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

BSW Integrated Care Board – Board Meeting in Public

Thursday 18 January 2024, 10:00hrs

Council Chamber, The Civic Trowbridge, St Stephen's Place, Trowbridge, Wiltshire, BA14 8AH

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 16 November 2023	Chair	Approve	ICBB/23-24/089
	4	Action Tracker and Matters Arising	Chair	Note	ICBB/23-24/090
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/23-24/091
STRATEGIC OBJECTIVE THREE: Excellent health and care services					
10:30	8	Workforce Effectiveness	Jas Sohal, Penny Smee	Discuss, Note	Presentation in meeting
Items for Assurance					
11:00	9	BSW Performance Report	Rachael Backler, Gill May	Note	ICBB/23-24/092
11:15	10	BSW ICB and NHS ICS Revenue Position	Gary Heneage	Note	ICBB/23-24/093
11:35 – Short break – 10 mins					

Timing	No	Item title	Lead	Action	Paper ref.
11:45	11	Annual Emergency Preparedness Resilience & Response (EPRR) Assurance Report	Rachael Backler	Note	ICBB/23-24/094
11:55	12	BSW ICB Corporate Risk Management	Rachael Backler	Approve	ICBB/23-24/095
12:10	13	BSW ICB Board - Declarations of Interests	Chair	Note	ICBB/23-24/096
12:15	14	Report from ICB Board Committees	Committee Chairs	Note	ICBB/23-24/097
STRATEGIC OBJECTIVE ONE: Focus on prevention and early intervention					
12:20	15	BSW Case for Change and Using Population Health Analysis to Drive Our Decision-Making	Rachael Backler, Kate Blackburn, Sam Wheeler	Discuss, Note	ICBB/23-24/098
Closing Business					
12:45	16	Any other business and closing comments	Chair	Note	

Next ICB Board Meeting in Public: 28 March 2024

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.
	Never Event	Never Events are incidents that require full investigation under the NHS Serious Incident Framework, with a key aim of promoting and maintaining a learning culture within healthcare to prevent future harm. The list of Never Events is set out within this framework and are defined as patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.
	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.

Acronym /abbreviation	Term	Definition
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 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 16 November 2023, 10:00hrs

Dorothy House Hospice Care, Winsley, Bradford on Avon, Wiltshire, BA15 2LE

Members present:
Integrated Care Board (ICB) Chair, Stephanie Elsy (SE)
ICB Chief Executive, Sue Harriman (SH)
Deputy - NHS Trusts & NHS Foundation Trusts Partner Member–acute sector, Cara Charles-Barks (CCB)
Non-Executive Director for Audit and Governance, Dr Claire Feehily (CF)
ICB Chief Finance Officer, Gary Heneage (GH)
Local Authority Partner Member – Wiltshire, Terence Herbert (TH)
Non-Executive Director for Public & Community Engagement, Julian Kirby (JK)
Non-Executive Director for Finance, Paul Miller (PM)
Deputy - ICB Chief Nurse, Sharren Pells (SPe)
Non-Executive Director for Remuneration and People, Suzannah Power (SP)
Deputy - NHS Trusts & NHS Foundation Trusts Partner Member –mental health sector, Alison Smith (AS)
ICB Chief Medical Officer, Dr Amanda Webb (AW)
Voluntary, Community and Social Enterprise (VCSE) Partner Member, Pam Webb (PW)

Regular Attendees:
ICB Chief Delivery Officer, Rachael Backler (RB)
Chief Executive, Wiltshire Health and Care, Shirley-Ann Carvill (SAC)
Chair of the BSW Integrated Care Partnership – Cllr Richard Clewer (RC)
ICB Chief of Staff, Richard Collinge (RCo)
ICB Director of Place – Wiltshire, Fiona Slevin-Brown (FSB)
Deputy - Director of Public Health, Swindon Borough Council – Steve Maddern (SM)
ICB Chief People Officer, Jasvinder Sohal (JS)
ICB Deputy Director of Corporate Affairs
ICB Board Secretary

Invited Attendees:
ICBC Programme Consultant - for item 8
CEO, Dorothy House Hospice, Consultant, Salisbury Hospice, and Director of Patient and Family Services, Prospect Hospice – for item 10

Apologies:
ICB Director of Place – BaNES, Laura Ambler (LA)
Primary Care Partner Member, Dr Francis Campbell (FC)
NHS Trusts and NHS Foundation Trusts Partner Member – acute sector, Stacey Hunter (SHu)
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector, Dominic Hardisty (DH)
Local Authority Partner Member – BaNES, Will Godfrey (WG)
ICB Chief Nurse, Gill May (GM)
Non-Executive Director for Quality, Alison Moon (AM)
Chief Executive, Swindon Borough Council, Sam Mowbray (SM)
ICB Director of Place – Swindon, Gordon Muvuti (GM)
Healthwatch Wiltshire, Stacey Sims (SS)
ICB Assistant Director of Communications and Engagement

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, and in particular welcomed those deputies in attendance as noted above.

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 21 September 2023

3.1 The minutes of the meeting held on 21 September 2023 were approved as an accurate record of the meeting, subject to the following amendment being made:

- The consolidated feedback from the voluntary sector (VCSE) had been reflected prior, and was correct in the version received by the Board on 21 September 2023, therefore the caveat could be removed from 9.4 of the minutes.

4. Action Tracker and Matters Arising

4.1 Two actions were noted on the tracker, both marked as CLOSED, with updates added for the Board to note.

4.2 The opening up of partners Employee Assistance Programmes to VCSE commissioned services, to support the sector resilience, was raised as a matter arising. This would be followed up out of meeting, and added as an action to the tracker.
ACTION: The opening up of partners Employee Assistance Programmes to VCSE commissioned services was to be considered.

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 Two questions had been submitted concerning the ICB's work and engagement with carers, and paediatric long COVID clinic provision across BSW. The Chair read out the ICB's response.

5.3 The full question and response will be published on the BSW ICB website: https://bsw.icb.nhs.uk/document/questions-from-the-public-and-responses-icb-board-16-november-2023/

6. BSW ICB Chair's Report

6.1 The Chair provided a verbal report on the following items:

- Interim Non-Executive Director for Quality - Following the resignation of Prof Rory Shaw from the BSW ICB Board, Alison Moon has been appointed as interim BSW ICB Non-Executive Director (NED) for Quality. Alison is a NED of neighbouring Bristol,

North Somerset and South Gloucestershire (BNSSG) ICB, and is also a NED of Gloucestershire Hospitals NHS Foundation Trust. As interim BSW ICB NED Quality, Alison will be a member of the BSW ICB Board, and will chair the BSW ICB Quality and Outcomes Committee. Alison will also be a member of the BSW ICB Finance and Investment Committee, and the BSW ICB Remuneration Committee. Alison's experience and skill set is welcomed to BSW during this challenging period.
We will shortly be commencing a formal recruitment process for a NED for Quality.

- ICB Freedom to Speak Up Non-Executive Sponsor - Julian Kirby, NED for Public and Community Engagement, has agreed to take on this non-executive role for the ICB, supporting the embedding of the new arrangements.
- Impending Governance Review - On establishment in July 2022, all ICBs were given the clear national expectation that they would review their governance and partnership arrangements after a year. BSW ICB will undertake a review of its governance and decision-making arrangements in quarter three of 2023/24. The Chair asked that Board members and attendees take the time to complete the survey once shared, to reflect what has worked well since establishment, and what changes and improvements are required.
- Catch Up Sessions with Board Members - One to one conversations were to be held with each Board Member over the coming weeks.

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, acknowledging that additional detail on a number of areas was included in supporting papers as part of the agenda.

