Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board
1st April 2021

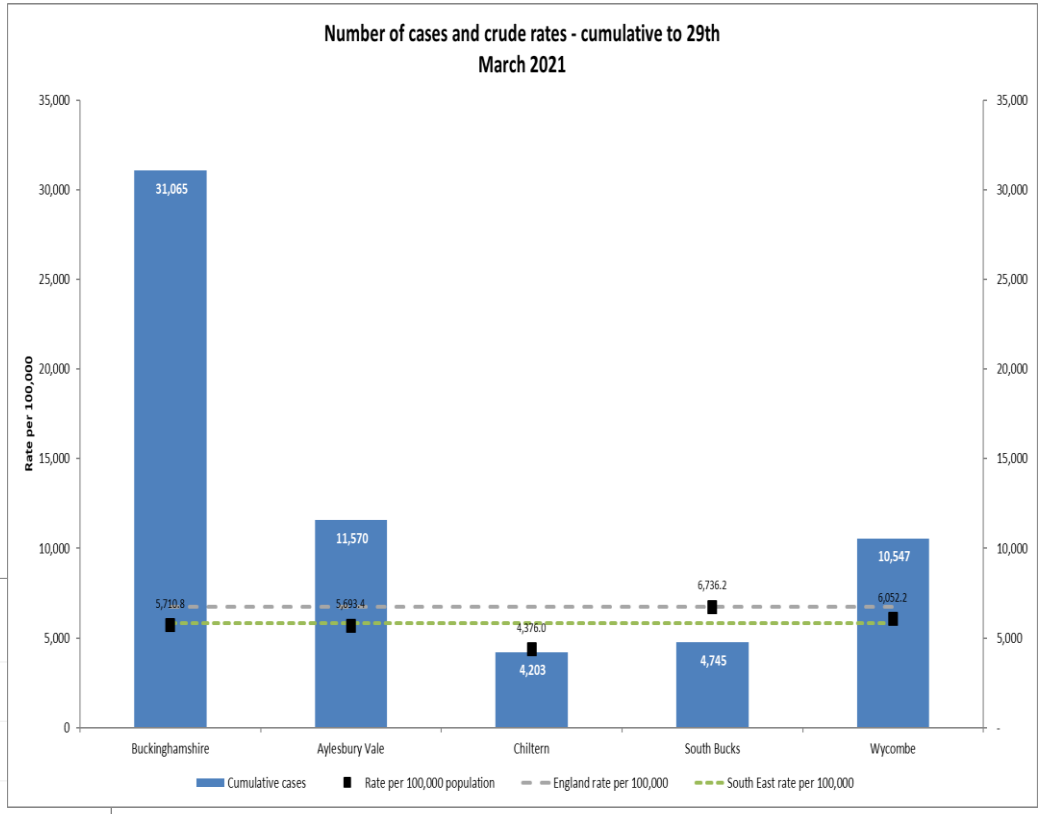
COVID-19 in Buckinghamshire update

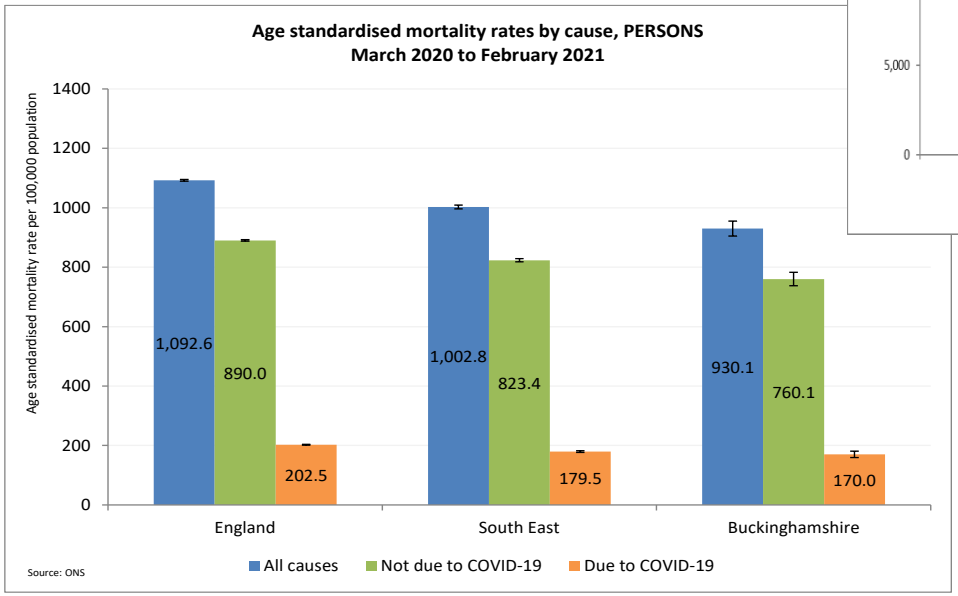
Dr Jane O'Grady, Director of Public Health,
Buckinghamshire Council

