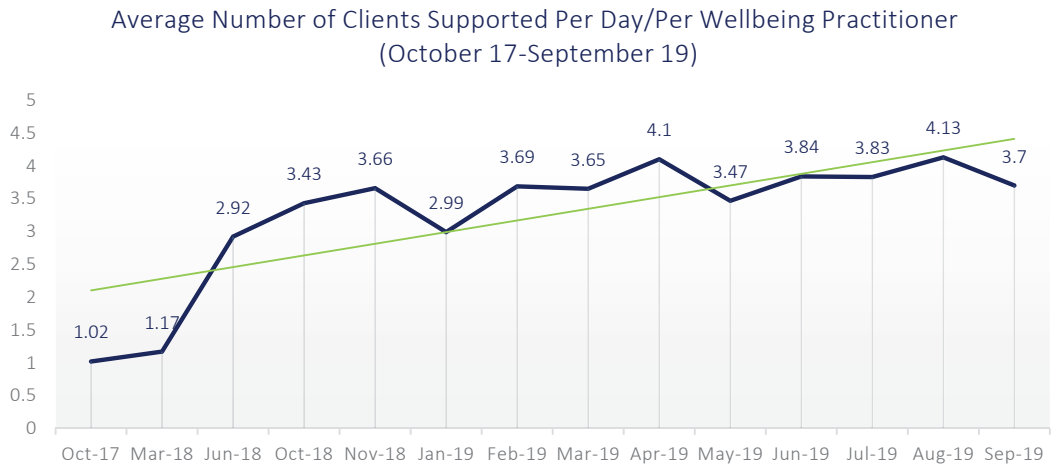
5.9 Long Term Condition Hub Pilot

Nationally the number of individuals with long term conditions is increasing, placing significant current, and future, demands on the health care system. Locally there are currently 29,295 patients on the local diabetes, asthma and COPD registers. Top down estimates suggest that the local health system spends up to £38-£45m on the care of these three disease groups. An estimate of a further increased pressure of £5.5m by 2025 in relation to diabetes is also demonstrated. The Long-Term Conditions (LTC) Hub in Portsmouth City is being developed on a pilot basis with two GP practice populations (constituting circa 25% of the patient population in Portsmouth). The pilot will focus on improved multidisciplinary patient pathways for two cohorts of patients, those with Type 2 diabetes and patients with chronic respiratory disease – asthma and Chronic Obstructive Airways Disease (COPD).

The LTC Pilot, initially due to start in April 2019, commencing in December 2019, sees the integration of the WBS in collaboration with Talking Change (iAPT services) into the care package provided by a multi-disciplinary team to address risk factors and emotional wellbeing.

It is anticipated the WBS will assess approx. 1060 patients during the pilot phase and working within this setting will facilitate uptake of support. Approx. 50% of the WBS staff have been upskilled in diabetes and respiratory interventions and this pilot is likely to utilise 25% of overall service capacity.

5.10 The overall performance of the WBS has improved significantly in the previous 2 years with a 300% improvement in efficiency (see appendix 8a-8c). The focus during 2018 was to improve efficiency in all provision, with each staff member achieving an average of 4 client appointments per day. At a service level this has been achieved. The focus for 2019 has been developing effectiveness, for example, smoking cessation outcome rates per staff member. The data dashboard enables managers to monitor individual staff performance.



6. Workforce. Following the restructure in November 2017 the workforce has remained stable with only one staff member leaving. Morale and motivation are high. Development opportunities have been significant within PCC, the Public Health Directorate and the WBS itself as it progressively adapts to new opportunities. Consideration of the current workforce to meet future service needs may require workforce review in the short term; the cost and impact of losing skilled staff can be significant and impede service development.

Sickness in the past year has been an average of 6.55 days per staff member, and performance in all staff is at a level deemed satisfactory or above.

7. Conclusion

The WBS has in the past 2 years, following the Vanguard Systems Thinking intervention and restructure (November 2017) met service demand with increased efficiency and effectiveness, despite nearly a 50% reduction in workforce and cost. The WBS management has continued to develop a highly skilled workforce able to add value, principally in training the wider public health workforce, and in specialist knowledge enabling participation in projects such as the Long-Term Condition Hub.

There have been significant achievements in the existing data management, which give valuable insight into health needs of the population enabling service provision to be targeted to those most appropriate.

Short term focus will be on improving accessibility to the service including the development of a web-based platform, improvement in referral outcomes and associated systems and innovation in working with weight management clients.

8. Equality impact assessment

No EIA completed as this is reporting on an existing service.

9. Legal implications

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Signed by: Director of Public Health

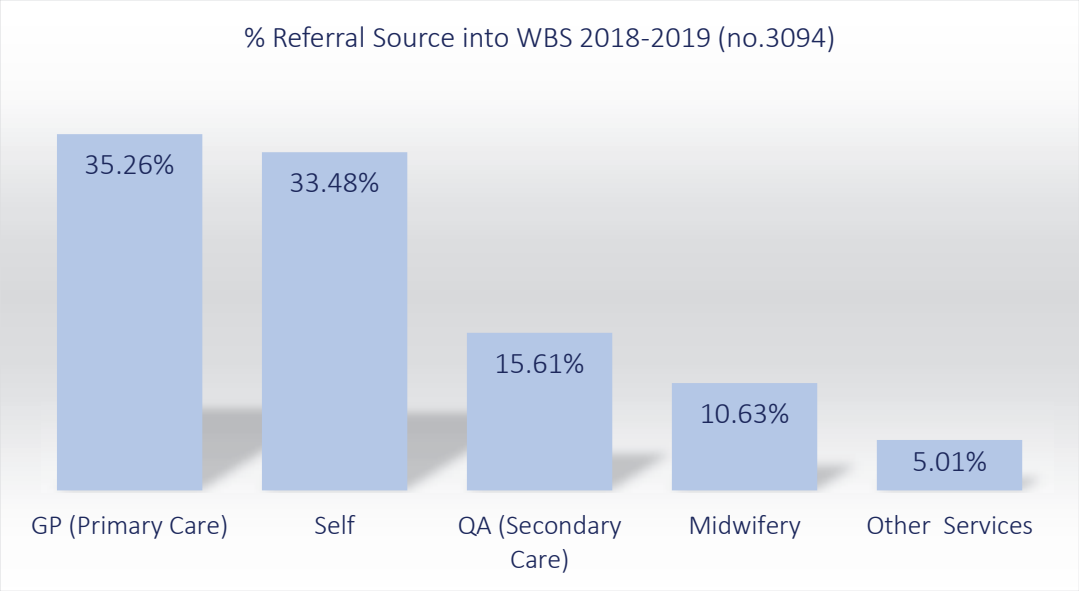
Appendices:
Appendix 1. Referral Source into Wellbeing Service 2018/2019
Appendix 2. Full breakdown of referral source into WBS 2018/2019
Appendix 3. Demographics
Appendix 4. Self-Reported Medical Conditions
Appendix 5. Reason for Closure (End of provision)
Appendix 6. Reason for closure of all clients referred to WBS
Appendix 7. Multiple Interventions provided by Principal Intervention
Appendix 8a. Diagram to show improvement in WBS Efficiency
Appendix 8b. Showing the total number of appointments in clinic settings – Overall numbers of clinics were reduced
Appendix 8c. Attendance at Wellbeing Clinics November 17 – September 19

Background list of documents: Section 100D of the Local Government Act 1972

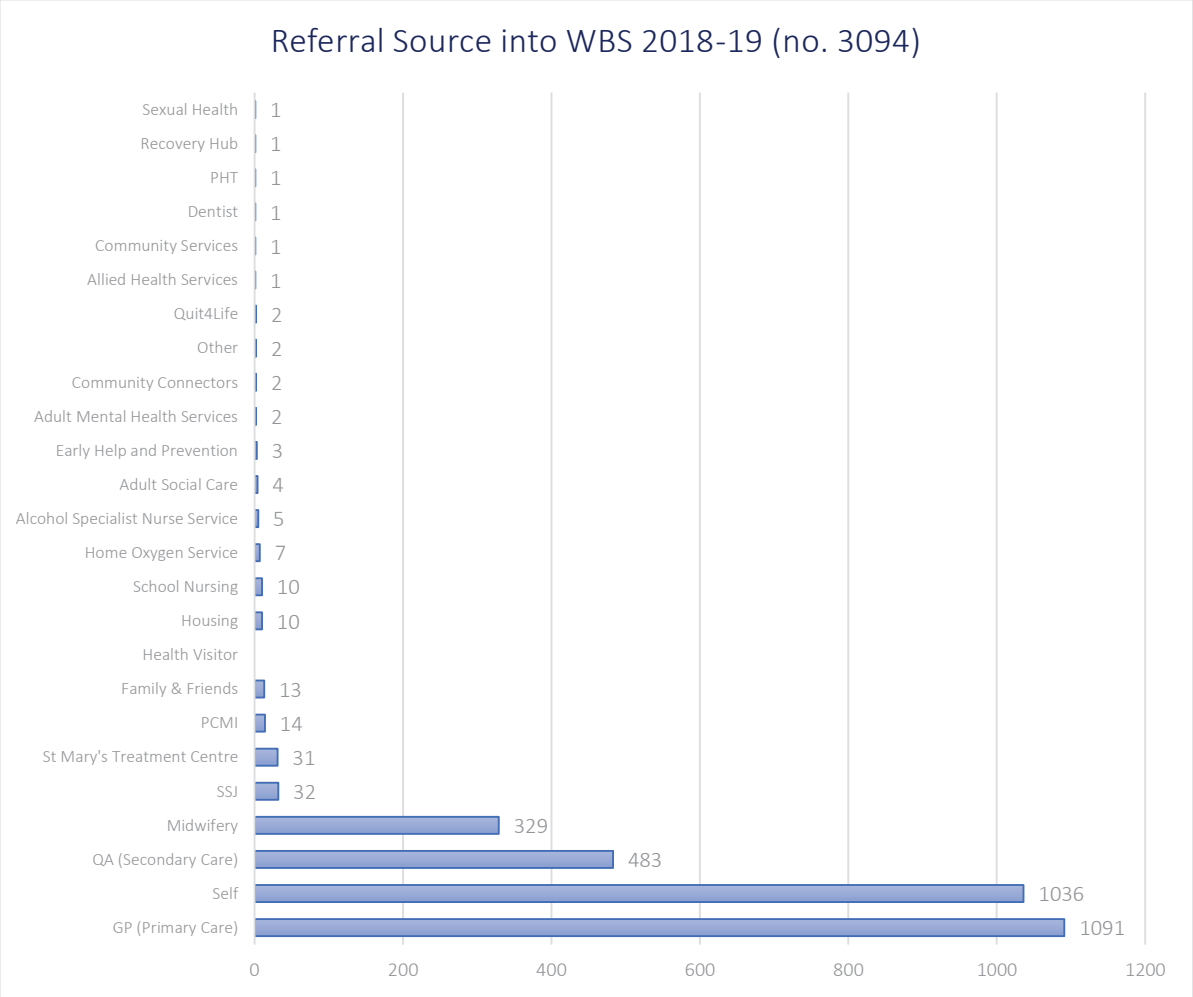
The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Appendix 1. Referral Source into Wellbeing Service 2018/2019

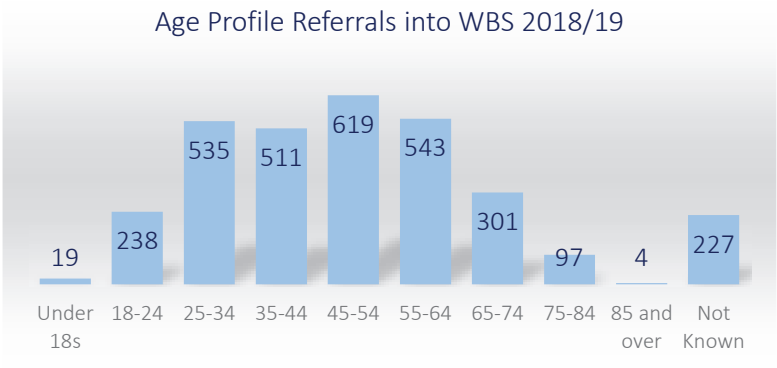


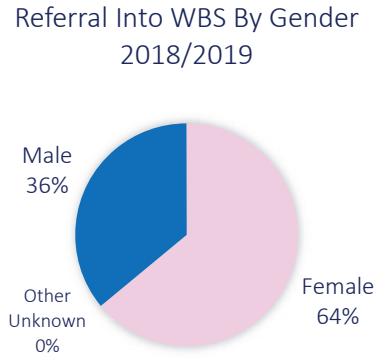
Appendix 2. Full breakdown of referral source into WBS 2018/2019



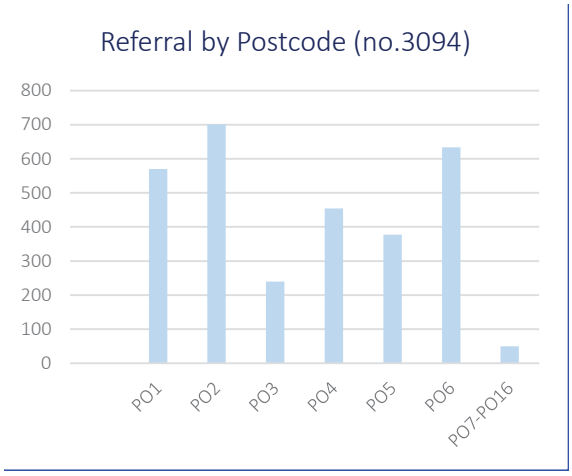
Appendix 3. Demographics

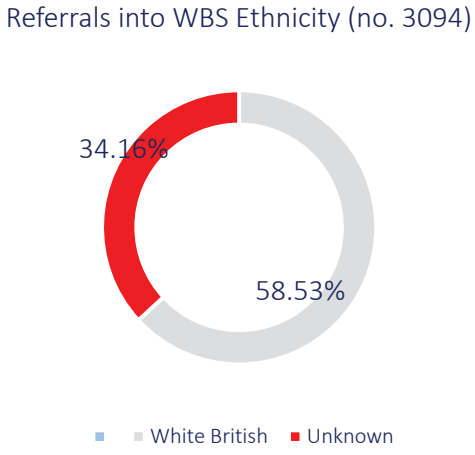
Age and Gender





Postcode and Ethnicity





Occupation and liable for Prescription Charges:

Data was not available at point of referral for client's occupation (34.55%) and if they were liable for prescription charges (36.04%).

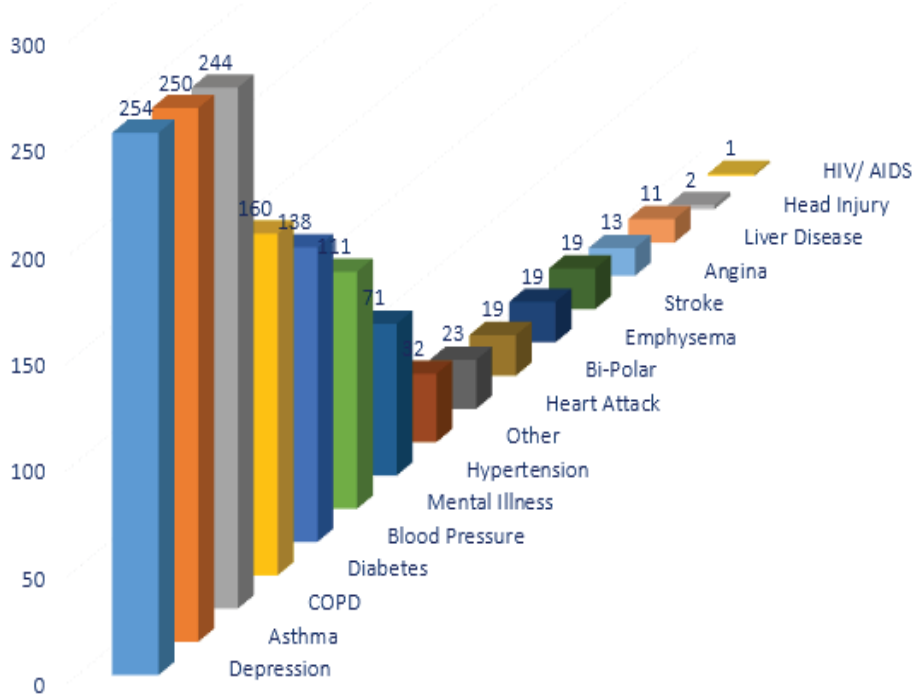
In considering client base occupation where data was available, nearly 25% comprised '*never worked/long term unemployed*' (10.86%) and '*routine and manual*' (13.67%).

Where data was available for prescription charges, 41.82% were exempt with 22.14% paying.

Appendix 4. Self-Reported Medical Conditions:

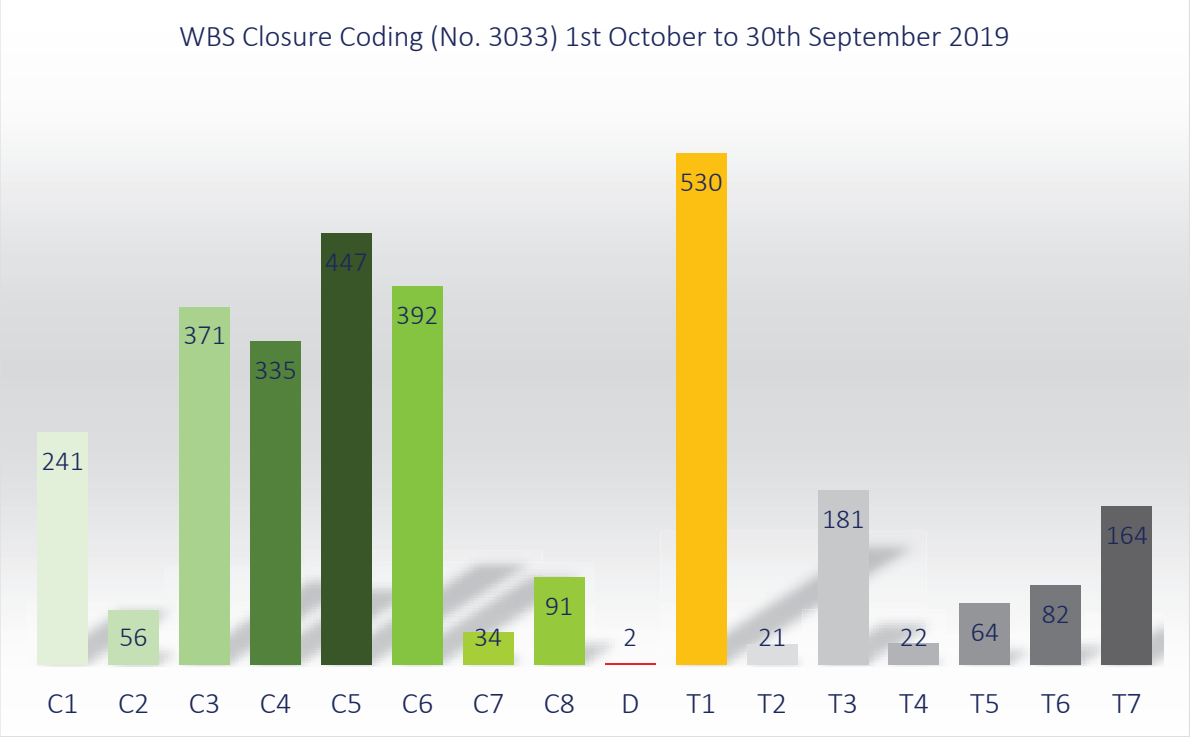
All clients accepting into WBS were asked about their current health/existing medical conditions. This information is recorded on to QuitManager.

The following diagram shows incidence of self-reported medical conditions (no. 1367).



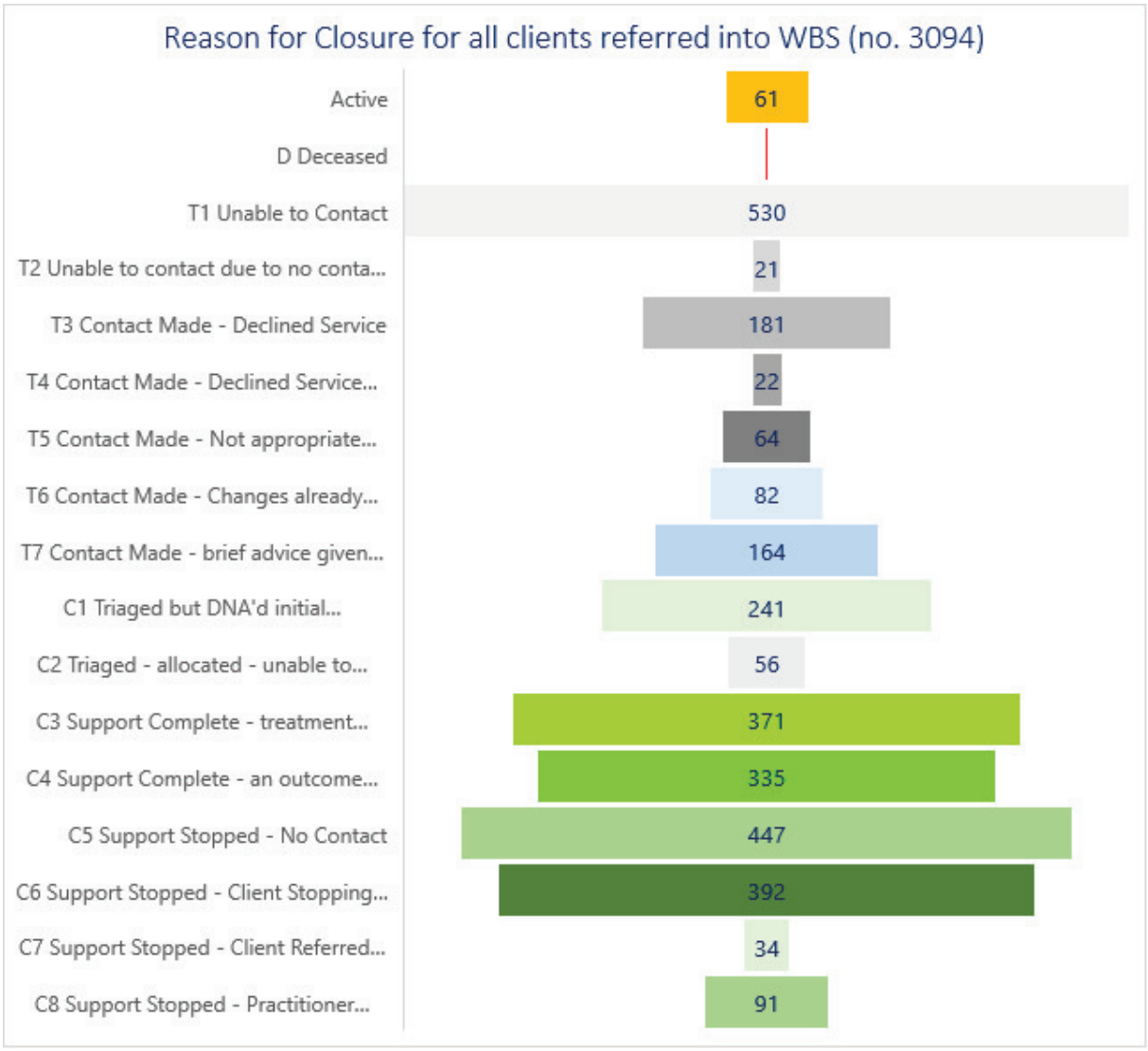
Appendix 5 Reason for Closure (End of provision).