7.2 The Chief Executive highlighted the following to members:

- Item 2.2 – The ambulance handover delays across BSW were a symptom of the challenges seen across all three acutes and the entire urgent and emergency care pathway, not just the emergency department. The ICB, three acutes and NHS England were working to ensure the pathway was working efficiency, with rapid handovers, working to avoid cohort bays. Dynamic risk assessments were to be undertaken by providers to determine the best place for patients, and if ambulances could be released. The 'call before convey' model being implemented by Cambridge and Peterborough ICB was being looked into.
- Item 2.5 – The letter from NHS England to each ICB on 8 November 2023 set out the action required for each system to ensure their agreed 2023-24 plans were met, which was breakeven for BSW. The 40 days of industrial action for the health sector had brought significant operational and financial impact, it was unknown if any further action was planned. The estimated national cost of action was £1bn over the last 10 months. Though national finance support had been allocated, it did not cover BSW costs in full. The priorities of the NHS England letter were to:
    - Achieve financial balance,
    - Protect patient safety,
    - Prioritise emergency performance and capacity,
    - Protect urgent care, and high priority - elective care,
    - Prioritise operational services over the winter period.

  BSW was working to recut its financial plan to resubmit by 22 November 2023. An extraordinary ICB Board meeting in private was scheduled for 21 November, with

providers each also holding their own extraordinary Trust Board meetings or Finance and Investment Committee meetings. Meetings with NHS England would be held w/c 27 November to discuss the plan.
Difficult decisions would need to be made concerning current and future investments, whilst considering the associated risk and extending the triple lock arrangements of provider, ICB and region approval. Workforce controls were to be established, restricting recruitment to essential only.

- Item 2.7 – With regards enhanced oversight, and segmentation via the Oversight Framework – for quarter one, the ICB is at SOF 3 driven largely by the financial position. RUH moved to SOF 3, predominantly in relation to its cancer position. The response from RUH expected them to meet their exit criteria by quarter 3.
- As the Senior Responsible Officer for Elective Care, CCB advised the Board that with regards cancer performance, the trajectory was on track to deliver by the end of the year. RUH's improvements would see them move from tier 2 to tier 1 status following four weeks of consistent performance. GWH and SFT were insourcing support to improve on the skin pathway, with improvements already recorded for SFT, and GWH on track for the end of the year. Cancer was a priority area to protect, with inpatient beds being made available. Diagnostics pressure points remained around non-obstetric ultrasound activity, and was being supported through insourcing resource. Growth had been seen in the referral to treatment (RTT) waiting list. BSW as a whole was seeing and treating increased referrals compared to last year. Resilience was being built for the winter period, with an incremental shift to day cases where possible and offsite activity. Sulis was also supporting the increase in elective capacity.
- Item 2.25 – The ICB team were working towards the nationally required 30% reduction in running costs, with a number of programmes underway to work towards this, whilst ensuring the organisation was fit for purpose, and evolving for the future. The Executive Team had changed shape and size, with the overall structure of the organisation now being considered as part of the next phase of Project Evolve, to conclude in quarter four. Mutually Agreed Redundancy Schemes/ Voluntary Redundancy Schemes could be used to support that process.

7.3 The Board discussion noted:

- The current difficulties and pressures on the ICB leadership team were acknowledged, though values, ethics and principles should still be honoured. It was a concern to note the national priority being placed on finances. The Board was to remain sighted on the quality and safety dimensions.
- Though a balance was needed and parameters had changed, financial focus could bring a required change in delivery. There were lessons to learn from local authority partners on their approaches used.
- Item 1.2 - The Provider Selection Regime was in relation to procuring health services only. Discussions had commenced at place level regarding the specific procurement codes and section 75 pooled funds, considering how these contracts would be commissioned going forwards, particularly to the voluntary sector, to maximise the benefit of working together.
- Item 2.19 - A total of 35 projects had been successful in securing health inequalities funding. The Integrated Care System (ICS) Strategy set out the aim on prevention and fairer outcomes for all. The VCSE Partner Member shared a case study to demonstrate how health inequalities monies were supporting the BSW population.

- Further explanation was requested against some of the data and metrics used within reporting to clarify if the position was at a positive or negative level, for example the dementia diagnosis rates.

8. The Future of Community Services in BSW

8.1 The ICB Place Director for Wiltshire provided an update to the Board on the transformation ambition of Community Services across BSW, through the strategic framing and delivery of the Integrated Community Based Care (ICBC) Programme. The desire was to level up the investment in self-care and primary and community care, against an emphasis on spend and activity via acute hospital services. The BSW Primary and Community Delivery Plan set out the transformation priorities, supported by the six enablers identified in the BSW Integrated Care Strategy. This was not an isolated programme of work; it would run in parallel to other areas to bring benefit the whole system. The Strategic Outline Case set out the case for change, acknowledging that the 'do nothing' option was not feasible, with increasing demand, inequalities and an aging population to be addressed with system partners.

8.2 The ICBC Programme Lead was in attendance, further adding that the ICBC programme aim was to help people to stay at home, join up services, and enable that proactive support. The procurement was now underway via a competitive tender. Colleagues and potential providers would be supported throughout the process. The underpinning principles would drive the procurement approach, shared at market engagement events, aligned with transformation ambitions. Working collaboratively was an important element of the programme, encouraging providers to come together to form a collective, innovative response.

8.3 The programme was currently in the selection questionnaire stage, with the invitation to negotiate (ITN) to be issued in January 2024. There would be up to two opportunities for dialogue with bidders and to test the process. Internal Audit would also be involved in reviewing and checking the processes followed. Six months for the mobilisation period had been built in, to ensure continuity and maintained quality of services, and sufficient time for the new services to commence from April 2025. The proposed contract award would be presented to the ICB Board in July/August 2024. The detailed timeline as part of the private session papers set out the full involvement of the Board and its Committees throughout the process. Significant interest in the procurement and programme had already been received.

8.4 The Board discussion noted:

- This was a significant journey for BSW, to bring real innovation and transformation – to bring a profound difference to the population, whilst achieving the strategic objectives.
- The NED for Public and Community Engagement was a member of the ICBC Programme Board, having that oversight of the direction and stages of the procurement. The programme and procurement is being carefully managed purposefully to ensure conflicts of interests are appropriately managed and a clean process followed. Legal advice has been sought throughout the process, to ensure this was managed in a fair way.
- It was expected that the risk map may alter during the process, with full risks, assumptions, issues, and dependencies (RAID) processes undertaken weekly. Risk

processes would be defined and assessed throughout, particularly regarding the move to the collaborative approach with the contract and services being under one lead provider.

8.5 The Board noted the strategic context of the ICBC Programme, progress to date and the next steps.

9. Primary Care Access Recovery Plan – System Level Access Improvement Plan

9.1 The ICB Place Director for Wiltshire presented the Primary Care Access Recovery Plan for BSW, as shared and discussed at the October Board Development Session. The production of the plan followed the publication of NHS England guidance earlier in the year, and has been led by the BSW ICB Primary Care team, working with all the GP practices across BSW, Primary Care Networks (PCNs), and system partners. This final version was to be approved by the ICB Board before submission to NHS England.

9.2 The Plan was to address two specific national ambitions; to make it easier for patients to contact their practice, and for patients' requests to be managed on the same day, whether that was an urgent appointment, a non-urgent appointment within two weeks, or signposting to another service. This brought four key areas of focus as set out in the Plan and covering paper, with associated national targets. Full detail sat behind each of these, and these were held with each Practice. Target timelines would be set against each to note expected achievement and trajectory performance, though noting each Practice and PCN was starting from different points. There would be a focus on where there was performance variation at Practice and PCN level.

