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Dorset Health and Wellbeing Board

Date: Wednesday, 23 June 2021

Time: 2.00 pm

Venue: A link to the meeting can be found on the front page of the agenda.

Membership: (Quorum 5)
Marc House, Rebecca Knox (Chairman), Forbes Watson (Vice-Chairman), Vivienne Broadhurst, Sam Crowe, Dani Farrell, Spencer Flower, Tim Goodson, Margaret Guy, Martin Longley, Theresa Leavy, Laura Miller, Patricia Miller, John Sellgren, James Vaughan, Simon Wraw and Simone Yule

Chief Executive: Matt Prosser, County Hall, Colliton Park, Dorchester, Dorset DT1 1XJ (Sat Nav DT1 1XJ)

For more information about this agenda please contact Fiona King 01305 224186 - fiona.king@dorsetcouncil.gov.uk

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https://youtu.be/GDUnXU1E4kU

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A G E N D A

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1 APOLOGIES

To receive any apologies for absence.

2 DECLARATIONS OF INTEREST

To disclose any pecuniary, other registerable or personal interest as set out in the adopted Code of Conduct. In making their disclosure councillors are asked to state the agenda item, the nature of the interest and any action they propose to take as part of their declaration.

If required, further advice should be sought from the Monitoring Officer in advance of the meeting.

3 PUBLIC PARTICIPATION

To receive questions or statements on the business of the committee from town and parish councils and members of the public.

Members of the public who live, work or represent an organisation within the Dorset Council area, may submit up to two questions or a statement of up to a maximum of 450 words. All submissions must be sent electronically to fiona.king@dorsetcouncil.gov.uk by the deadline set out below. When submitting a question please indicate who the question is for and include your name, address and contact details. Questions and statements received in line with the council's rules for public participation will be published as a supplement to the agenda.

Questions will be read out by an officer of the council and a response given by the appropriate Portfolio Holder or officer at the meeting. All questions, statements and responses will be published in full within the minutes of the meeting.

The deadline for submission of the full text of a question or statement is 8.30am on 18 June 2021.

Details of the Council's procedure rules can be found at: Public Participation at Committees.

4 QUESTIONS FROM MEMBERS

To receive any questions from members in accordance with procedure rule 13. The deadline for receipt of questions is 8.30am on **Friday 18 June 2021**.

5 SAFER SCHOOL REVIEW AND THE FUTURE OF PREVENTION IN DORSET POLICE

To receive a presentation from Dorset Police.

6 UPDATE ON THE LOCAL OUTBREAK MANAGEMENT PLAN 5 - 16

To receive a report from the Director for Public Health.

7 UPDATE ON THE INTEGRATED CARE SYSTEM (ICS) 17 - 34

To receive a report from the Director for Public Health.

8 JOINT STRATEGIC NEEDS ASSESSMENT - HEALTH INEQUALITIES

To receive a presentation from the Senior Analyst, Public Health Dorset.

9 PHYSICAL ACTIVITY STRATEGY

Members to receive a brief update from the Programme Co-ordinator.

10 BETTER CARE FUND (BCF) AND HOSPITAL DISCHARGE PROGRAMME 35 - 38

The Interim Executive Director for Adult Social Care to update members on the BCF for 2020/21 and the uplift allocated to existing schemes.

There was no formal reporting requirement for the BCF to the Health and Wellbeing Board during the period due to Covid. The 2021/22 BCF guidance is not yet available.

11 URGENT ITEMS

To consider any items of business which the Chairman has had prior notification and considers to be urgent pursuant to section 100B (4) b)

of the Local Government Act 1972. The reason for the urgency shall be recorded in the minutes.

12 EXEMPT BUSINESS

To move the exclusion of the press and the public for the following item in view of the likely disclosure of exempt information within the meaning of paragraph 3 of schedule 12 A to the Local Government Act 1972 (as amended).

The public and the press will be asked to leave the meeting whilst the item of business is considered.

Health and Wellbeing Board
23 June 2021

Update on the Local Outbreak Management Plan

For Review and Consultation

Portfolio Holder: Cllr L Miller, Adult Social Care and Health

Local Councillor(s): Cllr Laura Miller

Executive Director: S Crowe, Director of Public Health

Report Author: Sam Crowe
Title: Director of Public Health
Tel: 07775-811932
Email: sam.crowe@dorsetcouncil.gov.uk

Report Status: Public

Recommendation: None

1. Executive Summary

The Dorset Council Health and Wellbeing Board approved the refreshed Local Outbreak Management Plan at its March 2021 Meeting. The Board continues to support local outbreak management by regularly meeting as an outbreak engagement board to consider current communications and engagement activity in the context of the local COVID-19 situation. This report provides an update on current actions under the plan.

2. Financial Implications

The Local outbreak management plan delivery is supported by use of the non-recurrent Contain Outbreak Management Fund. Appendix A sets out how the fund has been used for the financial year 2020/21, in line with the grant conditions.

There are also ongoing financial costs to the public health shared service arising from COVID-19 which are likely to be met from reserves. This includes needing to fund an element of some fixed term roles, where these extend beyond the financial year 21/22.

3. Climate implications

No direct impacts.

4. Other Implications

Summary of legal implications

Councils have a legal duty to improve the health and wellbeing of their residents, and reduce inequalities in health between different areas within their Council. The Director of Public Health is responsible for ensuring the health and wellbeing of local residents through a range of statutory functions. Health protection is a statutory responsibility of Public Health England. However, because of the emergency nature of the pandemic, local public health teams in Councils have been fulfilling this statutory role, working closely with PHE, and based on delivery of strong local outbreak management plans.

This report shows how Dorset Council is fulfilling its legal duties by continuing to protect the local population from COVID-19 infection.

Summary of human resources implications

The continued success of a strong local outbreak management function is only possible through having a resilient, skilled and dedicated workforce. This report outlines the steps the public health team is taking to ensure continued resilience through developing a number of fixed term roles to bolster the team.

Summary of public health implications

Being able to continue to provide strong local outbreak management is essential to the continued protection of the public's health from COVID-19 infection. This report shows how the four priorities under the refreshed plan are being met locally, and ongoing risks managed.

5. Risk Assessment

There is an ongoing risk of further increases in the COVID-19 infection rate, some of which is related to factors outside of the control of those working to deliver the local outbreak management plan (further loosening of measures, international travel). However, this paper has set out a number of risks where mitigating actions are underway, including ongoing risk of fatigue to public health teams, the risk of unvaccinated populations leading to infection rate rises, and risks arising from increasing numbers of visitors to BCP Council over the summer. The ongoing risks are likely to present a medium chance of further infections and deaths from COVID-19 at the current time.