A system for coding exit from the service was introduced in the reporting year. 'T' codes classify reason for client closure occurring at triage and C codes classify closure post entry into service (detailed list of closure reasons can be found following).

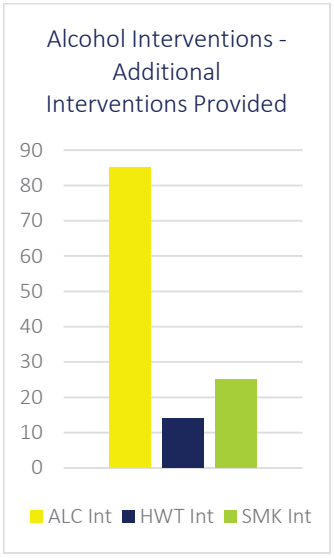


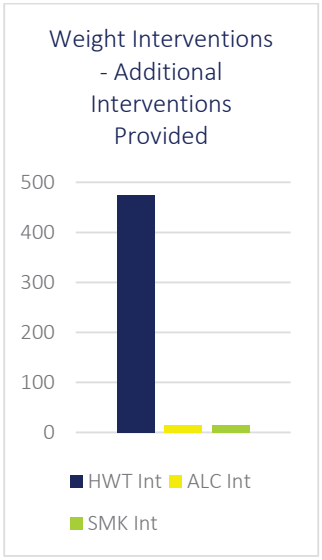
Processing Referrals and Triage:	
Code Excel	Reasons for Closure:
T1	Unable to Contact
T2	Unable to contact due to no contact method
T3	Contact Made - Declined Service
T4	Contact Made - Declined Service Not aware referral made
T5	Contact Made - Not appropriate service
T6	Contact Made - Changes already been/being made
T7	Contact Made - brief advice given/information given/signposted
D	Deceased
Clients (accepted service)	
	Reasons for Closure:
C1	Triaged but DNA'd initial appointment
C2	Triaged - allocated - unable to contact
C3	Support Complete - treatment programme complete
C4	Support Complete - an outcome achieved
C5	Support Stopped - No Contact
C6	Support Stopped - Client Stopping support
C7	Support Stopped - Client Referred On
C8	Support Stopped - Practitioner Stops Support
D	Deceased

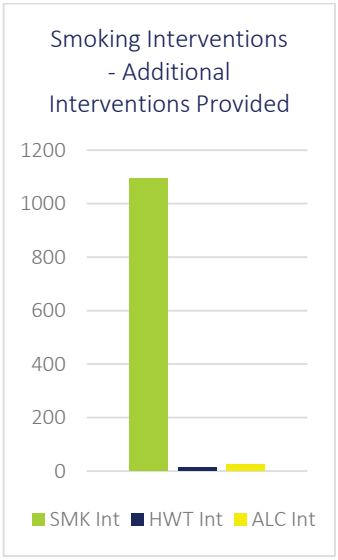
Appendix 6. Reason for closure of all clients referred to WBS

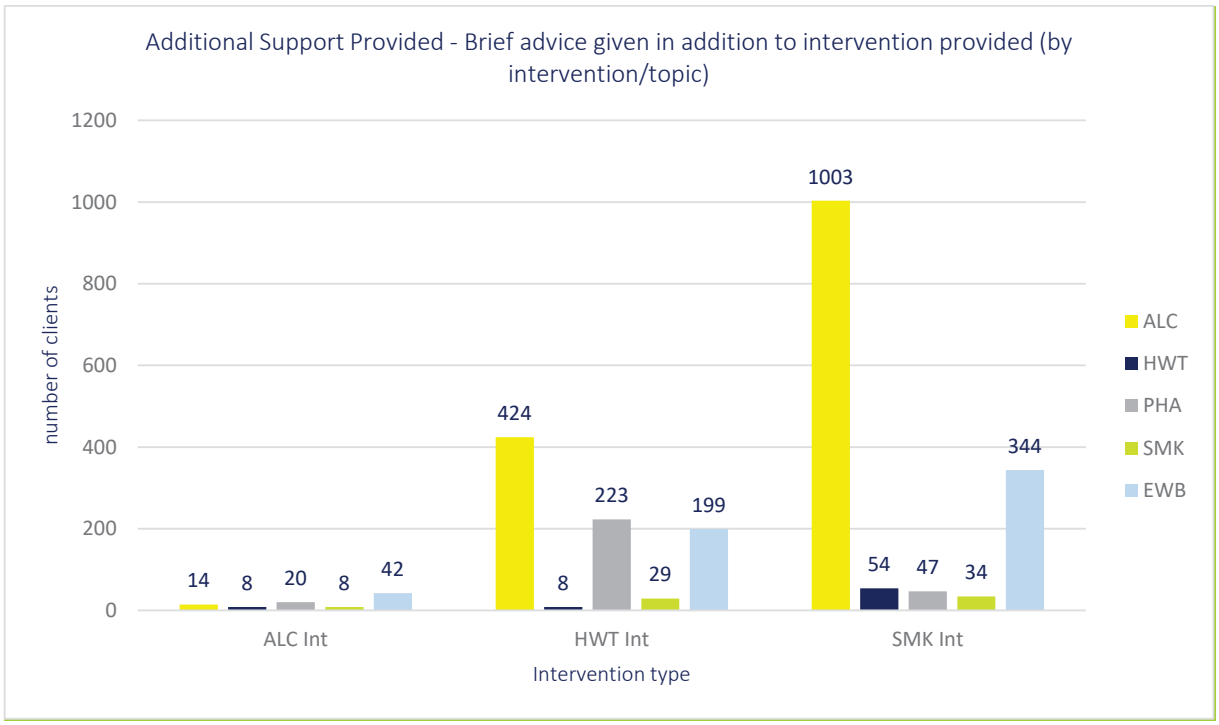


Appendix 7. Multiple Interventions provided by Principal Intervention:

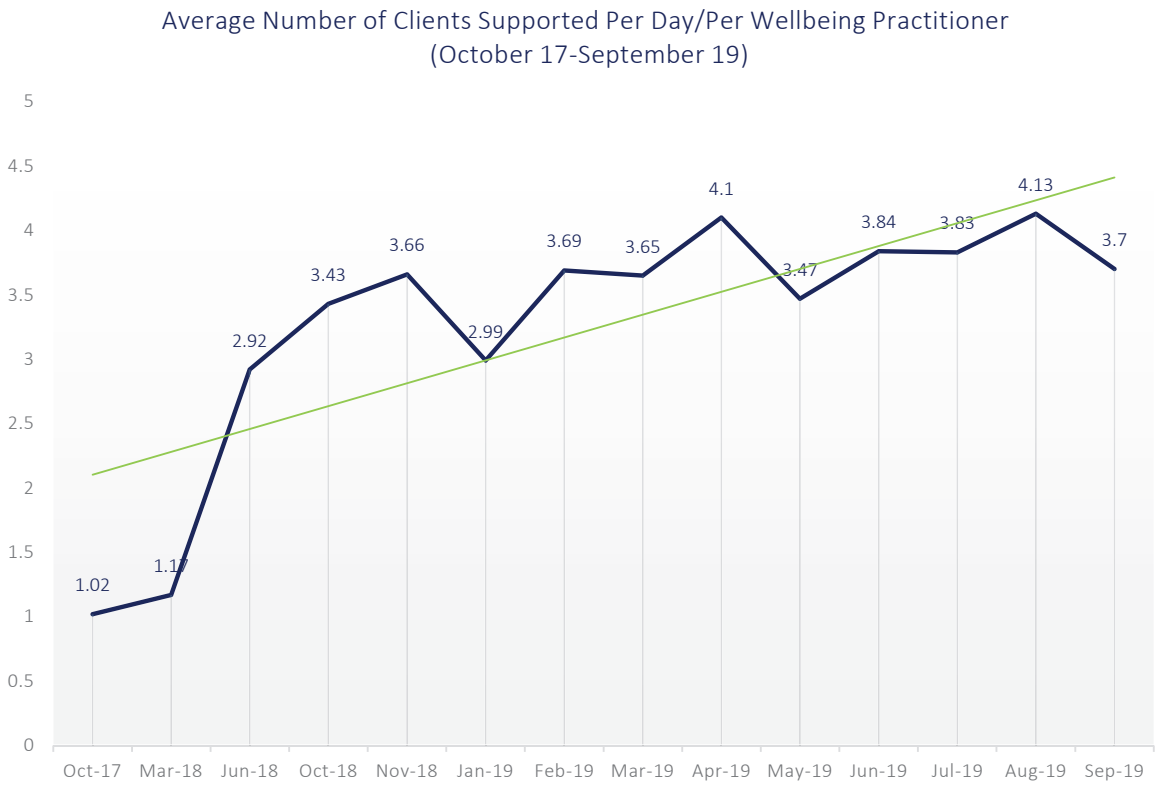




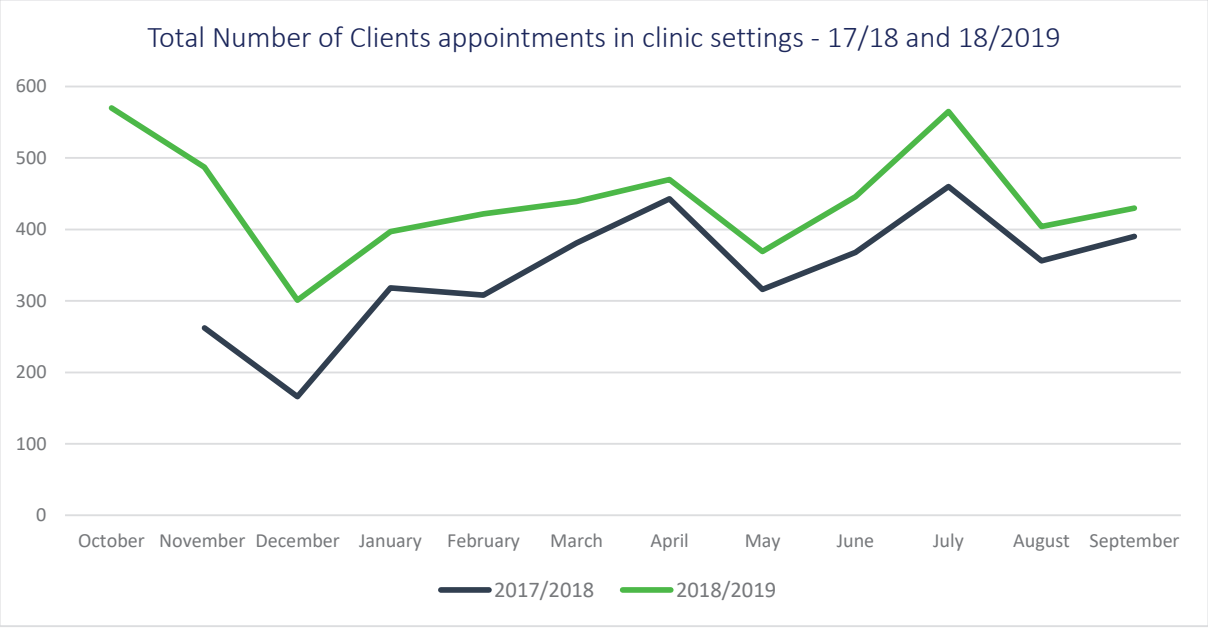




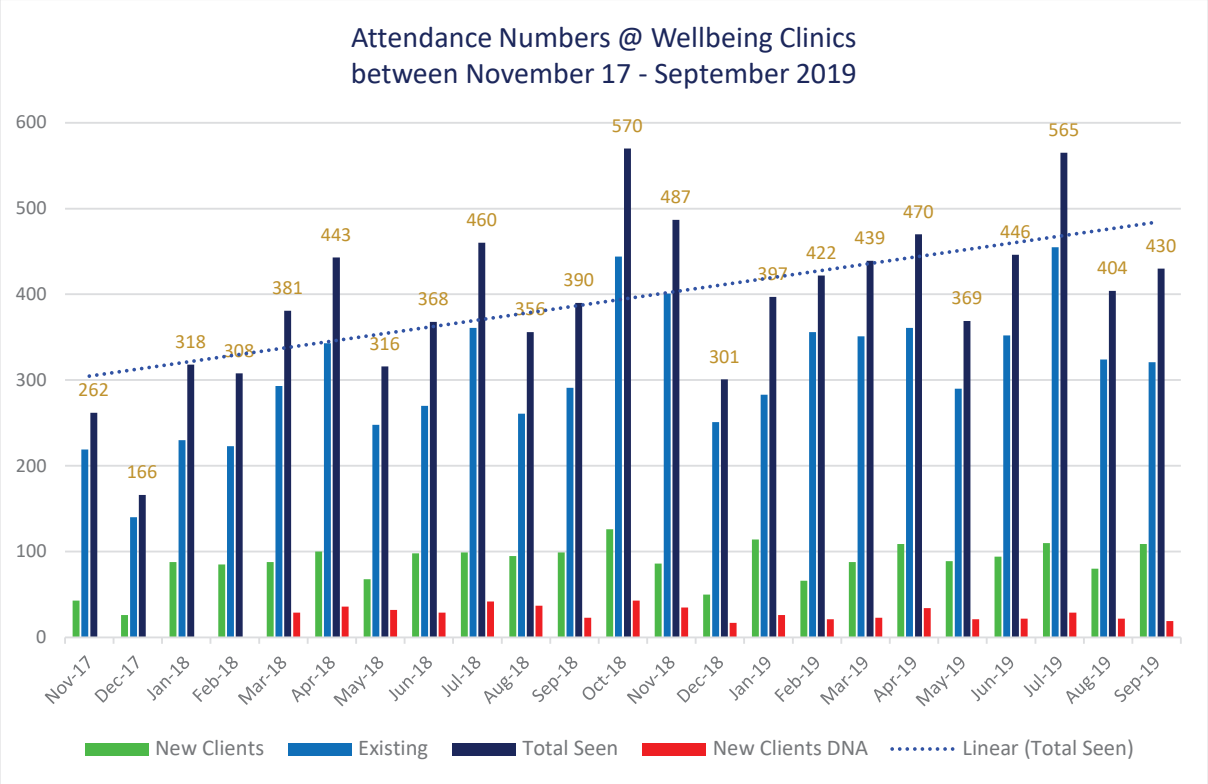
Appendix 8a. Diagram to show improvement in WBS Efficiency.



Appendix 8b. Showing the total number of appointments in clinic settings – Overall numbers of clinics were reduced.



Appendix 8c. Attendance at Wellbeing Clinics November 17 – September 19



[i] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2018-to-march-2019/introduction

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Date of meeting:	7 July 2020
Subject:	Adoption of Residential Care and Ethical Care Charters by Portsmouth City Council.
Report by:	Chief of Health & Care Portsmouth
Written by:	Andy Biddle - Assistant Director, Adult Social Care.
Wards affected:	All

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1. Purpose of report

A request was made for an update on progress with the implementation of the charters to come as an information paper to the Health, Wellbeing & Social Care decision meeting in March 2020. Given the COVID-19 pandemic, the business of the Council moved to business critical services from March to June 2020 and the Council continues to be in response to the pandemic whilst moving into recovery. During the period, the Council exercised its powers vested in the Chief Executive in the absence of the normal democratic public meetings of the Council. A March 2020 Decision making meeting therefore did not occur.

Links are provided to the Charters below:
http://www.savecarenow.org.uk/ethical-care-charter
http://www.savecarenow.org.uk/residential-care-charter

This report will set out the current practice in relation to the charters, updated for July 2020.

1.1. Context

The focus for work with the independent sector social care provider market since March 2020 has focussed on the COVID-19 response phase. Whilst a new model of pricing for residential care was due for introduction in the 2020/21 financial year, this has not been able to be introduced. Financial support from the Council has focussed financial support for providers on Personal Protective Equipment, (PPE) and increased staffing. In addition, the Council has offered a 'Minimum Income Guarantee' to maintain financial stability, based on the level of income a provider received pre-COVID-19. These measures were part of the Council ensuring its statutory responsibility to maintain safe provision, based on government funding allocate specifically for COVID-19.

Additionally, hospital discharge guidance issued in March 2020 by the government has underwritten payment for residential care placements from hospital via NHS COVID-19 funding.

1.2. ASC is an increasingly high profile area of local authority business. There is an acknowledgement at a national level that social care is under increasing pressure for a variety of reasons including an increasing demand to support people with more complex needs in their own homes. More broadly, the care market is also under pressure resulting from increasing costs of employment for providers of social care services that the council contracts with, due to rises in the National Living Wage and increases in 'auto-enrolment' pension contributions. For the NHS to be able to care for people's health, it is critical that social care is able to meet the needs of citizens.

1.3. It is currently unclear how the Council will manage financial stability given the significant loss of income and ability to make savings induced by the COVID-19 response. The focus may therefore continue to be supporting providers to maintain stability.

2. The Charters

The following pages contain information relating to the Charters and the progress made by ASC in implementing the principles and the areas for improvement.

3. Recommendation

The Cabinet Member for Health, Wellbeing & Social Care note the contents of this report.

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Comparison of UNISON Ethical Care Charter against Current Practice

Criteria	Current Practice	Update July 2020
Stage One		
Commissioning of visits to be based on client need not minutes or tasks	Commissioning of care starts with an assessment of the customer's needs, goals and wishes. Support is then offered to the individual as to how needs can be met. If a care provider is selected, the provider meets with the person to make their own assessment and the care and support plan will be finalised.	Most ASC domiciliary care is delivered based on time purchased. In order to move from 'time & task' to more personalised support ASC colleagues are working with a domiciliary care provider and a technology provider to implement a system of: 1) Real-time digital care records. 2) Scheduling care based on need and time required, rather than pre-planned multiples. 3) Adjusting support based on need. 4) Billing people with care and support needs on the basis of actual support required.
Time allocated will match need of clients. In general 15 minute visits will not be made	Adult Social Care practice remains not commissioning care in multiples less than 30mins, unless customer and provider agree the task can be managed within this timeframe.	The new model will move away from commissioning in pre-planned time slots.
Homecare workers to be paid travel time, travel costs and other necessary expenses e.g. mobile phones	The ASC cost matrix sets a base hourly rate set for home care. This included all associated costs including cost of regulation requirements, costs of travel and 'non-contact' time.	ASC followed the UK Home Care association model for negotiating the increase in rates for local providers in the 2020/21 financial year. UKHCA represents providers of domiciliary care at a national level.

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Criteria	Current Practice	Update July 2020
	ASC contracts continue to stipulate travel time between care calls in accordance with national best practice and the requirements of the CQC and Inland Revenue.	
Visits to be scheduled so that workers are not forced to rush their time with clients or leave to get to next client on time	The Council and its commissioned providers work to meet care and support needs in a dignified and caring way. Customer feedback is monitored to address areas of concerns with providers and contracts officers consider performance with providers on a regular basis.	The domiciliary care intervention will lead to more effective measurements of provision of support and individual feedback.
Workers who are eligible get paid SSP	Providers comply with all statutory requirements in terms of employment. For PCC employees they continue to receive Occupational Sick pay, casuals and temps receive SSP in accordance with whether they qualify dependent on earnings, length of service and National Insurance contributions.	
Stage 2		
Clients to be allocated same homecare worker wherever possible	Individual working practices and covering staff absence can make consistency challenging. However, continuity of carer is a priority and when there are changes required, care providers advise customers accordingly.	The new domiciliary care model will consider this aspect of care support as the new way of working is rolled in.
Zero hours contracts not to be used in place of permanent contracts	Based on discussions with staff, there can often be a preference to zero hour contracts due to flexibility they offer and there is a mix in the sector in Portsmouth.	If PCC were to insist on minimum hour contracts it is likely that the flexibility of the service would reduce, the workforce would reduce through a decline in staff acceptance of the terms, an increase in

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Criteria	Current Practice	Update July 2020
	PCC do not use zero hours contracts, we use temps or casual staff in addition to permanent staff.	'downtime' (not value for money) and increased costs through having to pay more to attract a different workforce into health and care.
Providers to have a clear and accountable procedure for following up staff concerns about their clients wellbeing	For PCC managed care homes supervision arrangements, (both formal and informal) enable an opportunity to raise any concerns up to and including 'whistleblowing'. CQC inspection takes account of how staff are led in registered services and therefore assure appropriate mechanisms through inspection. In addition, the quality team support providers to consider compliance with good practice and standards. Where concerns amount to safeguarding, PCC requires all providers to adhere to the pan regional safeguarding policy as well as incorporating it within their own policies.	
All homecare workers to be regularly trained to the necessary standard to provide good service at no cost to themselves and within work time.	Training is a requirement of our contracts with providers. Training is expected to be provided and paid for by providers within work time through the funding level set within our hourly rate. Some training is made available to the wider sector through PCC.	During the COVID-19 Pandemic, ASC have made a 'provider portal' available to all care providers in Portsmouth. This part of the website offers guidance and information and resources around freely available learning and development, including wellbeing resources. There is current work to identify any further wellbeing resources that can be provided

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Criteria	Current Practice	Update July 2020
		through PCC to independent sector providers.
Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation.	Supervision is a requirement of the regulator and many providers provide this both as 1:2:1 to discuss specific cases or as group supervision.	
Stage 3		
All homecare workers to be paid at least the Living Wage or where outsourced the provider is required to pay this and funded to pay it.	The rate set by Social Care in conjunction with providers is based upon the NLW and there is a requirement to pay NLW to employees. Many providers may pay higher than this in order to attract and retain staff. All eligible PCC staff, irrespective of age are paid £9.00 an hour, this includes casual staff and agency staff contracted to PCC.	
All homecare workers to be covered by an occupational sick pay scheme so they are not pressurised to work when ill in order to protect the welfare of vulnerable client	Providers have policies and procedures in place regarding managing sickness which protects them and their customers. Permanent PCC staff receive occupational sick pay in accordance with the NJC terms and conditions of employment.	The majority of the providers in the city pay Statutory Sick Pay. Two providers pay up to 7 days full pay within a one year period prior to SSP.