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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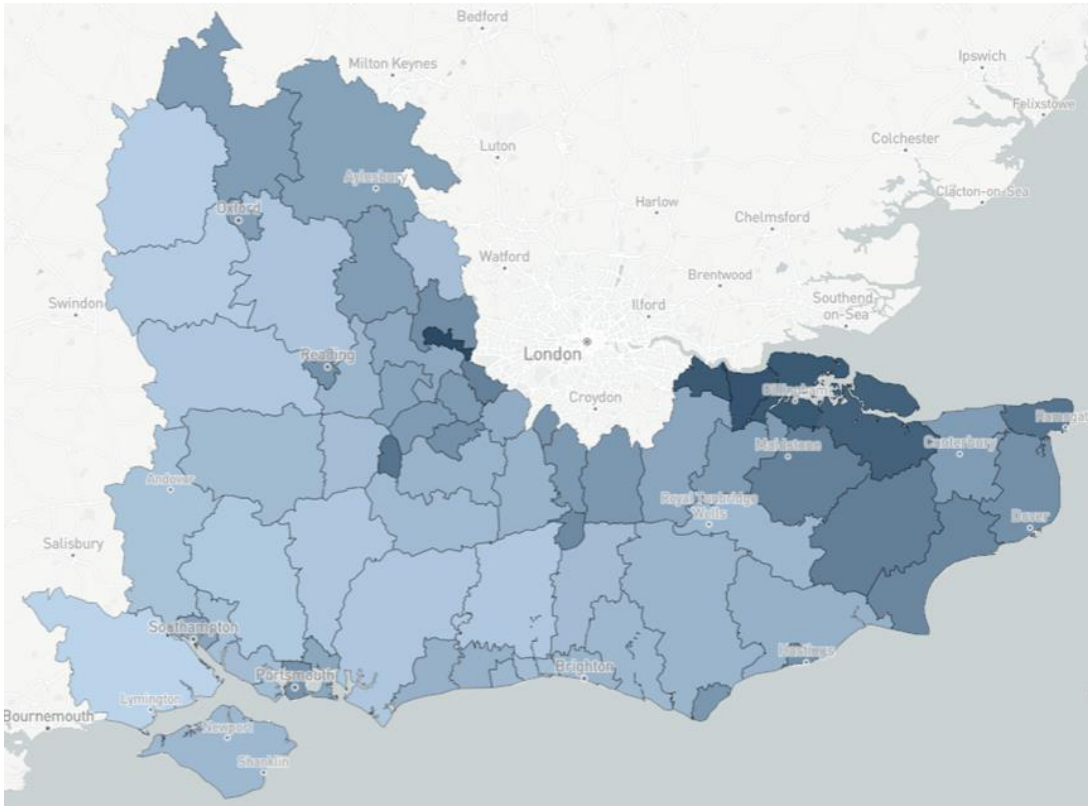
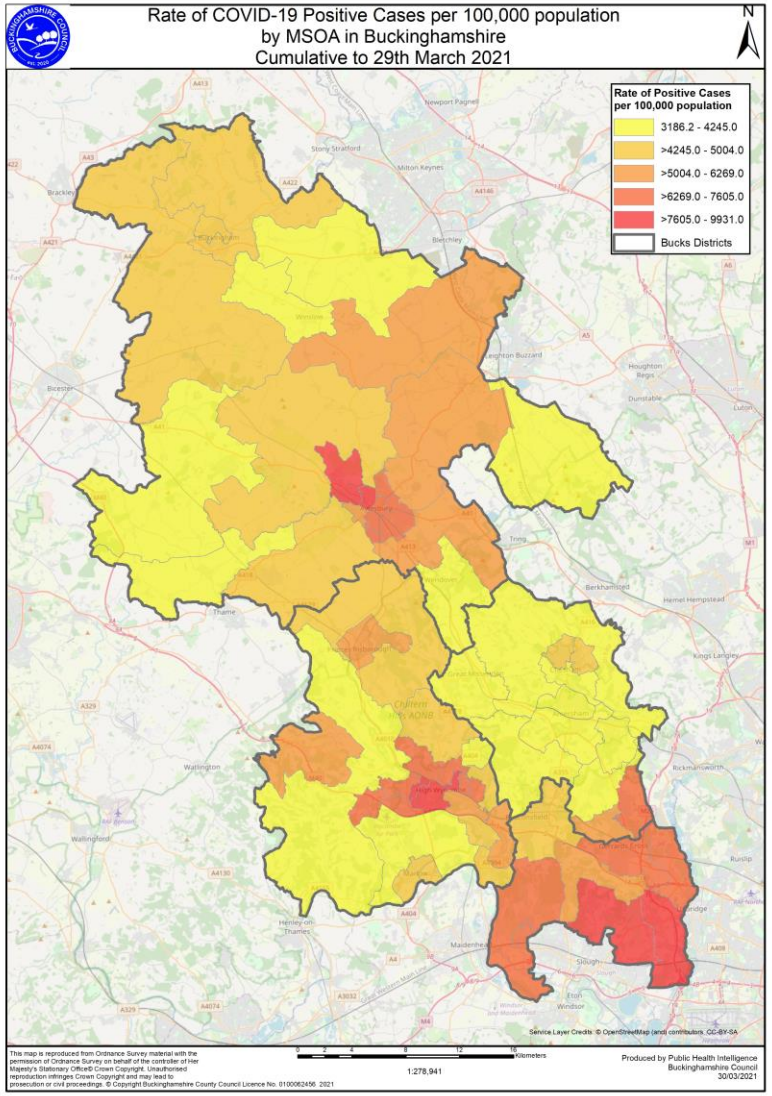
COVID Cumulative cases in the South East and Buckinghamshire

