The pack was amended post-meeting on 22/09/2023, with a revised ICB Chief Executive's Report inserted into the pack at page 19.

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

BSW Integrated Care Board – Board Meeting in Public

Thursday 21 September 2023, 10:00hrs

Function Room, Wyvern Theatre, Theatre Square, Swindon, SN1 1QN

Agenda

Timing	No	Item title	Lead	Action	Paper ref.
Opening Business					
10:00	1	Welcome and apologies	Chair	Note	Verbal
	2	Declarations of Interests	Chair	Note	Verbal
	3	Minutes from the ICB Board Meeting held in Public on 13 July 2023	Chair	Approve	ICBB/23-24/048
	4	Action Tracker and Matters Arising	Chair	Note	ICBB/23-24/049
10:05	5	Questions from the public *Pre-submitted questions and answers*	Chair	Note	Verbal
10:10	6	BSW ICB Chair's Report	Chair	Note	Verbal
10:15	7	BSW ICB Chief Executive's Report	Sue Harriman	Note	ICBB/23-24/050
10:25	8	Annual Report and Accounts 2022-23: a. BSW CCG 3-Month Annual Report and Accounts 2022-23 b. BSW ICB 9-Month Annual Report and Accounts 2022-23	Sue Harriman, Gary Heneage, Rachael Backler	Note	ICBB/23-24/051
STRATEGIC OBJECTIVE ONE: Focus on prevention and early intervention					
10:35	9	BSW Primary and Community Care Delivery Plan	Fiona Slevin-Brown	Approve	ICBB/23-24/052
STRATEGIC OBJECTIVE TWO: Fairer health and wellbeing outcomes					
10:50	10	NHS Equality, Diversity and Inclusion Improvement Plan	Jas Sohal	Approve	ICBB/23-24/053

Timing	No	Item title	Lead	Action	Paper ref.
STRATEGIC OBJECTIVE THREE: Excellent health and care services					
11:05	11	BSW Winter Plan	Gill May, Heather Cooper	Note	ICBB/23-24/054
11:20	12	BSW Elective Care Delivery Plan	Cara Charles-Barks, Paul Doyle	Note	ICBB/23-24/055
11:35 – Short break – 5 mins					
11:40	13	Review of Reading the Signals Maternity Report	Gill May, Sandra Richards	Note	ICBB/23-24/056
11:55	14	999 Lead Commissioner Arrangements – SWASFT Ambulances	Gill May	Approve	ICBB/23-24/057
Items for Assurance					
12:00	15	BSW Operational Performance and Quality Report	Rachael Backler, Gill May	Note	ICBB/23-24/058
12:10	16	BSW ICB and NHS ICS Revenue Position	Gary Heneage	Note	ICBB/23-24/059
12:20	17	Report from ICB Board Committees	Committee Chairs	Note	ICBB/23-24/060
Closing Business					
12:25	18	Any other business and closing comments	Chair	Note	

Next ICB Board Meeting in Public: 16 November 2023

Glossary of Terms and Acronyms

Acronym /abbreviation	Term	Definition
ALOS	Average Length of Stay	An average of the length of time a patient stays in a hospital when admitted. May be averaged for all patients or those with specific medical or social conditions. ALOS has national and local planning implications.
	Ambulatory Care	Rapid access, immediate and urgent care where the patient can walk into a centre and be seen or be directly referred by a doctor, nurse or therapist to avoid the need to admit a patient.
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust	Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a significant provider of mental health services across a core catchment area covering Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. The Trust also provides specialist services for a wider catchment extending throughout the south west. http://www.awp.nhs.uk/
BSW	Bath and North East Somerset (BaNES), Swindon and Wiltshire	The area covered by the BSW Integrated Care System (ICS) and Integrated Care Board (ICB).
CAMHS	Child and Adolescent Mental Health Services	CAMHS are specialist NHS services. They offer assessment and treatment for children and young people who have emotional, behavioural or mental health difficulties.
CCG	Clinical Commissioning Group	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
CHC	Continuing Healthcare	NHS Continuing Healthcare is free care outside of hospital that is arranged and funded by the NHS. It is only available for people who need ongoing healthcare. NHS Continuing Healthcare is sometimes called fully funded NHS care.

Acronym /abbreviation	Term	Definition
	Commissioning	Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a cycle of work from understanding the needs of a population, and identifying gaps or weaknesses in current provision, to procuring services to meet those needs.
CIP	Cost Improvement Programme	NHS organisations use CIPs to deliver and plan the savings they intend to make. Encompassing efficiency and transformation programmes.
D2A	Discharge to Assess	Funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. They can then be assessed for their longer-term needs in the right place.
DES	Directed Enhanced Service	Additional services that GPs can choose to provide to their patients that are financially incentivised by NHS England.
DTOC	Delayed Transfer of Care	Experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.
ED	Emergency Department	An accident and emergency department (also known as emergency department or casualty) deals with life-threatening emergencies, such as loss of consciousness, acute confused state, fits that are not stopping, persistent and severe chest pain, breathing difficulties, severe bleeding that can't be stopped, severe allergic reactions, severe burns or scalds. https://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx
	Elective Care	Elective care is pre-arranged, non-emergency care which includes scheduled operations. It is provided by medical specialists in a hospital or another care setting.
EFR	Exceptional Funding Request	An Exceptional Funding Request (EFR) is the route by which A health professional can apply on a patient's behalf for treatments, drugs and devices (collectively referred to as interventions) that are not routinely funded by a CCG.
FOT	Forecast Outturn	The total projected balance remaining at the end of the financial year.

Acronym /abbreviation	Term	Definition
HWB	Health and Wellbeing Board	The Health and Social Care Act 2012 established Health and Wellbeing Boards as forums where leaders from the NHS and local government can work together to improve the health and wellbeing of their local population and reduce health inequalities.
H2/HIP2	Health Infrastructure Plan	A rolling five-year programme announced in October 2019 of investment in health infrastructure, encompassing: capital to build new hospitals, modernise primary care estates and invest in new diagnostics and technology.
ICA	Integrated Care Alliance	Integrated Care Alliances (ICAs) involve commissioners, providers and other organisations working together to improve health and care for residents' in one locality, often co-terminous with local authority boundaries, working across organisational boundaries by choosing to focus on areas which are challenging for all partners and agreeing a picture of future population needs. In BSW, there will be three ICAs – Bath and North East Somerset, Swindon and Wiltshire.
ICB	Integrated Care Board	Each Integrated Care System (ICS) will have an Integrated Care Board (ICB), a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. When ICBs were legally established, clinical commissioning groups (CCGs) were abolished.
ICP	Integrated Care Partnership	The Integrated Care Partnership (ICP) is a statutory committee formed by the Bath and North East Somerset Integrated Care Board (BSW ICB), and local authorities in the BSW area. The BSW ICP brings together the NHS, local government, the voluntary, community and social enterprise (VCSE) sector and other partners to focus on prevention, wider social and economic factors affecting people's health and reducing health inequalities.
ICS	Integrated Care System	An Integrated Care System (ICS) is a way of working across health and care organisations that allows them to work closer together to take collective responsibility for managing resources, delivering care and improving the health and wellbeing of the population they serve. ICSs integrate primary and specialist care, physical and mental health services and health and social care
IG	Information Governance	Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations.

Acronym /abbreviation	Term	Definition
	Integrated Care	A concept that brings together the delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion, in order to improve services in terms of access, quality, user satisfaction and efficiency.
JSNA	Joint Strategic Needs Assessment	A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
KPIs	Key Performance Indicators	These are set out in contracts with providers and help to monitor performance. Examples of KPIs include length of stay in hospital for a particular treatment or how satisfied patients are with the care they receive.
LA	Local Authority	Local authorities are democratically elected bodies with responsibility for a range of functions as set out in government legislation. They have a duty to promote the economic, social and environmental wellbeing of their geographical area. This is done individually and in partnership with other agencies, by commissioning and providing a wide range of local services.
LES	Local Enhanced Service	Local scheme of additional services provided by GPs in response to local needs and priorities, sometimes adopting national NHS service specifications.
LMC	Local Medical Committee	LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. They interact and work with – and through – the General Practitioners Committee as well as other branches of practice committees and local specialist medical committees in various ways, including conferences.
LOS	Length of Stay	The time a patient will spend in hospital.
LPC	Local Pharmaceutical Committee	Local Pharmaceutical Committees (LPCs) represent all NHS pharmacy contractors in a defined locality. LPCs are recognised by local NHS Primary Care Organisations and are consulted on local matters affecting pharmacy contractors. In Swindon and Wiltshire, this is known as Community Pharmacy Swindon and Wiltshire. https://psnc.org.uk/swindon-and-wiltshire-lpc/
MASH	Multi Agency Safeguarding Hubs	Bringing key professionals together to facilitate early, better quality information sharing, analysis and decision-making, to safeguard vulnerable children and young people more effectively.

Acronym /abbreviation	Term	Definition
MDT	Multi-Disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. psychiatrists, social workers, etc.), each providing specific services to the patient.
	Non-elective care	Non-elective care is admitted patient care activity which takes place in a hospital setting where the admission was as an emergency.
OD	Organisational Development	Organisational development is a planned, systematic approach to improving organisational effectiveness and one that aligns strategy, people and processes. To achieve the desired goals of high performance and competitive advantage, organisations are often in the midst of significant change.
OPEL	Operational Pressures Escalation Levels	Framework system implemented by NHSE to provide a consistent approach in times of pressure.
	Primary Care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.
PCN	Primary Care Network	Primary care networks were introduced in January 2019 to encourage local GP practices to link up with other neighbouring practices to deliver care to groups of between 30,000 – 50,000 patients.
QIPP	Quality, Innovation, Productivity and Prevention	Quality, Innovation, Productivity and Prevention is a large scale programme introduced across the NHS to improve the quality of care the NHS delivers, whilst making efficiency savings to reinvest into frontline care.
QOF	Quality and Outcomes Frameworks	The quality and outcomes framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of quality care and helps to fund further improvements in the delivery of clinical care.
RTT	Referral to treatment	NHS England collects and publishes monthly referral to treatment (RTT) data, which are used to monitor NHS waiting times performance against the standards set out in the National Health Service Commissioning Board and Clinical Commissioning Groups
	Scheme of Financial Delegation	This Scheme of Financial Delegation contains both an overview of the Delegated Financial Limits (DFLs) and detail to support day-to-day operational decision making. It should be read in conjunction with the Standing Financial Instructions (SFIs) and the Scheme of Reservations and Delegations (SoRD) which

Acronym /abbreviation	Term	Definition
		sets out what decision-making authorities are reserved for the ICB Board or delegated to committees and individuals.
SoRD	Scheme of Reservations and Delegations	The SoRD sets out those decisions that are reserved to the ICB Board, and those decisions that the Board has delegated to committees, sub-committees, individuals, relevant bodies, incl. functions and decisions in accordance with section 65Z5 of the 2006 Act, or a local authority under section 75 of the 2006 Act committees.
	Secondary Care	Secondary care is the services provided by medical specialists, quite often at a community health centre or a main hospital. These services are provided by specialists following a referral from a GP, for example, cardiologists, urologists and dermatologists.
SFI	Standing Financial Instructions	The SFIs are part of the ICB's control environment for managing the organisation's financial affairs, as they are designed to ensure regularity and propriety of financial transactions. SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB.
YTD	Year to Date	A term covering the period between the beginning of the year and the present. It can apply to either calendar or financial years.

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

DRAFT Minutes of the BSW Integrated Care Board - Board Meeting in Public

Thursday 13 July 2023, 10:00hrs

Banqueting Room, Bath Guildhall, High Street, Bath BA1 5AW

Members present:
Integrated Care Board (ICB) Chair, Stephanie Elsy (SE)
ICB Chief Executive, Sue Harriman (SH)
Primary Care Partner Member, Dr Francis Campbell (FC)
Local Authority Partner Member – BaNES, Will Godfrey (WG)
ICB Chief Finance Officer, Gary Heneage (GH)
Local Authority Partner Member – Wiltshire, Terence Herbert (TH)
NHS Trusts and NHS Foundation Trusts Partner Member – acute sector, Stacey Hunter (SHu)
Local Authority Partner Member – Swindon, Susie Kemp (SK)
Non-Executive Director for Public & Community Engagement, Julian Kirby (JK)
ICB Chief Nurse, Gill May (GM)
Non-Executive Director for Quality, Professor Rory Shaw (RS)
Deputy - NHS Trusts & NHS Foundation Trusts Partner Member – mental health sector – Alison Smith
Voluntary, Community and Social Enterprise (VCSE) Partner Member, Pam Webb (PW)

Regular Attendees:
ICB Director of Place – BaNES, Laura Ambler (LA)
ICB Director of Planning and Performance, Rachael Backler (RB)
Chair of the BSW Integrated Care Partnership – Cllr Richard Clewer (RC)
ICB Chief of Staff, Richard Collinge (RCo)
ICB Director of Equalities, Innovation and Digital Enterprise, Jane Moore (JM)
ICB Director of Place – Swindon, Gordon Muvuti (GM)
ICB Director of Place – Wiltshire, Fiona Slevin-Brown (FSB)
ICB Chief People Officer, Jasvinder Sohal (JS)
Deputy Director of Corporate Affairs (minutes)

Invited Attendees:
ICB Interim Deputy Director – Planning & Programmes, for item 8

Apologies:
Non-Executive Director for Audit and Governance, Dr Claire Feehily (CF)
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector – Dominic Hardisty (DH)
Non-Executive Director for Finance, Paul Miller (PM)
Non-Executive Director for Remuneration and People, Suzannah Power (SP)
ICB Chief Medical Officer, Dr Amanda Webb (AW)
ICB Director of Strategy and Transformation, Richard Smale (RSm)

1. Welcome and Apologies

1.1 The Chair welcomed members, officers and observing members of the public to the meeting of the BaNES, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) held in public.

1.2 The above apologies were noted. The meeting was declared quorate.

2. Declarations of Interest

2.1 The ICB holds a register of interests for all staff and Board members. None of the interests registered were deemed to be relevant for the meeting business. There were no other interests declared regarding items on the meeting agenda.

3. Minutes from the ICB Board Meeting held in Public on 18 May 2023

3.1 The minutes of the meeting held on 18 May 2023 were **approved** as an accurate record of the meeting.

4. Action Tracker and Matters Arising

4.1 The Board noted the action tracker.

5. Questions from the Public

5.1 The Chair welcomed questions in advance of the Board meetings held in public. The ICB website details the process on how the public can submit questions to the Board, questions need to be sent in seven business days in advance of the meeting.

5.2 A question had been submitted regarding the BSW ICS's plans for the provision of community health and care services in Bath and NE Somerset for the period following 31 March 2024, when HCRG Care Group's contract ends; and whether there would be any public consultation on the options being considered for service provision.
The Chair responded by explaining that the BSW ICB had established the Integrated Community Based Care Programme (ICBC) to lead the process of securing specific community services from 2025 onwards, working on behalf of the Councils and BSW ICB. Plans for engaging with the public on this subject are in development. Updates on the ICBC will be given.

5.3 The full question and response will be published on the BSW ICB website.

6. BSW ICB Chair's Report

6.1 The Chair's verbal update report highlighted that this was the last BSW ICB Board meeting for Susie Kemp, Swindon Borough Council CEO and the Board's Local Authority Partner Member (Swindon). The Chair thanked Susie Kemp for her contributions to, and her work with, the BSW ICB and its predecessor CCG, and wished her well for the future.

7. BSW ICB Chief Executive's Report

7.1 The Board received and noted the Chief Executive's report as included in the meeting pack. While taking the report as read, the Chief Executive highlighted the following to members:

i. It was the NHS' 75 anniversary. The CEO reflected that the anniversary was an opportunity to celebrate, to thank partners for their work, and to look to the future. For a considerable period now, the NHS had been operating in an extremely challenging context which included industrial action by junior doctors (likely to be followed by industrial action of consultants). System working with partners meant that the NHS and its partners were preparing well for such periods of industrial action to ensure services remained available to the population. At the same time, the impact of industrial action on staff morale was significant and must not be underestimated. When considering NHS performance, the impact of industrial action on NHS services and finance must be borne in mind.

ii. The NHS Longterm Workforce Plan was nationally released on 30 June 2023. So far, there had been early information re the plan's intent / ambition, and broad indications of funding envelopes, however there was as yet no detail regarding ICBs' role in delivering the plan.

iii. The Population Health Board signed off the revised BSW Health Inequalities Strategy in June. The strategy had been presented to the Board at a previous meeting, and had been updated in light of the Board's observations, incl. consideration of the Core20PLUS5.

iv. In the context of the pay offer to NHS staff, guidance published by the Department of Health and Social Care confirmed that the non-consolidated payments would only apply to staff directly employed by NHS employers on 31 March 2023. The impact of this decision on the workforce e.g. bank staff and health and care workers outside the NHS was recognised as significant, and BSW was lobbying for national support to amend this decision.

v. At the time of writing the CEO report, BSW was relaunching established community engagement groups with the ambition to ensure that community engagement was inclusive

7.2 The CEO concluded by thanking Susie Kemp for her support to the BSW ICB Board, and to her as CEO when she joined the BSW system. The CEO informed the Board that Kevin McNamara, CEO of the Great Western Hospital (GWH), would be leaving GWH to join Gloucestershire Hospitals NHS Foundation Trust as Chief Executive. The CEO congratulated Mr McNamara on his achievements at GWH and in the BSW system and wished him well in his new position.

7.3 Board members offered reflections on the CEO's report.

i. The Partner Member (acutes) wished to bring alive to the attending members of the public and to non-NHS members of the Board the impact of the expected industrial action of junior doctors and consultants. There would be significant impact on planned elective care, and appointments across the three BSW acute trusts. After eight months of industrial action, the impact on staff, patients, services, NHS finances, and providers' revenue and capability to achieve targets must not be underestimated. All sides were urged to work towards a resolution.

ii. The Partner Member (VCSE) enquired what resource and investment the ICB intended to commit to community engagement which was referenced across the ICB's major strategies and plans. The Chair re-iterated the ICB's commitment to co-production. The Chair further reflected that the NHS fully recognised other organisations' and the local authorities expertise with regards to community engagement and wished the NHS to learn from it. The ICB would work closely with local authorities, building on and utilising existing and tried-and-tested community engagement mechanisms.

Action J Kirby: The Community Engagement Committee should consider ICB plans for community engagement in detail and seek assurance that such plans are adequately resourced.

Action S Elsy: To schedule community engagement as a Board development item.

8 BSW Implementation Plan

8.1 The ICB Director of Planning and Performance and the Deputy Director planning and Programmes presented the BSW Implementation Plan 2023/24 to the Board. The Implementation Plan set out how BSW partners would work together to deliver the BSW Strategy 2023-28.

8.2 The Plan was a statutory requirement (cf. the Joint Forward Plan provisions in the Health and Care Act 2022). The Plan would be annually refreshed, and the plan before the Board therefore focussed on deliverables for 2023/24 as well as setting out a picture of what will be different in five years' time at the end of the period covered by the BSW Strategy. As is statutorily required, the ICB had fully engaged the three Health and Wellbeing Boards (HWB) in BSW, who had also provided their respective opinion on the plan. Work on the Plan had been strongly supported by the ICB's public health partners. Attention was drawn to the Plan's dedicated chapter re children and young people (CYP). While CYP were embedded throughout the entire Plan, the dedicated chapter intended to demonstrate more clearly what the ICB and its partners were aiming to achieve.

8.3 The Board noted that the ICB and the system, and therefore the Implementation Plan, were at an early stage. The Board recognised that the Plan was therefore a continuously evolving piece of work, and there would be opportunities to further sharpen and focus the plan and its delivery. The Board further noted that the Plan was a noticeable departure from the NHS' historic annual planning cycle, and that adopting a longer-term perspective to planning and delivery posed challenges.

8.4 The CEO thanked those who had been working on the Plan at pace, and thanked system partners for their contributions. It was now vital that the Plan become embedded and be considered in the system's daily business, so that the right decisions were made at the right time to drive the Plan's implementation.

8.5 The Board **approved** the BSW Implementation Plan.

9 Health Inequalities Funding and Population Health Board *(item moved)*

9.1 At its meeting in May 2023, the Board was asked to approve delegation of funds to the BSW Population Health Board in relation to Health Inequalities. The Board asked for sight

of the updated BSW Inequalities Strategy, and for further information on the role of the Population Health Board, the use of the funding and how the Board would receive assurance on impact. This item provided the requested information to the Board.

9.2 In summary, the BSW Inequalities Strategy had been revised in light of the Board's comments and reflections, incl. inclusion / increase of focus on the Core20PLUS5 approach for CYP, the Equality Delivery System, updated JSNAs, and more detailed workplan to set out delivery objectives for 2023/24. The revised strategy was fully aligned with ICS Integrated Care Strategy and supports two of its three strategic objectives. As a sub-strategy of the BSW Integrated Care Strategy (approved by the Board in March 2023), the BSW Inequalities Strategy would now be taken to the ICB Quality and Outcomes Committee for approval; this was in line with the ICB's Scheme of Reservations and Delegations.

9.3 The Board's discussion highlighted the following:

i. 12 or 24 months KPIs / numeric outcomes would be desirable, as would a clear narrative re how consideration of health inequalities informs decisions and approach, clarity re intended benefits and actual outcomes of spend of health inequalities funding, and measurement of the impact of short interventions and longer term left shift;

ii. the ICB reiterated that the health inequalities workplan described outcomes-focussed objectives; process KPIs were required to describe the baseline, and to measure continuously if / how the health inequalities work had an impact; the ICB Health Inequalities lead confirmed the commitment and intent to be held accountable by the Board, to utilise resources efficiently to drive effective delivery, and to review and course correct if KPIs indicated the need to do so; processes were in place to monitor and report KPIs, and to evidence the benefits, effectiveness and impacts of the prevention-focussed approach;

iii. there was evidence that the health inequalities work was already yielding benefits, e.g. positive impact on acutes' work with high intensity users; Swindon's health inequalities specialist was assessing the outcomes, impact and benefit of grants received to do inequalities work.

Action (ICB Executives): Ensure that papers / documentation show whether the Board had previously commented on a matter, and how the Board's feedback had been taken into account.

9.4 The Board:

- noted the revised BSW Inequalities Strategy as recommended by the Population Health Board, and that it would receive final approval by the ICB's Quality and Outcomes Committee
- noted the work of the Population Health Board and the progress made on the development of a Health Inequalities and Prevention programme.
- noted the proposed use of the funds and how the Board would be assured on impact
- delegated to the Population Health Board the authority to make decisions on the prioritisation of the Health Inequalities Funding that will be used to support the delivery of the Health Inequalities Programme for the next five years.

10 NHS Workforce Plan

10.1 The ICB Chief People Officer (CPO) briefed the Board on NHS Longterm Workforce Plan which was nationally released on 30 June 2023.

10.2 The Board reflected that the plan was long expected and was welcome. The Board's discussions focussed on the plan's implications for education / training of future health and care workers, for the public sector's access to workforce, and for pay disparities between the public and the private sectors perpetuating:

i. there were concerns that quality and patient safety may be put at risk if 20% of training time was taken away from medical role training, and it was felt that regulators would need to play a key role in setting and upholding standards of training and education in medical roles

ii. widening participation re training and careers was welcome; it signified a shift in thinking re access to and progression in and across health and care careers, and needed to recognise that a more holistic workforce model must enable health and care workers to work across traditional sector, specialism and pathway boundaries; workforce strategies / plans needed to consider this creatively, and ensure that there was parity of esteem and recognition of health and care workers – this included informing the public appropriately about careers and competencies; noted that the BSW Academy was leading work in this regard;

iii. noted that the plan's intentions had considerable implications for the health and care estate which was not geared up to e.g. accommodate trainee GPs; noted that place of training often translated into place of residence for health and care workers, and this needed to be factored into training, education and workforce strategies and plans; noted that BSW universities and colleges recognised the need to work closer with the ICP to adapt their offer to the BSW labour market re health and care;

iv. health and care skills strategies would need to align across the public sector, otherwise the sector would become increasingly fragmented and compete with itself for a finite workforce;

v. the ICS structures offered a significant opportunity to implement the workforce plan to the best possible benefit of the BSW population and the wider system, and to deliver the NHS' contribution to wider socio-economic development; there was an expectation that much of the funding associated with the long term plan;

vi. the CPO reported that a mapping exercise was being undertaken against the long term plan to understand what was already in place and could be built on; it was recognised that the ICS workforce strategy needs to be co-developed and co-created; it was further noted that more detail and guidance was expected regarding implementation of the long term plan and organisations' and systems' expected responsibilities in this context

11 Delegation of Specialised Commissioning to ICBs

11.1 NHSE set out its intentions to delegate specialised services to Integrated Care Systems in the Roadmap for Integrating Specialised Services within Integrated Care Systems in May 2022. There was a request that ICB Boards be kept aware of this national direction of travel and potential risks. As the first step, NHSE and multi-ICB collaborations established statutory joint committees that oversee and take commissioning decisions for 59 specialised services. This was approved by the BSW ICB Board at its meeting on 16

March 2023. At its meeting in March, the Board had approved joint committee approach re spec comm per national direction of travel to move to fully delegated approach.

11.2 NHSE were now proposing that further delegation of commissioning of the identified 59 services suitable for greater integration by ICSs take place from 1 April 2024. This means that responsibility and liability for these services would transfer fully to ICBs, although accountability would remain with NHSE per its statutory responsibilities and functions.

11.3 The Board cautiously welcomed the opportunities arising from BSW becoming responsible for delegated specialised commissioning, which would place BSW in a position of ownership of these services. The Board noted the assessment of implications and risk to BSW ICB and ICS, incl. as yet unquantifiable demand on ICB capacity, financial risks re overspend against allocated budget which would sit with the ICB and the BSW system, and the implications of the geographic footprint for cross-border services and flow. At this point in time it was not clear what the risk share arrangements will look like between ICB and NHSE. In view of the assessed impact and risks, the ICB was exploring with the national level whether this was the right time for BSW to receive specialised commissioning delegation. The Board further noted the requirement and arrangements to complete the Pre-Delegation Assessment Framework before submission in September 2023, and that the final decision to accept delegation would take place after December 2023

12 BSW Operational Performance and Quality Report

12.1 The Board received the report for oversight and assurance on the safe and effective delivery of NHS care and NHS operational performance. The report had previously been considered by the ICB Quality and Outcomes Committee. The Board's attention was drawn to the persistent challenges re diagnostics and direct impact on elective care, and to Clostridium Difficile (CDI) rates exceeding thresholds – this was being closely monitored and focused quality improvement programmes were in place aimed at reducing infection rates.

12.2 The Board noted the report. Discussion surfaced that while the report provided explanations for performance metrics, some Board members felt that there was not sufficient information in the report for them to feel assured that all was being done that could be done to improve performance. Greater explanation and visibility of mitigations to bring performance back on track would be helpful. The ICB Director of Nursing noted the comment, pointing out that previous feedback from Board members had led to a reduction of such explanatory narrative to reduce the length of the performance report. Some Board members questioned whether this was sufficient to assure the Board that the right resource was on point to address performance issues. Others reflected that there is a duplication of assurance at committee and Board level. The intention is for committees to take the lead on risk-focused conversations and to assess when a matter needed to be escalated to the Board. A wider discussion followed re the role of the ICB Board, responsibilities of its members, and how Board members could be certain that they discharged their duties incl. accountability to the public. The Chair concluded that this topic should be the subject of a Board development session.

Action (Chair): To schedule a Board development session with focus on ICB Board function and Board members roles and responsibilities, and reporting to Board that offers assurance.

13 BSW ICB and NHS ICS Revenue Position

13.1 The ICB CFO presented the BSW ICB and NHS ICS Revenue Position for month 2, referring to the detailed report provided to Board members. The CFO explained that elective activity data were estimates because there was a significant amount of uncoded activity; available data suggested that BSW had delivered 109% activity and achieved NHSE targets.

13.2 The CFO provided a verbal update for month 3 as the position became available the day before the Board meeting:

i. position to date was £5m adverse variance, with £2.2m driven by industrial action; NHSE had confirmed that this was deemed an acceptable variance as it was never in plans, NHSE also conceded that the cost associated with industrial action would continue and likely increase; the remaining £2.8m adverse variance compared to £2.3m in month 2; while this was not where the ICB and the system wished to be, this showed improvement in the underlying run rate; the improvement was due to identification of previously unidentified efficiency, GWH delivering its in-month target, and Sulis achieving break-even; mitigations continued to further improve

ii. per national policy, for the elective recovery fund all elective care targets would be reduced by 2%, i.e. the previous target of 109% was now 107%, and the respective proportion of elective recovery funding would now not be clawed back – of £37m allocated to BSW, £31m are secured, with the remaining £6m at risk dependent on delivery of targets; the BSW Elective Care Board was tasked to drive and monitor delivery;

iii. the CFO reiterated that with traction on efficiencies from all partner organisation, there was an expectation to close the gap by year end; a discussion was scheduled with NHSE in September to discuss the 3-year trajectory / plan for recovery, and the CFO would engage with partners around this.

13.3 The Board **noted** the report. The Partner Member (acutes) reflected that the report showed clearly the significant impact of industrial action on finances, and this was important to acknowledge alongside the impact of industrial action on patients, services and workforce.

14 BSW ICB Board Assurance Framework (BAF)

14.1 The Board had previously considered the BAF in June. As an NHS body, the ICB needed to have a BAF in place for purposes of NHSE assurance. The BAF would support the Board in continuously assessing the risks to the achievement of the ICB's strategic objectives, and to agree and assess mitigations. The BAF would therefore inform future Board agendas by enabling focus on risks to the ICB's and the ICS's strategic objectives. The Board was reminded that the BAF was under development and would evolve.

14.2 The Board **approved** the BAF.

15 Report from ICB Board Committees

15.1 The Board received a summary report of business considered and decisions taken by the ICB Board committees.

15a ICB Quality and Outcomes Committee Terms of Reference

15.2 The Committee had over the past months extensively considered and reviewed its Terms of Reference. The Committee's Chair recommended the ToRs to the Board, and the Board approved the ICB Quality and Outcomes Committee ToRs.

16 BSW ICB Board Forward Planner to March 2024

16.1 The Board had previously requested that members be given the opportunity to co-create Board agendas. For this purpose, the Board regularly receives the forward planner. The Board **noted** the forward planner, with no comments made.

17 Any other business and closing comments

17.1 There being no other business, the Chair closed the meeting at 12:50hrs

Next ICB Board meeting in public: Thursday 21 September 2023

BSW Integrated Care Board - Board Meeting in Public Action Log - 2023-24

Updated following meeting held on 13/07/2023

OPEN actions

Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
13/07/2023	7. BSW ICB Chief Executive's Report - Community Engagement	The Community Engagement Committee should consider ICB plans for community engagement in detail, and seek assurance that such plans are adequately resourced.	Julian Kirby and the ICB Public and Community Engagement Committee	**Update 24/07/2023:** Added to committee planner for October meeting discussion.	CLOSED	Oct-23
13/07/2023	7. BSW ICB Chief Executive's Report - Community Engagement	To schedule community engagement as a Board development item.	Stephanie Elsy	Noted on the ICB Board forward planner to consider schedule.	CLOSED	
13/07/2023	9. Health Inequalities Funding and Population Health Board	Ensure that papers / documentation show whether the Board had previously commented on a matter, and how the Board's feedback had been taken into account.	ICB Executives	**Update 24/07/2023:** Rachael Backler shared reminder with ICB Executives.	CLOSED	
13/07/2023	12. BSW Operational Performance and Quality Report	To schedule a Board development session with focus on ICB Board function and Board members roles and responsibilities, and reporting to Board that offers assurance.	Stephanie Elsy	Noted on the ICB Board forward planner to consider schedule.	CLOSED	

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	7
Date of Meeting:	21 September 2023		

Title of Report:	CEO Report to BSW ICB Public Board
Report Author:	Sue Harriman, Chief Executive Officer
Board / Director Sponsor:	
Appendices:	None

Report classification	
ICB body corporate	Yes
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

1	Purpose of this paper
The CEO reports to the Board on sector developments that are expected to impact. the ICB, and key issues relating to ICB plans, operations, and performance.	

2	Summary of recommendations and any additional actions required
The ICB Board is invited to **note** the content of this report.	

1. National and Regional Context:

1.1. **Lessons from the Letby Trial**. An independent statutory inquiry has been announced by the Department of Health and Social Care to investigate the wider circumstances around what happened at the Countess of Chester Hospital, including the handling of concerns and governance, and to ensure vital lessons are learnt. We must await the outcome of the independent statutory inquiry to understand the full facts, but we are acting now to be sure that staff and patients are appropriately protected. For example, proactively examining our culture, approach to learning, patient safety procedures, and ensuring that our Freedom to Speak Up (FTSU) mechanisms are robust are all valuable steps, regardless of the outcomes of the inquiry.

1.2. This autumn the new Patient Safety Incident Framework will be fully implemented across the NHS, shifting the way we respond to patient safety incidents, with a focus on data and understanding of how incidents happen, engaging with patients, service users, families and carers and taking effective steps to improve and deliver safer care. The ICB will build on its arrangements to review mortality data and we are introducing a dedicated System mortality group. The roll out of medical examiners

since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

1.3. **Visit of Amanda Pritchard to Great Western Hospital**. On 4th August 2023 we were delighted that Amanda Pritchard (NHS England CEO) visited GWH to observe the innovative work happening there. During the visit Amanda spoke with the Chairs and CEOs from both GWH and the ICB, as well as front line staff. She visited the new integrated emergency department and urgent treatment centre, the care coordination centre (which has received significant positive media attention), the neonatal unit, and the *improving together* hub which is at the heart of the efforts to lead a culture of continuous improvement.

1.4. **Vaccination Programme Acceleration.** Following recent national announcements by UK Health Security Agency (UK HSA) regarding new Covid-19 variant BA.2.86, the NHS has been asked to bring forward and accelerate the vaccination programme for the autumn winter season. BSW ICB has been preparing for this and vaccinations started on 11th September, in accordance with DHSC direction, prioritising the most vulnerable in the population. This is through our well-established Community Vaccination Hub team delivering alongside GP practices, and a multitude of community pharmacies. The three local acute trusts will also deliver vaccinations to their staff, long stay in-patients and those who are pregnant.

1.5. We continue to ensure that the 2-3yr old flu vaccinations are delivered as early as possible in the season to prevent the spread to more vulnerable relatives, and all GP practices are aware of the importance of this. Working with our local authority colleagues, specific communities have been identified to focus our inequalities clinics during the autumn winter programme and deliver vaccinations via our community hubs.

1.6. **Winter Plans**. The national and regional teams have provided information and direction for ICBs to ensure that there is effective delivery of operational resilience across the NHS this winter, to minimise harm and delays in access to care in the right place. NHS England has outlined four areas of focus that Systems are required to concentrate on: ensuring delivery of ten high impact interventions, completing operational and surge planning, ensure effective System working across all partners, and supporting the workforce. A clear outline has been provided that reinforces the roles of all providers and System partners, including primary care. The national team have requested winter planning submissions, both in narrative and numerical format which are due for final submission at the end of September.

1.7. **NHS Enforcement Guidance:** Under the Health and Care Act 2022 (the 2022 Act), NHS England has statutory accountability for oversight of both Integrated Care Boards (ICBs) and NHS providers. The NHS enforcement guidance was introduced in 2013 alongside the provider licence. Much has changed since then, so NHSE wrote to the sector in October 2022 setting out proposals to update the NHS enforcement guidance and align it with current statutory and policy requirements, including new legislation. These proposed changes were subject to a statutory consultation from 27 October to 9 December 2022. BSW ICB responded to the consultation. The NHSE enforcement guidance is now finalised and in effect. The consultation response summary and the updated NHS enforcement guidance were published in August.

2. BSW ICB updates:

2.1. **Our Preparation for Winter.** Our winter plan is covered in detail on the Board agenda. The winter plan narrative and numerical submission that we have developed

in response to the national ask, reflects a whole system approach that has been developed using demand and capacity analysis to inform decision making, lessons learnt from 22/23, the operational delivery plan, and areas of best practice outlined by the national Urgent and Emergency Care (UEC) team. The plan outlines risks, and the actions that are being taken to mitigate those risks. Additional funding support has been provided for the Wiltshire locality to ensure additional capacity is created due to current pressures. The priority of the system is to ensure patients remain safe in our health and care services.

2.2. The ICS is also revising our urgent care escalation plan, following new guidance from NHS England, and will be explicit regarding the expectations of each organisation, particularly when there are periods of high demand.

2.3. We are also in discussions with the owners of the South Newton site regarding future opportunities to provide additional capacity for our system.

2.4. **BSW ICB Annual Assessment 2022-23 Outcome:** NHS England has a legal duty to undertake an annual assessment of each ICB's performance, as set out in Section 14Z59 of the NHS Act 2006 ("The Act"), as amended by the Health and Care Act 2022. BSW ICB's first annual assessment was undertaken by NHSE SW. The NHSE SW Regional Director, Elizabeth O'Mahony, confirmed to BSW ICB in July that based on the evidence received and reviewed by South West Regional Support Group (RSG), NHSE is satisfied that BSW ICB has discharged its duties and met its wider objectives, whilst noting areas for further development and improvement. As requested by NHSE, we are sharing the assessment with our Board here: https://bsw.icb.nhs.uk/document/bsw-icb-annual-assessment-letter-2022-23/ and publish it alongside our annual report. NHS England will also publish a summary of the outcomes of all ICB performance assessments as part of its 2022/23 Annual Report and Accounts.

2.5. **Financial Position.** Our financial position is covered in detail on the Board agenda. The BSW ICS reported financial position at month 4 is an adverse variance of £11.0m. This is a £6m deterioration since month 3. This is due to three main factors: Costs driven by industrial action of £2.4m, which was not accounted for in our plans, Unfunded pricing pressures within primary care prescribing £3.8m, and increased agency spend of £1.9m and other pressures of £3.0m.

2.6. There are risks associated with the delivery of the full year plan in addition to industrial action. These were all highlighted as risks as part of our plans. The main ones are:

- Deliverability of the £96m efficiency plan with some efficiencies not expected to be delivered until the end of the year; this is being driven and supported by the BSW Financial Recovery Board.
- Achieving our elective care target of 107% to land both the Elective Recovery Funding in full (£6m at risk) & over-performance on the independent sector (£4.1m forecast at risk) - will be funded nationally only if we exceed our elective target.
- Continuing Healthcare and Mental Health – both demand and excess inflation.
- Full year effect of prescribing pricing pressures which could be more than £10m and is being experienced nationally.

2.7. We continue to drive financial recovery through our workstreams: urgent and emergency care, elective recovery, medicines management, workforce, estates and facilities, procurement, community, and mental health. Our biggest opportunity is addressing productivity which is measured against 2019/20 in terms of provider expenditure and activity undertaken. All three acute providers have adverse productivity measurements. Productivity is also a key focus of our Medium-Term

Financial Plan. The core elements of this will be our elective recovery strategy and re-trenching of the workforce position.

2.8. Use of agency staff within BSW is currently £1.9m above the limit at month 4 but has an improved forecast position of £32.86m, £0.94m (2.7%) below the agency limit of £33.8m. All providers have workforce efficiency plans in place and GWH in particular has made significant headway in delivering its plan. BSW is currently leading a regional piece of work in this area and we continue to work with all our providers to look for areas of collaboration and best practice to deliver the agency target. These include a collaborative rate card for medical staff, the introduction of a mental health healthcare support worker bank from AWP to help reduce high-cost agency mental health shifts in the acute providers, and a focus on e-rostering and e-job planning.

2.9. **Medium Term Financial Plan.** The first iteration of the Medium-Term Financial Plan was submitted to the NHS England regional team on the 8th September 2023, as part of a national ask for all ICSs to complete this work. It is a three-year plan; Year 1 of the plan is 2023/24. There are several expectations in the plan, and they are:

- Meeting financial balance in 2024/25.
- Achieving non recurrent balance, at System level, in each financial year.
- Recovery of 2019/20 productivity levels.

2.10. We are developing our medium term financial plan in the context of striving to address our existing financial deficit and our productivity gaps, as well as aiming to deliver on our strategic ambition of improving outcomes and increasing our focus on prevention and early intervention. This will, in the long term, help to curtail growth in secondary care, align with best practice community models, and support increased virtual healthcare. To facilitate this shift, we need to invest in prevention and early intervention, dealing with the current demand on our acute services, whilst also developing our productivity and cost reduction schemes.

2.11. At this stage, the BSW ICS medium term financial plan does not achieve financial balance. There are further opportunities to improve this position between now and the final submission on the 29th September 2023. However, at this stage it appears unlikely that BSW will be able to present a balanced plan within 3 years. Importantly, efforts and focus will continue after submission, as we continue to develop our System thinking and recovery programme through our BSW Together Strategy.

2.12. **Armed Forces Covenant** and Operational (Op) COMMUNITY As part of wider efforts to tackle health inequalities, BSW ICB was proud to launch Op COMMUNITY on 1st August. Op COMMUNITY is one of eight pilots, sponsored by NHS England, to create an Armed Forces Single Point of Contact (AF SPOC) to allow service personnel, designated dependants, and veterans better access NHS services. This initiative helps the ICB to ensure compliance with the Armed Forces Act and Armed Forces Covenant by paying “due regard” to the unique nature of service life. This is a particularly important initiative for BSW, given the substantial number of serving personnel and veterans living in our community. As part of this work the ICB will be joining many of our provides in formally signing the Armed Forces Covenant and seeking accreditation through the Defence Employers Recognition Scheme.

2.13. **Industrial Action**. The system continues to prepare for and implement plans to maintain services during periods of industrial action. Unions representing junior doctors, hospital consultants, dental trainees and radiographers remain in discussion with Government and have coordinated further strike action from 19th to 23rd September and from 2nd to 5th October. Derogations are not in place and services are Christmas Day rotas. We have plans in place to maintain urgent and emergency care services, which have been exercised since the end of 2022. It should be noted

but these are not just limited to NHS striking organisations but include impacts from other sectors such as education and rail disruptions.

2.14. **Equality, Diversity and Inclusion (EDI).** The NHS recently launched the NHS EDI Improvement Plan setting out six high impact actions which must be implemented by all NHS partners. This is covered in detail on the Board agenda. The actions include expectations for Board development, inclusive recruitment, improvement on pay gaps, addressing health inequalities in the workplace, support for internationally recruited staff and tackling bullying, discrimination, harassment, and physical violence in the workplace. The plan has been shared, with an initial assessment against each high impact action undertaken for the ICB and a call for self-assessment from partner organisations. The assessment has included an analysis of available data with oversight through the BSW Equality, Diversity & Inclusion (EDI) leads community of practice, Chief People Officers, and Chief Nursing Officers/Senior Clinical Leads.

3. Performance Summary.

3.1. **Operational Demand**: Demand for services continues to increase in the context of post pandemic recovery, on-going industrial action, and financial recovery. This has an impact on the performance of the services in BSW, as set out in the performance report in the Board pack. This means that people are waiting longer than we, and they, want which potentially has an impact on their experience, and their overall health outcomes.

3.2. In addition, demand for the urgent care services remains high over the summer period and as noted above, we have written our winter plan in order to ensure we are prepared for a challenging winter ahead. Importantly, our workforce continues to do all they can to ensure services are responsive and of a high quality, but it must be acknowledged that morale has been impacted by the continuing industrial action and the on-going high demand for services.

3.3. **NHS Oversight Framework:** The Board will note in the performance report that actions are being taken to reduce our waiting times and improve performance, however we continue to have a mixed performance picture across the NHS Oversight Framework domains. We are currently awaiting the outcome of the NHS England Quarter 1 Segmentation process and we are aware that we are flagging for potential segment 3 performance in certain areas including diagnostics, cancer, mental health performance and finances. For all the identified areas, we already have recovery plans underway.

3.4. **Performance Oversight and Delivery:** We are working with NHS partners to agree and implement a revised performance and oversight framework that will allow us to have a shared understanding of our collective position, and the steps being taken to work towards recovery. We have circulated a draft proposal for comment and are aiming to go live with the new framework this quarter.

3.5. **UEC performance:** In the period to June we have seen an improvement on urgent and emergency care performance in terms of the percentage of people seen within 4 hours in A&E, virtual ward capacity and occupancy rates. However, we have continued challenge in ambulance handover times and urgent community response times. At the start of September, the system has experienced unexpected challenges, resulting in increased hospital handover delays and a deterioration in A&E performance.

3.6. The key areas of risk for our system across urgent and emergency care are:

- ensuring there is sufficient capacity to meet demand and making sure that we are able to admit patients to services when this is needed

- supporting appropriate discharge out of hospital facilities to enable people to return home or to community based health and care services;
- reducing the number and duration of delays in handing over patients from an ambulance to a hospital; and
- ensuring we can recruit and retain staff.

3.7. Improvement is led and overseen by our system Urgent Care and Flow Board, and delivering our winter plan is a key part of ensuring improvement in these key performance challenges and risk area.

3.8. **Elective Care:** The Elective Care Board oversees performance and recovery actions for elective targets. Elective activity is showing good delivery against the elective recovery fund which measures the planned increased activity versus the 19/20 pre covid period as an indicator of recovery. However, elective long waits reduction has plateaued, and we still have some patients who have not completed their treatment pathway within 78 weeks. At the end of August providers in the system had 24 patients over 78 weeks against a trajectory of 0. Actions are being taken to prioritise these patients and mutual aid within the system is overseen by the fortnightly elective recovery group.

3.9. **Diagnostic performance:** is showing some indications of recovery but there continue to be significant challenges at both RUH and GWH. Recovery actions are in place and should hopefully have a positive impact in the coming months alongside the additional capacity from the mobile units as part of the Community Diagnostic Hub mobilisation. NHSE regional deep dives are about to commence to support further improvement actions.