Having considered the risks associated with this decision, the level of risk has been identified as:
Current Risk: Medium
Residual Risk: Medium

6. Equalities Impact Assessment

Addressing issues of inequality and deprivation and ensuring equality duties are fully enacted are central to the ongoing success of the vaccination programme, ensuring coverage is as high as possible in our communities

7. Background

The Dorset Health and Wellbeing Board oversees the development and delivery of the local outbreak management plan for COVID-19, as well as providing leadership to the communications and engagement function for COVID-19 through the Local Outbreak Engagement Board.

A refreshed Local Outbreak Management Plan was published in March 2021, and the Health and Wellbeing Board approved the plan at its 18 March meeting. At the time of publication, the Government was publishing its updated Contain strategy, including a new Roadmap to outline how and when England would ease out of COVID-19 restrictions as infection rates began to fall.

This report provides Health and Wellbeing Board members with a short update on the current situation with COVID-19, and the response that is continuing under the refreshed local outbreak management plan. Because the refreshed plan set out 4 priorities to be delivered through the ongoing

work of the health protection board, the report will use these priorities to structure the current position and outlook.

Current position

Priority 1: bring infection rates down as low as possible and maintain them. Weekly infection rates have remained below 25 cases per 100,000 population in the Dorset Council area since 18 March 2021, and are currently below 10 cases per 100,000. The number of outbreaks and incidents has fallen to its lowest level since the start of the pandemic. This relatively stable position has continued for more than two months, and is similar in other councils in SW England. However, over the past 2 weeks the England infection rate has started to rise, partly due to increasing infection rates in other regions linked with the Delta Variant of Concern, B.1.617.2 which is becoming the dominant strain of coronavirus in England.

Priority 2: Surveillance of transmission including for Variants of Concern (VOCs) must be optimal. The EpiCell that was stood up early in the pandemic to provide weekly situation intelligence for COVID-19 continues to report weekly. In addition the work on a local short term forecast model continues, supported by system partners. Intelligence on surveillance of Variants has also improved in the past few months. Public Health England now provides a weekly regional summary of all VOCs, shared with Directors of Public Health. And the confidential line list of cases provided to DsPH also now contains information on the presence of S-gene or S-gene target failure – both proxy markers of the main variants currently in the country, Kent, or Alpha, B.1.1.7, and Delta (formerly known colloquially as Indian 02 variant, B.1.617.2). As well as enhanced surveillance for VOCs both Councils have surge testing plans in place and an emergency response pathway should the need to stand up rapid testing in any of our communities arise.

Priority 3: Contact tracing and isolation needs to work, with a clear testing strategy. Dorset Council has developed an effective contact tracing operation, and has progressively taken on more direct contact tracing under a scheme called Local Zero. This means the local team are able to access information on cases and contacts with almost no delay, and often make the first contact rather than waiting for NHS Test and Trace to try and reach contacts on the system. As there are now many fewer cases and contacts, the team is successful in reaching almost all of the contacts, using a combination of emails, text messages and phone calls. Testing capacity remains high locally, and there is a combination of community testing for asymptomatic COVID-19, using assisted lateral flow tests, and PCR testing for people who have symptoms of COVID-19 or who have tested positive on

lateral flow and need a confirmatory test. Testing positivity rates are very low due to the low infection rates. There has also been a fall in demand for assisted testing now that people are able to order tests by post or pick up from a collection site. For this reason the community asymptomatic testing programme is being reshaped to replace many of the static sites with mobile asymptomatic testing from the end of June onwards. Public Health Dorset will continue to promote regular asymptomatic testing through the summer, as we aim to maintain vigilance for asymptomatic transmission. Regular testing is one way of ensuring we can identify COVID-19 as early as possible and act to break transmission through isolation of contacts and cases.

Priority 4: Local vaccination must continue to be delivered effectively and equitably. The vaccination programme in Dorset is progressing extremely well, with more than 85% of age groups older than 50 years having received their first dose, and around half of 30-39 year olds vaccinated with one dose – the current focus of local efforts. In addition, 75% of those eligible for second doses have now been vaccinated – with a current big push on offering 50-59 year olds their second dose. The biggest challenge over the next few weeks will be ensuring that the coverage remains as equitable as possible. There are currently some differences in uptake emerging when analysed by primary care network – with slightly lower uptake among people living in areas with higher deprivation scores compared with the least deprived areas. Partly this is due to age (more deprived areas are more likely to have a younger population) but even comparing rates in older cohorts, there is still around an 11% difference in the proportion unvaccinated between most and least deprived areas (over 50s and clinically vulnerable). Work is underway via the Health Inequalities Group to support the vaccine delivery group with insights-led communications to overcome some of the barriers to uptake stemming from a lack of confidence in its safety and efficacy. Primary care also continues to plan additional capacity, including pop up clinics for people in areas with poorer uptake.

Forward look, key risks and issues

All of the national modelling is forecasting increases in infection rates as the country progresses through the final stages of the roadmap. The decision on moving to the final stage of opening up is expected on 14 June, to be implemented from 21 June. At this moment, it is difficult to predict how the decision will go as a number of public health advisors are recommending caution because of the increase in cases of Delta variant in parts of

England. The infection rate has also begun to rise in secondary school-aged children at a national level, although there are still relatively few local incidents and outbreaks in local schools. Any local increase in hospital occupancy linked with increasing infection rates is likely to begin to be seen from 1 June onwards, picking up in July. EpiCell will continue to monitor the situation on a weekly basis. The progress with vaccination is the main mitigation measure, and we are on track to meet the national target of vaccinating all eligible groups by the end of July.

The main risks during the summer period will be the risk of importing cases of Delta variant, either linked with international travel, but also as the number of domestic summer visitors rises in the holiday period. Extensive planning supported by use of the Contain Outbreak Management Fund has meant that BCP Council is better prepared to deal with the forecast increase in visitor numbers, with an emphasis on supporting people to enjoy the summer here safely. In addition, BCP Council has developed plans to deploy surge testing should it be needed quickly in response to new variants.

There is also an ongoing risk of fatigue from COVID-19. This is fatigue among the public, who have become less engaged with communications messaging in recent weeks about COVID-19 measures, and are undertaking less asymptomatic testing. And fatigue among public sector workers who have been involved in providing a response for well over a year now. The public health team continues to provide a day response team to handle incidents and outbreaks, as well as out of hours consultant cover. To ensure resilience going forwards, a number of fixed term roles are being advertised to ensure the capacity to continue to respond is in place, funded from the Contain outbreak management fund. Appendix A shows how the fund has been used in the past financial year to support local efforts to control outbreaks and promote COVID-19 resilience.

7. Appendices

Appendix A – Summary of how the Contain outbreak management fund has been used in 2020/21.

8. Background Papers

BCP and Dorset Council COVID-19 Local Outbreak Management Plan (Refresh, March 2021)

Footnote:
Issues relating to financial, legal, environmental, economic and equalities implications have been considered and any information relevant to the decision is included within the report.

