Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board minutes

Minutes of the meeting of the Health and Wellbeing Board held on Thursday 1 April 2021 Via MS Teams, commencing at 10.00 am and concluding at 11.56 am.

Members present

Dr R Bajwa, A Macpherson, M Shaw, G Williams (Chairman), Dr J O'Grady, G Quinton, I Darby, J Baker, R Majilton, Dr S Roberts, Dr J Sutton, D Williams and M Gallagher

Others in attendance

Dr V Kholsa, H Mee, Z McIntosh, S Hadwin, J Clacey, I Day, N Flint, T Ironmonger, K McDonald, S Khan, S Taylor, T Burch and G Drawmer

Agenda Item

1 Welcome

The Chairman, Councillor Gareth Williams, Cabinet Member for Communities and Public Health, welcomed everyone to the meeting.

2 Apologies

Apologies had been received from Dr Nick Broughton, Chief Executive, Oxford Health NHS Foundation Trust, Dr Vivek Kholsa attended in place of Dr Broughton; Katie Higginson, CEO, Community Impact Bucks and Tolis Vouyioukas, Corporate Director, Children's Services, Gareth Drawmer, Head of Achievement and Learning attended in place of Tolis Vouyioukas.

3 Announcements from the Chairman

There were no formal announcements from the Chairman.

4 Declarations of Interest

The Chairman declared an interest during item 11, Community Boards Update and Engagement, as he was Cabinet Member for Communities and Public Health which included the Community Boards.

5 Minutes of the previous meeting

The Chairman advised that the actions from the previous meeting had been carried out.

RESOLVED: The minutes of the meeting held on 18 February 2021 were **agreed** as an accurate record.

6 Public Questions

No public questions had been received.

7 COVID-19 - Cases in Buckinghamshire Update

Dr Jane O'Grady, Director of Public Health, provided a presentation, appended to the minutes. It was now one year on and the cumulative number of Covid-19 cases in Buckinghamshire (up to 29 March 2021) exceeded 31,000 since the start of the pandemic. This was an under representation as national testing was not carried out at the start of the pandemic. There had been 1,189 Covid-19 related deaths in Buckinghamshire up to 19 March 2021. The Aylesbury Vale and Wycombe areas were similar to the South East England average; the Chiltern area was below the national and South East England average and South Bucks was above the South East England average. The Buckinghamshire rates overall were lower than the England average. Maps were provided of the Covid-19 cumulative cases in the South East and Buckinghamshire and highlighted the hot spots. Research had been carried out and the following factors were contributors to enduring transmission:

- Higher levels of unmet financial need.
- Greater numbers of people in 'high contact and/or high risk' occupations (taxi-cab drivers, chauffeurs, security guards, restaurants and catering managers, nursing auxiliaries, nurses and care home workers).
- More high-density, multi-generational or overcrowded accommodation (the UKs largest households were almost three times more likely to get Covid and 7.5 times more likely to die from it).
- Lower literacy levels and more digital exclusion.
- Less engagement with testing, contact tracing and inability to self-isolate.

The number of deaths was now falling from the peak in January/February due to the highly effective lockdown and work was being undertaken to achieve 100% vaccine uptake. Dr O'Grady stressed the need for everyone to continue to follow the rules after being vaccinated; to get tested and, if positive, self-isolate. Rapid testing was now available at four sites in Buckinghamshire and information was available on the Covid dashboard on the Buckinghamshire Council website.

The following key points were raised during discussion:

- The Chairman highlighted that the ethnic minority community had been disproportionately affected by the pandemic; however, inequalities was a theme for the Health and Wellbeing Board (HWB), and a significant amount of work was being carried out in this area. Dr O'Grady added that information on Covid-19 and the vaccine was being shared via community leaders, members from ethnic communities, social media and online videos. Generally, the vaccine uptake was good; however, pop-up vaccine clinics had been organised in areas where the uptake was low. Long term health and wellbeing recovery plans, including mental health, which all partners had contributed to, would also be addressed. Work would be undertaken to co-design an approach which the communities and the NHS would be able to deliver.

- Dr Sian Roberts, Clinical Director, Mental Health, Learning Disabilities and Dementia, highlighted that there were other populations at risk who may not be as visible and asked how vaccine uptake could be increased in these vulnerable groups. Dr O'Grady advised that statistics were shared with key groups on a weekly basis but agreed that any suggestions of ways to share information within primary care would be helpful.
- Gareth Drawmer, Head of Achievement and Learning, provided an update on the Covid-19 cases in schools and advised that out of 60,500 pupils in school, 46 pupils had tested positive (18 cases in primary schools, 27 cases in secondary schools and one case in a special school). 49 teachers were absent due to Covid-19 related issues.
- Dr Raj Bajwa, Clinical Chair, advised that an issue with the data transmission had been escalated and, when resolved, the data system would provide the vaccine uptake by ethnicity at a practice level which would help support some of the initiatives.

8 Joint Health and Wellbeing Strategy - Start Well

Start Well Action Plan – Si Khan, Business Manager, Health and Wellbeing, advised that it had previously been agreed that future meetings would be themed around the three key priorities; Start Well, Live Well, Age Well, as identified in the HWB Strategy. It was also agreed that action plans would be used as a framework to provide the Board assurance that actions were identified and progressed by all partners and resulted in better outcomes being achieved for residents. The action plans would be live documents and would be presented to the Board every six months. S Khan proposed using infographics at the end of year one for each of the priorities to show the progress and highlight the outcomes achieved.

The following points were raised in discussion:

- The Chairman summarised that several meetings had taken place and a number of organisations were keen to be involved in the action plan.
- David Williams, Director of Strategy and Business Development, Buckinghamshire NHS Trust, suggested holding a workshop session for partners. The following leads were agreed for each priority:

    - Start Well – David Williams
    - Live Well – Martin Gallagher, Chief Executive Officer, The Clare Foundation
    - Age Well – Buckinghamshire Council.

RESOLVED: The Health and Wellbeing Board **noted** and **approved** the action plan and **agreed** to receive a further update at the October Board meeting

Mental Health School Age Children – Deep Dive Children and Adults Mental Health Services (CAMHS) and Buckinghamshire Educational Service - Service Update

The Chairman welcomed Sue Hadwin, Head of Service, Buckinghamshire CAMHS, and Joe Clacey, Medical Lead, CAMHS, Buckinghamshire, to the meeting. J Clacey

advised that the Service was under significant pressure due to an increase in the number and complexity of the referrals, particularly in the areas of eating disorders and young people presenting acutely in crisis. This had then linked to further difficulties in the availability of inpatient psychiatric beds or specialist residential provisions for children and young people. Also, long waiting times continued for the diagnosis of Neuro developmental conditions; however, work was ongoing with the commissioners and colleagues in the Buckinghamshire NHS Healthcare Trust (BHT) to resolve the issue. The Service was trying to increase the number of staff in the crisis and eating disorder teams. The Service had also increased the reach of its mental health support teams in schools to allow greater coverage. A member of staff was working with the BHT and was based on the paediatric ward to help assess young people who presented. The Service was also working closely with acute hospital and Children's Services' colleagues to improve the assessment and safeguarding process as many of the young people presenting had a combination of mental health conditions and social concerns that required collaborative care planning. There had always been an acute problem with funding and the recent increase in demand had exacerbated the issue; however, funding had been received to trial key workers for the most complex young people with autism and learning disabilities and was a positive development.

The following key points were raised in discussion:

- In response to being asked how much more funding was required and whether there was anything the HWB could do to help; S Hadwin acknowledged that all services needed extra funding and stressed the need to work in partnership to maximise resources. S Hadwin advised that it would not be possible to recruit enough staff to the workforce even if more funding was available. The Service was prioritising/moving things around to address the issues. The key worker project was a partner agency and was meeting the needs and keeping young people out of hospital. The Service had also been awarded another mental health school team to work in the Chesham area.
- It was noted that some of the Community Boards were funding mental health first aiders.
- Dr S Roberts explained that CAMHS was a jointly commissioned service and prioritised mental health across the whole age range. The Service was mindful that young children needed to 'start well' and the action plan needed to include increased support to build emotional resilience and wellbeing.
- In response to being asked if the funding included a deprivation weighting, Robert Majilton, Deputy Chief Officer, Buckinghamshire Clinical Commissioning Group (CCG), advised that overall, the funding allocations to the CCG were based on indices of need. There had been several years of expanding capacity in a number of areas, including children's mental health and eating disorders. R Majilton stressed the importance of collaborative working and advised that there were ongoing discussions around the immediate operational pressures and future demand/capacity.