3.10. **Cancer Performance:** Performance against the key cancer standards have deteriorated, with particular pressures relating to colorectal and skin at RUH and skin at all three providers. RUH is flagging as under-performing in relation to 62 day cancer and is in discussion with the NHSE regional team regarding mitigating actions. The published June position shows 62 day treatment standard at 59.2% versus the target of 85% (86 breaches more than the accepted target). In response, additional appointment lists are being put in place alongside additional surgeons and radiologists starting in the next month. RUH are forecasting to have improved performance in November as recovery actions take effect.

3.11. **IAPT Access rates** have continued to improve against our plan trajectory over the last four months although we have not achieved the national standard of 50%. It has been agreed with AWP, the provider, that a service review will be undertaken between now and December 2023 to maximise movement towards the national standard and to inform planning and delivery in 2024/25 to ensure improvement continues until the standard is attained.

3.12. **CYP access** is also thought to be improving although is still below trajectory. It should be noted that our main provider, Oxford Health, has not submitted data to the national portal since a cyber incident. Once resolved Oxford Health will resubmit finalised data. The ICB is undertaking remodelling work across all providers to fully understand performance and anticipate further improvement through the year.

3.13. The **Dementia Diagnosis Rate** transformation plan is starting to show improvement with BSW currently showing a rate of 58% against a national standard of 66.7% (BSW is third out seven south west systems currently). All GP practices are now signed up to report against this target.

3.14. **LD&A inpatient rates:** There have been significant reductions in inpatient numbers in BaNES and Wiltshire in line with the plan trajectory. In Swindon weekly calls are in place to discuss each patient and their discharge plans and support needed to achieve the necessary reductions in the locality. To ensure progress is maintained

across BSW monthly MADEs (multi agency discharge events) continue across all three localities.

4. Focus on Place:

4.1. **B&NES:** Good progress has been made with our Community Investment Fund. Working with five of our local third sector organisations; Southside Hardship Fund, Julian House, Citizens Advice Bureau, Age UK, West of England rural Network- (B&NES locality only), we have given grants to our most vulnerable communities for cost-of-living support, food and clothing, and warm home grants. Case studies will be prepared alongside the evaluation of the scheme so Board colleagues can see the outcomes from the investment and hear directly from our communities on what the ICB support has meant for them. This is a key part of our strategy on health inequalities and a demonstrable example of how our ICB is working directly with our communities at Place.

4.2. As agreed at the ICB in July, the next round of health inequalities funding will have some longer-term funding devolved to Places. The expectation is for Places to co-produce a programme for this funding and for each Alliance to oversee and to report this through the ICB for assurance. The B&NES Integrated Care Alliance (ICA) have agreed a process for identifying priorities and have opened a window for consideration of proposals. We will work these through the ICA in September and bring an update to the ICB Board on the outcome later in the year.

4.3. We continue to work in partnership across our ICA to deliver our Home is Best programme of work, which supports our residents to remain at home, aims to reduce our reliance on bed-based care, and improve patient outcomes and experience. This approach helps to enable operational to management of the System challenges and pressures. We continue to maintain good flow of people from our acute hospitals to community settings or home.

4.4. Working in partnership across health and social care, we are on track to deliver our plans to reduce the number of patients who do not meet the Criteria To Reside (NCTR) in our acutes hospitals, and to significantly reduce our number of discharge to assess beds by 40%. We have also continued to increase our use of virtual wards, a flagship BSW scheme. A key focus for the next month is on increasing referrals to the virtual ward step-up model, through continuing to raise profile of service through networking and roadshows. This is a good foundation to build on for winter and we have submitted the B&NES contribution to the BSW system winter plan.

4.5. **Swindon**: We are continuing to undertake actions to ensure patients can be discharged from our acute hospitals in a timely way. Home First celebrated their 500th patient using this Service in May 2023, with a 25% increase in Home First discharges for August 2023 (against KPI). The service was shortlisted in the patient safety category for the Health Service Journal award in July 2023.

4.6. The alliance has made its contribution to the BSW winter plan. All primary care networks are continuing to deliver enhanced access services through a combination of extended hours within practices. Saturday morning primary clinics now take place in two locations in the town which all patients in Swindon and Shrivenham can access. Livi, the remote GP service provides an additional 2,000 appointments for the Swindon practices each month with capacity available for some urgent appointments too.

4.7. We have also completed the capacity and access plans as part of the NHSE primary care recovery plan and are fully engaged in the components of developing their modern general practice. Key to the plans is engaging with patient and patient groups, and the practices' have Swindon Healthwatch's support with this. Finally, practices are engaging with the Integrated neighbourhood teams projects, with

specific projects on; service users known to adult social care and community services, weight management, mental health access and continuing care for children.

4.8. **Wiltshire:** The Neighbourhood Collaborative programme launched the Wiltshire wide collaborative forum on 4 September, the objective is to build momentum and focus on opportunities to develop future collaboratives. There are three collaboratives currently working across Wiltshire and several others in the pipeline. The Wiltshire Public Health Inequalities team are now embedded into the Neighbourhood Collaborative project group, bringing in experience and expertise on data insight tools and population health management techniques.

4.9. The bid process for 2023/24 health inequalities has generated great interest in Wiltshire, and we have received a significant number of bids from a range of partners. A partnership panel will review all the bids and we expect to be able to provide more detail on those successful bids in our next update. Our Living Well group has also been established and is leading the work on analysing our population health data for diabetes and CVD to identify local priorities, linked to the delivery of the Primary and Community Care Delivery plan and the NHSE Major conditions strategy.

4.10. Wiltshire Mental Health and Learning Disability Group is focused on developing the ICA dementia strategy. A learning disability community workshop was held on the 19th July to scope current community and third sector provision. The Wiltshire Service User Network and Healthwatch have completed a survey of autistic people living in Wiltshire, to understand experiences of health and care services, the report will come to the Wiltshire Mental Health and Learning Disability Group in September.

4.11. The Emergency Care Improvement Support Team (ECIST) report for Wiltshire was discussed at the Wiltshire Ageing Well and Urgent Care Group on 1st September. The report included a clear set of actions, and these will be considered as we review our actions in support of the winter plan, and the review of the demand and capacity modelling completed earlier in the year. A proposal was approved via the Recovery Board to redirect funding to enable further reductions in the numbers of Wiltshire residents waiting to be discharged.

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	8
Date of Meeting:	21 September 2023		

Title of Report:	BSW CCG 3-Month Annual Report and Accounts and BSW ICB 9-Month Annual Report and Accounts 2022-23
Report Author:	• Sharon Woolley, Board Secretary • Shaun Dix, Communications and Engagement Specialist – Media Relations • Michael Walker – Head of Financial Accounting – Reporting • Ian Loveys – Financial Accountant
Board / Director Sponsor:	Rachael Backler, Executive Director of Planning and Performance Gary Heneage, Chief Finance Officer
Appendices:	None

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	x
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	x
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
ICB Executive Team	8 August 2022	Assurance and review
ICB Audit Committee	17 August 2022	Assurance and review, and agreement of first draft submission to NHSE.
ICB Executive Team	11 April 2023	Assurance and review

ICB Audit and Risk Committee	18 April 2023	Assurance and review
ICB Executive Management Meeting	5 June 2023	Assurance and review
ICB Audit and Risk Committee	13 June 2023	Assurance and review, and to endorse and recommend to the ICB Board for approval
ICB Board – Meeting in Private	22 June 2023	Approval of submission to NHS England
NHS England	7 July 2023	Certificated and approved for publishing

1 Purpose of this paper

For the year 2022-23, the Integrated Care Board (ICB) has been required to prepare two Annual Reports and Accounts (AR&A): for quarter 1 of the BaNES, Swindon and Wiltshire (BSW) Clinical Commissioning Group (CCG) 1 April 2022 to 30 June 2022, and quarter 2 to 4 for BSW ICB 1 July 2022 to March 2023.

The AR&As are in line with the Department of Health and Social Care Group Accounting Manual (GAM), and guidance and templates as issued by NHS England.

The financial accounts, and the remuneration and staff report are subject to External Audit. Auditors have provided their findings in separate reports to the Audit and Risk Committee, and the ICB Board.

The AR&As were published upon the ICB's website on 17 July 2023 *(ICB AR&As updated on 12 September 2023 to include the Auditors final opinion and audit certificate)* – and can be found here:

- BSW CCG 3-Month Annual Report and Accounts 22-23 - https://bsw.icb.nhs.uk/document/bsw-ccg-annual-report-apr-22-jun-22/
- BSW ICB 9-Month Annual Report and Accounts 22-23 - https://bsw.icb.nhs.uk/document/bsw-icb-annual-report-incl-vfm-report-jul-22-mar-23/

2 Summary of recommendations and any additional actions required

The ICB Board is asked to note that the two Annual Reports and Accounts have received sign off by NHS England, and have subsequently been published upon the ICB's website.

In accordance with the NHS England reporting guidance, BSW ICB is presenting these two AR&As to its Board meeting held in public.

3	Legal/regulatory implications
The CCG and ICB is required to prepare an Annual Report and Accounts in line with the Department of Health Group Accounting Manual 2022-23.	

4	Risks
Failure to produce an AR&A to specified timelines and format means that the CCG/ICB does not fulfil one of its key duties with regards to public transparency and accountability, and may be taken as indication of governance failures which carries operational, organisational and reputational risks.	

5	Quality and resources impact
Not applicable	
Finance sign-off	N/A

6	Confirmation of completion of Equalities Impact Assessment
EIA not applicable.	

7	Communications and Engagement Considerations
The Annual Report is an important communication and analysis tool providing information and assurance to CCG/ICB stakeholders.	

8	Statement on confidentiality of report
The CCG and ICB Annual Reports and Accounts have been signed off by the ICB Board and NHS England, and have been published upon the ICB website.	

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	9
Date of Meeting:	21 September 2023		

Title of Report:	BSW Primary and Community Care Delivery Plan
Report Author:	Caroline Holmes, Deputy Place Director, Swindon Locality
Board / Director Sponsor:	Fiona Slevin-Brown, Place Director Wiltshire and BSW Exec Lead for Primary and Community care,
Appendices:	Appendix 1: Draft BSW Primary and Community Care Delivery Plan

Report classification	Please indicate to which body/collection of organisations this report is relevant. *Only one of the below should be selected* (x)
ICB body corporate	
ICS NHS organisations only	
Wider system	X

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	X
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	X
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
ICB Executives	29/8/23	Discussion – earlier version
BSW Primary and Community Care Delivery Plan Oversight Group	1/9/23	Formal engagement on the draft document to seek comment and any suggested changes to the draft
BSW ICB Quality and Outcomes Committee	6/9/23	Formal engagement on the draft document to seek comment and any suggested changes to the draft
BSW ICBC Programme Board	6/9/23	Formal engagement on the draft document to seek comment and any suggested changes to the draft

1	Purpose of this paper

The Board is asked to receive and approve the Primary and Community Care Delivery Plan.
The Board is also asked to note the importance of this plan in the context of the Integrated Community Based Care Programme, as the Primary and Community Care Delivery Plan provides the strategic framing for this programme.

2	Summary of recommendations and any additional actions required

This delivery plan builds on our existing strategies, including the BSW Together Integrated Care Strategy and Implementation Plan, national policy and guidance.

It consolidates existing documentation (over 20 documents) and reflects the engagement work completed with service users, providers (including market engagement events) and wider stakeholders to identify initiatives and solutions to deliver our ambition.

This delivery plan also incorporates feedback from over 40 stakeholders including primary care GPs, integrated care board (ICB) members, the clinical oversight group, and the integrated community-based care (ICBC) programme.

Our delivery plan sets out six transformation priorities:

1. **Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams**. We will build on our existing primary care networks to create more integrated neighbourhoods serviced by providers who can share information, caseloads, and estates to provide more joined up care and the capacity to do so.

2. **Adopt a scaled population health management approach by building capacity and knowledge.** We will use data and insight to understand our populations better, identify health inequalities, target marginalised groups, and develop initiatives and services that improve access and result in fairer health and outcomes.

3. **Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets**. We can promote healthier communities and increase healthy life expectancies through better understanding and working with our local communities. We recognise that care and support is best delivered by those who understand the adults and children who live within them.

4. **Increase personalisation of care through engaging and empowering our people.** We need to shift towards greater prevention and early intervention. We can do so by tailoring our support to a persons' specific

needs and using technology advances to provide support in formats that align with individuals' needs and preferences.

5. **Improve access to a wider range of services closer to home through greater connection and coordination.** We will deliver excellent health and care services closer to people's homes and overcome inequality of access by creating stronger physical and virtual connections between primary and community care and specialist services.

6. **Support access to the right care by providing co-ordinated urgent care within the community.** We want emergency care to be for those who need it most and know we can help people to address their urgent needs within the community. This can prevent avoidable admissions and result in better outcomes and experiences.

Next steps

Following approval by the Board, the plan will be published on our website, and circulated widely to key stakeholders. It will also be included as part of the ICBC Programme process.

Engagement in terms of delivery of the plan will continue with papers going through the Health and Wellbeing Board and Health Scrutiny in the coming months.

3	Legal/regulatory implications

The approach being undertaken has been adopted to ensure compliance with current procurement legislation. Legal support has been engaged to support the process.

4	Risks

Key potential risks include:

- Without a clear Primary and Community Care Delivery Plan the ICBC Programme does not have a clear strategic framework for the commissioning of community services from 2025
- The ICB is unable to make informed decisions on the development of the medium to long term financial plan in regards to Primary and Community care
- The ICB workforce strategy does not reflect the future delivery plans for Primary and Community Care
- The ICB is unable to deliver against the strategic objectives as laid out within the ICP Strategy.

5	Quality and resources impact
The Primary and Community Care Delivery Plan will directly inform the Medium-Term Financial Plan which will underpin ICB decisions on investment in primary and community-based servicers in support of our strategic objectives. The plan will also directly inform the overarching Equality and Quality Impact Assessment (EQIA) aligned to the Integrated Community Based Care Programme. Focus on National Quality Board quality domains: Safety, Experience, Effectiveness.	
Finance sign-off	Rebecca Paillin BSW Head of Finance – Programmes, Financial Planning, Co-ordination and Recovery

6	Confirmation of completion of Equalities Impact Assessment
An overall equalities impact assessment (EIA) for the integrated community-based care programme has been developed, and is being considered through the convened panel sub group of the QOAC in October. The Primary and Community Care Delivery Plan provided the strategic framing for that programme is considered within the assessment.	

7	Statement on confidentiality of report
This paper has been generated by colleagues who have been confirmed as not having any conflicts of interests relating to this programme of work.	

Primary and Community Care Delivery Plan

1. Executive Summary

1.1 In the Autumn of 2022 the BSW Integrated Care Board (ICB) on behalf of the Local Authorities and ICB within BSW established a programme of work called Integrated Community Based Care (ICBC) to lead the process of securing community services from 2025 onwards. The ICBC Programme commenced in Autumn 2022, with a Strategic Outline Case presented to the ICB Board in July 2023. A decision paper is being presented today at Board. On approval it is expected that a formal selection process will take place between October 2023 and August 2024, with a transition period planned from September 2024 through to March 2025.
To ensure that we can use the ICBC programme effectively as a mechanism for delivery of our ICP strategy, we require a dedicated document which sets out the detail of our strategic transformation priorities for Primary and Community Health and Care. This document will enable us to define the framework specification for the ICBC Programme, which will then directly inform both the market engagement and selection processes.

1.2 The primary and community care delivery plan builds directly on the vision set out within the Integrated Care Strategy and ICP Implementation Plan and uses the BSW health and care model as its foundation. The delivery plan consolidates key transformation priorities taken from the ICP Implementation Plan and details these into actions. It is driven by a suite of overarching principles, supported by enablers.

1.3 This report explains the process undertaken to create the plan and seeks approval for its content.

2. Creating the plan – a summary of the process and content

2.1 The Primary and Community Care Delivery plan draws heavily on national and local strategies to set the context for transformation and change. These strategies include for example the Fuller Report, the Major Conditions strategy and the NHS Long Term Plan.

2.2 Alongside national strategic direction, the BSW health and care model and ICP strategy and its implementation plan give the delivery plan its BSW foundations and local vision. The plan draws on the feedback given during the engagement on both initiatives which means that the Delivery Plan is built on a strong understanding of local experience, shared by providers, local people and communities. The plan sets out key transformation priorities for primary and

community care and mirrors the integrated care strategy's focus on enablers. The diagram below at figure 1 outlines the overall structure of the plan.

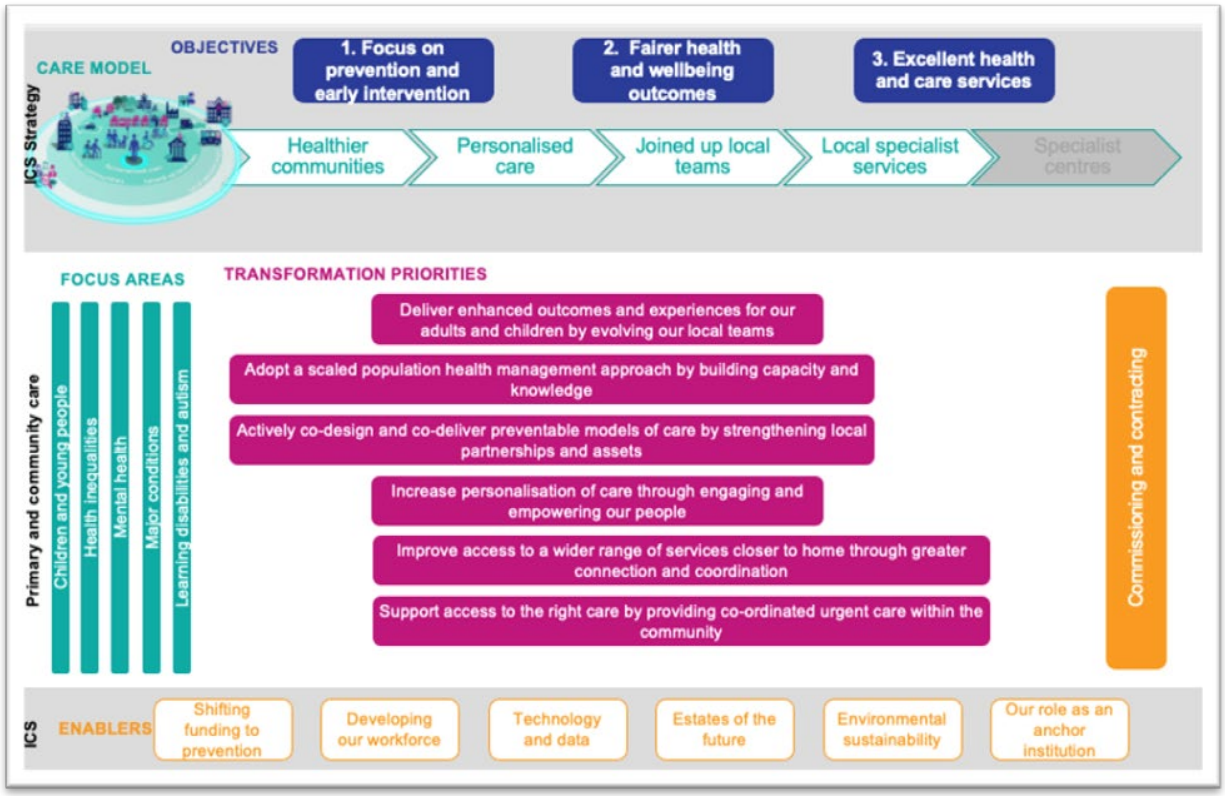

Figure 1

2.3 The plan has been shaped and led by the BSW Delivery Plan Oversight Group which meets fortnightly and is made up of key stakeholders across BSW including providers, the VCSE sector and Healthwatch. Section five describes in more detail the engagement that has taken place to shape the delivery plan.

2.4 In terms of governance, the Oversight Group reports into the BSW Executive and the ICBC Programme Board which is responsible overall for the delivery of the ICBC Programme. Regular updates have been provided to the ICBC Steering Group and ICBC Programme Board.

2.5 The plan seeks to address the known quality concerns and issues raised by local people and providers, and the inequalities in the community offer across BSW. In turn, it informs the service specifications for the ICBC Programme selection process that have been developed to meet the requirements of the plan.

2.6 As a summary of BSW's strategic intent, the plan is aligned to the Medium Term Financial Plan (MTFP) which will seek to identify the optimum level of funding to deliver the outcomes the plan is seeking and to deliver a sustainable health and care system overall. A key priority during the first 3-5 years is to put in

place the shift left of funding within the system to support the prevention agenda. The finances associated with the plan will be signed off as part of the wider ICBC programme decision papers being presented to the ICB Board on 21st September.

3. Transformation priorities

3.1 A key aim of the Delivery plan is to articulate and set out actions to deliver transformation priorities for primary and community care. As explained above, these priorities have been identified through local engagement and they demonstrate a golden thread back to the ICS Strategy and to the key priorities that local people have told us are important to them.

3.2 The service transformation priorities have been translated into the two specifications (adults and children's) for community services.

3.3 Figure 1 on p5 shows how the transformation priorities are mapped to the health and care model and underpinned by enablers. The plan itself gives further detail on the rationale for each priority and describes the indicative interventions aligned to each transformation priority. These interventions have been directly mapped into the service specifications.

3.4 The plan notes that there are some key areas that apply across all transformation priorities and should be addressed due to be significant at either national or BSW level. These include:

- Children and young people
- Mental health
- Health inequalities
- Major conditions (eg Cardio-vascular disease and diabetes)
- Learning disability and autism spectrum disorder.

3.5 The ICB Board is specifically asked to support these transformation priorities, and their inclusion in the delivery plan.

4. Stakeholder engagement

4.1 As noted above, the plan has been drafted using extensive feedback from previous engagement exercises. This has enabled the plan to be based on what local people have already told the ICB and partners such as Healthwatch. It includes gaps, issues, opportunities, and concerns within primary and community services.

4.2 Throughout the early drafts of the plan, key elements have been tested and shaped with stakeholder groups including the Clinical and Professional

Reference Group, the Delivery Plan Oversight Group and with specific stakeholders such as general practice, dental and optometry operational groups. Both the Oversight Group and the Clinical and Professional Reference Group are made up of a wide range of partner agencies, professional groups and VCSE partners as well as Healthwatch.

4.3 A critical element in our stakeholder engagement approach has been to work with providers and partners during three recent market engagement events that have taken place during July and August. These events have enabled the ICB to test element of the plan, and to work with stakeholders to scope and test the transformation priorities outlined in section four of this report.

4.4 Healthwatch also carried out a dedicated exercise to review the content of the plan against recent public engagement feedback to test whether we are following a "you said, we did" approach and to help strengthen the content of the plan.

4.5 In recognition that many Primary Care colleagues could not always attend face to face engagement events, a short clip explaining the plan with a dedicated feedback process was developed for GP practices to ensure they could contribute fully to the shaping of the plan.

4.6 A key theme within the feedback received has been a concern about the pace with which the plan has been developed and the restrictions this has created on providing feedback. This is acknowledged and the approach to developing the plan recognises that further engagement between providers and local communities will take place over the next few months, as providers and partners work with local communities to understand their needs and design models as part of the forthcoming selection process for community services.

5. Next steps

5.1 Following approval by the Board, the plan will be published on our website, and circulated widely to key stakeholders. It will also be included as part of the ICBC Programme process.

5.2 Engagement in terms of delivery of the plan will continue with papers going through the Health and Wellbeing Board and Health Scrutiny in the coming months.

6. Recommendations

6.1 To receive and approve the Primary and Community Care Delivery Plan for BSW including the transformation priorities.

Bath and North East Somerset,
Swindon and Wiltshire Together

Bath and North East Somerset, Swindon, and Wiltshire Integrated Care System (BSW Together)

Primary and Community Care Delivery Plan

September 2023

V1

Contents

Executive summary

Primary and community care services work to improve our populations' health, support them when they are unwell, and achieve fairer outcomes for children and adults across our system.

BSW Together has the opportunity to transform how we deliver primary and community care services across the integrated care system (ICS). We want those living and working within our communities, and those who use and deliver these services to feel a step change in how we come together and collaborate. This will create a truly integrated network where everyone's contribution is valued and recognised.

We need to address important drivers including an ageing population with increasingly complex needs, including frailty; growing demand and pressure across our services and on our workforce; the need for a person-centred approach to care; and the relationship between greater equality, better care, and a healthier economy.

This delivery plan builds on our existing strategies, including the BSW Together Integrated Care Strategy and Implementation Plan, and national policy and guidance. It consolidates existing documentation (over 20 documents) and reflects the engagement work completed to date with service users, providers (including market engagement events) and wider stakeholders to identify initiatives and solutions to deliver our ambition. This delivery plan also incorporates direct feedback from over 40 stakeholders including primary care GPs, integrated care board (ICB) members, the clinical oversight group, and the integrated community-based care (ICBC) programme.

Our delivery plan sets out six transformation priorities:

1. **Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams.** We will build on our existing primary care networks to create more integrated neighbourhoods serviced by providers who can share information, caseloads, and estates to provide more joined up care and the capacity to do so.

2. **Adopt a scaled population health management approach by building capacity and knowledge.** We will use data and insight to understand our populations better, identify health inequalities, target marginalised groups, and develop initiatives and services that improve access and result in fairer health and outcomes.

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4. **Increase personalisation of care through engaging and empowering our people.** We need to shift towards greater prevention and early intervention. We can do so by tailoring our support to a persons' specific needs and using technology

advances to provide support in formats that fit with individuals' needs and preferences.

5. **Improve access to a wider range of services closer to home through greater connection and coordination.** We will deliver excellent health and care services closer to people's homes and overcome inequality of access by creating stronger physical and virtual connections between primary and community care and specialist services.

6. **Support access to the right care by providing co-ordinated urgent care within the community.** We want emergency care to be for those who need it most and know we can help people to address their urgent needs within the community. This can prevent avoidable admissions and result in better outcomes and experiences.

Within each priority, we have outlined its **context** and rationale, the **ambition** of what will look and feel different and identified **interventions and actions** that will support its delivery. These are intended to enable places, neighbourhoods, and providers to understand the direction of travel for primary and community care and support them to make decisions on how they are delivered within their local populations.

We also recognise the importance of the five **focus areas** which have been considered for each priority. The focus areas are health inequalities, children and young people, mental health, major conditions, and learning disabilities and autism.

This delivery plan will be supported by the six enablers identified in the BSW Together Integrated Care Strategy, as well as an additional enabler on commissioning and contracting:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as an anchor institution
- Commissioning and contracting

This document is intended to be a strategic articulation of the future of our primary and community care services across BSW as we work better, and closer, with our partners and providers including the NHS, local authorities, the private sector, and voluntary, community and social enterprise (VCSE) organisations.

The intention is for this delivery plan to evolve over time as we hear and learn more from those who deliver and those who receive our services. We know we have more work to do to build the detail to deliver on these priorities and recognise this document is the starting point for our journey to transform primary and community services across BSW.

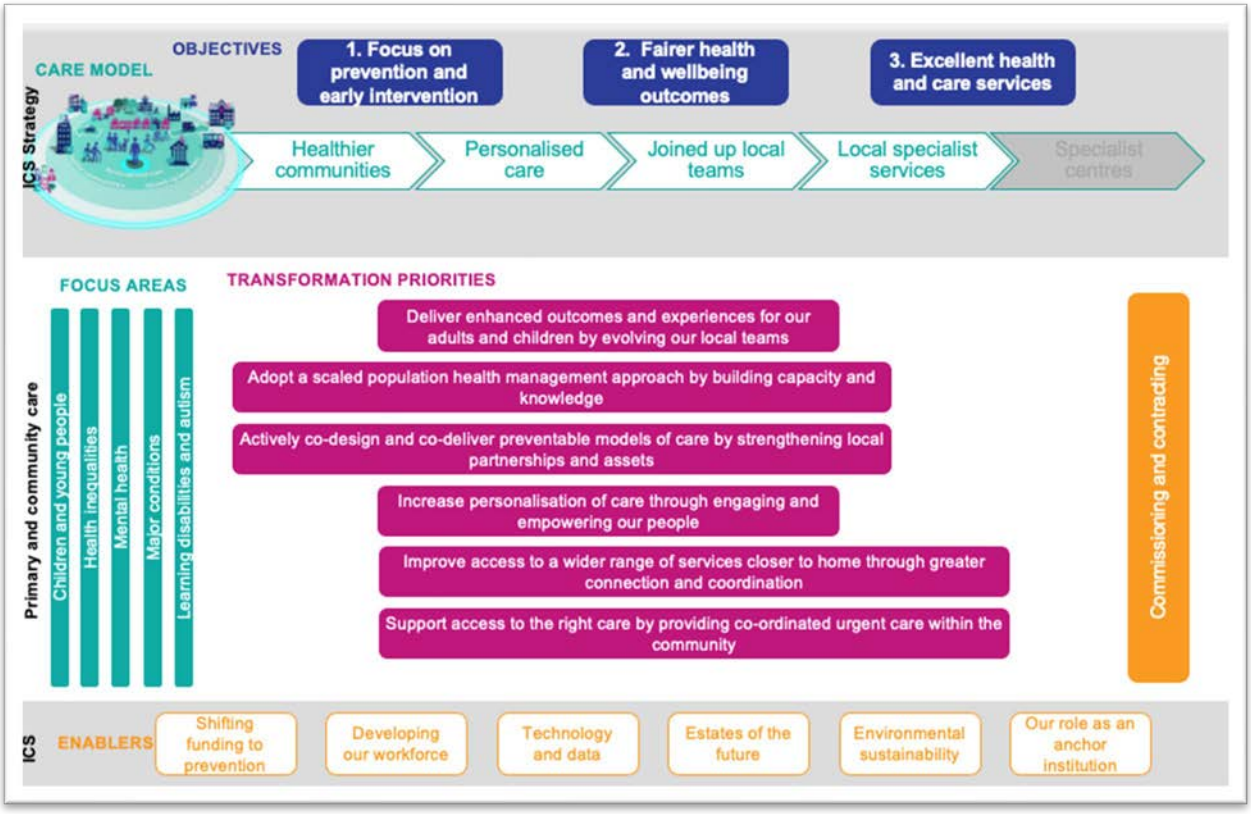


Figure 1: Summary of transformation priorities and alignment to BSW care model

Delivering our transformation priorities will mean:

- Our children, young people and their families and carers are recognised and valued, with a healthy environment to grow and learn in, and access to the support they need
- Individuals can equitably access care closer to home, within their communities and delivered by people who understand their specific needs
- Our older people, particularly those living with frailty, are supported to age well and stay independent at home for longer, where they are cared for at or near their home
- Our workforce is engaged and inspired, supported by technology, data and space that helps them to be happier at work
- Our providers and partners collaborate and innovate to drive fairer outcomes as well as delivering services. These providers are supported to be sustainable, providing the basis for transformation and shifting services into the community.

Introduction

The primary and community care delivery plan is a strategic document that supports the broader BSW Together Integrated Care Strategy and Implementation Plan and informs operational planning and financial recovery, so that we can better serve our BSW population of children and adults.

Scope

This delivery plan has been developed at the system level and encompasses primary and community care services. It focusses on the first four parts of the BSW care model (personalised care, healthier communities, joined up local teams, and local specialist services).

Central to delivering locally is our ability to enable joined-up local teams. However, we also need to consider how we best provide care and support to our communities and our peoples' individual needs, reduce health inequalities, and how we integrate with secondary care. As a result, not all care will be provided through joined-up teams, some will be delivered by other providers, across multiple neighbourhoods or at place to address the challenges we face.

Primary care, specifically general practice (GP), will remain the point of access for many patients and, working within PCNs/neighbourhoods are the foundations for transforming community-based care. We recognise the challenges faced by GPs both in terms of demand (increasing activity), and supply (workforce, estates). As such, focus will be given to creating a resilient structure.

This system level delivery plan outlines transformation priorities for primary and community care services. It is not prescriptive, as the way in which places, neighbourhoods and providers deliver these priorities may differ. We want to empower GPs, VCSEs, or individual providers to make their own decisions for their local populations.

This is intended to be a dynamic document that represents current priorities and activities and should not be seen as an exhaustive list of actions to be taken.

Key definitions[1]

- **Primary care services** ("primary care") should be considered in its broadest sense and encompasses GPs/ Primary Care Networks (PCNs), pharmacy, optometry and dental (POD) services.
- **Community based care services** ("community care") includes universal or core services (place based), extended services, and community-based specialist services (such as virtual wards and community diagnostic services).

We expect that a variety of partners and providers (including VCSEs, NHS, local authorities, and the private sector) will contribute to the delivery of these services, as we

[1] As defined in the Primary and Community Care exec summary presentation

acknowledge that many different organisations operate across our neighbourhoods and places.

Acute level care is out of scope of this delivery plan. We have however considered where primary and community care services intersect with acute services and pathways.

Investment assumptions

Defining the financial envelope required to deliver the priorities outlined within this delivery plan is out of scope. We have indicated a desire to shift activity and outcomes through the BSW Together Integrated Care Strategy. This infers an associated increase in investment in future years. The system is however required to ensure fiscal sustainability and final investment decisions will emerge through the development of the BSW ICB Medium Term Financial Plan. Consideration by the ICB and Local Authority partners of the strategic benefits as part of this work will identify the optimal and sustainable level of investment they wish to commit into primary and community care services.

Key drivers

This delivery plan is an opportunity to address drivers for change across the system; reframing and transforming how we deliver primary and community care. It will also guide the upcoming recommissioning exercise for community service providers. Below is a summary of drivers, with a more complete narrative provided in the appendix.

- **Addressing an ageing population** – ageing well and keeping people healthier for longer within our communities can reduce pressure from increased complexity, multimorbidity, and frailty.

- **Increasing pressure on existing primary, community, and social care services** – many of our services are already stretched and we must transform how we deliver care and support to either reduce pressure or improve our ability to deal with it.

- **Addressing wider health and care pressure** – improving prevention and early intervention will not only help people to live healthier lives, but reduce avoidable demand on our wider health system, meaning resources can be utilised elsewhere.

- **Integrating to deliver a better experience and outcome for our adults and children** – we need to reduce the number of people falling through the gaps as they move between providers and improve our design of services by basing them on what our people need and want.

- **The economic value of health and care** – a healthier population is not only happier, but also more economically active. Investing in care, particularly prevention and early intervention, is key to our ability to maintain a healthy economy.

Delivery plan methodology

This delivery plan was developed through consolidation and alignment of existing documentation as well as engagement with stakeholders across the system.

This delivery plan builds on the Integrated Care Strategy and is aligned to the BSW care model. It should be read in conjunction with wider BSW transformation programmes and strategies outlined in the Implementation Plan. It consolidates and aligns to existing system and national strategies, policy, and guidance. Supporting narrative is provided in the appendix.

Stakeholder engagement took place through a series of market engagement events conducted to gather views from local providers. Feedback was also gathered from primary care GPs, ICB members, the Clinical Oversight group, and the ICBC Programme.

To structure the plan, a framework was developed with five interlinked areas, visualized below. The plan flows from the six **transformation priorities** which are delivered through **interventions and actions** (pink). These are driven by **principles** (blue), supported by **enablers** (yellow), and feature cross cutting **focus areas** (green).

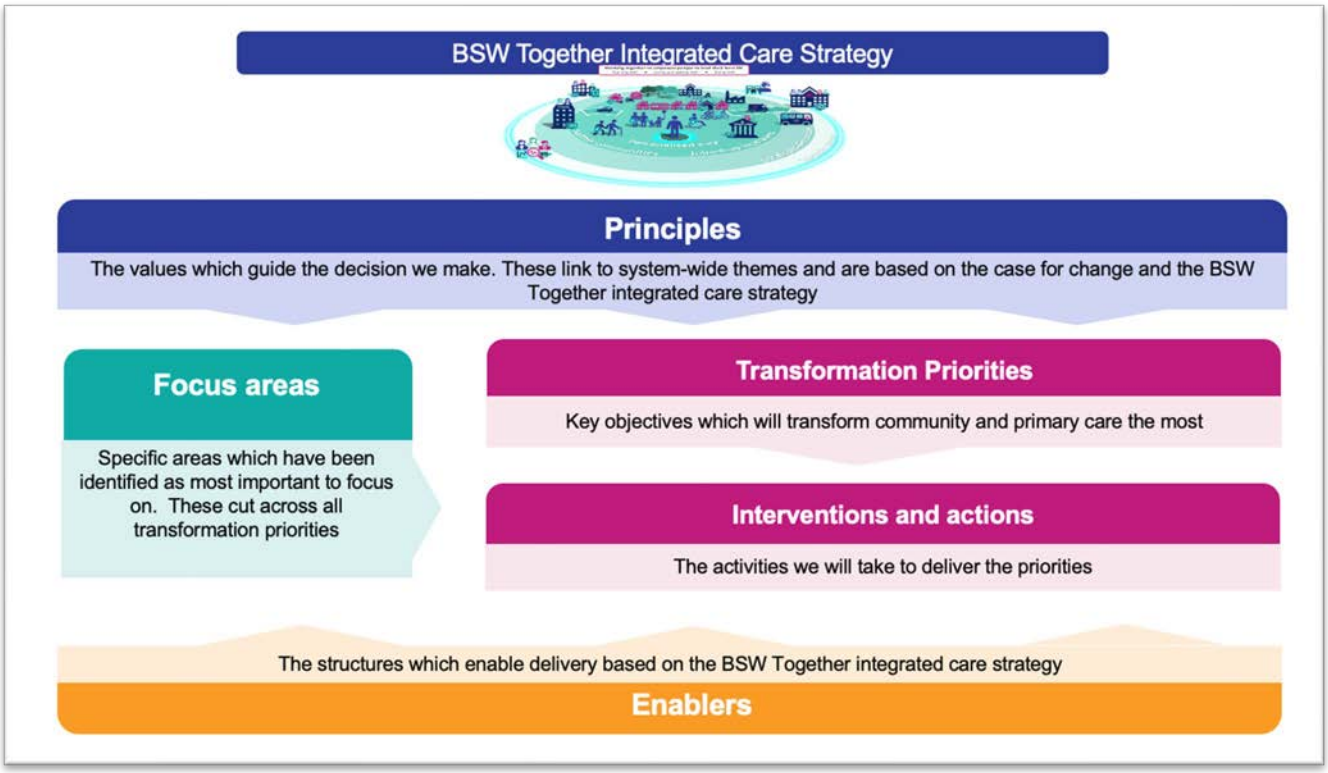


Figure 2: Structure of the delivery plan

Principles

These principles link to system-wide themes and have been developed based on existing principles across system strategy and programmes. They have guided, and underpin, all the focus areas, transformation priorities (including interventions and actions), and enablers.

Localisation - Focusing on the population's needs rather than sectors, organisations, or services. Highlighting the importance of community engagement and activation and emphasising the involvement of the third sector.

Equitable access - Reducing inequalities by utilising data and intelligence to inform planning and decision-making processes. Target interventions and enhancements based on identified areas for improvement.

Collaborating for outcomes - Changing our ways of working (both formal and informal) to create a culture of trust and innovation across providers. Empower local decision-making and delivery and strive for better outcomes.

Closer to home - Wherever possible, our people should be seen, supported, and treated within at-home or near-home settings and in their local communities so that we can keep people well and healthy at home.

Transformation Priorities

Based on the system strategy, national policy and guidance, case for change, and guided by the principles and focus areas, six transformation priorities have been identified for primary and community care:

1. Deliver enhanced outcomes and experiences of our adults and children by evolving our local teams
2. Adopt a scaled population health management approach by building capacity and knowledge
3. Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets
4. Increase personalisation of care through engaging and empowering our people
5. Improve access to a wider range of services closer to home through greater connection and coordination
6. Support access to the right care by providing co-ordinated urgent care within the community

These priorities support the delivery of, and are aligned to, the BSW care model and focus areas.

Focus areas

At the system, and national level, there are several focus areas that have been identified that should be considered across all transformation priorities:

- Health inequalities
- Children and young people (CYP)
- Mental health
- Major conditions
- Learning disability (LD) and autism spectrum disorder (ASD)

Where relevant, interventions or actions within this plan have been identified for a specific focus area. Those mentioned are not an exhaustive plan for each focus area. Further work is required to align this delivery plan to existing programmes or develop new strategies. Additional detail can be found in the appendix.

Enablers

Reflecting the enablers identified in the BSW Together Integrated Care Strategy, this delivery plan will be supported by the following enablers:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as an anchor institution

We have identified an additional enabler for the purposes of this delivery plan:

- Commissioning and contracting

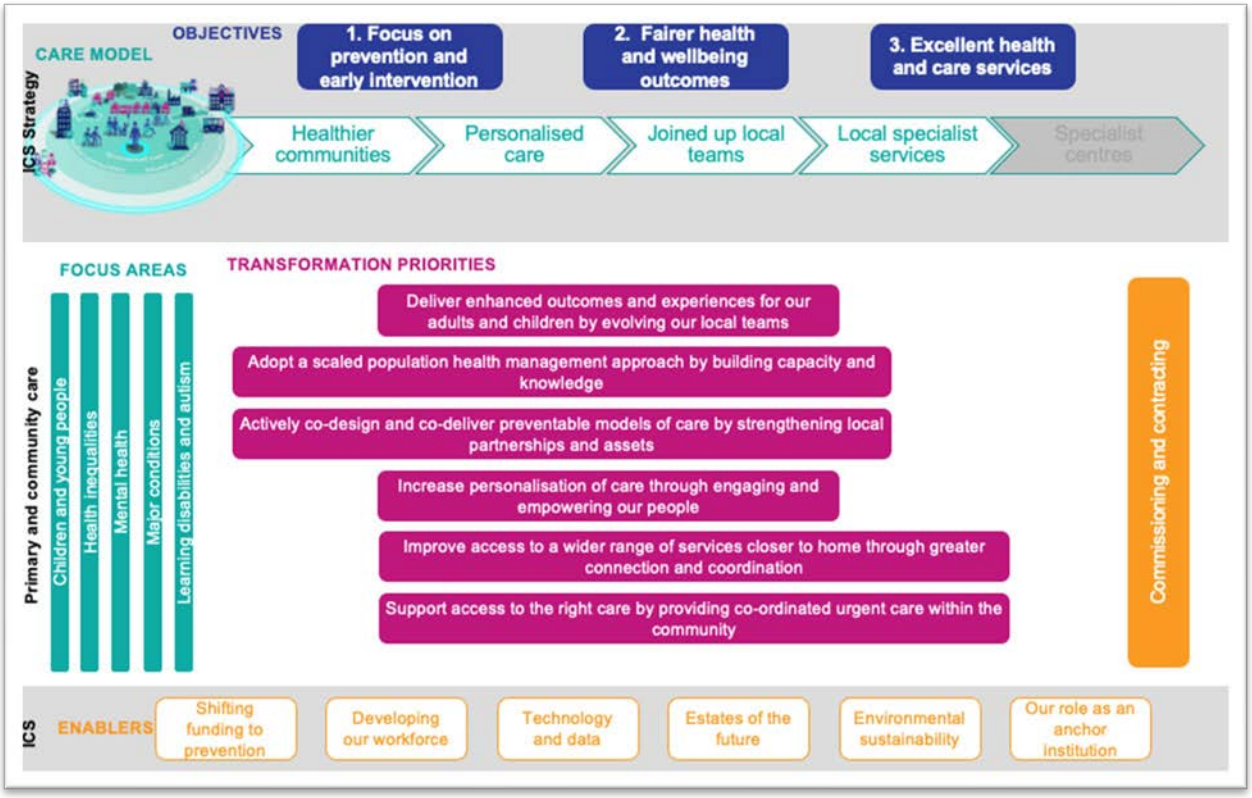


Figure 3: Summary of transformation priorities and alignment to BSW care model

Each transformation priority is described in four sections:

- **Context** – an overview of the priority and rationale
- **Our ambition** – what will be achieved by delivering the transformation priority and address the key drivers identified
- **How we will deliver** – detail on the interventions and activities that support delivery. Interventions and actions are not intended to be exhaustive and further work is required to build the detail required to implement.
- **Impact on focus areas** – commentary outlining how the transformation priority will affect each specific focus area

Priority 1: Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams

Context

Our care model states that joined-up local teams will enable us to deliver in a more coordinated way. We need to shift from operating as individual providers to operating together, using the strengths and expertise of different professionals.

Joined-up local teams[2] (sometimes referred to as integrated neighbourhood teams, INTs) enable providers to work together to personalise the care they deliver to a specific person. INTs were described in the Fuller Stocktake as having the potential to deliver more personalised care through support provided by a multidisciplinary team (MDT) of professionals. Designing our services around our neighbourhoods and connecting health and care professionals through these teams will provide coordinated lifestyle, psychological and medical advice, and support.

These teams bring together individuals from the health and social care sector, such as social care leads, nurse leads, health development coordinators, and GP leads, working alongside local partners such as local housing associations, policy, mental health services and voluntary organisations. Teams do not necessarily need to be physically located together, nor is a dedicated resource needed in every team and neighbourhood from every provider. We need to develop a model that provides greater connection between services so that we can pull in the right expertise when it is needed.

Joined-up local teams and their ways of working will provide benefits to all our adults and children within BSW but be particularly beneficial to those who need the most care or those with the multiple and complex needs including moderate frailty.

As outlined in the Fuller report, support for the new INTs will need to come from ‘larger providers such as GP federations, supra-PCNs, NHS trusts’ as they have the scale required to support this new way of working. This will include integrating enablers such as HR, quality improvement, organisational development, data and analytics, finance, etc.