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Comparison of UNISON Residential Care Charter against current practice

Criteria	Current Practice	Update July 2020
Protecting and Supporting Residents		
Employers will maintain adequate staffing ratios that enable quality care to be delivered. This must be care that extends beyond basic tasks and includes a social dimension.	This is current custom and practice which falls within regulatory scrutiny, which is the responsibility of the Care Quality Commission. Adult Social Care is notified where care falls below standard by CQC and act upon this information. ASC and the Clinical Commissioning Group have commissioned a quality team working within Portsmouth. The team's general role is to work with care home providers and support them to provide appropriate care and support. Within PCC owned and managed care homes, the 'turn around team' was commissioned in 2018 to work with managers to implement better practice standards and staffing was reviewed to ensure adequate staffing ratios.	During the COVID-19 pandemic, ASC put in place a system whereby providers can claim one off payments for increasing agency staff to ensure care is maintained. As of May 2020, the government's Infection Prevention control grant allocates funding directly to care homes to pay for extra staff and prevent cross infection. Most care home providers in Portsmouth have 'activity coordinators' as part of their staffing complement.
Care workers, residents and families must be given information about how to raise concerns and protection if they decide it is necessary	Within PCC owned and managed care homes, staff are able to raise concerns through the supervision, (formal and informal) process with line managers. Residents can raise any concerns through the keyworker mechanism in place and families and visiting professionals are able to raise any concerns through staff on duty or discussions with the Unit Manager. A governance framework is followed regarding	

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Criteria	Current Practice	Update July 2020
Employers will have clear and accountable procedures to follow up any concerns raised	concerns via safeguarding / CQC / PCC complaints team. This will be the same within non-PCC managed homes and will be scrutinised by CQC. The ASC/CCG quality team regularly review these arrangements with providers they work with.	
Care home providers will ensure all residents have ready access to any NHS services required	There are good relationships with NHS services and staff within the city, appropriate referrals are made as per PCC guidance for PCC managed homes The 'care home team' commissioned through Solent NHS Trust work with care home providers in Portsmouth and act as a gateway to ensure that residents have access to NHS services.	As part of the NHS direction to primary care and community services, there is a named clinician for care homes in Portsmouth to ensure the NHS provides clinical and medical services to care homes. In terms of day to day support, the 'offer' from the NHS to all care homes in Portsmouth is of an NHS Solent Nurse-led team, providing physical and mental health support to all residents on both a planned and reactive basis. In addition, the enhanced care home team offer GP and Pharmacist support as part of the multi-disciplinary team which involves Speech & Language, Physiotherapy and nursing. Care homes in Portsmouth also have access to the 'Airedale' system which provides 24/7 access to a healthcare professional (B7/8a Nurse) for advice.

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Criteria	Current Practice	Update July 2020
		The Nurses have access to specialist consultants and the ability to contact any service in Portsmouth to refer on routine or in urgent situations. In addition to this clinical support, all care homes have been offered Infection Prevention and Control, (IPC) training.
Providers will carry out thorough risk assessments to ensure the safety of residents and care workers	All points in the protecting and supporting residents section are adhered to with clear guidance and procedures.	
Employers will provide care workers with safe equipment	All points in the protecting and supporting residents section are adhered to with clear guidance and procedures.	
Care workers will be given time to provide regular activities and effective forms of therapy for residents	Care workers are expected to be given time to meet the needs of the residents based upon their care plans.	
Training and support for employees		
All care workers - including bank and relief staff will be regularly trained to meet the needs of all residents as set out in their care plans.	This is a current expectation. The nominated individual in any organisation is responsible for ensuring that staff are trained to expectations and requirements as per the regulations.	
Training requirements will be met. Training must be met and carried out in work time, so cover staff must be arranged	Comprehensive induction and training is provided to in-house residential staff. Mixture of standard and/or bespoke off-site, in-house, e-learning and DVD training is used.	

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Criteria	Current Practice	Update July 2020
	Training is made available through the Local Authority to non-PCC managed care homes and will be monitored via regulation inspection.	
DVD and e-learning will be used to complement high quality and face to face training.	As above	
Decent Pay for Quality Work		
All residential care workers will be paid at least the Foundation living wage	There is a requirement to pay the National Living Wage. All eligible PCC staff, irrespective of age are paid £9.00 an hour, this includes casual staff and agency staff contracted to PCC.	
Councils which outsource employees on or above the Living wage should ensure that the new providers are required to maintain pay levels throughout the contract.	This would be covered under Regulation 13 of the TUPE Regulations as part of any TUPE transfer and is incorporated into PCC Procurement processes.	
Councils which outsource employees on or above the Living wage should ensure that the new providers are required to maintain pay levels throughout the contract.	This would be covered under Regulation 13 of the TUPE Regulations as part of any TUPE transfer and is incorporated into PCC Procurement processes.	
Extra payment will be made for working un-social hours, including weekends and Bank Holidays	As care is a 24/7, 365 days per year activity, there are less enhancements required for working outside of traditional office hours. Where such payments are necessary to attract staff to shifts are generally special holidays such as Easter and Christmas.	

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Criteria	Current Practice	Update July 2020
	PCC staff receive a shift allowance of either 7% 17% or 33% dependent on hours or days/nights worked following LPR.	
Pay for Sleep ins must be at a level to ensure that the average hourly rate does not drop below the Living Wage	PCC legal services have been advising contract and commissioning staff on this matter for some time. Whilst we are committed to ensure the NLW is paid to staff, what constitutes working hours and non-working hours in regards to sleep-in is still under review. Varied judgements have emerged following a Department for Work & Pensions case in 2017, however, the current situation is that an hourly rate is not required. Any sleep in amounts paid to PCC permanent employees, are paid at the minimum rate of £9.00 per hour.	The Supreme Court heard a case relating to payment for 'sleep in' in February 2020, the judgement has not yet been issued.
Holiday periods must be paid as if at work	Pay arrangements and complying with statutory duties are the responsibility of the provider. Permanent PCC employees receive their normal pay during holiday periods.	
All care workers must be paid occupational sick pay	Permanent employees are paid occupational sick pay. Casuals or temp staff would be paid in accordance with their eligibility for SSP.	
Employers will pay for DBS checks	PCC complete and pay for DBS checks for PCC staff.	Residential Care providers in the city pay for this.

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Signed by:

Appendices: None

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

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Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Date of meeting:	07 July 2020
Subject:	Adult Social Care Charging Arrangements
Report from:	Innes Richens, Chief of Health & Care Portsmouth
Report by:	Richard Webb, Finance Manager
Wards affected:	All Wards
Key decision:	No
Full Council decision:	No

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1. **Purpose of report**

1.1 The purpose of this report is to respond to the motion adopted by Full Council on the 14th January 2020, which sought the Cabinet Member for Health, Wellbeing and Social Care to investigate the introduction of a day care cap for all Social Care client groups and to advise councillors of the financial cost of this.

2. **Recommendations**

2.1 It is recommended that the Cabinet Member:

a. Consider and approve one of the following options:

1. **Maintain the current charging arrangements within Adult Social Care, in line with Care Act 2014 and the related charging Regulations; or**
   Subject to recommendations (b) and (c) below:
2. **Reinstate a financial cap for Day Care, Community Support and Health & Independence Services; or**
3. **Implement a financial cap across all Adult Social Care services.**

b. Confirm the level of the financial cap to be applied from Monday 06 April 2020, should the implementation of a financial cap be approved as set out in recommendation (a2) or (a3) above.

c. Agree that should the implementation of a financial cap be approved as set out in recommendation (a2) or (a3) above, it will on a temporary basis, until the publication and implementation of the anticipated government reforms of the financial arrangements for the Adult Social Care sector and how people fund their care and their eligibility for financial support from Local Authorities in the future.

d. Request the Chief of Health & Care Portsmouth to identify and implement alternative income or savings strategies in order to offset any lost income in 2020-21 and future years, and enable Adult Social Care to maintain a balanced budget.

3. Background

3.1. At the Health, Wellbeing & Social Care Portfolio meeting on 25 September 2018, it was agreed to remove the financial cap of £60.00 per week for client contributions for all client groups, for the following services:

- Day care
- Community Support
- Health & Independence

3.2. Following the removal of the financial cap, clients contribute up to their maximum assessed charge; based on a financial assessment of their means in accordance with the Care Act 2014 and related Care and Support (Charging & Assessment of Resources) Regulations. This is consistent with the charging principles applied to other chargeable Adult Social Care services such as: Domiciliary, Nursing and Residential Care.

3.3. One of the main reasons for removing the financial cap from the above services, was to ensure that clients across Adult Social Care were treated consistently and equitably for charging purposes.

3.4. A motion (9c) was presented to Full Council on the 14th January 2020 which stated:

> *"……The council believes that charging for both day care and residential care has been unfair in its effect. It therefore calls on the Cabinet member for Health, Wellbeing and Social Care to investigate the introduction of a day care cap for all Social Care client groups and to advise councillors of the financial cost of this. This consideration of all Social Care client groups would protect the council from potential legal action under equalities legislation which would be a risk if a change was made for just one client group…."*

3.5. Subsequently, at Full Council on 11 February 2020, it was suggested that any financial cap could be reinstated at £250 per week in respect of Day Care, Community Support and Health & Independence services.

However, any reinstatement of the financial cap would be conditional upon legal opinion confirming that the implementation of such a cap is not discriminatory in law and that clients with a protected characteristic will not be determined to be treated unfairly.

4. Legal Power Charge

4.1. The Care Act provides a single legal framework for charging for care and support under sections 14 and 17 of the Act. It enables a local authority to decide whether or not to charge a person when it is arranging to meet a person's care and support needs or a carer's support needs. Where a local authority arranges care and support to meet a person's needs, it may charge the adult, except where the local authority is required to arrange care and support free of charge.

4.2. Under the Care Act, Local Authorities have a duty to arrange care and support for those with eligible needs and a power to meet both eligible and non-eligible needs. In all cases, a local authority has the discretion to choose whether or not to charge under section 14 of the Care Act following a person's needs assessment. Where it decides to charge, it must follow the Care and Support (Charging and Assessment of Resources) Regulations and have regard to the Care Act guidance. The detail of how to charge an individual is different depending on whether someone is receiving care in a care home, or their own home, or another setting.

4.3. In deciding what it is reasonable to charge, local authorities must ensure that they do not charge more than is permitted under the regulations and guidance.

4.4. When choosing to charge, a local authority must not charge more than the cost that it incurs in meeting the assessed needs of the person. It also cannot recover any administration fee relating to arranging that care and support. The only exception is in the case of a person with eligible needs and assets above the upper capital limit (currently £23,250) who have asked the local authority to arrange their care and support on their behalf in a non-care home setting.

5. Financial Assessment Methodology

5.1 As highlighted above, where the Council decides to charge for services, it must follow the requirements of the Care Act 2014, the Care and Support (Charging and Assessment of Resources) Regulations as well as having regard to the statutory guidance.

5.2 The mechanism for charging an individual will also depend on whether someone is receiving care in a care home, or their own home, or another setting.

5.3 In applying the principles of the Care Act and the Charging Regulations, the Council will undertake a means tested financial assessment for each individual.

5.4 Capital thresholds and Minimum Income Guarantee (MIG) values are set nationally by the Department of Health and are not a local decision. The current upper capital threshold is £23,250. This means that any client with capital[1] above this threshold is considered as having the financial resources available to meet full cost of services. Where a person refuses a financial assessment the Local Authority can assume the client has sufficient financial resource and will be considered full cost. The Council offers a full welfare benefits check for all clients (including full cost clients) to ensure they are accessing all the financial support available to them to help sustain affordability of care.

5.5 Where a person has less than the upper capital threshold a full financial assessment is completed. For care other than that in a care home setting, there are a number of sources of income that the Council is required to disregard. These include:[2]

a. Direct Payments
b. Guaranteed Income Payments made to veterans under the Armed Forces Compensation Scheme
c. War Pension Scheme payments made to veterans with the exception of Constant Attendance Allowance payments
d. Mobility component of Disability Living Allowance
e. Mobility component of Personal Independence Payments
f. Money from employment, such as wages.
g. Payments received on behalf of a child, such as child tax credit.
h. Charitable payments.

5.6 The means tested financial assessment will consider the clients eligible income, allowable expenses, (housing costs and disability related expenditure) and a personal allowance or Minimum Income Guarantee, which is set according to an individual's age bracket, living arrangements and disability[3]. An example means test assessment is shown below.

[1] Annex B of the Care Act Statutory Guidance provides guidance of the treatment of capital
[2] Annex C of the Care Act Statutory Guidance provides guidance of the treatment of income
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772969/Social_care_charging_for_care_and_support_-_LAC_2019.pdf

FINANCIAL ASSESSMENT:

Total Income/Benefits	£276.20
Tariff Income from Total Capital	£0.00
Total Disregarded Income	-£23.20
Total Allowances/Expenses	-£32.50
Minimum Income Guarantee (MIG)	-£151.45
Calculated Disposable Income	£69.05
MAXIMUM WEEKLY CHARGE	**£69.05**
ACTUAL WEEKLY CHARGE ***(Based on current care package cost)***	**£69.05**

5.7 If, after deducting allowable expenses and the Minimum Income Guarantee (MIG) value from the client's total income there is a remaining value, this is considered to be the client's disposable income and would constitute their maximum weekly charge. Clients are charged either their assessed maximum charge or the actual cost of service(s) whichever is the lower amount.

5.8 The Council seeks to comply with the Care Act 2014 charging principles and apply these to all clients across all services. Based on the application of these principles, some clients will pay the full cost of services, some will contribute towards the cost of services and some will pay nothing at all; the determining factor being the individual's financial circumstances.

5.9 The principles are that the approach to charging for care and support needs should:

- apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings
- be sustainable for local authorities in the long-term
- ensure that people are not charged more than it is reasonably practicable for them to pay
- be comprehensive, to reduce variation in the way people are assessed and charged
- be clear and transparent, so people know what they will be charged
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control
- support carers to look after their own health and wellbeing and to care effectively and safely
- be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs
- encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so

6. **Financial & Administrative Impact**

6.1 As at February 2020, 90% of the Adult Social Care Clients in receipt of Day care, Community Support and Health & Independence services, were either paying nothing (37%) or contributing up to £60.00 per week (53%). Of the remaining 10% of clients, 7% were contributing between £60.01 and £100.00 per week.

6.2 The table below provides a breakdown of the clients contributing in excess of £60.00 per week according to the level of their weekly contribution.

Weekly Contribution £	Number of Clients No.
60.01 - 100.00	38
100.01 - 150.00	6
150.01 - 200.00	7
200.01 - 250.00	1
250.01 - 300.00	3
300.01 - 350.00	0
350.01 +	1
	56

6.3 The table above shows four clients with financial contributions in excess of £250 per week. From an analysis of the financial assessments for these clients, the reasons their current level of contributions, is due to a combination of the level of services being utilised and all clients having capital in excess of the threshold of £23,250.

6.4 The motion approved by Full Council sought to understand the financial impact of reinstating a financial cap. The table below shows the potential cost to Adult Social Care (as a consequence of lost income) if the financial cap were to be reintroduced for the Day Care, Community Support and Health & Independence services.

Level of financial cap £	Estimated reduction in income £
60	146,704
100	85,352
150	48,696
200	29,488
250	17,527
300	11,117

6.5 As highlighted within the September 2018 report, the removal of the financial cap sought to align the charging policy across all Adult Social Care services, so that all clients would be financially assessed in line with the Care Act and related charging Regulations, and contribute only up to the their maximum assessed charge. This change was also line with the Care Act charging principle which seeks to ensure that the charging rules

are applied equally so those with similar needs or services are treated the same and minimise anomalies between different care settings

6.6 Should the reintroduction of the cap be applied across all Adult Social Care services (including Domiciliary, Nursing and Residential Care) the table below shows the potential cost to Adult Social Care, as a consequence of lost income.

Level of financial cap £	No. of clients affected	Estimated reduction in income £	Estimated reduction in income as % of ASC 2020/21 Cash Limit
60	1,057	6,010,500	13.07%
100	724	4,156,200	9.04%
150	331	2,805,000	6.10%
200	201	2,163,900	4.71%
250	128	1,767,600	3.84%
300	90	1,511,300	3.29%

6.7 If the financial cap were to be reintroduced, then Adult Social Care would need to identify and implement alternative income or savings strategies to maintain a balanced budget in order to offset any lost income in 2020-21 and future years. The table above also shows the estimated reduction in income as a percentage of the net budget for 2020-21.

Administrative Impact

6.8 Since the previous financial cap was removed, the Adult Social Care case management system and related finance systems have been replaced. As a consequence the new systems are configured to apply the Care Act financial assessment framework. Should the financial cap be reintroduced, the application of the change could not currently be applied automatically within the system and therefore manual intervention would be required.

6.9 Any manual intervention would need to be undertaken on each client's record on a weekly basis for billing purposes. The staffing resources required to administer the application of any financial cap will be dependent on the level of the cap and the number of clients affected. For every 100 clients that the cap would apply to, it is currently estimated that an additional 1 FTE of billing support staff would be required to process the weekly adjustments.

7. Community Engagement

7.1 Throughout the implementation period an engagement exercise was undertaken, which included information letters being sent to clients and/or their representatives. Additionally, visits were offered to all clients, in order to undertake a review of their current assessment and/or a welfare benefits check to ensure clients are in receipt of all the Welfare Benefits that they may be entitled to; specifically Attendance Allowance and Personal Independence Payment. These benefits are non-mean's tested and therefore would offer an additional income stream to minimise impact of the charging policy change.

7.2 No formal complaints in relation to this policy change were received through the Adult Social Care complaints team.

8. Options for consideration

8.1 There are three main options available for consideration, which are assessed in detail below.

i. Maintain the current charging arrangements
ii. Reinstate a financial cap for specific services
iii. Reinstate a financial cap all Adult Social Care services

Option 1 - Maintain the current charging arrangements

Under the current charging arrangements, all clients will only pay for Adult Social Care services up to their maximum assessed contribution, in accordance with the Care Act 2014, the Care and Support (Charging and Assessment of Resources) Regulations. This approach to charging is also consistent with the following Care Act charging principles:

- *apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings*
- *be sustainable for local authorities in the long-term*

As shown above, under these arrangements 90% of the clients in receipts of the Day Care, Community Support and Health & Independence services are either paying nothing (37%) or contributing up to £60.00 per week (53%). A further 7% are contributing between £60.01 and £100 per week.

There are 4 clients who are contributing in excess of £250.00 based on a combination of the level of services they are utilising and their individual financial circumstances.

Option 2 - Reinstate a financial cap for specific services

Reinstating a financial cap for Day Care, Community Support and Health & Independence services would:

- Reduce the costs borne by individual users of these services.
- Create an anomaly in the charging rules between the different care settings, as this would be inconsistent with the Care Act charging principles.
- Potentially not be financially sustainable for Adult Social Care in the long-term.
- Require the disapplication of the charging framework specified in the Care Act and the related Charging Regulations for specific individuals.
- Create additional administrative tasks, as each system generated bill would require manual adjustment.

Based on the data above, under the current charging arrangements 97% of the client cohort are either paying nothing or contributing up to £100 per week for the services they are receiving. Therefore any financial cap above this amount would create a charging anomaly for 18 clients or less.

An alternative sub-option that could also be considered here, is to reinstate a financial cap for Day Care, Community Support and Health & Independence Services, for those clients who were in receipt of these services prior to the removal of the financial cap; and continue to be in receipt of these services. New clients would continue to be assessed in accordance with the Care Act 2014, the Care and Support (Charging and Assessment of Resources) Regulations.

It should be noted that any decrease in an individual's charges for these services may not automatically lead to a decrease in their financial contributions. The reason for this is that if the cost of other services that they utilising, together with the cost of the capped services is equal to or greater than their maximum assessed charge, then the client's contributions will remain at the current level.