RESOLVED: The Health and Wellbeing Board **noted** the report.

9 Integrated Care Partnership Update
Elective Surgery Backlogs and Recovery

The Chairman welcomed Isobel Day, Director of Business Recovery, BHT and Neil Flint, Head of Commissioning for Planned Care, Buckinghamshire CCG. I Day advised that urgent and emergency surgery P1 had continued throughout the pandemic. Cancer surgery had also continued and the number of referrals and treatment of people within two weeks of referral had been maintained. The overall waiting list had increased by approximately 1,000 since March 2020 with those people waiting for routine elective surgery or outpatient appointments had had a longer wait. Patients waiting for diagnostic services, MRI scans or CT scans had been maintained and there was no backlog. A number of actions were being taken to address those waiting for outpatient and follow up appointments to allow patients to manage their condition. Remote monitoring in changes in conditions was being carried out and it was possible that this would be extended to virtual outpatients. Virtual appointments had worked well in the first wave of the pandemic with an increase of virtual outpatients to 60%; it had now decreased to 30-40% as more patients were being seen overall. A lot of activity was suspended during the first wave; whereas it had continued throughout the second wave. 65-70% of day cases and inpatient activity had been delivered along with approximately 85% of outpatients.

The following key points were raised in discussion:

- In response to being asked about communications issued to manage patients' expectations, I Day advised that all patients on the waiting list had been provided an explanation of the process in writing. Signposting was provided to those patients who had concerns over a change in their condition and patients were given the opportunity to delay their appointment if they preferred not to visit the hospital due to Covid-19. Patients had been categorised as P1-P6 with the high risk categories being P1-P3. Each high risk patient case was reviewed by a lead consultant and offered a consultation to discuss the implication of a delay. Those classified as 'routine' were offered phone consultations with a nurse or consultant. Work was now being undertaken with Comms and patient engagement to build on activities already carried out. Videos of patient journeys had been shared.
- The Chairman asked for clarification on the number of people on the waiting list. I Day explained that there were approximately 31,000 on the active waiting list with roughly 8,000 waiting for an inpatient procedure. Approximately 5,000 had been on a waiting list for 52 weeks. The remaining patients were waiting for an outpatient appointment to determine their treatment. There was also a number of patients waiting to be referred. However, there was a concerted effort to reduce the number of patients who had been on the waiting list for more than 52 weeks.

The Chairman thanked Isobel and Neil for attending the meeting.

Better Care Fund Bi-Annual update

Tracey Ironmonger, Service Director, Integrated Commissioning, provided a presentation, appended to the minutes and highlighted the following key points:

- The reporting on the Better Care Fund (BCF) had been impacted by Covid-19 and it had been agreed that formal plans for 2020-21 would not need to be submitted for approval but would be an extension of the 19/20 plan.
- Formal reporting would be needed for reconciliation of the funding.
- Expenditure had been discussed and agreed by the Integrated Commissioning Executive Team.
- BCF activities needed to deliver the High Impact Change model. Currently Bucks had self-assessed as 'established' against the 9 domains, meaning that systems were in place and operating for each area. The future three year plan would look to improve these ratings to 'mature' or 'exemplary'.
- An additional domain was expected on 'admission avoidance'.
- A new Hospital Discharge Policy had been implemented in March 2020.
- Examples of projects within the BCF were shared.
- The funding for 2021-2022 had been confirmed and planning guidance was awaited.

The following key points were raised in discussion:

- R Majilton acknowledged the huge amount of work that had taken place and advised that there was still a relatively high number of people in hospital; the main discharge points were Wexham Park Hospital and BHT and the focus would remain on how to support the BCF sustainably.
- It was noted that the CCG was a key partner in the BCF and when asked, in view of the new White Paper, whether this would continue; T Ironmonger stated that the BCF would be ongoing, but the infrastructure around it might change. Gill Quinton, Corporate Director, Adults and Health, added that the BCF funding was significant and that an announcement was expected shortly.

RESOLVED: The Health and Wellbeing Board **noted** the Better Care Fund update for 2020-21 and 2021-22**, noted** the current position in relation to Better Care Fund and performance and **noted** the plans to review the Better Care Fund.

Integration and Innovation: Working together to improve health and social care for all - DHSC White Paper, Feb 2021

Gill Quinton, Corporate Director, Adults and Health, provided a presentation, appended to the minutes. G Quinton advised that several national bodies had commented on the White Paper, which concerned the future of integration between health and social care and proposals on how integration could be improved across the system, and these had been included in the agenda pack on page 39. G Quinton summarised the key points of the White Paper:

- The Integrated Care Systems (ICS) would become statutory bodies and would

have new powers and budget.

- Two boards would be required; a statutory board and a partnership board to engage with all the partners.
- The HWB would be the place-based planner and would have a significant role in setting the place priorities.
- The CQC would assess the Local Authority's delivery of adult social care duties.
- There would be no changes to Public Health within local authorities.
- The implications for Buckinghamshire were that a strong place-based footprint would be required for the HWB with clarity on place-based commissioning and expectations.

The following key points were raised during discussion:

- The Chairman advised that the Government was not inviting comments, but it would be useful to share partner feedback.
- David Williams stated that the Paper endorsed the journey and provided a framework for greater collaboration; it was a positive Paper for BHT and followed what had been carried out in Buckinghamshire in recent years.
- Jenny Baker, Chair of Healthwatch Bucks, advised that Healthwatch England had called for increased inclusion of the 'voice of the patient'. Healthwatch Bucks would be working with Healthwatch England on this area.

Resolved: The Health and Wellbeing Board **noted** the content of the Government's White Paper, particularly in relation to the Health and Wellbeing Board.

10 Joint Strategic Needs Assessment (JSNA) - Update on Priorities

Tiffany Burch, Public Health Consultant, referred to the paper contained in the agenda pack and advised that the Joint Strategic Needs Assessment (JSNA) was a statutory requirement for the Local Authority and the CCG to assess the current and future healthcare needs in order to improve the health and wellbeing of residents. The core principles were that it be current, embedded in the Council and NHS processes, was relevant to the Buckinghamshire population, was partner driven and informed by residents to develop a local evidence base. The JSNA would be available to the public via the online portal. A development group had carried out work over the last five years and approximately 50 chapters were on the Health and Wellbeing website along with other resources. The JSNA needed to be refreshed and would link to the three priority areas in the Health and Wellbeing Board Strategy and align to the Covid-19 Recovery Plan. The next steps would be to reconvene and update the membership of the JSNA Development Group to reflect the new organisational landscape.

The Chairman added that the Voluntary and Community Social Enterprise (VCSE) should be embedded in all the relevant groups across the Council but had noted that it was not listed in the membership for JSNA Development Group. T Burch advised that Healthwatch Bucks was part of the key group and, based on topics in the HWB action plan, the relevant partners and voluntary sector would be invited to develop

chapters. The role of the Development Group was primarily a sign off group, but all suggestions were welcome. It was agreed that this would be discussed outside of the meeting.

ACTION: Tiffany Burch

Dr Roberts advised that the Primary Care Networks (PCNs) were carrying out population health engagement which should be fed into the new JSNA.

RESOLVED: The Health and Wellbeing Board **noted** the content that was delivered for the 2016- 2020 JSNA, **agreed** the core principles to underpin the JSNA, **agreed** to the relaunch of the Development Group and **agreed** the actions for 2021/22 to be overseen by the Development Group.