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Test and Trace grant, and Contain Outbreak Management fund for Dorset Council

Summary of funding for financial year 2020/21

During the pandemic Government provided funding to Councils under the Contain strategy to support the development and delivery of local outbreak management plans. Plans set out how local government would respond to COVID-19 in their communities, setting out the end to end outbreak management and response. Funding was provided under two Grants – the Test and Trace Grant (TTG) and Contain Outbreak Management Fund (COMF). The table below shows the total amount received for each grant, the total of schemes approved, and the amount spent so far.

	T&T and COMF allocation summary DC 20/21 Year-end			
		£		
	Test and Trace	(1,287,650.00)		
	Contained Outbreak Management Fund 20/21	(8,732,720.00)		
	COMF 2021/22	(2,208,619.00)		
	Total Grant received	**(12,228,989.00)**		
TTG	Test and Trace	617,880.00	Approved	
COMF	Contained Outbreak Management Fund	5,116,597.00	Approved	
	Total approved schemes	**5,734,477.85**		
TTG/COMF	Spend as at 31st March	544,652.02	**Actual**	**31/03/2021**
	Approved remaining to spend	**5,189,825.83**		
	Total grant remaining	**(6,494,512.00)**		

Grant conditions

MHCLG wrote to Councils setting out the grant conditions for use of funds during the financial year 2020-21. These are set out below.

Test & Trace Grant:

The purpose of the grant is to provide support to local authorities in England towards expenditure lawfully incurred or to be incurred in relation to the mitigation against and management of local outbreaks of COVID-19.

COMF Grant:

This was paid on the basis of a per capita amount depending on the severity of local outbreaks, and the time spent under local restrictions during the Tier system. Financial support for Local Authorities at Local COVID Alert Level Medium and High is to fund the following activities:

a. Targeted testing for hard-to-reach groups out of scope of other testing programmes.
b. Additional contact tracing.
c. Enhanced communication and marketing e.g. towards hard-to-reach groups and other localised messaging.

d. Delivery of essentials for those in self-isolation.
e. Targeted interventions for specific sections of the local community and workplaces.
f. Harnessing capacity within local sectors (voluntary, academic, commercial).
g. Extension/introduction of specialist support (behavioural science, bespoke comms).
h. Additional resource for compliance with, and enforcement of, restrictions and guidance
Financial support for Local Authorities at Local COVID Alert Level Very High has a broader scope, to support local economies and public health. We expect this to include activities such as (this list is not exhaustive):
i. Measures to support the continued functioning of commercial areas and their compliance with public health guidance.
j. Funding Military Aid to the Civil Authorities (marginal costs only).
k. Targeted support for school/university outbreaks.
l. Community-based support for those disproportionately impacted such as the BAME population.
m. Support for engagement and analysis of regional areas to assess and learn from local initiatives.
n. Providing initial support, as needed, to vulnerable people classed as Clinically Extremely Vulnerable who are following tier 3 guidance.
o. Support for rough sleepers.

The Department of Health has confirmed in correspondence that Local Authorities are best placed to determine how to use their COMF allocation to meet the needs in their communities, within the guidelines set out above, including how the funding can support a smooth de-escalation in their local area through the roadmap stages. This will ensure that we can continue to progress at the same pace nationally through the steps of exiting lockdown, protecting citizens, our health care systems and the economy.

The specific public health activities that can be funded from the COMF are left to the judgement of LAs in conjunction with their Directors of Public Health.

We have updated the Local Outbreak Management Plan for Dorset, and COMF funding is designed to support delivery of the objectives set out in these plans.

A further payment for this financial year was received in April. Updated guidance and grant conditions for 2021/22 was recently published. The Grant payment is dependent on Councils submitting regular returns for monitoring purposes for the Grant paid during the previous year. In addition, the criteria have been amended slightly to make clear that the purpose of the funding is to support local areas to ensure cases remain low as we progress through the Spring Roadmap.

We have an established and robust process to approve and monitor the schemes, to ensure they meet the criteria and are spent accordingly. This is co-ordinated by the Public Health

team on behalf of the Health Protection Board and overseen by the Director of Public Health. Dorset Council's Internal Audit team are reviewing the process and records and will provide a report in due course.

We submit a monthly monitoring report to DHSC in line with national requirements.

This table shows the schemes approved from the Test and Trace grant

TTG2	Testing resources 1/10/20-30/9/21	72,494.00	22/10/2020
TTG3	Programme Manager	24,466.00	22/10/2020
TTG5	Regulatory services	20,000.00	27/10/2020
TTG7	Trusted Voices engagement leads	10,000.00	22/10/2020
TTG8	Local COVID-19 health protection rota costs	11,500.00	05/11/2020
TTG12	Welfare calls capacity, Revs & Bens	152,770.00	05/11/2020
TTG14	Young people's campaign	15,000.00	05/11/2020
TTG15	On call comms covering weekends for 6 months DC	6,000.00	05/11/2020
TTG16	Comms backfill in Public Health	20,000.00	05/11/2020
TTG17	Bespoke resources for Trusted Voices and other activities	10,000.00	03/12/2020
TTG18	Project management for lateral flow testing (JC)	9,650.00	03/12/2020
TTG19	Various costs for testing cell	1,000.00	03/12/2020
TTG20	Pre Christmas communications	15,000.00	03/12/2020
TTG21	Public Health resources	215,000.00	06/01/2021
TTG22	Drugs and Alcohol support	15,000.00	06/01/2021
TTG24	PHD Day response team	20,000.00	11/02/2021
	Total approved schemes	617,880.00	
	Spend as at 31st March 2021	152,273.74	
	Approved remaining to spend	465,606.26	
	Total grant remaining	669,770.00	

This table shows the schemes approved from the Contain Outbreak Management fund

COMF09	LFD testing for DC key staff	190,000.00	28/01/2021
COMF02	Local Contract Tracing Partnership	220,000.00	05/01/2021
COMF03	Postal mailing to all DC households	92,761.35	05/01/2021
COMF15	Community outreach to support vulnerable young adults	120,000.00	04/02/2021
COMF07	SW BI - A Tapp	17,206.50	28/01/2021
COMF22	Best start in life resources	125,000.00	11/02/2021
COMF10	Age UK	30,000.00	04/02/2021
COMF11	G&T community	20,000.00	04/02/2021
COMF12	Citizens Advice caseworker	10,186.00	04/02/2021
COMF19	Cabs for Jabs DC	13,000.00	11/02/2021
COMF 28	Covid measures for HRCs	240,000.00	11/03/2021
COMF71	Health protection/day response	404,000.00	25/03/2021
COMF72	Data science capability	170,000.00	25/03/2021
COMF77	Enhanced contact tracing	98,000.00	25/03/2021
COMF75	Communications, Trusted voices, behavioural insights	173,000.00	25/03/2021
COMF78	Summer opening	1,930,900.00	25/03/2021
COMF79	Customer services reopening	321,000.00	25/03/2021
COMF80	Community recovery	390,000.00	25/03/2021
COMF81	Education recovery	425,000.00	25/03/2021
COMF82	Employee/provider recovery	10,000.00	25/03/2021
COMF83	Adults social care management database	60,000.00	25/03/2021
COMF84	Adult Access team	56,544.00	06/05/2021
	Total approved schemes	5,116,597.85	
	Spend as at 31st March	392,378.28	
	Approved remaining to spend	4,472,220.00	
	Total grant remaining	5,824,741.00	