Option 3 - Reinstate a financial cap all Adult Social Care services

If a financial cap was implemented for all Adult Social Care Services, then it would ensure there was consistency in the charging principles applied across all services and client groups. It was also reduce the costs borne by individual users of these services (where their charges would have been in excess of any proposed financial cap). However the changes would:

- Potentially not be financially sustainable for Adult Social Care in the long-term.
- Require the disapplication of the charging framework specified in the Care Act and the related Charging Regulations for specific individuals.
- Create additional administrative tasks, as each system generated bill would require manual adjustment.

Any level of financial cap across all services would result in significant reductions in income for Adult Social Care. Therefore the service would need to identify and implement alternative income or savings strategies to maintain a balanced budget in order to offset any lost income in 2020-21 and future years. The table at paragraph 6.6 shows estimated loss of income at different levels of financial cap.

8.2 Should it be considered appropriate to reintroduce a financial cap on the financial contributions expected from Adult Social Care clients, then a further option for consideration may be to time limit the application of any financial cap.

8.3 The Adult Social Care sector has been awaiting the publication by the government of its proposals for the potential reform of the financial arrangements for this sector and how people fund their care and their eligibility for financial support from Local Authorities in the future. These potential reforms could therefore affect the future charging arrangements for Adult Social Care service, including Day Care, Community Support and Health & Independence services.

9. Reasons for recommendations

9.1 The report provides a response to the motion adopted by Full Council on the 14th January 2020 and seeks to consider the impacts of implementing a financial cap to the charging arrangements for Adult Social Care services. The recommendation requests the Cabinet Member to consider and approve one of the potential options available in response to the motion.

9.2 Any reinstatement of the financial cap would be conditional upon legal opinion confirming that the implementation of such a cap is not discriminatory in law and that clients with a protected characteristic will not be determined to be treated unfairly.

10. **Integrated Impact Assessment (IIA)**

10.1 A preliminary Integrated Impact Assessment (IIA) has been carried out (Appendix 1). From this it was been determined that a full IIA would not be required.

10.2 As highlighted within the Legal Comments section below, the reason the original cap of £60 per week was looked at (September 25th 2018) was that it created wide disparity, was inconsistent, inequitable and confusing.

10.3 The current position is that all service users are financially assessed in accordance with the Care Act 2014 and related charging regulations. Under this arrangement clients may pay different amounts, but their expected contribution will be based on their individual circumstances.

10.4 Should any financial cap be reintroduced then it is likely to increase the level of disparity, inconsistency and inequality; and therefore create charging anomalies across different care settings.

10.5 In order to minimise the risk that the introduction of the financial cap will create direct discrimination, any financial cap should be applied equally to services across all client groups. Additionally, the policy should not differentiate on the basis of age or disability.

10.6 In terms of indirect discrimination, the reinstatement of the financial cap would will have a financial impact and will result in those with higher levels of disposable income and higher levels of need, paying less proportionately towards the cost of their care and support.

11. **Legal Comments**

11.1 The power to set charges is found in sections 14 and 17 of the care Act 2014 and the Care and Support (Charging and Assessment of Resources) Regulations 2014. The Local Authority (LA) has a power to charge and currently charges service users up to their maximum assessed charge based upon the individual service users own financial assessment.

11.2 There is nothing wrong with the premise that a) a charge can be made and b) it is based upon the statutory regulations.

11.3 The fact that individual service users may all pay different amounts is purely based upon their own individual circumstances.

11.4 Looking back, the reason the original cap of £60 was looked at (September 25th 2018) was that it created wide disparity was inconsistent, inequitable and confusing. The change meant that moving on post September all those who made a contribution were assessed as

having to pay the maximum amount, this Provision Criteria or Practice (PCP) being applied to the whole group (circa 71 service users at the time).

11.5 The current position is that all service users make the assessed contribution.

11.6 Claims based upon engaging the Equality Act 2010 could potentially be initiated. The duty here is in the provision of services or indeed in interpreting the process for financial assessment as part of the initial process. The starting point is section 29 of the Equality Act that prohibits service providers and persons exercising public functions from doing anything that constitutes discrimination. This duty applies to most protected characteristics, which for our purposes are confined to age and disability.

11.7 What is a service is not defined in the act other than to say that the provision of a service includes the provision of goods or facilities in the exercise of a public function (here we as the LA are engaged in providing the facilities). The question to ask is in providing the service and applying the provision criterion or practice (paying the full assessed contribution) does that amount to a discrimination in the sense that a service user is being treated less favourably than those because of the protected characteristic. On a direct basis there is limited possibility of a claim being raised because:

a. We are looking at the same policy for all with the same application process being applied to all.

b. We do not differentiate about contribution just saying that the maximum assessed payment will be taken.

c. We do not differentiate on the basis of age, or disability.

11.8 The existing policy in its current form and application exposes the LA to very limited challenge.

11.9 On the issue of indirect discrimination that occurs when the service provider applies a provision, criterion or practice that places service users sharing a protected characteristic at a particular disadvantage that cannot be justified. The current blanket PCP whilst costing more to some than others is such that on the face of it is not placing any user at a particular disadvantage and even it that was the case it could be justified that the PCP is a proportionate means of achieving a legitimate aim. The LA could suggest that the removal of the cap was to redress the unfairness as in the original 2018 decision.

11.10 The fact that persons pay more or less is a fact and may seem unfair which of itself is not an illegality.

11.11 The reinstatement of the financial cap would have as the report espouses a financial impact along with a potential argument about the rationality of such a decision as in effect those with higher need would be in receipt of a higher disposable income as their contribution would be less. There is an argument that this is an unreasonable decision and not one any reasonable LA would make.

12. Finance Comments

12.1 Under the current charging arrangements, clients are only expected to contribute up to their maximum assessed charge; based on a financial assessment of their means in accordance with the Care Act 2014 and related Care and Support (Charging & Assessment of Resources) Regulations.

12.2 Any decision to introduce a financial cap to any assessed client charges will result in a reduction in the level of income received by Adult Social Care. The tables within the report provide estimates of the potential lost income at different levels of financial cap, depending on whether they are applied to all Adult Social Care services or limited to Day Care, Community Support and Health & Independence services.

12.3 If a financial cap was to be implemented, Adult Social Care would need to identify and implement alternative income or savings strategies to maintain a balanced budget in order to offset any lost income in 2020-21 and future years.

……
Signed by:
Innes Richens, Chief of Health & Care Portsmouth

Appendices:

1 - Integrated Impact Assessment

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
The Care Act	www.legislation.gov.uk
The Care and Support	

(Charging and Assessment of Resources) Regulations	www.legislation.gov.uk
Care & Support Statutory Guidance	https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#charging-and-financial-assessment

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

Integrated Impact Assessment (IIA)

Integrated impact assessment (IIA) form December 2019

www.portsmouth.gov.uk

The integrated impact assessment is a quick and easy screening process. It should:

- identify those policies, projects, services, functions or strategies that could impact positively or negatively on the following areas:
  - Communities and safety
  - Regeneration and culture
  - Environment and public space
  - Equality & diversity

Directorate: Adult Social Care

Service, function: Chargeable Services

Title of policy, service, function, project or strategy (new or old) :

Adult Social Care Charging Arrangements

Type of policy, service, function, project or strategy:

- ★ Existing
- ☐ New / proposed
- ☐ Changed

What is the aim of your policy, service, function, project or strategy?

The purpose of this is to respond to the motion adopted by Full Council on the 14th January 2020, which sought the Cabinet Member for Health, Wellbeing and Social Care to investigate the introduction of a day care cap for all Social Care client groups and to advise councillors of the financial cost of this.

Has any consultation has been undertaken for this proposal? What were the outcomes of the consultations? Has anything changed because of the consultation? Did this inform your proposal?

No.

A - Communities and safety	Yes	No

Is your policy, proposal relevent to the following questions?

A1-Crime - Will it make our city safer?	☐	★

In thinking about this question:

- How will it reduce crime, disorder, ASB and the fear of crime?
- How will it prevent the misuse of drugs, alcohol and other stubstances?
- How will it protect and support young people at risk of harm?
- How will it discourage re-offending?

If you want more information contact Lisa.Wills@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-spp-plan-2018-20.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How will you measure/check the impact of your proposal?

A - Communities and safety	Yes	No

Is your policy, proposal relevent to the following questions?

A2-Housing - Will it provide good quality homes?	☐	★

In thinking about this question:

- How will it increase good quality affordable housing, including social housing?
- How will it reduce the number of poor quality homes and accommodation?
- How will it produce well-insulated and sustainable buildings?
- How will it provide a mix of housing for different groups and needs?

If you want more information contact Daniel.Young@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/psh-providing-affordable-housing-in-portsmouth-april-19.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

A - Communities and safety	Yes	No
Is your policy, proposal relevent to the following questions?		
A3-Health - Will this help promote healthy, safe and independent living?	☐	★

In thinking about this question:

- How will it improve physical and mental health?
- How will it improve quality of life?
- How will it encourage healthy lifestyle choices?
- How will it create healthy places? (Including workplaces)

If you want more information contact Daniel.Young@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/psh-providing-affordable-housing-in-portsmouth-april-19.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

A - Communities and safety	Yes	No
Is your policy, proposal relevent to the following questions?		
A4-Income deprivation and poverty-Will it consider income deprivation and reduce poverty?	☐	★

In thinking about this question:

- How will it support those vulnerable to falling into poverty; e.g., single working age adults and lone parent households?
- How will it consider low-income communities, households and individuals?
- How will it support those unable to work?
- How will it support those with no educational qualifications?

If you want more information contact Mark.Sage@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-homelessness-strategy-2018-to-2023.pdf
https://www.portsmouth.gov.uk/ext/health-and-care/health/joint-strategic-needs-assessment

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

A - Communities and safety	Yes	No

Is your policy, proposal relevent to the following questions?

A5-Equality & diversity - Will it have any positive/negitive impacts on the protected characteristics?	☐	★

In thinking about this question:

- How will it impact on the protected characteristics-Positive or negative impact (Protected characteristics under the Equality Act 2010, Age, disability, race/ethnicity, Sexual orientation, gender reassignment, sex, religion or belief, pregnancy and maternity, marriage and civil partnership,socio-economic)
- What mitigation has been put in place to lessen any impacts or barriers removed?
- How will it help promote equality for a specific protected characteristic?

If you want more information contact gina.perryman@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cmu-equality-strategy-2019-22-final.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

The current position is that all service users are financially assessed in accordance with the Care Act 2014 and related charging regulations. Under this arrangement clients may pay different amounts, but their expected contribution will be based on their individual circumstances.

The comments provided by Legal services within section 11 of the attached Portfolio report, should be considered in deciding whether to reintroduce any financial cap.

Should any financial cap be reintroduced then it is likely to increase the level of disparity, inconsistency and inequality across, and therefore create charging anomalies across different care settings.

In order to minimise the risk that the introduction of the financial cap will create direct discrimination, any financial cap should be equally to services across all client groups. Additionally, the policy should not differentiate on the basis of age or disability.

How are you going to measure/check the impact of your proposal?

Any reinstatement of the financial cap will be conditional upon legal opinion confirming that the implementation of such a cap is not discriminatory in law and that clients with a protected characteristic will not be determined to be

B - Environment and climate change	Yes	No

Is your policy, proposal relevent to the following questions?

B1-Carbon emissions - Will it reduce carbon emissions?	☐	★

In thinking about this question:

- How will it reduce greenhouse gas emissions?
- How will it provide renewable sources of energy?
- How will it reduce the need for motorised vehicle travel?
- How will it encourage and support residents to reduce carbon emissions?

If you want more information contact Tristan.thorn@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cmu-sustainability-strategy.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

B - Environment and climate change	Yes	No

Is your policy, proposal relevent to the following questions?

B2-Energy use - Will it reduce energy use?	☐	★

In thinking about this question:

- How will it reduce water consumption?
- How will it reduce electricity consumption?
- How will it reduce gas consumption?
- How will it reduce the production of waste?

If you want more information contact Daniel.Young@portsmouthcc.gov.uk or go to:
https://www.portsmouth.gov.uk/ext/documents-external/psh-providing-affordable-housing-in-portsmouth-april-19.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

B - Environment and climate change	Yes	No

Is your policy, proposal relevent to the following questions?

B3 - Climate change mitigation and flooding-Will it proactively mitigate against a changing climate and flooding ?	☐	★

In thinking about this question:

- How will it minimise flood risk from both coastal and surface flooding in the future?
- How will it protect properties and buildings from flooding?
- How will it make local people aware of the risk from flooding?
- How will it mitigate for future changes in temperature and extreme weather events?

If you want more information contact Tristan.thorn@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/env-surface-water-management-plan-2019.pdf
https://www.portsmouth.gov.uk/ext/documents-external/cou-flood-risk-management-plan.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

B - Environment and climate change	Yes	No

Is your policy, proposal relevent to the following questions?

B4-Natural environment-Will it ensure public spaces are greener, more sustainable and well-maintained?	☐	★

In thinking about this question:

- How will it encourage biodiversity and protect habitats?
- How will it preserve natural sites?
- How will it conserve and enhance natural species?

If you want more information contact Daniel.Young@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/pln-solent-recreation-mitigation-strategy-dec-17.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

B - Environment and climate change	Yes	No

Is your policy, proposal relevent to the following questions?

B5-Air quality - Will it improve air quality?	☐	★

In thinking about this question:

- How will it reduce motor-vehicle traffic congestion?
- How will it reduce emissions of key pollutants?
- How will it discourage the idling of motor vehicles?
- How will it reduce reliance on private car use?

If you want more information contact Hayley.Trower@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/env-aq-air-quality-plan-outline-business-case.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

B - Environment and climate change	Yes	No

Is your policy, proposal relevent to the following questions?

B6-Transport - Will it improve road safety and transport for the whole community?	☐	★

In thinking about this question:

- How will it prioritise pedestrians, cyclists and public transport users over users of private vehicles?
- How will it be safe and comfortable for children and older people to cycle and walk in the area?
- How will it increase the proportion of journeys made using sustainable and active transport?
- How will it reduce the risk of traffic collisions, and near misses, with pedestrians and cyclists?

If you want more information contact Pam.Turton@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/travel/local-transport-plan-3

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

B - Environment and climate change	Yes	No
Is your policy, proposal relevent to the following questions?		
B7-Waste management - Will it increase recycling and reduce the production of waste?	☐	★

In thinking about this question:

- How will it reduce household waste and consumption?
- How will it increase recycling?
- How will it reduce industrial and construction waste?

If you want more information contact Steven.Russell@portsmouthcc.gov.uk or go to:

https://documents.hants.gov.uk/mineralsandwaste/HampshireMineralsWastePlanADOPTED.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

C - Regeneration of our city	Yes	No

Is your policy, proposal relevent to the following questions?

C1-Culture and heritage - Will it promote, protect and enhance our culture and heritage?	☐	★

In thinking about this question:

- How will it protect areas of cultural value?
- How will it protect listed buildings?
- How will it encourage events and attractions?
- How will it make Portsmouth a city people want to live in?

If you want more information contact Claire.Looney@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/pln-portsmouth-plan-post-adoption.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

C - Regeneration of our city	Yes	No

Is your policy, proposal relevent to the following questions?

C2-Employment and opportunities - Will it promote the development of a skilled workforce?	☐	★

In thinking about this question:

- How will it improve qualifications and skills for local people?
- How will it reduce unemployment?
- How will it create high quality jobs?
- How will it improve earnings?

If you want more information contact Mark.Pembleton@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-regeneration-strategy.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

C - Regeneration of our city	Yes	No

Is your policy, proposal relevent to the following questions?

C3 - Economy - Will it encourage businesses to invest in the city, support sustainable growth and regeneration?	☐	★

In thinking about this question:

- How will it encourage the development of key industries?
- How will it improve the local economy?
- How will it create valuable employment opportunities for local people?
- How will it promote employment and growth to the city?

If you want more information contact Mark.Pembleton@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-regeneration-strategy.pdf

Please expand on the impact on these issues your proposal will have, and how you propose to mitigate any negative impacts?

How are you going to measure/check the impact of your proposal?

Q8 - Who was involved in the Integrated integrated assessment?

Richard Webb

This IIA has been approved by: Andy Biddle

Contact number: 8697

Date: 06/03/20

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Date of meeting:	7 July 2020
Subject:	Adult Social Care Response to the COVID-19 Pandemic
Report by:	Innes Richens - Chief of Health & Care Portsmouth
Written by:	Andy Biddle - Assistant Director, Adult Social Care.
Wards affected:	All

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1. Purpose of report

An initial request was made for a summary of the Adult Social Care, (ASC) response to the COVID-19 Pandemic at the March 2020 portfolio holder decision meeting. Given the pandemic, the business of the Council moved to business critical services from March to June 2020 and the Council continues to be in response to the pandemic whilst moving into recovery. During the period, the Council exercised its powers vested in the Chief Executive in the absence of the normal democratic public meetings of the Council. A March 2020 Decision making meeting therefore did not occur.

This report will summarise some of the key issues and work undertaken by ASC in relation to COVID-19 from March to June 2020. These issues will be divided according to the main themes of response priorities for ASC during the pandemic.

1.2 Context

The focus for the ASC response to COVID-19 has been governed by the release of government guidance, as adult social care in England is governed by statutory duties contained in the Care Act 2014, Mental Health Act 2007 and Mental Capacity Act 2005.

The ASC business continuity plan for COVID-19 focussed initially on maintaining staffing in core provided and purchased services and identification of those with the highest priority need should shortages mean a rapid reprioritisation was required. In addition, ASC reduced or closed non-critical services and redeployed staff to support both care homes and the emerging work in working with people who were 'shielding' in response to government guidance, where food and medication needs were identified.

2. Response priorities

2.1 Personal Protective Equipment (PPE)
Emerging shortages in March 2020 around the use of Personal Protective Equipment, (PPE) caused ASC to work with the Locality Resilience Forum, (LRF) and the establishment of a 'strategic reserve' at regional level for urgent supplies. This moved to PCC appointing an officer and a team to oversee establishment of a city reserve for PPE. The team was able to make proactive as well as reactive support to providers of care and support and, working with procurement, establish a strategic reserve in Portsmouth. The PPE reserve has been able to meet all needs for supply in Portsmouth even in the face of supply shortages.

2.2 Hospital Discharge
Government Guidance on Hospital discharge published in March 2020 directed ASC to work with NHS partners to enable rapid discharge from Hospital, so that the NHS could manage the impact of those who needed acute care due to COVID-19. The guidance directed that people were discharged more rapidly to care home beds or their own homes with care and support.

The Coronavirus Act became law in England on 25th March 2020 which contained the ability for the Local Authority to apply 'Care Act Easements' if this was required. This would have meant prioritising some needs and not meeting others and would have required notification to Secretary of State and local Members of Parliament in addition to local Councillors. To this point, Portsmouth City Council ASC has not had to apply the easements.

2.3 Care Homes
Sadly, across the country, many care homes have experienced the death of residents with suspected or confirmed COVID-19. This was no different for care homes run by PCC and other care homes in the city. The fact that this is not unexpected in a pandemic from an airborne disease that is easily spread does not take away from the impact that every death has on family, the care home community and PCC staff. PCC care homes focussed on Infection Prevention and Control, (IPC) measures, following government and Public Health England guidance to try and manage the spread of infection.

In April 2020, the Social Care Action Plan was published by government, covering four main areas:

a) Controlling the spread of infection in care settings - through cleaning; use of PPE; managing outbreaks; discharge from NHS acute settings to care homes
b) Supporting the workforce - Testing for care workers; returning social care workforce to work; employment of people new to the sector; volunteering; wellbeing support to workers.
c) Supporting independence - supporting people at the end of their lives and responding to individual needs, guidance for informal carers, the application of the Mental Capacity Act.
d) Supporting local authorities and the providers of care - funding committed to and a requirement for care homes to complete a national 'Capacity tracker'.

The action plan obliged the Local Authority to secure alternative accommodation for people who needed care in isolation on discharge from hospital where their own care home could not provide this. The care home estate (locally and nationally) is variable in its age and suitability; this is particularly so for Portsmouth, with many care homes being adapted from a previous non-care home use. This makes it difficult for some care homes to care for people in isolation, whatever the outcome of the pre-discharge test. Given these factors, without an isolated care solution at a local level, the spread in care homes could be far greater. Any solution therefore needed to be able to provide appropriate facilities.

Portsmouth City Council and its partner organisations considered several options in the provision of this resource. The option pursued was to open a unit at Harry Sotnick House. The building design enabled people to be cared for individually in isolation until the post-discharge period has elapsed. A specific staff group was recruited to work in this unit, a separate entrance created and a lift dedicated to the use of the unit.

The Social Care Action plan also detailed a Care Home Support plan required from the Local Authority, focusing on support provided around Infection prevention and control, testing for COVID-19; Personal Protective Equipment; workforce support and clinical support. Portsmouth ASC worked with local NHs colleagues to return a letter, a template and a plan to the Minister for Social Care. This was published on the Portsmouth City Council website;
https://www.portsmouth.gov.uk/ext/documents-external/dhsc-29may20-let.pdf
Part of the Care Homes plan was distribution of a grant to care homes to enable funds for IPC related needs.

2.4 Provider Support

In terms of support for providers of care and support in Portsmouth, ASC has established a provider portal to publish links to national guidance and local information for providers. Additionally, care homes have a weekly virtual meeting with local NHS and ASC representatives. Providers of domiciliary care have a virtual meeting fortnightly and providers of day services and supported living have regular virtual meetings. These meetings are focussed on providing information, answering questions and queries and understanding the challenges to the sector.

Additionally, PCC offer a package of financial support measures to the sector focussing on increased costs for PPE and increased staffing due to COVID-19. A minimum income guarantee has also been established to ensure financial stability for providers of social care during the pandemic. This will begin to taper down between July and October 2020.