Our ambition

- Organisations and providers work together to deliver co-ordinated care for those with complex and long-term conditions, delivering continuity of care throughout and leading to a better experience for service users
- Local teams deliver targeted initiatives that support prevention and early intervention and reduce inappropriate referrals and avoidable admissions, reducing pressure on the wider system
- Joined-up local teams and primary care deliver place-based integration of mental and physical health and ensure parity of esteem

[2] As defined in the BSW care model

- We take a trauma informed approach to assessment and care planning so that we can recognise that lived experiences can impact how we support and care for children and adults

How we will deliver

1.1 Create a system-wide blueprint for local teams and set up the structures needed to enable it

1.1.1 Define the 'core' capabilities which should be aligned to neighbourhoods and interactions between neighbourhood-place-system providers
1.1.2 Understand the feasibility (including value for money) of sharing estates and equipment and design a model that enables greater awareness of estate / equipment that is available across the system
1.1.3 Define a BSW approach/policy identifying and removing blockers for sharing risk and caseloads between providers
1.1.4 Define requirements to deliver interoperable systems and required supporting processes and workforce to deliver
1.1.5 Clarify data governance and process requirements to enable and increase the sharing of information and data (such as a shared care record) to deliver greater continuity of care
1.1.6 Review feasibility (including value for money) for establishing a centralised back-office and transformation function for joined-up neighbourhood teams. If feasible define how teams can access it.
1.1.7 Identify what is required (investment, resources, training, etc.) to deliver joined up local teams

1.2 Harness the role of wider primary care in local delivery

1.2.1 Work with providers to understand the variation in provision, and future required alignment and provision of pharmacy, optometry and dental (POD)
1.2.2 Identify opportunities to support GP practices by providing additional capacity through alternative delivery models
1.2.3 Use understanding of community assets (action 3.2.1) to identify opportunities and partnerships that can be used to deliver signposting and preventative measures (such as blood pressure monitors) within non-NHS services

1.3 Build the capacity and capability to deliver local teams within primary care

1.3.1 Support Places to undertake a maturity assessment against the local teams' blueprint (action 1.1) and identify required actions
1.3.2 Develop solutions to address existing challenges impacting general practice sustainability (such as physical estates, workforce recruitment, and finance)
1.3.3 Specific examples include identifying plans to address the need for local teams to have:
- Adequate physical space within general practice required for MDT meetings and delivery of onsite training
- Adequate workforce resource to deliver local teams
- Reasonable adjustments for those with learning disabilities, autism, and other complex needs

- Statutory duties for babies, children and young people, and parental/carer support requirements for CYP specific services

Impact on focus areas

- **Health inequalities** – by knowing communities and the people within them, our local teams can use their interactions to identify and tackle instances of inequality or wider determinants of ill health.
- **Children and young people** – local teams can support those who may be on multiple pathways and have co-dependencies, and during their transition from child to adult services. These local teams must deliver connected care aligned with Connecting Care for Children.[3]
- **Mental health** – local teams will adopt a team-based approach that will include expertise from a range of professions, support greater parity of esteem and recognise the interdependency between mental and physical health.
- **Major conditions** – local teams will be able to support those with long-term and complex conditions to stay at home and access care and support in the community, reducing growth in hospital demand and shift away from a hospital-centric model of care.
- **Learning disability and autism spectrum disorder** – local teams will help us to improve the autism assessment process and post diagnostic services and help to implement the Key Worker Programme.

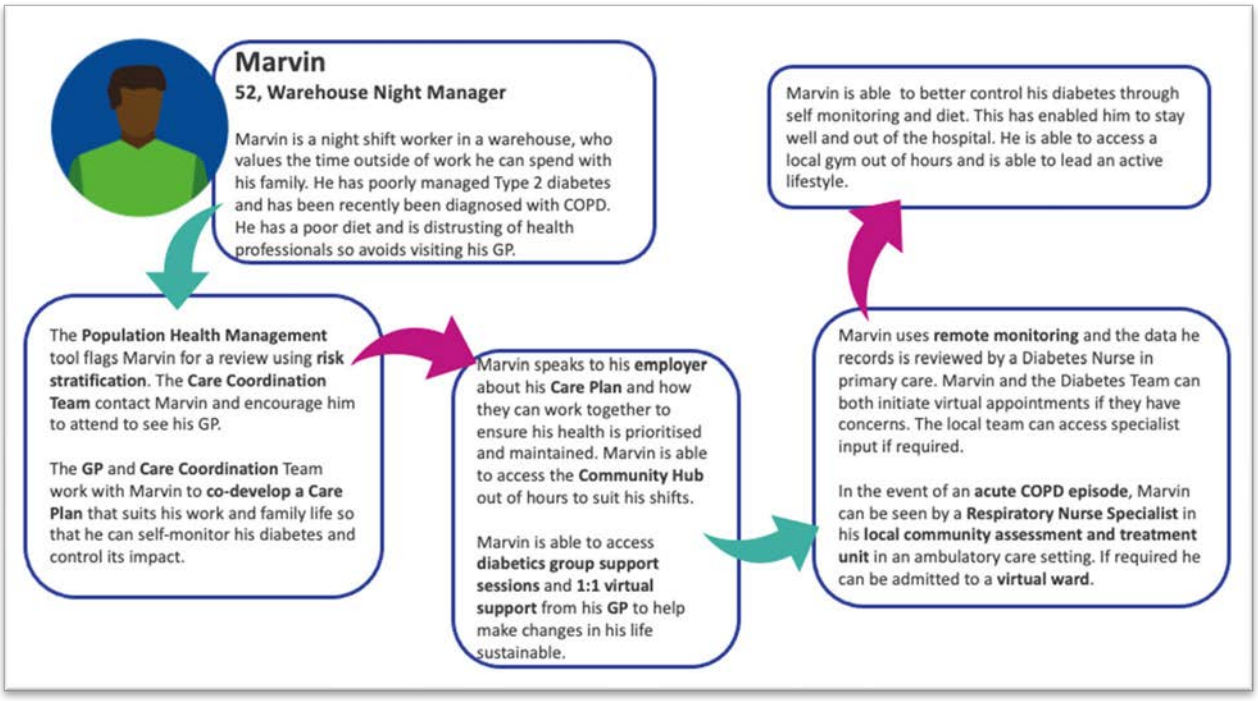


Figure 4: How care could be different – long term conditions[4]

[3] https://www.cc4c.imperial.nhs.uk/
[4] From BSW Together Integrated Care Strategy

Priority 2: Adopt a scaled population health management approach by building capacity and knowledge

Context

Population health management (PHM) is an approach used to understand a populations' current needs and predict what children and adults will need in the future. It uses historical and forecasted data to generate insight that enables providers to tailor better care for individuals, design and deliver in a more joined-up way, ensure that services are sustainable, and make better use of resources.[5]

Approaches typically focus on wider determinants of health to identify at-risk individuals and groups that can benefit from targeted, personalised, or preventative interventions. It can also be used to target and overcome barriers impacting marginalised groups or provide proactive support to older people living with frailty in the community. It is included in the NHS Long Term Plan; Fuller Stocktake; the Major Conditions Strategy; and BSW Together Integrated Care Strategy. We should consider Core20PLUS5 and CYP Core20PLUS5 approaches to reduce inequalities when designing these interventions.

Following participation in the NHSE funded programme, PHM has become an important driver in BSW's ICS journey and will be a key source of intelligence and insight driven solutions. BSW is currently piloting five projects across PCNs. A suite of tools is available to many organisations including data sets of identifiable cohorts, a health inequalities dashboard, and support for population health analysis.[6]

Primary and community care providers and partners must use PHM to support the delivery of longitudinal and preventative care.

Our ambition

- Services provided locally are based on the needs of local populations. While access is equitable there is some variation to reflect local need
- The ICB will develop and commission services according to local need of our children and adults so that we can prioritise resources and effort
- Organisations and providers will be able to work together to deliver across boundaries (organisational and geographical)
- Providers have access to data (both NHS and non-NHS) that enables them to use a PHM approach in their work

[5] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/
[6] BSW Together Integrated Care Strategy and Implementation plan

How we will deliver

2.1 Provide system-wide support to embed a consistent PHM approach

2.1.1 Complete review of current attitudes, cultures, and ways of working to PHM approaches

2.1.2 Define the minimum expectations in relation to PHM approaches (such as risk stratification, segmentation, impact modelling, alignment to Core20PLUS5 approaches) that should be adopted by local teams and set up methods to monitor and support its use

2.1.3 Establish formalised mechanisms to share good practice and learning across the system to spread innovation and success stories

2.1.4 Establish governance and plans related to data sharing and inclusion of non-NHS data such as that provided by adult social care, children's services, domiciliary care and VCSEs

2.1.5 Build dashboards to support providers to understand and identify differences in NHS health check invites and updates, delivery of vaccines, treatment targets, and care process attainment (including health inequality cohorts)

2.2 Use insight to identify care gaps and develop and prioritise targeted initiatives

2.2.1 Based on 2.1.2, use PHM to make evidence-based decisions on prioritisation, specific initiatives currently identified include:

- Increase capacity to provide annual health checks for those with long term conditions, learning disabilities and autism, serious mental health illness and CYP
- Increase focus on behavioural interventions including initiatives like tobacco control/ smoking cessation, weight management, alcohol use, oral health promotion, and high-risk condition monitoring
- Identify groups at risk of missing cancer screening and develop targeted initiatives to increase uptake
- Increase access to tailored Talking Therapies including digitalised programmes for those with long-term physical health conditions and child and adolescent mental health services (CAMHS)

2.3 Support local teams to scale the use of PHM in their work

2.3.1 Establish a programme to boost capability and resource capacity to apply PHM standards across the system, with specific focus on local neighbourhood teams. Specific examples include:

- Undertake a readiness review based on PHM standards of local teams' existing capability and access to data sets
- Review local teams' access to PHM toolkit and provide upskilling on how to use it
- Ensure local teams can operate within governance frameworks

Impact on focus areas

- **Health inequalities** – a PHM approach (such as expanding the use of the BSW Health Inequalities dashboard, and better use of deprivation and ethnicity data) increases our ability to identify where there are areas or cohorts of unwarranted variation such as in access or provision and develop initiatives to address them. Improved identification and targeting is central to reducing inequalities.
- **Children and young people** – we can use insight to better understand our CYP groups[7] and drive a reduction in inequalities. A data-led approach will mean developing targeted initiatives that are specific to their needs and those of their parents and carers.
- **Mental health** – we can use PHM to identify wider determinants of health which are increasing risk of mental illness, and tailor our mental health services for certain cohorts such as asylum seekers / refugees. Bringing data together will allow us to better target patients with both mental and physical health conditions, promoting earlier intervention.
- **Major conditions** - using PHM will enable us to develop more tailored prevention and early intervention initiatives through identifying and closing care gaps. As above, joint datasets will enable us to identify patients with both physical and mental health conditions, as well as those in receiving other services.
- **Learning disability and autism spectrum disorder** – we can use the insight from PHM to identify and deliver our LD, ASD, and neurodevelopment pathways including improving access and uptake of annual health checks.

[7] BSW Together Implementation Plan

Priority 3: Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets

Context

Care and support are best delivered by those who understand the children and adults who live within their communities. Similarly, organisations outside of the NHS can help people live healthier lives and help us deliver services in a more sustainable, accessible way.

While GP practices remain the foundations, neighbourhoods have multiple assets including physical space and estates, relationships and partnerships, and capabilities. Understanding these mean that we can support people in the most appropriate way and support the resilience of providers within and outside the NHS.

Part of integration is building on and strengthening closer working between health and care providers and wider organisations that operate within our communities. This includes local authorities, VCSEs, the wider public sector, and private organisations. They can be the bridge into local communities and help connect and deliver important services. The information flows both ways; they also provide a wealth of insight and expertise. They will be key to us improving our ability to deliver prevention and early intervention through closer links and better partnerships.

Better and stronger partnerships can help us to direct adults and children to self-care or self-initiated care. Promoting and signposting these services within primary and community care will help us shift towards greater prevention and early intervention.

Our ambition

- Community and local teams work with local organisations to support the design and delivery of health and care services for children and adults, working together to coordinate care and support
- We make best use of our assets including workforce, estates, and technology to reduce pressure across the system

How we will deliver

3.1 Address current barriers to working with local partners and providers

3.1.1 Explore and adapt our approach to commissioning and funding models (with consideration to long term investment in VCSEs and inclusion of training budget for the third sector)

3.1.2 Increase local partner representation within clinical and professional leadership forums and groups (including decision making) across BSW, at Place and Neighbourhood level

3.1.3 Increase training and development pathways available for the community workforce, leveraging opportunities such as the BSW Academy. Specific examples include:

- Community nurses

- Mental first aid
- Physiotherapy rehabilitation for care workers

3.2 Increase our awareness and use of community assets in the delivery of care

3.2.1 Support neighbourhoods to review and record community assets through the creation of frameworks, toolkits, and resources to assist completion

3.2.2 Identify and promote opportunities to promote the multi-use of space within neighbourhoods, utilising NHS estates and other assets

3.2.3 Use alternate workforce roles to complement existing services. Potential options include:

- Uplift in capability and capacity of wellbeing advocates, link workers, care navigators, or village agents
- Increased use of trusted assessor status to reduce delays such as in treatment assessment and discharge

3.2.4 Identify opportunities to increase use of community assets, specific examples include:

- Design a standardised social prescribing offering within local teams
- Continue to build a community mental health model that uses third sector mental health alliance partners to deliver a 'no wrong front door' approach
- Expand and develop our mental health support teams (MHSTs) in schools and work with education providers to support delivery of their local mental health plans
- Increase connections between local authorities, education providers, and health providers within the special education needs and disabilities (SEND) programme
- Deliver healthy weight programmes in partnership with, and based at, schools, gyms, and community centres

3.3 Build meaningful relationships to ensure our communities and local people are involved in the design and delivery of services

3.3.1 Support partners and providers to identify and increase use of innovation and community engagement with the services they provide. Specific examples include:

- Increase resource capacity to undertake community engagement initiatives
- Identify and connect with local groups and agencies (such as education probation, charity organisations, and faith leaders) to understand lived experience and use this to drive design
- Identify and proactively engage with marginalised groups to identify and breakdown barriers to accessing healthcare
- Tailor approach to contacting at-risk people who are less likely to attend services due to barriers they may experience

3.3.2 Create formalised feedback loops (supported by resource and capacity) between providers, VCSEs, and individuals (such as child and adult participation groups and community conversations) to gather and respond to feedback

3.3.3 Demonstrate ongoing commitment to local area partnerships and alignment to initiatives. Specific examples include:

- Healthy high streets[8] and Liveable neighbourhoods[9]
- Local Area Inclusion Partnership (LAIP)
- Family hubs[10]

Impact on focus areas

- **Health inequalities** – research suggests that wider determinants of health are more important to healthcare in determining health outcomes[11]. Closer working of the NHS, local authorities and the VCSE sector can help to improve the lives of people in our communities such as to ensure warm houses and clean air.
- **Children and young people** – stronger relationships with our schools and local authorities will ensure we can give our children and young people a better start in life both in the prevention of preventable conditions and management of long-term conditions.
- **Mental health** – increasing our use of community-based wellbeing services means our third sector mental health alliance partners can 'walk alongside' and direct people to alternative offers in local communities, aligned to the community mental health framework.
- **Major conditions** – initiatives like social prescribing can help those living with long term physical and mental health conditions to build knowledge and skills so that they are confident to live well with their condition.
- **Learning disability and autism spectrum disorder** – if we can strengthen the support in the community, we can build on preventative support that avoids crises and helps to enable people to be active members of their communities, learn new skills and have new experiences.

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699295/26.01.18_Healthy_High_Streets_Full_Report_Final_version_3.pdf
[9] https://beta.bathnes.gov.uk/liveable-neighbourhoods
[10] https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme
[11] https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

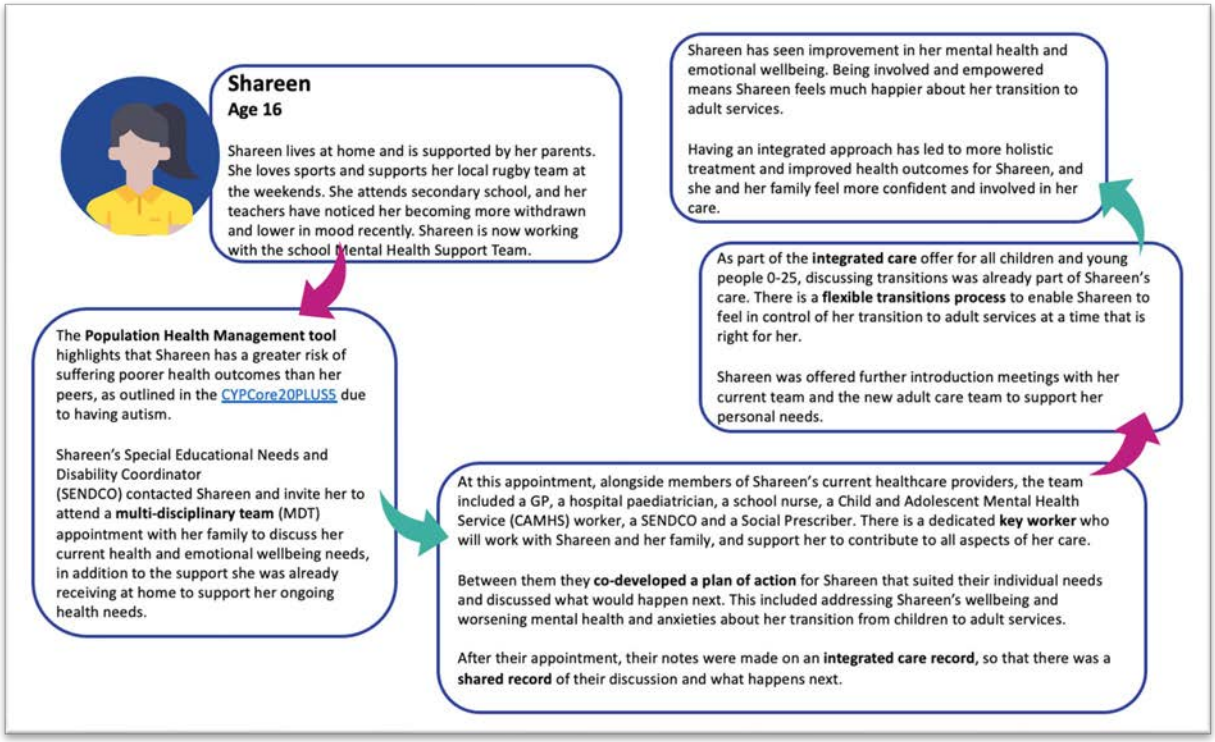


Figure 5: How care could be different – improving outcomes[12]

[12] Provided by the CYP Programme

Priority 4: Increase personalisation of care through engaging and empowering our people

Context

We know that engaged people are more likely to take an active role in their health and wellbeing. We need to support our people to shift mindsets away from doctor-led, on-demand care and encourage self-care and the use of alternate services and professionals. We need to put people at the heart of care: giving them choice and control, and better, fairer access.

Engaging children and adults in the design of services is the first step in supporting their empowerment. By giving a voice to residents and communities, they are actively involved in the design and ongoing improvement of services. This increases our chance of providing services they will be able to, and want to, access.

By providing adults and children with tools, services, and opportunities tailored to their needs, we can give them greater autonomy over their health and wellbeing. Digital and technological based services represent a major opportunity in this area. We expect developments like artificial intelligence (AI) to play an increasing role in future delivery.

Our ambition

- Our people are proactively offered initiatives that are tailored to their needs and circumstances so they can have better experiences and outcomes
- Individuals feel supported by a team that understands their specific needs, provides them choice, and involves them in decision-making
- Children and adults feel they have a voice in the services provided to them and know what services exist and how to access them, so that they access the right care and support

How we will deliver

4.1 Expand the use of personalised budgets across the system

4.1.1 Define a system-level standard set of practices for personalised care and support planning for children and adults

4.1.2 Implement standardised practices for personalised budgets so people have the maximum amount of control on the support they receive

4.2 Increase awareness of services to support better decision making

4.2.1 Undertake ongoing campaigns to increase awareness of alternatives to GPs amongst our communities so that more people access alternate services

4.2.2 Review use of patient-held records and identify initiatives to increase availability and support providers to use technology such as the NHSApp[13] to do so

[13] https://www.nhs.uk/nhs-app/about-the-nhs-app/

4.2.3 Identify and unlock barriers to support providers to access and offer clinical trials and research to their local populations

4.3 Roll out digital and remote initiatives that support at-home and near-home management

4.3.1 Increase the provision and use of NHS@Home[14] offerings including self-monitoring and at-home diagnostics
4.3.2 Build resource capacity and capability, and provide career development pathways across the system to deliver virtual wards (aligned to the BSW NHS@Home virtual wards programme)
4.3.3 Review and select digital tools and systems to enhance care coordination across providers
4.3.4 Support providers to expand the new digital NHS health check to boost capacity

Impact on focus areas

- **Health inequalities** – personalised care will empower our people to take more control of their health. Providing greater choice and awareness will help improve access for all patients, similarly, increasing capacity within primary and community care will enable providers to focus on addressing inequalities and supporting more complex patients.
- **Children and young people** – greater personalised care means that children and young people are actively involved as service users of health services in their own right.
- **Mental health** - we need to bring together treatment for physical and mental health and consider what holistic support an adult or child specifically needs and how best they can access it. Personalised budgets can improve delivery of care and support for those with mental health needs and their unpaid carers.
- **Major conditions** – greater use of technology and personalised care will enable us to consider treatment and support over the long term, particularly when recovery is not possible, managing periods of intensive support followed by periods where less support is needed.
- **Learning disability and autism spectrum disorder** – people with Down's syndrome are at significantly higher risk of experiencing other conditions[15] and we need to make sure we look at people as individuals with needs that may not fit neatly into condition specific pathways.

[14] Refers to NHS@Home definition https://www.england.nhs.uk/nhs-at-home/ which is different to BSW Together NHS@Home (virtual wards programme)
[15] Major conditions strategy

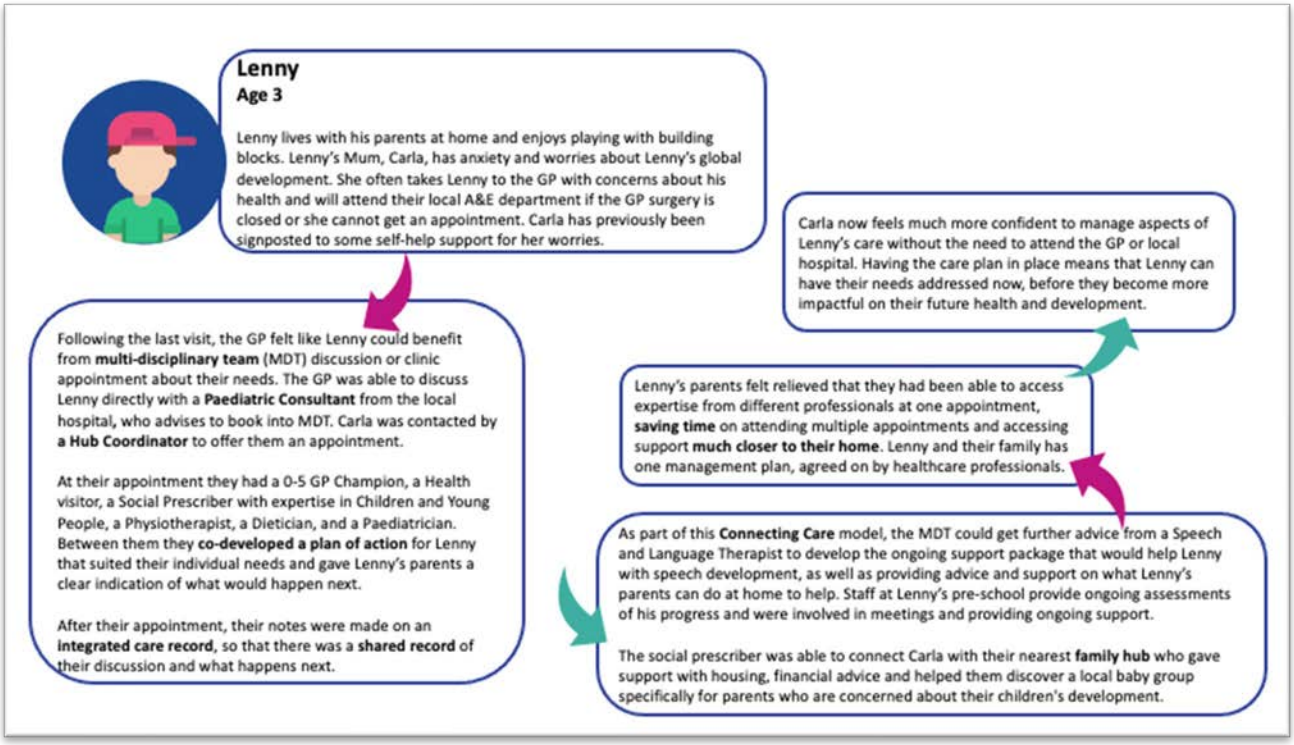


Figure 6: How care could be different – personalised care[16]

[16] Provided by CYP Programme

Priority 5: Improve access to a wider range of services closer to home through greater connection and coordination

Context

Aligned to the BSW Care model, we want to enable our services, particularly specialist services, to be provided and accessed more easily. Equitable access to healthcare and better outcomes can be achieved when we deliver care either at home or closer to where people live. This is particularly the case where there are issues of frailty, deprivation or where there are significant distances required to travel to acute sites from rural locations.

Some local specialist services[17] are already organised around neighbourhoods. We want to increase the range that are delivered closer to communities, provide a greater choice of how and where children and adults access services and deepen connections between services. This will require revising existing models of care, where patients are referred to external specialists, and instead focus on embedding specialists within local teams. This may involve providing advice and guidance to our clinicians, to use case finding for the early identification of individuals who require specialist support, and to prevent referrals for acute care that could have been managed, with appropriate resource and governance, more locally.

Traditional models of delivering care through doctors and nurses can be transformed using non-traditional roles and realising the potential of existing community services. Whilst this might not result in the physical relocation of services or people, we want to create better and stronger links between our services and use technology, data, and our facilities to enable this. This will result in improved experience for patients and resilience of providers working within our neighbourhoods, including general practice.

Our ambition

- Local specialist services are designed around treating co-morbidities with equitable delivery and access to children and adults living in the community
- Providers and organisations work together to support the early identification and treatment of conditions and those at risk of potential deterioration

How we will deliver

5.1 Define the local specialist care model to link services together

5.1.1 Aligned to the local team blueprint (1.1.1), develop a local specialist team system level blueprint that supports a 'core' offer through local specialist teams including where they are located, how they interact and how they can support continuity of care. Specific examples include:

- Explore and adopt alternative referral mechanisms such as self-referral, triage of need, or stepped care delivery (reducing the need for a GP to act as a gatekeeper)

[17] As defined in the BSW Care Model

- Explore integration with providers to improve timely conversion of urgent referrals (such as urgent mental health or urgent suspected cancer referral) including booking and validation activities
- Define a risk stratification, complexity-based model that maximises opportunities to provide care outside of an acute setting

5.1.2 Support local teams to define the required representation and alignment of generalist and specialist resources within their area based on the 5.1.1 blueprint

5.2 Provide more wrap around services within the community

5.2.1 Develop processes to increase coordination between local teams and social care in complex discharge and care planning. Specific examples include:

- Dementia, delirium, and diabetes pathways
- Discharge to assess
- Enhanced health in care homes

5.2.2 Drive increased use of pre-habilitation and re-habilitation to enable patients to manage conditions at home while they wait for elective procedures and recover more effectively following a procedure

5.2.3 Increase provision and acute outreach within the community. Specific examples include:

- Provide seven-day extended access to community diagnostic services (both fixed and mobile) to deliver lower complexity services such as cancer screening, phlebotomy, electrocardiograms, spirometry, childhood asthma, and endoscopies
- Provide pulmonary rehab in areas with health inequalities
- Increase use of geriatricians
- Uplift capacity of urgent community response services

5.3 Increase local teams' access and connections to specialist advice and guidance

5.3.1 Support local teams to utilise existing technologies such as Cinapsis to access advice, guidance, and referrals more effectively

5.3.2 Identify opportunities to improve efficiency in shared-care referral and handover processes for individuals moving into and out of secondary care

5.3.3 Create opportunities for providers to identify and engage with local specialists to build strong working relationships that reduce bounce backs and inappropriate referrals

5.3.4 Create opportunities to transfer skills from specialist colleagues to other members of local teams

Impact on focus areas

- **Health inequalities** – extending services to the most vulnerable groups and places with the highest need enables us to have the greatest impact. Driving secondary prevention (stopping, or delaying the progress of conditions) at the local level means we can shape services to meet the needs of different communities and address inequalities. By diversifying how we deliver services, we can reach more people and reduce their risk of developing more serious illness.
- **Children and young people** – we want to reduce out of area placements which can be disruptive and difficult for both CYP and their families and carers. We can

consider the specific needs of children with complex needs through neurodevelopmental pathways and ensure they receive packages of care that are home-based.

- **Mental health** – we can deliver more local mental health offers and improve access to mental health support for people with Severe Mental Illness by using new access models that provide immediate advice, support and signposting to community and secondary services.
- **Major conditions** – pursuing the full potential of pre-habilitation and rehabilitation, such as those waiting for surgery for or in advance of cancer treatment can improve outcomes and result in children and adults who feel more empowered in their care.
- **Learning disability and autism spectrum disorder** – we want to reduce the number of people cared for in an inpatient unit out of area and deliver a centralised, consistent approach to how we manage escalations and complex cases.

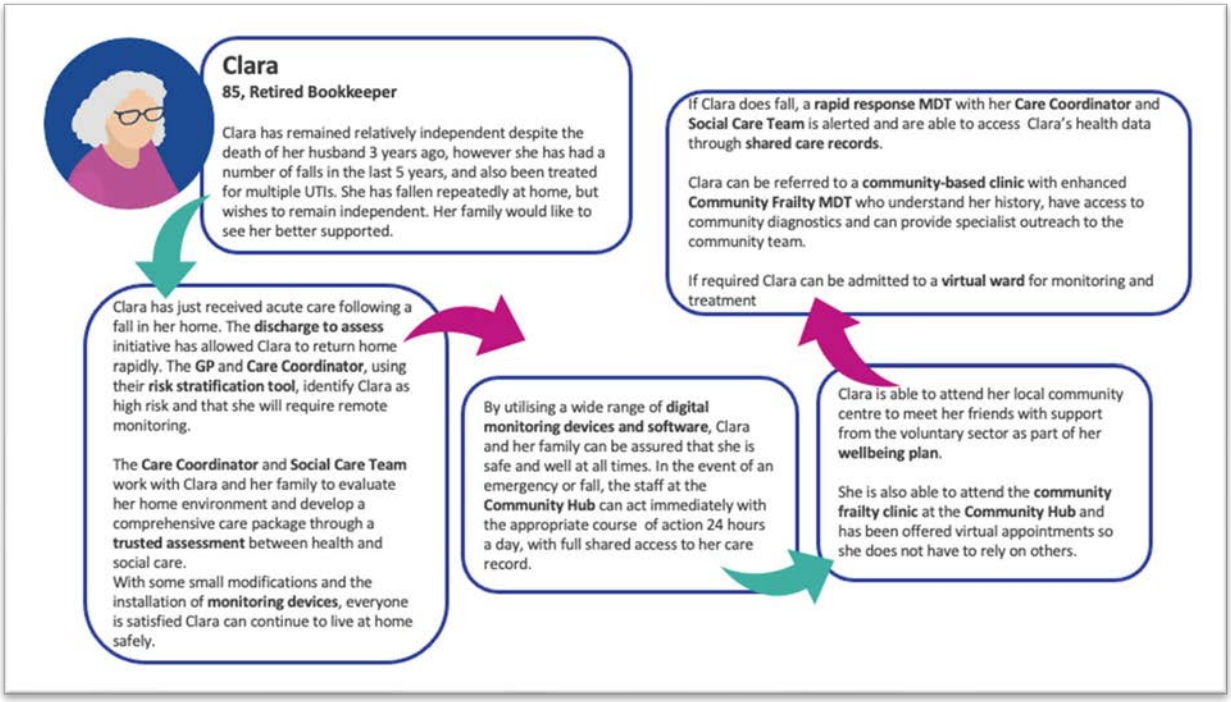


Figure 7: How care could be different – ageing well[18]

[18] BSW Together Integrated Care Strategy

Priority 6: Support access to the right care by providing co-ordinated urgent care within the community

Context

Many children and adults struggle to access same-day urgent care, and this increases the demand on both GP practices and emergency care. In turn, this impacts GPs' ability to provide continuity of care to those who need it most and reduces the capacity of emergency care services to deal with the most life-threatening cases.

Changing how we deliver urgent care – making it more accessible and bringing it closer to babies, children, young people, their parents and carers, and adults – will improve service user experience, staff experience and better management of system wide demand.

Urgent care is currently provided across many different, and often confusing services. They include GP in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community response services, home visiting, community pharmacy, 111 call handling and 111 clinical assessments[19]. We need to move away from these services operating in siloes to a connected system that works together to manage front door demand. We need to make it easier for people to know how they access the right care in the right place, which may be self-care, so they can achieve better outcomes and the system can cope with the demand.

Our ambition

- Increase capacity and capability within the community to enable individuals to resolve urgent but non-emergency needs without recourse to emergency services, reducing avoidable admission and pressure
- Primary and community providers provide consistent access and pathways to manage capacity and demand both in and out of hours, so that we can provide some services 24 hours a day / 7 days a week
- As a system, we offer care that is appropriate to need and makes best use of clinician and patient time
- We use a graduated response in our pathway design to support step-up and step-down services, supporting children and adults to be cared for closer to home

How we will deliver

6.1 Design a system wide single integrated urgent care pathway that can flex to local needs

6.1.1 Investigate opportunities to simplify and standardise services across the system
6.1.2 Explore opportunities to use co-location, local coordination services, or community hubs to deliver single front door access to urgent care

[19] Fuller Stocktake

6.1.3 Identify opportunities to increase access and reduce pressure through winter, while allowing teams to be redeployed as demand changes

6.2 Increase awareness and optimise use of same day urgent care services

6.2.1 Pilot and evaluate a community pharmacy prescribing service for minor ailments, urgent care, and urgent prescriptions

6.2.2 Initiate engagement and communications plan with local communities to improve awareness of urgent care services offered in their area

6.3 Improve the community-based mental health interfaces

6.3.1 Develop appropriate crisis response provision within the community, with first contact provided by third sector partners

6.3.2 Support local teams to deliver mental health crisis response services out of hours and ensure there is provision in rural as well as town areas

6.3.3 Review the provision of mental health practitioners within existing services (such as within general practice)

6.3.4 Deliver the expansion of NHS111 to provide universal access to mental health support

Impact on focus areas

- **Health inequalities** – using co-located hubs and services like community pharmacies, especially those provided locally, can help us to improve access and prevent and reduce health inequalities. Examples include the hypertension care finding service.
- **Children and young people** – delivering urgent care and same day services that are appropriate for children, young people and their parents and carers (such as paediatric short-stay assessment units) can enable them to be cared for closer to home and avoid admission to hospital.
- **Mental health** – we must ensure that we can expand community-based crisis services that are open access, age appropriate and meet local population needs. For example using NHS111 to ensure 24/7 freephone access to mental health helplines
- **Major conditions** – patients with major conditions will have better access to a range of providers to help manage their condition. This will promote and support earlier intervention.
- **Learning disability and autism spectrum disorder** – targeted interventions and support for those at risk of requiring urgent care will improve experience and outcomes.

Enablers

The six enablers outlined in the BSW Together Integrated Care Strategy will underpin interventions and actions that are detailed in this Delivery Plan. Where specifically relevant, the enabling actions are outlined within the transformation priorities, interventions, and actions. Ownership and delivery of these is expected to be driven through existing transformation programmes and strategies.

A summary of the enablers is provided below.

7.1 Financial sustainability and shifting funding to prevention

A key enabler to the primary and community care delivery plan will be the left shift of funds, currently dedicated to treating ill-health, towards initiatives and structures which prevent it in the first place.

The first step will require the system to gain an accurate and consolidated picture of funding and resourcing across self-care, primary care, community care, and hospital care.

Shifting funding to prevention may look like:

- Savings made in core mental health provision are reinvested into targeted wellbeing initiatives, directing funding through our Third Sector Mental Health Alliance
- Focussing on children and young people as they are ‘tomorrow’s adults’
- Investment being reorganised and geared towards personalisation including the wider rollout of personal budgets for service users
- Changing the way we invest so there is more funding for targeted initiatives that address health inequalities
- Supporting our providers (including VCSE and community partners) through more sustainable models

7.2 Developing our workforce

The NHS workforce is under strain throughout the system. To enable this delivery plan, we need to develop both the capacity and the capability of our workforce. Key to unlocking both will be to partner with community partners and VCSEs. This must be aligned with broader programmes such as the BSW workforce programme.

Over 37,600 people work in health and care in BSW, with many more across the VCSE sector as formal and informal carers. Work is underway to develop a BSW People Strategy, with a strong focus on recruitment and retention of the workforce. We must make primary and community care (including non-NHS providers such as adult social care and children’s services) an attractive place to work, address reputational challenges that we know exist and ensure our workforce diversity reflects the communities in which we operate. In particular, we need to build general practice capacity as this workforce is fundamental to our ability to deliver joined-up local teams.

One course of action could be to invest in staff training across providers through links with the BSW Academy so that we can better train, retain and reform. We must also understand how we can offer and support training of the third sector through opportunities like shared budgets, and paid volunteering time. Reviewing our existing ways of working will enable us

to ensure equity of time and funding for workforce development across all our providers and partners.

Additionally, a more flexible approach to resourcing will need to be adopted. Workforce planning will need to include Social Care partners, independent/ private providers, and VCSE provision. We must focus on leadership at all levels and across all providers to contribute to and drive our workforce planning. This will require building on our work on Health and Care Professional leadership to develop our system leaders. We should also consider how we can better share the workforce across providers and make the most of non-traditional roles and workforce models across the system.

A particular area of demand is domiciliary care. BSW workforce projections have identified a growing demand with raising rates of frailty and dementia against a backdrop of high staff turnover and decreasing numbers of people applying for care worker roles. In 2022/23, partnership work led by Local Authorities across BSW resulted in the development of a domiciliary care workforce modelling tool. This now needs to be implemented and integrated into wider community workforce planning.

7.3 Technology and data

The BSW Digital Strategy commits to (1) an electronic patient record (2) shared infrastructure across BSW and (3) a system wide approach to the use of technology. All three commitments will be required to enable a significant part of this primary and community care delivery plan.

We must also understand how our information governance frameworks can enable greater sharing of information and risk across partners, and make sure our workforce has the digital skills to deliver. Specifically, data and technology should support:

- Data unlocking areas within PHM including using predictive capabilities to promote prevention and reduce health inequalities
- Joined-up local teams to work together seamlessly through shared care records and increased sharing of information
- Virtual wards and supporting patients to receive treatment and care at or close to home
- Individuals who are empowered to access information and deliver self-directed care
- Improving service user experience through digital tools including self-monitoring and self-referrals where appropriate
- Increased access through tele-medicine and online appointments
- Successful implementation of Modern General Practice Access[20] in PCNs and practices
- Increasing use of AI to support delivery and clinical decision making

[20] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/

7.4 Estates of the future

The way we use estate needs to evolve and become more flexible to the changing needs of our populations. In addition our estates must be supported by integrated technology that enables us to deliver care at the right place based on those needs.

The ICS Estates Board is already working with NHSE to develop a national estates toolkit and the BSW Infrastructure Strategy[21]. One of its aims is to support clinical pathway redesign and the left-shift of care delivery in line with the BSW care model.

This new direction will support the primary and community care delivery plan. For example, estates should support:

- Modernisation of primary care infrastructure including GP surgeries that creates a positive working environment for staff and service users
- Virtual consultations to reduce the need to come into buildings and bring care closer to home
- Multi-use of existing wider public, community and third sector estates to be able to provide services closer to home
- Increased flexible and mixed use of NHS Estates including allowing community use
- Consolidation of back-office functions enabling the workforce to work across different locations, reducing unwarranted variation in care, and enabling joined-up working
- The removal of organisational barriers and an increase in utilisation across all settings to maximise the use of our investments

7.5 Environmental sustainability

The BSW Green Plan 2022-25 published in July 2022 sets out how we will begin to reduce the environmental and carbon impact of our health and care estate, services, and wider activities over the next three years. It sets out how we will work towards achieving net zero by 2040 for direct emissions and 2045 for the emissions we can influence.

We must consider how we enable people and organisations to make decisions which benefit the environment. Any design or delivery of primary and community services must consider the environmental impact and seek to reduce it wherever possible. Bringing care closer to home can reduce travel time for both service users and practitioners and making better use of our resources and estates can reduce waste and emissions.

7.6 Our role as anchor institutions

We must harness the potential of our anchor institutions (such as the ICS, acutes and local authorities) to play a greater role in promoting the social and economic interests of the local areas they are rooted in.

All primary and community care providers and partners should seek to support and benefit from BSW's role as an anchor institution. This includes creating jobs for local people, investing in local infrastructure, and supporting local businesses. Using local providers for

[21] BSW Together Implementation Plan

our primary and community care services will also support a greater contribution to the social and economic wellbeing of our communities.

7.7 Commissioning and contracting

The way in which our services are commissioned and contracted needs to change for us to deliver more joined up care. We have therefore included an additional enabler for the purposes of this delivery plan.

Our providers will only be able to deliver if they are sustainable, so we need to create a funding model that enables that.

Greater emphasis should be placed on collaboration and working across the system and therefore we must consider how services are funded and incentivised to enable this. At the same time contracts should be reviewed to remove unnecessary barriers as well as support new models of care.

We need to include all those who can support us to deliver better health and care, such as the voluntary sector, and move away from only looking at traditional providers.

Key areas that we need to consider include:

- Exploring alternate models of funding and commissioning such as outcome based and place-based contracts
- Reviewing the primary care and GP commissioning approach
- Develop the capability to measure ‘value for money’ and track progress towards a ‘left shift’
- Reduce contractual barriers between providers that is increasing competition and inhibiting collaboration
- Enabling innovation within our contracts by increasing flexibility of available funding

Appendix

Appendix 1.1: Key drivers

Addressing an ageing population

The BSW population is projected to grow by 6% over the next 15 years with an additional 60,000 residents in 2038 falling in the over-60 category (representing a 35% increase in this age category).[22] An older demography is associated with increasing complexity, multi-morbidity, and frailty of our people. This increases pressure across health and care providers, local authorities, VCSE organisations, and the wider public sector. Primary and community care supports better management of age-related conditions locally, which can prevent deterioration and help people to live independently for longer.

Increasing pressure on existing primary, community, and social care services

Demand on health and care services is increasing year-on-year and is acutely felt on front-line staff and services. Within primary care, there is growing discontent from both children and adult service users and professionals, with patient satisfaction at an all-time low. Challenges with urgent care access is impacting GPs' ability to delivery continuity of care to those who need it most. Additionally, social care services are under pressure both locally and nationally. Growing demand, longer waiting times for both physical and mental health and complex health needs are adding pressure to services for children and young people and leading to preventable deterioration of conditions.

GPs practices are having to work harder and longer to meet contractual targets and they face inflexible funding streams. Estates and technology are extremely variable; old buildings with poor connectivity limit GPs' ability to increase capacity through a digital-first offering. Within community care, BSW needs to improve the sustainability of providers and overcome current commissioning challenges. Without sustainable provision, particularly in GPs, PCNs and VCSEs, BSW will struggle to deliver the core elements of this delivery plan.

Addressing wider health and care pressure

Increasing complexity and frailty for adults is anticipated to cost our acute, inpatient, outpatient, and accident and emergency services an additional £5M per year for the next 15 years (before inflation or new treatments). An already stretched urgent and emergency care is facing an additional 115 acute beds, 40 ambulance journeys, and 51 emergency department attendances a day in five years' time.[23]. This significantly impacts the quality of care that individuals receive. For children, there has been an increase in attendances where they could have been seen in community settings and we must address the complex reasons for presenting in urgent care and out of hours settings.

Primary and community care can reduce front door emergency demand and provide alternate urgent care pathways within the community. Similarly, it can support flow through

[22] BSW Case for Change analysis
[23] BSW Case for Change analysis

admission avoidance as well as discharge and at home-support to ensure better continuity of care.

Integrating to deliver a better experience and outcomes for our adults and children

A key tenet of ICSs is to integrate the delivery of health and care services across an area and between providers. Primary and community care is often the first, and last, interaction that individuals have with the health system. Children and adults move from GPs through to secondary and tertiary care, and then are discharged back into the care of primary, community, and social providers. Many people will recognise the pain of constantly repeating symptoms, diagnostic tests, and ineffective and confusing care and support as they are transferred between providers.

Truly integrated care must be based on local population needs and a person-centred approach. This means increasingly integrated ways of working between primary and community care workers and the wider system. This should be supported by technology and data, new commissioning arrangements and flexible estates so that can be coordinated to respond to the individual needs of children and adults.