Dorset Health and Wellbeing Board
23 June 2021
Update on the Integrated Care System

For Decision

Portfolio Holder: Cllr L Miller, Adult Social Care and Health

Local Councillor(s): All wards

Executive Director: S Crowe, Director of Public Health

Report Author: Sam Crowe
Title: Director of Public Health
Tel: 01305-225891
Email: sam.crowe@dorsetcouncil.gov.uk

Report Status: Public

Recommendation: Board members are asked to support the recommendation to hold a development session in the next two months to consider how the Board will work with the place-based partnership forum of the ICS, and its statutory body.

Reason for Recommendation: Health and Wellbeing Boards are the statutory boards responsible for promoting prevention and integration, as well as being leaders for improving health and wellbeing at a place level. The draft legislation and policy development driving the creation of Integrated Care Systems as legal entities requires both a statutory ICS board, and a place-based partnership board to collaborate to improve health outcomes for Dorset residents. As decisions about the governance and form of the Dorset ICS take shape over the next few months, it is essential the Health and Wellbeing Board has development time set aside to discuss and agree how it will work alongside the new ICS structures, and continue to work for better outcomes for Dorset residents.

1. Executive Summary

The integration of health and social care is a long-standing ambition of Government. National policy direction has been heading firmly in this

direction ever since the requirement for all local health and care systems to publish a Sustainability and Transformation plan, back in 2016. In Dorset, early progress on integrated working enabled the partnership, known as Our Dorset, to be recognised as one of 10 shadow Integrated Care Systems in England, in 2018.

The Government White Paper *'Integration and Innovation: working together to improve Health and Social Care for all'* published on 11 February 2021 now sets out the next stage of proposed legislative reforms, which would see the formation of a statutory Integrated Care System (ICS) including:

- a statutory Health and Care Partnership that brings together a wider group of partners to confirm their shared ambition for the health of their population and develop overarching plans across health, social care and public health;
- a statutory ICS body to lead and oversee planning and delivery of NHS services across the whole system. The ICS body will hold the NHS budget for the system and will maintain the appropriate governance and systems to ensure the proper management and accounting for public money.

This briefing paper for the Dorset Health and Wellbeing Board is intended to provide a summary of the next steps in the development of Integrated Care Systems. However, it is also intended to highlight some important proposed policy developments, including the formation of the statutory Health and Care Partnership, as outlined above. This is because within the current Dorset system, two Health and Wellbeing Boards already exist as statutory boards, responsible for the promotion of prevention and integration at a place-based level.

The proposal to create a new, statutory partnership for the ICS, with an agreed health care and public health plan, will require Health and Wellbeing Boards to consider how they will work with the partnership to ensure their leadership role in improving health and wellbeing for local residents continues to be recognised, with an agreed focus on the right outcomes for Dorset residents reflected in the ICS partnership plan.

The Health and Wellbeing Board should also consider how it will continue to influence the ICS going forwards including through the statutory ICS body. For example, when the Sustainability and Transformation Plan was developed, the Health and Wellbeing Board led the development of the

Prevention at Scale portfolio within the shadow ICS. Building on this strong progress with the Prevention at Scale work is a prerequisite for a successful statutory Integrated Care System and place-based partnership approach.

2. Financial Implications

No direct financial implications arising from this paper, or recommendation. However, having a strong and successful Integrated Care System will ensure consideration of how the Dorset pound is best used to achieve improved outcomes for residents. Decisions about how the NHS locally uses its recurrent revenue will have implications for Dorset Council services, not least where joint commissioning or integrated services are expected to develop going forwards.

3. Climate implications

No direct implications arising from this decision. However, all ICS organisations should be challenged as to how they will work together at a local level to achieve targets around net carbon zero, see https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/. Dorset Council has also declared a Climate and Ecological Emergency, with a developing strategy, while other Board members will also contribute to the local public sector efforts to become sustainable. Working together through a strong ICS is one way of sharing expertise and challenging one another to go further, faster.

4. Other Implications

There are several other implications arising from having a strong ICS partnership going forwards, including improving public health and children's outcomes, safeguarding, efficient use of estates and assets.

5. Risk Assessment

There is a medium risk that failure to properly agree how the Health and Wellbeing Board will work alongside the statutory Integrated Care System risks confusing strategic priorities at place level, and not making the most of a strong place-based partnership approach to improve outcomes and tackle inequalities in health.

Having considered the risks associated with this decision, the level of risk has been identified as:
Current Risk: Medium
Residual Risk: Low

6. Equalities Impact Assessment

No equalities impact assessment has been carried out at this stage, as the development of the ICS is in progress, and an EIA will be done on any proposed changes for the system. However, having the Health and Wellbeing Board well place to play a key role in the partnership board will ensure that equalities considerations are actively considered, as part of the Board's remit to improve health outcomes and tackle inequalities in health.

7. Appendices

Appendix A: ICS next steps paper – a report setting out the current requirements for becoming a legal entity by April 2022, developed for all local health and care organisations. 17 May 2021, Dorset CCG.

8. Background Papers

Footnote:
Issues relating to financial, legal, environmental, economic and equalities implications have been considered and any information relevant to the decision is included within the report.

INTEGRATING CARE - NEXT STEPS

17 May 2021

Purpose of report	The purpose of the report is to summarise the key proposals and legislative changes and next steps in response to NHS England and Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care system across England.*
Recommendation	The paper is to Note only.
Author	R. Kendall, Head of Planning and Assurance Dorset CCG

1. Introduction

1.1 The Governments White Paper *'Integration and Innovation: working together to improve Health and Social Care for all'* published on 11 February 2021 setting out the proposed reforms which would see the formation of a statutory Integrated Care System (ICS) including:

- a statutory Health and Care Partnership that would bring together a wider group of partners to confirm their shared ambition for the health of their population and develop overarching plans across health, social care and public health
- a statutory ICS body to lead and oversee planning and delivery of NHS services across the whole system. The body will hold the NHS budget for the system and will maintain the appropriate governance and systems to ensure the proper management and accounting for public money.

1.3 The purpose of this paper is to:

- provide an overview of the ICS
- summarise the key proposals and legislative changes
- set out what does this mean for Dorset
- next steps.