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





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Risk of transmission

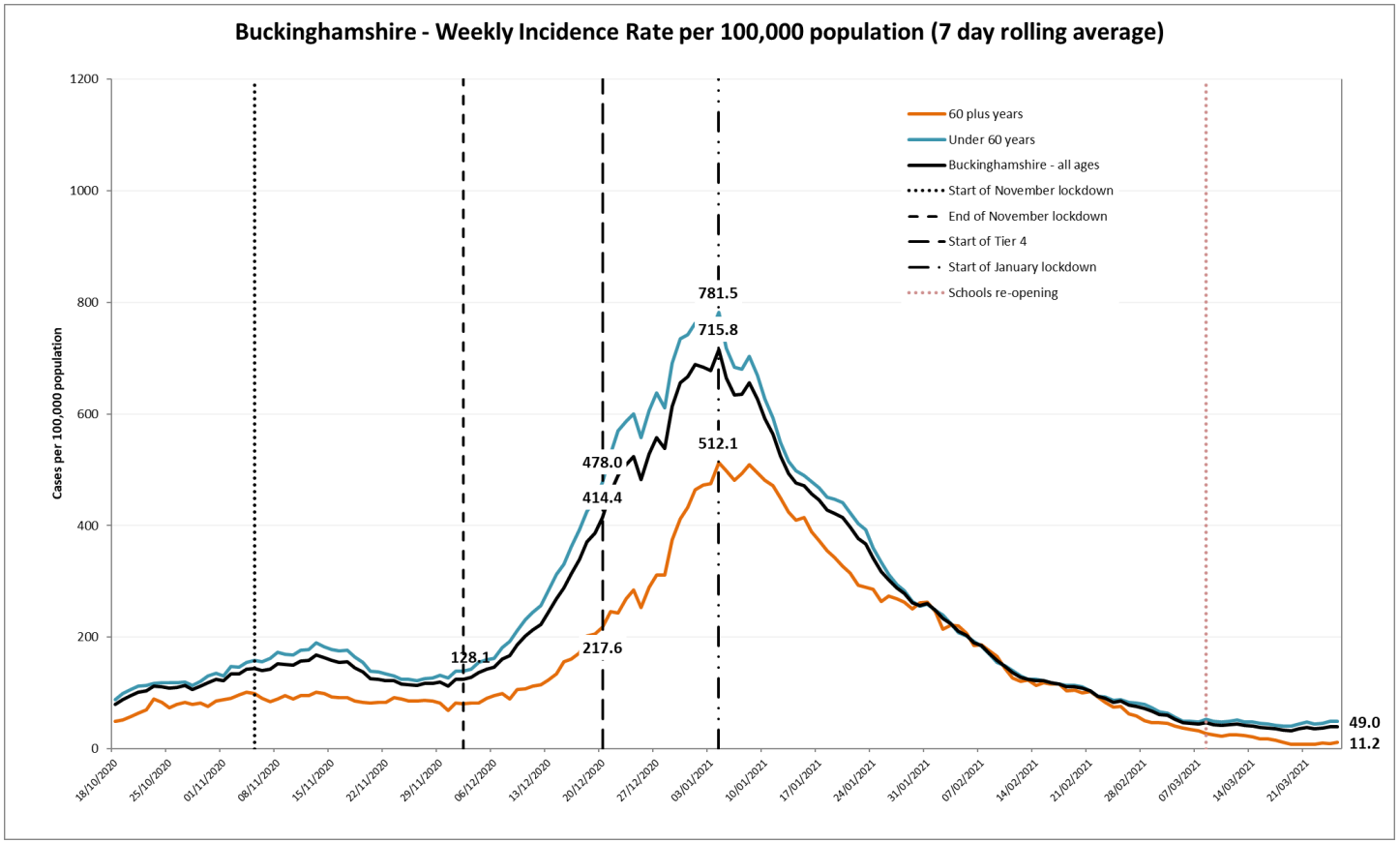
National research on areas with "enduring transmission"