9.3 Work was now underway with each Practice, PCNs and the ICB Communications Team to launch the Plan against the Communications Plan, to manage expectations. A national campaign was also to be released.

9.4 Governance surrounding primary care had recently been strengthened, with the ICB Executive now receiving regular reports from the Primary Care Executive Group. Updates had also fed frequently into the ICB Quality and Outcomes Committee, though this needed to be formalised to ensure the broader strategic piece was brought out. Improved governance and assurance for primary care would be a factor to address through the ICB Governance Review.

9.5 The Board approved the BSW Primary Care Access Recovery Plan, and its submission to NHS England.

10. Palliative Care Alliance

10.1 The Board welcomed the CEO of Dorothy House Hospice, a Consultant from Salisbury Hospice, and Director of Patient and Family Services from Prospect Hospice to the meeting, each of which were part of BSW Hospices Together. The briefing for the Board focused on the specialist palliative and end of life care services offered across BSW, equitable access to hospice care, integrated working with SFT, reducing variation, and the BSW Palliative and End of Life Care Alliance formed of all providers and commissioners of palliative and end of life care across BSW.

10.2 The Board discussion noted:

- A system mapping session had been held to identify the service gaps, population coverage, and those not currently being reached. The death literacy piece per neighbourhood had also been undertaken to establish where the needs were and indicate gaps. Population health data was also used to inform services and provision. Two specific neighbourhoods in the BaNES area had been selected for focussed work on reaching those deprived and social inequality areas. Colleagues were working with Bath City Football Club to empower the community and encourage care for one another.
- Noting the rural geography of the patch, it had been acknowledged that services may be difficult to access. Hospice clinics had been established in the surgery in Marlborough and were soon to be set up in Swindon. Virtual consultations were also offered.
- The education, research and professional development element of services provided brought that joint working with the acute teams, to share knowledge and information, to bring that beneficial wider impact. Advanced Care Planning was also being encouraged amongst all professionals.
- 1% of the population accessed end of life care, in BSW 0.3% of the population were recorded on the end of life registers, the national average was 0.5%. The challenge to the Board was to encourage and support the ICB and ICS to do more to support this valuable end of life care, to manage more at community level, whilst also bringing savings in acute activity.

10.3 The Chair thanked BSW Hospice Together partners for the comprehensive briefing and sharing of case studies to raise awareness of services and integrated working.

11. BSW Operational Performance and Quality Report

11.1 The Board received and noted the NHS Operational Performance and Quality Report, providing that assurance to the Board against the key operational performance indicators. The ICB Quality and Outcomes Committee had also reviewed the report at its November meeting. The ICB Chief Delivery Officer advised that work continued to develop the dashboard and data feeds, noting that gaps currently remained whilst this was work in progress.

11.2 The following was highlighted to the Board:

- Improvements against mental health standards were now being seen.
- Significant challenges remained across urgent and emergency care.
- Elective care pathways were showing some improvement in more recent data following the implementation of recovery plans. The elective care waiting list was starting to stabilise.
- The 62-day cancer target had shown dramatic improvement across all three acutes, particularly at the RUH in recent weeks. This was not yet showing in published data.
- The diagnostics 6-week waiting list is now beginning to show improvement, with a push on ultra sound and CT scans recovery.
- Though an improvement in the 65-week waiting list, 78-week remained an issue – being addressed by the acutes.

11.3 The Deputy ICB Chief Nurse drew the Boards attention to the following quality elements:

- The Serious Incident Framework was changing to the Patient Safety Incident Response Framework. Never Events were monitored and reported through this, with one low risk event reported in this period, at no harm to the patient. Themes are monitored and reported through to the BSW System Quality Group.
- The dashboard indicated high numbers of Clostridium Difficile and E.coli infections. Infection control measures and the healthcare associated infections were important measures of good quality care, and were routinely reviewed as a metric. A rise had been seen in the acutes, and was now moving to community settings. The Infection, Prevention and Control Network was reviewing data, though full outbreaks or themes were not yet apparent. This was driving a review of community infections and the antimicrobial prescribing.
- Two quality improvement programmes were underway concerning hydration, staying well, eating well, and moving well; and review of urinary tract infection cases to reduce infections, to present back to region.

11.4 The Board discussion noted:

- The BSW Mortality Surveillance Group was reflecting on indicator data and identifying learning, particularly following the Letby Case, ensuring also that clinical coding was correct. Trust Chief Medical Officers were involved in this.
- Whilst considering disinvestments, it was critical that the ICB and system continued with routine and additional monitoring through the quality framework, noting no, low, medium and severe harm incidents, and identifying risks and mitigations. The BSW System Quality Group was also assessing themes and trends. Leading indicators would be defined when disinvesting, to track and course correct. The Extraordinary Board meeting would consider the quality impacts of the Board decision-making as part of the revised financial plan.
- It was queried whether additional narrative could be provided to enable Board members to understand the issues, action being taken to address it, and provide that level of assurance. It was noted that additional detail was presented to the ICB Quality and Outcomes Committee, with an oversight level shared with the Board. Similarly, the ICB Finance and Investment Committee received and discussed the supporting data.
- The BSW Integrated Care Partnership (ICP) had agreed to use its meetings to track and measure against the three Strategy priorities in turn. In parallel to this, the commitment and achievement against the Implementation Plan would also be monitored. The Health and Wellbeing Boards would also play a role in monitoring delivery.

12. BSW ICB and NHS ICS Revenue Position

12.1 The ICB Chief Finance Officer presented the report on the ICB and NHS ICS revenue position, highlighting the following to members:

- At month 6, the ICS NHS position was reported as £20m off plan, largely due to the costs associated with industrial action, and underfunded pricing pressures in prescribing.
- The letter received from NHS England on 8 November 2023 clearly set out the priority for ICS's to achieve financial balance, presenting a real challenge for BSW to address. To help manage the position, £800m of national funding had been allocated against industrial action costs and system pressures. BSW would receive an allocation of £10.8m from this. The elective care target had also been reduced, bringing a benefit of

£5m. This confirmed £16m against the £20m pressure. Significant work would continue to close the remaining gap, and to breakeven. NHS England had advised that urgent and ambulatory care, maternity, primary care recovery plans, and the primary care Additional Roles Reimbursement Scheme were not to be impacted by these financial reviews.

12.2 The Board noted the report and the financial position of the BSW NHS ICS. The system would be taking difficult decisions to realise the savings required. An extraordinary ICB Board meeting in private was to be held on 21 November 2023 to consider the revised financial plan in response to the letter.

13. BSW ICB Corporate Risk Register

13.1 The ICB Chief Delivery Officer presented the ICB's Corporate Risk Register, which recorded the significant risks facing the ICB body corporate. The Register was shared regularly with the Board for oversight and assurance. The Board Assurance Framework (BAF), as approved in July, would be a focus for the December development session to consider the ICB's risk appetite.

13.2 The risk management approach had matured, linking with all Executive discussion and flowing through to the relevant committee for review and scrutiny.

13.3 The articulation of the risks surrounding the financial challenge would be reviewed, to ensure this appropriately reflected the potential impact on services, and quality and safety. The risk of not achieving the prevention agenda as set out in the Strategy was also raised, and would be reflected via the BAF as the ICB corporate not achieving its objective.

13.4 The Board noted the BSW ICB's Corporate Risk Register.

14. Briefing on 2024/25 Planning Approach

14.1 The ICB Chief Delivery Officer advised the Board on the ICBs requirement to produce an NHS Operating Plan for 2024-25, and the proposed process to produce the plan with system sign off. The paper had set out an indicative timeline, though this was expected to shift due to this two week action to review the financial plan for 2023-24. Guidance was expected later in December, with this to be a focus for the Board development session. The draft was expected to be submitted in January, though the deadline may be pushed back. The planning cycle would be used to affect left-shift and to state bold ambitions.