11 Community Boards Update and Engagement

Katie McDonald, Head of Service, Localities, advised that the report in the agenda pack provided a flavour of the work of the Community Boards (CBs) and how they had used the public health profiles and the allocated £500k of public health fund contributions and the potential for summer workshops. K McDonald emphasised that the CBs were new and there would be an opportunity to influence their work following the elections. The CBs had a delayed start due to the pandemic, but fantastic work had taken place to support residents during the pandemic via the Councillor Crisis Fund. Support had also been provided to the LGBT community and in suicide prevention. The Service was undergoing a re-set and review and discussions had taken place with the VCSE Recovery Board and partners regarding their interaction with the CBs. The CBs should be seen as an asset and discussions had also been undertaken with CCG colleagues on how support could be provided to the maternity service. Focus would centre on higher population and deprivation areas. K McDonald requested volunteers from the HWB, the VCSE and PCNs to be involved in the project team for the summer workshop sessions. Input and reflection on how her Service should regularly engage with the HWB to report on how the CBs were delivering the Joint Health and Wellbeing Strategy action plan was also requested.

The following key points were raised in discussion:

- Dr Roberts advised that it would be a natural match for the CBs to be aligned with the PCNs; K McDonald agreed to re-visit and map across if possible, as she recognised that PCNs were an important part of the picture. The Chairman agreed that the PCNs needed to be involved in the workshops as the CBs had decent budgets and would be investing in HWB projects in their areas. K McDonald acknowledged that it would be difficult for organisations to engage with 16 CBs and asked for suggestions on how the PCNs would like to engage. Dr Bajwa stated that recent lack of engagement might have been a timing issue as the PCNs had been working under difficult circumstances and were also leading the vaccination drive. Dr Bajwa recommended contact be made with Dr Rashmi Sawney regarding PCN engagement.
- Healthwatch Bucks welcomed the opportunity to engage with the CBs.

RESOLVED: The Health and Wellbeing Board members **noted** and **commented** on the report**.**

12 Health and Wellbeing Board Engagement Plan

Si Khan, Business Manager, Health and Wellbeing, stated that the HWB Engagement Plan showed the live and planned activity. It was a working document and could be added to by partners in order to provide transparency and minimise the level of survey fatigue. It was proposed that the Engagement Plan should be a standing item on future HWB agendas.

The following points were raised in discussion:

- The Chairman agreed that the Plan was much needed due to the volume of consultations carried out by BC and its partners.
- Zoe McIntosh, Chief Executive Officer, Healthwatch Bucks, stated that the VCS activity should be included in the Engagement Plan and suggested it be taken to the VCS Recovery Board.

ACTION: Si Khan

- Jenny Baker advised that there would be several voluntary sector surveys and that it would be useful to know what was happening at a national level. It was agreed that S Khan would discuss the Engagement Plan with Kim Parfitt, Head of Communications for CHASC/ICS/CCG.

ACTION: Si Khan

- Zoe McIntosh requested the date of the next meeting for the Getting Bucks Involved Steering Group which last met in December 2020. S Khan agreed to find out from K Parfitt.

ACTION: Si Khan

13 Health and Wellbeing Board Work Programme

Si Khan, Business Manager, Health and Wellbeing, asked the HWB members to note what was planned for future meetings and to contact her if there were any other items to be included.

14 Health Care Survey - Final Report

The report was included for information.

15 Healthwatch Bucks Update Paper

The paper was included for information. Zoe McIntosh added that there had been a good response to vaccine survey with over 3,300 received to date and the feedback was overwhelmingly positive. A report was being sent to the CCG on a weekly basis.

The Chairman thanked everyone for their attendance and contributions.

16 Date of next meeting

24 June 2021.

Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board
1st April 2021

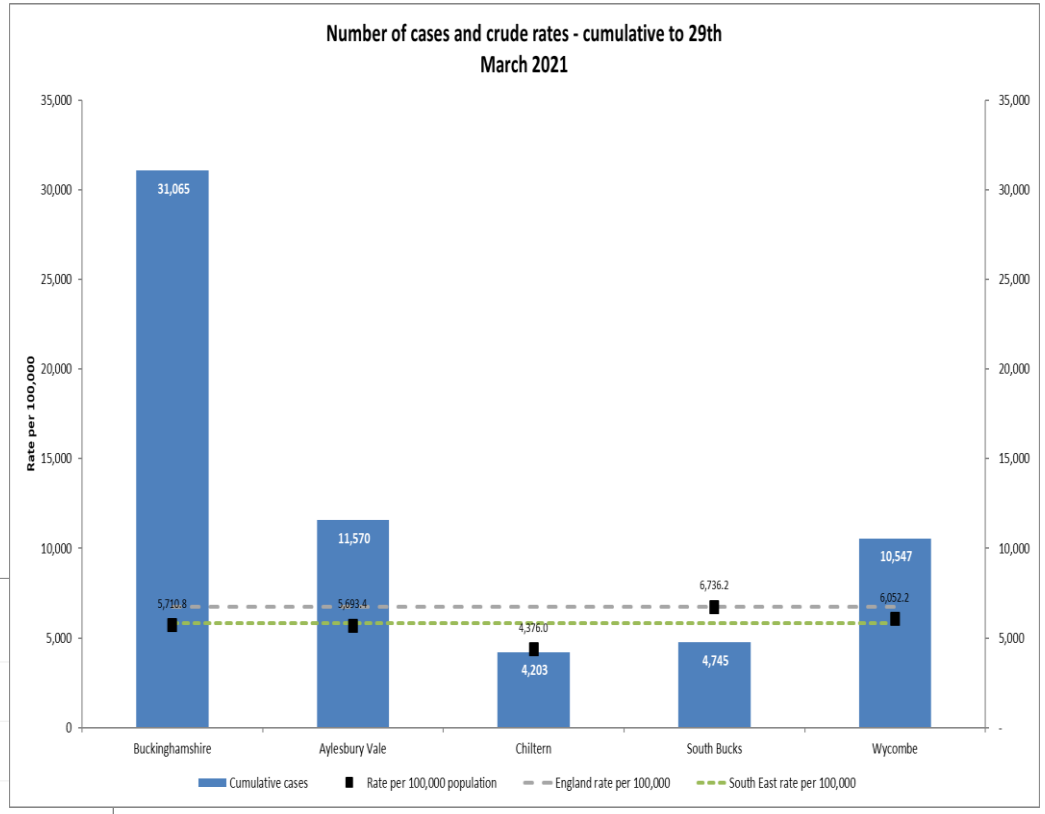
COVID-19 in Buckinghamshire update

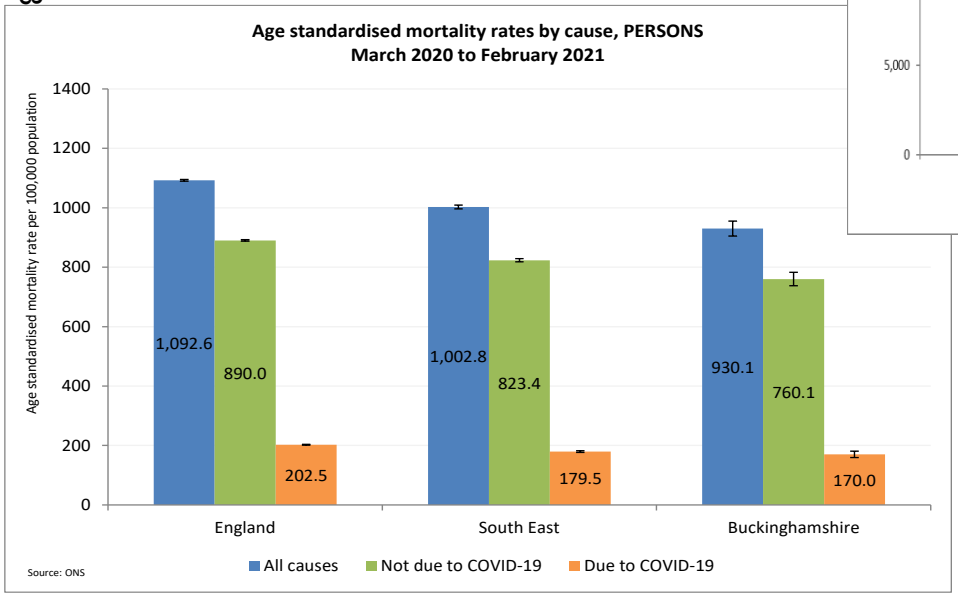
Dr Jane O'Grady, Director of Public Health,
Buckinghamshire Council

COVID - One year on – cumulative cases and deaths

	Buckinghamshire
Cumulative no. of cases to 29th March 2021	31,065
Cumulative no. of deaths* to 19th March 2021	1,189

* The number of deaths involving coronavirus (COVID-19), based on any mention of COVID-19 on the death certificate.