- 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)	⇔

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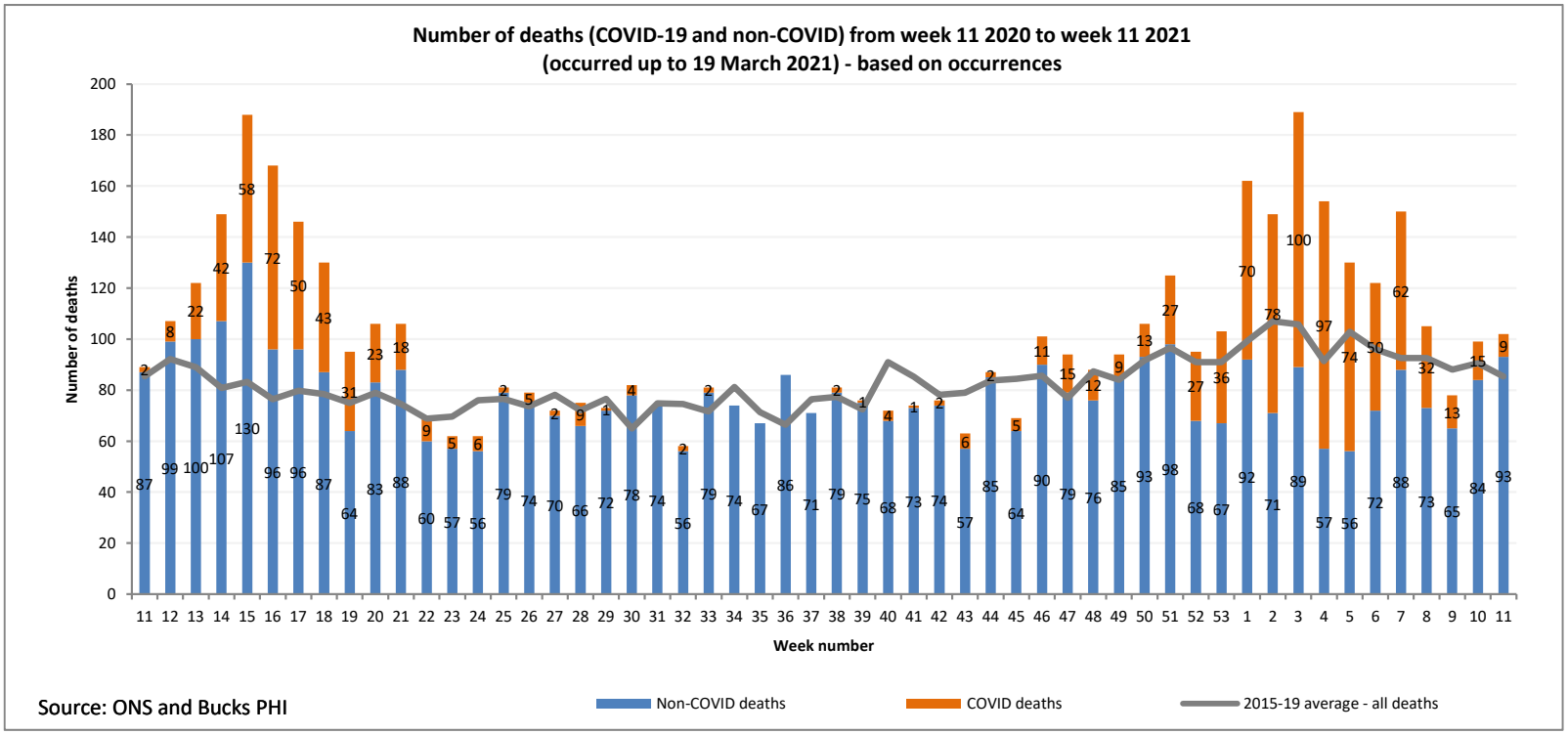
COVID-19 Related Deaths - Buckinghamshire residents



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.