15. Report from ICB Board Committees

15.1 The Board noted the summary report from the ICB Board Committees.

16. Any other business and closing comments

16.1 There being no other business, the Chair closed the meeting at 12:35hrs

Next ICB Board meeting in public: Thursday 18 January 2024

Item 4

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

Updated following meeting held on 16/11/2023

OPEN actions

Meeting Date	Item	Action	Responsible	Progress/update	Status	Expected Completion Date
16/11/2023	4. Action Tracker and Matters Arising	The opening up of partners Employee Assistance Programmes to VCSE commissioned services was to be considered.	Jas Sohal	**Update 19/12/2023:** The requirement for a system wide approach to Employee Assistance Programmes access has now been captured within the procurement documents for the Integrated Community Based Care (ICBC) programme. In the short term, existing partners are asked to review their current arrangements and explore opportunities to support VCSE partners if possible.	CLOSED	

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	7
Date of Meeting:	18 January 2024		

Title of Report:	CEO Report to BSW ICB Public Board
Report Author:	Sue Harriman, Chief Executive Officer
Board / Director Sponsor:	
Appendices:	

Report classification	Public elements of 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	

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 **Industrial Action**. British Medical Association (BMA) Junior Doctors took strike action between 20th December to 23rd December 2023 and 3rd January to 9th January 2024. The Hospital Consultants and Specialists Association (HSCA) Junior Doctors also agreed to strike concurrently. A full walk out was agreed, and no derogations (protected services) were confirmed by BMA, as had previously been the case, for areas such as A&E. The action coincided with the NHS's busiest period of activity with winter illnesses, annual leave over the festive period, and limited childcare with schools' and nurseries closed. Incident coordination arrangements were put in place with operational teams strengthening plans to support areas such as NHS 111 and Urgent Emergency Care, ensuring access to Urgent Treatment Centres and Minor Injury Units, improving discharge and flow arrangements, and with a strong communications strategy ensuring the public are aware of how best to use services. At the time of writing this report the second strike has just concluded. As papers are issued, a full understanding of the BSW recovery is still being formed, but it is clear that great efforts, by many colleagues and providers across the system, have

prevented the impact from being as harmful as it could have been. Further details will be provided verbally at the ICB meeting.

1.2 **Planning Guidance**. Prior to Christmas initial planning guidance was received from NHS England. The key points in the guidance were: System plans need to achieve and prioritise financial balance; The priorities and objectives in the 23/24 planning guidance and the national recovery plans for urgent and emergency care, primary care access and elective and cancer care will not change fundamentally; The focus for the coming year will be on recovering our core service delivery and productivity, and target a reduction in the cost of temporary staffing; and systems should work on the basis that initial planning returns will be expected by the end of February. Further details about how BSW is implementing this guidance are at paragraph 2.17.

2. BSW ICB updates:

2.1. **Operational Demand.** BSW continues to experience Urgent & Emergency Care (UEC) pressures across the system, notwithstanding the current strike action, with ambulance handover delays, and the ability of the ambulance service to respond to calls, being the most significant challenge. There are improvement plans in place across the areas where handover delays are the most significant. These articulate actions required to improve the position, and outcomes for patients, through a system-wide ambulance improvement group working collaboratively with the ambulance service and providers.

2.2. There are some delays in people leaving hospital leading to impact on system flow. To deliver improvement, more capacity has been provided across the health and social care system to support improvements in flow, in the form of additional funding and additional primary care support. This is having a positive impact. In addition, process improvements that are being made to improve efficiency across the pathway and ensure more effective system flow.

2.3. The ongoing industrial action of junior doctors continues to have an impact on flow across the system and all partners are working together to mitigate the risks and ensure patient safety is maintained. A review of harm is being undertaken by the quality teams that will also include a review of delays in urgent and emergency care pathways. The system priority is to ensure patients remain safe in our health and care services.

2.4. **Financial Position.** The BSW ICS reported financial position at month eight is an adverse variance of £11.1m. This is a favourable movement of £11.5m since month seven, mainly due to the national industrial action funding of £10.8m and the benefits from ERF. The year-to-date adverse variance is driven by the following:

- Unfunded pricing pressures within primary care prescribing (£6.8m).
- Industrial action (£1.2m) – the national funding did not cover all our industrial action pressures, or any other pressures as intended.
- Efficiency shortfall £0.5m.
- Other £2.6m.

2.5. Following the recent regional and national exercise around the forecast outturn, the BSW system has now agreed a £9.9m deficit position for 23/24. All systems were

instructed not to plan for any further Industrial Action in H2. However, given the latest round of industrial action, we have now been advised that if we are not able to mitigate these further costs then we should amend our forecast (the £9.9m above) to reflect the costs/lost income from December and January in our M9 forecast position. This was still being finalised at the time of this report. This updated forecast will be recognised at M9 as per the national guidance.

2.6. There is still a significant risk to the delivery of this updated plan, the main risks being operational pressures including seasonal winter pressures, H2 efficiency delivery and further industrial action.

2.7. As part of agreeing to the updated forecast, the system has committed to:

- Enhanced workforce controls.
- Further controls on discretionary spend.
- Rigorous focus and oversight on the M9-M12 run rate.
- A review of safer staffing investments since 2019/20.

2.8. **Performance, Oversight, and Delivery**.

2.9. **Performance Oversight Framework**. The Board were updated in November that the outcome of the NHS England Quarter 1 Segmentation process had been confirmed with both the ICB and RUH moving to Segment 3 performance (deterioration). This has remained the case at the Quarter 2 Segmentation process with Salisbury Foundation Trust also moving to Segment 3. For all the identified areas flagging as Segment 3, recovery plans are in place with improvement trajectories which are set to be achieved by the end of Quarter 4. The impact of most recent industrial action on these trajectories has not yet been fully assessed.

2.10. **Elective Care.** The Elective Care Board oversees performance and recovery actions for elective targets and has received detailed remedial action plans and trajectories for the areas requiring most improvement. The ICB has seen an improvement in over 78-week waiters at the end of October (from 65 to 47). Fifteen of these breaches were within providers in BSW, with the remainder at non-local providers, predominately Bristol providers. There remains an increasing risk in the delivery of both the 78-week position and the 65-week target by March 24 due to the impacts of Industrial Action.

2.11. **Diagnostic Performance.** Diagnostic performance remains an issue at both RUH and GWH, in large part as a result of non-obstetric ultrasound capacity. Detailed remedial action plans showing a recovery trajectory for March 24 have already commenced with increased insourced capacity a key contributor to the improvement plans. RUH were forecasting to be on track to reduce to a breach rate of 33% (versus 15% target) in December and GWH have been targeting the longest waiting patients, clearing 518 over 26-week waiters since November.

2.12. **Cancer Performance.** Performance against the key cancer standards remain below national targets with pressures relating to colorectal and skin at RUH and skin at all

three providers. Remedial action plans are in place. Additional insourced activity for the skin pathway is delivering improvements with a trajectory to achieve the 62-day backlog target by March 24. The improvement will be mostly seen towards the end of Quarter 4 given the focus in on addressing the longest waiters that have already failed the 62-day and 28 day Faster Diagnostic Standard targets. Most recently GWH has been placed in additional NHSE scrutiny related to cancer performance which relates to the September published data. Unvalidated, more recent data is showing the improvements from the remedial action plans in place that will support these discussions. In parallel to the Acute actions for skin cancer there is a pan-BSW focus on dermatology through the Acute Hospital Alliance Working Group, looking at medium- to longer-term improvement opportunities, for example expanding nurse led clinics to support increased demand.