- Current new case rate is **39.9 per 100k** for Buckinghamshire, **217 cases. SE R = 0.7-1**
- **1 in 3 cases from LFTs**

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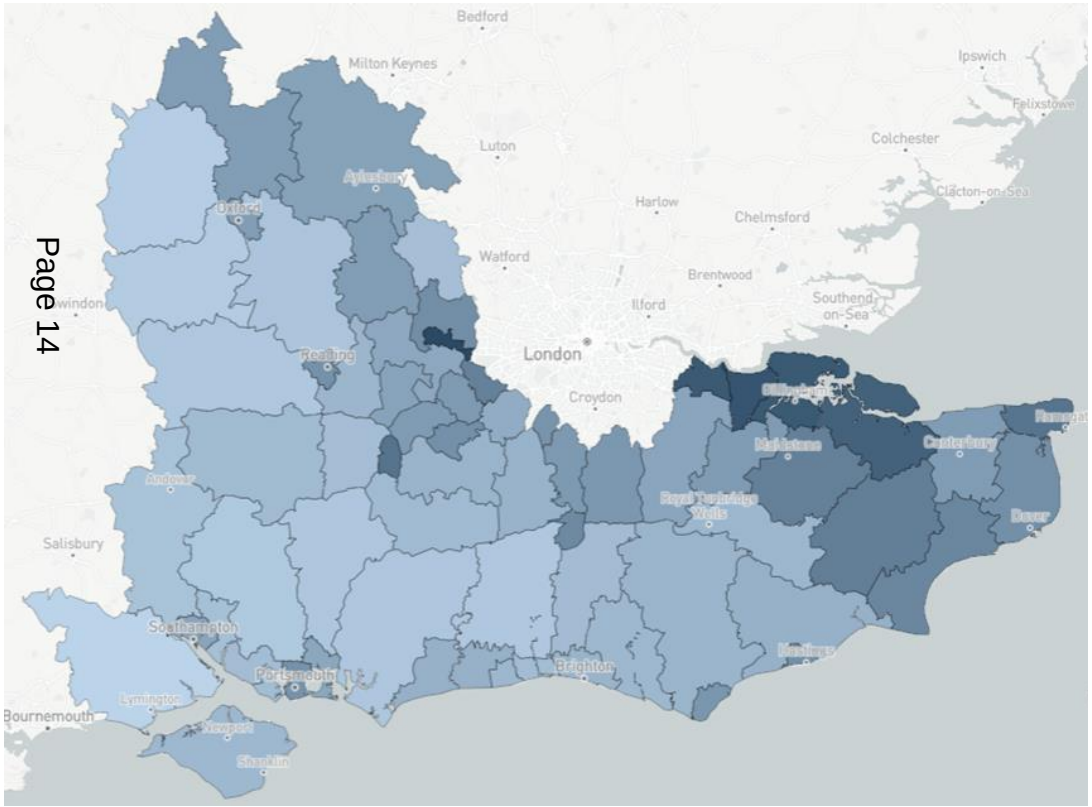
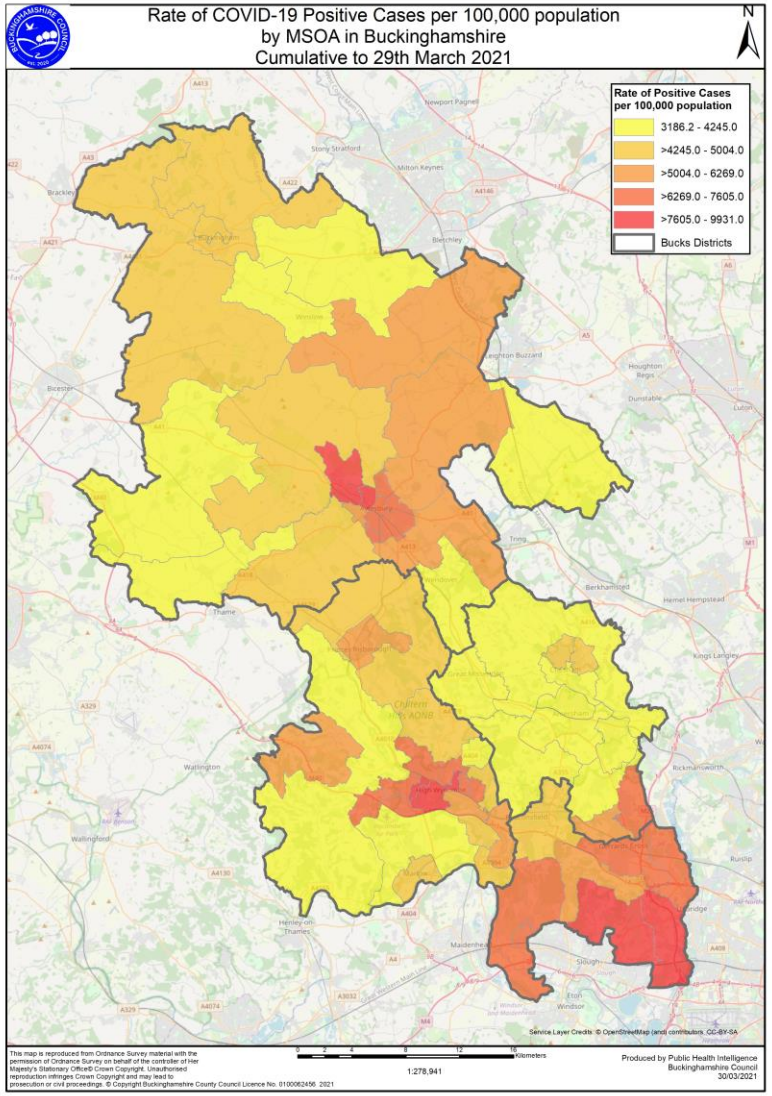
COVID Cumulative cases in the South East and Buckinghamshire

COVID-19 cumulative cases by Lower Tier Local Authority of residence in the South East PHE Centre – crude rate per 100,000 as a
29/03/2021