2. Report

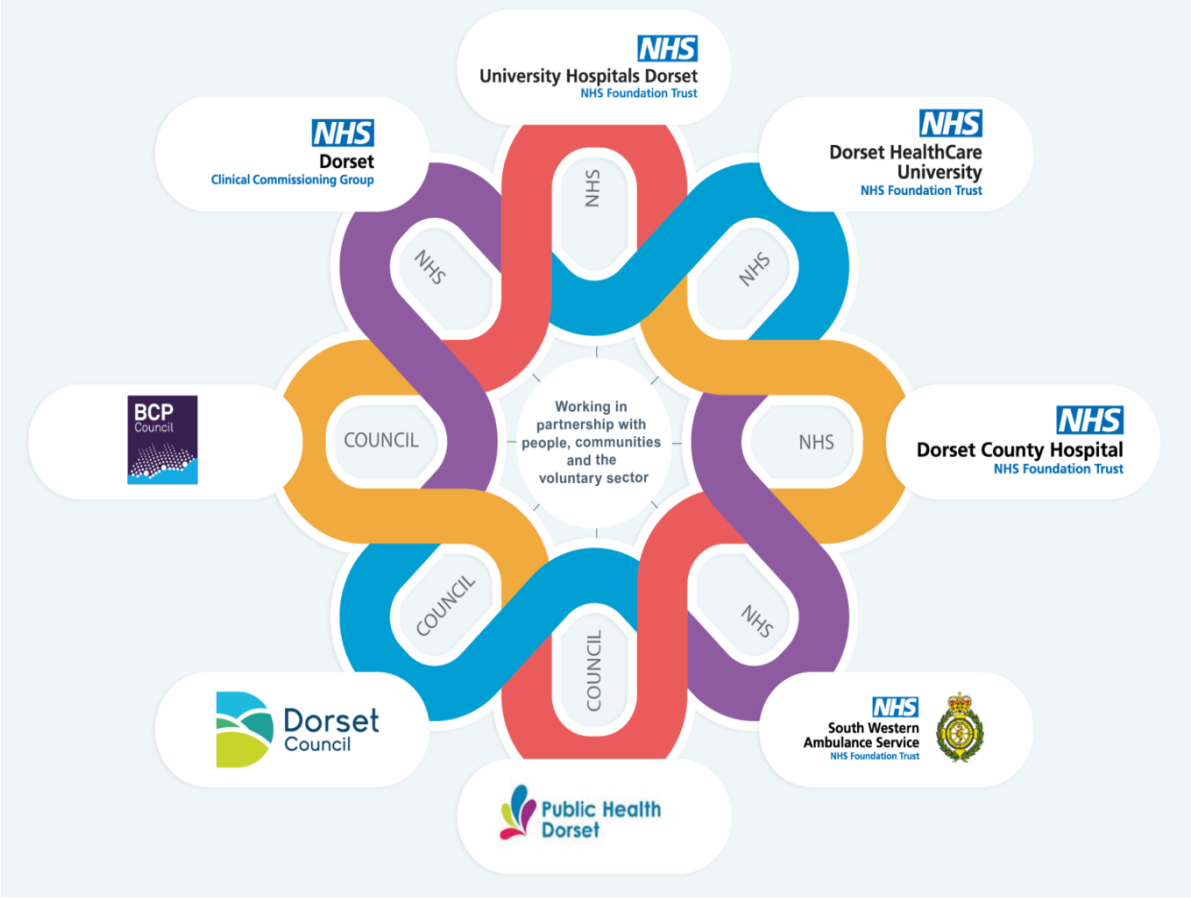
Integrated Care Systems (ICS) Overview

2.1 Integrated care systems are partnerships of providers and commissioners of NHS and social care services who work together across a geographical area to plan and integrate care to:

- improve outcomes
- tackle inequalities
- enhance productivity
- support broader social and economic development.

2.2 Dorset has been an Integrated Care System in since 2018. Our eight partner organisations work together as anchor institutions to address our health, wellbeing, quality and financial challenges in line with the national vision.

Fig 1: Dorset ICS Partners



Summary of key proposals and legislative changes

2.1 The proposals set out the ambition for how all parts of the health and care system can work together as ICSs, involving

- stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale;
- developing strategic commissioning through systems with a focus on population health outcomes;
- using digital and data to drive system working, connect health and care providers, improve outcomes and putting the citizen at the heart of their one care

2.2 As described in paragraph 1.1, the legislative changes will see a statutory corporate NHS Body that brings the CCG statutory functions into the ICS, therefore:

- CCGs will be abolished and replaced with:
    - **ICS NHS Body** - Integrated Care Board (ICB), consist of representatives from NHS Providers, primary care and local government, alongside a Chair, a Chief Executive. The ICS will be able to appoint any other members as it deems appropriate.

      Responsible for developing a plan to meet population health needs; capital plan for NHS providers; and securing provision of health services. They have no power to direct NHS providers.
    - **ICS Health and Care Partnership Body** - Integrated Partnership Board, consist of representatives from the ICB, local government, Health and Wellbeing Boards, Public Health, voluntary, third and independent sectors.

      Responsible for developing a plan that addresses wider health, public health and social care needs of the system