2.13. **Improving Access to Psychological Therapies (IAPT)**. IAPT rates have improved overall through 2023 although not yet reaching the national standard (50%). Access rates have dipped in August and September and while the performance remains above the trajectory to achieve by end of March, additional focus will be required to ensure the improvement trajectory year to date is sustained.

2.14. **Children and Young Persons (CYP) Access**. CYP access (12 month rolling) is at 80% of plan in October 2023 (target is 90% of plan). This is using local Oxford Health data while we wait for national published reporting to refresh in April 2024.

2.15. **Dementia Diagnosis**. The Dementia Diagnosis Rate (DDR) is showing a slight improvement to 58.8% (versus 58%) against a national standard of 66.7%. We are forecasting a year end position of 62.9-64.4% as the DDR transformation plan is implemented further.

2.16. **Learning Difficulties and Autism (LD&A) Inpatient Rates**. We continue to see an increase in inpatient numbers across BaNES and Wiltshire above the agreed trajectory (42 against a target of 35). Weekly patient level calls are now in place with BSW leads to discuss each patient and discharge plans and support being provided to the locality to expedite actions. These actions are overseen by the BSW LD&A Programme Board.

2.17. **Operational Planning and Joint Forward Plan/Implementation Plan Refresh**. As in previous years, BSW is required to submit a System Operating Plan for 2024/25 to NHS England that is jointly produced and owned by ICS NHS partners. In advance of publication of the full guidance, which is expected in mid-January, all ICBs and NHS trusts received an update letter from NHS England on 22nd December.

2.18. We have started preparing our plans. System planning principles have been produced and shared with the Board, and the Operating Plan Steering Group (OPSG) has commenced meeting for the 2024/25 round on a weekly basis with membership from the ICB and NHS partners. In addition, the Planning Executive Group, has commenced meeting, chaired by the ICB Chief Delivery Officer, bringing together executive planning leads from the ICB and acute NHS partners to provide executive oversight on the planning process and provides an escalation route for the OPSG.

2.19. NHSE has also issued guidance for the 2024/25 refresh of the Joint Forward Plan, known as our Implementation Plan in BSW. The refresh is required to be completed by 31 March 2024.

2.20. **Quality and Safety - Vaccination Strategy.** In December, the publication of the National Vaccination Strategy confirmed that BSW ICB approach to delivering vaccinations across our area is right. Whilst vaccinations will continue to be delivered by Community Pharmacies, GP practices and in schools, provision in the wider community will continue to develop, offering a wider range of vaccines at non-healthcare settings, often as part of wider public health initiatives. Over the next 2 years, the technology will also evolve to allow easier booking for a wider range of vaccines, regardless of where they are delivered. Making the most of the learnings from the COVID-19 vaccination programme, we will continue to work closely with our local authority Public Health teams, with focused engagement with communities or groups who may struggle to access vaccination for reasons such as language barriers, cultural diversity, and deprivation, we will provide health prevention via vaccination to those who need it most.

2.21. **Working Together to Safeguard Children 2023: Summary of Changes:** The Department for Education (DfE) published a new edition of its statutory guidance Working Together to Safeguard Children in December 2023. This 2023 edition replaces Working Together to Safeguard Children 2018, which underwent a limited factual update in 2020. The guidance outlines what organisations and agencies must and should do to help, protect, and promote the welfare of all children and young people under the age of eighteen in England.

2.22. BSW ICB's three statutory Safeguarding Children's and Adult Partnerships: B&NES - Community Safety and Safeguarding Partnership (BCSSP), Swindon – Swindon Safeguarding Partnership (SSP), Wiltshire- Safeguarding Vulnerable People Partnership (SVPP) will undertake work to:

- Review multi-agency safeguarding arrangements and multi-agency expectations for all practitioners working with parents and families.
- Identify where improvements may be needed to strengthen services to deliver the best possible outcomes for children, young people, and families.
- Identify and agree named lead and delegate safeguarding partners for each statutory agency.
- Appoint one of the delegated safeguarding partners as the partnership chair for the multi-agency arrangements.
- Remove the role of independent chair.
- Consider the role of education partners within the partnership structure and strengthen this where necessary.
- Publish and submit a yearly report by September 2024 and publish revised multi-agency arrangements by December 2024.
- Implement effective information-sharing arrangements between agencies.

2.23. **Reinforced Autoclaved Aerated Concrete (RAAC).** There has been extensive news reporting relating to Reinforced Autoclaved Aerated Concrete (RAAC), and a lot of work has been undertaken to assess the current level of RAAC in the Health estate. The current situation in BSW is as follows:

- We are following national guidance for the identification of RAAC across the Health Estate.
- Only one site in BSW has been identified, following national guidance, as containing a small amount of RAAC in the roof void, where remedial work has now taken place.
- Work is ongoing to assess further RAAC.
- RAAC matters are regularly discussed at the ICS estates board meetings, where a master schedule is maintained.

2.24. Our paramount concern is the safety and well-being of all staff and users. We will continue to provide regular updates to the ICB Board.

2.25. **Health Inequalities (HI).** It has been agreed that HI grants will be awarded to a total of thirty-seven projects across the system, some payments will be made for eleven projects for Q4 of 23/24 with the remaining projects being funded from Q1 of 24/25, all from the 24/25 HI budget. The Population Health Board's membership and ToR is being reviewed to ensure there is representation from ICB Locality leads, Directors of Public Health, Local Authority CYP leads, Acute leads, the VCSE Alliance and Healthwatch. The three Directors of Public Health will each take a lead on the following: Swindon for Health Inequalities, B@NES for Prevention and Wiltshire for Data & Intelligence. The membership and ToRs for the Health Inequalities Strategy group and the Prevention group is also being reviewed with the intention for it to have more formal reporting and better aligned to the Population Health Board. The HI team, working with the Place Director for BANES, is currently scoping work on the systems response for homeless people accessing primary care, this will involve taking learning from existing good practices within BSW which could be shared and replicated across the system.

2.26. **Prescriptions Ordering Direct (POD) System.** At the end of September 2023 a consultation and engagement was launched to consider an organisational change to stop the POD system in its current form and look for alternative models that could be used across BSW. POD is run by BSW ICB and serves 25 of the 88 BSW practices who have chosen to opt in to the service for repeat prescriptions. It is closed to new applications, and it cannot be offered equitably across BSW. The repeat prescribing context has changed since POD was first launched in 2017. One of the ambitions set out in the national Delivery plan for recovering access to primary care is to enable patients in over 90% of practices to order repeat prescriptions using the NHS App by March 2024. The 63 BSW GP practices who are not signed up to POD manage repeat prescribing internally or via the NHS App.

2.27. The consultation with POD colleagues has been accompanied by wide stakeholder engagement and communications, with strong engagement with POD colleagues via staff-side representatives throughout the process. Executives met on 8 January 2024, at an extraordinary Executive Management Meeting, to consider the feedback from the consultation and associated recommendations and to make a decision. This decision will be reported verbally, and recorded in the ICB meeting minutes, to ensure that a respectful period of reflection is offered to affected colleagues and their line managers before the outcome is in the public domain. More details about the

implementation of the decision and ongoing communication and engagement with all affected stakeholders will be available in due course.

2.28. **People.** Industrial action has recommenced amongst junior doctors with pay negotiations having collapsed. As part of our response the People Directorate collaborated with acute providers to understand where specific shortfalls existed. Shortfalls often being exacerbated by staff sickness. The Directorate prepared to deploy ICB clinical staff volunteers to assist but this mitigation was not required.