The economic value of health and care

A healthy population is critical to a healthy economy. In BSW, around 30% of GPs are over 50, and the ratio of people who are over the retirement working age will drop from 1:3.1 to 1:2.3 in 15 years.[24] This ageing population is impacting the number of people in our communities who are economically active and contributing to our economy. Ill health is also a large contributor to economic cost, with lost output due to illness among working age people estimated to be 7% of gross domestic product (GDP).[25] There is some evidence of a relationship between health spending and economic growth, with spend on community and primary care having the largest effect.[26] Healthy babies, children and young people will be the healthy adults of our future and are the future working population. This supports a key enabler of the BSW Together Integrated Care Strategy – shifting funding to prevention (left shift).

[24] BSW Case for change analysis
[25] Major Conditions Strategy
[26] https://www.nhsconfed.org/publications/creating-better-health-value-economic-impact-care-setting

Appendix 1.2: Delivery plan methodology

System and national documents reviewed

- BSW Together Integrated Care Strategy
- BSW Together Implementation Plan
- NHS Long term plan
- Fuller stocktake report
- Major conditions strategy
- Delivery plan for recovering access to primary care
- NHS long term workforce plan
- BSW Case for change
- Avoidable admissions + Frailty
- Benefits Master Version
- SO CSF PWF and Benefits
- ICBC Programme outputs
- ICBC service design
- ICBC service design CYP
- Children's services review
- Care model personas
- NHS long term workforce plan
- Major Conditions Strategy
- Creating better health value: understanding the economic impact of NHS spending by care setting
- Market engagement July
- Market Engagement August
- ICBC SOC extract
- Healthwatch report

Supporting narrative

BSW Together Integrated Care Strategy[27] and Implementation Plan[28]

The BSW Together Integrated Care Strategy 2023-2028 was published in March 2023. It sets out the ambition for the BSW ICS as well as partners in health, social care, and the voluntary sector, to enable local people to live happier and healthier for longer.

The strategy outlines three objectives

1. Focus on prevention and early intervention
2. Fairer health and wellbeing outcomes
3. Excellent health and care services

It is supported by an Implementation Plan published in July 2023. This brings together initiatives underway or planned across the ICS, including Place based plans, related to the strategic objectives and commitments outlined in the strategy. This delivery plan has identified and consolidated key priorities from the Implementation Plan.

NHS long term plan[29]

The 10-year plan published in 2019 sets out the NHS's plan to be fit-for-the-future and for delivering care for patients. Within the plan are commitments to increase investment for primary medical and community health services; increase rapid community response teams; bring people together to coordinate care better; and tackle health inequalities; and a focus on babies, children, young people, and their parents and carers. To enable this, there

[27] https://bswtogether.org.uk/wp-content/uploads/Integrated-Care-Strategy-v4.pdf
[28] https://bsw.icb.nhs.uk/document/bsw-implementation-plan/
[29]https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

must be a focus on attracting and retaining a flexible workforce, and making better use of data, digital and technology.

Fuller stocktake[30]

Published in May 2022, the Fuller report covers the current challenges and outlines a vision for better integration of primary care. Key elements include: the evolution of PCNs into integrated neighbourhood teams; using a population-based approach to build models of personalised care and targeted interventions; bringing together specialist and generalist workforces; and developing a single integrated urgent care pathway. Underpinning these is the ability to drive improvement through system leadership; optimising estates across networks; improving data and digital transformation; and ensuring ongoing primary care sustainability.

The vision outlines key areas for primary and community care: greater choice about how people access care which is available in the community when they need it; providing proactive personalised care through multidisciplinary teams; and helping people stay well for longer.

Major conditions strategy[31]

This strategy, released in August 2023, considers the whole care pathway from prevention to treatment for six major conditions: cancer, cardiovascular diseases including stroke and diabetes, chronic respiratory diseases, dementia, mental ill health, and musculoskeletal disorders. It articulates how these affect people throughout their lives, including children, young people and working age adults as well as older people.

25% of adults in the UK have at least two of these conditions and they drive over 60% of mortality and morbidity. The strategy takes a whole care and whole life approach to tackling these conditions by focussing on proactive prevention and early intervention; better management of multiple conditions; investing in Children's Health; and better connection, integration, and design of services. For those conditions that aren't preventable, we need to deliver specialist support and ongoing management that can be delivered easily in the community.

Delivery plan for recovering access to primary care[32]

Published in May 2023, the delivery plan aims to tackle the 8am rush and ensure individuals get the help they need from primary care. It focuses on four areas to reduce pressure and improve access: building capacity; reducing bureaucracy; empowering patients; and modernising GP access. Delivering this will require improving information,

[30] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf
[31] https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2
[32] https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf

functionality, and interoperability of technology; expanding community pharmacy; and increasing capacity through enabling workforce and estates initiatives.

NHS long term workforce plan[33]

Workforce remains a key challenge for the NHS and this plan, published in June 2023, aims to understand future requirements, and set direction for the workforce. It outlines three key areas of focus: train, retain and reform. Train recognises the need to grow the workforce through increased training for doctors and nurses and the expansion of other professions. Retain centres on improving culture, leadership, and wellbeing to improve retention. Reform aims to support the workforce to work and train differently, within multidisciplinary teams, and harnessing digital and technological innovations.

[33] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Appendix 2.1: Focus areas

A summary of the focus area and relevance to primary and community care is provided below.

Health inequalities

Although more affluent than the England average, BSW has a highly inequal distribution of wealth[34]. There is a strong link between a higher prevalence of health conditions, poorer life outcomes and living in less advantaged communities. For example, the most deprived 20% areas of Wiltshire have repeatedly poorer outcomes than the least deprived 20%, with similar patterns seen in other areas.[35] This can be due to factors including ease of access to health and care services and wider determinants of health. Delivering health and care interventions within the community and as close to peoples' homes is key: it improves access; promotes prevention; and often results in better outcomes due to better treatment uptake. We can also build on safeguarding work to have oversight of our most vulnerable communities aligned to our ambition to reduce inequalities.

Primary and community care providers can come together and use data, insight, and their local links to better understand where inequalities exist, and design tailored initiatives that tackle them. A greater focus on improving the life chances of children, especially those under five with a focus on early years will create fairer society and reduce health inequality.[36]

Children and young people (CYP)

Children and young people (0-25 years) represent 30%[37] of our population and are a key opportunity to break progression cycles and enable prevention in action for the improved health and wellbeing of our future population. However, many services are under extreme pressure due to growing demand post-Covid resulting in long waiting times and poorer health and learning outcomes.

As part of the CYP strategy development, BSW must scope, plan, and deliver a comprehensive suite of CYP primary and community services for babies, children and young people that meet local needs. We need to work more closely with local authorities and the education sector to make sure our children get the best possible start in life.

Mental health

Mental health conditions have been rising across BSW for adults and children. We need to focus on improving mental health across the system and ensure the principle of 'parity of esteem' is encompassed across our priorities. People with a mental illness are statistically

[34] BSW Together Integrated Care Strategy
[35] BSW Together Implementation Plan
[36] https://www.bmj.com/content/340/bmj.c818#:~:text=News-,Focus%20on%20early%20years%20will%20create%20fairer%20society,health%20inequality%2C%20Marmot%20review%20says&text=More%20public%20money%20should%20be,evidence%20based%20review%20has%20concluded
[37] BSW Integrated Care Strategy

more likely to also have a physical health condition[38] and we need to co-deliver services to provide a more holistic approach to comorbidity.

Many mental health services can, and should, be provided within the community. Aligned to the community mental health framework[39] and BSW mental health strategies[40], we need to expand services by working with local partners and providers who can help people with mental health conditions to easily access services when and where they need it, manage their conditions, or support individualised recovery, and enable them to contribute to and be participants in the community.

Major conditions

Nationally, people with two or more conditions account for around 50% of hospital admissions, outpatient visits and primary care consultations, over half of NHS costs and around three-quarters of the costs of primary care prescriptions. They also have an economic cost to the nation where long-term sickness is the most common reason for being economically inactive.[41] 16% of children up to 15 years old had one or more long standing condition, increasing to one in four for those aged 16 to 24[42]. These children will require support throughout their lives in the management of their long-term conditions.

Locally, major conditions are also a challenge with BSW currently spending over £120m on events and complications due to diabetes and cardiovascular disease.[43] We can address lifestyle drivers and behavioural risk factors, increase prevention, and maximise early intervention through targeted and considered involvement and integration of primary and community providers and partners.

Learning disability (LD) and autism spectrum disorder (ASD)

People with a learning disability have a 49% rate of avoidable death, compared to 22% in the general population.[44] One of BSW's transformation programmes centres around Learning disability and autism and is a key theme within local Implementation Plans for Bath and North East Somerset, Swindon, and Wiltshire. Across the system, we want to reduce the number of people who receive inpatient care; by expanding community provision and delivering initiatives locally that reduce admission. We need to identify and address care gaps such as missing recommended screening or access to early diagnosis and intervention services. We want to improve accessibility and ensure we can deliver care that recognises the specific needs of this cohort and the impact of comorbidity.

[38] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing
[39] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf
[40] BSW Together implementation plan
[41] Major Conditions Strategy
[42] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018
[43] BSW Together Implementation Plan
[44] https://www.kcl.ac.uk/research/leder

Glossary

Term	Description
AI	Artificial intelligence
ASD	Autism spectrum disorder
BSW Together	Bath and North East Somerset, Swindon, and Wiltshire integrated care system
CAMHS	Child and adolescent mental health service
COPD	Chronic obstructive pulmonary disease
CYP	Children and young people
GP	General practice
HR	Human resources
ICB	Integrated care board
ICBC	Integrated community-based care
ICS	Integrated care system
INT	Integrated neighbourhood team
LD	Learning disability
MDT	Multidisciplinary team
MHST	Mental health support teams
PCN	Primary care network
PHM	Population health management
POD	Pharmacy, optometry, and dentistry
SEND	Special educational needs and disabilities
SENDCO	Special education needs and disability coordinator
UTI	Urinary tract infection
VCSE	Voluntary, community and social enterprise

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	10
Date of Meeting:	21 September 2023		

Title of Report:	Equality, Diversity and Inclusion (EDI) Improvement Plan
Report Author:	Sarah Green, Director BSW Academy Gayle Williams Inclusion pillar lead Lowri Williams, Director of People
Board / Director Sponsor:	Jasvinder Sohal, Chief People Officer
Appendices:	Nil

Report classification	
ICB body corporate	
ICS NHS organisations only	x
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	x
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	x
2. Fairer health and wellbeing outcomes	x
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
BSW Academy EDI Community of Practice	04/07/2023	Discussion
BSW ICB People Committee	13/09/2023	Discussion and approval. Comments received set out at end of paper for Board consideration.

1	Purpose of this paper
The aim of the paper is to share a description, initial analysis, and implications of the recently launched NHS EDI Improvement Plan. The paper has been developed with both an internal ICB and external ICS perspective.	

The paper has accessed available data and information to offer baseline starting points against each of the EDI High Impact Actions with future recommendations. The paper has also referenced the broader aspects of the statutory duties and sharing an overview of EDI reporting and milestones.

The significance of the EDI Improvement plan has been highlighted from national and regional NHSE leads as being core to Long Term Workforce Plans and requiring a greater commitment to action; for both the people who work with us and the communities we serve. The plan/progress of action will feature as part of CQC well led review and other inter dependent work streams such as leadership behaviours and development, NHS Impact (Quality Improvement).

NHSE has recently reported that there is an expectation that the EDI improvement plan sets the overarching ambition and requirements for progression of delivery. There is not a request for a submission of a written action plan, rather that existing work should be aligned with any gaps identified with necessary actions progressed. The organisations response to the EDI improvement plan would meet the Public Sector Health Equality Duty (PSED) and can be used toward evidence for the Equality Delivery System (EDS). EDI will become a standing agenda item for regional people boards.

2	Summary of recommendations and any additional actions required

- Integrated reporting oversight of action plans and frameworks will be developed identifying clarity between ICB, ICS and BSW provider organisations. This will include progression of the gap analysis/RAG as identified through the initial analysis documented in the paper.
- EDI, inclusive of the action plan, to be standing agenda item on People Committee and reporting of delivery into SWG; this will reflect EDI being a standing agenda item on regional people boards.
- The ICB develops, and reviews, the organisational EDI strategy.
- The in-scope BSW workforce strategy sets a strong intent on addressing workforce and health inequalities.
- Identification of capacity to continue the work as a joint solution between the ICB and external facing BSW Academy or further escalation of noted risk in having no recurrent EDI expertise/resource.
- The ICB workforce planning team support the development of one EDI data dashboard that will link with regional and national teams.
- Further explicit opportunities are made for co-design with staff groups and our communities to enable the lived experiences to be paramount; often easy to be lost in the many operational and strategic intents.
- The HIA although an NHS scope are shared with all partners for enabling enhanced sharing, insight, and efficiency.
- The HIA and EDI activity are shared widely across programme boards in order that EDI becomes everyone's responsibility.

• Progress discussion for oversight of data and responsibilities with ICS partners through the Strategic Workforce Group and with ICS CPOs.	
3	Legal/regulatory implications
NHS Contract, PSED, CQC well led Domain	

4	Risks
Recognition of associated Risks: • From 19th Sep 2023 no EDI expertise or project management as part of ICB or BSW Academy (local risk register) • Sharing and access of data • Commitment and visibility to EDI.	

5	Quality and resources impact
Impacts on: Staff engagement- NSS WRES and WDES action plans EDS oversight and reporting Southwest Inclusion Strategy NHS Long Term Workforce Plan Gap in assurance regarding EDI resource at ICB and ICS oversight with enhanced devolution of expectations of ICS /ICB role from NHSE.	
Finance sign-off	N/A

6	Confirmation of completion of Equalities Impact Assessment
Impact for staff with protected characteristics and potential for positive increase in staff experience and engagement. Part of Public Sector Equality Duty; with due regard to: • eliminate unlawful discrimination, harassment, and victimisation • advance equality of opportunity • foster good relations. • Initial scoping completed with EDI leads from across BSW partners	

7	Statement on confidentiality of report
Able to be shared	

NHS Equality, Diversity, and Inclusion Improvement Plan - Implications as part of collective NHS EDI responsibilities

1. Introduction

1.1. On 8 June 2023, NHS England (NHSE) published its first equality, diversity, and inclusion (EDI) improvement plan that has been developed in consultation with diverse staff, staff networks and stakeholders. The expectation is that the Six High Impact Actions (HIA) set out will be implemented by all NHS partners with a framework provided for ICBs to produce their own plans. It is expected that future iterations will address EDI challenges in social care.

1.2. This paper outlines an initial analysis and recommendations of the high impact actions and the accountability framework for BSW. For clarity of responsibility and accountability the paper has differentiated between the ICB and the ICS partners.

1.3. To inform the paper a readiness assessment was undertaken on available data against the requirements as laid out in the HIA with the findings of:

- ESR, WRES/WDES, gender pay gap data available for secondary care partners and ICB.
- Currently no central mechanism for system oversight and to establish this would require access to data through working with partners.
- Further work required to identify baseline data for each HIA and agreed improvement.

2. Context

2.1. Inclusive workplace culture is imperative for staff engagement, attracting new talent, staff retention, social mobility and improving patient outcomes. However, despite evidence and positive intent outcome measures such as WRES and WDES have failed to reflect significant improvements; both across BSW, region and nationally. The new EDI Improvement Plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. It is focused on improvement actions and capturing impact, and aligns with the People Plan, People Promise, the Messenger Review and the newly published long term workforce plan.

2.2. The plan acknowledges intersectionality and includes a section on interventions by protected characteristic – this is crucial as survey data, particularly from granular WRES data, shows inconsistent experiences from staff with multiple and diverse characteristics. The plan highlights the importance of the workforce being representative of communities and supporting health inequality strategies and continues to support the NHS strategic EDI outcomes of:

- Addressing discrimination
- Increasing accountability of all leaders
- Support levelling up agenda, (the NHS as a model employer and anchor institution)
- Making opportunities for progression equitable for all.

2.3 It is expected that the EDI Improvement plan is implemented in partnership with trade unions, staff colleagues and forums and with staff networks.

3. Analysis of the High Impact Actions (HIA)

3.1 Each High Impact Action has been analysed and reviewed within the current available information and provided with an initial RAG. This activity has been further informed by an

initial extrapolation of available data according to each HIA. The RAG has been awarded from an ICB position and with further partner engagement the RAG will be undertaken as an ICS position.

The BSW workforce team were asked to review data as a baseline against each of the HIAs and what was and was not available-. A separate document has been provided with this information. Of note access to data is limited and if the ICB requires oversight of the activity from across the system it will require further discussion and support from NHS partners.

HIA 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.			
Actions 1	**ICB**	**ICB**	**ICS (RAG rating to be undertaken)**
All board members must have SMART (specific, measurable, achievable, relevant and timebound **(March 2024)** **EDI objectives and be assessed against these as part of their annual appraisal. (March 2024)**	• 100% of Board members to have an EDI objective as part of the appraisal process **A** • EDI board development to be agreed in 23/24 **A**	**A**	Overseen through BSW people directorate. Opportunity to share and agree executive behaviour inclusive of EDI objectives
Board members should demonstrate how data and lived experience have been utilised to improve organisational culture. (March 2025)	• Board patient stories and part of other groups such as UEC, quality, community engagement and people A • Standing Agenda Item on People Committee A • WRES and WDES data **A**	**A**	Agree 3 monthly reporting into Strategic Workforce Group
NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. (March 2024) **Progress will be tracked and monitored via the Board Assurance Framework (March 2024).**	• BAF to be reviewed. • EDI governance oversight to be agreed according to agreed milestones A	**A**	BSW Board for ICS oversight
HIA 1 Success Metric: Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).			
High Impact Action 2: Embed Fair and inclusive recruitment processes and talent management strategies that target under–representation and lack of diversity			
Actions 2	**ICB**	**ICB**	**ICS (RAG rating to be undertaken)**
Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (June 2024) and evidence progress of implementation (June 2025)	• To develop a talent management programme **R**	**R**	Scope and develop a complementary ICS talent programme. Implement a shadowing programme across the ICS

Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (October 2024). **Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.**	• Part of ICS inclusive recruitment working group **A** • Opportunities to increase apprenticeships and work experience **A** • Increase diversity and number of applicants on the Regional/National Aspiring Director Talent programme **R**		Inclusive Recruitment Group implementing high impact actions for consistency across the ICS. Well established use of apprenticeships and T levels – further review for diversity of applicants and entry level pipelines Developing new data oversight for measuring social mobility Graduate Trainee Management Scheme in place with places awarded through NHSE across the ICS Community engagement with local colleges, Princes Trust, and Schools
HIA 2 Success Metrics: **2a.** Relative likelihood of staff being appointed from shortlisting across all posts, **2b.** NSS Q on access to career progression and training and development opportunities, **2c.** Improvement in race and disability representation leading to parity, **2d.** Improvement in representation senior leadership (Band 8C upwards) leading to parity, **2e.** Diversity in shortlisted candidates, **2f.** National Education & Training Survey, (NETS) Combined Indicator Score metric on quality of training			
High Impact Action 3: Develop and implement an improvement plan to eliminate Pay Gaps			
Actions 3	**ICB**	**ICB**	**ICS (RAG rating to be undertaken)**
Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024).	• Review to further explore and address medical pay. **R**	**R**	Scope across AHA and ICS
Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. **Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.**	• Annual report and action plan on gender pay gap. **G** • Expand data sets for further breakdown according to sex, race, and disability by 2025. **A**	**A**	Individual organisation board assurance AWP already report pay gap by ethnicity, disability, and gender
Implement an effective flexible working policy including advertising flexible working options	• Flexible working policy in place and reviewed in May 2023 **G**	**G**	Scope feasibility of BSW flexible working and wellbeing as part of recruitment campaign

on organisations' recruitment campaigns. (March 2024)	• Assessment to understand take up and success of flexible working in general and by protected characteristics A		
Success Metric: 3a. Improvement in gender, race, and disability pay gap			
High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce			
Actions 4	**ICB**	**ICB**	**ICS (RAG rating to be undertaken)**
Line managers and supervisors should have regular effective wellbeing conversations with their teams, utilising resources such as the national NHS health and wellbeing framework. (October 2023).	• Wellbeing conversations part of appraisals and team development G	G	Part of ICS wellbeing offers and linked to retention programme of work. Quality Improvement method to be employed as part of oversight
Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. **For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (April 2025).**	• Understand org social mobility data and map to health data outcomes for targeted support activities A	A	EDI network through BSW Academy inclusive of Local Authorities, VSCE and DWP Partnership in place with colleges for example keeping in touch days and supporting employability skills. Opportunities to further work across universities and VSCE for local place-based recruitment and developing a pipeline for access to education and employment
Success Metric: 4a NSS Q on wellbeing concerns, 4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training, 4c. To be developed in Year 2			
High Impact Action 5: Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff			
Actions 5	**ICB**	**ICB**	**ICS (RAG rating to be undertaken)**
Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety (March 2024).	• No International Recruits		Diversity and Inclusion embedded within Line Manager onboarding Welcome packs. All Trusts have achieved the pastoral care mark or close to achieving it. Network IENs in place as well as access to buddy's and freedom to speak up guardians. All trusts working on cultural awareness.

Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. **They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression (March 2024).**			ICB currently working with trusts to deliver training to international nurses on how to navigate NHS Jobs, Trac, and the application process. For example, 'what a good interview' looks like. International retention lead developing a retention toolkit that will include career development.
Success Metric 5: 5a. NSS Q on belonging for IR staff ,5b. NSS Q on bullying, harassment from team/line manager for IR staff, 5c. NETS Combined Indicator Score metric on quality of training IR staff			
High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur			
Actions	**ICB**	**ICB**	**ICS (RAG rating to be undertaken)**
Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter formal processes are treated with compassion, equity, and fairness, irrespective of any protected characteristics. **Where the data shows inconsistency in approach, immediate steps must be taken to improve this (March 2024).**	• Raising concerns policy reviewed May 23. **G** • Employee Engagement Forum launched June 23 **G** • New Appraisal process and timeline launched May 23 which will support better quality conversations and a point in time oversight cross-org **G.** • FTSU revised and strengthened – re-launch programme in July 23 **G**	**G**	Data part of individual organisational assurance Further opportunities for spread and adoption of Just and Learning Culture – Merseyside Training places supported across partners from an NHSE regional offer
Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it. (June 2024)	• Robust Domestic Abuse policy in place including several supportive provisions. **G**	**G**	Policies and processes in place

Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff (March 2024).	• FTSU revised and strengthened – re-launch programme in July 23 **G**	**G**	FTSU in place across partners Further review for assurance regrading protected characteristics and parity
Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination, or violence (March 2024).	• EAP in place **G** • Mental Health wellbeing leads **G.** • Occupational Health services available **G** • HR Business Partners provide confidential support **G**	**G**	Individual policies and processes in place
Have mechanisms to ensure staff who raise concerns are protected by their organisation.	• Trade Union support recognised. **G** • Employee Engagement Forum in place **G** • Robust policies in place • Staff surveys report strong line management relationships **G**	**G**	Individual policies and processes in place
Success Metrics 6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff), 6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff), 6c. NETS Bullying & Harassment score metric (NHS professional groups)			

4 Protected Characteristics in NHS EDI Improvement Plan

4.1 NHSE Interventions According to Protected Characteristic

The plan also includes interventions to address the negative experiences of staff with individual protected characteristics, as defined in the Equality Act 2010. They supplement the intersectional high impact actions and suggest how organisations can go further in specific areas The table below outlines a RAG rating for each activity for the ICB (Employer). This may be an area to develop across the system, but this level of information is not currently available:

	Intervention and corresponding HIA	ICB RAG
Age	Review recruitment practices to ensure they are fully inclusive of all ages, removing bias and improving accessibility for people wishing to join the NHS for the first time. (HIA 2)	A
	Line managers should have meaningful conversations with their teams, to align personal aspirations with job roles and requirements. This should include the option of phasing retirement and exploring alternative work patterns. (HIA 2)	A
	Organisations should encourage flexible working as part of local attraction, recruitment, retention and return plans. The plan should embed the NHS Pension Scheme and highlight its value across the career journey, with special focus on flexible retirement for staff in late-stage careers. (HIA 2)	A

	NHS organisations should work in partnership with local educational institutions and voluntary sector partners to support social mobility by improving recruitment from local communities, and by considering alternative entry routes to the NHS, such as apprenticeships and volunteering. (HIA 2, 4)	A/G
Disability	Demonstrate year on year improvement in disability declaration rates so that ESR data is accurate about people with a disability, as measured by the WDES. (HIA All) Promote the visibility of leaders with a disability through effective campaigns alongside providing leadership and career development opportunities tailored to disabled staff, such as the Calibre Leadership programme or Disability Rights UK development programmes. Progress can be measured by tracking the number of disabled staff in leadership roles. (HIA 2) Implement recommendations from the inclusive recruitment and promotion practices programme and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages people with disabilities to apply for roles in the NHS. This can be tracked via the WDES, using Trac data. (HIA 2) Commissioners and providers of talent management and career development programmes must ensure that these are fully accessible and inclusive. Progress can be measured by tracking the number of Disabled people in leadership roles. (HIA 2) NHS organisations should take steps to address the disproportionate levels of bullying and harassment experienced by disabled staff. Progress can be measured from NHS Staff Survey results. (HIA 6) NHS organisations should ensure that their reasonable adjustments policy is effectively and efficiently implemented and achieves year-on-year improvement in NHS Staff Survey metrics relating to reasonable adjustments at work. (HIA, 2, 4)	R R A R A A/G
Race	Boards should be able to demonstrate their understanding of and progress towards race equality, an essential criterion in job descriptions for board members and all very senior manager (VSM) grades. Appraisals of senior executives will include a focus on EDI, as recommended by the Messenger Review. (HIA 1) Board will use the EDI dashboard to establish internal data driven accountability and scrutinise progress at an organisational, divisional, departmental, occupation, and site level to address under-representation and pay gaps. (HIA 2,3) To tackle race discrimination effectively, Boards must give due consideration to national policies and recommendations from other Arms Lengths Bodies such as the Equality and Human Rights Commission inquiry and General Medical Council In addition, boards must proactively raise awareness of their commitment with patients and public. (HIA, 1, 6) Boards should ensure concerns raised about race discrimination are dealt with in a proactive, preventative, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians (HIA, 6)	A R G A
Religion or Belief	ESR and qualitative data should be tracked to highlight the experience of people with different faiths or no faith through all stages of the employment journey. For example, NHS organisations can track turnover data by religion to identify and address trends. (HIA, All) NHS organisations should review their policies and processes to ensure they are supportive of religious expression in the workplace. This includes access to	R

	facilities for prayer, understanding of cultural differences, including religious clothing, and flexibility around religious observances such as the Sabbath and Ramadan. (HIA, All) Boards should ensure concerns raised about religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including by encouraging diversity in Freedom to Speak Up guardians. (HIA, 6)	A A
Sex and pregnancy and maternity	NHS organisations to focus on closing the gender pay gap and improving the experiences of the lowest paid people, extending the Mend the gap review recommendations for medical workforce to the wider workforce. (HIA, 2,3) NHS organisations should ensure that their flexible working policy is easily accessible and suitable for all their staff, supporting their work–life balance, management of caring responsibilities, health, and wellbeing, and enabling continued professional development. (HIA, 2) NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues. This will ensure they fully support colleagues experiencing menopause, maximising their wellbeing, and allowing them to work for as long as they wish to contribute. (HIA, All)	A A G
Gender reassignment and sexual orientation	Where colleagues feel comfortable, actively encourage LGBT+ staff to self-declare their sexual orientation on ESR and TRAC, emphasising how this can improve the experiences of LGBT+ staff. We recognise that national changes to ESR must be made before trans and non-binary staff are able to do so. (HIA, All) Review organisational data for LGBT+ staff across multiple sources such as ESR, TRAC, NHS Staff Survey, and local qualitative and quantitative data from LGBT+ staff networks and communities. This will inform the key areas of concern that need to be addressed. (HIA, All) Organisations to ensure that diversity training on gender reassignment and sexual orientation is included within mandatory training. (HIA, 1) Executive teams within the organisations should actively talk about the benefits of allyship as well as champion and sponsor LGBT+ staff networks. They should also build the concept of allyship into existing and new development programmes. (HIA, 1) Organisations to ensure that LGBT+ staff are closely involved in the development and delivery of its LGBT+ training and educational interventions and its health & wellbeing programmes so that these are fully inclusive. (HIA, All)	A A R A R

5 The Accountability Framework of the NHSE Improvement Plan

Excerpt taken from the improvement plan.

Providers	ICSs / ICBs	Regional	National
✓ Delivery of high impact actions and interventions by protected characteristic at trust level. ✓ Measure progress against success metrics consistently within the organisation. ✓ Engagement with staff and system partners to ensure that actions are embedded within the organisation. ✓ Effective system working and delivery to ICS strategies and plans ✓ Compliance with provider licence, Care Quality Commissions standards and professional regulator standards.	✓ Effective system leadership overseeing NHS delivery of EDI improvement plan, ensuring progress toward achievement of high impact actions and Long-Term Plan priorities. ✓ Ensuring delivery of ICB statutory functions of arranging health services for its populations and compliance with statutory duties. ✓ Measure progress against success metrics consistently and coordinate a system view. ✓ Compliance with Care Quality Commissions assessment frameworks.	✓ Primary interaction between national and systems ✓ Translate national policy to fit local circumstances, ensuring local health and workforce inequalities are addressed ✓ Agree 'local strategic priorities' with individual ICSs and provide oversight and support. ✓ Measure progress against success metrics consistently and coordinate a regional view.	✓ Set expectations for equality and inclusion through the NHS EDI improvement plan ✓ With regions, facilitate supportive interventions to implement the high impact actions, improve EDI performance and outcomes ✓ Measure progress against success metrics consistently and coordinate a national view.

5.1 Implications of the Accountability Framework**:**

- Coherent working across the ICS
- ICS oversight and assurance of the NHS EDI improvement plan
- Development of an EDI data dashboard able to identify outcome measures and the impact of improvement work on the measures.
- Opportunities for increased collaboration, scaling and sharing.
- EDI part of a standing agenda item on regional people board meetings

5.2 Responsibilities

ICB responsibilities are two-fold in this space – as an employer of people, and as a system leader.

5.3 ICB (Employer):

- Delivery of high impact actions and interventions by protected characteristic at org level. Measure progress against success metrics consistently within the organisation.
- Engagement with staff, and system partners, to ensure that actions are embedded within the organisation.
- Effective system working and delivery to ICS strategies and plan.
- Compliance with provider licence, Care Quality Commissions standards and professional regulator standards.

5.4 ICB (System Leader):

- Effective system leadership overseeing and supporting NHS delivery of EDI improvement plan, ensuring progress toward achievement of high impact actions and Long-Term Plan priorities.
- Ensure delivery of ICB statutory functions of arranging health services for its populations and compliance with statutory duties.
- Measure, and embed, progress against success metrics and other EDI action plans consistently and coordinate a system view.
- Compliance with Care Quality Commissions assessment framework.

6 Alignment with Public Sector Health Equality Duty (PSED)

6.1 The NHS Contract requires all NHS providers to report on its performance against WRES and WDES and the EDS in compliance of the PSED. NHSE has recently recommended that the EDI improvement plan set out the over arching ambition and requirements of organisations to progress delivery; there is not an expectation for a submission of a written action plan. Instead, existing work should be undertaken for alignment with any gaps identified. The organsaitions response to the EDI improvement plan would meet the PSED objectives and can be used as evidence of EDS (Equality Delivery System).

6.2 The PSED sets out the statutory duty that all public authorities must exercise in their functions. This is to ensure due regard of:

- Eliminating unlawful discrimination, harassment, and victimization
- Advancing equality of opportunity for people with protected characteristics
- Fostering good relations between people with and without protected characteristics.

6.3 It is recommended that NHS publish their PSED reports in Q1 reporting on the outcomes of the previous financial year. It important that the information is available to the community, the public and outcomes for staff.

6.4 Reporting of the PSED requires:

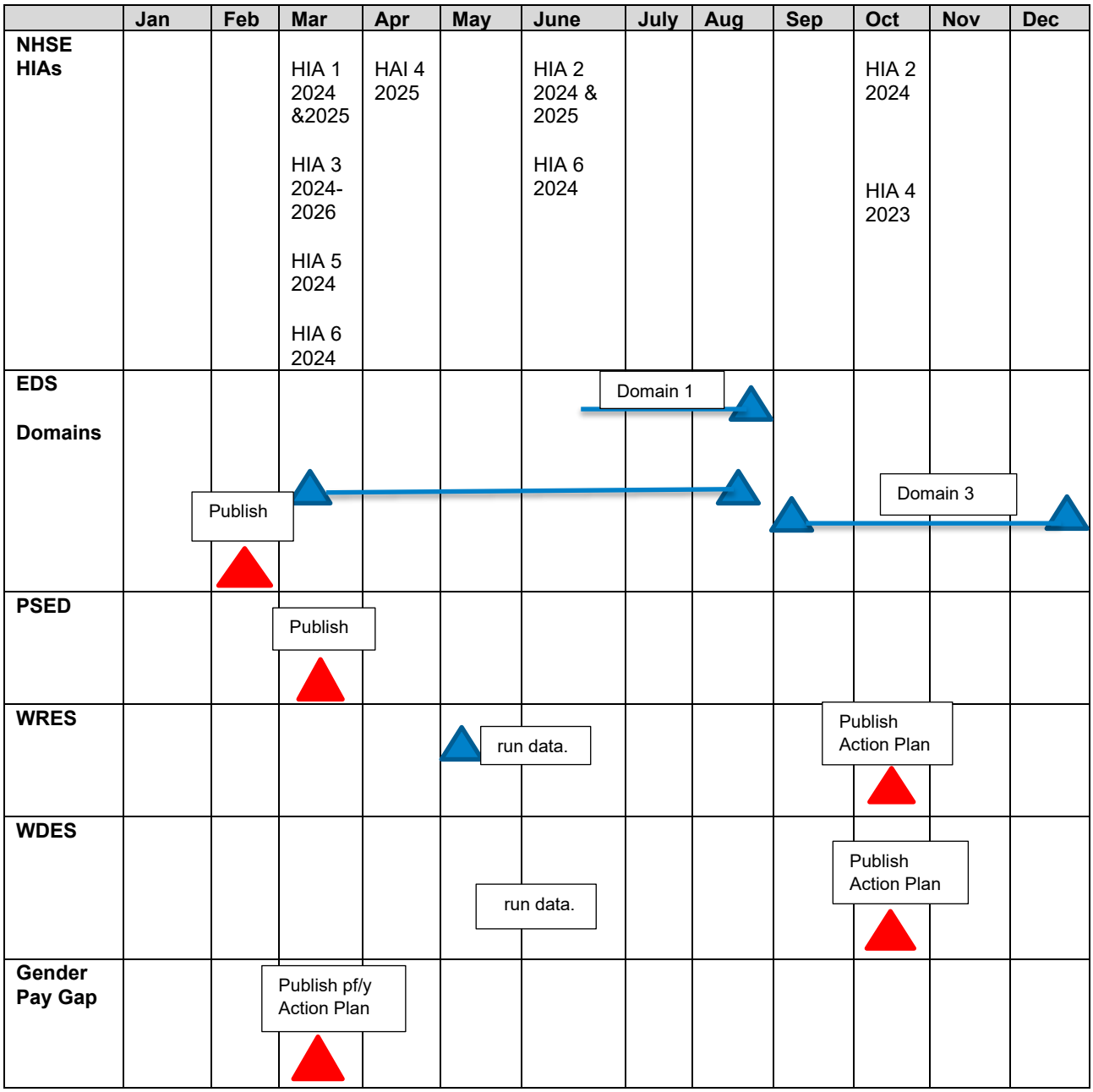
- Publish information for compliance on general duty: An annual PSED report with a summary of activities inclusive of EDS that highlights patient and service user by protected characteristics.
- Publish data on workforce: summary of workforce demographic, WRES, WDES, Gender Pay Gap, EDS action plan and NHSE HIA.
- Publish data on staff affected by policies and procedures: EDS action plan, EQIAs.
- Publish one or more equality objective. WRES, WDES, EDS and HIA action plans

6.5 The NHSE EDI Improvement plan offers an opportunity for the ICB and ICS to bring together a robust oversight and accountability framework for the many activities under the umbrella of EDI/PSED.

6.6 Equality Standards: WRES, WDES and Gender Pay Gap

6.7 As indicted above the NHS contract requires providers to report annually on compliance with WRES and WDES. WRES and WDES are also part of the ‘well led’ domain in CQCs inspection programmes. The Equality Standards form part of the PSED obligations. Annual reports should show the results of staff survey and workforce data with a published action plan able to evidence compliance with PSED.

6.8 Collective Oversight /Milestones for EDI reporting



The above offers a collective oversight on core milestones and reporting.
Publication points require action plans to be made available via website, prior to the publication points governance timelines to be identified for prior reporting into Executive, People Committee and Board.

7 Data

7.1 To inform the paper a readiness assessment was undertaken on available data against the requirements as laid out in the HIAs with the findings of:

- ESR, WRES/WDES, gender pay gap available for secondary care partners and ICB.
- There is currently no central mechanism for a system oversight of EDI data and to establish this would require access to data through working with partners.
- Further work is required to identify baseline data for each HIA and agreed improvement.

8 Risks

- Sharing, and access, to data from BSW partners
- Multiple regional and national strategies with similar outcomes risking diluting the message and clarity of work programmes; this has been fed back to NHSE.
- EDI not being provided with the visibility and commitment as part of all work programmes.
- Currently the only resource for both the ICB and ICS EDI work programmes is an Inclusion pillar lead as part of the BSW Academy. With no long-term recurrent income stream the post ceases on 19th September 2023 with no alternative solution found for an ever-expanding programme of work.
- Currently a heavy focus on reporting and data collection which means that many roles focusing on EDI spend most of their time, and effort, in this space rather than enabling tangible actions to make a difference. This focus needs changing so we use teams with data analysis skills to help do this element of the work and EDI roles ensuring that action is taken.

9 Recommendations

- One integrated reporting oversight of action plans and frameworks will be developed identifying clarity between ICB, ICS and BSW provider organisations. This will include progression of the gap analysis /RAG as identified through the initial analysis documented in the paper.
- EDI, inclusive of the action plan, to be standing agenda item on People Committee and reporting of delivery into SWG; this will reflect EDI being a standing agenda item on regional people boards.
- The ICB develops and reviews the organisational EDI strategy.
- The in scope BSW workforce strategy sets a strong intent on addressing workforce and health inequalities.
- Identification of capacity to continue the work as a joint solution between the ICB and external facing BSW Academy or further escalation of noted risk in having no EDI expertise/resource.
- The ICB workforce planning team support the development of one EDI data dashboard that will link with regional and national teams.
- Further explicit opportunities are made for co design with staff groups and our communities to enable the lived experiences to be paramount; often easy to be lost in the many operational and strategic intents.
- The HIA although an NHS scope are shared with all partners for enabling enhanced sharing, insight, and efficiency.
- The HIA and EDI activity are shared widely across programme boards in order that EDI becomes everyone's responsibility.
- Progress discussion for oversight of data and responsibilities with ICS partners through the Strategic Workforce Group and with ICS CPOs

Update Following People Committee on 14/09/2023.

Discussed and paper approved at people committee with following core points of note:

- Noted risk on escalation of no EDI lead role for ICB. Part of an ongoing discussion for the ICB to consolidate areas of focus of which EDI is part of.
- Opportunity for EDI to be part of every programme board.
- Acknowledgment for need to simplify and focus on making this plan happen, rather than becoming victim to policy fatigue. It may be preferable to focus on less and prioritise three areas to deliver tangible outputs.
- An NHS led policy but need to acknowledge broader role of other sectors such as VSCE.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	11
Date of Meeting:	21 September 2023		

Title of Report:	BSW ICS Winter Plan
Report Author:	Heather Cooper – Director of Urgent Care and Flow Emma Smith – Head of Urgent Care
Board / Director Sponsor:	Gill May – Chief Nurse
Appendices:	BSW 2324 UEC Winter Plan Overview Final

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	
ICS NHS organisations only	
Wider system	X

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
BSW ICB Executive	04/09/23	To provide assurance on the plan, share the initial narrative KLOE report ahead of submission on 11th Sep
BSW UEC Tactical	01/09/23	Report on Progress with Winter Plan Submission
BSW UCFB	13/09/23	Review of Winter Plan

1	Purpose of this paper
The aim of this paper is to provide an update on the BSW Integrated Care System (ICS) Urgent and Emergency Care Winter Plan for 2023-24 and to share key risks and challenges including measures to ensure the risk is shared and mitigated.	

2	Summary of recommendations and any additional actions required

The Board are asked to note:

- The contents of the report and supporting presentation that outline the work that has been taken to date and the planned actions expected to be taken ahead of final Winter KLOE submission.
- BSW Urgent Care and Flow Board will monitor the delivery schemes and report back to Recovery Board and Quality and Outcomes Committee.

3	Legal/regulatory implications

BSW ICB is required to have in place a plan for managing winter demand.

4	Risks

There are several risks on the BSW ICB Corporate Risk Register that relate to the risks identified specifically in the Winter Plan: BSW ICB 01 – Insufficient capacity for Urgent and Emergency Care and Flow; BSW ICB 03 – Ambulance Hospital Handovers delays; BSW ICB 04 – Impact of Industrial Action; BSW ICB 06 – System workforce Challenges; BSW ICB 09 – Recovery of Elective Care Capacity
There are a number of other risks that are set out within this paper. Mitigations are in place and they and will be monitored on a regularly basis through our existing governance routes and where required escalated to the Corporate Risk register.

5	Quality and resources impact

Please outline any impact on
Quality, Patient Experience and Safeguarding: requirement to monitor and inform Urgent Care and Flow Board of harm because of the plan. Support with any additional EQIAs that may be required if plans change.
Finance: No specific funding request are associated with this paper, however, additional winter funding has been shared with local authorities as part of the BCF for the Adult Discharge Fund (£5.04m) and the BSW recovery board have supported Wiltshire with £0.5m additional funding.
Workforce: requirement for the whole system to continue to oversee the delivery of key work programmes and agreed actions that will support delivery of the winter plan, including Quality, Finance and Business Intelligent team support.

Finance sign-off	n/a

6	Confirmation of completion of Equalities and Quality Impact Assessment

Equality impact assessments will be undertaken for key specific changes in the plan for individual schemes and initiatives as and when required.

7	Communications and Engagement Considerations

A system-wide communications planning group has been stood up to develop a coordinated winter campaign and pool assets.

8	Statement on confidentiality of report

This report can be shared publicly.

BSW ICS Winter 23/24 Plan

1. Introduction

1.1. The aim of this paper is to build on the operational plan for 2023/24 and provide an overview of the Integrated Care System plan to provide resilience over Winter and expected governance arrangements.

2. Background and wider context

2.1. In January 2023, NHS England published **the delivery plan for recovering urgent and emergency care (UEC)** which set two ambitions for 23/24 and into 24/25. These were:

- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

2.2. The delivery plan outlines five key areas of focus, which required a cross system approach including primary and community services, mental health, intermediate care, and social care working jointly to ensure people get the best care and ensure flow through hospitals into social care when needed to achieve the two ambitions.

2.3. BSW ICS Urgent Care and Flow Board (UCFB) tasked the UEC tactical group to create a system wide UEC recovery plan that will outline the plans to deliver the recovery plan as part of our wider system recovery programme. This plan incorporated several key actions that are part of our Wider system recovery and implementation plan over 2023/24 and specifically to support delivery over the winter period.

2.4. BSW Winter Lessons learnt event was held in April 2023 with all system partners. Most partners reflected that Winter 22/23 was very challenging and workforce were left exhausted. It was also the start of Industrial Action by several unions, there were not originally built into the Winter plans but the system was supported by EPRR plans to mitigate responses.

2.5. The three big initiatives that were agreed to be our UEC priorities in 23/24 were Virtual Ward, Care Coordination and Home First. These feature heavily in our 23/24 Programme of work.

2.6. BSW system also secured £6.87m of additional capacity investment for 2023/24 to support with capacity and flow across the system. The schemes utilising this funding are fundamental to our system recovery plan to achieve the 4hr A&E target, hospital handover delays, 21+ Day LOS position, our non-Criteria to reside position and most importantly our G&A bed occupancy.

2.7. In July 2023, Sarah-Jane Marsh and Dr Vin Diwaker wrote to Tier 2 and Tier 3 systems as part of the UEC Recovery Plan and improvement support offer (The Universal Offer) and required the ICS to carry out a self-assessment exercise against nine of the high impact interventions that are outlined in the delivery plan for recovering urgent and emergency care services. The aim of the exercise was to identify the maturity of services and strengthen improvement plans of Winter utilising tools and support available through NHS Impact.

2.8. The 10 high impact interventions identified in the letter were:

High Impact intervention		Area of focus
1	Same Day Emergency Care (SDEC)	In-hospital
2	Frailty	In-hospital
3	Inpatient flow and length of stay (Acute)	In-hospital
4	Community bed productivity and flow	In-hospital
5	Care Transfer Hubs	In / Out of hospital
6	Intermediate Care demand and capacity	Out of hospital
7	Virtual Wards	Out of hospital
8	Urgent Community response (UCR)	Out of hospital
9	Single point of access (SPoA)	Out of hospital
10	Acute respiratory Illness hubs (ARI)	Out of hospital

2.9. Following a completion of the self-assessment, BSW identified that Same Day Emergency Care, Frailty, Inpatient Flow and Length of Stay (Acute) were our 3 In-Hospital areas of focus and Acute Respiratory Illness Hubs our out of Hospital initiatives that needed priority focus on ahead of Winter. Urgent Community Response was also identified as an area that required further focus to ensure consistency across BSW.

2.10. In August 2023, Sarah-Jane Marsh wrote to the ICB to submit a narrative key line of enquiry (KLOE) and numerical return as part of our Winter planning assurance building on our operational plans that were completed at the start of the year.