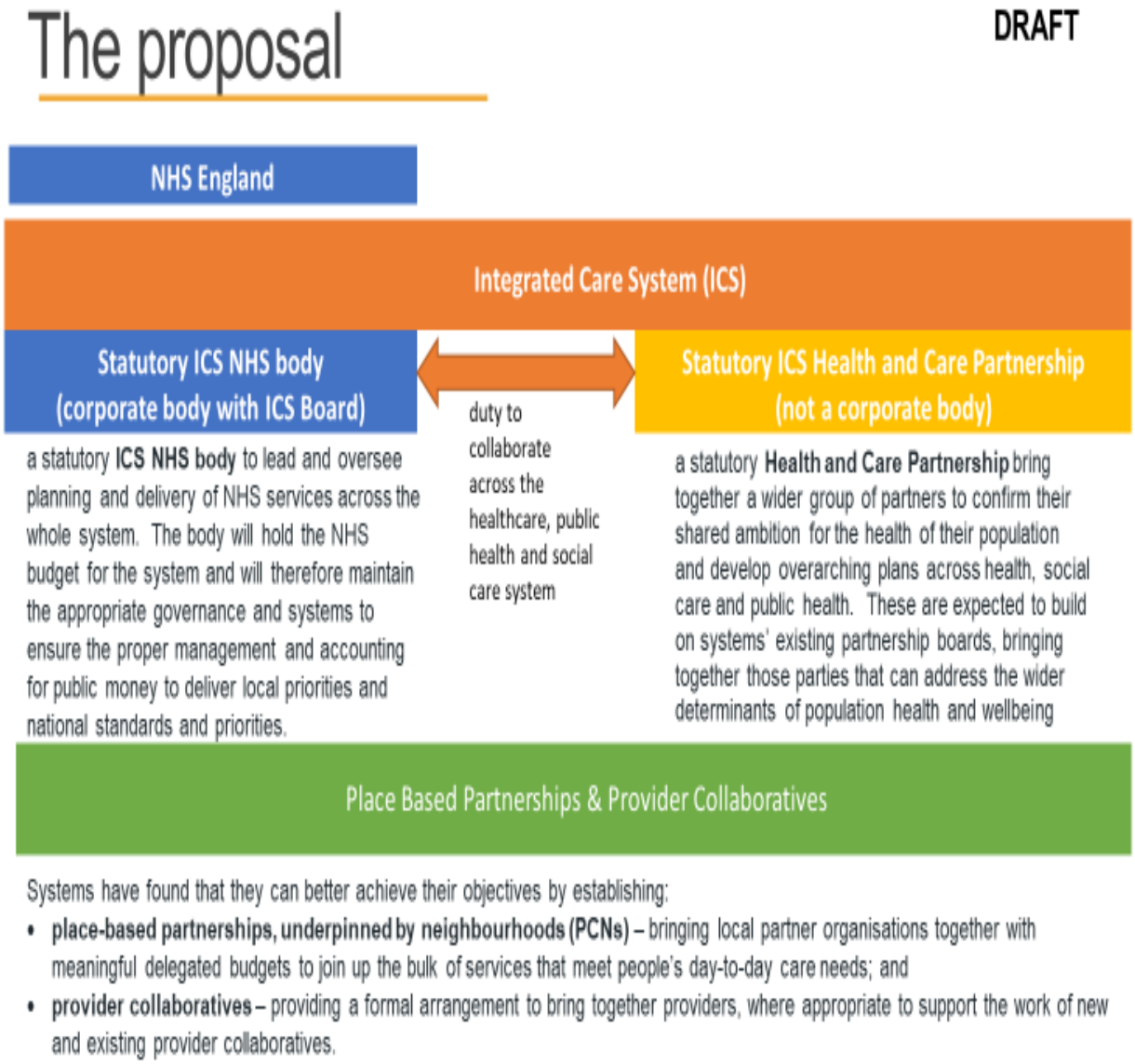
To support systems to better achieved their objectives, they should establish:

- Place Based Partnerships who will be responsible for services to meet the day to day care needs of their population for example:
    - Staying well and preventative services
    - Integrated care and treatment
    - Digital services (non-digital alternative)
    - Proactive support to keep people as well as possible where they are vulnerable or at high risk
- Provider Collaboratives- providing a formal arrangement to bring together providers to maximise the delivery of services at scale, where appropriate

2.3 There will be a number of new duties and powers aimed to remove barriers to integration across health organisations and with social care and foster collaboration as follows:

- **Duty to collaborate**- promote collaboration across healthcare, public health and social care system
- **Triple Aim** - shared duty that requires NHS organisations that plan services across a system and nationally, as well as NHS Trusts and FTs, to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources
- **Power over Foundation Trusts Capital Spend Limits** – NHS England reserve power to set a capital spending limit on Foundation Trusts, moving away from each organisation making decisions in its own interests, supporting the collaborative approach
- **Data Sharing**- health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
- **Patient Choice**- repeal s.75 HSCA and introduce a new NHS Provider Selection Regime for clinical services. Enable patients to choose provider from a list for specific clinical services

Fig 2: National ICS proposed structure

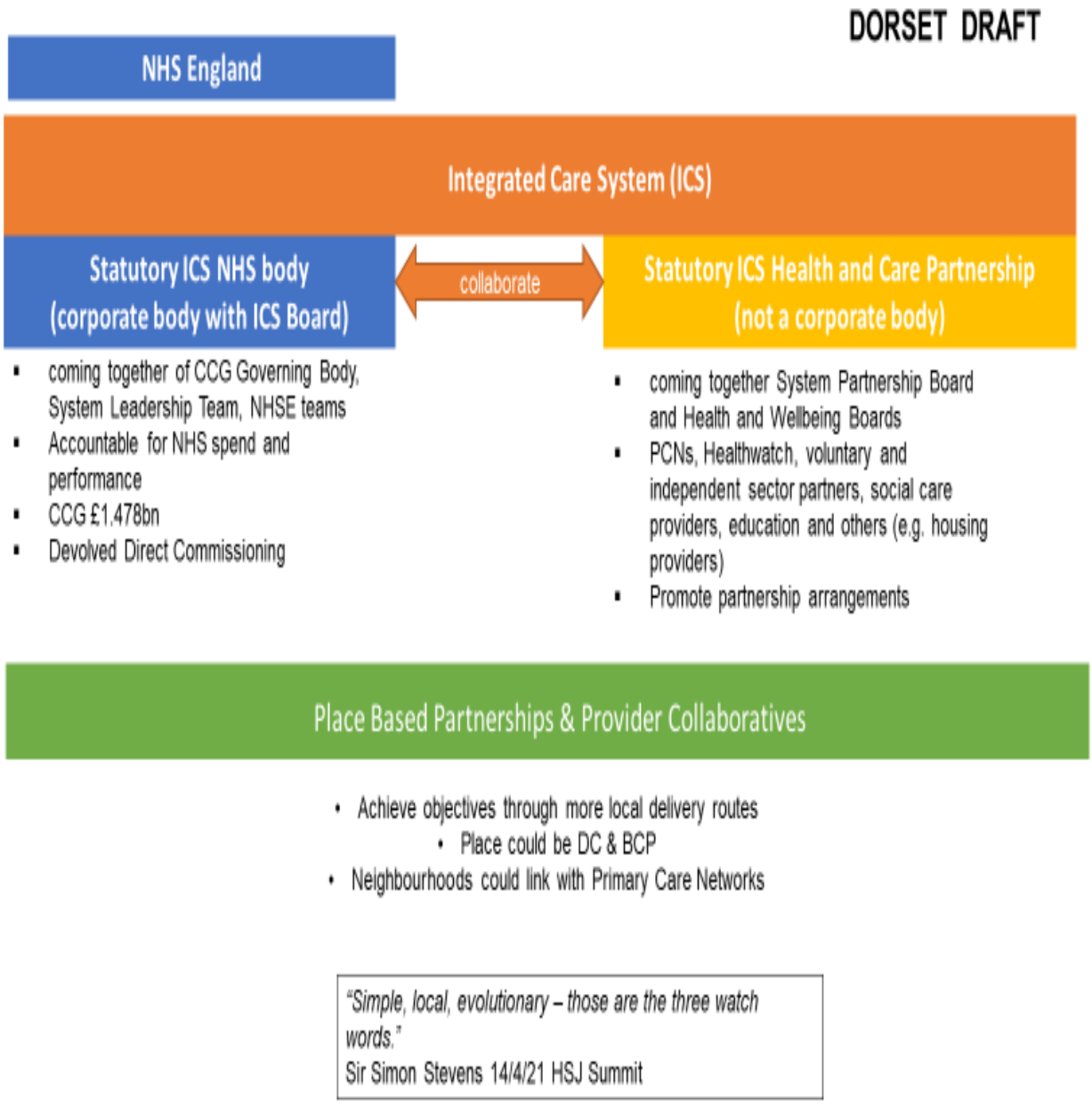


2.4 In Dorset we have we have many of the building blocks in place, the table in **Appendix 1** sets out eight main areas of change which will need to be in place by April 2022 and our current position in Dorset.