2.29. In our ICB, we continue to work on our organisational redesign programme named Project Evolve. A voluntary redundancy (VR) scheme has been launched in the ICB and is running from 12 December until 15 January. At the same time, work is being completed on the *form* of the organisation, ensuring that teams will be shaped in the best way to align to our Target Operating Model.

3. Focus on Place (reports by exception, matters unique to a locality):

3.1. **B&NES.** Nothing exceptional to report which has not been covered elsewhere.

3.2. **Swindon**. Nothing exceptional to report which has not been covered elsewhere.

3.3. **Wiltshire:** The System Investment committee agreed additional Home First winter funding to be spent in Wiltshire on additional domiciliary care capacity. The local team are now working on mobilisation as quickly as possible to reduce the Non-criteria to Reside (NCTR) position for Pathway 1 for Wiltshire residents. The impact of this funding will be considered as part of the strategic commissioning plan for 2024/25, a core part of which is the ambition to extend Home First as our default Discharge to Assess (D2A) model, further reducing reliance on bedded capacity. Wiltshire Council were recently awarded outstanding in the recent Ofsted inspection of local authority children's services. See link for full report 50235241 (ofsted.gov.uk) and a fantastic video to go with it https://youtu.be/nJ3xTvh4IBE.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	9
Date of Meeting:	18 January 2024		

Title of Report:	BSW Performance Report
Report Author:	Sharren Pells – Deputy Chief Nurse, Jo Gallaway – Performance Manager
Board / Director Sponsor:	Gill May – Chief Nurse Rachael Backler – Chief Delivery Officer
Appendices:	Integrated Performance & Quality Dashboard and 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	

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 Management Meeting	20/12/23	Review of performance across the oversight framework domains
ICB Quality and Outcomes Committee	09/01/24	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 key ICB Governance meetings, particularly the Quality and Outcomes Committee and 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, for the meetings attention. We continue to progress with the development of an integrated performance report covering the key domains of quality, finance, workforce and operational performance. These metrics are closely aligned to the 2023/24 NHS Oversight Framework metrics and the 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, the NHS Constitution and the NHS operational plan.	

4	Risks

There are several risks on the BSW ICB Corporate Risk Register (dated 07/11/23) 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 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
- BSW ICB 22 – Mental Health transformation - community
- BSW ICB 25 – Mental Health inpatient discharge delays

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.	

Overview of Performance

1. Introduction and purpose of report

1.1. This report is provided to give an overview of current performance and to summarise the key information contained within the detailed performance dashboards attached to this document.

1.2. We have amended this report in light of recent feedback to summarise key information only, with the supplementary reports providing more detailed performance analysis and detail of mitigation actions.

2. Key operational performance information

2.1. The Q2 NHSE Oversight Framework Segmentation process for the ICB and providers reflected the challenges noted above and has resulted in SFT moving to Segment 3.

2.2. For the ICB, segment 3 flags were also raised at Q2 in relation to virtual wards and urgent care response. We have recovery actions in place in relation to virtual wards and UCR, and are expecting improved performance in future months.

2.3. The most up to date operational performance information is not included in this report due to reporting lags, but we note that BSW has seen increased ambulance response times and handover delays in recent weeks, resulting in GWH in particular receiving national and regional scrutiny. GWH have been under particular pressure over the new year period and into the most recent period of industrial action, and has had to take exceptional measures to offload patients from ambulances into boarded beds and cohort areas.

2.4. There are a mix of drivers being reviewed by the System UEC tactical meeting. Care Co-ordination support to 999 is diverting more patients from ED than previously, supported by a specialist paramedic from SWASFT. Four hour performance and bed occupancy are showing signs of pressure, though non-criteria to reside is unchanged.

2.5. October shows a decrease in over 78 week waiters from 65 to 47 (reduction of 18). 15 of these breaches are at providers within BSW with the remaining breaches predominately in Bristol providers. A recent notification from a neighbouring ICB has alerted BSW ICB to some unreported 78 week breaches at a non local independent sector provider and this has now been clarified as 8 BSW patients that are not currently showing in reported figures.

2.6. Diagnostic performance continues to be a significant challenge, DM01 performance (the % of the waiting list over 6 weeks) worsened over the Summer. Key driver of the challenged performance is the non-obstetric ultrasound workforce and capacity. Remedial action plans were formed and presented to the Elective Care Board detailing additional recruitment and insourcing to address the backlog and actions are now live. Additional capacity has commenced and recovery is expected by March 24 for both RUH and GWH. RUH is showing improvement from the additional ultrasound

insourcing and is on track to deliver a 33% breach rate in December as part of recovery trajectory. GWH have also insourced ultrasound capacity and are targeting the longest waiters (over 26 weeks) initially and seeing significant progress, clearing 518 patients since November.

2.7. Cancer waiting time reporting for October shows BSW did not meet the new national standards or in year plans. The most challenged pathways all have recovery plans underway. Increased executive focus and oversight is being brought to the recovery plans via the Elective Care Board. The number waiting over 62 days for start of treatment continues to reduce because of recovery actions at our trusts. Further reductions are expected.

2.8. In parallel, clearing the backlog of long waiters means the expected continued failure against many of the other performance targets as many of these long waiters have already failed e.g. 28 day FDS and 62 day targets. RUH long waiters have predominantly been in lower GI (now resolving due to recovery plans) and skin; SFT and GWH long waiter 62 day breaches are predominantly in the skin pathway and use of insourced external additional capacity is expected to reduce this backlog from the end of December 23. These combined actions support overall system forecast of target achievement by March 24.

2.9. In mental health, BSW Talking Therapies (TT) access rate reduced in September and has dipped below trajectory. The Talking Therapies Fundamental Service Review (FSR) scope has been agreed by partners and will now be implemented.

2.10. Dementia diagnosis rates have improved slightly and are expected to continue to improve. Q4 focus will be on assessing and diagnosing people in care homes, which should provide significant improvement, year end position anticipated below target.

2.11. CYP access in October at 80% of committed trajectory from local data. National reporting will take a few months to catch up. Ongoing improvement plan to ensure all eligible providers are submitting CYP access data to MHSDS.

2.12. Complex LDA inpatient numbers continue to rise above the agreed trajectory. Direct management progressing through the Acute Care Pathway, Prevention and Oversight (pillar of the refreshed BSW LDA Programme), with objective to ensure quality of care and reduce inpatient admissions.

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. 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. **IPC** - Hospital cases of Clostridium Difficile (CDI) are reducing, with case incidences reducing by up to 50%. Despite this reduction, BSW ICS remain at risk of breaching the overall threshold set by NHSE (this includes community onset) and are currently above threshold for current year position.

4.2. **AMS/AMR** - A key focus to reduce CDI is the continued monitoring of antibiotic (AB) prescribing. The South-West region is the 2nd lowest on total antibiotics prescribing in primary care among the 7 regions.

4.3. BSW proportion of broad-spectrum antibiotics (primary care) follows South West regional average trend.

4.4. **Complaints and Concerns -** There has been an increase in ICB led complaints and concerns in Q2 in comparison to Q1. The key theme areas being:

- Primary Care
- Acute Care – concerns around delays that patients have experienced
- Lack of available Dentists
- Access to FreeStyle Libre 2 continuous glucose monitoring for people with type 2 diabetes.
- Enquiries about access to Covid-19 Autumn Vaccination Programme for people who are housebound

5. Key workforce performance information

5.1. Agency usage has continued to reduce and there has been a statistically significant trend with usage dropping to below planned levels for the first time this year. This is also alongside the reduction of off framework usage, an improving price cap compliance.

5.2. Bank usage continues to fluctuate with no significant increase or decrease in the monthly amount of bank shifts used. However, this is above the operating plan submission for 2023/24 and is being reviewed with providers.