2.11. In is expected that Providers, ICBs and NHSE regional teams should work collaboratively to develop these plans and they should be signed-off by ICB Boards. The initial submission is due on the 11th of September with an opportunity to re-submit plans following NHSE RAG assessment and feedback by the 25th September.

2.12. The Winter KLOE return focuses specifically on the following areas;

a) System-working
b) High-impact interventions
c) Discharge, intermediate care and social care
d) H2 numerical planning submission
e) Surge plans
f) Workforce

2.13. Utilising the existing operational plans and working with ICB leads and system partners to create our BSW winter plan. We have submitted our initial narrative

KLOE position on 11th September and awaiting feedback with our numerical update confirming that no demand or supply assumptions have been changed based on our original operational plan submissions.

2.14. New guidance around System Co-ordination Centres (SCC) and OPEL Escalation Frameworks was also issued in August 2023 with the expectation that SCCs will need to achieve compliance within readiness for winter operations 2023/24 and beyond by 6th December 2023.

3. Impact on resources

3.1. The creation and development of the 23/24 BSW Winter plan has been supported by all partners of the health and social care board.

3.2. All partners will be required to ensure delivery against agreed actions and any further mitigating actions that are agreed.

3.3. BSW Recovery board has supported BSW's Urgent Care and Flow team with additional fixed term resources (1 x UEC Programme Manager and 1x Urgent Care and Flow Support officer) to increase the capacity with the team to support the delivery of the 23/24 UEC programme of Work.

3.4. Additionally, members from the Quality, Finance and BI teams will support BSW's Urgent Care and Flow board with information and intelligence to provide with system assurance against our local plans.

4. Risks

4.1. The system has experienced unexpected challenges at the beginning of September, resulting in increased hospital handover delays and a deterioration in A&E performance. SWAST have declared their highest escalation levels of REAP 4 and have implemented escalation plans to support this level. Contingency arrangements to support this are being tested by the system, and opportunities for improvements are being assessed.

4.2. There are a few risks BSW ICB Corporate Risk Register that relate to the risks identified specifically in the Winter Plan:

- BSW ICB 01 – Insufficient capacity for Urgent and Emergency Care and Flow
- BSW ICB 03 – Ambulance Hospital Handovers delays
- BSW ICB 04 – Impact of Industrial Action
- BSW ICB 06 – System workforce Challenges
- BSW ICB 09 – Recover of Elective Care Capacity

4.3. There are also several additional risks with each element of the Winter Plan, but the main risks are highlighted in the areas below:

Risk theme	RAG	Mitigations
Unexpected shortfall in capacity	RED	• Ongoing monitoring and review of ICA led capacity schemes • Weekly monitoring (DUCTR report) on key objectives • Demand and capacity work programme and steering group

Funding solution for mitigating actions	RED	• Re-prioritisation of existing schemes • Utilisation of any underspend on other schemes • Escalations to BSW Recovery Board • Bids of any non-recurrent short notice NHSE funding releases
Vaccination boosters	AMBER	• PCN and whole system planning approach to maximise opportunities for vaccination • Workforce support and wellbeing initiatives to avoid burnout
Clinical workforce gaps in core key frontline services	AMBER	• NHS 111 Recruitment plan and ongoing monitoring of Health advisor and clinical recruitment . IUC CAS additional ED validation profiles; review at contract meetings. • WH&C workforce plans • SWAST Incentive plans including Workforce plan 4 • AWP are exploring the option of supplying senior HCA to the acute partners to reduce the reliance on high-cost agency RMNs, this should also have benefits on AWPs workforce with less RMN usage within the acutes
Unexpected respiratory surge	AMBER	• Monitoring of UKHSA data and soft intel from local sources around presentations of respiratory illnesses
Ongoing industrial actions	RED	• EPRR planning across providers to put in mitigations in place and lessons learnt from previous industrial action mitigations • Providers identifying any derogations required for local patient services

5. Stakeholder engagement including patient and public consultation

5.1. All BSW system providers have contributed to the development of the BSW Winter Plan. Patient and public consultation was not sought specifically in the development of this plan.

6. Impact on equalities

6.1. An equality impact assessment has not been completed as part of this report.

7. Next steps

7.1. BSW representatives will be meeting with Southwest NHS England leads between 18th to 22nd September to discuss and seek reassurance on any Red or Amber areas that have been identified through our Key Lines of Enquiry.

7.2. BSW will submit a final updated KLOE assurance by the 25th September.

7.3. Locality discussions planned at place to review demand and capacity plans in line with the BCF refresh submissions expected in October 2023.

7.4. EPRR and UEC team are currently scoping out options for further training and exercise requirements to enhance our resilience and response in and out of hours across Winter.

7.5. BSW Urgent Care and Flow board will monitor the delivery of system-wide schemes on a monthly over the winter period, with ICA schemes being reviewed weekly at UEC tactical meetings.

8. Recommendations

8.1. The Board is asked to note the report and the actions taken to date as well as the planned activity of the system over the Winter period.

8.2. The Urgent Care and Flow board will report directly to the ICB Quality and Outcomes Committee and the BSW Recovery Board on progress against Winter plan and performance metrics.

Bath and North East Somerset,
Swindon and Wiltshire Together

BSW Winter Plan – 2023/24

Overview for BSW ICB Board

Version 3.0 - 11-09-2023

Introduction

Bath and North East Somerset, Swindon and Wiltshire Together

The winter plan aims to demonstrate that the BSW ICS system:

1. Reflects a whole system approach to the delivery of services over the forthcoming winter period
2. Understands the demand on all sectors and their dependency on one another
3. Has a system escalation plan, using the SHREWD system, which is explicit about the expectations of each organisation, particularly in periods of heightened escalation
4. Will ensure that seasonal infection demand will not compromise patient care, experience and service standards.
5. Has robust policies and procedures in place to ensure that patients remain safe in our health and care services
6. Has identified the potential risks and has actions in place to mitigate against them

The 23/24 plans considers the following:

- Lessons learnt from 22/23
- Delivery plan for recovering urgent and emergency care services
- Annual demand and capacity plan
- BSW Operational Implementation plan
- 10 High Impact interventions and maturity index

Winter 23/24 Planning approach

Bath and North East Somerset, Swindon and Wiltshire Together

- Urgent and Emergency Care and Flow planning for Winter 23/24 started significantly earlier in BSW ICS this year compared to previous years starting in January 2023 when NHS England published **the delivery plan for recovering urgent and emergency care (UEC)** which set two ambitions for 23/24 and into 24/25. These were;
  - **Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25**
  - **Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels**.

- The delivery plan outlines five key areas of focus, which required a cross system approach including primary and community services, mental health, intermediate care and social care working jointly to ensure people get the best care and ensure flow through hospitals into social care when needed to achieve the two ambitions. BSW ICS Urgent Care and Flow Board (UCFB) has tasked the UEC tactical group to create a system wide UEC recovery plan that will outline the plans to deliver the recovery plan as part of our wider system recovery programme.

- A gap analysis was completed in March 23 by system partners to inform the plan, which collectively alongside the plans from ICAs and system partners have also been used to inform the wider system recovery and implementation plans to achieve our ***Strategic Objective 3: Excellent Health and Care services*** as part of our Integrated Care Strategy.

Demand and Capacity planning

Bath and North East Somerset, Swindon and Wiltshire Together

- The work of the BSW Demand and Capacity planning group informed our annual planning process and supported our initial case for additional investment in 23/24 which would support capacity throughout the year and over Winter. This work has informed our Non-Criteria to reside trajectories and Ambulance handover trajectory

- The Demand and Capacity Steering group continues to meet on a regular basis and revisits the plan that support the system to make iterative plans as required to ensure patient flow across the system. This work is delivered at place level and reports back into the Urgent Care and Flow board, as well as the BSW Recovery board.

- Each Integrated Care system was also asked in July 2023 to carry out a self-assessment exercise against nine of the high impact interventions that are outlined in the delivery plan for recovering urgent and emergency care services. The aim of the exercise was to identify the maturity of services and strengthen improvement plans ahead of Winter utilising tools and support available through NHS Impact.

- In addition, each system were asked to identify UEC recovery champions to attend virtual development sessions, access to online improvement skills that will build development capacity for people throughout the system who play a role in delivering improvement across iUEC Pathways

Non Criteria to Reside trajectory

- The UEC recovery plan requires the system to support work to get back to the 92% bed occupancy levels which is deemed safer and more efficient as it improves flow through the hospital, and in conjunction with other additional capacity plans and UEC recovery actions will help to support delivery of the 4hr performance target.

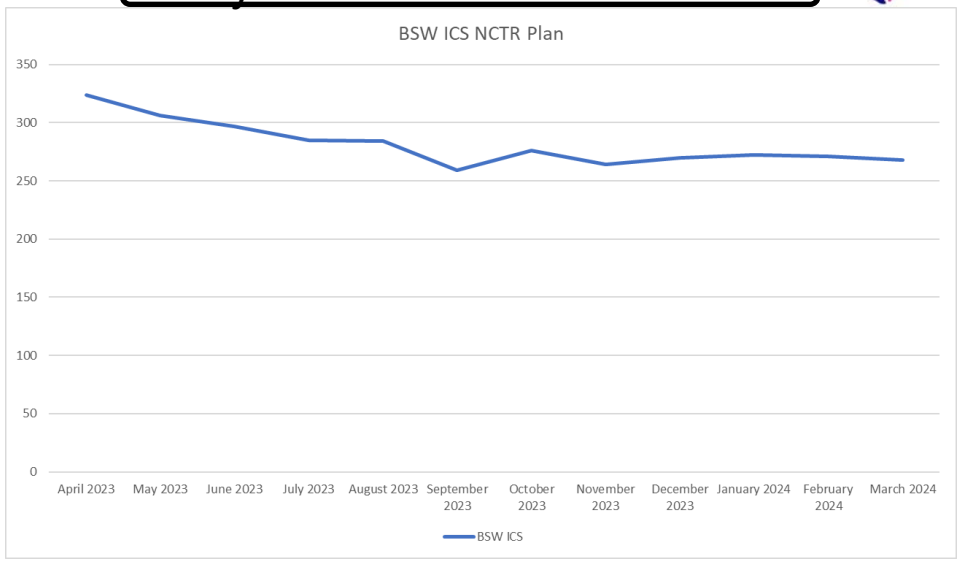
- Our submitted operational plans in May 2023 were predicting bed occupancy higher than the national target. These plans were informed by our local Demand and Capacity planning assumptions and what our expected non-criteria to reside position would be.

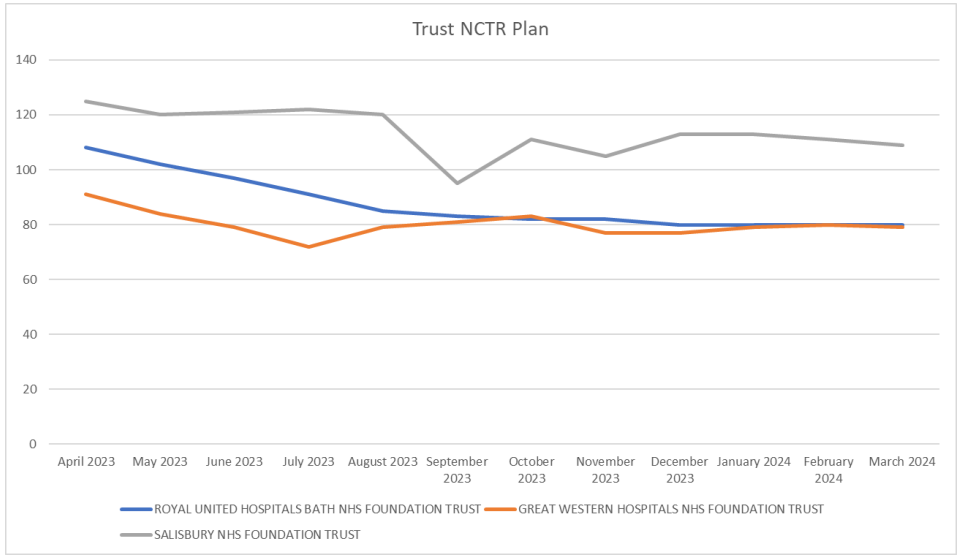
- As part of the Winter planning process the system has had an opportunity in August to review our plans if we needed to change any of our expected assumptions, including the bed occupancy non-criteria reside target of 18%

- Following the review in August we can confirm that there have been no changes to our demand or supply assumptions form our initial plans.

- Demand and capacity assumptions are continued to be reviewed within BSW steering group.

May 2023 Non Criteria Plans





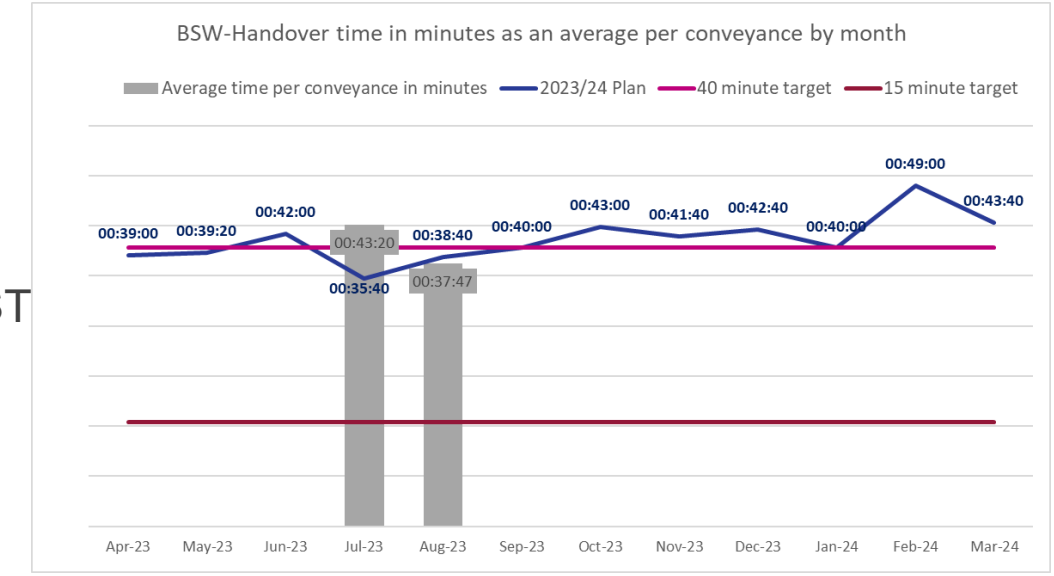
Ambulance Handover Trajectory

- Using regression analysis, Non-Criteria to Reside, ED attendance and Non-Elective Admissions had been identified a statistically significant ability of predicting handover hours better than chance. Using these produce our trajectory.

- The initial trajectory plans for 23/24 fell short of enabling the achievement of average handover delays of 40 mins to enable SWAST to reach interim Cat 2 mean of 30 mins across BSW as a whole.

- Further actions will be required by the system to ensure that we achieve the average handover delays of 40 mins; this includes understanding the impact of the following actions outlined in the UEC recovery plan:

  - Consistent discharge model hub offers across each of the 3 acute trusts 7 days per week (Complete)
  - Adopting the Best Practice for Hospital Handovers (ongoing)
  - BSW ICB pharmacy pathway finder bid
  - Supporting patients to access the right care – using NHS 111 online and NHS 111 (Ongoing)
  - Impact of SWAST's Cat 2 segmentation plan (Initiated)
  - Utilisation of BSW's Care Coordination



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
RUH	51	58	67	60	66	72	68	65	70	67	83	75
GWH	45	41	41	30	35	37	46	45	43	38	46	40
SFT	29	27	28	27	27	18	23	22	24	24	29	25
ICB	56	56	60	51	56	57	62	59	61	57	70	62

BSW Urgent Care 23/24 Priorities including our high impact interventions ahead of Winter

- BSW's 22/23 Winter Washup identified 3 key areas that would be our main priorities for 23/24 to support demand and capacity within the system that informed our operating plans:

    1. Virtual Wards
    2. Care Coordination
    3. Home First

- Following the completion to the self-assessment exercise in July 2023 on the high impact interventions identified by NHSE as part of the UEC recovery programme, our system identified the for key areas for further improvement were needed over Winter:

    1. Same day emergency care
    2. Frailty
    3. Inpatient Flow and length of stay
    4. Acute respiratory infection hubs

- Urgent Community Response was also identified as a low scoring maturity but was further ahead at a system level than the other 4 priorities.

10 High impact interventions	Score
Same Day Emergency Care (SDEC)	5
Frailty	4
Inpatient flow and length of stay (acute)	3
Community bed productivity and flow	7
Care transfer hubs	Not required, previously completed
Intermediate care demand and capacity	7
Virtual wards	6
Urgent Community response (UCR)	5
Single point of access	6
Acute respiratory infection hubs	1

BSW Additional Capacity investment 23/24

- The table opposite outlines the initial schemes that were approved by the system and NHSE and will be funded in 23/24 to support system improve capacity and flow across the system.
- These schemes were developed following locality planning utilising our BSW Demand and Capacity model as well as based on lessons learnt from schemes and initiatives in 22/23.
- They are fundamental to our system recovery plan to achieve the 4hr A&E target, hospital handover delays, 21+ Day LOS position, our Non Criteria to reside position and most importantly our G&A bed occupancy.
- In additional Localities are working through Better Care Funding requirements for 23/24 which are due for submission by end of May 2023
- Further funding has been released to support winter through the DHSC fund into Adult social care, This equates to an additional £5.04m in BSW.
- In addition, BSW Recovery Board have supported Wiltshire place with an additional £0.5m to support with additional out of hospital capacity.
- The impact and spend on these additional funding schemes will be monitored through our internal governance routes.

Scheme type	Description	Forecast cost (£'000)
Beds – G&A	23 additional beds step down beds	£1,400
Facilitated discharge – intermediate care	Home first	£1,187
Facilitated discharge – intermediate care	Homecare D2A care home packages including overnight	£2,000
Facilitated discharge - other	Domiciliary Care – night runs	£151
Beds – intermediate care	Supports P2 Flow	£750
Facilitated discharge – intermediate care	ART+ Additional capacity scheme	£450
Facilitated discharge – intermediate care	Discharge Flow hub (7 day working)	£648
Beds – Intermediate Care	GP Cover of D2A Care Homes	£291
BSW Total Additional Capacity investments 23/24		**£6,877**

Specific Winter Annual Plans

Bath and North East Somerset, Swindon and Wiltshire Together

- There are several areas that have specific plans associated with them as follows:
  - Infection prevention and control
  - Vaccination programme
  - Mental Health
  - Maternity
  - Children and young people
  - Primary care
  - Integrated Urgent Care
  - Ambulance
  - Emergency Preparedness, Resilience and response
- We have also reviewed our plans specifically for care home residents and patients requiring intermediate care (linked through to our Better Care plans at place) to reduce avoidable attendances and conveyances and improve length of stay.

Impact on Elective Capacity

Bath and North East Somerset, Swindon and Wiltshire Together

- Ensuring we maintain delivery of the elective care programme is essential. BSW Elective Care Board(ECB) maintains oversight of the elective care plan.

- Key risks to delivery of the elective programme this winter are a shortage of beds, impacts on flow through each hospital, and high numbers of non criteria to reside patients. If these risks materialise they will impact our ability to eliminate waits over 65 weeks by April 2024, reduce the number of people waiting more than 62 days for an urgent cancer referral, and reduce capacity for cancer treatments.

- Several actions have been implemented, including:
    - Protected elective capacity arrangements
    - Additional capacity at Sulis
    - Theatre improvement programme
    - Focus on reducing outpatient follow ups, and increasing outpatient first appointments
    - Monitoring and proposed improvements to Wait List prioritisation taking into account inequalities and populations at higher risk of harm on waiting lists.

Workforce and Wellbeing

Bath and North East Somerset, Swindon and Wiltshire Together

- The BSW 23/24 system Operating Plan workforce plan was drafted by system provider colleagues considering the clinical and non-clinical staff requirements over the financial year including consideration for winter.

- Organisations have planned for both agency and bank staffing capacity within their plans but are planning to be within the target metric of 3.7% usage of total pay bill. Providers have made plans to shift staffing from temporary to permanent where possible to reduce cost and enable resilience.

- Additional modelling has been undertaken with Local Authorities across BSW using a domiciliary care workforce modelling tool and detailed analysis of the workforce with several recommendations are being taken forward throughout 23/24. This includes exploring use of logistics for enhanced staff efficiency , increased upskilling opportunities, care certificate.e pass porting and shared on boarding

- AWP are exploring the option of supplying senior HCA to the acute partners to reduce the reliance on high-cost agency RMNs, this should also have benefits on AWPs workforce with less RMN usage within the acutes.

- There is an existing MOU in place should any of the providers decide to move staff between each other

- All providers have their own health and wellbeing resources in place for their staff, these include occupational health, employee assistance programs and many additional items such as free tea and coffee, thank you cards, extra day’s annual leave, gym memberships and salary sacrifice schemes

Communication and Engagement Plan

Bath and North East Somerset, Swindon and Wiltshire Together

- A system-wide communications planning group will be stood up to develop a coordinated winter campaign and pool assets (people, insight, assets).
- Insight from Business Intelligence, local Citizen Panels, public and staff engagement forums will be used to draw insight to inform and then develop the campaign approach.
- The campaign will support the national NHS England approach but at a local level will specifically focus on taking a staged behaviour change approach taking our public from awareness through to understanding, behaviour and advocacy around vaccine uptake, appropriate behaviour adoption (self-care, mask wearing, hygiene etc) and service use. We will seek to support our staff and VCSE partners in championing the campaign and understanding their role in its effective execution.
- The campaign will also look to not only support the “front door” to NHS services but also the “back door” - driving awareness, understanding and adoption of Winter support services and aid flow.
- The campaign will seek to draw on local data and will work with local outreach and engagement teams in the system to reach seldom heard audiences.
- The campaign activity will regularly be monitored and evaluated for ongoing optimisation.
- The principles of being proactive, measurable, responsive, innovative and timely will underpin the approach to Winter communications.
- 10 themes will underpin the overall Winter campaign plan which will be addressed in phased campaign bursts.

Vaccine	Admission Avoidance	Discharge	Out of Hospital healthcare	Service Use
Reputation	Mental Health	Behaviour	Educate	Workforce

Management of Operational Pressures

Bath and North East Somerset, Swindon and Wiltshire Together

- There are established fora for actions to be taken through the UCFB , weekly UEC tactical meetings, regular locality meetings and as required system calls
- There are defined requirements of leaders across the system in times of escalation and where concerns raised for patient safety because of poor flow
- There are daily calls with all providers to ensure that there is oversight and actions taken at the earliest opportunity to mitigate risk
- BSW has had an Operations Hub in place since October 2022 along with Care Coordination since Dec 2022. The system for winter 23/24 will continue to develop the System Coordination Centre (SCC) function to ensure the system aligns to the recently published SCC guidance and the two functions will be aligned from October 2023.
- The SCC will provide clinical and operational oversight into emerging system pressures using SHREWD as the reporting tool that provides consistency of reporting across all providers in line with the OPEL Framework requirements as published in August 2023 and previous requirements for system partners other than acute trusts.
- The OPEL Framework has been realigned to comply with new national guidance published in August 2023 and action cards are being developed to incorporate the mandated actions alongside the local system agreed actions and updated by November 2023.
- We will continue to work with all the EPRR teams across the system to ensure we have robust processes in place whilst ensuring that the focus on UEC is maintained through the SCC whilst EPRR providing information that will relate to impacts on UEC and appropriate actions taken

BSW Patient Safety and Quality Oversight

Bath and North East Somerset, Swindon and Wiltshire Together

Monthly reporting to Urgent Care and Flow Board → Bi-monthly reporting to Quality & Outcomes Committee → Bi-monthly reporting to Performance and Risk Committee → Reporting to System Quality Group → Monthly Risk Review → Patient Safety Risk Framework

Insight	Involvement	Improvement

Improve our understanding of safety by drawing insight from multiple sources of patient safety information.
 	
- Patient Safety Risk Framework supports improvement across the system
- Themes, Trends and Learning from incidents including serious incidents
- Monthly Quality metrics including:
  - National A&E metrics – Re-attendance, Leaving department before seen, time in department,
- Patient experience – Complaints, Concerns and FFT
- Mortality
- Learning from Deaths reports
- Falls with harm
- NEWS2
- Regulation 28 reports
- Staff surveys
- CQC inspection reports
- ED safety checklist organisational report
- EQIA's to support service changes including opening surge spaces
- Clinical Audit
- Industrial action risk management
	People have the skills and opportunities to improve patient safety, throughout the whole system
	
	• Horizon scanning – Getting It Right First Time, Association of Ambulance Chief Executive reports, HSIB reports
	
	• Patient Stories
	
	• Inclusion of Patient Safety Partners to secure the voice of the patient in decision, service development and improvement
	
	• Patient Safety Specialists Community of Practice
	
	• Embedding implementation of Patient Safety Syllabus across organisations in BSW
	
	• Roll out of Patient Safety Incident Response Framework (PSIRF)
		Improvement programmes enable effective and sustainable change in the most important areas
		
		• Collaborative observational visits with system providers as utilising improvement methodology such as 15 Steps methodology
		• End to End reviews for patients identified through a variety of sources as having experienced delays or omissions in their treatment pathway.
		  - Primary care LFPSE reports
		  - Incidents from SWAST
		  - Post Infection reviews
		  - Learning from Deaths
		  - Safeguarding Alerts
		
		• Pathway deep dive reviews – e.g. Stroke, Paediatrics and End of Life
		Quality support to Urgent Care and Flow Workstreams
		Additional bed capacity
		Virtual Ward
		Coordination Centre
		• Implementation of Improvement metrics linked to patient safety priorities
		  • Deteriorating patient
		  • Safe discharge

Risks and constraints over Winter

Bath and North East Somerset, Swindon and Wiltshire Together

Description and impact	RAG	Mitigations
Unexpected capacity reductions not accounted for in existing capacity plans may lead to a shortfall in both acute and out of hospital capacity which reduce system flow and increasing bed occupancy hospitals and increasing handover delays and impact on BSW Elective Care recovery programme. This includes Care Home market .		• Ongoing monitoring and review of ICA led capacity schemes • Weekly monitoring (DUCTR report) on key objectives • Demand and capacity work programme and steering group
If funding is required to delivery mitigation actions in response to unexpected demand and with our current financial position, the further funding solution may be required to minimise impact and deliver alternative solutions.		• Re-prioritisation of existing schemes • Utilisation of any underspend on other schemes • Escalations to BSW Recovery Board • Bids of any non-recurrent short notice NHSE funding releases
Vaccination capacity is challenged because of changes to the vaccination programme and the potential requirement for additional boosters during Winter		• PCN and whole system planning approach to maximise opportunities for vaccination • Workforce support and wellbeing initiatives to avoid burnout
Challenges in Clinical workforce capacity will affect delivery of cores services such as MIU and NHS 111 and 999 that result in poor experience and patients presenting to other pressurised emergency services		• NHS 111 Recruitment plan and ongoing monitoring of Health advisor and clinical recruitment . IUC CAS additional ED validation profiles; review at contract meetings. • WH&C workforce plans • SWAST Incentive plans including Workforce plan 4
Unexpected increase in respiratory type illnesses across all ages and earlier than any planned additional capacity is in place		• Monitoring of UKHSA data and soft intel from local sources around presentations of respiratory illnesses
Ongoing industrial action and potential ongoing action in Swindon's emergency care AMPs are likely to cause impact on patient flow, experience and create additional delays for patients waiting for elective treatment and impact on staff morale and delays at ED and Front door.		• EPRR planning across providers to put in mitigations in place and lessons learnt from previous industrial action mitigations • Providers identifying any derogations required for local patient services • Support from system partners

Summary

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- It has been highlighted in previous slides that BSW will be in a better position approaching winter this year compared to 22/23. However, there is still a requirement for significant system cooperation and effort to ensure that a safe service can be provided across all providers.

- There are still a number of key priorities that will require focused attention to deliver the additional capacity and improvements in patient experience and to maintain patient safety and minimise risk

- Further information is required to finalise the ICB's assessment against the key lines of enquiry during September to be assured that we have sufficient mitigations in place against our UEC priorities over winter to delivery operational resilience over this winter.

- It is not currently clear if these KLOEs will lead into a specific monthly UEC Board Assurance requirement as the previous winter but based on NHS England's expected roles and responsibilities the BSW ICB board will be required to monitor overarching system delivery.

- The BSW Urgent Care and Flow board will be responsible and accountable for monitoring the UEC priorities and delivery against high impact interventions monthly and will identify where further mitigation including remedial action is required.

- The detailed winter plan is a live document and will be updated as required to continue to mitigate the remaining gaps between our identified plans and predicted demand over winter

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	12
Date of Meeting:	21 September 2023		

Title of Report:	BSW Elective Care Delivery Plan
Report Author:	Paul Doyle
Board / Director Sponsor:	Cara Charles-Barks
Appendices:	Power point presentation enclosed

Report classification	Please indicate to which body/collection of organisations this report is relevant. *Only one of the below should be selected* (x)
ICB body corporate	
ICS NHS organisations only	
Wider system	X

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
COO meeting	09 August 2023	For update and discussion on current BSW wide Elective Care Plan.
BSW ICB Executive Meeting	4 September 2023	For update and discussion on current BSW wide Elective Care Plan.
BSW ICB Quality and Outcomes Committee	5 September 2023	For update and discussion on current BSW wide Elective Care Plan.

1	Purpose of this paper
To present the BSW Elective Care Delivery Plan as it currently stands for awareness and discussion. The Elective Plan is being developed in two parts – this first part relates to quality and productivity improvement. The second part which will be developed in the coming months will set out our strategic plan for	

elective care development across BSW, the demand and capacity required and the anticipated financial and quality impacts.

2	Summary of recommendations and any additional actions required
The Elective Care delivery plan is presented for initial discussion and approval for ongoing progression, whilst noting further work up is required to map against system demand and capacity modelling in conjunction with the 24/25 planning round.	

3	Legal/regulatory implications
The Elective Care Plan should significantly contribute to improvement in Elective, diagnostics and cancer performance across BSW. We are an outlier for diagnostics performance and our cancer performance is coming under increased pressure. Taking forward this plan is key to ensure providers and the ICB comply with our regulatory obligations under the oversight framework/provider licences.	

4	Risks
The Elective Care Plan will contribute to the mitigation of risks on the corporate risk register pertaining to elective and cancer performance.	

5	Quality and resources impact
Please outline any impact on: **Quality, Patient Experience and Safeguarding:** The implementation of the Elective Care Plan will significantly contribute to increasing Quality and Patient Experience due to the increase in Elective Capacity and subsequent Elective Waiting Lists that will happen as a result of implementation. **Finance**: There are various financial implications relating to each workstream within the elective care plan, as described in the individual slides or as monitored in the individual workstream governance processes. **Workforce:** There are various workforce implications for the Elective Care Plan pertaining to the individual workstreams. **Sustainability/Green agenda:** For any new build capital projects the sustainability/green agenda will be considered as per other capital projects.	
Finance sign-off	

6	Confirmation of completion of Equalities and Quality Impact Assessment
EQIA will be completed as required for service changes.	

7	Communications and Engagement Considerations

As each workstream is at different stages, communication and engagement are at different stages and will be picked up as part of the workstream groups. In terms of the overall Elective Care Plan, there has been engagement with the different workstream groups during the plan development. As various workstreams move into the operational stage, wider comms and engagement for the elective care plan will be considered.

8	Statement on confidentiality of report
The Elective Care delivery plan is in the early stages of development, so subject to change, however it is not commercially sensitive information.	

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Elective Care Plan

August 2023

Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

1. Elective Care Ambition

2. Elective Care Plan

3. Delivering the Elective Plan

4. Governance

Context

- Covid had a significant impact on the delivery of elective care, meaning many patients are now waiting much longer to receive care than they were prior to the pandemic.
- The short term focus (next 2 years) needs to be on clearing the backlog of patients in an inclusive way, consistent with the ambitions set out in the elective recovery plan.
- BSW starts in a strong position – we have virtually eliminated 78week waits, and have low numbers of 65ww and 52ww compared to many trusts nationally.
- Much of this short term recovery will be delivered by making sure we are doing the basics right. But that alone will not be enough – we need to transform the way we deliver services to speed up access, continuously improve the quality of care, support our staff and drive out efficiencies.
- In the medium to longer term (3-5 years) we should be aiming the get back to the RTT standard and develop different innovative approaches to delivering care, including in out of hospital settings; and making best use of digital technology, including AI.
- We need to build on many of the good initiatives that are in place in the system e.g. evolving the referral support service into a broader elective referral and coordination model.
- But there are significant opportunities to improve, and go further and faster through:
    - Ensuring there is equity of access and outcomes for patients across BSW, through leveling up performance across trusts and specialties, and benchmarking against other systems and trusts
    - Adopting a ‘one team’ system approach to delivering our ambitions
    - Holding ourselves, and each other, to account for delivery
    - Making more use of data and insight to drive improvement
    - Adopting a programmatic approach to delivery, breaking down boundaries between programmes and trusts
    - Utilising and adding capacity and capability on key areas to drive progress

Achievements to date

Delivery:

- Eliminated 104ww and virtually eliminated 78ww

Additional BSW Capacity:

- CDC Hub business case approved
- Sulis Elective Orthopaedic Centre business case approved

Cross BSW working:

- All trusts using IECCP inpatient module to manage waiting list, and will be first ICB in the country to have all trusts using inpatient and outpatient module
- Integrated model of care across the Gynaecology Oncology Cancer treatment pathways at RUH and GWH
- Paediatric shared waiting lists
- Referral support service offering patients choice for their treatment incl. in NHS and the Independent Sector
- Shared access policy arrangements
- Learning across cancer teams (even though in different networks), and roll out of Targeted Lung Health Checks and colon capsule endoscopy cameras to test for bowel cancer

Digital integration:

- All trusts now using DrDoctor text message services to engage with patients
- Development of shared electronic patient record

Our Aim

Aim: To have Elective services that are accessible, responsive and sustainable for the population of BSW

In practice this means:

Accessible	Responsive	Sustainable
• Working across all health & care providers to prioritise access for those in greatest need. • Taking practical steps to address new and existing inequalities. • Ensuring our delivery of services is accessible for the population.	• Supporting people to make outcome choices that are right for them; strengths and lifestyle focused. • Listening to patients to design pathways of care which are patient-led, integrated and coherent. • Ensuring the our population can access the right service at the right time. • Continuously improving, informed by and informing, best practice.	• Supporting people to stay healthy and well at all stages of life. • Making best value of our collective planned care resources. • Increasing collaboration between services to improve productivity and effectiveness. • Investing together in our workforce, digital & physical infrastructure. • BSW recognised as a great place to work. Teams working as one, with our people operating at the top of their licence.

Our Ambitions

Outcomes:

- Aim for upper quartile performance across all of our services, when benchmarked against other providers
- Contribute towards reducing health inequalities, including an increased focus on children and young people

Staff:

- Contribute to improving both recruitment and retention of staff across BSW by creating a culture in which our workforce enjoy satisfying careers, feel valued and are able to make their best contribution.
- Develop innovate workforce models to support new ways of delivering care

Performance:

Next 2 years to March 2025, driven by National Elective Recovery Plan approach. Key metrics for each year are:

- 2023/24 – Increase BSW activity to 107%, with the aim of delivering around 30% more activity by the end of 2024/25
- 2023/24 – No one waits longer than 65 weeks for elective care by March 2024;
- 2023/24 – further reducing 62-day cancer backlog and deliver the Faster Diagnosis Standard in line with plan
- 2023/24 – No waits of more than a year for OPFA by end Sept 2023; No non-admitted patients wait more than a year by end Dec 2023 [Regional target]
- 2024/25 – waits of longer than a year are eliminated by March 2025
- 2024/25 – 95% of patients needing a diagnostic test receive it within six weeks by March 2025

In period March 2025 – March 2028:

- Aspiration to return performance to 18 week RTT standard (subject to completion of demand and capacity modelling)

Finance:

- Recoup COVID productivity loss, then deliver ongoing year-on-year productivity improvements
- Contribute towards reducing the system underlying deficit, then year-on-year surpluses

Key interdependencies

The Elective Plan focuses primarily on within hospital activity, particularly in the short term where the headline objective is to reduce long waits and the number of people already on the waiting list. But there are links to several other sector strategies, and over the medium term focus will increasingly shift to managing demand and providing care in non-hospital settings.

Key linked strategies / objectives are:

- Individual Trust Strategies
- Acute Services Clinical Strategy
- Financial Sustainability
- People Strategy
- Health Inequalities Strategy
- Children and Young People Strategy
- Primary Care Strategy
- Urgent Care and Flow Strategy
- Digital Strategy

There are also a number of existing approaches to out of hospital care we will continue to develop, and look where they can be refined or expanded to other services as part of the plan, including:

- Orthopaedic Interface Service
- Community Cardiology Service
- Community Dermatology Service
- Weight Management Service

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1. Elective Care Ambition

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4. Governance

Elective plan on a page

Theme	Topic	Workstreams		Enablers
Accessible	1 Independent Sector Capacity	Use of IS capacity to reduce long waits and WL reduction Increasing cancer activity		Workforce Digital, data and technology, including AI Healthcare inequalities improvement Bespoke approaches for adults, and children and young people Finance (revenue and capital) Improving Together approach
	2 Additional and protected Capacity	Sulis Elective Orthopaedic Centre GWH 15th Theatre; SFT additional ward and theatres	RUH Cancer Centre	
	3 Long wait recovery	Demand and capacity modelling Improvement and performance support		
	4 Referrals	Networked referral model and system waiting list Enhanced direct access phases 1 and 2	Advice & Guidance rollout and expansion Expansion of out of hospital advice and treatment	
Responsive	5 Patient Choice	Choice at point of referral Choice for long waits (incl. mutual aid, DMAS, PIDMAS)	Market management approach	
	6 Patient Empowerment	Use of My Planned Care platform PEP roll out and use of NHS App		
Sustainable	7 Waiting list management	Excellence in basics Validation and prioritisation		
	8 Outpatients productivity	Reduction in follow ups, incl. PIFU, discharge Digital outpatients, incl. DrDoctor	DNAs Cancer pathway re-design	
	9 Surgical productivity	Hitting 85% theatre utilisation; and 85% day case Surgical hubs and hub accreditation	Robotic surgery HIT Lists	
	10 Diagnostic productivity	CDC hub and spoke model. Hub at Sulis Improve diagnostic performance and productivity	Must do cancer testing – FIT, telederm, mpMRI Other cancer testing – Lynch, CCE, Liver, TLHC, NSS	

Phasing and Priorities

The plan is split into 2 phases:

- **Phase 1 (years 1&2)** – A strong focus on waiting list reduction, ensuring all the basics of elective delivery are in place, and driving up productivity and efficiency. Delivery of agreed capacity and service changes. Scope out larger scale transformation to ways of delivering care, including a focus on the workforce required, and any financial implications.
- **Phase 2 (years 3+)** – Start to implement larger scale transformation to new ways of delivering care across BSW

Phase 1

Priority workstreams for phase 1 are:

1. **Development of an BSW wide elective referral and coordination approach (incl. Demand and Capacity modelling / pathway redesign / system waiting list)** – to feed into the planning round for next year, future investment decisions, and short term tactical approach to addressing bottlenecks across BSW
2. **Excellence in basics** – sharing good practice to ensure all organisations have the basics of elective delivery in place, building on work already started. This is also part of the national Board Checklist
3. **Sulis Elective Orthopaedic Centre** – implementing the approved business case; and working up the BSW and regional wide operational model, including pathway redesign and link to BSW clinical strategy
4. **Community Diagnostic Centre** – working alongside the AHA to support implementation of the CDC hub and spoke model

Phase 2

Specific schemes will be decided in due course but the approach will be broadly based around the following areas:

- **Expanding capacity** – specific schemes to address identified capacity issues in BSW
- **Services reconfiguration** – looking at the scope, scale and location of services provided in BSW, including repatriating activity and service consolidation where clinically appropriate
- **Adopting different ways of working** – looking at new ways of delivering care, including prevention, demand management, and care in out of hospital settings; and making best use of digital technology, including AI, to support areas like outpatients, diagnostics and validation.

BSW ICB — Demand and Capacity Modelling

Lead	Sam Wheeler	**SRO**	Paul Doyle
Timescales	23/24 to be used as part of 24/25 planning round		

Rationale for Action

1. Problem

- It is key the elective plan is informed by a robust evidence base.
- Currently there is no single view of the demand and capacity available across BSW, bringing together electives, cancer and diagnostics.
- At a strategic level this impacts long term and annual planning, and investment decisions, in particular around the quantum and location of new capacity.
- At an operational level, it is difficult to pre-empt and react to near term potential issues and bottlenecks.

2. Target / Intended Future State

- A model which allows a projection of Planned Care activity and performance, at system and trust level, over the next five years to 2028
- Multiple scenarios for future growth in demand including 'bounce-back', GP appointments, referral thresholds, and consultant referrals.
- Ability to see impact of key interventions e.g. productivity initiatives, service Re-design initiatives, new capacity
- Model embedded in week-to-week, month-to-month, year-to-year operational planning

3. What will make a difference?

- Short term external support to develop the model
- ICS and trusts ownership and operationalisation of the model
- Combining this with other building blocks – single waiting list, networked referral approach – to enable choice and ensure patients treated as quickly as possible

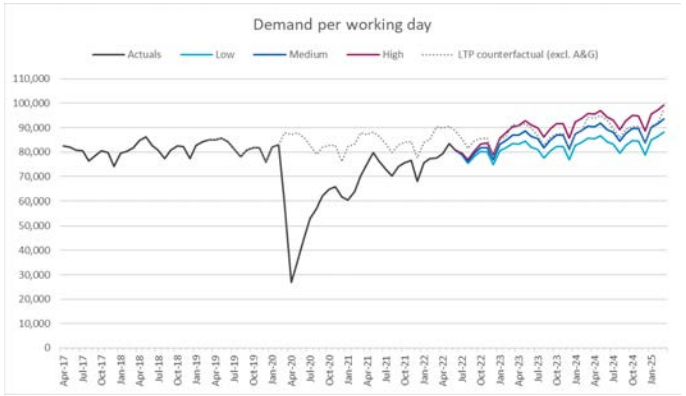
4. Actions & Interventions

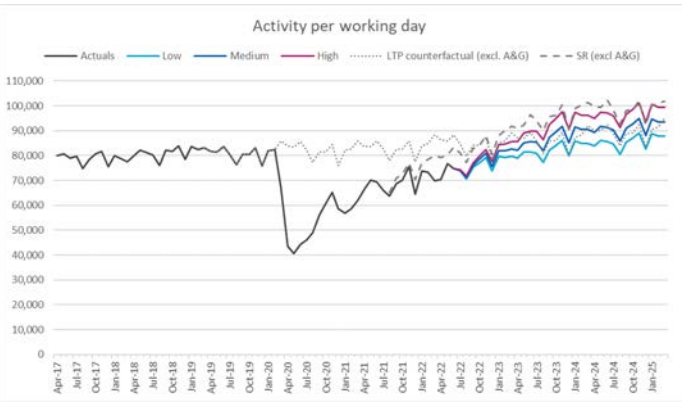
- Development of model
- Effective handover to ICS and trusts analysts
- Use by referral support service to give patients clear view on their choices
- Use as part of planning round to look at activity and performance
- Use as part of sector wide investment decisions
- In year use of tool to identify and manage potential issues and bottlenecks

5. Monitoring & Measurement

- Oversight through new whole plan delivery group and Elective Care Board
- Steering group for model development work with external supplier
- Progress measured qualitatively and quantitatively through use in planning round to manage demand and assess impact of interventions.
- In-year impact measured by smoothing of waiting times between providers.