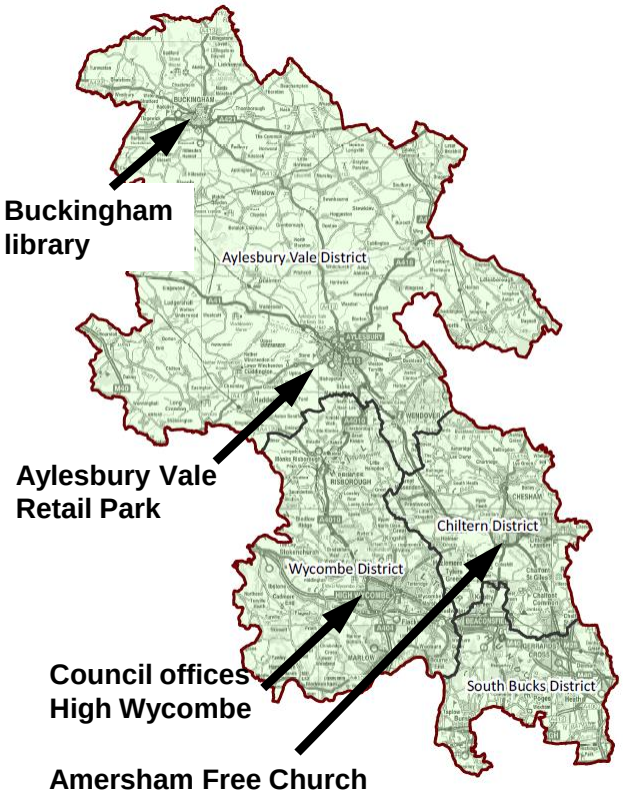
Key Messages

- 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

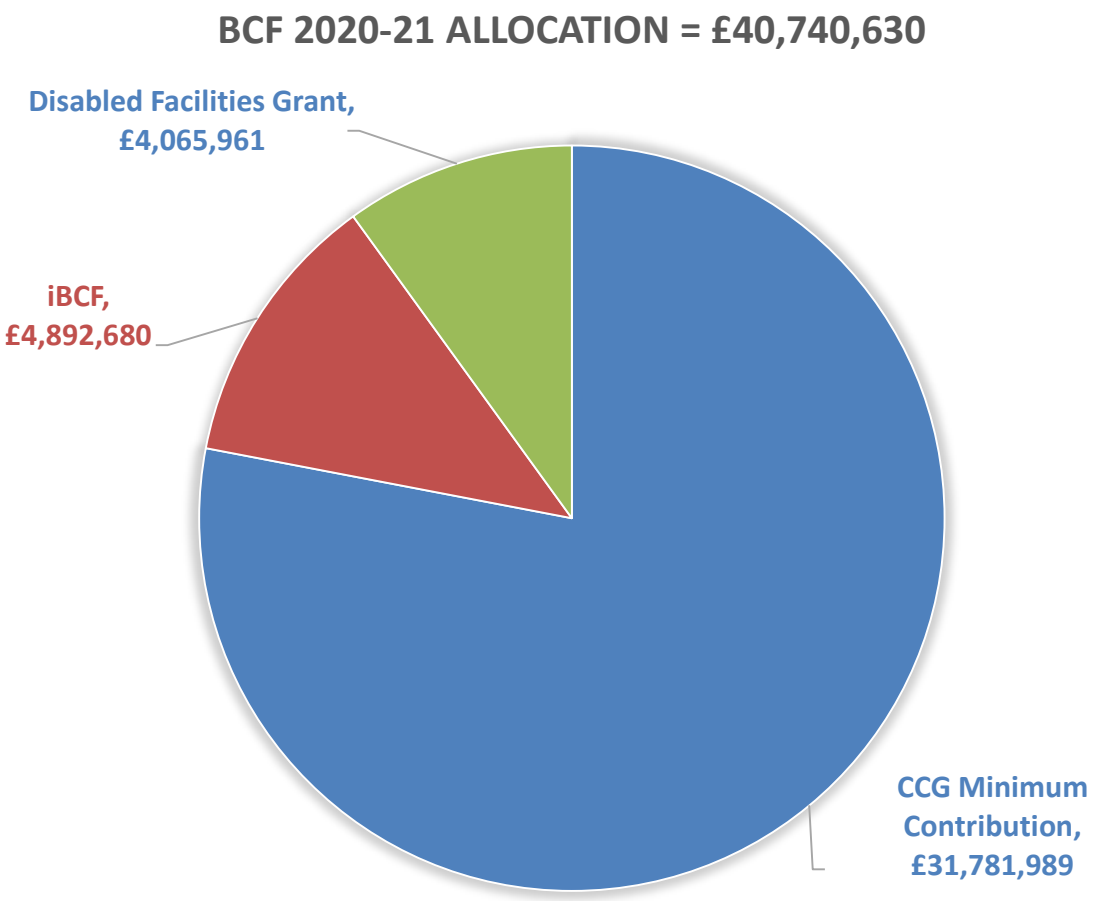
2020-21 Update – Meeting National Requirements