5.3. We are reporting in more detail on monitoring of bank and agency as part of the monthly temporary staff report that goes to recovery board.

5.4. Vacancy rate continues to decrease as vacancies are filled and budget remains constant. However, bank and agency usage is now approximately double the vacancy rate across the acute providers in BSW ICB.

5.5. Unfortunately, due to the national team no longer publishing the Sickness and Turnover information we are unable to provide an update on these metrics. We are reviewing a solution to this with the national team and local provider organisations.

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

BSW Integrated Performance Dashboard December 2023

Quality Assurance and Outcomes Committee, 09/01/2024

ICB Board, 18/01/2024 (reduced pack)

BSW Integrated Performance Dashboard

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

The following slides provide the latest published 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 (including the recent review and replan) plus additional in year ambitions set by NHSE and BSW system partners.

The wider reporting of these metrics continues to be developed with the summary dashboards now including performance against the monthly plan where relevant and a year end or national target

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. The assurance icons are looking at delivering the target shown and are based on the actual numbers only and will not always reflect local knowledge.

Metrics with limited data points e.g. annual and with planned / expected change across the year will usually need further interpretation outside of the SPC process.

The dashboard shows where the indicator is also an NHS oversight metrics (SOF) – see next slide.

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.

NHS Oversight Framework: BSW 23/24 Q2 Rating

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

- Under the NHS Oversight Framework, NHSE are required to undertake quarterly segmentation reviews to identify where organisations may benefit from, or require, support to improve performance and quality of care outcomes for patients.

2023/24 Q2	BSW ICB	GWH	RUH	SFT	AWP
Overall Rating by segment 1-4	3 ⟷	2 ⟷	3 ⟷	3 ↓	3 ⟷
Areas in which improvement and further assurance is required	Key areas of concern noted were • Elective – diagnostics • Mental Health CYP Access, Talking Therapies and Dementia • Finance - efficiency, stability and agency spend • LDA – Inpatients • Virtual Wards • Urgent community response	Key areas of concern noted were • Finance - - efficiency, stability and agency spend • Elective – diagnostics • Quality – CQC overall – Requires improvement • Cancer – 62 day backlog • SHMI	Key areas of concern noted were • Cancer – 62 day • Finance - efficiency, stability and agency spend • Elective – diagnostics • UEC – A&E 4 hour standard	Key areas of concern noted were • Finance - efficiency, stability and agency spend • Maternity – safety support programme • Workforce – safety culture and leaver rate • Cancer – 62 day backlog	Key areas of concern noted were • Workforce – Leaver Rate and Senior Leadership roles • Quality – CQC overall – Requires improvement • Agency spend

- Further detail on these metrics is given in the relevant places in this report. We note that finance and workforce are subject to their own detailed report through the relevant committees.
- In Q2 SFT has entered segment 3; the ICB are required to provide an 'enhanced oversight' process whereby we are now meeting with each of the Trusts monthly to carry out oversight of the recovery plans against their segment 3 exit criteria. These are in the process of being arranged.

Segment	Support offered
1. High performing	No specific support
2. On development journey	Flexible peer support in system and NHSE BAU
3. Significant support needs	Bespoke mandated support led by NHSE region
4. Serious, complex issues	Mandated intensive support delivered through the Recovery Support Programme

BSW Integrated Performance Dashboard

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

ELECTIVE CARE

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
Cancer - % 2WW seen in 2 weeks	BSW COMMISSIONER TOTAL		Oct-23	54.0%	52.0%	▼			93.0%	▲		
Cancer - 28 Days Faster Diagnosis SOF	BSW COMMISSIONER TOTAL		Oct-23	59.0%	60.0%	▲	74.0%	No	75.0%	▲		
Cancer - 62 Day Pathways SOF	ALL_ICB - ACUTE TOTAL		Dec-23	472	505	▲	486	No		▼		
Cancer - 62 Day Standard	BSW COMMISSIONER TOTAL		Oct-23	56.0%	53.0%	▼			85.0%	▲		
Cancer - Waits >104 Days	ALL_ICB - ACUTE TOTAL		Dec-23	72	64	▼				▼		
Diagnostics - % of WL over 13 weeks - All Mobalities	BSW COMMISSIONER TOTAL		Oct-23	22.0%	23.0%	▲			0.0%	▼		
Diagnostics - % of WL over 6 Weeks - All Modalities SOF	BSW COMMISSIONER TOTAL		Oct-23	44.0%	43.0%	▼			15.0%	▼		
ERF (Elective Recovery Fund) - % Against 19/20 Baseline SOF	BSW COMMISSIONER TOTAL		Nov-23	108.7%	108.3%	▼	112.0%	No	107.1%	▲		
RTT - Waiting List 65 Weeks+ SOF	BSW COMMISSIONER TOTAL		Oct-23	1,389	1,175	▼	574	No	0	▼		
RTT - Waiting List 78 Weeks+	BSW COMMISSIONER TOTAL		Oct-23	65	47	▼	0	No	0	▼		

Cancer Standards Update– Following the clinically-led review of NHS access standards, a new, simplified set of three patient-centred standards, appropriate to modern cancer care that are understandable both clinically and to the public, are being implemented. These replace the current nine access standards and have been published for the first time in December (October data) and the new combined metrics will be reported here in future. The 3 metrics are:

- 28 day faster diagnosis (from referral) – National standard is 75% - already reported.
- 31 day Decision to Treat to Treatment combined – National standard is 96%
- 62 day (combined) referral to 1st treatment – National standard is 85%.

SOF Denotes an NHS oversight framework metric

Link for further details on cancer standards : https://www.england.nhs.uk/long-read/cancer-waiting-times-review/

BSW Integrated Performance Dashboard

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

QUALITY

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
Percentage of GP Appointments With Good Experience - Annual SOF	BSW COMMISSIONER TOTAL		Dec-22		62.5%					▲		
c.Diff Infection Rate SOF	BSW COMMISSIONER TOTAL		Oct-23	145.9%	157.8%	▲			100.0%	▼	H	F
E.coli Infection Rate SOF	BSW COMMISSIONER TOTAL		Oct-23	139.2%	139.2%	◀ ▶			100.0%	▼	H	F
MRSA Infection Rate SOF	BSW COMMISSIONER TOTAL		Oct-23	06	05	▼			0	▼	H	F
SHMI (Summary Hospital Level Mortality Indicator) Rating SOF	ALL_ICB - BY ACUTE	GWH	Jul-23	02	02	◀ ▶				▼		
SHMI (Summary Hospital Level Mortality Indicator) Rating SOF	ALL_ICB - BY ACUTE	RUH	Jul-23	02	02	◀ ▶				▼		
SHMI (Summary Hospital Level Mortality Indicator) Rating SOF	ALL_ICB - BY ACUTE	SFT	Jul-23	02	02	◀ ▶				▼		

SHMI from oversight framework, key:
1 higher than expected
2 as expected
3 lower than expected

SOF Denotes an NHS oversight framework metric

BSW Integrated Performance Dashboard

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

URGENT CARE

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
4 hour % total Attendances SOF	ALL_ICB - ACUTE TOTAL		Nov-23	66.2%	68.1%	▲	70.0%	No	76.0%	▲		
Average Handover Delays > 15 mins	ALL_ICB - ACUTE TOTAL		Nov-23	01:09	01:08	▼	00:57:30	No	00:25	▼		
Average Response Time (HH:MM) Category 2 Incid... SOF	BSW COMMISSIONER TOTAL		Nov-23	00:58	00:44	▼			00:30	▼		
NCTR % Occupancy SOF	ALL_ICB - ACUTE TOTAL		Nov-23	18.0%	16.0%	▼	17.6%	No	13.0%	▼		
Total Ambulance Conveyances	ALL_ICB - ACUTE TOTAL		Nov-23	5,525	5,565	▲				▼		