Sample national data





Key Actions

Actions	Timescales	Owner	Resource Requirements	Key Risks
Development of model	July / Aug 23	Sam Wheeler	External resource to develop mode; BI resource for handover	Data availability and capacity of BI to provide data; ineffective handover of model
Implementation of model	Sept 23 onwards	Sam Wheeler / Paul Doyle / Mark Harris / Trust operational leads	BI resource; project manager; Referral Support Service staff; trust operational teams	Resourcing to operationalise and run; willingness of patients to not go to their local trust / move trust

BSW ICB

Elective Referral and Coordination approach incl. System View of the Waiting List

Lead	TBC	**SRO**	Lisa Thomas
Timescales	To be operational in 24/25		

Rationale for Action

1. Problem

- Need to align demand and capacity across all BSW providers to patients are treated in the right place at the right time:
  - in the short term the key focus needs to be reducing waiting lists and maximising the efficiency of our workforce and capacity
  - In the medium term the focus needs to be driving waits as low as possible while ensuring the operational and financially sustainability of organisations.
- Need to establish clear pathways and drive clinical standardisation across all providers.
- Need to integrate IS capacity to treat patients at appropriate point on waiting list

2. Target / Intended Future State

- Efficient referral process ensuing patient in right pathway and provider from the start, including a choice of providers
- Ability to offer choice mid pathway to reduce waiting time.
- BAU model that offers maximum efficiency (£ and operational)
- Workforce model that is sustainable for rota's/training.
- IS capacity fulling integrated
- Expanded / augmented RSS to manage new networked approach

3. What will make a difference?

- Demand and capacity model
- Single view of waiting list, including IS
- Clinical standardisation (pathways/treatments) across all providers including IS
- Flexible working model across sites (primarily consultants)
- Structured mutual aid process

4. Actions & Interventions

- Demand and capacity analysis – to understand gaps in specialty level capacity (see separate A3)
- IECPP tool to view single waiting list (outpatients starting summer 2023)
- Link with AHA on specialty reviews
- Design scope and approach of expanded / augmented referral support service
- Review of choice legislation to ensure choice offered helps to improve waiting times

5. Monitoring & Measurement

- Steering group to oversee development of approach
- Impact measured by:
  - smoothing of waiting times between providers.
  - Reduction in clinical variation
  - Choice offered / patients moving mid-pathway
  - LT operational / financial sustainability of providers
  - Staff feedback

Key Actions

Actions	Timescales	Owner	Resource Requirements	Key Risks
Demand and capacity modelling	July / August	Paul Doyle / Sam Wheeler	External modelling support (agreed)	Ensuring model practical; handover to BI team
Single view of waiting list	Q3 23/24	Felicity T-D / Paul Doyle / Trusts elective leads	Central IECCP support / trust elective leads / RSS team support	IG governance; operationalisation and roll out across RSS and trusts
Alignment to AHA pathway work	Q3 23/24	Lisa Thomas / Paul Doyle	AHA time (Ben Irvine); resource to support pathway mapping and redesign	Resourcing; aligning choice and operational imperatives
Design expanded / augmented referral support service	Q4 23/24	Lisa Thomas / Paul Doyle / Mark Harris	RSS time; AHA time;	Resourcing; aligning choice and operational imperatives

BSW ICB | Excellence in Basics

Lead	xxx	**SRO**	[Niall Prosser]
Timescales	To be operational in Q2 23/24		

Rationale for Action

1. Problem

- A focus on the pandemic and away from waiting list management, and staff turnover, has resulted in a loosening of processes and a weakening of skills of staff to manage waiting lists effectively.
- Doing the basics well is key to reducing long waits, the size of the waiting list, and helping patients to manage their condition while waiting
- One of the national elective priorities is focused on excellence in basics.
- Need to help our staff to upskill on waiting list management and elective delivery

2. Target / Intended Future State

- Well embedded processes for ongoing validation and prioritisation of the waiting list.
- Patients clear what their wait is likely to be and able to manage their condition
- Training programme / materials for staff
- Well functioning trust and specialty systems and processes in place

3. What will make a difference?

- Development of training materials / sharing of existing training materials
- Single view of the waiting list
- Potentially some short term external validation support
- Making excellent use of data and insight to drive improvement

4. Actions & Interventions

- Development / sharing of training materials
- Link in with IECCP work on single view of the waiting list
- Explore some short term external validation support, including looking at what other trusts / systems do (e.g. Dorset)
- Link in with BI on data requirements
- Find out what is currently happening on patient comms, and support to wait well

5. Monitoring & Measurement

- Overall performance measured against long waits / waiting list reduction
- Specific excellence in basics metrics:
  - % patients over 26 weeks validated in last 12 weeks
  - Performance against EBI
  - Number of P4s treated out of sequence
- Patient feedback on experience of waiting
- Staff feedback on training and support

Chart showing % of patients over 26 weeks validated in last 12 weeks?
EBI chart?

Key Actions

Actions	Timescales	Owner	Resource Requirements	Key Risks
Development / sharing of training materials	June to share; June – Aug for further development	COOs / Paul Doyle	Potentially resource (8a-8c) to develop training materials	Lack of resource
Explore external validation options	Autumn	COOs (or deputies) / Paul Doyle	Potentially funding to get in external support	Funding for external support
Look at current performance against EBI procedures	Autumn	BI	BI resource	Lack of resource

BSW ICB | Sulis Elective Orthopaedic Centre (SEOC)

Lead	Victoria MacFarlane	**SRO**	Paul Doyle
Timescales	Phased delivery of increased SEOC capacity at Sulis Hospital, Bath from 23/24 onwards		

Rationale for Action

1. Problem

- Pre covid there were 4.4 million patients awaiting elective surgery
- Post covid this has risen to 7 million
- Median wait times have increased from 6.9 wks to 13.8 wks
- Those seen within 18 weeks has fallen from around 85% to 61%
- The number of people waiting more than 52 weeks for elective orthopaedic surgery per 100,000 population in England is 99.7 average.
- Devon and Bristol are outliers with 52 weeks wait more than double this.

2. Target / Intended Future State

- Surgical hub developed at Sulis Hospital, Bath to serve the populations across BSW and the wider South West Region inc Devon and Cornwall
- Dedicated orthopaedic theatres with ring fenced post operative care
- Theatre working to GIRFT HVLC standards
- 2.5 additional theatres worth of activity operationalised at Sulis Hospital
- Aim of 1500 patients treated per theatre pre annum, a total of 3750 patients

3. What will make a difference?

- Additional capacity
- Ring fenced care
- Integrated networked pathways across the BSW acute hospitals
- Dedicated pathways for patients further afield
- Elective surgical hub as centre of excellence

4. Actions & Interventions

- Recruit dedicated operational project management resource to support with the mobilisation at Sulis Hospital
- Finalise floorplans and submit for planning permission
- Ensure subsequent construction project execution plan adheres to timescales
- Carry out staff and consultant engagement events to announce the achievement of the business case and offer staff opportunity to ask questions
- Develop workforce model and agree it across the BSW system
- Develop a recruitment and retention plan for the additional 98 staff required
- Refresh the SEOC SG and launch implementation phase with the required sub-groups of System, design & operations.

5. Monitoring & Measurement

- Delivery of construction and implementation programme as per project plan timeframes
- Monitoring of RTT performance for T&O across BSW and the South West
- Monitoring of actual number of delivery of patients through the additional SEOC capacity
- Monitoring of patient clinical outcomes
- Staff satisfaction survey
- Patient satisfaction survey

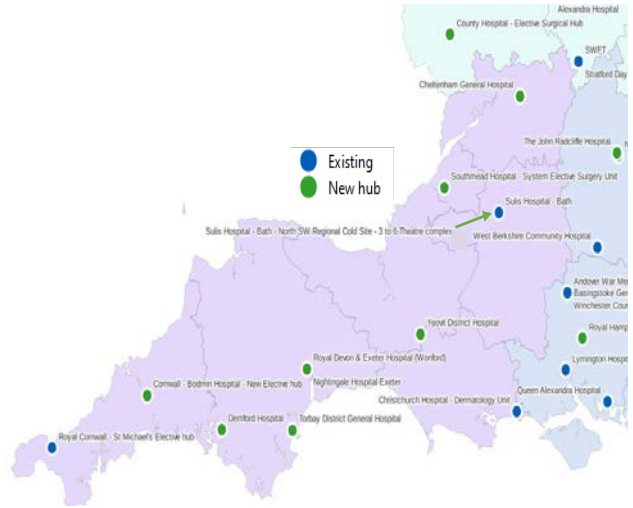


Table 7: Potential short term demand for the SEOC from providers in areas nearest BSW – all Bath demand and 'excess' demand from other areas

Base Provider / Procedures	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Bath	2197	2237	2147	2182	2208	2236	2262	2286	2313	2329
N Bristol	1011	1076	847	899	942	986	1036	1082	1112	1144
Great Western	349	400	442	487	520	556	588	620	654	675
Yeovil	469	500	374	402	429	456	481	505	523	537
Taunton	601	631	235	262	288	313	338	361	378	391
Salisbury	204	230	181	204	222	240	257	274	291	302
University Bristol	129	152	159	178	194	210	228	245	256	267
Royal Devon	2018	2114	1172	1254	1343	1417	1493	1557	1607	1646
Total	**9003**	**9366**	**7584**	**7896**	**8175**	**8444**	**8714**	**8962**	**9167**	**9325**

Key Actions

Actions	Timescales	Owner	Resource Requirements	Key Risks
Finalise design and submit for planning permission	Aug 23	Jeremy Sneddon / Victoria MacFarlane	Design team	Availability, cost envelope, delivery to timescales
Recruit project implementation manager	Aug/Sep 23	Victoria MacFarlane	Recruitment	Availability of staff, length of time to recruit, cost of agency backfill as interim
Contract and construction	Oct – Mar 24	Jeremy Sneddon/ Victoria MacFarlane	Construction team, contract managers	Cost envelope, construction timelines
Operationalisation	Feb 24 onwards	Simon Milner / Victoria MacFarlane	Operational and clinical teams	Workforce recruitment and retention, capacity of existing teams to deliver operationally and on the SEOC expansion

BSW ICB | Community Diagnostic Centre (CDC)

Lead	Rob Gittins	**SRO**	Claire Thompson / Peter Collins
Timescales	Phased implementation of additional CDC capacity from March '23 to December 24		

Rationale for Action

1. Problem

- Demand and capacity modelling indicates that demand for diagnostics is rising, and this has already led to growing waiting lists and increased waiting times for diagnostic investigations. Forecasts indicate this situation will continue to exacerbate.
- This is across all different diagnostic modalities
- There is a national policy driver to move elective diagnostics to cold sites permitting rapid local access (Richards report)

2. Target / Intended Future State

- Develop diagnostic services to support the elective recovery programme & rapid diagnosis particularly of cancer
- Meet the forecast growth in diagnostic demand c-3-7% over the next 5 years
- Reduce concern for patients through faster diagnosis
- Dispersed provision of mobile and fixed community sites for wider range of diagnostic tests
- Single oversight and management of CDC capacity across BSW

3. What will make a difference?

- Additional capacity across the whole BSW system as a Hub and Spoke model
- Deliver a full range of co-ordinated diagnostic tests, which support integration across primary, community and secondary care and which minimise the number of journeys the patient has to make to access services
- Provide a digital infrastructure that underpins these key priorities ensuring that the results of the diagnostic examinations are promptly available to the clinicians who need them
- Hub is at Sulis Hospital in Bath, with two intended spokes at Swindon and Salisbury.

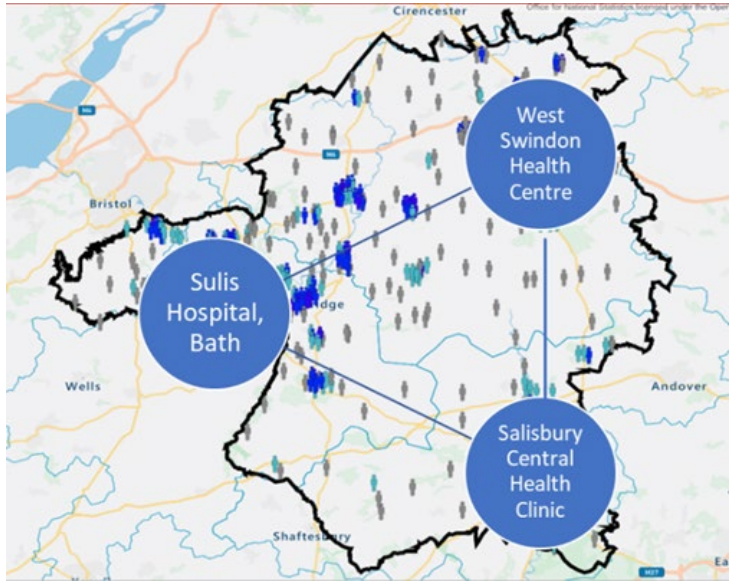
4. Actions & Interventions

- Additional diagnostic capacity has gone live at Sulis (Hub) in Q4 of 22/23 with more capacity and modalities planned for later in the year
- Spoke sites to be set up at Swindon and Salisbury– to provide capacity across the system in a hub and spoke model
- New capability is supported by c£14m capital funding for estates works and procurement of equipment. Revenue funded on a tariff basis.
- The development of revised clinical pathways and system working will be supported through a separate central grant.

5. Monitoring & Measurement

- Monitoring of activity delivery per site
- Monitoring of waiting lists at system level and by individual provider level (to ensure capacity in the correct area)
- Monitoring of patient outcomes
- Staff satisfaction survey

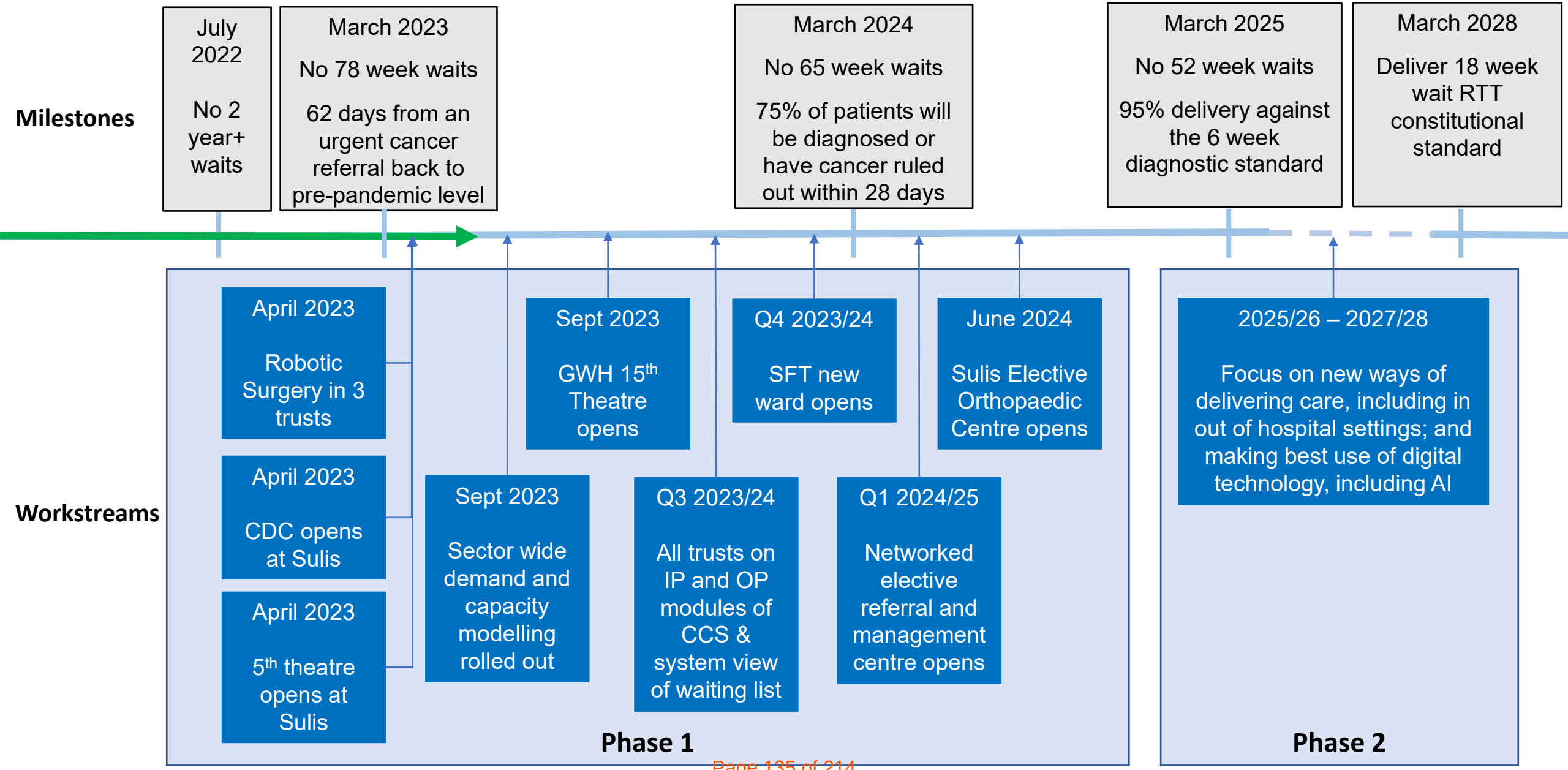
Map of BSW CDC Hub and spoke locations



Key Actions

Actions	Timescales	Owner	Resource Requirements	Key Risks
Approval of spokes Business case by National CDC team	July 23 – Aug 23	Rob Gittins	Progress with design and consultancy work delayed as awaiting MoU. Escalated issue to ICB DoF.	National team do not approve business case for both hub and spokes and model has to be revisited
Recruitment of project team for operalisation of new spokes and expansion of hub	July 23 – Oct 23	Rob Gittins	Project management resource as per business case	Approval of business case and ability to recruit staff in a timely way
Work up of plans to deliver next programme phase	Aug 23 – for plans Oct23- Jan 24 – for delivery	Rob Gittins and Victoria MacFarlane	Project team as per above. Clinical staff to input into model; Design and build team; Trust staff to mobilise.	Recruitment of specialist staff
Development of revised clinical pathways	Oct 23	Rob Gittins and clinical leads	Proposing to use SWCSU as project team and clinical staff.	Time limited funding until mar 24; More immediate requirement for next phase development at Sulis this autumn.

Our Roadmap


Milestones
July 2022
No 2 year+ waits
March 2023
No 78 week waits
62 days from an urgent cancer referral back to pre-pandemic level
March 2024
No 65 week waits
75% of patients will be diagnosed or have cancer ruled out within 28 days
March 2025
No 52 week waits
95% delivery against the 6 week diagnostic standard
March 2028
Deliver 18 week wait RTT constitutional standard
Workstreams
April 2023
Robotic Surgery in 3 trusts
April 2023
CDC opens at Sulis
April 2023
5th theatre opens at Sulis
Sept 2023
Sector wide demand and capacity modelling rolled out
Sept 2023
GWH 15th Theatre opens
Q3 2023/24
All trusts on IP and OP modules of CCS & system view of waiting list
Q4 2023/24
SFT new ward opens
Q1 2024/25
Networked elective referral and management centre opens
June 2024
Sulis Elective Orthopaedic Centre opens
2025/26 – 2027/28
Focus on new ways of delivering care, including in out of hospital settings; and making best use of digital technology, including AI
Phase 1
Phase 2

Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

1. Elective Care Ambition

2. Elective Care Plan

3. Delivering the Elective Plan

4. Governance

Delivery Framework

Delivery: The outcomes of the elective plan will primarily be delivered by frontline teams within individual organisations and specialties.

Creating the conditions for delivery: the role of the elective plan, ICS and Trust senior management teams is to create the conditions for delivery. This will be achieved in 3 ways:

1. Set the overall ambition

Key principles:

1. Focus on a limited number of ambitions / targets
2. Ensure those ambitions can be performance monitored from top to bottom – the concept of managing 'inch wide – mile deep'
3. There is a single version of the truth – consistent metrics and data set to monitor performance

2. Priority x-cutting issues, or where it makes sense to do something once

Key Principles:

1. 'task and finish' project approach where the ICS and trusts would work together to address an issue and work with frontline teams to make BAU
2. Ongoing task and finish type process to address issues that arise over time
3. Use improving together methodology

3. Improvement and Performance Support

Key Principles:

1. Using our Improving Together methodology, peer to peer learning, and sharing of best practice to support all trusts and specialties to push for to provide excellent and timely care for our patients
2. Targeted support to a limited number of trusts and specialties that are off track

1. The overall ambition

Approach

- Developing an elective recovery scorecard viewable at system, provider and specialty level to maintain oversight on delivery.
- Information available to all to allow shared insight and understanding across internal and external stakeholders, and see performance trends over time.
- Single version of the truth used to track progress on a weekly basis

Core Outcome Metrics

- 2023/24 – Increase activity to 109%, with the aim of delivering around 30% more activity by the end of 2024/25
- 2023/24 – No one waits longer than 65 weeks for elective care by March 2024;
- 2023/24 – further reducing 62-day backlog cancer backlog and deliver the Faster Diagnosis Standard.
- 2023/24 – No waits of more than a year for OPFA by end Sept 2023; No non-admitted patients wait more than a year by end Dec 2023 [Regional target]
- 2024/25 – waits of longer than a year are eliminated by March 2025
- 2024/25 – 95% of patients needing a diagnostic test receive it within six weeks by March 2025

Core Operational Improvement Metrics

- Activity breakdown by POD
- Activity volumes by POD, split by RTT and non-RTT
- Booking rates for 40+ week cohort
- Long waiter clearance rates
- Theatre utilisation and progress against 85% BADs target
- Progress against 25% OPFU reduction
- % of patients on PIFU pathway
- DM01 performance
- Diagnostic volumes split by CDC vs non-CDC

2. Priority x-cutting issues, or where it makes sense to do something once

Approach

- Projects with x-cutting focus
- 'Start and finish' projects with clearly defined task and work programme. Typically lasting <12 months
- Representation from each trust and ICS covering appropriate mix of clinical, operational and financial
- Support to trusts / specialties to make operational
- Use Improving Together methodology

Key priorities for 2023/34

- Demand and Capacity modelling / Networked referral model / system waiting list
- Excellence in basics
- Sulis Elective Orthopaedic Centre
- CDC implementation
- Specific surgery, diagnostic, cancer and outpatient projects

3. Improvement and Performance Support

Approach

- Data based approach to improvement and performance support based on 2 core areas:

1. Using our Improving Together methodology, peer to peer learning, and sharing of best practice to support all trusts and specialties to push for to provide excellent and timely care for our patients
2. Performance support for trusts and specialties that are challenged or are not on course to deliver our elective ambitions. The level of oversight and support (e.g. trust or system) will be determined on a case by case basis (see performance approach below).

Potential improvement offers

Cancer improvement:	Including buddying arrangements with specialties that have successfully re-designed relevant tumour pathways and/or use of national / regional clinical leads, and use of Cancer Alliance funding and support
Outpatient productivity:	Including support implementing booking, virtual outpatient appointments, PIFU, health inequalities
Diagnostic productivity:	Including mutual aid between trusts, prioritisation of long wait patients within new CDC capacity, and health inequalities
Surgical productivity:	Regional / local GIRFT and peer support to review surgical productivity and prioritisation, and health inequalities
Excellence in Basics:	Including support with booking, validation, application of national RTT and Cancer Waiting Times rules, and good waiting list management practice, incl. health inequalities
Optimising NHS and Independent Sector Capacity:	Including support with brokering insourcing and outsourcing arrangements with Independent Sector providers
Patient Choice / Mutual aid:	Including support for inter-system patient transfers, virtual consultations across providers, and implementation of ERS capacity alerts

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1. Elective Care Ambition

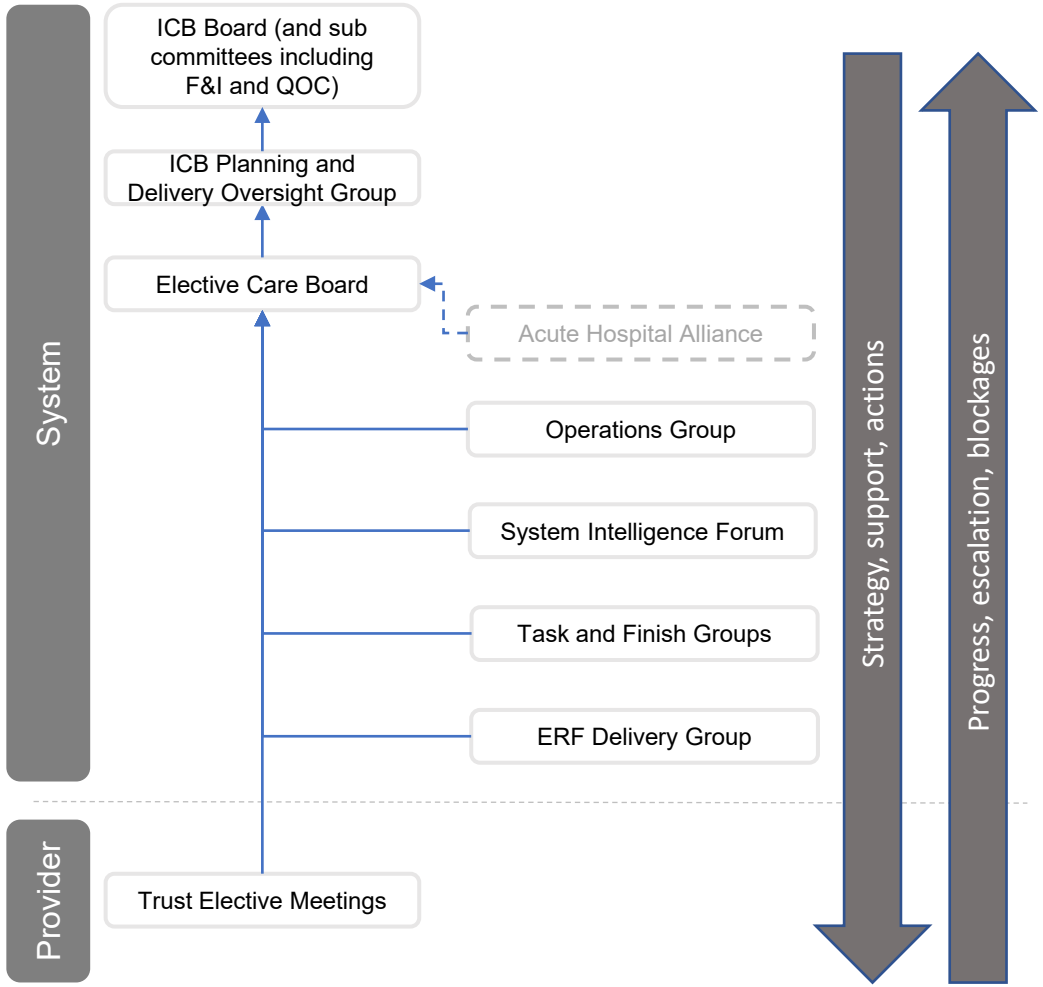
2. Elective Care Plan

3. Delivering the Elective Plan

4. Governance

Elective Plan Governance

Governance



Accountability

	Purpose	Membership
Elective Care Board **Monthly**	Accountability for overall Elective Care Plan delivery and risks. Accountable for ERF delivery. Sets and oversees direction of travel for the elective care	• **Chair**: Cara Charles-Barks • **Attendees**: Trust COOs; Transformation Director, BSW Elective Care Programme; Director of Commissioning, BSW ICB; Task and Finish Group Leads; finance support
Operations group **Fortnightly**	Identify and agree approach to addressing x-cutting delivery issues, including working with and through task and finish groups as required. Review actions from previous ECB, and escalate issues to next ECB.	• **Chair**: Paul Doyle • **Attendees**: Trust Elective leads; Task and Finish Group Leads as necessary
System Intelligence Forum **Fortnightly**	Focus on data / insights / benchmarking to identify potential areas for action to support delivery. To commission any further deep dive data requirements.	• **Chair**: Charlie Gale • **Attendees**: ICS and Trust BI / performance rep; Ops rep from each trust
Task and Finish Groups	Take forward specific projects such as the elective referral and coordination approach, and specific surgery, outpatient, diagnostic and cancer priority projects.	• **Chair**: TBC by area • **Attendees**: Mix of clinical, operational and finance as appropriate
ERF Delivery Group	Oversee delivery of ICB ERF plan	• **Chair**: Paul Doyle • **Attendees**: Mix of operations, BI and finance
Trust Elective Meetings	Existing trust governance frameworks. To support and challenge progress on elective plan delivery. Escalate issues to Elective Care Board as appropriate	• **Chair**: Trust COO / Deputy COO • **Attendees**: trust reps;

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	13
Date of Meeting:	21 September 2023		

Title of Report:	Review of Reading the Signals – Report on East Kent maternity services and recommendations
Report Author:	Sandra Richards, Maternity Lead
Board / Director Sponsor:	Gill May, Chief Nurse
Appendices:	Presentation Slides

Report classification	BSW ICB Board
ICB body corporate	Yes
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	x
Noting	For noting without the need for discussion	

Previous consideration by:	Date	Please clarify the purpose
ICB Quality and Outcomes Assurance Committee	March 2023	Discussion/Assurance
BSW ICB Executives	August 2023	Discussion/Assurance

1	Purpose of this paper

To provide an overview of BSW Local Maternity Neonatal System (LMNS) ICB position relating to progress against the recommendations set out within the "Reading the Signals report into East Kent Maternity services", published in October 2022.

The "Reading the Signals" report set out the devastating consequences of failings and the loss and harm suffered by families. The report reconfirms the requirement for ICB boards, provider Trusts and LMNS Boards to remain focused on delivering personalised and safe maternity and neonatal care. There is also the need to ensure that the experience of women, babies and families who use our services

are listened to, understood and responded to with respect, compassion and kindness. The report identified key recommendations for national bodies, ICB's and provider Trusts including the processes to be in place for oversight of maternity services.

A letter sent to ICB Chief Executives in 2022 identified the expectation that every Trust and ICB reviews the findings of the report at the public board meeting and that boards are clear about the action they will take and how effective assurance mechanisms are at "reading the signals" to identify when a maternity or neonatal service requires support before adverse outcomes are identified.

NHSE has now published a 3 year delivery plan for maternity and neonatal care which includes key principles from the national report recommendations and other programmes of maternity and neonatal workstreams for safety, quality and transformation. Each provider has reviewed the delivery plan to identify any additional actions that were not already part of the provider action plans. NHSE have asked services to concentrate on 4 key themes:

- Listening to and working with women and families with compassion
- Growing, retaining and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structure that underpin safer, more personalised and more equitable care

These themes have been integrated into the BSW Care Strategy implementation plan as key principles for ongoing, planned actions for maternity and neonatal services.

On 20th July 2023 the Government published their response to "Reading the Signals: maternity and neonatal services in East Kent-the report of the independent investigation" Government response to 'Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation' - GOV.UK (www.gov.uk). The Government noted that the key principles in the report have been incorporated into the 3 Year Plan for Maternity and Neonatal services.

2	Summary of recommendations and any additional actions required

Recommendations within the "Reading the Signals" report are primarily for national bodies/organisations but learning has been discussed within Trusts and the LMNS and presented to provider Trust boards to identify any actions required in addition to implementation of recommended national changes.

Appendix 1 sets out the key findings and recommendations from the East Kent report and ICB/LMNS actions identified in response. The actions we have identified are:

The board is asked to note this report for assurance regarding BSW position and identified actions and monitoring processes.

- Monitoring Safety Performance to get better at identifying poorly performing units
- Standards of clinical behaviour and management to ensure that care is provided with compassion and kindness
- Effective teamworking approach – effective relationships within and between professional groups and common purpose.
- Organisational behaviour – Trusts prioritising reputation management to the detriment of being open and straight forward with families, with regulators and others.

The recent outcome of the trial of Lucy Letby who was found guilty of the murder of seven babies in the Countess of Chester hospital neonatal unit has led to further action for all providers and systems including strengthening awareness and processes in regard to Freedom to Speak Up, boards are regularly reporting , reviewing and action upon available. BSW ICB will be setting up a System Mortality Group.

There will be a statutory inquiry into the Chester neonatal deaths which is likely to take a significant period of time and recommendations will be considered as part of the ongoing perinatal and neonatal surveillance within BSW system.

3	Legal/regulatory implications

Links to NHS oversight framework – outcomes for stillbirths, neonatal deaths and maternal deaths descriptors.
Links to CQC single assessment framework - Quality Statements for Safety, Effective, Caring and Well-led
Regulatory requirement for oversight of all non-coroner deaths by a Medical Examiner in place in providers which ensures independent scrutiny of all deaths.

4	Risks

This is a national report which links to similar reports nationally including Ockenden Report in maternity services in Shrewsbury and Telford and there is an additional investigation in process in Nottingham. There is an associated finance risk on corporate register relating to potential required funding required for additional Ockenden staffing recommendations.

5	Quality and resources impact

Please outline any impact on
Quality, Patient Experience and Safeguarding: This report highlights the significant impact on babies, mothers, fathers and families. The Healthcare Safety

Investigation Branch (HSIB) evidence route cause analysis from incidents providing further learning. Finance: Maternity Transformation Monies have supported all actions and drive for improvements . These funds have now been used and the ICB are considering how re continue to transform and work differently whilst address the considerable actions following multiple national reports and incidents, Sustainability/Green agenda: Not considered	
Finance sign-off	n/a

6	Confirmation of completion of Equalities Impact Assessment
A self assessment has been completed in each acute trust and the LMNS will pull this into an EQIA to understand system impact.	

7	Statement on confidentiality of report
This is not confidential.	

Bath & North East Somerset, Swindon and Wiltshire LMNS
Local Maternity & Neonatal System (LMNS)

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Reading the Signals- Update on progress with recommendations from East Kent maternity services review report (published Oct 2022)

BSW ICB Board
S Richards, BSW LMNS(ICB) Midwife
September 2023

Reading the Signals Report, October 19th 2022

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

- Independent investigation led by Dr Bill Kirkup on maternity and neonatal services in East Kent of care provided 2009-2020.
- Identified that suboptimal clinical care provided which led to significant harm, they failed to listen to families involved and acted in ways that unacceptably distressed families
- Outcomes could have been different in 97 (48%) of 202 cases assessed by panel, and the outcome could have been different in 45 of the 65 baby deaths (69%) of cases.

Reading the Signals- Findings

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

1. **Problems with care-** failures in teamworking, professionalism, compassion and listening, problems between different MDT

2. Problems with trust response at Trust Board level and whether to the Trust sought to learn from lessons- denied responsibility, failed to communicate openly with families, investigations conducted narrowly and defensively with no learning achieved. Minimised what had happened and provided false reassurance – did not acknowledge errors openly and learn from them. Board attributed cases to individual clinical error (junior or locum). HR functions not effective managing bullying or divisive behaviour. Trust replaced staff in key managerial roles who identified and challenged poor behaviour. Defensive and aggressive relationship with HSIB, RCOG report on culture issues, poor governance and response to safety – not shared with CQC. Board failed to act on Morecombe Bay report.

3. Trusts engagement with regulators including CQC and the actions and responses of regulators, commissioners and NHS regionally and nationally called into question- 8 clear opportunities to have acknowledged and tackled the problems at various times but failed to do so in reviews.

Reading the Signals- Recommendations

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

- Different from Ockenden report as did not set out specific detailed changes of policy directed at specific areas of practice or management.
- Recommendations primarily for national bodies/organisations but learning being discussed in Trusts and LMNS to identify any actions required in addition to implementation of recommended national changes. 4 Key areas for action and oversight by BSW LMNS Programme Board

1. **Monitoring Safety Performance**
2. **Standards of clinical behaviour and management**
3. **Effective teamworking approach – effective relationships within and between professional groups and common purpose.**
4. **Organisational behaviour – Trusts not prioritising reputation management to the detriment of being open and straight forward with families, with regulators and others.**

Action area 1

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Monitoring safety performance – finding signals among noise-Key report points

- Need have more reliable early warning of problems in maternity and neonatal services before significant harm is caused. Each trust to have a nationally agreed, standardised mechanism in place.
- Improved outcome measures that are meaningful, reliable, risk adjusted and timely
- Trends and comparators both for individual units and national overview
- Identification of significant signals among random noise using techniques that account properly for variation while avoiding spurious ranking into league tables
- Concerns raised by families are not noise but are a signal of real problems
- Noted that trusts should not take reassurance from statistics that suggest number of baby deaths not being higher than in other trusts.

Recommendation 1 – Monitoring Safety Performance

Recommendation 1

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

BSW ICB/LMNS Local Actions

- Still awaiting outcomes from national Task Force. (no outputs yet)
- Outcome measures identified by BSW LMNS for interim period.
- LMNS Dashboard additional work in progress to streamline data provision for oversight
- Collaborative approach to potential standardised monthly board IPR reports
- Providers working to understand outcomes filtered by ethnicity and deprivation as part of BSW LMNS Equity and Equality Action Plan
- LMNS Safety Group monitoring of monthly board reports
- BSW LMNS participation in SW Perinatal Quality Surveillance group and quarterly reports to support identification and triangulation of information between systems and regulatory bodies.

Action area 2

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Standards of clinical behaviour – technical care is not enough

- Staff must explain what is happening and listen to women and family members
- Importance of robust telephone advice (particularly regarding staying at home if thought not to be in labour)
- Need HR and GMC processes in place to effectively manage Obstetric Consultant behaviour, cultural or attitudinal issues

Recommendation 2- Standards of Clinical behaviour

Recommendation 2

- **Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.**
- **Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.**

BSW ICB/LMNS_ Local Actions

- Acute Health Care Alliance now continuing initial LMNS and BSW Academy work to support pathways of career development and training through workforce workstream
- Maternity Voices Partnership surveys and engagement with families regularly with feedback from themes . MVP embedded in BSW LMNS workstreams. Kindness and compassion regularly features in this feedback from BSW maternity and neonatal services.
- Culture Surveys being repeated in all maternity service providers later this year (SCORE) following Maternity and Neonatal Quadrumvirate participation from each provider in national leadership training (SFT team attended in first wave Score Survey in the Autumn. GWH and RUH attending November 2023.

Action area 3

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Flawed teamworking – Pulling in different directions

- Decisions in pregnancy/birth should be free from inherent prejudice about the best method of delivery – E.g. Vaginal birth after caesarean section
- Trainees need to be supported and need a sense of belonging
- Staff need to train together

Recommendation 3- Teamworking

Recommendation 3

- **Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.**
- **Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.**

BSW ICB/LMNS- Local Actions

- Continued work with national maternity team to repeat culture surveys to assess progress against original culture surveys. LMNS Midwife trained to support debriefing if required.
- Trusts continue to focus on building safe and effective perinatal teams, breaking down professional boundaries- examples include recent SW award for PERIprem – improvement of outcomes for pre- term neonates, respect campaigns, speak out training, Safety Champion walkabouts, Joint matron for maternity and neonatal unit at GWH
- MDT training for teams working together in maternity and neonatal embedded

Action area 4

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Organisational behaviour – looking good whilst doing badly

- Trust prioritized reputation management to the detriment of being open and straightforward with regulators. Concerns raised to board were dismissed, complaints managed rather than consideration of feedback and learning.
- Focus on heroic leadership but pattern of dismissing people in senior positions quickly rather than tackle the issues.

Recommendation 4- Organisational behaviour

Recommendation 4

- **The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.**
- **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.**
- **NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.**

BSW ICB/LMNS

- Appointment of Director of Midwifery at each of BSW three providers of maternity and neonatal services
- Safety champions for maternity and neonatal within each provider board
- Early stages of utilisation of national guidance for quality risk response and escalation framework supporting oversight and scrutiny provided by BSW System Quality Group.
- Established BSW LMNS board/Maternity and Neonatal Safety Groups triangulation of information relating to safety and quality with onward reporting to BSW Quality Assurance and Outcomes Committee
- Successful BSW LMNS application for pilot of Independent Senior Advocate for families involved in investigations into care- appointed and commences September 2023 ensuring advocacy for service users

Ockenden Update

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

- Repeat Ockenden/national reports Insight visits booked with all three maternity providers between September and November 2023 by BSW LMNS (including the BSW Maternity and Neonatal Voices representatives and SW Regional team members.
- Ockenden Final Report recommendations – action plans in place in each provider, with majority of the 92 actions either in progress or in place . A few actions not in progress and not in place (mostly those awaiting national body guidance (E.g. Obstetric Anaesthetic Association guidance data sets and records, national training for labour ward co-ordinators, and succession planning programmes for senior midwifery leaders and managers). Providers will continue to work on actions within trusts and collaboratively across the system wherever possible with some actions being support by regional team. As further national guidance becomes available current action plans will be reviewed to incorporate any required adjustments. SFT working at pace to complete outstanding actions from initial report.
- Initial national steer was to await guidance from new national taskforce group on some recommendations that required national approach e.g. workforce analysis models etc – No outputs from this group yet, with advice from region for systems to work on own plans with current models for workforce. BSW Acute Health Care Alliance oversight of workforce development in place. This presents challenges regarding workforce modelling for future models such as Continuity of Care.

Any Questions?

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	14
Date of Meeting:	21 September 2023		

Title of Report:	999 Lead Commissioner Arrangements – SWASFT, ambulances
Report Author:	Anett Loescher, Deputy Director of Corporate Affairs
Board / Director Sponsor:	Gill May, Chief Nurse
Appendices:	1 – 999 Lead Commissioning Model supporting information

Report classification	
ICB body corporate	x
ICS NHS organisations only	
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	x
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
Discussion with each SW ICB & SWASFT	Oct-Nov 2022	Seek out feedback on current commissioning model for ambulance services, and appetite to explore an alternative approach
AJCC	31 January 2023	Agreement that Dorset ICB continues to develop a Lead Commissioner Model.
AJCC	28 March 2023	Consider draft proposal incl. vision, working principles, key functions, resource and costings
AJCC	30 May 2023	Commitment from AJCC to take the 999 Lead Commissioning Agreement through

		the South West ICBs for signing off during summer 2023
BSW ICB Executive Meeting	3 July 2023	Consideration of the lead commissioner proposal

1	Purpose of this paper

The South West ICBs have for some time co-commissioned South Western Ambulance Services Foundation Trust (SWASFT) to provide ambulance services across the region. NHS Dorset ICB hosted the arrangement, including the Ambulance Joint Commissioning Committee (AJCC) as the key decision-making forum of the arrangement.

Earlier in the year, the SW ICBs via the AJCC agreed in principle that they wish to refresh the arrangement and enter into a formal lead commissioner arrangement with Dorset ICB, whereby Dorset ICB will move from its current role as a coordinating commissioner to a lead commissioner for SWASFT. As lead commissioner, Dorset ICB will in effect act on behalf of the SW ICBs to commission the ambulance service and to manage the commissioning contract.

The SW ICBs are invited to delegate their ambulance commissioning function to Dorset ICB, together with the relevant authorities and powers so that Dorset ICB can deliver its proposed lead commissioner function. Following agreement and delegation, Dorset ICB wishes to commence the transition into the lead commissioner arrangement in autumn 2023.

For the purposes of transitioning and implementing the lead commissioner arrangement, Dorset ICB are finalising the formal delegation agreement for this arrangement and the full Terms of Reference for the forums within the proposed governance structure. A Lead Commissioning Agreement (LCA) has been produced following consultation and engagement with colleagues across the SW and has been shared with all SW ICBs via the AJCC. The LCA sets out the scope of delegation and limits of authority of the lead commissioner; the roles and responsibilities of the lead commissioner and the co-commissioners to the agreement; the governance structure to support the decision making and functions of the lead commissioner model; and resource required for the ambulance commissioning support service. This document is available to Board members on request should they wish to see it.

Updates will continue to be made to the ICB Board through the Committee Report.

2	Summary of recommendations and any additional actions required

The ICB Board is asked to **agree** to the proposed lead commissioning arrangement for SWAFT, and to **approve** the delegation of the ambulance

commissioning function together with the relevant powers and authorities to NHS Dorset ICB. The Board is asked to **note** the associated financial cost to support the additional resource (capped at £104,469 for 2023/24 for NHS BSW ICB).

3	Legal/regulatory implications
The national NHSE guidance 'Integrated Care Board Commissioning of Ambulance Services' sets out minimum expectations for Ambulance Trusts and Integrated Care Systems (ICSs) in England for the commissioning of ambulance services as part of the new ICB arrangements.	

4	Risks
This paper relates to risks ICB01 and ICB 04 on the corporate risk register relating to urgent care and flow and ambulance handovers.	

5	Quality and resources impact
Quality, Patient Experience and Safeguarding: No changes expected in terms on quality, patient experience and safeguarding of the 999 service. To note that Dorset ICB are developing the 999 Quality Framework. **Finance**: The current model indicates an increase in the costs shared between all seven systems. For BSW ICB, based on its 15% share of the SWASFT contract, this amounts to £104,469, capped for 2023/24. This is a material increase in cost by £46,003, compared to £58,466 paid in 2022/23. **Workforce**: The increase in costs will support the recruitment of additional resource to support the ambulance commissioning team to deliver the ambulance commissioning function and contract management (described in the LCA).	
Finance sign-off	Gary Heneage

6	Confirmation of completion of Equalities and Quality Impact Assessment
EIA not been completed. No significant changes will be made to any service.	

7	Communications and Engagement Considerations
n/a	

8	Statement on confidentiality of report
This paper can be shared publicly.	

NHS Dorset

999 Lead Commissioner Model

Supporting Information for ICB Board Sign Off

The problems we're trying to solve…

A quick bit of history

- **2017** – Co-ordinating commissioner to Dorset & refreshed governance to ASPB
- **2018** – agreed to stop rotation of the coordinating commissioner role across the SW & adopt a single lead (Dorset)
- **2019** – improved governance to create AJCC
- **2020** – commissioning support team established

Challenges with the current model

- **Decision-making processes lengthy & complex** when issues / recommendations / needs are often urgent:
  - £ Risk-share agreement
  - Medium and longer term improvement and transformation planning (esp. non-recurrent funds)
  - Co-ordination means taking the time to bring all partners together to work through each issue, challenge or opportunity

Performance and commissioning models

- Performance across the SWASFT and UEC has been **some of the most challenging in the country**
- **SW is an outlier** in terms of commissioning model and scope of responsibilities – **as sense this is adding** to improvement delivery and performance challenges
- **Top performing** Trusts/regions have **a lead commissioner model**. Worst performing regions (EoE & SW) have a co-ordinating commissioner model

How we got here today…

Oct & Nov 2022

1:1 conversations with all CEOs – *do you support the case for change?*

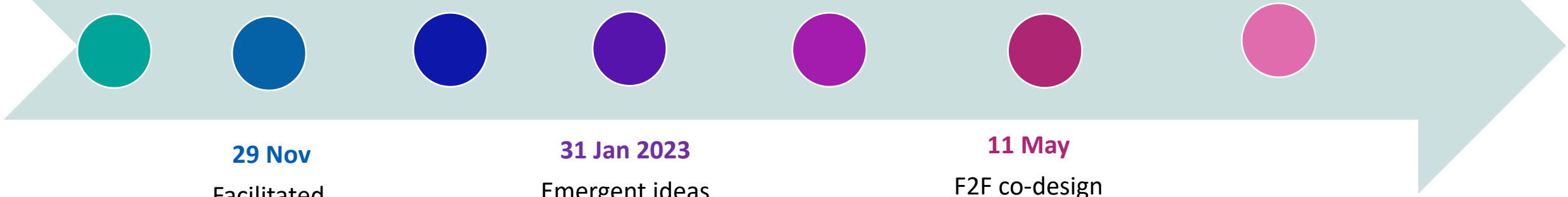
Nov – Jan 23, *discussions & exploration of best practice by Dorset team*

28 March 2023

AJCC supports further draft proposals & co-design workshop

30 May 2023

AJCC supported the principle that the Lead Commissioner Agreement (LCA) will be a 'good enough' version to launch with and commitment was sought to take through ICB Boards for approval during July / August



29 Nov

Facilitated workshop CEOs agreed options to explore

31 Jan 2023

Emergent ideas tested with AJCC – full support given for LC & further iteration

11 May

F2F co-design workshop with ICB commng leads

Draft LCA developed and shared for comment

What did people say during development?