Risk of transmission

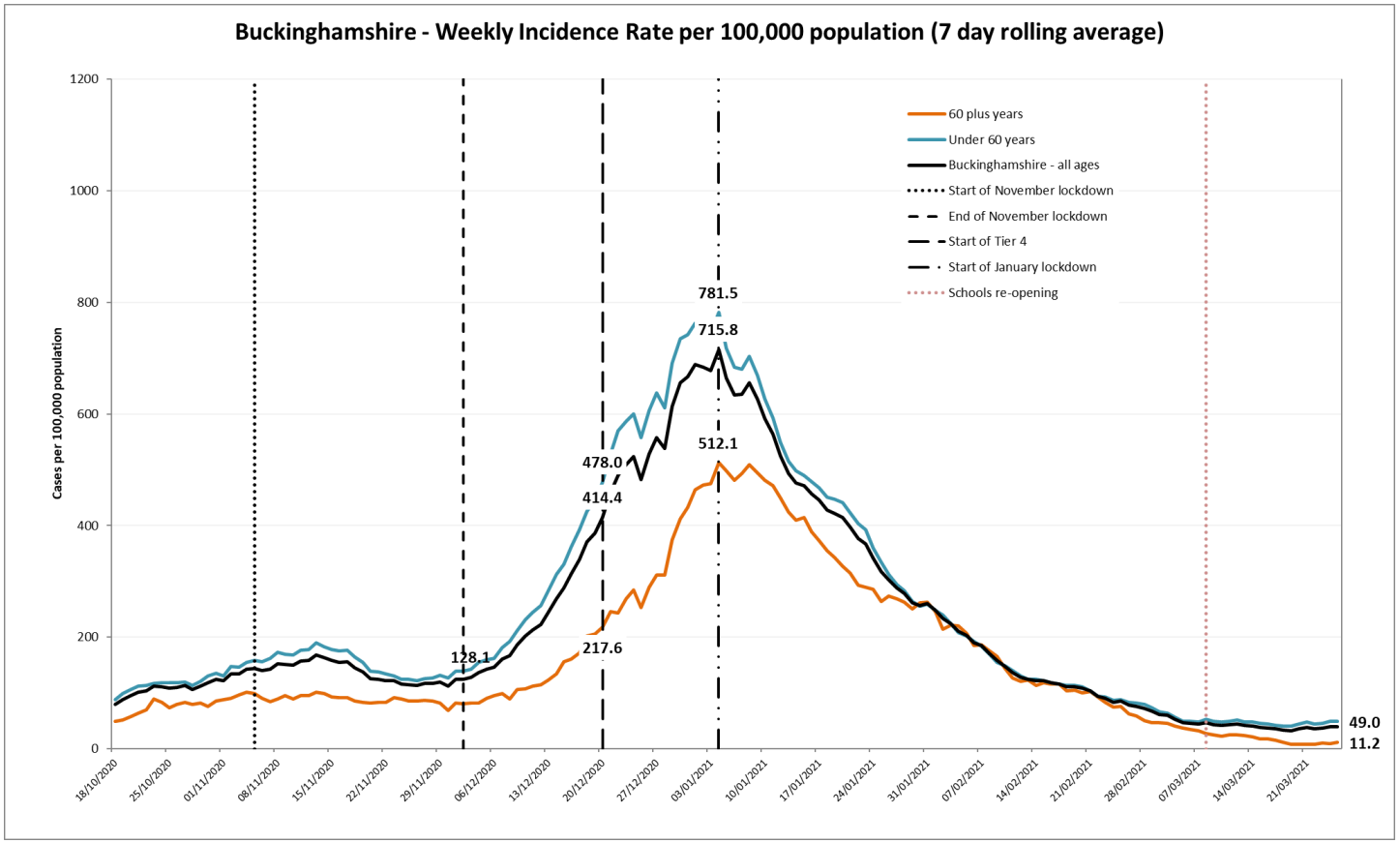
National research on areas with "enduring transmission"

- Higher levels of unmet financial need
- Greater numbers of people in 'high contact and/or high risk' occupations
- More high-density, multi-generational or overcrowded accommodation
- Lower literacy levels and more digital exclusion
- Less engagement with testing, contact tracing and inability to self-isolate

Some Statistics behind enduring transmission

- **UKs largest households almost 3x more likely to get COVID and 7.5 times more likely to die from it** (6+ vs 1-2 per household, adjusted for confounders)
- 36% of Pakistani or Bangladeshi live in households of 6+ people, compared to just 3.5% white
- Ethnic minority men over represented in 8/10 **highest death rate occupations** - Percentage of men from ethnic minority groups - **57%** taxi cab drivers chauffeurs, **37%** security guards, **34%** restaurants and catering managers, **31%** nursing auxiliaries, **29%** nurses, **27%** care home workers vs approx. **13% BAME in working age male population**
- Vaccine concerns highest in Black/Black British at more than 40%, more than double other BAME groups and more than 4x higher than white British and lower uptake in Black groups nationally

Buckinghamshire – Change in Weekly Rate of New COVID-19 Cases



Weekly case rate change in past 7 days

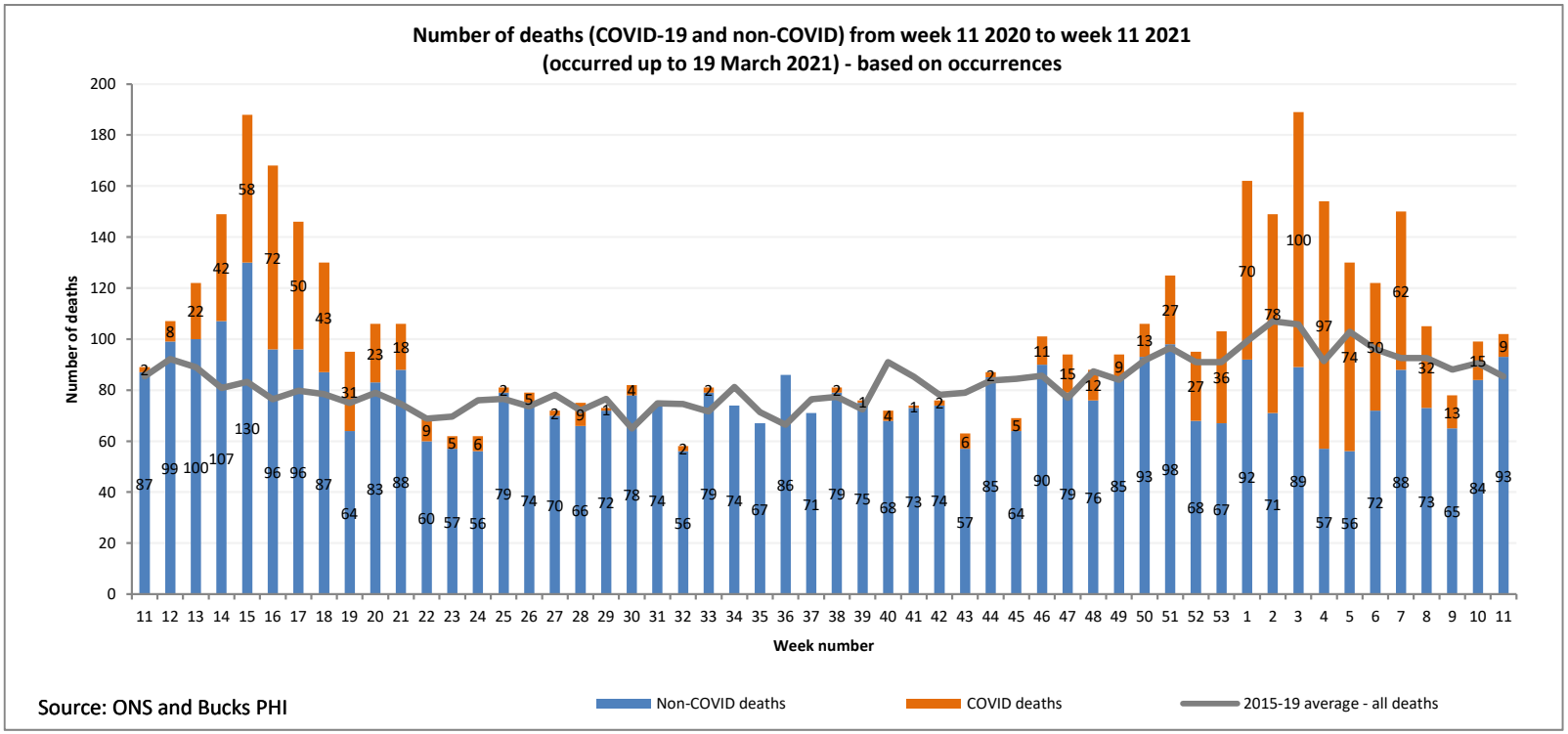
between 12-Mar to 18-Mar and 19-Mar to 25-Mar		
All ages	17.9%	⇧
<60	18.9%	⇧
60+	0.0%	⇔

Weekly number of cases change in past 7 days

All ages	+33 (184 to 217)	⇧
<60	+32 (169 to 201)	⇧
60+	+0 (15 to 15)	⇔

Health & Wellbeing Board Buckinghamshire

COVID-19 Related Deaths - Buckinghamshire residents



In the last reported week **(up to 19 March)**,
there were **9 deaths** related to COVID-19* for a Buckinghamshire resident.