2.5 Testing

Testing for COVID-19 has been an emergent issue throughout the pandemic. Initially, limited testing was available if a care home had 2 or more residents with suspected or confirmed COVID-19. The local Hospital, Queen Alexandra, then made testing available to staff who could get to the Hospital. The drive in Tipner site development enabled staff to drive to be tested. Subsequently postal testing kits were available and whole care home testing for non-symptomatic staff and all

residents was enabled at the beginning of June. Portsmouth ASC also participated in a pilot for domiciliary care worker testing in the city. As of 2nd July 2020, the government has directed that whole care homes testing of staff should take place weekly and of residents monthly. ASC are in the process of understanding how to support this in the local area.

Signed by:

Appendices: None

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

Portsmouth CITY COUNCIL

Report to:	Cabinet Member for Health, Wellbeing and Social Care
Subject:	COVID-19 Briefing
Date of meeting:	7 July 2020
Report from:	Helen Atkinson - Director of Public Health
Report by:	Helen Atkinson and Matt Gummerson
Wards affected:	All
Key decision:	No
Full Council decision:	No
Key decision:	For information

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1. Purpose of report

1.1 To brief the Cabinet Member for Health, Wellbeing and Social Care meeting on the work led by public health on the Covid-19 initial response in Portsmouth, current plans in place, including current insight data, and the local governance arrangements in place for the next stage of the response for Test and Trace, Outbreak Plans and the Health Protection Board and Member Led Engagement Board.

2. Background

2.1. Public Health Leadership within the Portsmouth City Council corporate response and the HIOW Local Resilience Forum

Early in the pandemic response, we ensured that we were maintaining our statutory responsibilities and PH service delivery as well as supporting the council around specialist advice for preventing the spread of infection. This work included providing advice and interpretation of the national guidance into HR plans for staff including use of PPE, social distancing, resident home visits, volunteering and infection control in care homes, schools, sheltered housing and our homeless accommodation. PH set up a daily rota to reply to queries that came in from the HR team and other senior managers in the council via our generic emails address. PH also supported, via our Communications lead, much of the internal and external facing communication messages on our intranet and internet sites.

2.2. The three Directors of Public Health (DPHs) for Portsmouth, Southampton, Hampshire and the IOW have played a senior leadership role within the COVID-19

Local Resilience Forum (LRF) response as the local specialists for infectious disease pandemics. We have each taken a lead for specific areas of the response within the LRF. Simon Bryant (HIOW DPH) has led the work for preventing the spread of infection as the Strategic Coordinating Group (SCG) Deputy Chair; Debbie Chase (Southampton DPH) has led the work of the LRF Modelling Cell and Helen Atkinson (Portsmouth DPH) has led on the PH in-put to the Health and Social Care Cell and specialist PH advice, including the recovery timeline, to the Recovery Coordinating Group RCG) chaired by our Chief Executive, David Williams. The DPHs and their teams have worked closely together to ensure a networked response to COVID-19 across HIOW as well as taking a lead role in their individual local authority response.

2.3. The Public Health Team in Portsmouth City Council are core members of several of the groups and provide specialist in-put to the work of the LRF response to the pandemic. Please find below details of which groups we have been supporting:

- Helen Atkinson, DPH - Member of the Strategic Coordinating Group; the Recovery Coordinating Group, the Modelling cell, chairing the Recovery Intelligence Cell and member of the Health and Social Care Cell.
- Fiona Wright, Consultant in Public Health (CPH) - The Tactical Coordinating Group (TCG); protecting our Most Vulnerable Residents group and co-chairing the Portsmouth Mental Health Alliance.
- Dominique Le Touze, CPH - The Portsmouth City Council GOLD Business Continuity Group and the Preventing Spread of Infection Group.
- Matt Gummerson, Strategic Lead for Intelligence - The Recovery Coordinating Group, the Modelling cell, GOLD Business Continuity Group and the Recovery Intelligence Cell.
- Alan Knobel, PH Development Manager - Covid-19 Homelessness work-stream and the PCC Homeless Management Group
- Cheryl Scott, PH Communications Lead - LRF Media Cell.

2.4. PH are also involved in regional and national work as members of the Association of Directors of Public Health (ADPH). To mention two examples of this work - the SE ADASS Recovery Reference Group and the DHSC Whole Care Home Testing Task and Finish Group.

The SE ADASS Recovery Reference Group was set up to support the work on recovery that all DPHs in the region are currently involved with. We are all looking at the evidence from other pandemics and current response from other parts of the world to identify opportunities for learning during recovery. To reduce duplication and save on scarce PH resource we are undertaking this work together across the South East. Emma Richards, Specialist Registrar in PH, and Matt Gummerson, Strategic Lead for PH Intelligence at PCC are taking the lead on the literature review work for the whole region. The aim of the group is to:-

- identify issues relating to whole population health and wellbeing for consideration in the recovery phase of COVID 19

- set out a whole systems approach to health and wellbeing recovery based on available evidence and learning from previous pandemics, disasters and emergencies
- collate / generate resources that PH teams can use to feed in to their local recovery plans/systems which will all be different

Whole Care Home Testing - in mid-May the Minister of State for Care, Helen Whately MP announced whole care home testing across the sector. In a letter to local Directors of Public Health and Directors of Adult Social Services, she asked them to lead work with local NHS providers and PHE Regional Directors to ensure that testing of staff and residents in care settings is joined up. This program, along with the Test and Trace program will allow us to get a better understanding of where our local community infection 'hot spots' and outbreaks are so that we can direct effective prevention measure to reduce the spread of infection.

2.5 Public Health Intelligence and COVID-19

Public Health Portsmouth has worked in partnership with colleagues across Hampshire and the Isle of Wight (HIOW) to develop a range of Covid-19 Intelligence products that are being used to inform the local response and recovery efforts.

Modelling - Coronavirus is a newly emergent virus and much remains to be understood about COVID-19 transmission dynamics. Its precise impact on individuals is not fully known. Through the Local Resilience Forum (LRF) Modelling Cell, we aim to distil the emerging evidence and try to infer from that to what it may mean for us and the impact on our area for capacity and demand planning.
Our model adopts a public health approach to modelling infectious diseases. It uses the epidemiological evidence that we know of COVID-19 and simulates infection spread through a population. Population age structure, density and household composition are strong determinants of how infection spreads, so every area is different. So far, our model has been successful in predicting COVID-19 rates for the LRF, and we continue to adapt the model as new evidence becomes available. Our next step is to model different scenarios in response to the relaxation of lockdown restrictions and identify potential early warnings in the local system.

Portsmouth Gold Dashboard - As well as data and analysis at LRF level, we have produced a local dashboard for GOLD that highlights key information about the progression of COVID-19 in Portsmouth. An updated Dashboard (Appendix 1) is presented weekly to GOLD, summarising key data into charts covering:

- Infection rates for Portsmouth, HIOW authorities and comparators
- Epidemiological care of Portsmouth new cases
- Deaths in Portsmouth Hospitals NHS Trust from COVID-19
- Excess deaths each week in Portsmouth compared to previous weekly averages

Recovery timelines - Public Health Intelligence supports the LRF Recovery Coordinating Group through the Recovery Intelligence Cell. We provide advice and information on potential timelines and emerging challenges and opportunities for the next phases of the response to, and recovery from, COVID-19. This includes analysing national policy, local sector intelligence, and wider evidence on recovery. A summary slide of the latest assumptions on Recovery timelines is attached as Appendix 2.

Additional information and analysis - We continue to respond to local demand for new information and analysis around COVID-19 e.g. working closely with Adult Social Care and the Clinical Commissioning Group to provide an intelligence-led approach to the challenges in the local care sector.

3. Next phase of the COVID-19 response including Test and Trace, local outbreak plans and local health protection and engagement boards.

3.1 On Friday 22nd May, national Government announced the requirement for Local Outbreak Control Plans (CoVid-19) to be developed to reduce local spread of infection and for the establishment of a Member-led Covid-19 Engagement Board for each upper tier Local Authority to communicate with the general public, supported by an Officer-led Health Protection Board connected into existing Local Resilience Forum command structures (PCC GOLD). A £300m funding offer to upper tier Local Authorities accompanied this announcement, though individual allocations.

3.2 Work is continuing on the design of the national test and trace programme, which was launched on Tuesday 26th May. This will form a central part of the government's Covid-19 recovery strategy. The primary objectives of the national test and trace programme, and our local programme including the requirements for outbreak plans, will be to control the Covid-19 rate of reproduction (R), reduce the spread of infection and save lives. In doing so, we can help to return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy.

3.3 Achieving these objectives will require a co-ordinated effort from local and national government, the NHS, GPs, businesses and employers, voluntary organisations and other community partners, and the public. Local planning and response will be an essential part of the Test and Trace service, and local government has a central role to play in the identification and management of infection and to develop and action their plans to reduce the spread of the virus in their area.

3.4 Building on the statutory role of Directors of Public Health (DPHs) at the upper tier local authority level, and working with Public Health England's (PHE) local health protection teams (HPTs), local government will build on existing health protection plans to put in place measures to identify and contain outbreaks and protect the public's health. Local DPHs will be responsible for defining these measures and producing the plans, working through Covid-19 Health Protection Boards. They will

be supported by and work in collaboration with Gold command emergency planning forums and a public-facing Board led by council members to communicate openly with the public.

3.5 Cross-party and cross-sector working will be strongly encouraged, and all tiers of Government will be engaged in a joint endeavour to contain the virus, including Local Resilience Forums, NHS Integrated Care Systems and Mayoral Combined Authorities. Councils are free to work at wider geographic levels if they so choose.

4. Local Outbreak Plans

4.1 Government guidance requires that local plans should be centred on 7 themes:

- Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, identifying potential scenarios and planning the required response).
- Identifying and planning how to manage other high-risk places, locations and communities of interest including sheltered housing, dormitories for migrant workers, transport access points (e.g., ports, airports), detained settings, rough sleepers etc. (e.g. defining preventative measures and outbreak management strategies).
- Identifying methods for local testing to ensure a swift response that is accessible to the entire population. This could include delivering tests to isolated individuals, establishing local pop-up sites or hosting mobile testing units at high-risk locations (e.g. defining how to prioritise and manage deployment).
- Assessing local and regional contact tracing and infection control capability in complex settings (e.g., Tier 1b) and the need for mutual aid (e.g. identifying specific local complex communities of interest and settings, developing assumptions to estimate demand, developing options to scale capacity if needed).
- Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g., data management planning including data security, data requirements including NHS linkages).
- Supporting vulnerable local people to get help to self-isolate (e.g. encouraging neighbours to offer support, identifying relevant community groups, planning how to co-ordinate and deploy) and ensuring services meet the needs of diverse communities.
- Establishing governance structures led by existing Covid-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the public.

4.2 All upper tier local authorities need to develop local outbreak control plans in June ahead of further phases of the national infection control framework. This work is being supported by eleven pilot areas (Surrey in the SE) that are rapidly developing best practices and capturing learning. Local councils outside these areas will be invited to participate in regular engagement and best-practice sharing sessions provided by the LGA and ADPH.

4.3 A National Outbreak Control Plans Advisory Board will be established, led by Tom Riordan, CEO Leeds City Council, to draw on expertise from across local government and ensure the national Test and Trace programme builds on local capability, and to share best practice and inform future programme development. The local plans, linked with the work of the Joint Biosecurity Council, will be at the heart of the next phase of the response.

4.4 DPHs will lead the development of Local Outbreak Plans and work with PHE local HPTs to lead the work on contact tracing and managing outbreaks in complex settings and situations. HPTs will lead at centre level and DPHs will lead within their Authorities. This is described as Level 1, which is delivered with partners at local levels. The management of local outbreaks is resource intensive work and so local authorities through the leadership of their DPHs and PHE will work closely together in building capacity of both the local authority teams and the PHE local HPTs, which will be a key part of the Local Outbreak Control Plans.

5. Test and Trace - contact tracing

5.1 The national approach to contact tracing has been highly iterative and remains so, however, is proposed to include two main elements:

- **Covid 19 App:** This is an innovative, but largely untested approach to using technology to support people to identify when they are symptomatic, order swab tests, and send tailored and targeted alerts to other app users who have had close contact. Even when operational, this feature of the national model will be insufficient as a standalone approach due to limitations in terms of reach and functionality. The NHSX app will no longer go forward but government are working with Apple/Google to develop an App that will be in place by the autumn.

- **National Contact Tracing Service (NCTS):** This incorporates a significant scaling up of the tried and tested contact tracing approach and has 3 proposed tiers:
  Tier 3: A new cohort (c.25, 000) of contact tracing call handlers based within a national call handling centre providing phone-based contact tracing (PBCT);
  Tier 2: A significantly increased cohort (c.3, 000) of trained contact tracing Specialists providing phone-based contact tracing (PBCT) to be recruited through a national recruitment approach;
  Tier 1b: A regionalised network, including sub-regional and localised delivery providing contact tracing, consequence management and support in relation to complex settings, cohorts and individuals / households.
  Tier 1a: A national co-ordinating function to lead on policy, data science, and quality assurance of the service.

5.2 Tier 1b will have 3 primary functions:

1. Complex Contact Tracing with:

- Potentially complex settings (for example: Special Schools, Homeless Accommodation; DV refuges; Police Stations; HMO's; Day Centre Provision; NHS Settings; Social Care settings; Statutory Service HQ's; residential children's homes)
- Potentially complex cohorts (for example: rough sleepers; faith communities, asylum seekers)
- Potentially complex individuals and households (for example: Clinically shielded; Learning Disability; diagnosed Mental Illness; Rough Sleepers; Victims of Domestic Abuse; complex social-economic circumstances)

2. Providing direct support to those identified through contact tracing for whom adherence to self-isolation measures may be challenging, including links into locality hub pathways for our shielded and vulnerable cohorts.

3. Consequence management as a result of managing an outbreak in a complex setting or within a complex cohort.

6. The role of the Local Resilience Forum

6.1 The Strategic Co-ordinating Group of the Local Resilience Forum has responsibility to agree and co-ordinate strategic actions by Category 1 and 2 responders for the purposes of the Civil Contingencies Act in managing demand on systems, infrastructures and services and protecting human life and welfare. The SCG has crucial capabilities in aligning and deploying the capabilities of a range of agencies at local level in supporting the prevention and control of transmission of COVID-19. An LRF may often cover multiple local authority areas and at a local level, the relationship between each local authority and the SCG needs to be agreed and understood by stakeholders. In this respect, the SCG will add value to co-ordination and oversight across larger geographical footprints. Local areas are best left to determine how these arrangements will work.

7. The role of the Integrated Care System (ICS)

7.1 Just as the Public Health "system within a system" is necessary to a strong Local Outbreak Plan, so the Capabilities of the whole system, including the ICS, will be crucial to preventing and managing Outbreaks. Both are necessary parts of a system. A good local Outbreak Plan will:

1. Have a clear role for the Strategic Co-ordinating Group in deploying and aligning multi-agency capabilities in furtherance of the Plan
2. Ensure that agencies play to their strengths and capabilities and do not try to do the roles of others with specific statutory responsibilities or more suited to a specific role
3. Ensure the capabilities needed from all agencies, from analysts and data specialists to clinicians, local authority, NHS, police and voluntary sector functions are harnessed for appropriate roles ranging from supporting those self-isolating to the use of legal powers where needed.

4. Ensure NHS infection control capabilities will deliver clinical leadership fully playing their part in supporting the leadership of the Director of Public Health in NHS and Care settings, and the ICS and NHS organisations will facilitate this

8. Recommended terms of reference and membership of the Local Health Protection Board

8.1 The Local Health Protection Board will be an operational group that will develop and be responsible for the ongoing implementation of the Local Outbreak Plan. It is recommended that as a minimum, this group includes:

Director of Public Health (PCC) - Chair

Assistant Director - Regulatory Services, PCC (and Deputy Chair)

Representative from PCC communications

Assistant Director - Adult Social Care (care homes a key focus of Local Outbreak Plans)

Deputy Director of Children, Families and Education - Education (schools a key focus of Local Outbreak Plans)

Emergency Planning and Resilience Representative

PHE - link to wider health protection structures

Housing (appropriate representation to pick up homeless and sheltered housing as both groups are a focus of the Local Outbreak Plans)

Culture and Leisure (link to high-risk locations or events)

The HIVE (Supporting local vulnerable people to self-isolate)

PCC finance (to support resource allocation)

CCG - Infection control specialism

Portsmouth Hospitals Trust

Solent NHS

8.2 It is recommended that the Board meets at least weekly in the immediate phase to drive the development of the plan. There will be scope for extraordinary meetings if required.

9. Recommended terms of reference and membership of the Local Engagement Board

9.1 The Local Engagement Board will provide strategic oversight for the Health Protection Board and the development of the Local Outbreak Plan. Guidance envisages that this oversight is provided through the Health and Wellbeing Board, in its statutory role as bringing local system partners together. It is recommended that in Portsmouth, the Local Engagement Board is established as a sub-committee of the Health and Wellbeing Board, as the full board has a wide membership and only

meets quarterly. A sub-committee can have a focused membership and be more responsive to immediate need of the Health Protection Board.

9.2 It is recommended that the membership of the Board is balanced to be composed half of elected members, and half of other membership, with the elected membership representing political proportionality. It is therefore recommended that the membership is:

Cabinet Member for Health, Care and Wellbeing (PCC) - Chair

Five elected members (1 Liberal Democrat, 2 Conservatives, 1 Labour and 1 Progressive Portsmouth Party)

Director of Public Health

Accountable Officer (PCCG)

Healthwatch

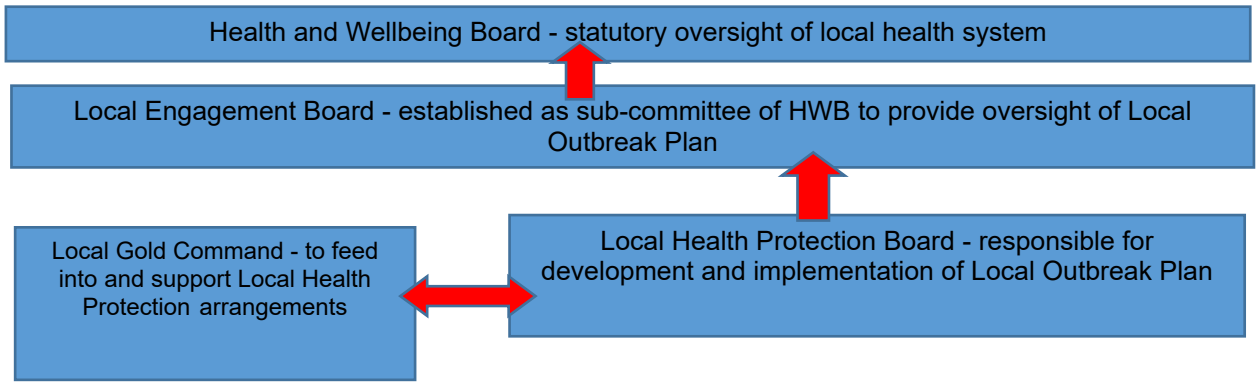
The Hive

Two additional members drawn from Business and Education

9.3 It is recommended that the Local Engagement Board sub-committee be established formally through the Health and Wellbeing Board meeting on 17th June, and meets monthly. There will be scope for extraordinary meetings if required.

10. Summary structure

10.1 In summary, the reporting structure can be summarised as below:



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Appendix 1.
Portsmouth GOLD Dashboard

Overview

1. Please read – Official sensitive
2. Infections
   - Case Rate per 10,000 population: HIOW Local Authorities and comparators
   - Epidemiological curve: Portsmouth new cases (3 day average)
3. Deaths
   - New deaths in Hospital (3 day overage): Portsmouth Hospitals
   - Cumulative deaths in Hospital: Portsmouth Hospitals
   - Extra deaths occurring in 2020 compared to average of corresponding week by week of death

1. Please read – Official sensitive

This dashboard is owned by the Hampshire & Isle of Wight LRF for the purpose of emergency planning and response.

This dashboard is marked ***official sensitive*** and has been developed for the purpose of planning and responding to CoVid19 in Hampshire and IOW (including the unitary authorities of Southampton and Portsmouth) known hereon as HIOW. Data and information in this product has been processed under the COVID-19 Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

https://www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information?utm_source=d05aa30e-95d2-48e3-93e0-0a696c35bd3c&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

The information and data in this product should only be used, processed and shared for a Covid-19 Purpose and solely for that COVID-19 purpose. A Covid-19 Purpose includes but is not limited to the following:

> Understanding Covid-19 and risks to public health, trends in Covid-19 and such risks, and controlling and preventing the spread of Covid-19 and such risks;

> Monitoring and managing the response to Covid-19 by health and social care bodies and the Government including providing information to the public about Covid-19 and its effectiveness and information about capacity, medicines, equipment, supplies, services and the workforce within the health services and adult social care services;

> Identifying and understanding information about patients or potential patients with or at risk of Covid-19, information about incidents of patient exposure to Covid-19 and the management of patients with or at risk of Covid-19 including: locating, contacting, screening, flagging and monitoring such patients and collecting information about and providing services in relation to testing, diagnosis, self-isolation, fitness to work, treatment, medical and social interventions and recovery from Covid-19;

> Understanding information about patient access to health services and adult social care services and the need for wider care of patients and vulnerable groups as a direct or indirect result of Covid-19 and the availability and capacity of those services or that care;

> Delivering services to patients, clinicians, the health services and adult social care services workforce and the public about and in connection with Covid-19, including the provision of information, fit notes and the provision of health care and adult social care services; and

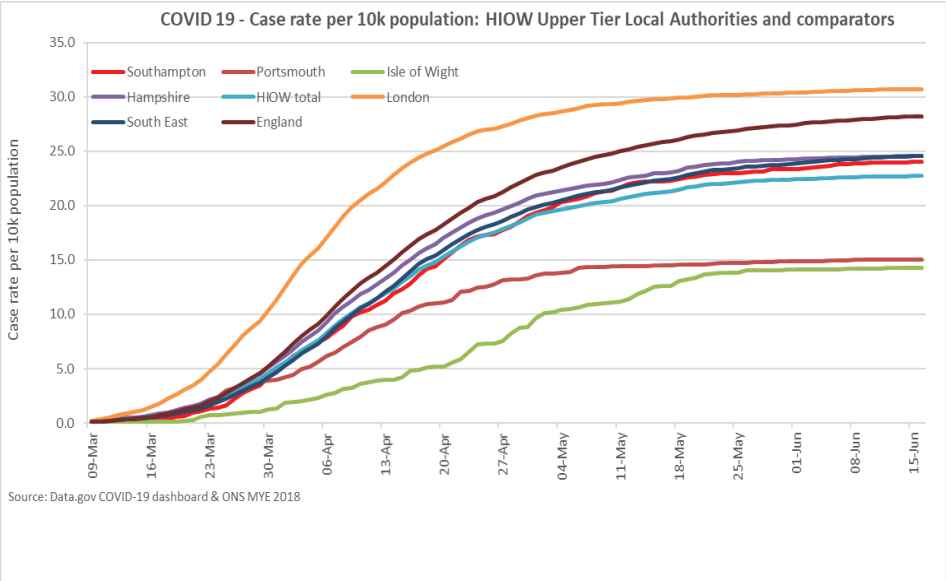
> Research and planning in relation to Covid-19.