NHS Dorset

To secure Lead Commissioner Model:

- Be helpful to **see key features** of lead commissioner models / high performing Ambulance Trusts
- Can we describe **what success would look like?**
- Confirm **what resources** the lead commissioner is going to need
- **Ensuring representation from ICSs** into each layer of Lead Commissioner operating model and / or governance structures
- **ICSs involved in co-design** is essential
- **Clinical leadership** and championing for delivery, improvement & transformation **seen as essential**
- Certain degree of **agility between scale & local** = 85% at scale, 15% local

Key concerns to address:

- **Does this mean ICSs lose control?** What about funding and future activity?
- **Ability and pace of SWAST** to deliver improvement & transformation
- **Need clarity on role of commissioner & benefits of working at scale** – needs more commissioning grip, better achieved through local ownership [1]
- **Want to be involved in shaping** the principles, clinical models & priority workstreams and in designing interface with ICB teams and local UEC delivery
- **Co-ordinating commissioner role could work** if more time to have the right discussions [1]

[1] = only one ICB said this

The key benefits partners noted

Respond to issues and opportunities in real time

Better able to drive delivery against key plans

Holding provider and each other to account for agreed targets/goals

Best performers in UK have lead commissioner model, must be something in this!

Regulatory Oversight following confirmation of segment can be done more effectively on behalf of ICSs

Clearer accountability & responsibilities

Enables faster decision making

Being better organised strengthens our national influence

Lead Commissioner Model – based on work to date:

Delegated authority to the strategic board established and agreed. To include financial/contractual limitations as well as Lead Commissioner decision making remit.

Review and overhaul of the governance to enable timely decision making and key work to progress. Reducing the need to pass back through to 7 individual ICBs. Also links to the delegated authority requirement.

Recognising the wealth of knowledge and expertise across the SW, ensure there are strong mechanisms in place to enable continued engagement and communication with all partners.

Ensure there is an agreed collaborative commissioning agreement in place, which clearly defines the role of the Lead Commissioner as well as the role of co commissioners.

To ensure the agreed key operational and accountability functions of the Lead Commissioner can happen a strengthened team will need to be in place to support the commissioning support function.

Clinical oversight and leadership will be embedded as part of the Lead Commissioner model to support the championing for improved patient outcomes, strengthening the role of the ambulance sector in reducing healthcare inequalities, performance improvement & transformation.

An annual Lead Commissioner Agreement

NHS Dorset

A **Lead Commissioning Agreement (LCA)** will describe the scope of the lead commissioner's authority to act and ensure each ICB contributes to recommendation building and/or decision making. The LCA will restrict the lead commissioner to agreed annual budgets and targets. **The Lead Commissioner will be a single ICB who will:**

- **Work directly with SWASFT to:**
  - ✓ Commission services within the parameters of the LCA;
  - ✓ Identify and troubleshoot delivery/performance issues;
  - ✓ Develop and deliver improvement opportunities.

- **Work directly with SWASFT and ICBs to:**
  - ✓ Develop the joint annual plan for finances and activity, a multi-year strategy with in-year deliverables;
  - ✓ Troubleshoot local issues impacting on SWASFTs performance.

- **Drive transformation** of provider services to **ensure sustained and equitable benefit to ICB systems**;
- **Ensure decisions are made through agreed governance structures**, seeking to resolve at the lowest level possible in real time without the need to revert to each ICB Board for final decision;
- **Decisions required outside** the LCA (for example additional funding needs, performance shifts outside expected ranges) **will be referred to ICB Boards**.

How is this different to now?

- At the moment under our co-commissioning arrangements, **our main task is to ensure ICB representatives are brought together** to ensure issues are discussed, proposals developed and that recommendations can be built

- These go back to individual ICBs **each time for approval**

- Equally, **our ability to work directly with SWASFT to tackle challenges** or seize opportunities is constrained by a lack of delegated authority to act

- In essence, our arrangements are geared towards discussion of issues and challenges **rather than being properly organised to support and drive** delivery of agreed plans

Financial Summary

Function	Costs (subject to annual inflation uplift)
Ambulance Commissioning Support Service (inc. top up funding) – ***current funding envelope***	£382,000
Additional resource required to support Lead Commissioner Arrangement	£309,000
Total Capped Amount	**£691,000**

Commissioner	Percentage of Contribution 2023/2024	Amount of Contribution 2023/2024
NHS Bath & North East Somerset, Swindon & Wiltshire ICB	15%	£104,469
NHS Bristol, North Somerset & South Gloucester ICB	15.5%	£107,236
NHS Devon ICB	22.1%	£152,898
NHS Dorset ICB	13.4%	£92,707
NHS Gloucestershire ICB	11.3%	£78,178
NHS Cornwall & Isles of Scilly ICB	12.2%	£84,405
NHS Somerset ICB	10.3%	£71,260

To note: percentage splits above are based on the 2023/25 contract apportionment per ICB which reflect the new approach for the redistribution of the 999 contract between the 7 commissioning systems.

- Commissioners have each agreed to contribute a percentage in respect of the costs incurred by the Lead Commissioner in undertaking the commissioning support arrangements.
- The tables opposite outlines the funding envelope as well as the amount of contribution per ICB for the commissioning support service for 2023/24.
- The envelope will be capped at the amount specified with no overspend.
- As part of the phased implementation and embedding of this agreement during 2023/24, the commissioning support service and associated resource will be recruited to as part of a phased process as we further develop and define the Lead Commissioner role and functions.
- The additional costs will support the recruitment of additional resource to ensure the ambulance commissioning support team is fit for purpose and strengthened to enable delivery of the agreed key functions as described in schedule 3 of the Lead Commissioning Agreement.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	15
Date of Meeting:	21 September 2023		

Title of Report:	BSW Operational Performance and Quality Report
Report Author:	Sarah-Jane Peffers – Associate Director of Patient Safety and Quality, Sharren Pells - Deputy Chief Nurse, Jo Gallaway – Performance Manager
Board / Director Sponsor:	Gill May – Chief Nurse Rachael Backler – Director of Planning and Performance
Appendices:	Summary Operational Performance Dashboard Quality Assurance Report

Report classification	
ICB body corporate	
ICS NHS organisations only	Yes
Wider system	

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	x
Noting	For noting without the need for discussion	

Previous consideration by:	Date	Please clarify the purpose
ICB Executive Performance and Risk Meeting	21/08/23	Review of performance across the oversight framework domains
ICB Quality and Outcomes Committee	05/09/23	Assurance

1	Purpose of this paper

The aim of this paper is to provide oversight and assurance on the safe and effective delivery of NHS care and NHS operational performance to the ICB Board.

Quality and performance are considered in detail at a number of executive-led meetings within the system and therefore this report presents items for assurance and where necessary, escalation, in the first instance for the Quality and Outcomes Committee's attention and then to the ICB Board. The System Quality

Group is the main executive-led group that reviews quality matters, operational performance is considered within the ICS programme boards and also through the ICB Performance and Risk meeting that takes place each month. We have made progress with the development of an integrated performance report covering the key domains of quality, finance, workforce and operational performance. This is included within the appendices, along with detailed exception reports/ We are expecting the revised NHS Oversight Framework metrics to be finalised shortly which will enable us to align our internal reporting with regional and national assurance processes.

2	Summary of recommendations and any additional actions required
The Board is asked to receive this report for assurance purposes.	

3	Legal/regulatory implications
This report is part of the BSW assurance framework including the delivery of: NHS Oversight Framework (SOF), the NHS Constitution and the NHS operational plan.	

4	Risks
There are several risks on the BSW ICB Corporate Risk Register (dated 15/08/23) that reflect the challenges to delivering Quality and Performance. • BSW ICB 01 – Insufficient capacity for Urgent and Emergency Care and Flow • BSW ICB 03 – Ambulance Hospital handover delays • BSW ICB 04 – Impact of Industrial Action • BSW ICB 06 – System workforce challenges. • BSW ICB 08 – Workforce challenges in MH services • BSW ICB 09 – Recovery of Elective Care capacity • BSW ICB 10 – Cancer waiting times underperforming • BSW ICB 11 – Impact of difficulty finding placements for children looked after • BSW ICB 13 – Primary Care POD delegation impacted by lack of reporting	

5	Quality and resources impact
Quality impacts linked to the performance of the system are highlighted in this report. Where appropriate action is taken to address this impact.	
Finance sign-off	Not required.

6	Confirmation of completion of Equalities Impact Assessment
N/A	

7	Statement on confidentiality of report
This report is not considered to be confidential.	

BSW Executive Escalation and Assurance Report
Operational Performance and Quality Report to the ICB Board

1. Introduction and purpose of report

1.1. This report is provided in order to assure the Board on the work undertaken within the system in relation to management and overview of key quality and operational indicators.

1.2. This report provides a concise update of key issues for the Board. We note that there are a number of executive meetings across the ICS that focus on detailed scrutiny of performance across the domains of finance, quality, workforce and operational performance.

2. Key operational performance information

2.1. In the round, BSW continues to be challenged across several performance metrics. We are awaiting the outcome of the NHS Oversight Framework segmentation process for Quarter 1 and aware that we are flagging as a potential segment 3 across some domains.

2.2. BSW have improved and maintained performance in April to June for ambulance handover, four hour performance and bed occupancy. This aligns to small improvements in the non-criteria to reside performance overall, however, ICAs are working through their improvement plan with a particular focus on NCTR in Wiltshire.

2.3. BSW did not meet the initial March 23 deadline to clear all 78 week waiters, and we have not yet treated all patients waiting within this category. In addition, a cohort of long waiting patients awaiting breast reconstruction surgery who had not previously been categorised as RTT have been identified at SFT. Further detail is set out in the exception report. At the end of August providers in the system had 24 patients over 78 weeks against a trajectory of 0. Actions are being taken to prioritise these patients and mutual aid within the system is overseen by the fortnightly elective recovery group.

2.1. Industrial action continued in August causing cancellations of elective care appointments and procedures / operations. BSW continues to monitor and manage the impact of the strikes to minimise the impact on patients.

2.2. Cancer waiting time reporting against the ten national targets for June showed only one of the ten cancer waiting time targets were met for BSW ICB patients. BSW patients are waiting longer than is acceptable for their diagnosis and treatment. The most challenged pathways all have recovery plans underway and we are discussing how to bring increased executive focus and oversight to the recovery plans. We note that performance against the two weeks wait standard remained below target but has continued to improve.

2.3. Diagnostic performance continues to be a significant challenge, DM01 performance (the % of the waiting list over 6 weeks) for June has improved to

60%. Key driver of the challenged performance is the non-obstetric ultrasound workforce, NHSE region are coordinating work to resolve.

2.4. In mental health we continue to see significant challenges. BSW Talking Therapies recovery rates have improved in the last four months, not yet reaching the national standard (50%). Access rates continue below target. Both low and high intensity waiting lists are growing reflective of the fact that although workforce expansion is progressing the trainee workforce can only hold a limited case load.

2.5. Dementia diagnosis rates have improved slightly and are expected to continue to improve. BSW currently showing a rate of 58% against a national standard of 66.7% (BSW is third out seven south west systems currently). All GP practices are now signed up to report against this target.

2.6. CYP Access to mental health is reporting significantly below trajectory. Oxford Health have not yet resumed data reporting following their cyber incident in July 2022. Oxford Health have shared draft access information with the ICB in July and will be resubmitting their data to the national Mental Health Services Data Set (MHSDS) when the data reporting window is reopened for those providers affected by the cyber incident.

2.7. Complex LDA (Learning Disability and Autism) inpatients have seen a continued reduction in line with the agreed trajectory. Oversight will be undertaken under the new Acute Care Pathway, Prevention and Oversight pillar of the refreshed BSW LDA Programme.

3. Key financial performance information

3.1. We continue to see challenges across the NHSE Oversight Framework for each of the finance metrics including Financial efficiency, Financial stability and Agency spending.

3.2. We are in the process of producing a three year financial plan.

3.3. Further detail is available within the finance reports considered by the Finance and Investment Committee and the Board.

4. Key quality performance information

4.1. In July there were 2 Never Events reported, with a further never event reported in August – all wrong site surgery. Immediate learning review has taken place and a new protocol for lesion removal is being developed.

4.2. Eleven Serious Incidents were reported in July across the system. Learning is being triangulated with system demand and industrial action. There is no evidence that these can be directly attributed to industrial action at this time. However this will require ongoing monitoring.

4.3. The ICB Quality Team is working with system partners to undertake a system wide audit review to understand the current systems in place and risks relating to Mixed Sex Accommodation Breaches. This includes comparing current practice with NHSE guidance and need for appropriate risk assessment when in extreme escalation.

4.4. There has been an increase in PALS enquiries in relation to community pharmacy. The ICB Quality Lead is working with the Collaborate Commissioning Hub to understand the issues and agree actions which will be monitored through the Pharmacy Operational Group and the Primary Care Executive Committee.

4.5. Overall incidents reported relating to Urgent Care have reduced for Q1 23/24 compared to the three previous quarters with 5 reported compared to 10 for Q2 22/23, 9 for Q3 and 16 for Q4.

4.6. Mental Health: In May 2023 a HSIB interim report was published in relation to children and young people with mental health needs and their care when admitted to paediatric wards. The BSW Thrive Board has considered the learning from this national report and is progressing a quality and safety SBAR assessment to understand the current picture in BSW. This report is focusing on any current risks, national guidance, research, admissions data and self-harm. There will be a consideration of other services in the country to support shared learning within BSW and to inform any actions needed to mitigate any identified risks, with input from health and social care services. Final SBAR report to be shared with MH Thrive Board, Quality and Outcomes Committee and System Quality Group

4.7. Patient Safety Incident Response Framework (PSIRF) principles: a co-produced handbook for staff, created by Making Families Count; AWP; Oxford Health, Nottinghamshire Healthcare; BSW ICB, BNSSG ICB, Berkshire Healthcare and Nottinghamshire Healthcare will be launched as part of World Patient Safety Day (17th September 2023) across the patient safety networks. Resource is designed to give colleagues the tools and guidance to support patients and families through the new review process, following a reported patient safety incident, in line with PSIRF principles.

4.8. GWH and RUH compliant with initial Ockenden actions. SFT currently have outstanding actions and are working to complete. Chief Nursing Officers have agreed timeframe for outstanding actions. BSW Pilot Maternity and Neonatal Independent Senior Advocate role (Ockenden recommendation) appointed to commence in role Sept 2023. Work continues in all maternity provider trusts regarding DAU capacity and triage processes and progressing final Ockenden actions.

4.9. The impact on waiting times is being monitored by providers through the triangulation of patient safety and quality information, including case reviews where necessary. Complaints, concerns and experience data is highlighting themes with regard wait times, communication, clinical care and treatment

4.10. There is a risk of breaching Clostridium Difficile (CDI) threshold set by NHSE. BSW ICB breached the threshold set by NHSE in 22/23 with 238 cases against threshold of 216, all acute trusts breached their set thresholds. There was a notable rise in CDI in the last 2 months of Q4 and this rise in being sustained into 23/24. Multiple actions are being taken forward by the BSW ICS Health Care Associated Infection (HCAI) collaborative.

4.11. CHC operational performance remains challenged. A recovery plan is in place and monitored weekly, with reporting to the BSW Quality and Outcomes Committee

5. Key workforce performance information

5.1. The vacancy rate across BSW is 7.1% for Acutes. Currently, it is neither improving nor deteriorating.

5.2. Bank usage continues to fluctuate. This month 6.4% of the budgeted WTE was spent on bank staff.

5.3. In the last 6 months there have been improved average sickness levels. This is because Covid related sickness absences have decreased.

5.4. It is anticipated that 12-month turnover rate will not meet the 12% target this year. However, there has been a consistent trend of improvement since August 2022, down from a peak of 15%.

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BSW Integrated Performance Dashboard September 2023

Quality Assurance and Outcomes Committee, 05/09/2023

ICB Board, 21/09/2023

BSW Integrated Performance Dashboard

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The following slides provide the June position on system level key performance, quality, finance and workforce metrics. The data shows performance for the BSW population, and not only the population treated by providers within our geographical boundary.

The data is taken from the NHS oversight framework and wider system metrics against the targets set out in the BSW 23/24 Operating Plan plus additional in year ambitions set by NHSE and BSW system partners.

The wider reporting of these metrics continues to be developed with supporting detail.

Each metric is supported by a statistical process control chart (SPC charts). SPC charts are constructed by plotting data in time order, calculating and displaying the average (the mean) and some data comparisons known as the upper and lower control limits as lines. These limits, which are a function of the data, give an indication by means of chart interpretation rules as to whether the process exhibits common cause (predictable) variation or whether there are special causes.

The summary icons shown in the dashboard indicate how a specific metric is performing using symbols for variation and assurance – more detail is shown on the right.

What are summary icons?

Summary icons provide an instant view of how a specific metric is performing using symbols for variation and assurance. Variation shows if there are any trends in the most recent data and assurance shows how the metric is performing in relation to a target.

Assurance Icons

The current process is capable and will consistently pass the target if nothing changes.

The current process will hit and miss the target as the target lies between process limits.

The current process is not capable and will fail the target if nothing changes.

Assurance cannot be given as there is no target.

Or blank

Variation Icons

Special cause variation of an improving nature.

Common cause variation, no significant change.

Special cause variation of an concerning nature.

Not enough data for an SPC chart, so variation cannot be given.

Or blank

Special cause variation where up or down is not necessarily improving or concerning.

BSW Integrated Performance Dashboard

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Elective Care				COMMISSIONER VIEW			
Metric	**Latest Month**	**Actual**	**Target**	**In-month**	**Change**	**Variation**	**Assurance**
Value weighted activity vs local ERF target	Jun-23	108%	106%				
Total number of patients waiting >65 weeks	Jun-23	1,281	1,165				
Total number of patients waiting >78 weeks	Jun-23	43	-				
% of DM01 activity completed within 6 weeks / OR the normal DM01 - WL meas	Jun-23	60%	95%				
% of DM01 WL over 13 weeks	Jun-23	18%	-				
% of patients meeting the faster diagnosis standard	Jun-23	68%	72%				
Cancer 62 Day Backlog	Jun-23	443	Reduce volumes				
% of DM01 WL over 13 weeks	Jun-23	19%	-				
62 Day Cancer Standard	Jun-23	57%	85%				
% 2WW seen in 2 weeks	Jun-23	64%	93%				
Cancer 104 Day Backlog	Jun-23	104	Reduce volumes				

BSW Integrated Performance Dashboard

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Quality

COMMISSIONER VIEW

Metric	Latest Month	Actual	Target	In-month	Change	Variation	Assurance
Percentage of patients describing their overall experience of making a GP appointment as good (annual data)	Dec-22	62.50%	-		⇩		
Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12 month rolling count)	May-23	5	0	✖	⇧	H	
Clostridium difficile infection rate (12 month rolling count)	May-23	151%	100%	✖	⇧		F
E. coli bloodstream infection rate (12 month rolling count)	May-23	140%	100%	✖	⇧	H	F

Primary Care

COMMISSIONER VIEW

Metric	Latest Month	Actual	Target	In-month	Change	Variation	Assurance
Primary Care Access - booked appointments	Jun-23	527,664	458646	✖	⇩		
Primary Care Access - % booked within 14 days	Jun-23	77%	-		⇩		

BSW Integrated Performance Dashboard

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Urgent Care				COMMISSIONER VIEW			
Metric	**Latest Month**	**Actual**	**Target**	**In-month**	**Change**	**Variation**	**Assurance**
A&E 4 hour standard - All types	Jun-23	66%	76%	✗	⇧	L	?
Adult G&A bed occupancy	Jun-23	97%	92%	✗	⇩	H	F
% of beds occupied by patients meeting Non Criteria to Reside	Jun-23	21%	13%	✗	⇔		F
Ambulance mean response Cat 2	Jun-23	00:47:12	00:30:00	✗	⇧		F
Ambulance activity - See and Convey	Jun-23	4,699	-		⇩	L	
Ambulance handovers by ICB > 15 mins	Jun-23	00:49:37	0	✗	⇩		F
Virtual Ward Capacity	Jun-23	114	370	✗	⇧		?
Virtual Ward Occupancy	Jun-23	56%	80%	✗	⇧		?
Urgent Community Response- % responded to within 2 hours	Jun-23	67%	80%	✗	⇩	L	?

BSW Integrated Performance Dashboard

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Mental Health/LDA				COMMISSIONER VIEW			
Metric	**Latest Month**	**Actual**	**Target**	**In-month**	**Change**	**Variation**	**Assurance**
Access to talking therapies	May-23	3,090	2,757	✓	⇧		
Out of area placements (bed days)	Jun-23	10	73	✓	⇧	L	F
Access to CYP MH services	Jun-23	10,659	10,883	✗	⇧		
Community MH Adult Access	Jun-23	4,240	4,220	✓	⇩	H	P
Perinatal MH access	May-23	280	166	✓	⇧		
Dementia diagnosis rate 65+	Jun-23	58%	64%	✗	⇧		F
% of people with a learning disability receiving an annual health check	Jun-23	8.8%	9.0%	✗	⇧		
LDA inpatients per 1m head of population	Jun-23	39.5		✗	⇩		

BSW Integrated Performance Dashboard

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People				COMMISSIONER VIEW			
Metrics - For BSW Acutes only - GWH,RUH, SFT	Latest Month	Actual	Target	In-month	Change	Variation	Assurance
BSW Vacancy %	Jun-23	7.1%	6.0%				
BSW Bank Staff %	Jun-23	6.4%	4.0%				
BSW Agency Staff % (2% operating plan)	Jun-23	2.5%	2.0%				
BSW Sickness (1M)	Jun-23	3.7%	4.0%				
BSW Sickness (12M)	Jun-23	4.6%	4.0%				
BSW Turnover (1M)	Jun-23	1.1%	1.0%				
BSW Turnover (12M)	Jun-23	13.5%	12.0%				

Note: The Agency staff usage plan target can be expressed in people / WTE as 2% and in finance / £s as 3.7%

BSW Integrated Performance Dashboard

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Finance		COMMISSIONER AND PROVIDER VIEW					
Metric	Latest Month	Great Western Hospital	Royal United Hospital	Salisbury FT	BSW ICB	BSW NHS ICS	Target
Financial stability - variance from plan (£m YTD)	Jun-23	-£2.9	-£2.4	-£0.2	£2.1	-£3.4	£0
Financial efficiency - variance from efficiency (£m YTD)	Jun-23	-£0.1	-£0.2	-£0.7	£0.0	-£0.9	£0
Efficiencies % recurrent Actual	Jun-23	£0.9	£0.6	£0.6	£0.8	£0.8	79%
Agency Spend vs agency ceiling (% over plan YTD)	Jun-23					£1.2	100%
Achievement of Mental Health Investment (annual measure)	Jun-23				achieved		Yes

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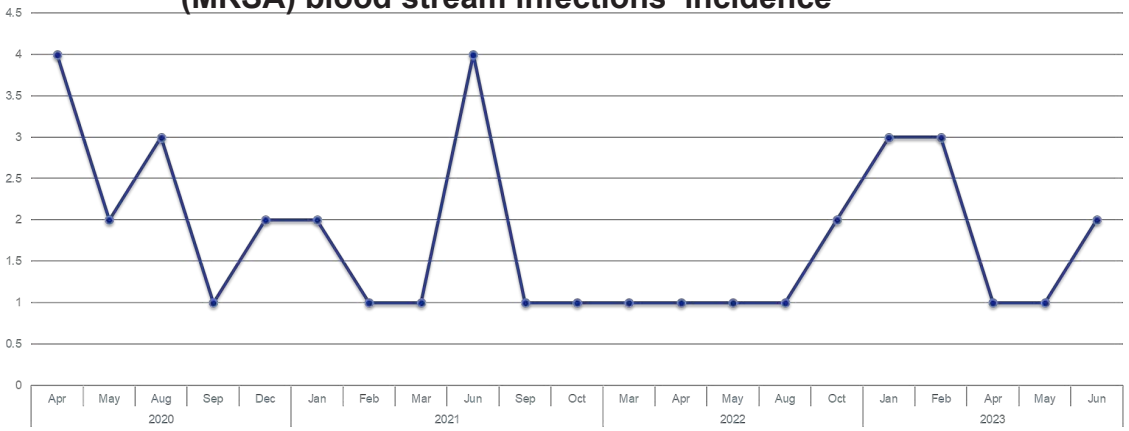
Quality and Safety Update: Infection Prevention and Control and Healthcare associated infections

Connie Timmins, Lead Nurse for infection Prevention and Control, NHS BSW ICB

Healthcare Associated Infections

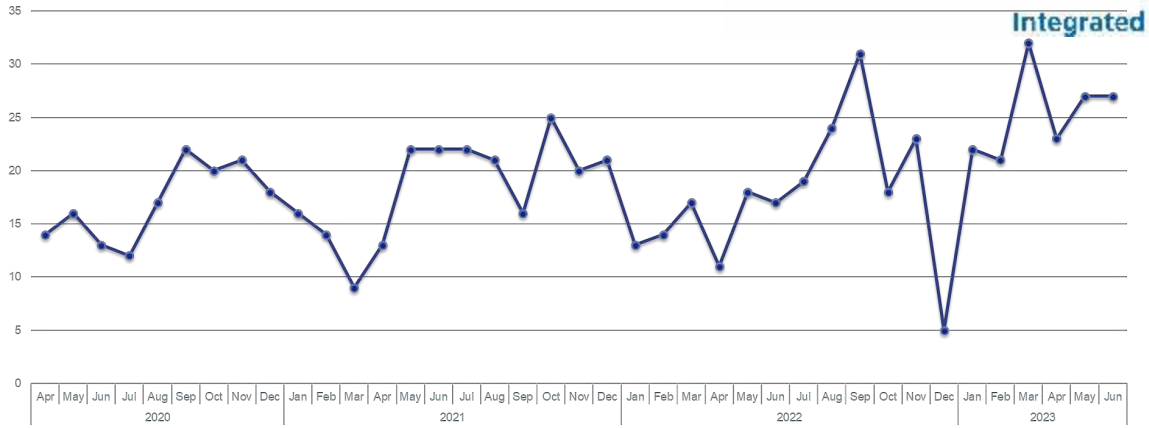
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

BSW ICS rolling Methicillin Resistant Staphylococcus Aureus (MRSA) blood stream infections incidence



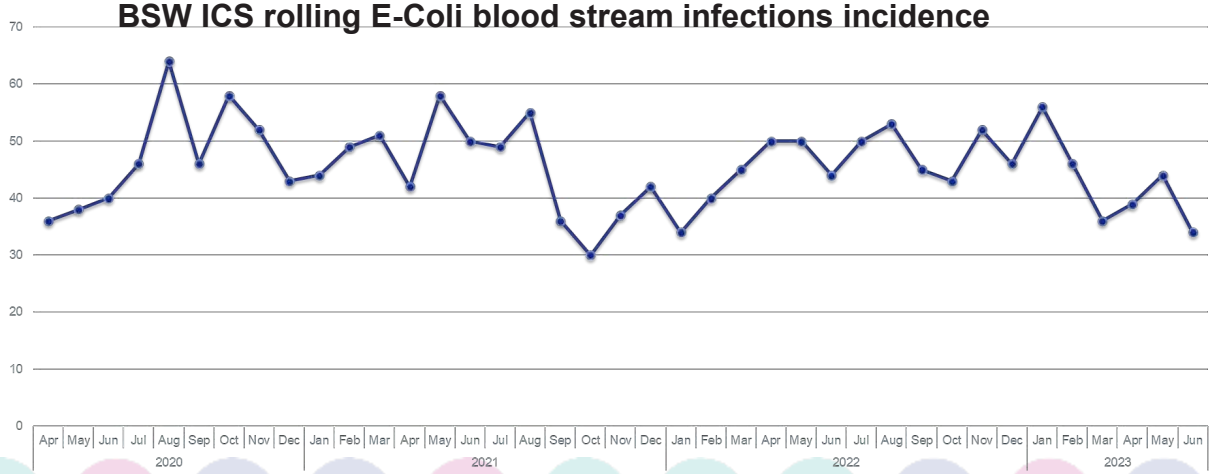
Total BSW MRSA	Threshold set by NHSE/I	Same time period 22/23	Difference
4	0	2	+2

BSW ICS rolling Clostridioides difficile (CDI) infection incidence



Total BSW CDI	Threshold set by NHSE/I	Same time period 22/23	Difference
77	216	46	+31

BSW ICS rolling E-Coli blood stream infections incidence



Total BSW E-coli	Threshold set by NHSE/I	Same time period 22/23	Difference
117	489	118	-1

E-Coli Blood Stream Infections (BSI)

- E-Coli blood stream infections remain stable across the ICS currently
- BSW ICS E-coli threshold is 489, there have been 117 cases, 1 less than the same period in 2022/23.

Clostridioides difficile (CDI)

- NHS England have set BSW ICB a threshold of 516 cases
- Current cases are 77, this is 31 case higher than the same period in 2022/23 and places BSW ICS at risk of breaching the threshold

MRSA

- There have been 4 incidence of MRSA blood stream infections across BSW ICS
- 2 Hospital onset, Healthcare Associated and 2 Community Onset, Community Associated. 2 more than the same period in 2022/23.

Healthcare Associated Infections

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E-Coli

- E-Coli blood stream infections (BSI) currently remain stable across BSW ICS.
- Post infection reviews continue to be undertaken by the ICB and system providers.

Learning

- Post infection reviews (PIR) undertaken for E. coli so far have noted themes in inappropriate prescribing relating to Lower Urinary Tract Infections and hepatobiliary issues within primary care services.
- Waiting list times for hepatobiliary procedures is also currently being looked at to understand this emerging theme identified through the reviews in greater detail, including those with gall bladder infections awaiting surgical review.

Next steps and Actions:

- Actions being undertaken by the BSW ICS HCAI collaborative to reduce incidence include:
- QI project for E. coli BSI which is ongoing with the three workstreams of
    1. improved hydration
    2. antimicrobial management and
    3. improved catheter care
- All workstreams are gathering traction with hydration resources being disseminated to providers, third sector, social care and primary care.
- Colleagues in medicines optimization are undertaking work relating to antimicrobial stewardship with providers and primary care
- community care colleagues are currently undertaking focused audits to understand the number of urinary catheters in the community and current management of these.

Clostridioides difficile (CDI)

- BSW ICS have seen a rising trend in Clostridioides difficile infections, with a higher proportion of hospital cases have been noted compared to community cases.
- Post infection reviews are highlighting where antimicrobial prescribing for managing of other infections, such as skin and soft tissue and chest infections are a potential contributory factor for the rise in the hospital cases and impacting the outcome for these patients.
- Post infection reviews continue to be undertaken across the system, to understand contributory factors in greater detail and therefore target specific actions.

Learning

- Skin and soft tissue and community acquired pneumonia prescribing within primary care are a contributory factor to the development of c.difficile
- Acute colleagues have identified use of proton pump inhibitors as an additional factor to CDIs identified within the acute hospital setting
- Comorbidities of obesity and diabetes are also prevalent in nearly all cases reviewed.

Next steps and Actions:

- Continue to review CDI cases
- Review system wide to understand themes and trends
- Define key actions to reduce prescribing associated with skin and soft tissue and community acquired pneumonia in collaboration with medicines optimisation colleagues
- Share learning across the ICS and ICB
- Liaise with public health colleagues to discuss actions around obesity and diabetes.
- Liaise with tissue viability specialist across community care to review current practices and identify any actions that can be taken.

MRSA

- NHS England have set a zero tolerance approach to MRSA blood stream infections.
- There has been a rise in cases when compared to the same time period in 2022/23 across BSW ICS.
- Review of all MRSA cases continue to be undertaken by the ICB and system providers.

Learning

- Skin and soft tissue are primary source of all MRSA cases
- 1 case is linked to foreign travel
- 1 case is linked to a groin abscess
- 2 cases remain under investigation through the post infection review process

Next steps and Actions:

- Liaise with primary care and drug and alcohol services to identify how we can support and safety net Persons Who Inject Drugs to prevent MRSA blood stream infections in this population.
- The BSW ICS infection prevention and control network are in the process of carrying out a focused review of Intra Venous line care bundles and skin preparation pre insertion of intravenous lines.

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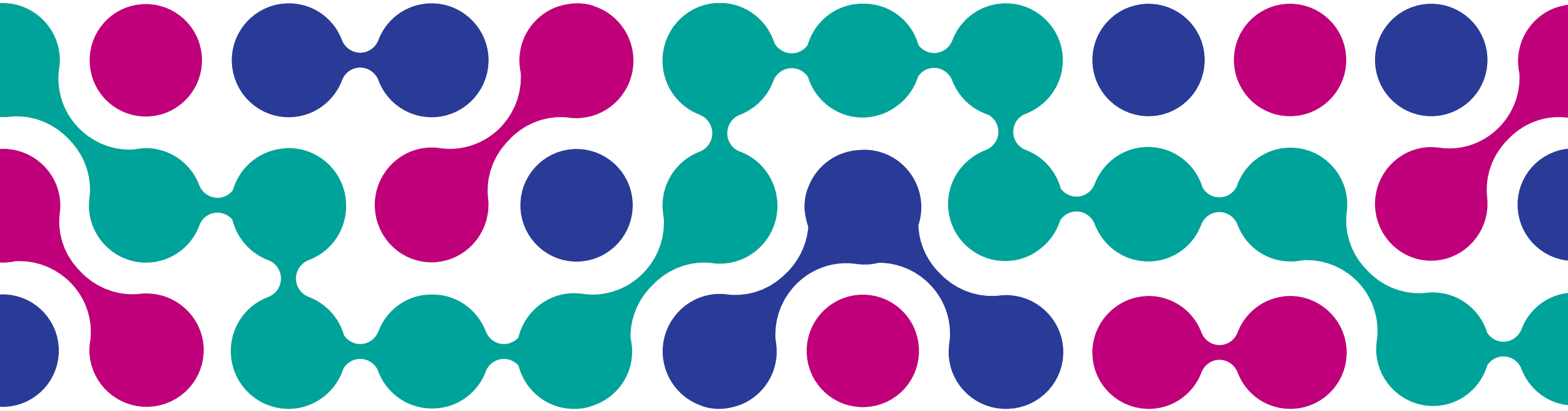
Operational performance exception reports



Operational performance exception reports

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

The following slides in each future report will set out more detail for those operational performance metrics where we have concern about performance against target – either from the statistical analysis or from other qualitative or quantitative information. We are refining this process and building out this report to incorporate more detail for future reporting cycles.

For this report, we have covered the key operational performance areas where the metric is flagging as a '3' per the NHS oversight framework for the ICB as indicated by the NHSE South West regional team.

- MH CYP access
- MH IAPT – Talking therapies
- Dementia Diagnosis
- LD inpatient rates
- Diagnostics
- RTT long waiters

We have also included an exception report on cancer, given the particular challenges we are facing across BSW.

Please note:

Mental Health – Access

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Access to talking therapies

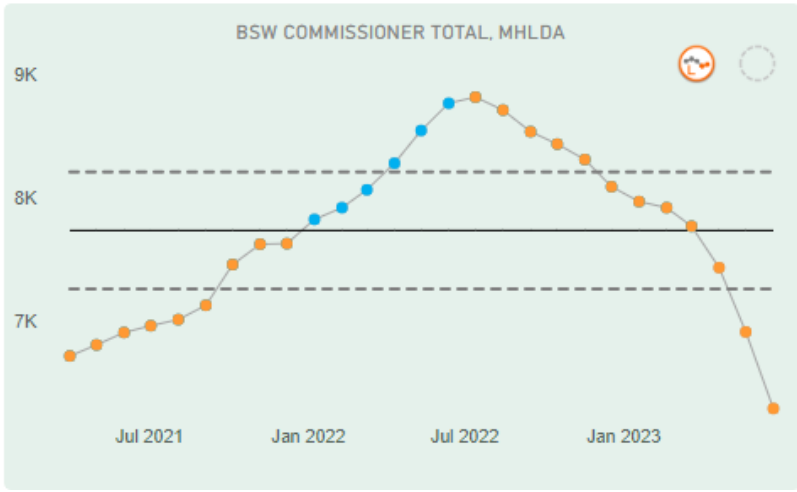
Performance analysis

Continued improvement in recovery rates reflecting implementation of the IAPT transformation plan. The rolling 3 month access rate has continued to rise but continue to be below target. Recovery rates have improved in the last four months, not yet reaching the national standard (50%).

Actions underway

BSW Talking Therapies has formally 'launched' its new NHSE and NICE compliant model. Further discussions have taken place with AWP leads and it has been agreed that a fundamental service review will be carried out between now and December 2023 to inform future commissioning intentions and financial planning for 2024/25.

% Children and Young Peoples Access



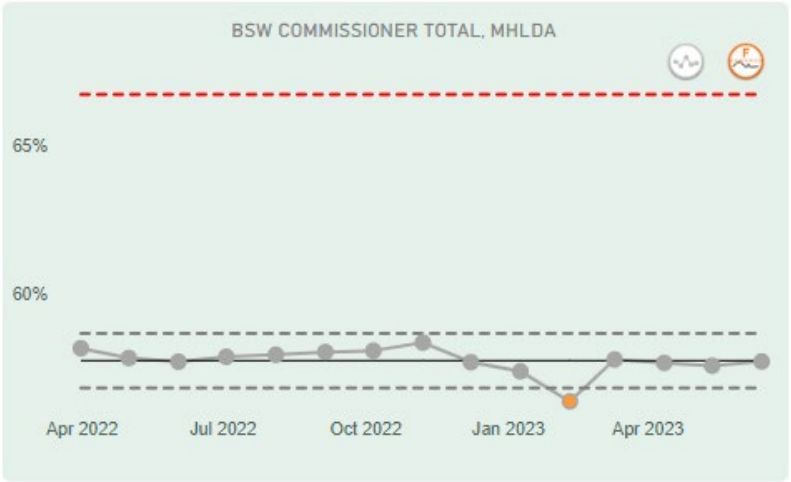
Performance analysis

CYP MH data is a rolling 12 month figure. Our main provider, Oxford Health, has not submitted data to the MHSDS since the cyber incident which caused an Adastra outage. This means their reported activity is reducing, Oxford Health have shared draft access information with the ICB in July. This shows positive improvement in access rates, exceeding their original trajectory.

Actions underway

Remodelling work has started across all providers to understand likely performance against trajectory by year end. We anticipate that this will demonstrate a continued positive improvement. Oxford Health will be resubmitting their data to the national Mental Health Services Data Set (MHSDS) when the data reporting window is reopened for those providers affected by the cyber incident.

Dementia Diagnosis Rate



Performance analysis

Performance has improved slightly in month, we anticipate that as the DDR transformation plan is implemented further, we will continue to see positive improvement. It is worth noting that across the south west, DDR rates remain low, with June data showing that BSW was ranked 3rd of the 7 south west systems in terms of performance against the national standard of 66.7%.

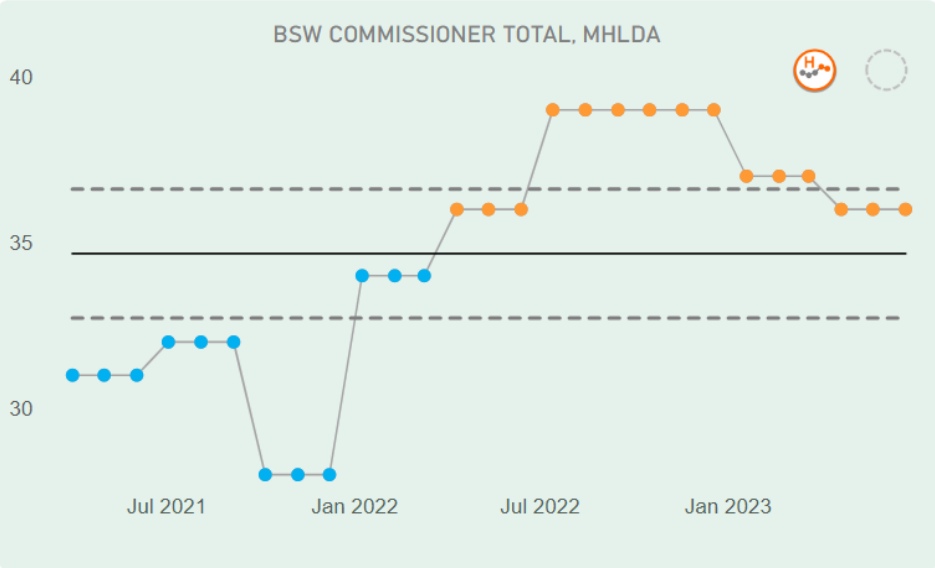
Actions underway

DDR transformation plan continues to be implemented. All GP practices are now signed up to reporting (the one remaining practice has now confirmed they are signed up to the system).

Learning Disabilities

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

LDA Inpatients (all age)



Performance analysis

We continue to see significant reduction in inpatient numbers across BaNES and Wiltshire in line with the agreed trajectory and mitigations are in place as described below to bring inpatient levels in line with plan. Adult inpatient numbers are on plan for Q1 and children's inpatient numbers are above plan*.

* Children's inpatient numbers are small and the data is suppressed, but are included as part of the all age total.

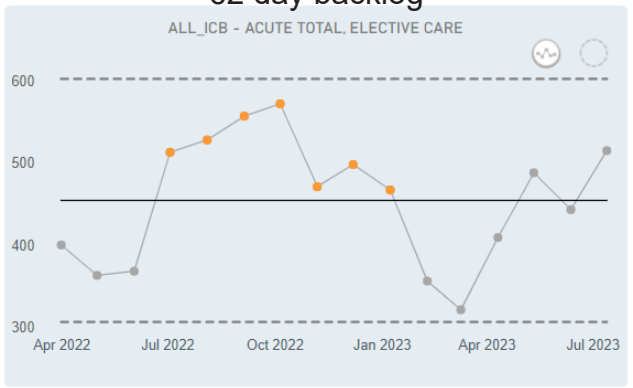
Actions underway

Oversight of actions continues to be undertaken through the BSW LDA Acute Care Pathway, Prevention and Oversight Pillar (ACPPO) reporting through to the BSW LDA Programme Board. Weekly patient level calls are now in place with Swindon leads to discuss each patient and discharge plans and support being provided to the locality to expedite actions. Monthly MADE events continue across all three localities. ACPPO continues to co-ordinate themes, case review learning and development of mitigating actions. Oversight and actions for NHSE commissioned inpatients remains with NHSE. BSW ICB, through the ACPPO pilar, are increasing level of oversight of these individuals to ensure we are clear on actions and discharge plans. Concerns around process and progress in some cases has been formally escalated to NHSE.

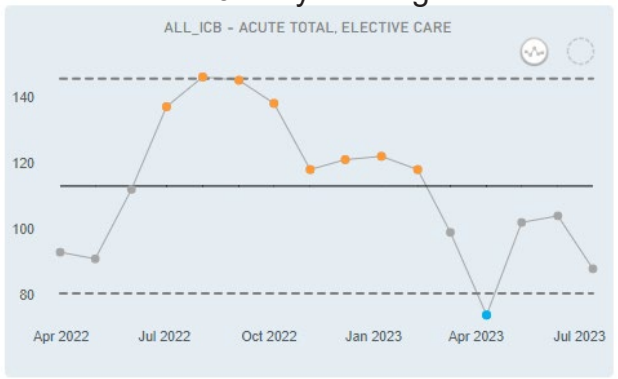
Elective Care – Cancer

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

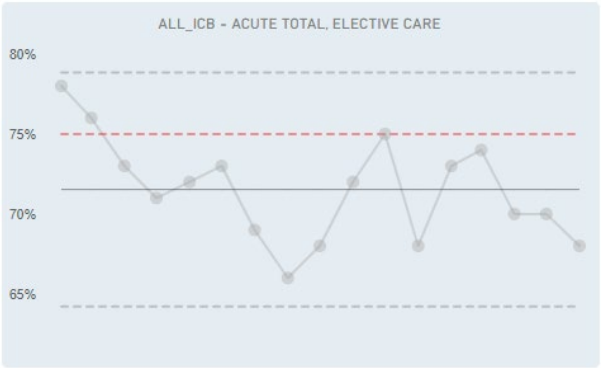
62 day backlog



104 day backlog



28 day faster diagnosis



Performance analysis

- BSW performance has deteriorated across most cancer performance measures in recent months which is slightly worse than the deterioration in performance nationally
- Performance against cancer targets is particularly volatile, month by month, due to generally low numbers, and the impact on performance of even a single or small number of gapped post(s) within particular tumour pathways. Hence, although data is published monthly – and some is published unvalidated, weekly - formal accountability is based on quarterly performance.
- Numbers of long waiters has increased in recent months at both RUH and GWH.
- Main causes of poorer performance – staffing; OP and minor ops capacity; clinic space; diagnostic capacity (endoscopy, radiology); and the impact of junior doctor, consultant, radiographer and, previously, nursing strikes. Greatest challenge is seen in skin (GWH SFT and RUH), colorectal (RUH).