1,189 deaths overall, twice as many in the second wave compared to the first.

Data from the Office for National Statistics.

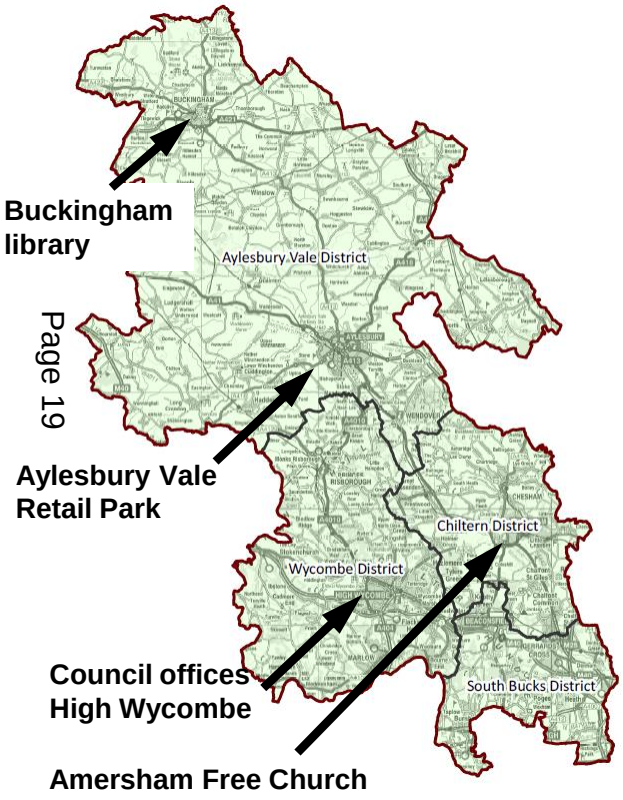
Key Messages

- Lockdown highly effective in reducing infection rates but now easing
- Vaccine progress is good so far but
- No vaccine is 100% effective, some people, including some more at risk groups, may choose not to have it
- The epidemic is driven by younger working age who are not yet vaccinated & ? may have lower uptake of vaccine ?
- Vaccine protection will wane – not yet sure when
- **If** there are high levels of circulating virus in presence of partially vaccinated populations **plus** importing variants of concern e.g. from travel and holidays abroad we risk reducing effectiveness of vaccine programme
- **We need to keep following the rules <u>even when vaccinated</u>** and *just because you can doesn't mean you should……*

- ***Hands, face, space, ventilate*** **(fresh air)**
- **Get tested and if positive *<u>self isolate</u>***

Rapid Testing and Community Collect (LFDs)

Council rapid testing and Community Collect sites



Rapid testing and Community Collect (home testing)

- Government scheme for employers of > 10 people
- Schools etc have separate scheme
- Council scheme for people at risk, e.g. 'risky' job, carer, underlying health condition, meeting in a higher-risk setting, e.g. religious service
- Community Collect also from some PCR test sites and, soon, from participating local pharmacies

More information

For more information please see the Buckinghamshire COVID dashboard

https://covid-dashboard.buckinghamshire.gov.uk/

Better Care Fund Update

Tracey Ironmonger – Service Director,
Integrated Commissioning

March 2021

Recommendations for the Board

- **To note** the Better Care Fund update for 2020-21 and 2021-22

- **To note** the current position in relation to Better Care Fund and performance

- **To note** the plans to review the Better Care Fund

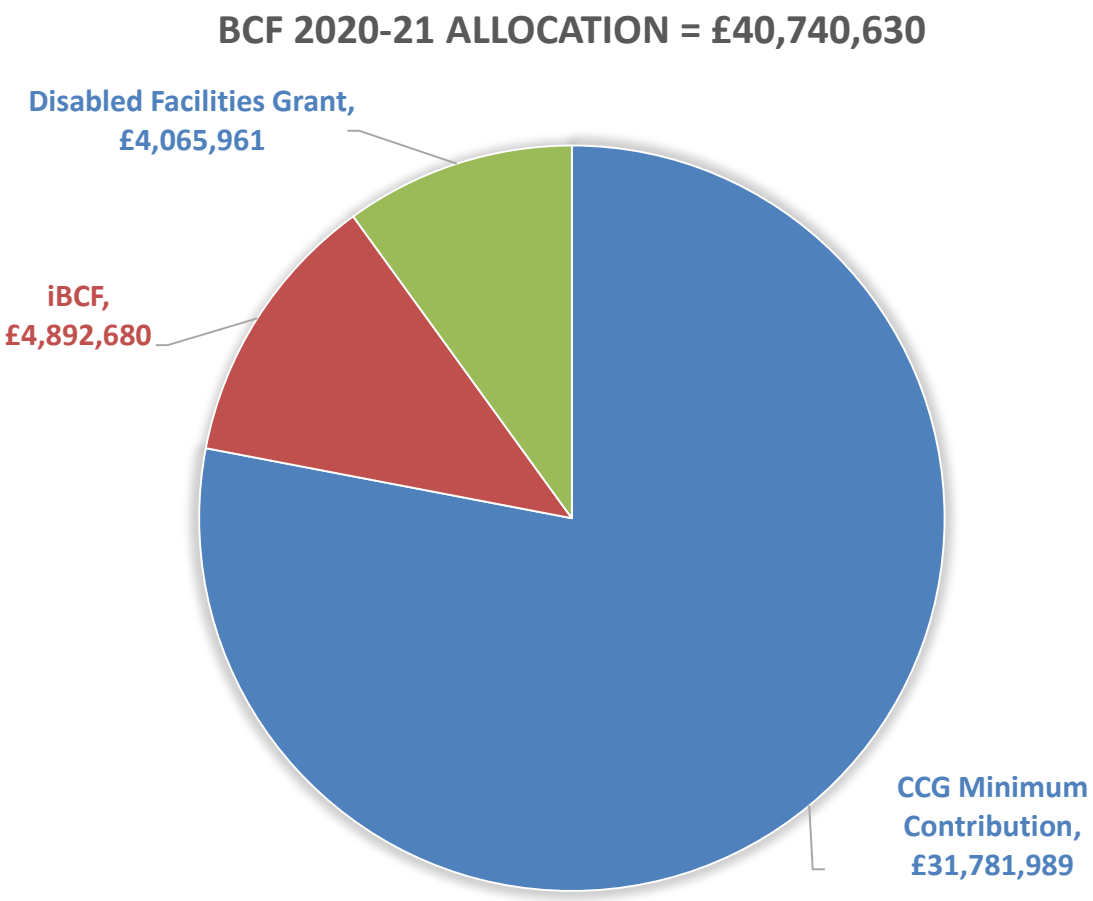
2020-21 Update – Meeting National Requirements

- Given the ongoing pressures on systems, it has been agreed that formal BCF plans for 2020-21 will not have to be submitted for approval

- HWBBs are required to provide an end of year reconciliation confirming
  - National conditions have been met
  - The required minimum contributions to social care and out of hospital services have been met
  - Total spend from the mandatory funding sources

- Expenditure has been discussed and agreed via delegated authority to the Integrated Commissioning Executive Team

2020-21 Funding



Of which

- **£10,648,961** must be spent on **Adult Social Care**
- **£9,037,847** must be spent on **NHS Commissioned Out of Hospital Care**

High Impact Change Model (HICM)

- HICM are a series of 9 domains which care systems should use to benchmark themselves against a broad set of maturity levels. They form part of our BCF reporting arrangements.

- HICM guidance has been updated in light of COVID, together with a link to new Hospital Discharge Guidance and strategic adoption of a Home First approach.

- Buckinghamshire continues to accelerate its development of the 9 domains that will further enable patient flow, improving admission avoidance and ensuring effective discharge.