Under no circumstances should this information be shared into the public domain; it does not contain patient identifiable data, but it does contain sensitive information and data.
Users acknowledge that this is a live dashboard that will be continually updated and is correct at the time of submission. It is wholly dependent on the quality and accuracy of the data received.

The modelling cell of the HIOW LRF are the owner of this product. Any changes to the above purposes will be at the discretion of the modelling cell. Onward sharing of this product may be outside of the principles of the General Data Protection Regulations which apply.

2. Infections

Case rate per 10,000 population: HIOW Local Authorities and comparators



The chart shows the crude rate of confirmed cases (cumulative) per 10,000 population for HIOW Local Authorities and comparators.

Data on confirmed cases is from Data.gov COVID-19 dashboard and population data is from ONS (mid year estimates 2018).

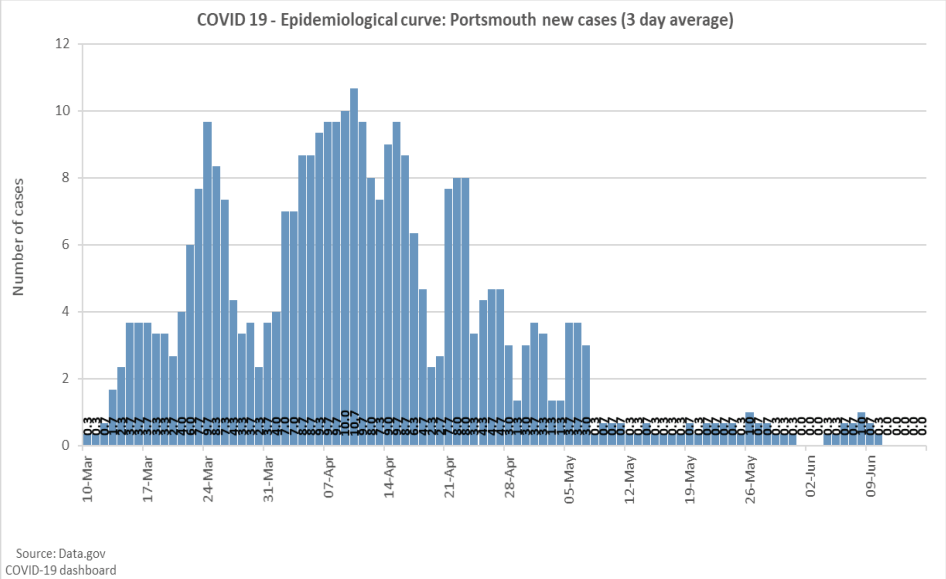
Case numbers are subject to revisions, especially most recent numbers.

Isle of Wight has implemented track and trace from 07/05.

Publically available data.

2. Infections

Epidemiological curve: Portsmouth new cases (3 day average)



The chart shows the epidemiological curve of new cases (3 day average) in the area that is selected from the dropdown.

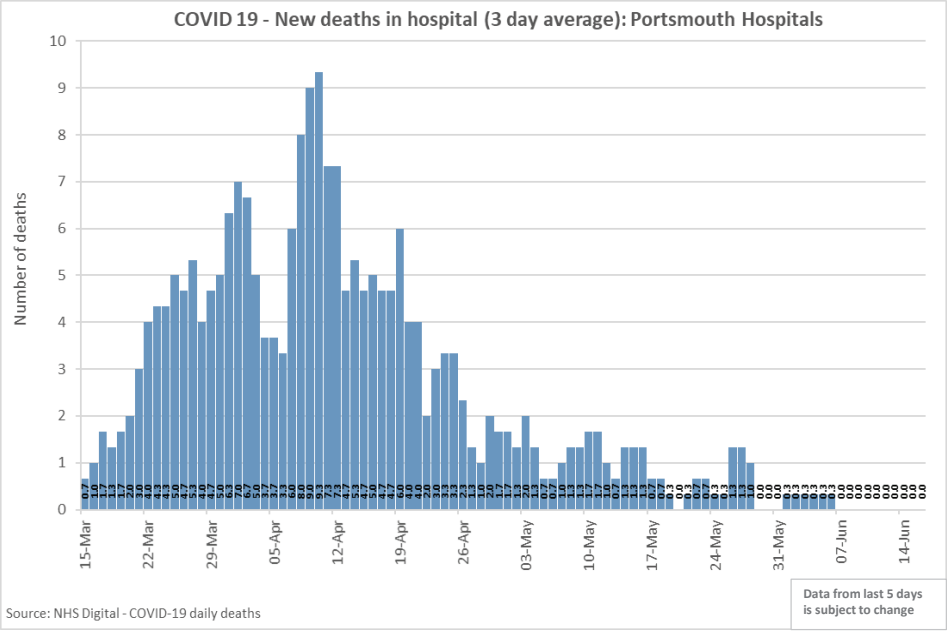
Data is from Data.gov COVID-19 dashboard.

Case numbers are subject to revisions, especially most recent numbers.

Publically available data.

3. Deaths

New deaths in Hospital (3 day average): Portsmouth Hospitals



The chart shows the number of new deaths (3 day average) from COVID-19 at the trust selected from the dropdown - note this is not just exclusive to residents, but any patient who has died at hospital and had tested positive for COVID-19 at the time of death.

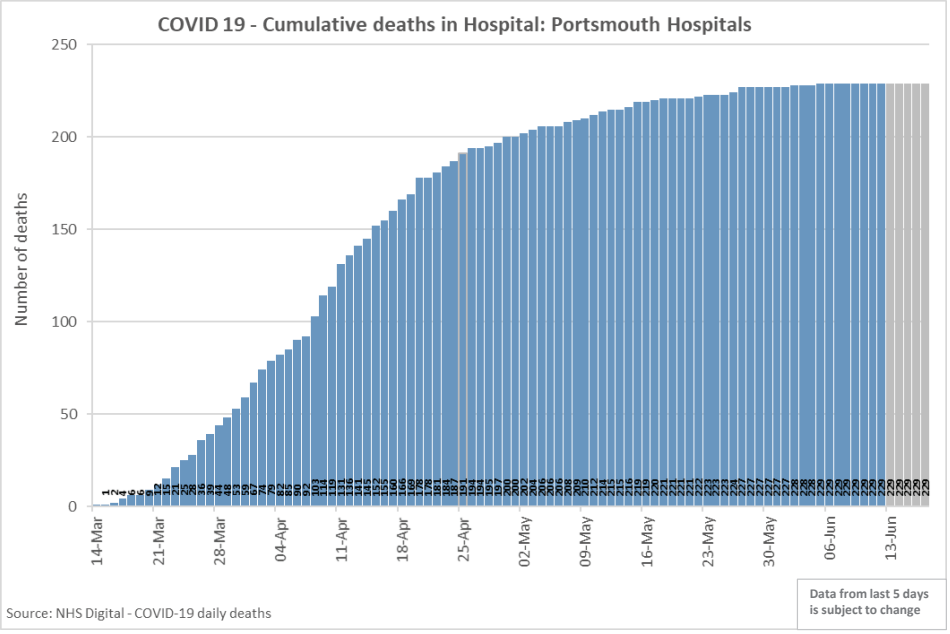
COVID-19 deaths that occur in the community or care home are not included in this figure. Totals by day are based on date of death.

Data is from NHS Digital COVID-19 daily deaths. Figures are subject to revisions, particularly for the most recent data, as more post-mortem tests are processed and data from them are validated.

Publically available data.

3. Deaths

Cumulative deaths in Hospital: Portsmouth Hospitals



The chart shows the number of cumulative deaths from COVID-19 at the trust selected from the dropdown - note this is not just exclusive to residents, but any patient who has died at hospital and had tested positive for COVID-19 at the time of death.

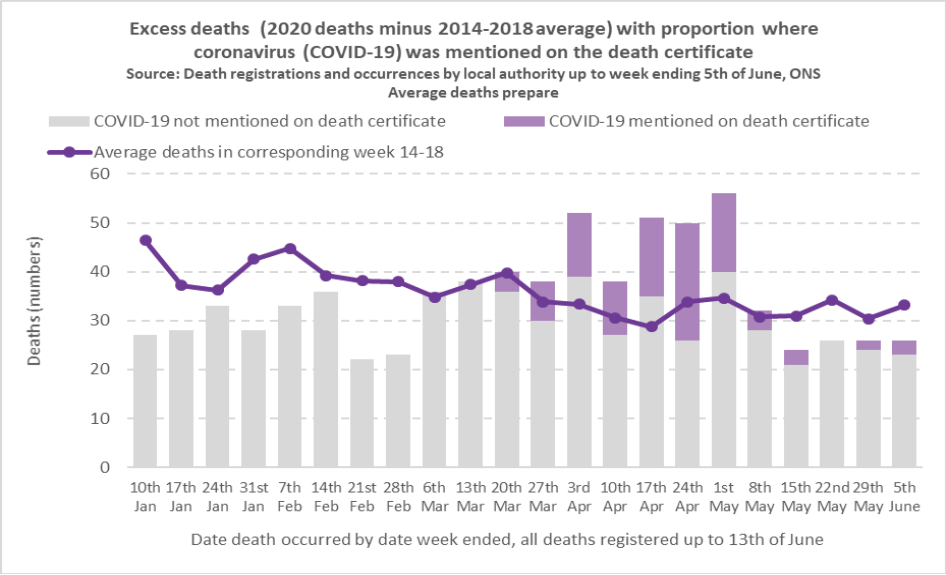
COVID-19 deaths that occur in the community or care home are not included in this figure. Totals by day are based on date of death.

Data is from NHS Digital COVID-19 daily deaths. Figures are subject to revisions, particularly for the most recent data, as more post-mortem tests are processed and data from them are validated.

Publically available data.

3. Deaths

Excess deaths (2020 deaths minus 2014-2018 average) with proportion where coronavirus (COVID-19) was mentioned on the death certificate



The chart shows the number of deaths by week of occurrence for the selected geography.

The number of deaths where COVID-19 was not mentioned on the death certificate are shown in pale grey.

The number of deaths where COVID-19 was mentioned on the death certificate are overlaid in purple.

The total number of deaths is shown by the total height of the bar.

The average number of deaths for the corresponding week of the relevant years are displayed as a dark purple line.

Numbers are subject to revisions, especially most recent numbers.

4. Early Warning Dashboard - see separate pdf file

- The Early Warning dashboard presents data which could provide an indication that infection rates within our community have increased or may be about to.
- Analysis of Wave 1 data suggest that earlier COVID19-related activity in NHS pathways, GP consultation and Ambulance call out surveillance systems peaked approximately 1-2 weeks before hitting hospital systems.
- Some datasets are relatively new (e.g. the mobility data) and therefore the nuances of these may not yet be fully understood. Interpretation should be based on patterns and trends across all indicators and viewed in the context of any policy changes.

- **In summary the data in the Early Warning Dashboard suggest infection rates in our community remain low.**

Any questions?

HIOW Recovery

Modelling Update &
Service Recovery Assumptions

BEST ESTIMATES AS OF 24 JUNE 2020

Caveats about Recovery Timeline slides

- These slides present a range of information designed to assist in planning recovery from the Covid-19 pandemic. They are shared in the interests of transparency but further information and context may be required to support interpretation of what is presented.

- The slides represent best estimates and current assumptions, based on the information available at the time. Spread of infection, national policy and local response are all constantly changing, and the information in the slides needs to be viewed in that context.

- The slides do not represent official positions or recommendations from the Local Resilience Forum Recovery Coordinating Group or the organisations represented on it. They are presented to RCG to support decision-making on recovery across HIOW.

New cases and deaths continue to fall (slowly)

Coronavirus (COVID-19) in the UK

Last updated on Wednesday 24 June 2020 at 4:20pm

Total number of lab-confirmed UK cases
306,862
Includes tests carried out by commercial partners which are not included in the 4 National totals

Daily number of lab-confirmed UK cases
653
Number of additional cases on Wednesday 24 June 2020

Total number of COVID-19 associated UK deaths
43,081
Deaths of people who have had a positive test result

Daily number of COVID-19 associated UK deaths
154
Number of additional deaths on Wednesday 24 June 2020

Cases in Hampshire and Isle of Wight

(includes Pillar 1 and Pillar 2)

27 new lab-confirmed cases across HIOW from 16-22 June

Hampshire and the Isle of Wight Local Resilience Forum

The R number and the growth rate

The reproduction number (**R**) is the average number of secondary infections produced by 1 infected person. If R is less than 1 the epidemic is shrinking.

The **growth rate** reflects how quickly the number of infections are changing day by day. If the growth rate is less than zero (- negative) then the disease will shrink. -5% means it is shrinking faster than -1%

The number of people currently infected is also very important for monitoring spread of a disease

https://www.gov.uk/guidance/the-r-number-in-the-uk

Region	R	Growth rate % per day
UK	0.7-0.9	-4 to -2
England	0.7-0.9	-4 to -1
East of England	0.7-0.9	-6 to -1
London	0.7-1.0	-5 to +1
Midlands	0.8-1.0	-4 to 0
North East and Yorkshire	0.7-0.9	-5 to -2
North West	0.7-1.0	-4 to 0
South East	0.7-0.9	-5 to -1
South West	0.6-0.9	-6 to 0

New nationwide outbreak not expected in Germany despite R number rising above 1

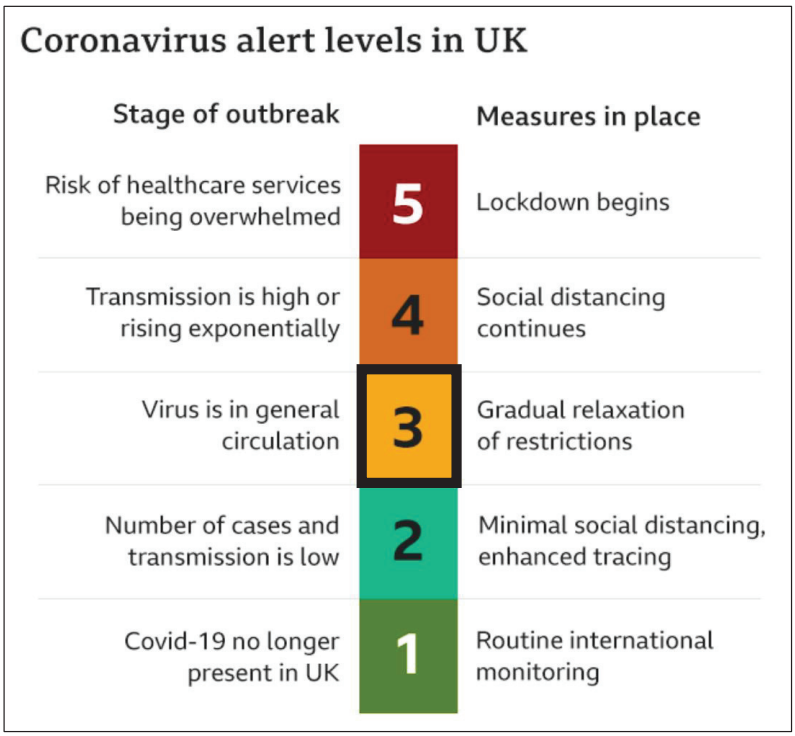
Seven day R value rises to 1.55 while the four day R value rose to 1.79

R value can fluctuate, especially with small numbers of cases

19.06.20

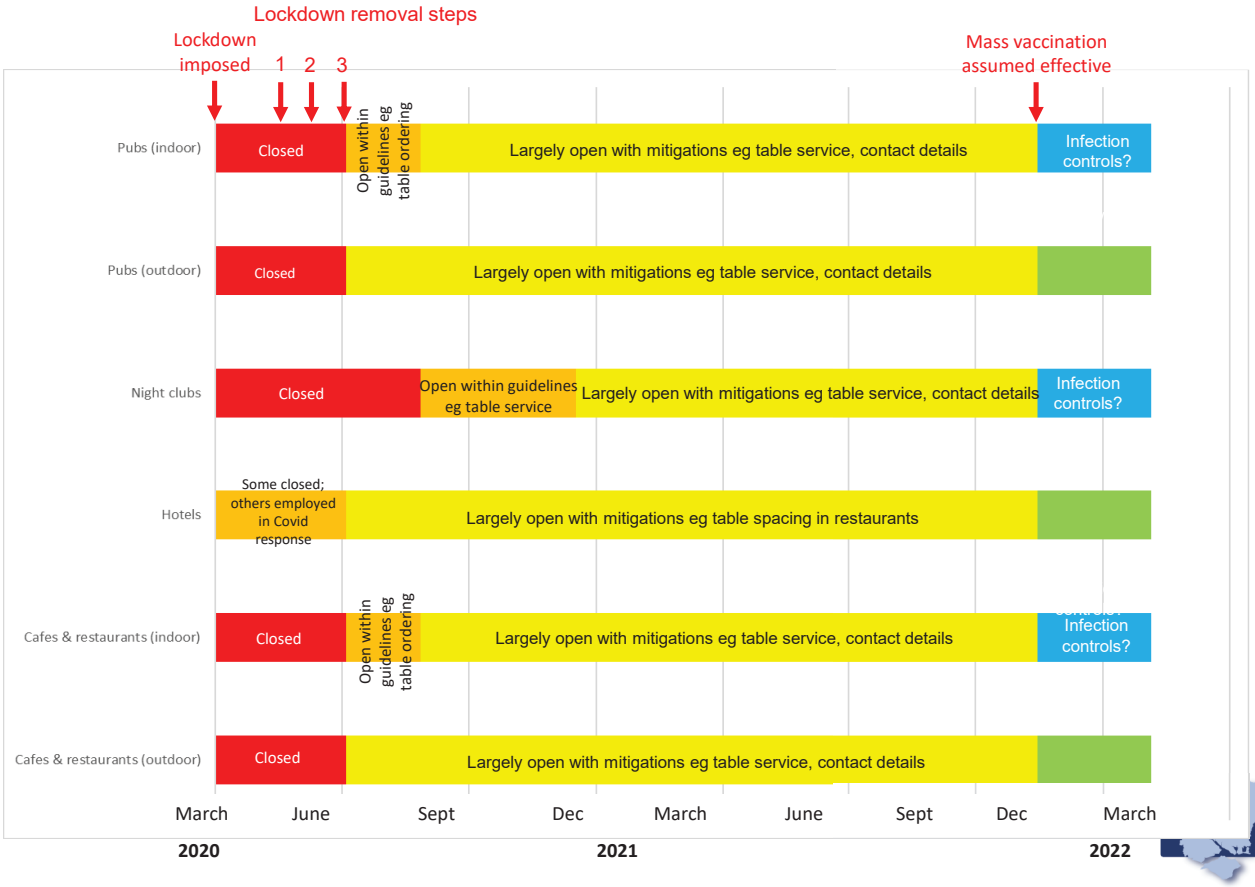
Hampshire and the Isle of Wight Local Resilience Forum