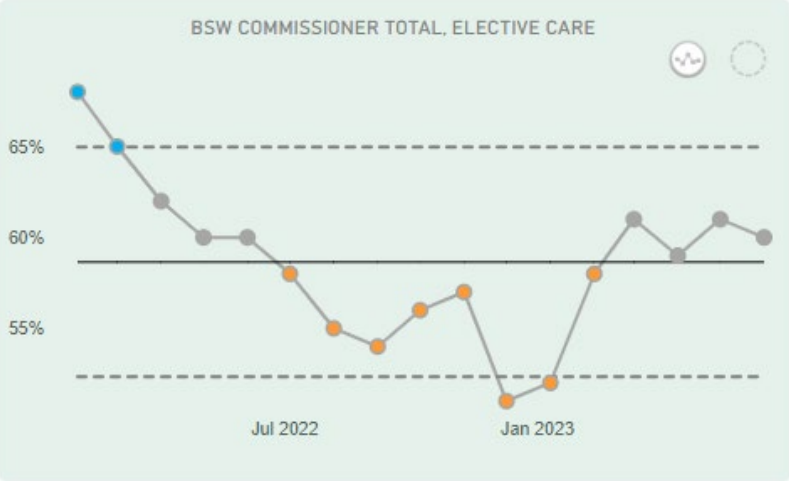
Actions underway

- GWH skin - deep dive root cause analysis and PDSA programme underway; locums and use of other providers being maximised; expanding nurse led clinics to free up consultant capacity; regular COO level review of actions and impact (expect improvement but not resolution).
- RUH colorectal – additional endoscopy capacity from September (planned resolution in December).
- RUH skin – additional locum funding from SWAG and additional GP with Extended role (GPwER)
- SFT skin – additional clinicians being appointed.
- SFT colorectal – strengthened management capacity to manage impact of strike action and improve list efficiency (will improve but may not resolve)
- Performance and long wait challenges also exist in other pathways - urology, breast, gynae (but not on the same scale), predominantly at RUH and GWH. These are being focused on to seek improvement.
- Improvement is anticipated at RUH (colorectal) but limited confidence regarding GWH and SFT resolving skin backlogs, skin performance, and skin long waiters – despite continued ongoing focus and raft of measures aiming to try and mitigate the issues, including via a pan-BSW focus on dermatology through the BSW Acute Hospital Alliance Working Group, looking at nurse-led clinics as current priority for expansion.

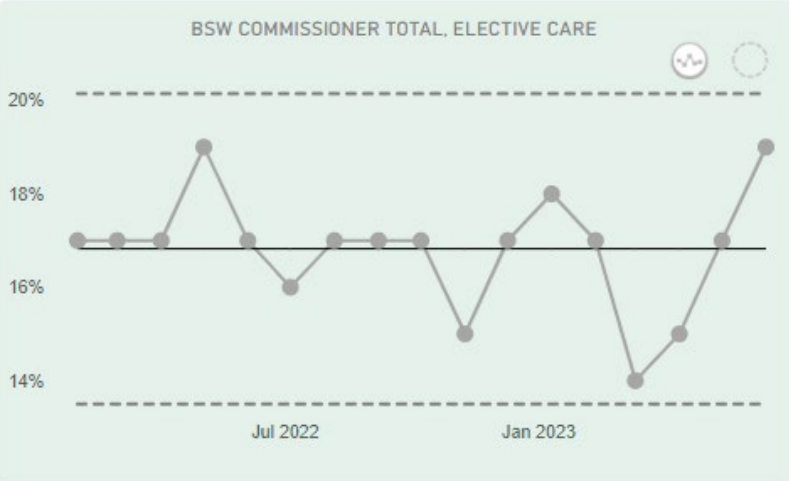
Elective Care – Diagnostics

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

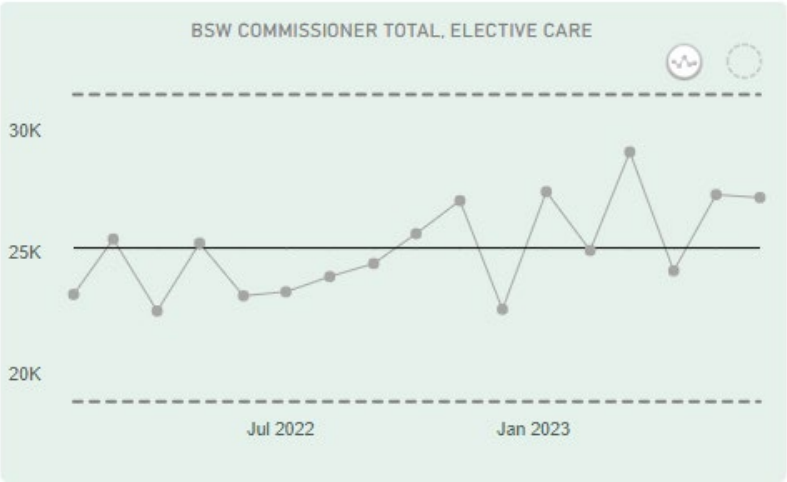
% diagnostic WL > 6 weeks (planned)



% diagnostic WL > 13 weeks



Total (planned) diagnostic tests



Performance Analysis

Please note: these charts are based on the operational plan metrics and only the main 7 of the 13 modalities are included. They vary slightly from the total DM01 diagnostics results in the dashboard.

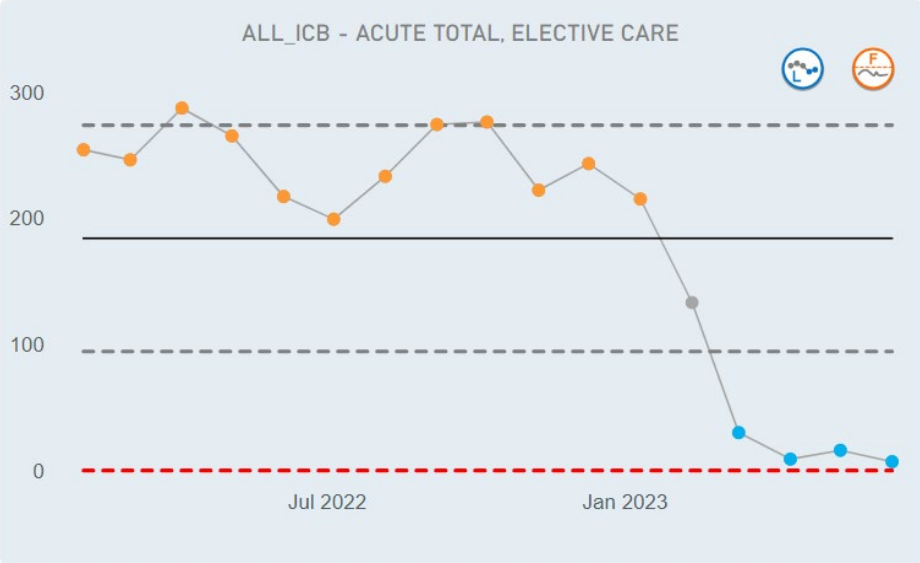
- Plan assumed no ongoing industrial action and achieving the 85% target for 6 week waits (DM01) by end of March.
- DM01 performance by provider is : GWH 52.1%, RUH 58.9% and SFT 79.3%.
- Key drivers are non obstetric ultrasound (all providers and highest volume test); GWH (CT and Colonoscopy), RUH (CT), SFT (Audiology)

Actions underway

- Improvement plans in place at all three providers but there remains capacity gaps, in particular, for non obstetric ultrasound which is recruitment related.
- Impact from endoscopy community diagnostic centre (CDC) activity will show from July position onwards.
- CDC mobile capacity for MRI and CT has been revised to place vans at GWH and SFT based on current pressures.
- CDC non obstetric ultrasound starts at Sulis from October. Initially limited by staffing with work underway to identify any further staffing to maximise capacity potential.
- NHSE Regional adopt and adapt visits planned to ensure best practice and adoption of improvement actions from other systems is being maximised.
- NHSE Regional review of non obstetric ultrasound as it is a driver for performance across the region.

Elective Care – RTT Long Waiters – 78 & 104+ weeks

RTT 78 week waiters



Performance Analysis

- 2 BSW commissioned 104 week waits at end of June. 1 at Southampton (corneal graft awaiting nationally led supply of graft tissue) and 1 at PPG Emersons Green (Oral Surgery). Both patients have now been clock stopped.
- *78 weeks - BSW Acute total actuals were 7 at end of June. BSW commissioned position including non local providers was 43. (July 23 provisional figure for BSW commissioned is 34)*
- GWH forecasting 2 x 78 week breaches at end of August due to diagnostics required at a non local provider with limited capacity.

Actions underway

- SFT have recruited additional plastics locum to clear breast reconstruction cases. No identified alternative capacity identified through national mutual aid system. Joint work with Portsmouth on waiting lists as 50% of the patients are Hampshire and Dorset.
- Weekly reviews of dated and non dated providers informing system mutual aid and wider mutual aid requests. Specific focus on use of local Independent Sector to support local acutes.
- Forthcoming implementation of Patient Initiated Mutual aid requests for all patients over 40 weeks.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	16
Date of Meeting:	21 September 2023		

Title of Report:	BSW ICB & NHS ICS Revenue Position
Report Author:	Rebecca Paillin, Head of Finance Programmes, Financial Planning, Co-ordination and Recovery
Board / Director Sponsor:	Gary Heneage, Chief Finance Officer
Appendices:	BSW ICS Finance Report M4

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	x
ICS NHS organisations only	x
Wider system	x

Purpose:	Description	Select (x)
Discussion	To discuss, in depth, a report noting its implications	x
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	x

Previous consideration by:	Date	Please clarify the purpose
ICB Finance & Investment Committee	7 September 2023	Discussion & Assurance

1	Purpose of this paper

This is a high-level BSW NHS ICS 2023-24 overview of the revenue position for information. Key points are:

- The BSW ICS NHS position is a reported £19.8m deficit. This is £11.1m behind the planned deficit of £8.7m.
- The ICS breakeven position is dependent on achievement of £96.3m of efficiencies representing 5.1% of system allocation;
- Net risk stands at £28.2m including £5m against the failure to deliver CIP;
- 4.1% of efficiencies remain unidentified with a further 4.2% only opportunities in M4 with over a third of schemes non-recurrent in nature. As a system 21.1% are seen as high risk in terms of delivery in this year;

- Agency Limit has been exceeded by £1.9m with a forecast £0.9m (2.7%) below the £33.8m threshold. This is being supported by the Workforce Group;
- Implementation of protocols including reviews of investments over £100k continue through the Financial Recovery Group who are also supporting delivery of efficiency targets and triangulating efforts to maximise productivity benefit in year.

2	Summary of recommendations and any additional actions required
The Board is asked to **note** the report and the Financial Position of the BSW NHS ICS.	

3	Legal/regulatory implications
As a system to hold to a financial position of breakeven .	

4	Risks
This report links to risk on the corporate risk register. The most significant risk is that the breakeven financial position will not be achieved. The report contains a section on risks and mitigating actions stating the factors impacting this risk	

5	Quality and resources impact
Resources: The report is created by BSW ICB Financial Recovery Team and uses information from ICB, NHSE and BSW NHS Acute and Community Partners. It details the Revenue and Capital position of all organisations as reported to NHSE. It is labour intensive currently to produce.	
Finance sign-off	Gary Heneage

6	Confirmation of completion of Equalities and Quality Impact Assessment
N/A	

7	Communications and Engagement Considerations
N/A	

8	Statement on confidentiality of report
The financial position noted within the reporting pack has been approved by all parties and reflects the position reported to their Boards. It is therefore sensitive but not confidential.	

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NHS BSW ICS Finance Report

July 2023 (Month 4)

1. ICS Financial Position

BSW NHS ICS reported financial position at month 4 is an **adverse variance of £11.1m**. This is driven by the following:

- Industrial Action £2.4m
- Agency £1.9m
- Prescribing price £3.8m
- Other £3.0m

This is a movement of £6m adverse month on month mainly driven by prescribing.

There are no reserves/contingency to manage the financial position with the ICB position moving away from breakeven as a result.

The deterioration in the year-to-date position demonstrates the deviation from plan being managed by non-recurrent measures. The impact this will have on the underlying position and the Medium-Term Financial Planning is being worked through.

	Year-to-date					Forecast Outturn			
	Plan	Reported Actual	Variance to Plan			Plan	FOT	Variance to Plan	
	£m	£m	£m	%		£m	£m	£m	%
Great Western Hospital	(1.4)	(5.3)	(3.9)	(277.5%)		0.0	(0.0)	(0.0)	(0.0%)
Royal United Hospital	(5.5)	(7.0)	(1.6)	(28.4%)		0.0	0.0	0.0	0.0%
Salisbury Hospital	(1.9)	(3.7)	(1.8)	(99.0%)		0.0	0.0	0.0	0.0%
Provider surplus / (deficit)	(8.7)	(16.0)	(7.3)	(83.2%)		0.0	(0.0)	(0.0)	(0.0%)
BSW ICB surplus / (deficit)	**0.0**	**(3.8)**	**(3.8)**	**(0.6%)**		0.0	0.0	0.0	0.0%
ICS surplus / (deficit)	**(8.7)**	**(19.8)**	**(11.1)**	**(126.7%)**		**0.0**	**(0.0)**	**(0.0)**	**0.0%**

2. ICS Risks and Mitigations

Gross Risks	Total £m	ICB £m	GWH £m	RUH £m	SFT £m
Additional cost risk	(36.9)	(15.8)	(9.1)	(4.0)	(8.0)
Additional inflation	(26.9)	(17.0)	(3.9)	(4.0)	(2.0)
Contract risk (excl. ERF)	(5.3)	(5.3)	0.0	0.0	0.0
COVID risk	(1.5)	0.0	(0.5)	(1.0)	0.0
Efficiency risk	(19.4)	(1.0)	(8.4)	(10.0)	0.0
Income risk	(2.5)	0.0	(2.0)	(0.5)	0.0
BSW ICS Gross Risks	**(92.5)**	**(39.1)**	**(23.9)**	**(19.5)**	**(10.0)**

Mitigations	Total £m	ICB £m	GWH £m	RUH £m	SFT £m
Additional cost control	**34.4**	15.8	9.1	3.0	6.5
Risk share	**14.5**	14.5	0.0	0.0	0.0
Transformational / Pathway changes	**7.5**	0.0	0.0	7.5	0.0
Unmitigated: COVID	**0.0**	0.0	0.0	0.0	0.0
Efficiency mitigation	**6.9**	0.0	6.9	0.0	0.0
Mitigations not yet identified	**1.0**	0.0	1.0	0.0	0.0
BSW ICS Mitigations	**64.2**	**30.3**	**16.9**	**10.5**	**6.5**

Net Risk	Total £m	ICB £m	GWH £m	RUH £m	SFT £m
Additional cost risk	(2.5)	0.0	0.0	(1.0)	(1.5)
Additional inflation	(12.4)	(2.5)	(3.9)	(4.0)	(2.0)
Contract risk (excl. ERF)	(5.3)	(5.3)	0.0	0.0	0.0
COVID risk	(1.5)	0.0	(0.5)	(1.0)	0.0
Efficiency risk	(5.0)	(1.0)	(1.5)	(2.5)	0.0
Income risk	(1.5)	0.0	(1.0)	(0.5)	0.0
BSW ICS Net Risk	**(28.2)**	**(8.8)**	**(6.9)**	**(9.0)**	**(3.5)**

Risk positions are largely reflective of the submitted plan.

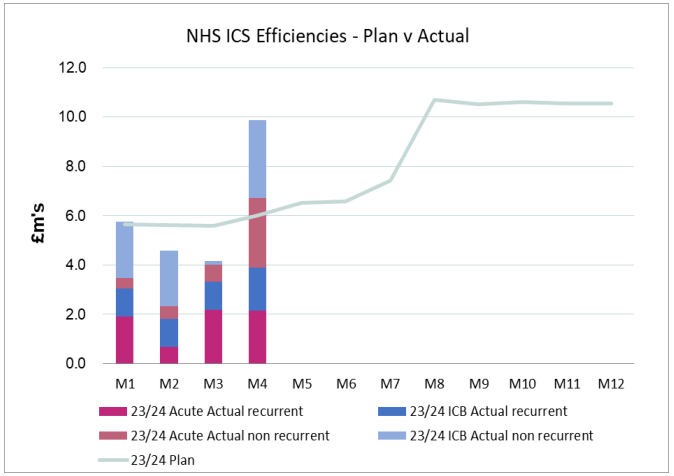
The ICB also continues to receive challenge from Non-NHS providers, including hospices, relating to the perceived inequality in the application of the non-consolidated pay award for 22/23. Currently we are following National guidance and are not including this as a risk. If this were to crystalise the cost pressure would be between £4m and £6m.

There are a number of financial risks being managed by providers, the most significant being the delivery of the savings target; continued industrial action; temporary staffing costs to meet demands in services and under delivery of the elective recovery programme. They are managing these risks through internal programmes.

3. ICS Efficiency Schemes

Overall efficiencies within the 2023-24 NHS system plan to enable the required breakeven position total £96.3m. This represents 5.1% of the overall NHS system allocation. We are currently forecasting to achieve only 4.9%, **0.2% below** our planned target.

YTD ICS achievement has swung by 20.6% to a favourable variance of 6.6% (£1.5m). The forecast has also improved by 2.2% (£2.1m). All providers have seen a fall in the percentage delivered against recurrent schemes which has been mitigated by non-recurrent replacements and the recurrent forecast has fallen as a result.



	Year-to-date					Forecast Outturn				
	Plan £m	Actual £m	(Under)/over delivery £m	(Under)/over delivery %		Plan £m	FOT £m	(Under)/over delivery £m	(Under)/over delivery %	
BSW ICB	10.6	5.1	(5.4)	(51.3%)	↑	31.7	16.8	(15.0)	(47.1%)	↑
Great Western Hospital	1.9	3.9	2.0	105.5%	↓	9.9	9.3	(0.6)	(6.3%)	→
Royal United Hospital	1.4	0.7	(0.7)	(50.2%)	↓	23.5	20.7	(2.8)	(11.7%)	↓
Salisbury Hospital	2.2	2.3	0.1	2.9%	↓	10.8	11.2	0.5	4.2%	↑
Recurrent Efficiencies	**16.1**	**12.1**	**(4.1)**	**(25.2%)**	↑	**75.8**	**58.0**	**(17.9)**	**(23.6%)**	↓
BSW ICB	3.0	7.8	4.8	159.5%	↑	9.1	20.0	11.0	121.2%	↑
Great Western Hospital	1.7	0.9	(0.7)	(43.8%)	↑	6.8	7.4	0.6	9.1%	↑
Royal United Hospital	0.0	2.0	2.0	100.0%	→	0.0	2.8	2.8	100.0%	→
Salisbury Hospital	2.0	1.5	(0.5)	(26.4%)	↑	4.6	4.1	(0.5)	(10.0%)	↓
Non Recurrent Efficiencies	**6.7**	**12.3**	**5.6**	**83.2%**	↑	**20.4**	**34.3**	**13.9**	**68.1%**	↑
Total Efficiencies	**22.8**	**24.4**	**1.5**	**6.6%**	↑	**96.3**	**92.3**	**(4.0)**	**(4.1%)**	↑

3. ICS Efficiency Status and Risk by organisation

	GWH £m	RUH £m	SFT £m	ICB £m	Total £m	Total %
Fully Developed - in delivery	7.7	5.5	8.6	35.8	57.6	62.4%
Fully Developed - delivery not yet started	3.7	6.8	0.8	1.0	12.3	13.3%
Plans in Progress	5.2	6.7	2.8	0.0	14.7	16.0%
Opportunity	0.0	0.8	3.0	0.0	3.8	4.2%
Unidentified	0.0	3.8	0.0	0.0	3.8	4.1%
Forecast status of Efficiency Schemes	**16.7**	**23.5**	**15.3**	**36.8**	**92.3**	
Recurrent as % of all Efficiency Schemes (YTD)	80.7%	26.2%	60.2%	39.6%	49.5%	
Recurrent as % of all Efficiency Schemes (FCST)	55.5%	88.3%	73.2%	45.5%	62.8%	

91.7% of efficiency schemes required to deliver the savings target have now been identified

Recurrent schemes as a percentage of overall target savings account for 62.8%, **over a third are non-recurrent** which will mean additional savings will need to be found next year to close the underlying gap.

Increased risk in delivery within ICB and GWH has led to High Risk moving to 21.1% of total schemes.

Low risk schemes account for over half of the overall delivery target but include unidentified.

	Low Risk £m	Med Risk £m	High Risk £m	Total £m	Low Risk %	Med Risk %	High Risk %
BSW ICB	31.8	0.7	4.3	36.8	86.3%	2.0%	11.6%
Great Western Hospital	7.7	5.2	3.8	16.7	46.3%	31.2%	22.5%
Royal United Hospital	7.9	10.5	5.1	23.5	33.5%	44.9%	21.6%
Salisbury hospital	4.5	4.4	6.4	15.3	29.5%	28.6%	41.8%
Level of Risk in delivery of Efficiency Schemes	**51.9**	**20.9**	**19.5**	**92.3**	**56.2%**	**22.6%**	**21.1%**

4. ICS Workforce

	Year-to-date					Forecast Outturn				
	Plan £m	Actual £m	Under/(over) spend £m	Under/(over) spend %		Plan £m	FOT £m	Under/(over) spend £m	Under/(over) spend %	
Registered Nursing Midwifery and HV's	85.0	89.6	(4.6)	(5.4%)	↑	250.3	241.6	8.7	3.5%	↑
Healthcare Scientists and Techincal Staff	31.1	30.6	0.5	1.6%	↑	93.4	94.3	(0.9)	(1.0%)	↑
Qualified Ambulance Service Staff	0.4	0.5	(0.2)	(51.0%)	↑	1.1	1.6	(0.5)	(49.3%)	↓
Support to Clinical Staff	36.0	40.3	(4.2)	(11.8%)	↑	107.1	116.6	(9.5)	(8.9%)	↓
Consultants	46.5	46.1	0.4	1.0%	↓	138.2	130.6	7.6	5.5%	↑
Other Medical staff	28.1	32.2	(4.1)	(14.6%)	↓	84.3	95.2	(10.8)	(12.8%)	↓
Non-medical/Non-clinical	48.3	50.1	(1.7)	(3.6%)	↓	143.6	142.9	0.6	0.4%	↑
Other Employee Benefit costs *	0.4	0.8	(0.4)	(107.0%)	↓	1.1	1.6	(0.5)	(39.9%)	→
Total Provider Workforce Expenditure	**275.8**	**290.1**	**(14.4)**	**(5.2%)**	↓	**819.1**	**824.4**	**(5.4)**	**(0.7%)**	↑

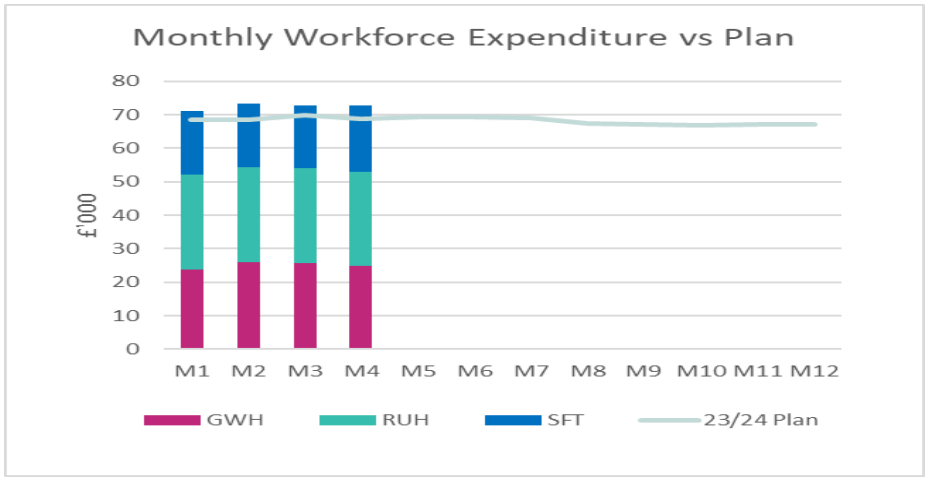
*Aprenticeship levy

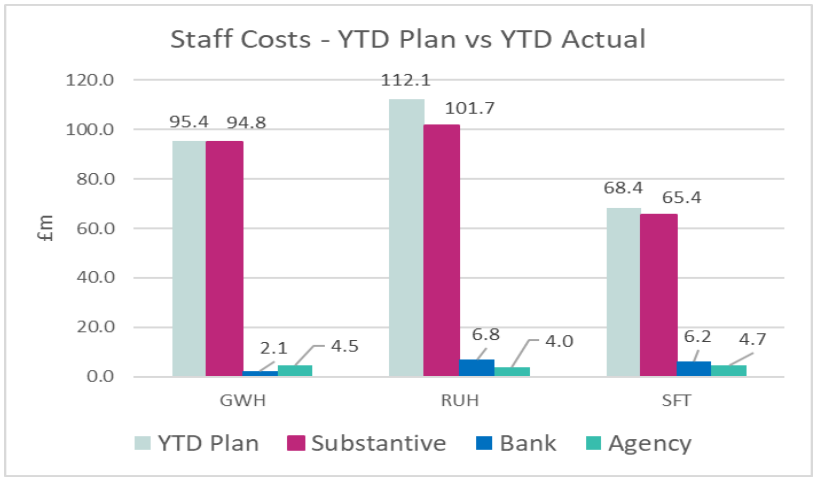
The planed level of expenditure which we report against does not reflect in year changes made as part of the financial recovery process to improve the financial position. Overall staff costs exceed the year-to-date plan in part due to industrial action which can be seen this month in the deterioration of consultants and medical costs. This is mirrored with increases in both unplanned bank and agency medical staff costs. The **overall position** in percentage terms has marginally **deteriorated by £4.1m (0.2%).** The forecast however has marginally improved reflecting the expected impact of the introduction of internal control measures.

Use of **Bank** staff has increased to **£3.5m (30.5%) above the planned level** of £11.6m with a resultant reduction in the forecast underspend to £0.5m (1.5%).

Use of **Agency** is currently £1.9m above the limit but has an improved forecast position of £32.9m, **£0.9m (2.7%) below the agency limit**.

4. ICS Workforce – Delivery vs Plan

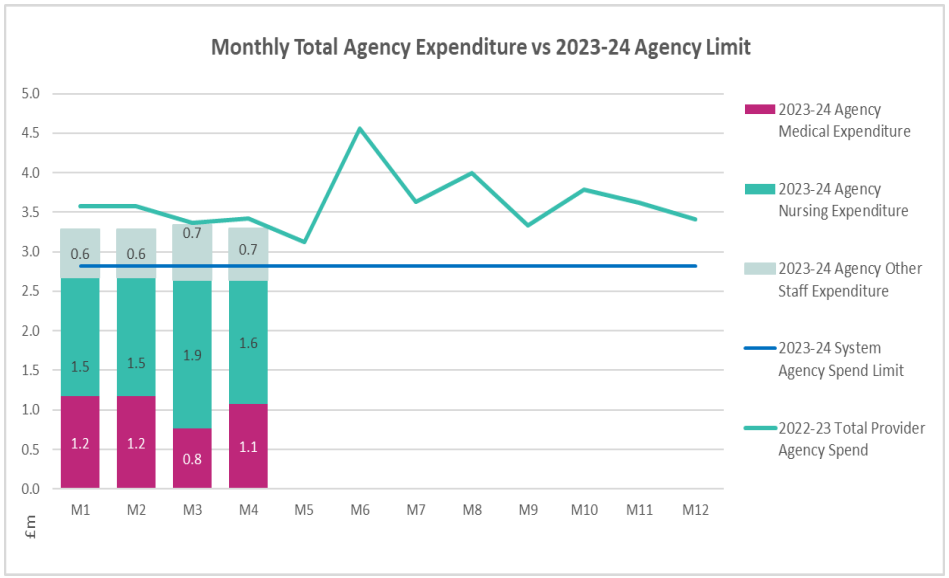


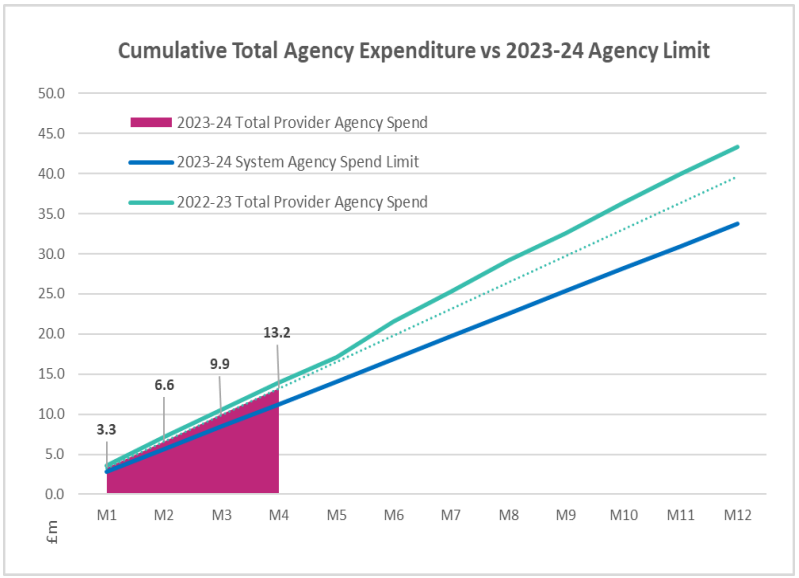


Year-to-date	Substantive				Bank				Agency			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%	£m	£m	£m	%
Registered Nursing Midwifery and HV's	74.2	78.8	(4.6)	(6.2%)	4.7	4.3	0.3	7.2%	6.1	6.5	(0.3)	(5.7%)
Healthcare Scientists and Techincal Staff	30.5	29.2	1.3	4.2%	0.2	0.3	(0.0)	(13.7%)	0.3	1.1	(0.7)	(241.1%)
Qualified Ambulance Service Staff	0.3	0.5	(0.1)	(39.4%)	0.0	0.1	(0.1)	(432.7%)	0.0	0.0	0.0	100.0%
Support to Clinical Staff	34.2	37.0	(2.8)	(8.3%)	1.8	3.2	(1.4)	(76.1%)	0.1	0.1	(0.0)	(64.3%)
Consultants	43.8	42.0	1.7	3.9%	1.2	1.8	(0.6)	(51.5%)	1.6	2.2	(0.7)	(42.4%)
Other Medical staff	24.0	26.6	(2.5)	(10.5%)	1.5	3.7	(2.2)	(150.2%)	2.6	2.0	0.6	24.1%
Non-medical/Non-clinical	45.5	46.9	(1.4)	(3.2%)	2.1	1.7	0.4	19.4%	0.7	1.4	(0.7)	(94.8%)
Other Employee Benefit costs *	0.4	0.8	(0.4)	(107.0%)								
Total Provider Workforce Expenditure	**252.9**	**261.9**	**(9.0)**	**(3.5%)**	**11.6**	**15.1**	**(3.5)**	**(30.5%)**	**11.4**	**13.2**	**(1.9)**	**(16.3%)**

*Aprenticeship levy

4. ICS Workforce - Agency





	APR £m	MAY £m	JUN £m	JUL £m	AUG £m	SEP £m	OCT £m	NOV £m	DEC £m	JAN £m	FEB £m	MAR £m	YTD	GWH	RUH	SFT
2023-24 Agency Medical Expenditure	1.2	1.2	0.8	1.1									4.2	2.3	1.1	0.8
2023-24 Agency Nursing Expenditure	1.5	1.5	1.9	1.6									6.5	1.9	1.6	3.0
2023-24 Agency Other Staff Expenditure	0.6	0.6	0.7	0.7									2.6	0.4	1.3	0.9
2023-24 Total Provider Agency Spend	**3.3**	**3.3**	**3.3**	**3.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**13.2**	**4.5**	**4.0**	**4.7**
2023-24 System Agency Spend Limit	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**11.3**	**4.7**	**4.1**	**2.5**
Variance to planned Limit (over)/under	**(0.5)**	**(0.5)**	**(0.5)**	**(0.5)**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**	**(1.9)**	**0.2**	**0.0**	**(2.2)**
2022-23 Total Provider Agency Spend	**3.6**	**3.6**	**3.4**	**3.4**	**3.1**	**4.6**	**3.6**	**4.0**	**3.3**	**3.8**	**3.6**	**3.4**	**13.9**	**5.8**	**5.0**	**3.1**
Variance to previous year Spend (over)/under	**0.3**	**0.3**	**0.0**	**0.1**	**3.1**	**4.6**	**3.6**	**4.0**	**3.3**	**3.8**	**3.6**	**3.4**	**0.7**	**1.3**	**1.0**	**(1.6)**

5. ERF Performance

ERF performance at month 4 is still heavily impacted by 'above average' rates of uncoded inpatient activity, resulting in higher volumes of **zero tariff** spells. Month 4 uncoded inpatient activity is at **32% (30% Daycase, 43% Ordinary admission)**

The below highlights uncoded activity levels by POD and provider for month 4

Org	Daycase	Ordinary	Total
ICB	***30.0%***	***46.3%***	***31.9%***
Salisbury Hospital	61.0%	86.3%	63.8%
Great Western Hospital	49.2%	84.6%	53.5%
Royal United Hospital	7.3%	9.1%	7.5%
Independent Sector	7.2%	5.7%	7.0%

Nb provider splits are ICB commissioned, not trust total)

Month 4 activity has been cost adjusted to estimate performance, as per 'normal' levels of uncoded activity.

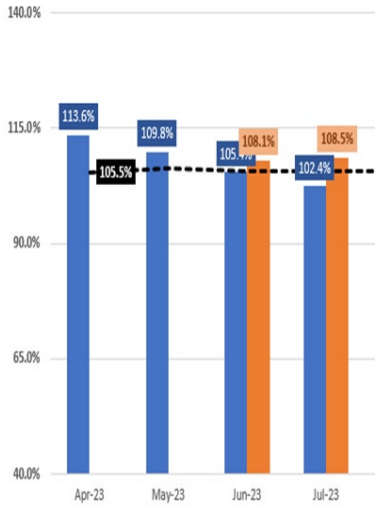
A reflective percentage of uncoded activity has been costed at an average POD price, however adjusted performance should be used with caution as performance is likely to be overstated.

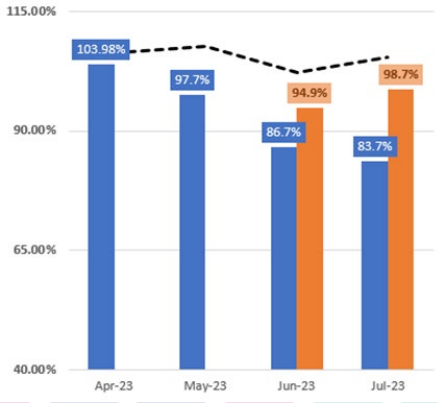
- **All activity** is currently costed at 22/23 tariff.
- **Performance** is monitored against the NHSE Op plan baseline target of **107.1%**

The below highlights adjusted and non-adjusted performance by organisation, against ytd cumulative plan.

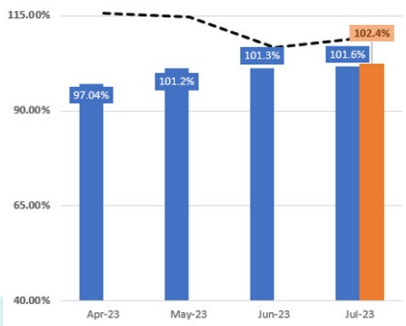
Org	Plan	Non-Adj	Adj
ICB	***105.7%***	***102.4%***	***108.5%***
Salisbury Hospital	97.1%	90.7%	100.1%
Great Western Hospital	105.4%	83.7%	98.7%
Royal United Hospital	109.2%	101.6%	102.4%
Independent Sector	126.3%	129.1%	131.0%

ICB

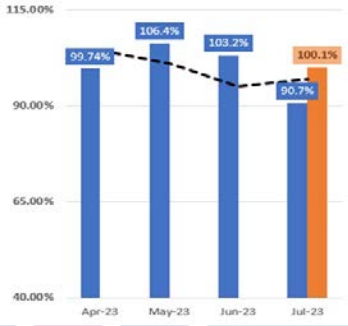




Great WesternHospital



Royal United Hospital



Salisbury Hospital

Independent Sector

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	17
Date of Meeting:	21 September 2023		

Title of Report:	Summary Report from Integrated Care Board (ICB) Board Committees
Report Author:	Sharon Woolley, Board Secretary
Board / Director Sponsor:	Rachael Backler, Executive Director of Performance and Planning
Appendices:	None

Report classification	BSW ICB Board
ICB body corporate	Yes
ICS NHS organisations only	No
Wider system	No

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with a remedy	x
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
Relevant Committee Chair		To agree report for inclusion in Board paper pack

1	Purpose of this paper
This summary report provides an update of meetings of ICB Board committees since the last meeting of the ICB Board. The report brings to the attention of the Board the business covered by each Committee, and any decisions made by the Committees.	

Committee Terms of Reference can be found on the BSW ICB website as part of the Governance Handbook - https://bsw.icb.nhs.uk/about-us/governance/our-constitution-and-governance-handbook/

2	Summary of recommendations and any additional actions required
The ICB Board is asked to **note** this report, and to raise any further questions with the respective Committee Chair's.	

3	Legal/regulatory implications
None	

4	Risks
N/A	

5	Quality and resources impact
N/A	
Finance sign-off	N/A

6	Confirmation of completion of Equalities Impact Assessment
N/A	

7	Communications and Engagement Considerations
N/A – Considered as part of each item presented to committees.	

7	Statement on confidentiality of report
N/A	

Summary Report from Integrated Care Board (ICB) Board Committees

1. BSW ICB Audit and Risk Committee

1.1 The BSW ICB Audit and Risk Committee of the BaNES, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) is a mandatory committee.

1.2 The Committee is responsible for providing assurance to the Board on governance, risk management and internal control processes.

1.3 The meeting of the BSW ICB Audit and Risk Committee held on 7 September 2023 was chaired by the Non-Executive Director for Audit and Governance, Dr Claire Feehily.

Received and Noted:

- External Audit - BSW ICB 9-Month Auditor's Annual Report
- Internal Audit:
    - Progress Report and Action Tracking
    - Internal Audit Review - Data Security and Protection Toolkit
- Counter Fraud Services Plan 2023-24
- Counter Fraud Services Progress Report
- Risk Management
- Exception Report from the Information Governance Steering Group
- Finance Update
    - Forecast Protocol Update
    - Overview of Management Consultancy and Interim Contractual Arrangements
- Single Tender Waiver for NHSE Representative Supporting the BSW System Financial Stability
- Single Tender Waiver for Programme Lead for Community Transformation Support

Items Escalated to Board:

- None

Endorsed / Approved:

- Internal Audit Plan 2023-24
- Counter Fraud Services Plan 2023-24

1.4 The next meeting of the BSW ICB Audit and Risk Committee will be held on 7 December 2023.

2 BSW ICB Quality and Outcomes Committee

2.1 The ICB has a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.

2.2 The purpose of the BSW ICB Quality and Outcomes Committee is therefore to provide assurance to the ICB Board that the ICB is discharging this duty and its functions with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services; the ICB as a body corporate has the right quality governance processes in place; and the ICB is working effectively with providers of health services in its area to ensure the effectiveness, safety and good user experience of services.

2.3 The meeting of the BSW ICB Quality and Outcomes Committee held on 5 September 2023 was chaired by the Non-Executive Director for Finance, Paul Miller.

Received and Noted:
- BSW Quality and Patient Safety Report & Operational Performance
- BSW Elective Care Delivery Plan
- BSW Primary and Community Care Plan
- Update on implementation of revised Committee terms of refence and forward planning cycle
- BSW Winter Plan
- Letby Letter from Amanda Pritchard

Items Escalated to Board:
- None

Endorsed / Approved:
- BSW Safeguarding Adults and Safeguarding Children Annual Report
- BSW Looked After Children Annual Report

2.4 The next meeting of the BSW ICB Quality and Outcomes Committee will be held on 7 November 2023.

3 BSW ICB Finance and Investment Committee

3.1 The BSW ICB Finance and Investment Committee provides assurance to the ICB Board in relation to the financial management and sustainability of the ICB as a body corporate; the financial sustainability and achievement of agreed financial and productivity goals of NHS providers that operate in the ICB's area, and the effectiveness of the ICB's efforts, with partners in the wider health and care economy in the area, to achieve financial sustainability of health and care services.

3.2 The meetings of the BSW ICB Finance and Investment Committee held on 5 July 2023, 2 August 2023, and 7 September 2023 were chaired by the Non-Executive Director for Finance, Paul Miller.

5 July 2023

Received and Noted:
- BSW ICB and System Revenue Positions
- Update on the BSW Recovery Board and associated actions
- 23-24 Operational and Financial Plan Update
- Commissioning and Business Cases
- Finance Risk Register
- Letter RE forecast protocols received from NHS England CEO
- BSW Inventory Protocols

Items Escalated to Board:
- None

Endorsed / Approved:

- Approved two health care business cases, and direct award contracts *(detail in private report due to commercial sensitivities)*

2 August 2023

Received and Noted:

- BSW ICB and System Revenue Positions
- BSW ICB Efficiencies Update
- Update from the BSW Recovery Board
- BSW Capital Update
- South Newton Update
- Forecast Protocol Update
- Trowbridge Capital Project Update
- Electronic Patient Record Update
- Finance Risk Register

Items Escalated to Board:

- None

Endorsed / Approved:

- Pre-assessment Delegation Assessment Framework for Specialised Commissioning

7 September 2023

Received and Noted:

- BSW ICB and System Revenue Positions
- Update from the BSW Recovery Board
- BSW Capital Update
- BSW Inventory Update
- Draft Medium Term Finance Plan
- Finance Risk Register
- BSW Green Plan / Sustainability Update

Items Escalated to Board:

- None

Endorsed / Approved:

- Approved the award of two health care contracts *(detail in private report due to commercial sensitivities)*

3.3 The next meeting of the BSW ICB Finance and Investment Committee will be held on 4 October 2023.

4 BSW ICB Remuneration Committee

4.1 The BSW ICB Remuneration Committee of the BSW ICB Board is a mandatory committee.

4.2 The Remuneration Committee is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006, setting the ICB pay policy and frameworks, and approving executive remuneration and terms of employment.

4.3 The next meeting of the BSW ICB Remuneration Committee is scheduled for 17 October 2023.

5 BSW ICB Public and Community Engagement Committee

5.1 The BSW ICB Public and Community Engagement Committee provides assurance to the Board that that the ICB discharges its statutory duties and functions regarding public involvement and engagement. The Committee provides assurance that the ICB and its system partners have effective public and community engagement processes, at system and place level.

5.2 The meeting of the BSW ICB Public and Community Engagement Committee held on 15 August 2023 was chaired by the Non-Executive Director for Public and Community Engagement, Julian Kirby.

Received and Noted:

- Overview approach to Public Engagement – Wiltshire
- BANES Your Health Your Voice update
- Overview Public and Community Engagement – next 18 months

Items Escalated to Board:

- None

Endorsed / Approved:

- None

5.3 The next meeting of the BSW ICB Public and Community Engagement Committee will be held on 31 October 2023.

6 BSW ICB People Committee

6.1 The BSW ICB People Committee is to advise the Board and provide assurance on matters relating to the BSW health and care workforce, and the ICB staff.

6.2 The next meeting of the BSW ICB People Committee will be held on 13 September 2023.

7 Ambulance Joint Commissioning Committee

7.1 A collaborative commissioning model is in place for the commissioning of ambulance services across the South West. The Ambulance Joint Commissioning Committee (AJCC) has been established to jointly commission emergency ambulance services across the South West and to manage the commissioning contract with the provider of emergency ambulance services. The ICBs covered by these joint commissioning arrangements are BSW; Bristol, North Somerset and South Gloucester; Devon; Dorset; Gloucestershire; Kernow and Somerset.

7.2 The meeting of the AJCC held on 25 July 2023 considered the following business:

- Assurance, Contracting and Performance update
- Lead Commissioner Model – update
- AJCC Annual Work Programme for 2023/24
- South West 999 Dashboard

7.3 The next meeting of the AJCC is scheduled for 26 September 2023.

8 South West Joint Specialised Services Committee

8.1 From April 2023, those ICBs who entered joint working agreements with NHS England, have become jointly responsible, with NHS England, for commissioning the Joint Specialised Services, and for any associated Joint Functions.

8.2 NHS England and the South West ICBs have formed a statutory joint committee to collaboratively make decisions on the planning and delivery of the Joint Specialised Services, inclusive of the programme of services delivered by the Operational Delivery Networks and Specialised Mental Health, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transitional mechanism prior to each ICB taking on full delegated commissioning responsibility.

8.3 The ICBs covered by these joint commissioning arrangements are BSW; Bristol, North Somerset and South Gloucester; Devon; Dorset; Gloucestershire; Kernow and Somerset.

8.4 The meeting of the Committee held on 22 August 2023 considered the following business:

- Arrangements for Review of Joint Specialised Services Committee and Joint Directors' Group Terms of Reference
- Committee Chairing Arrangements and Non-Executive Representation
- Pre-Delegation Assessment Framework
- Formal Recommendations from the Joint Directors Group
- Feedback from Key National Meetings
- Operational Delivery Network Update
- Specialised Commissioning Operational Performance
- Specialised Commissioning Financial Planning and Performance
- Development of a South West Specialised Commissioning Strategy

8.5 The next meeting is scheduled for 31 October 2023.