High Impact Change Model

	HICM Domain	Estimated maturity by March 2021
Chg 1	**Early discharge planning**	Established
Chg 2	**Systems to monitor patient flow**	Established
Chg 3	**Multi-disciplinary / Multi-agency discharge teams**	Established
Chg 4	**Home first / discharge to assess**	Established
Chg 5	**Seven-day service**	Established
Chg 6	**Trusted assessors**	Established
Chg 7	**Focus on choice**	Established
Chg 8	**Enhancing health in care homes**	Established
Chg 9	**Housing and related services**	Established

2020-21 Achievements

- With the implementation of the new Hospital discharge policy in March 2020, BCF funded schemes and services have been a lever to building a responsive discharge to assess service

- Covid response has significantly enhanced integrated working across the system

- Built on the use of trusted assessment and multidisciplinary working supporting maturity of the High Impact Change Model

- Maintained a seven day social care output supporting A&E departments as well as enabling D2A assessments to take place

2020-21 Achievements

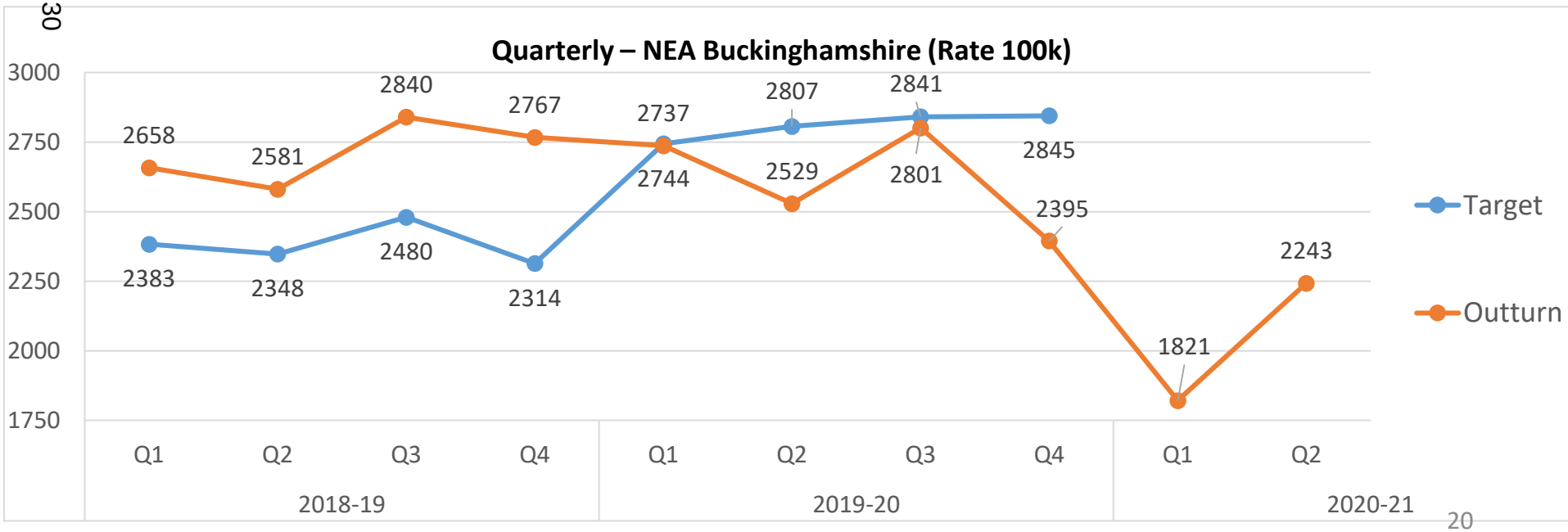
- Supported pathway 0, with 795 people supported through the Red Cross Home from Hospital Service (April – December 2020)
- Supported pathway 1, with 1,051 reablement referrals (April 2020 – Feb 2021) and an average of 36.2% of service users leaving with no ongoing care needs
- Supported 90 people to source their own care via the hospital brokerage service
- 605 new adult carers referred to Carers Bucks for support

2020-21 Update - Metrics

- There is no requirement this year to submit local trajectories for the BCF national metrics
- Systems are required to continue to work to make progress against them
- National reporting of Delayed Transfers of Care was suspended from 19 March 2020
- Local areas are reporting on a new set of related metrics under the Hospital Discharge Service Policy

Performance – Non-elective admissions (NEAs)

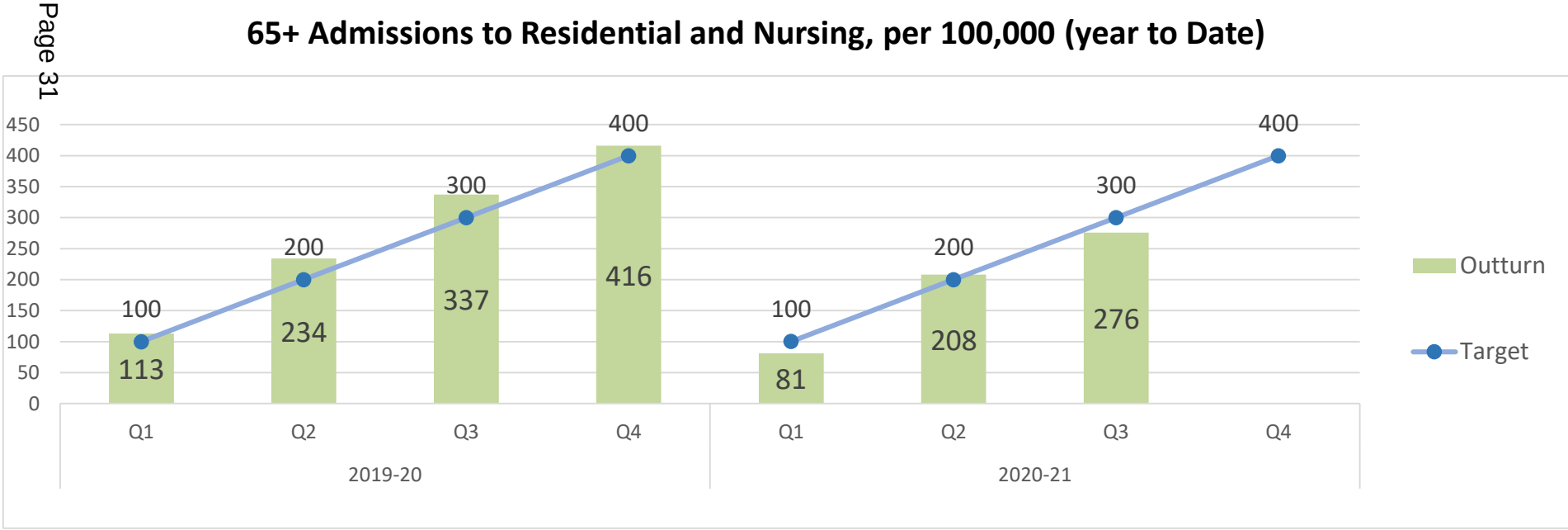
- No target set for 2020-21
- Q3 (Oct – Nov) = 1,559
- Reporting currently suspended locally due to staff redeployment
- Confirmed for 2021-22 that this metric will be replaced with 'avoidable admissions' metric



Source: NHS Digital - Secondary Uses Service (SUS)

Performance – Admissions to care homes

- Target 400 per year – set locally
- January = 320 (target 333)
- This metric will continue for 2021-22



2021 – 22 Update

- BCF funding has been confirmed for 2021-22
- iBCF and Disabled Facilities Grant will continue at their current level
- The CCG contribution will increase by an average of 5.3% in line with the NHS Long Term Plan settlement
- Planning and policy guidance is expected but delayed due to ongoing discussion regarding future discharge funding
- Although not confirmed, funding is expected to continue as a two year planning cycle in addition to planning for 2021 - 22

Local BCF Review

- Buckinghamshire's BCF has remained stable and consistent in recent years. Most expenditure is on a recurrent basis for specified schemes and contracts

- Aim to review the BCF jointly with our health partners to
  - Fully understand the current allocation and utilisations of the BCF
  - Identify progress and gaps in relation to key priorities
  - To develop a 1+2 BCF plan which meets current needs and priorities
  - To review use of the BCF allocations considering this new plan

Local BCF Review – Timescales

- **Stage 1 – Priority areas for 2021-22 planning (March – April 2021)**
  - Priority areas to be reviewed in line with planning guidance including creating funding to support delivery of home first throughout 2021-22

- **Stage 2 – In-depth review to feed into 2022-23 planning and beyond (May 2021 – April 2022)**
  - Funding for 2022-23 has not been formally agreed but it has been indicated that planning for 2022 may be for a two or three-year cycle
  - It is the expectation that most changes to BCF expenditure will be from 2022 onwards.