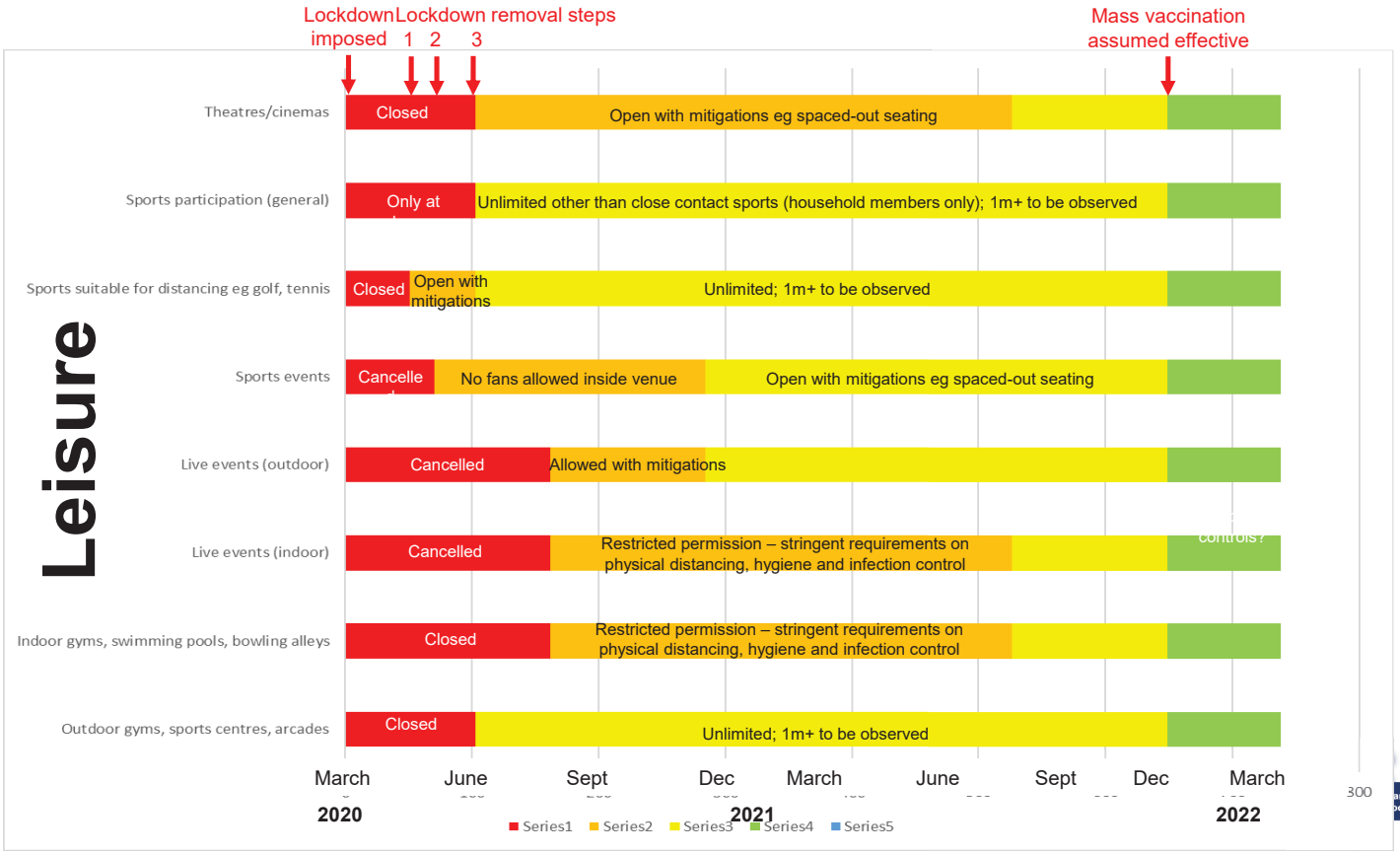
now at level three



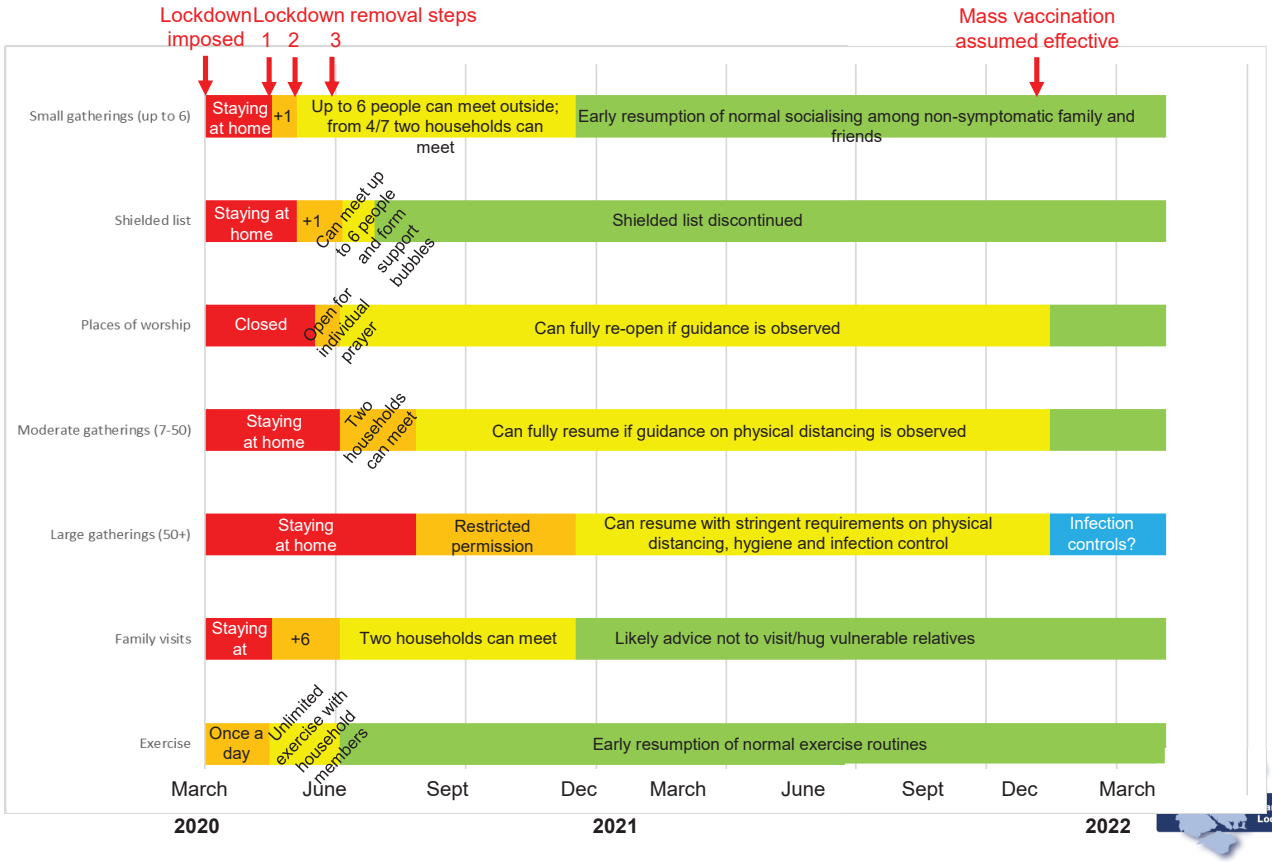
Hampshire and the Isle of Wight Local Resilience Forum

Hospitality

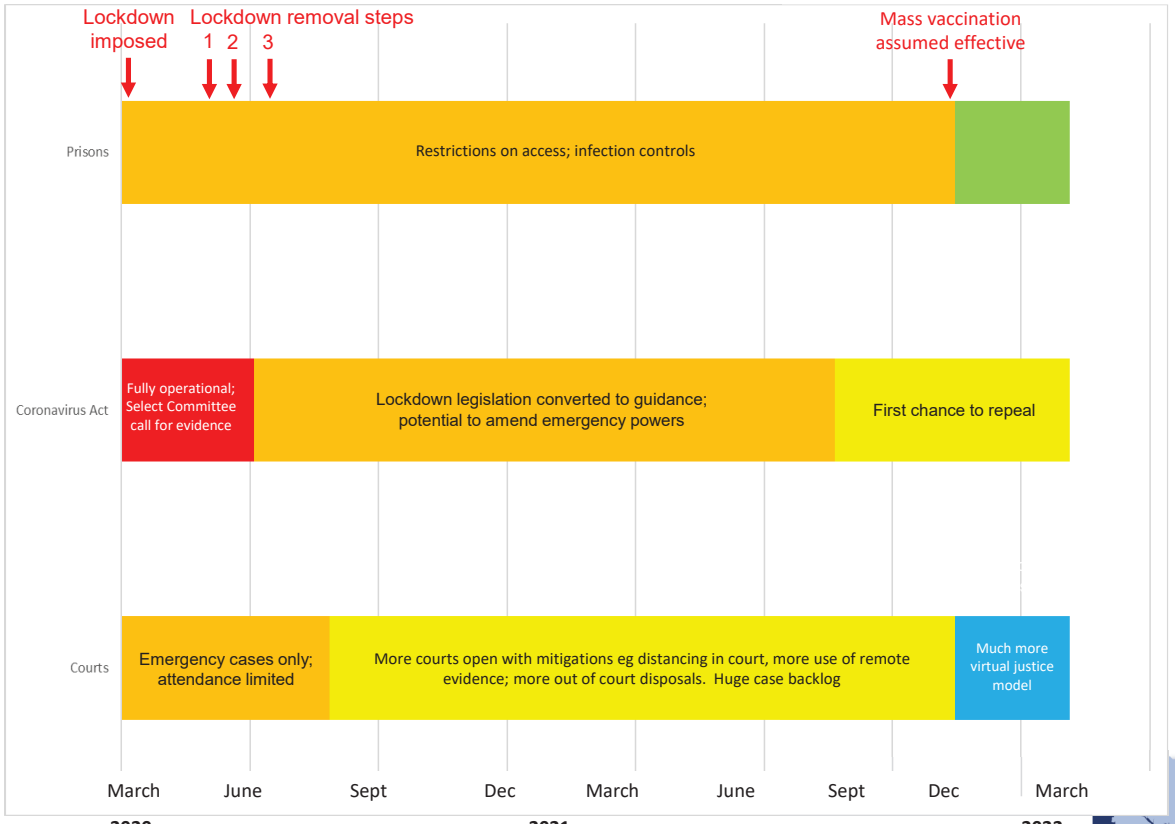



Lockdown imposed
Lockdown removal steps 1 2 3
Mass vaccination assumed effective
Leisure
Theatres/cinemas
Closed
Open with mitigations eg spaced-out seating
Sports participation (general)
Only at
Unlimited other than close contact sports (household members only); 1m+ to be observed
Sports suitable for distancing eg golf, tennis
Closed
Open with mitigations
Unlimited; 1m+ to be observed
Sports events
Cancelle
No fans allowed inside venue
Open with mitigations eg spaced-out seating
Live events (outdoor)
Cancelled
Allowed with mitigations
Live events (indoor)
Cancelled
Restricted permission – stringent requirements on physical distancing, hygiene and infection control
controls?
Indoor gyms, swimming pools, bowling alleys
Closed
Restricted permission – stringent requirements on physical distancing, hygiene and infection control
Outdoor gyms, sports centres, arcades
Closed
Unlimited; 1m+ to be observed
March
June
Sept
Dec
March
June
Sept
Dec
March
2020
2021
2022
300
Series1
Series2
Series3
Series4
Series5

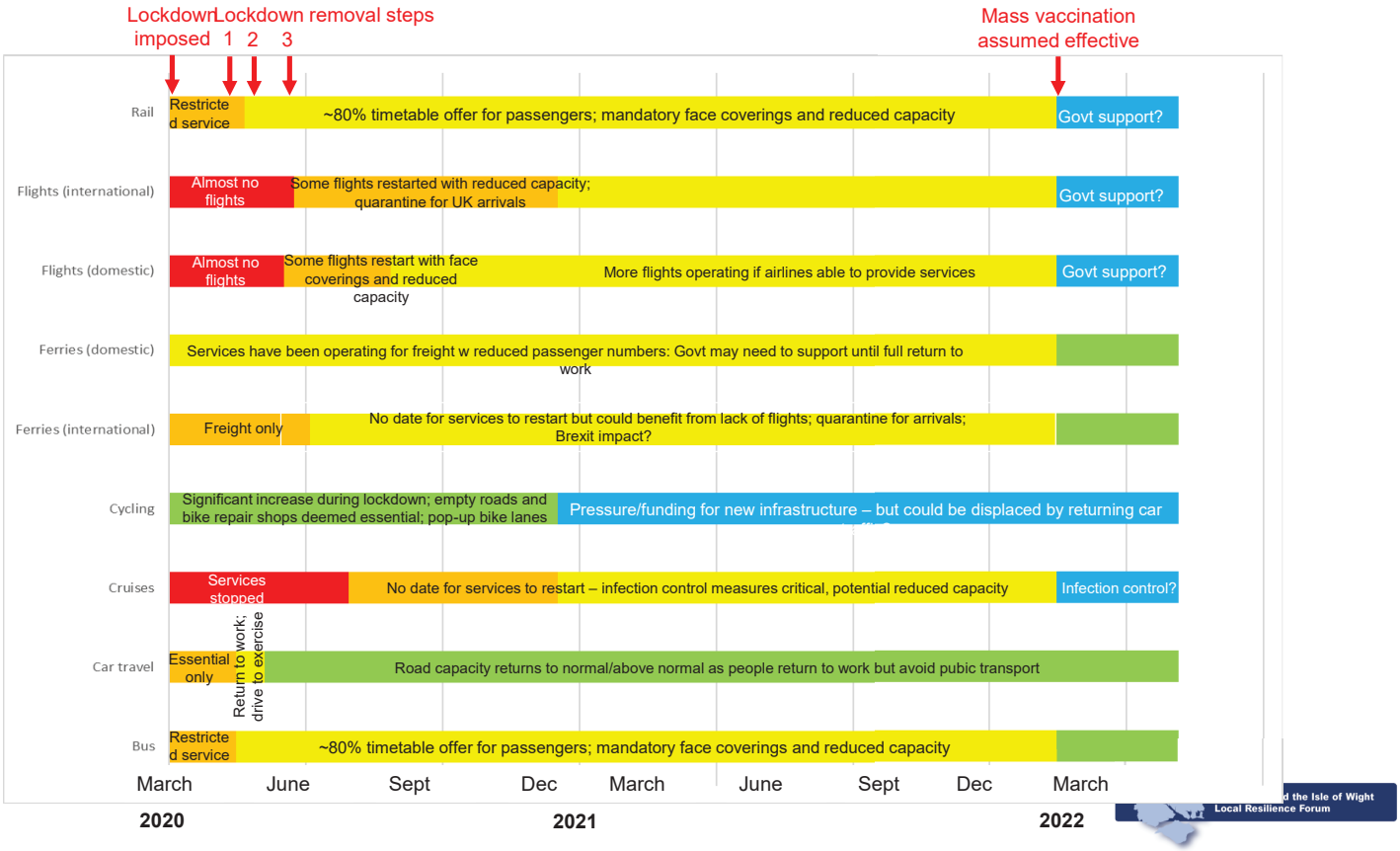
Social contact/ exercise



Justice/Legal



Transport


Lockdown imposed
Lockdown removal steps 1 2 3
Mass vaccination assumed effective
Rail
Restricted service
~80% timetable offer for passengers; mandatory face coverings and reduced capacity
Govt support?
Flights (international)
Almost no flights
Some flights restarted with reduced capacity; quarantine for UK arrivals
Govt support?
Flights (domestic)
Almost no flights
Some flights restart with face coverings and reduced capacity
More flights operating if airlines able to provide services
Govt support?
Ferries (domestic)
Services have been operating for freight w reduced passenger numbers: Govt may need to support until full return to work
Ferries (international)
Freight only
No date for services to restart but could benefit from lack of flights; quarantine for arrivals; Brexit impact?
Cycling
Significant increase during lockdown; empty roads and bike repair shops deemed essential; pop-up bike lanes
Pressure/funding for new infrastructure – but could be displaced by returning car
Cruises
Services stopped
No date for services to restart – infection control measures critical, potential reduced capacity
Infection control?
Car travel
Essential only
Return to work; drive to exercise
Road capacity returns to normal/above normal as people return to work but avoid pubic transport
Bus
Restricted service
~80% timetable offer for passengers; mandatory face coverings and reduced capacity
March
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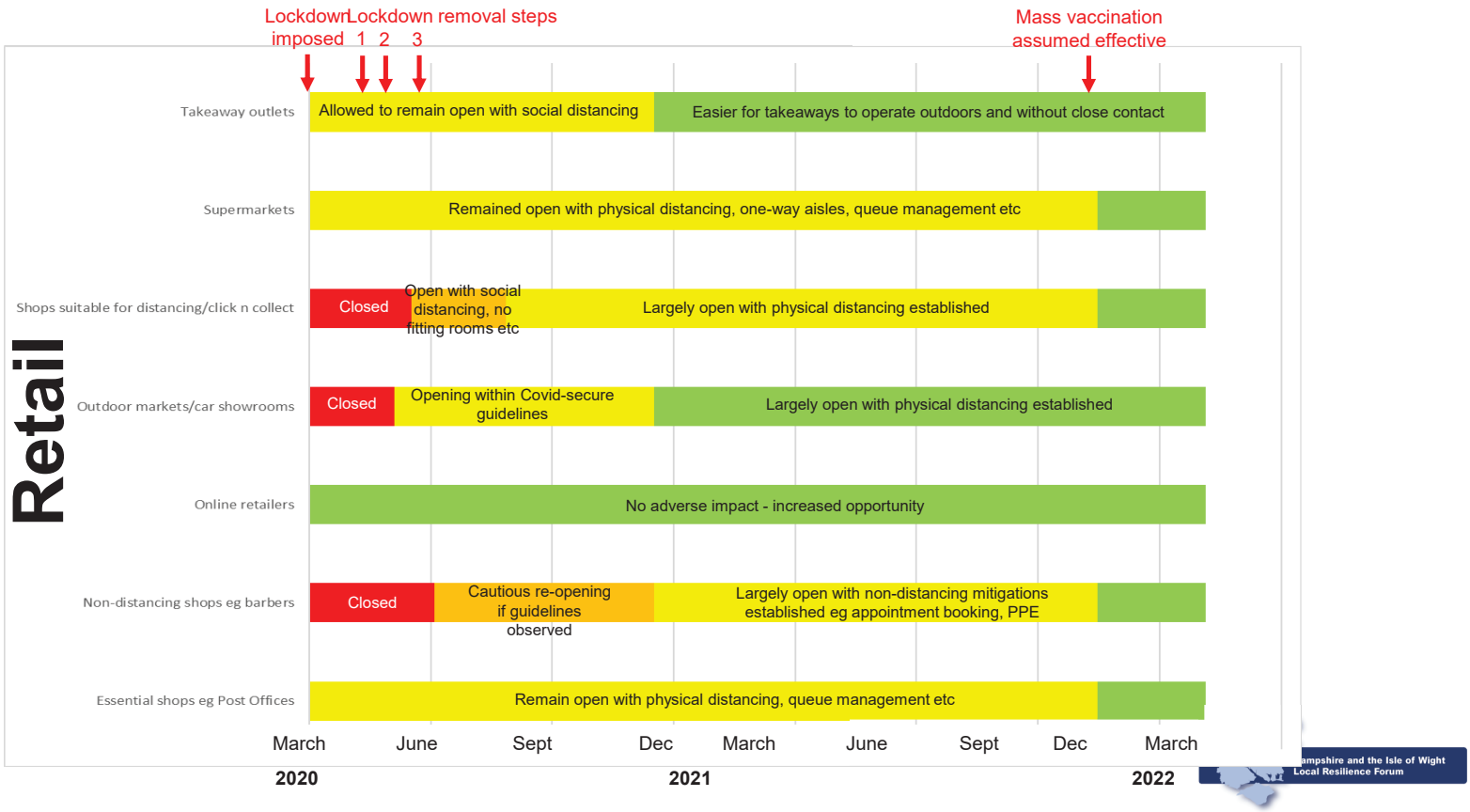
Return to school


Lockdown imposed
Lockdown removal steps 1 2 3
Mass vaccination assumed effective
Retail
Takeaway outlets
Allowed to remain open with social distancing
Easier for takeaways to operate outdoors and without close contact
Supermarkets
Remained open with physical distancing, one-way aisles, queue management etc
Shops suitable for distancing/click n collect
Closed
Open with social distancing, no fitting rooms etc
Largely open with physical distancing established
Outdoor markets/car showrooms
Closed
Opening within Covid-secure guidelines
Largely open with physical distancing established
Online retailers
No adverse impact - increased opportunity
Non-distancing shops eg barbers
Closed
Cautious re-opening if guidelines observed
Largely open with non-distancing mitigations established eg appointment booking, PPE
Essential shops eg Post Offices
Remain open with physical distancing, queue management etc
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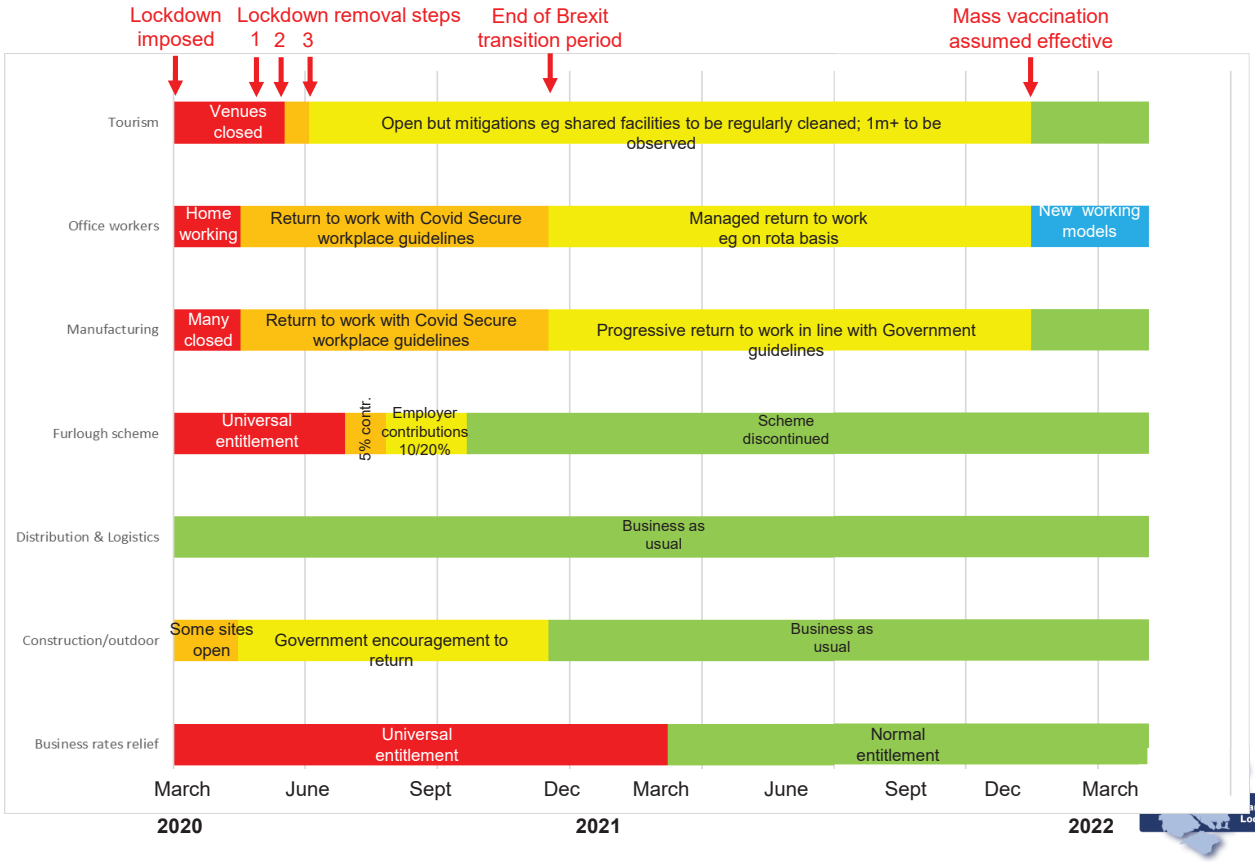
Business