What does this mean for Dorset?

2.5 The proposal will see many changes as to how we work across the system, further integrating, collective responsibility for the health outcomes for the people of Dorset.

Fig 3: A possible Dorset ICS structure based on the current national guidance



> *"Simple, local, evolutionary – those are the three watch words."*
> Sir Simon Stevens 14/4/21 HSJ Summit

Key benefits could include:

Benefits for Communities	Benefits for the System
• Consistent advice and proactive support to help people stay well, particularly those who are at higher risk • Joined up care and treatment when needed • Digital services that put people at the heart of their own care • Support social and economic development through employment, training, procurement and volunteering activities	• Collective responsibility for managing resources, delivering care and improving the health of our population • More control over how local services are delivered • Freedom and flexibility to do things that benefit everyone in Dorset • Shared digital developments and data to drive better system working

The next steps for Dorset

2.6 Dorset ICS has well established ICS Engagement and Communications Leads networks – with representatives from across all partner organisations. As we move to the new ICS, our engagement and communications team will continue to work closely together, responding to opportunities in an agile way, working in line with Statutory Duties to Collaborate and Involve. The priority areas are as follows:

- Engagement and Communications to inform how the ICS will work in partnership with people and communities in the future.
- Engagement and Communications to support and inform the ICS development workstreams, reflecting what is nationally mandated and what is for local determination.
- Strengthening the existing "Dorset Story", setting out the Dorset ICS narrative and what we are collectively here to achieve and sign up to as a member of the 'system' (**see Appendix 2**).
- Dorset wide engagement and communications/overall ICS engagement and communications approach and mechanisms to support the above.

2.7 We have a number of key next steps and actions to take as follows:

By end Q1	• Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements.
By end Q2	• Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI). Confirm proposed governance arrangements for health and care partnership and NHS ICS body.
By end Q3	• Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles.
By end Q4	• Confirm designate appointments to any remaining senior ICS roles. • Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies. • Submit ICS NHS body Constitution for approval and agree "MOU" with NHS England and NHS Improvement
1 April 2022	• Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.

3. Conclusion

3.1 Members are asked to note the report and next steps set out in paragraph 2.7.

Author's name and Title: **R. Kendall, Head of Planning and Assurance**

Date : **17 May 2021**

APPENDICES	
Appendix 1	**Eight Main areas of Change and Dorset Position**
Appendix 2	**Dorset ICS Narrative Presentation**

Appendix 1

Eight Main areas of Change and Dorset Position

Theme	Requirements	Current Position in Dorset
Provider Collaboratives	All NHS providers to be part of a provider collaborative either within or between places at ICS level – or pan-ICS level for providers working in smaller systems.	Two approaches to provider collaboratives: 1) NHS Led Provider Collaboratives e.g. Dorset HealthCare NHS Foundation Trust is working with strategic partners across the SW region and IOW to become lead provider an eating disorder provider collaboratives and Young Persons MH services in Dorset have become members of the CAMHS provider collaborative model. 2) Clinical Programmes – examples include programmes include Cancer Network, Renal Services, Urgent and Emergency Care Board, Elective Care Board, Maternity
Place-based partnerships	Place Based Model' focuses on improving the health and wellbeing through providing access to preventative services, advice on staying well, integrated care, self-care support. It focusses on supporting Primary Care Networks, other health, social care and the voluntary community service using a population health manage approach to improve the outcomes in health wellbeing and independence of local people	Our 'Place Based Partnership' model is based on the geographical boundaries of our two Local Authorities - Dorset Council and Bournemouth, Christchurch and Poole Council. We have in place: • 18 established Primary Care Networks, all of whom have Clinical Directors and appropriate leadership • Joint commissioning arrangement are in place with both local authorities as well as for placements such as home first.

		• Our both Health and Wellbeing Boards have representation from across the system and focus on priorities within the geography •
Clinical and professional leadership	Embed system wide clinical and professional leadership through partnership board and other governance arrangements, including primary care network representation, specialist clinical leadership and wider professional such as nursing, social care	We have a strong history of system wide clinical involvement and collaboration and supporting ongoing leadership. We have in place: • Clinical voice within our governance from System Leadership Team to our oversight and assurance groups such as Clinical Reference Group, Quality Surveillance Group, People Board • Clinicians from across all sectors supporting our Dorset programmes • Primary Care represented within our System Leadership Team
Governance and accountability	• Place leadership arrangements, which includes joint decision-making with local government, with Director of Public Health, providers of community and mental health services, primary care leadership and HealthWatch representation on ICS Board • Provider collaborative leadership arrangements, including joint decision-making arrangements across providers and appropriate representation on ICS Boards	• Formally appointed ICS Independent Chair and Leader • System Partnership Board (Chairs and CE from across the system), with an Independent Chair • System Leadership Team- Executives across the system representing provider trusts, primary care, local authority • Assurance and oversight groups (OFRG, CRG, QSG, DWAB)- representation across they system

	• Individual organisational accountability for their current range of formal and statutory responsibilities and relationship between the organisation and system at place and provider collaborative	• System wide programmes such as Urgent and Emergency Care, Elective Care
Financial framework	• ICS to manage a 'Single Pot' bringing together the CCG commissioning, primary care budgets and majority of specialist commissioning spend and sustainability and transformation funding • ICS Leaders to have allocation decisions and duties - working with provider collaboratives to distribute in line with national rules for mental health/community and primary care, as well as local priorities • Blended payment model for secondary care services • Each ICSs to agree how financial risk will be managed across places and between provider collaboratives. • New powers will make it easier to form joint budgets with the local authority, including for public health functions.	• Financial strategy development underway, including the agreement of an ICS financial vision and risk appetite. • Whole system revenue prioritisation process (transparency of risk within the system) and learning taken from this. Ensures system agreement, alignment and overview of increases to cost base. • Supported strategic revenue investment decisions particularly linked to workforce pipeline for RNDA and digital over the medium term. • Collective understanding of the underlying financial position as we exit covid financial regime. • Compliant CDEL capital plan for 2021/22 and H1 2021/22 revenue plan
Data and digital	• Build smart digital and data foundations- including Board accountability and digital transformation plan, digital and data literacy and invest in infrastructure • Connect health and care services- shared care records, tools to allow collaborative working e.g. shared booking	• Board level leadership and accountability in place for digital and data • developed Dorset Intelligence & Insight Service (DiiS), range of dashboard and tools to support patient care and commissioning