- 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

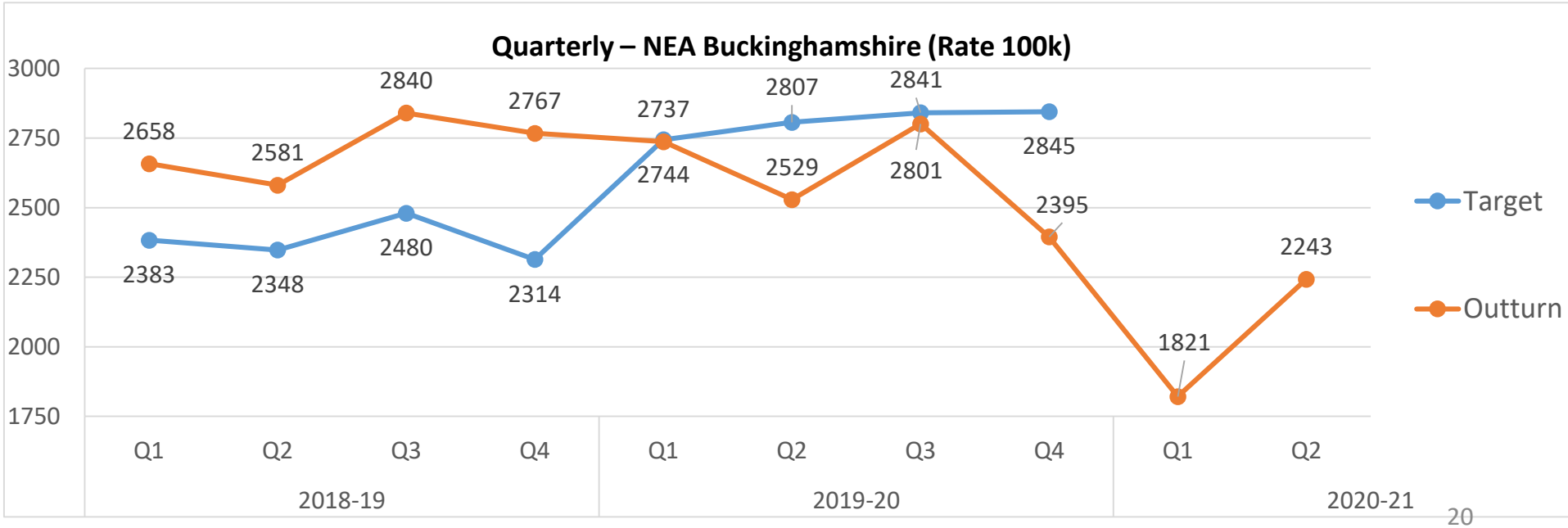
- 605 new adult carers referred to Carers Bucks for support

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

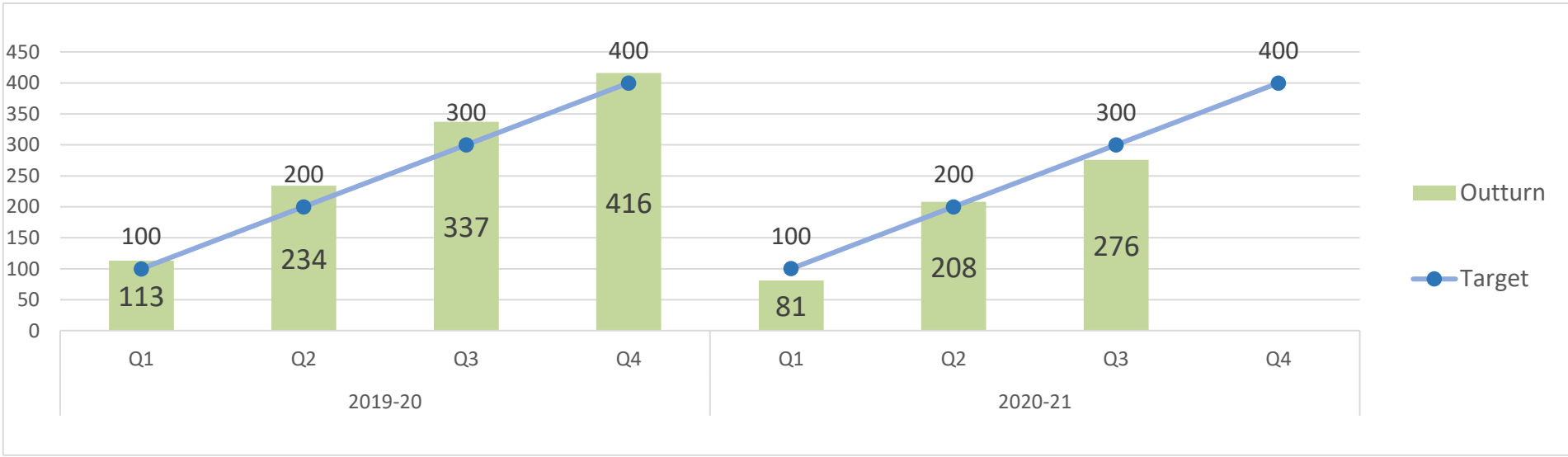


Source: NHS Digital - Secondary Uses Service (SUS)

Performance – Admissions to care homes

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

65+ Admissions to Residential and Nursing, per 100,000 (year to Date)



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