Lockdown imposed
Lockdown removal steps 1 2 3
End of Brexit transition period
Mass vaccination assumed effective
Tourism
Venues closed
Open but mitigations eg shared facilities to be regularly cleaned; 1m+ to be observed
Office workers
Home working
Return to work with Covid Secure workplace guidelines
Managed return to work eg on rota basis
New working models
Manufacturing
Many closed
Return to work with Covid Secure workplace guidelines
Progressive return to work in line with Government guidelines
Furlough scheme
Universal entitlement
5% contr.
Employer contributions 10/20%
Scheme discontinued
Distribution & Logistics
Business as usual
Construction/outdoor
Some sites open
Government encouragement to return
Business as usual
Business rates relief
Universal entitlement
Normal entitlement
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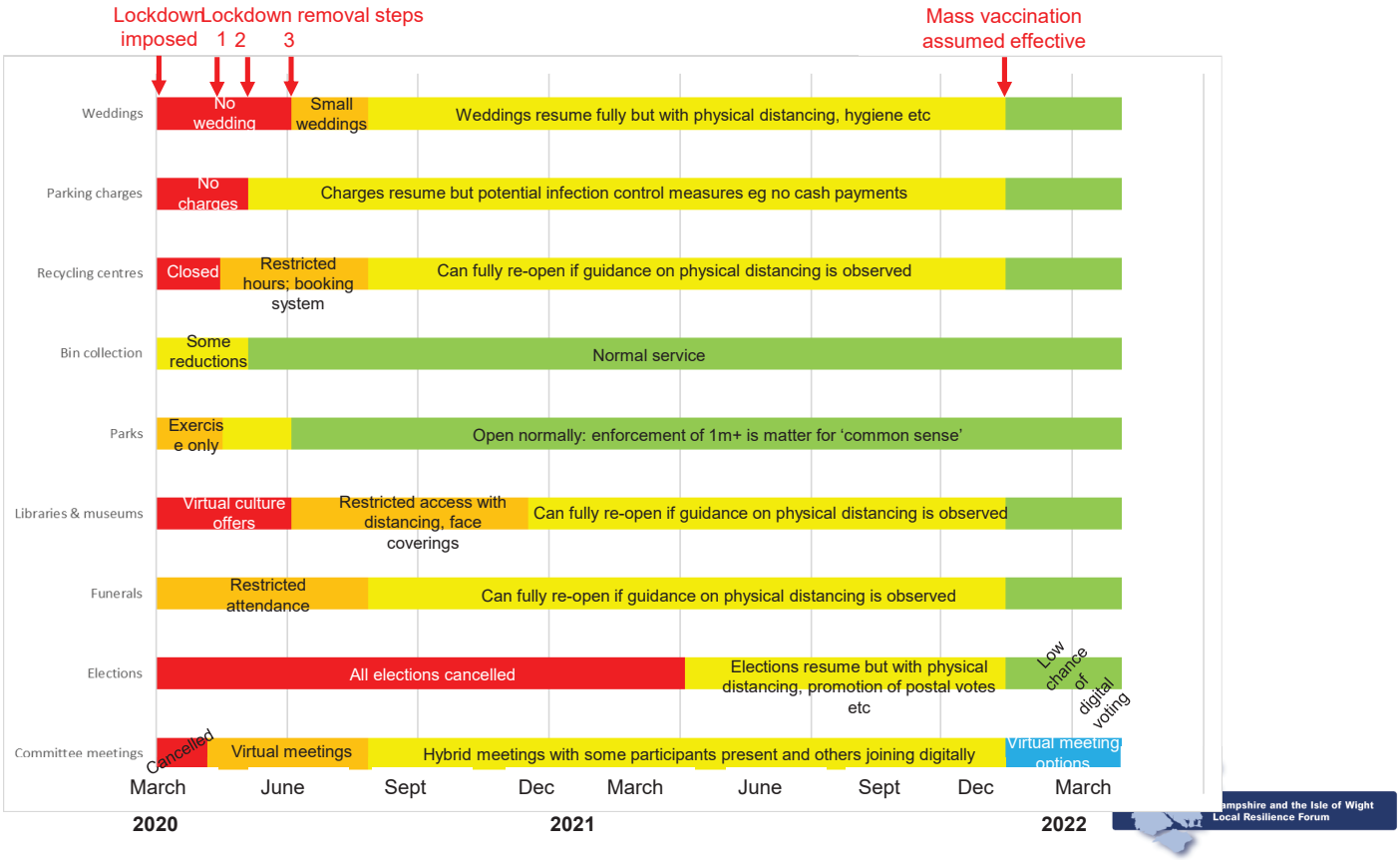
Council


Lockdown imposed
Lockdown removal steps 1 2 3
Mass vaccination assumed effective
Weddings
No wedding
Small weddings
Weddings resume fully but with physical distancing, hygiene etc
Parking charges
No charges
Charges resume but potential infection control measures eg no cash payments
Recycling centres
Closed
Restricted hours; booking system
Can fully re-open if guidance on physical distancing is observed
Bin collection
Some reductions
Normal service
Parks
Exercise only
Open normally: enforcement of 1m+ is matter for 'common sense'
Libraries & museums
Virtual culture offers
Restricted access with distancing, face coverings
Can fully re-open if guidance on physical distancing is observed
Funerals
Restricted attendance
Can fully re-open if guidance on physical distancing is observed
Elections
All elections cancelled
Elections resume but with physical distancing, promotion of postal votes etc
Low chance of digital voting
Committee meetings
Cancelled
Virtual meetings
Hybrid meetings with some participants present and others joining digitally
Virtual meeting options
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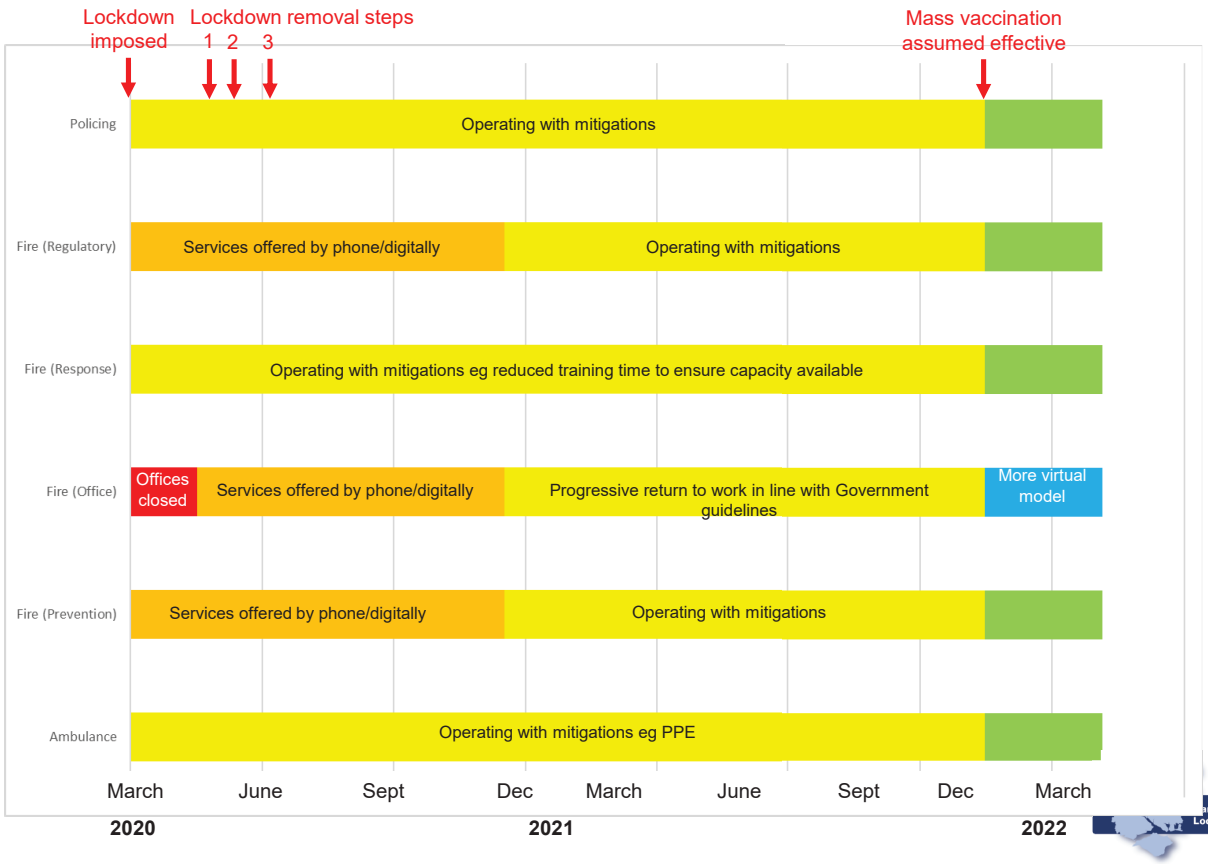
Emergency


Lockdown imposed
Lockdown removal steps 1 2 3
Mass vaccination assumed effective
Policing
Operating with mitigations
Fire (Regulatory)
Services offered by phone/digitally
Operating with mitigations
Fire (Response)
Operating with mitigations eg reduced training time to ensure capacity available
Fire (Office)
Offices closed
Services offered by phone/digitally
Progressive return to work in line with Government guidelines
More virtual model
Fire (Prevention)
Services offered by phone/digitally
Operating with mitigations
Ambulance
Operating with mitigations eg PPE
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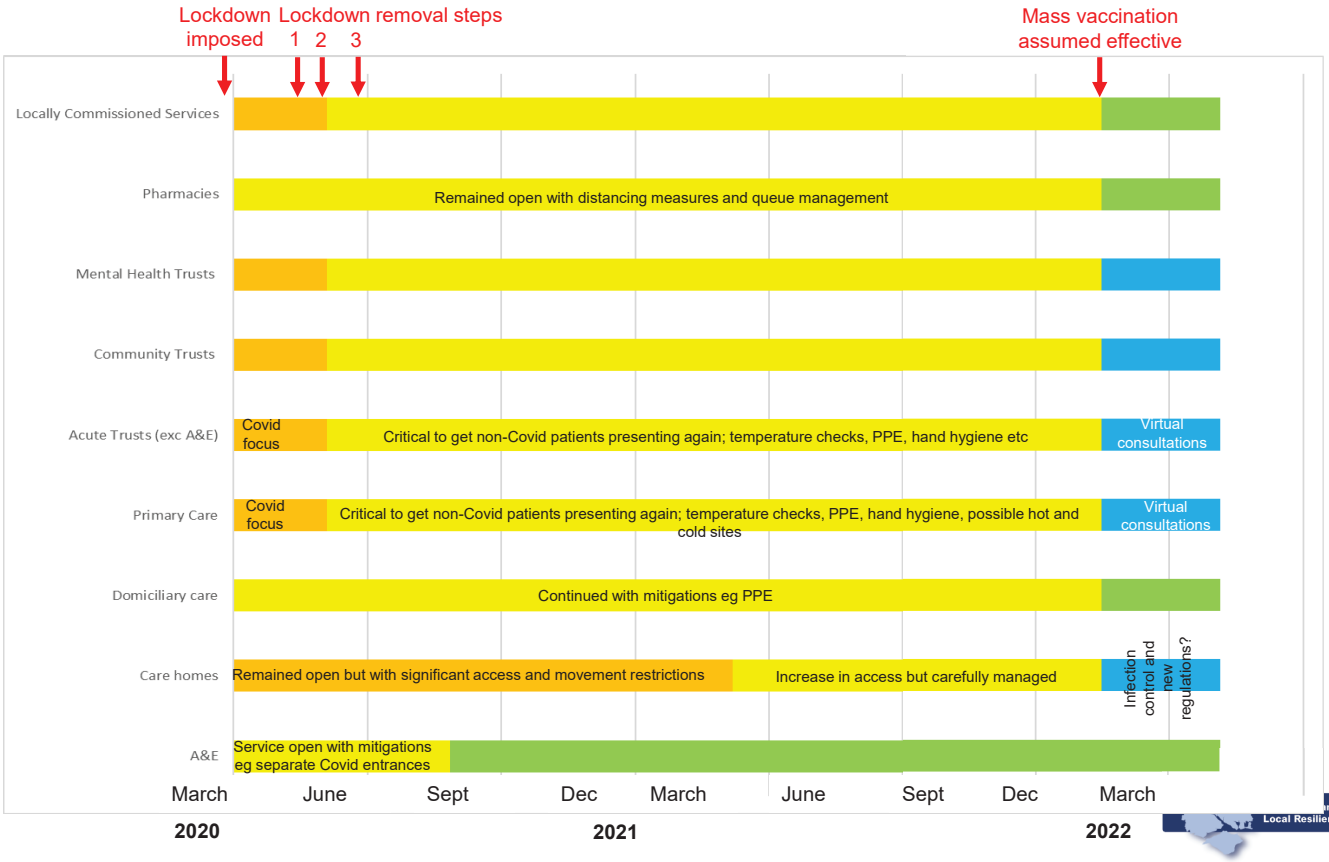
Health


Lockdown imposed
Lockdown removal steps 1 2 3
Mass vaccination assumed effective
Locally Commissioned Services
Pharmacies
Remained open with distancing measures and queue management
Mental Health Trusts
Community Trusts
Acute Trusts (exc A&E)
Covid focus
Critical to get non-Covid patients presenting again; temperature checks, PPE, hand hygiene etc
Virtual consultations
Primary Care
Covid focus
Critical to get non-Covid patients presenting again; temperature checks, PPE, hand hygiene, possible hot and cold sites
Virtual consultations
Domiciliary care
Continued with mitigations eg PPE
Care homes
Remained open but with significant access and movement restrictions
Increase in access but carefully managed
Infection control and new regulations?
A&E
Service open with mitigations eg separate Covid entrances
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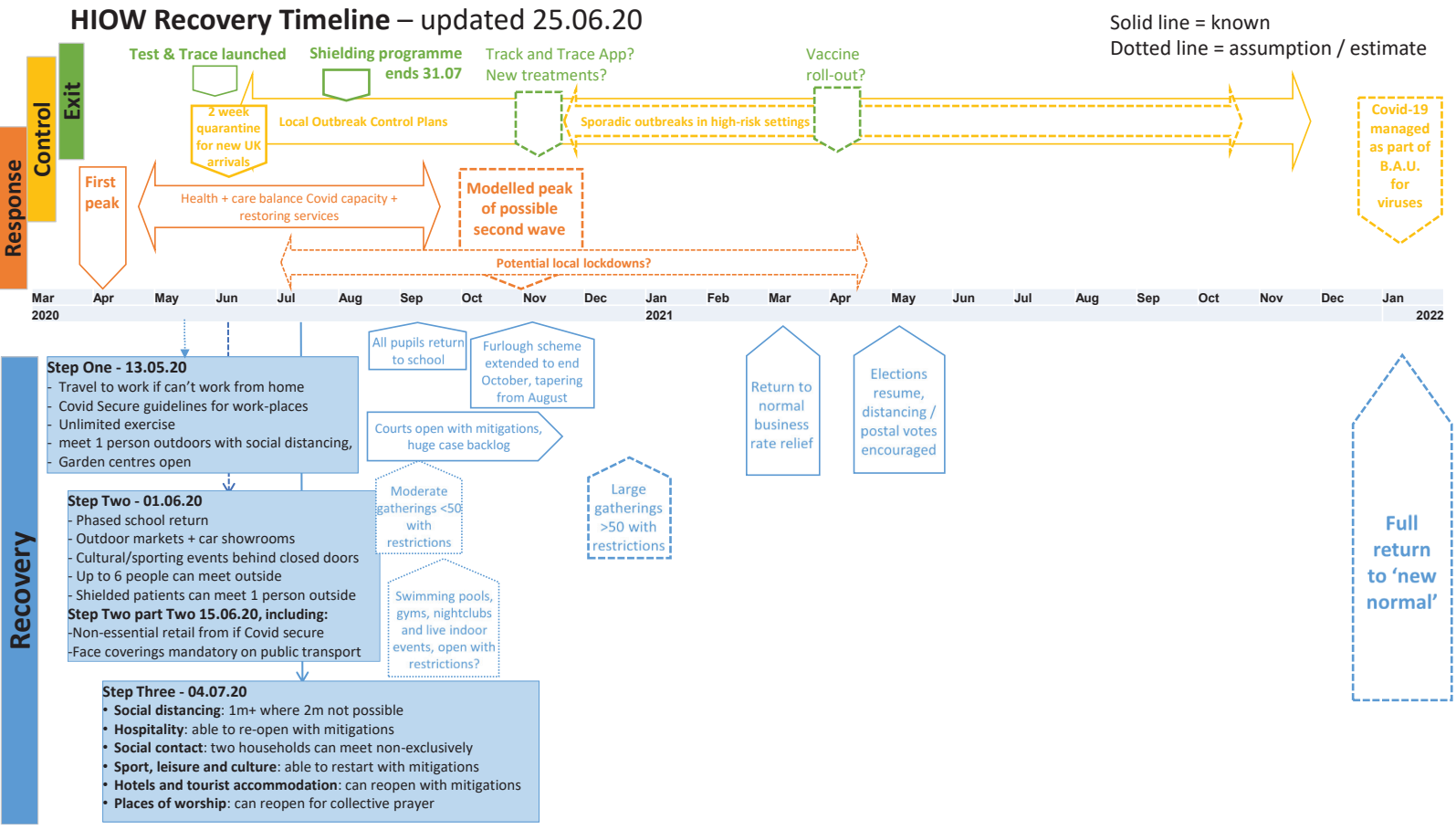
HIOW Recovery Timeline – updated 25.06.20
Solid line = known
Dotted line = assumption / estimate
Response
Control
Exit
Test & Trace launched
Shielding programme ends 31.07
Track and Trace App? New treatments?
Vaccine roll-out?
2 week quarantine for new UK arrivals
Local Outbreak Control Plans
Sporadic outbreaks in high-risk settings
Covid-19 managed as part of B.A.U. for viruses
First peak
Health + care balance Covid capacity + restoring services
Modelled peak of possible second wave
Potential local lockdowns?
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2020
2021
2022
Recovery
Step One - 13.05.20
- Travel to work if can't work from home
- Covid Secure guidelines for work-places
- Unlimited exercise
- meet 1 person outdoors with social distancing,
- Garden centres open
All pupils return to school
Furlough scheme extended to end October, tapering from August
Courts open with mitigations, huge case backlog
Step Two - 01.06.20
- Phased school return
- Outdoor markets + car showrooms
- Cultural/sporting events behind closed doors
- Up to 6 people can meet outside
- Shielded patients can meet 1 person outside
Step Two part Two 15.06.20, including:
-Non-essential retail from if Covid secure
-Face coverings mandatory on public transport
Moderate gatherings <50 with restrictions
Large gatherings >50 with restrictions
Swimming pools, gyms, nightclubs and live indoor events, open with restrictions?
Step Three - 04.07.20
• Social distancing: 1m+ where 2m not possible
• Hospitality: able to re-open with mitigations
• Social contact: two households can meet non-exclusively
• Sport, leisure and culture: able to restart with mitigations
• Hotels and tourist accommodation: can reopen with mitigations
• Places of worship: can reopen for collective prayer
Return to normal business rate relief
Elections resume, distancing / postal votes encouraged
Full return to 'new normal'

Early Warning Dashboard

- Presents data which could indicate infection rates have increased or may be about to.
- Wave 1 data suggest activity in NHS pathways, GP consultation and Ambulance call out surveillance systems peaked approximately 1-2 weeks before hitting hospital systems.
- New(ish) data, not all fully understood. Interpretation should be based on patterns and trends across all indicators and viewed in the context of any policy changes.

The early warning dashboard (19/06/20) shows population mobility flows generally still much lower than pre-lockdown (February 20). Slight increase in last 7 days in suspected COVID cases in primary care but daily lab confirmed cases and hospital admissions are low and on a downward trajectory.

In summary the data suggest infection rates in our community remain low.

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Transport – recovery / early warnings

- 15th June (non-essential shops opened) saw 20% increase in rail travel from previous week (still low, able to distance, good compliance with face coverings)
- Planned uplift in train services on 6th July
- Sea passenger numbers to IoW up around 7% from 01.06 to 08.06 but from very low baseline
- Bus use on IoW up 5% from 08.06 to 15.06, but still down 83% on previous year. Up 23% April – May in Southampton.
- Portsmouth road traffic now at 92% of March levels. Cycling still up 72% on pre-lockdown
- Southampton road traffic up 7% this week, now at 77% of March levels. Cycling up 100% on March (500% at Riverside Park).

Social impacts of Covid-19

- 92% adults left home this week, 18% went somewhere crowded
- 6% had been shopping for non-essentials
- 15% adults had self-isolated, 29% of 70+
- 8/10 employed adults worked, either at home or travelling, up from 7/10 previous week
- 49% worked from home, up from 41%
- 4/10 used face coverings outside home, up from 3/10 previous week
- 95% said they had always or often stayed 2m away from others when outside the home
- 21% reported being asked to send children back to school (2/3 of these now were)

ONS Opinions and Lifestyle Survey 11-14 June

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