	and referral management, follow nationally defined standards • Use digital and data to transform care- technology to drive pathways, cross system intelligence and analytical functions • Put citizen at centre of their care- citizen digital channels, remote monitoring.	• early implementer and received national recognition for our PHM approach • deployed the Our Digital Dorset App Library empowering self care • Dorset Care Record , Wessex Care Record (one of the first Local Health and Care Records (LHCR)) in place • Supported remote working through Covid through the deployment of laptops and Teams • Created robotic automation reporting for the testing and vaccination of our workforce and patients • Draft 'Our Digital Dorset Strategy' setting out our ambition and recommends several development priorities
Regulation and oversight	• ICSs greater role in regulation and oversight • System oversight framework (national) • Intensive Recovery Support Programme for those system facing greatest quality/ or financial challenges • 'Integration index' to support greater adoption of system and place level performance and outcomes measure to be develop by each ICS	• Programme boards • Oversight and assurance group e.g. operations and finance reference group • Executive oversight through System Leadership Team • Memorandum of Understanding with NHS England and Improvement • NHSEI are members of our SLT, Dorset programmes
How commissioning will change	• Strategic commissioning will take place at ICS level, including assessing population health needs and prioritising how to address them, modelling capacity and	• Population Health Management already rolling out across Dorset. • Joint Commissioning Board in place for some areas between CCG and LAs.

	demand, and tackling health inequalities • Other commissioning activities will move to provider organisations/collaboratives/place-based partnerships, including service transformation and pathway redesign • Greater focus on population health and outcomes in contracts and collective system ownership of financial envelope – shift from transactional contracting and managing performance	• Co-design and productions already in place in some areas.

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Health & Wellbeing Board
23rd June 2021
Hospital Discharge Programme

For Decision

Portfolio Holder: Cllr L Miller, Adult Social Care and Health

Local Councillor(s): All

Executive Director: V Broadhurst, Interim Executive Director of People - Adults

Report Author: Lesley Hutchinson
Title: Corporate Director for Adults Commissioning
Tel: 01305 224680
Email: lesley.hutchinson@dorsetcouncil.gov.uk

Report Status: Public

Recommendation:
The Portfolio Holder for Adult Care and Health is given delegated authority in consultation with the Chair and Vice-Chair of the Health and Well-being Board (and following Council and CCG governance processes) to agree Dorset Integrated Care System funding for the Hospital Discharge Programme for the period April to September 2021 if needed in advance of a report coming to the Board in October 2021.

Reason for Recommendation:
National funding has been made available to support the Hospital Discharge Programme during 2020/21 and has been extended (albeit with revised criteria) for the period April to September 2021. Recently issued national guidance regarding this funding has requested that Health and Well-Being Boards should be involved in making decisions on local budgets for this programme.
Note the BCP Health and Well-Being Board are considering a request for the same delegated authority.

1. Executive Summary

The Portfolio Holder for Adult Care and Health is given delegated authority in consultation with the Chair and Vice-Chair of the Health and Well-being Board (and following Council and CCG governance processes) to agree Dorset Integrated Care System funding for the Hospital Discharge Programme for the period April to September 2021 if needed in advance of a report coming to the Board in October 2021.

These decisions will be taken in conjunction with the BCP Health and Well-Being Board.

Council lead officers will set out the relevant issues alongside CCG and BCP. Council and CCG governance processes will be followed ensuring correct sign off arrangements have been completed.
A full report will be provided to the Health and Well-Being Board on the HDP funding at its meeting in October 2021.

2. Financial Implications

The financial situation in relation to the Hospital Discharge Programme from its inception to current day will be shared in the report for the Health and Well-Being Board in October 2021. There have been changes to eligibility for the funding during the period and a cap (£8.4 million) has been introduced for the current spend which the local authorities and CCG will continue to work through identifying the risks associated with this and how to mitigate these.

The local authority and the CCG continue to review the government guidance.

3. Climate implications

All partner agencies are mindful in their strategic and operational planning of the commitments, which they have taken on to address the impact of climate change.

4. Other Implications

The Hospital Discharge Programme requires NHS organisations and local authorities to provide access to safe and timely discharge seven days per week. This has led to the requirement across agencies to have suitably qualified and experienced staff available at weekends and for evening working.

It is important that people receive care and support in the most appropriate setting. This includes ensuring that people are provided with quality community treatment, care and support services so that they are not admitted to hospital when this could be avoided and also ensuring that people are discharged from hospital safely and with access to services which will support their continued recovery, at the earliest possible opportunity when they are medically fit to leave hospital.

5. Risk Assessment

The Hospital Discharge Programme was initiated in March 2020 to ensure that NHS, particularly hospital services, were able to respond to the very high demand for care and particularly hospital admissions which arose as a consequence of the COVID19 pandemic. It continues to be essential that NHS, Council, the social care sector and the voluntary sector work together to support people to receive quality, safe and care in the right setting. Pressures continue in terms of demands for NHS services, including hospital services.

Having considered the risks associated with this decision, the level of risk has been identified as:
Current Risk:
Residual Risk:

6. Equalities Impact Assessment

It is important that all partners ensure that the individual needs and rights of every person receiving treatment, care and support are respected, including people with protected characteristics so the requirements of the Equalities Act 2010 are met by all partners.

7. Appendices

N/A

8. Background Papers

N/A

Background

1. At the start of the covid-19 pandemic, a national fund was provided to support the rapid discharge of patients from hospital settings as soon as it was clinically safe to do so.

2. Initially the costs of care for all discharged patients, from the time of discharge to the point of completing assessments of care requirements, were eligible to be reimbursed. This was scheme 1 and was in place from mid-March to the start of September 2020.

3. From September 2020 until the end of March 2021, the eligibility rules changed and only the additional costs of care, for up to the first six weeks following discharge, were eligible for reimbursement. This was extended until June 2021.

4. From 1st July to end of September 2021, the eligibility rules have remained the same however the length of time has reduced from six weeks to four weeks following discharge, are eligible for reimbursement.

5. The Association of the Directors of Adult Social Services (ADASS) will be distributing a Frequently Asked Questions document related to Scheme 3 of the HDP but this is not yet available. It is anticipated that this further guidance will aid local decision-making.

6. The funding for the schemes has been managed via amendments to existing Better Care Fund Section 75 Agreements between the local authorities and the CCG, as recommended in the guidance. Details of this will be provided in the October report. Paragraph 3.4 of the guidance states that an ICS should undertake joint budget

Health and Well-Being Board Requirement

7. For clarity the requirement for the Health and Well-Being Board is set out below:

CCGs and local authorities should ensure they undertake joint planning at health and wellbeing board (HWB) level, in line with the wider funding allocation for the ICS footprint to ensure equitable distribution. This should include agreeing budgets at the HWB level where possible, as well as operational planning. ICSs will need to manage their budgets for hospital discharge to support planning at this level. Should there be concerns about the ICS allocation of funding to a HWB level, including that the funding may be exceeded, decision making to address the situation should involve both health and social care partners.