- **Stage 3 – Final stage review (May – December 2022)**
  - Some elements of the BCF may require a longer timeframe in order to consider potential changes
  - These will feed into 2023-24 planning

Integration and Innovation: Working together to improve health and social care for all DHSC White Paper, Feb 2021

Gillian Quinton, Corporate Director, Adults & Health

Buckinghamshire Council

Recommendation to Health and Wellbeing Board

Members of the Health and Wellbeing Board are asked to note the content of the Government's White Paper, particularly in relation to the Health and Wellbeing Board

Introduction – The White Paper

- Sets out proposals for a Health and Care Bill
- Builds on the NHS Long Term Plan, on the collaborations seen during Covid, and on a recent consultation on the future of ICSs. Also ties in with the current consultation from CQC on the way it works
- Focuses on improving integration in two ways:
  - Within the NHS to remove barriers to collaboration; and
  - Between partners in the health and care system to improve health & wellbeing outcomes for local people

Commentary

The White Paper has been received relatively quietly:

Think Tank/Media Commentators

The WP doesn't explain the 'why' –the problem that the WP is trying to solve & the need for Government to gain back control from NHSE? - and a general feeling it is not a coherent whole, with lots of little bits rather than a clear direction/narrative. The Paper does provide an opportunity to really focus on the person and their journey, away from the barriers arising from a focus on which organisation someone works for.

Political objections to date have been focussed on the timing, rather than the content

ADASS has welcomed greater assurance for social care & the establishment of ICSs on a permanent footing, but has reinforced its view that social care reform is vital to include parity of esteem for social care workers, significant improvements in support for family carers and long-term funding

LGA - a 'promising base' to build stronger collaborative culture and for NHS and local government to be equal partners. More work needed on roles of new ICS boards and concerns around: potential undermining of HWB Boards & HASCs; impact on integrated activity at a local level; centralisation of PH powers & impact on local authorities; and lack of a timetable for social care reforms

NHS Confederation welcomes duty of collaboration & principle of subsidiarity but concerns about powers of intervention over the NHS by the SoS

Key Points: Integrated Care Systems

'Integration is the new competition'

- ICSs will be made statutory and will be able to hold budgets: NHS England will get an explicit power to set a financial allocation or other financial objectives at a system level.
- Each ICS will comprise an ICS NHS Body and an ICS Health and Care Partnership, and will take on the commissioning functions of CCGs (and some from the NHS Commissioning Board).
- The ICS NHS Body (for the day-to-day running of the ICS) will have a statutory board:
  - Responsible for plan to address health needs of system; setting strategic direction and budget plans (including capital NHS plan)
  - Be directly accountable for NHS spend and performance within the system
  - As minimum will include CEO (Chair) and reps from NHS trusts, GPs and local authorities
  - Guidance on how these should be constituted & appointed, will be published
- The ICS Health and Care Partnership will:
  - Be locally determined - no guidance on membership or function will be issued
  - Be expected to comprise a wider group of organisations than the ICS NHS Body
  - Develop a plan to address health, public health and social care needs
  - Be tasked with promoting partnership arrangements (no power to impose arrangements)

Key Points: Integrated Care Systems (cont.)

- Health and Wellbeing Boards are seen as 'place-based' planners:
  - The ICS will have to have regard to the Health and Wellbeing Boards' Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
  - Health and Wellbeing Boards will have to have regard to ICS plans
- NHS and local authorities will have a legal 'duty of collaboration' with expectation that local authorities and NHS bodies will work together under one system umbrella
- ICSs and NHS providers can form joint committees, the former at place to align allocation functions.
- Place level commissioning aligned to local authority boundaries is expected to be common
- The Better Care Fund will be a tool for agreeing priorities
- ICSs will be able to apply to the Secretary Of State to create new Trusts to provide integrated care.
- The national NHS tariff will be altered to support the right financial framework for integration, whilst maintaining the financial rigour and benchmarking that tariff offers.
- NHS England will issue guidance on joint appointments
- NHS England will be able to commission with more than one ICS & ICSs can collaborate with others where it makes sense to do so

Key Points: Social Care

- The White Paper repeatedly mentions social care reform. A few changes are set out:
  - a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties
  - powers for the Secretary of State to intervene and provide support where there is a risk of local authorities failing to meet these duties
  - a tweak to let the SOS make direct funding to social care providers in emergencies (which will not replace the existing funding mechanism), and
  - Legal framework for a 'Discharge To Access' mechanism, replacing legal requirement for assessments to take place prior to discharge.
- Proposals on social care reform will be forthcoming 'later in the year'

Key Points: Public Health

- Creation of the National Institute for Health Protection (NIHP) to replace PHE
- SoS power to require NHS England to discharge public health functions (which were transferred to local government by the 2012 Act) without annual section 7A agreements
- Legislation to support the national obesity strategy including introduce further restrictions on food advertising and contemplate banning adverts for unhealthy food online and before 9 pm on television
- Fluoridation of water to return to central government control from local authorities

Key Points: Role of the Secretary of State

Reversing change

- The WP undoes 2012's Health And Social Care Act 'Equity And Excellence: Liberating The NHS' and abolishes competition and competitive tendering in the NHS. This could be problematic for integrated commissioning arrangements.

Role of the Secretary of State

- Removes independence of NHS Foundation Trusts, as well as ending the system for developing them, with the formal abolition of NHS Improvement and the Trust Development Authority.

- The Secretary of State is put back in charge:
  - Of the overall system, of each local Integrated Care System and of the NHS Commissioning Board (NHS England)
  - Resuming formal powers of direction:
    - new powers to intervene at any point of an NHS reconfiguration process
    - a new process for reconfiguration that will enable the SoS to intervene earlier and enable speedier local decision-making
    - new powers to transfer functions to and from specified arms-length bodies (ALBs) and to abolish ALBs (exercisable via a Statutory Instrument (SI) following formal consultation)
    - New power to make payments directly to social care providers

Key Points: General

- Data sharing is going to be a significant focus but the White Paper says very little about how – a Data Strategy for Health and Care will set out proposals to address barriers. Data provision will be mandated from private providers and on services to self-funders (not clear about whether this will be shared locally though).
- The annually-set NHS Mandate from the SoS to NHS Commissioning Board to drive its planning guidance is replaced by a need to always have a Mandate in place. This is not a net gain in accountability.
- The issue of the workforce shortage is not addressed. The Secretary Of State will have to *"publish a document, once every Parliament, which sets out roles and responsibilities for workforce planning and supply"*.
- Amendment to the Coroners and Justice Act 2009 so that NHS bodies, rather than local authorities, appoint Medical Examiners (to establish a statutory medical examiner system within the NHS).
- No appetite in the WP to change the distinct lines of accountability: NHS to national government and Parliament; local government to local people.
- Triple aim duty for NHS – better health and wellbeing for all; better quality of health services for all; and sustainable use of NHS resources.

Key Points: General (cont.)

- It will extend the scope of professions who can be regulated using the powers in Section 60 of the Health Act 1999. While it states that *"there are no plans at this stage to statutorily regulate senior NHS managers and leaders",* this change *"would enable this to be brought forward in the future"*.
- It ends the need for new legislation to remove one of the professions from statutory regulation. Currently, nine regulatory bodies (10 including Social Work England) perform similar regulatory functions in relation to different professions: these regulators will be able to be abolished under secondary legislation.

Next steps

- The Government is not inviting comment on the White Paper
- The Government plans for a Bill later in 2021, with changes proposed to be implemented from April 2022

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