OCCUPANCY

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
G&A Bed Occupancy - Adult % SOF	ALL_ICB - ACUTE TOTAL		Nov-23	98.0%	98.0%	◀ ▶				▼		

SOF Denotes an NHS oversight framework metric

BSW Integrated Performance Dashboard

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

COMMUNITY

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
UCR % 2hour Response SOF	ALL_ICB - ACUTE TOTAL		Oct-23	74.0%	77.0%	▲			70.0%	▲		
Virtual Wards: Average Occupancy % SOF	ALL_ICB - ACUTE TOTAL		Nov-23	64.0%	66.0%	▲	70.0%	No	80.0%	▲		
Virtual Wards: Capacity	ALL_ICB - ACUTE TOTAL		Nov-23	159	164	▲	164	Yes		▲		
Community Waiting List	BSW COMMISSIONER TOTAL		Nov-23	23,519	22,441	▼	20,322	No		▼		

PRIMARY CARE

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
% GP Appointments Booked within 14 days SOF	BSW COMMISSIONER TOTAL		Oct-23	70.0%	69.0%	▼				▲		
GP Appointments	BSW COMMISSIONER TOTAL		Oct-23	571,152	636,692	▲	642,821	Yes		◀ ▶		

SOF Denotes an NHS oversight framework metric

BSW Integrated Performance Dashboard

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

MHLDA

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
Access to Community Mental Health Services *	BSW COMMISSIONER TOTAL		Oct-23	4,390	4,420	▲	5,225	No	5,656	▲		
Access to Talking Therapy Services SOF	BSW COMMISSIONER TOTAL		Sep-23	3,360	2,810	▼	2,963	No	4,199	▲		
CYP Mental Health Access SOF	BSW COMMISSIONER TOTAL		Oct-23	9,982	9,931	▼	12,213	No	13,160	▲		
Dementia Diagnosis Rate SOF	BSW COMMISSIONER TOTAL		Nov-23	58.5%	58.8%	▲	66.0%	No	66.7%	▲		
LD - % Annual Health Checks Carried Out SOF	BSW COMMISSIONER TOTAL		Oct-23	22.1%	27.7%	▲	24.0%	Yes	75.0%	▲		
Specialist Community Perinatal Mental Health Access SOF	BSW COMMISSIONER TOTAL		Oct-23	635	730	▲	747	No	996	▲		
Acute Mental Health Out of Area Placements SOF	BSW COMMISSIONER TOTAL		Sep-23	55	75	▲	74	No	00	▼		
LD - Inpatients (Rate per million) SOF	BSW COMMISSIONER TOTAL		Sep-23	42	42	◄►	35	No	25	▼		

*LD health checks are carried out once annually, performance starts at zero each year and most activity is in Q3 and Q4, and the SPC assurance icons are not able to reflect this performance format

SOF Denotes an NHS oversight framework metric

BSW Integrated Performance Dashboard

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

WORKFORCE

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
Agency Usage % - all staff SOF	BSW COMMISSIONER TOTAL		Oct-23	2.0%	1.7%	▼			2.0%	▼		
Bank Usage % - all staff	BSW COMMISSIONER TOTAL		Oct-23	7.0%	6.9%	▼			4.0%	▼		
Sickness Rate - 12m SOF	BSW COMMISSIONER TOTAL		Oct-23	4.4%	4.3%	▼			4.0%	▼		
Sickness Rate - in month	ALL_ICB - ACUTE TOTAL		Oct-23	4.0%	4.4%	▲			4.0%	▼		
Turnover Rate - 12m	ALL_ICB - ACUTE TOTAL		Oct-23	12.2%	11.9%	▼			12.0%	▼		
Turnover Rate - in month SOF	ALL_ICB - ACUTE TOTAL		Oct-23	1.2%	0.9%	▼			1.0%	▼		
Vacancy Rate - all staff	BSW COMMISSIONER TOTAL		Oct-23	4.6%	3.7%	▼			6.0%	▼		

SOF Denotes an NHS oversight framework metric

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

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

FINANCE

Metric	Group	Provider	Latest Date	Previous Value (Activity)	Latest Value (Activity)	Change	Latest Value (Plan)	In Month (Activity v Plan)	Target	Improvement Direction	Variation	Assurance
Agency Spend vs agency ceiling (% over plan YTD) SOF	BSW NHS ICS - TOTAL		Nov-23	11.0%	8.0%	▼				▼		
Efficiencies % recurrent Actual SOF	BSW COMMISSIONER TOTAL		Nov-23	43.0%	39.0%	▼				▼		
Financial efficiency - variance from efficiency (?m YTD) SOF	BSW COMMISSIONER TOTAL		Nov-23	£01	£00	▼				◀ ▶		
Financial stability - variance from plan (?m YTD) SOF	BSW COMMISSIONER TOTAL		Nov-23	£-07	£-04	▲				◀ ▶		
Mental Health Investment - variance from plan (?m YTD) SOF	BSW COMMISSIONER TOTAL		Nov-23	£00	£00	◀ ▶				◀ ▶		

Please note the financial results are being reviewed across the system and the Month 9 (Dec) results are expected to show the results of this work including the expected year end deficit.

SOF Denotes an NHS oversight framework metric

BSW System Status – Health Care Acquired Infection (SOF)

Bath and North East Somerset, Swindon and Wiltshire

MRSA

- There have been 6 incidence of MRSA blood stream infections to date during 23/24 across BSW ICS, against a zero target.
- x3 Hospital onset, Healthcare Associated (HOHA); x2 Community Onset, Community Associated (COCA) and x1 community onset, Healthcare acquired (COHA)
- Skin and soft tissue infection are a key theme
- BSW ICS Infection Prevention and Management collaborative are ensuring a system approach to shared learning from all infection reviews

Clostridioides difficile

- Throughout the last number of years, nationally there has been a steady year on year rise of CDI cases. This is also seen within the BSW system and the Southwest region.
- Hospital cases are reducing and BSW has had a notable drop across acute hospital care, with case incidences reducing by up to 50%. Despite this reduction, BSW ICS remain at risk of breaching the threshold set by NHSE and are currently above threshold for current year position.
- Current cases are 142, this is 31 cases higher than the same time period in 22/23.
- Work continues to ensure that this downward trajectory remains for the system, through the continuation of post infection reviews (PIR) and patient journey end – end reviews. Themes and trends continue to be analysed as a system and shared within relevant health and care forums
- Continuous monitoring of community antibiotic prescribing continues, with key actions identified to reduce prescribing associated with skin and soft tissue infection and community acquired pneumonia in collaboration with medicines optimisation teams

BSW System Status - Health Care Acquired Infections

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

E-coli Infections

- E. coli threshold set by NHSE for 23/24 is 489 cases, there have been 281 incidences for Q1&Q2, 23 less than same time period last year, and a 7.5% reduction in cases
- The downward trajectory in these cases has been maintained for Q2, a time period where we typically see the highest incidence, work is now underway to review the impact of the hydration quality improvement project has had on these cases.
- Validated data for Qtr 3 will be available Feb 2024 and reported to QaOC in March 2024
- Actions being undertaken by the BSW ICS HCAI collaborative to further reduce incidence include:
  - Hydration resources created by the IP&M collaborative being disseminated to providers, third sector, social care and primary care.
  - Colleagues in medicines optimisation are undertaking work relating to antimicrobial stewardship with providers and primary care related to Lower urinary Tract Infections
  - Community care colleagues are currently undertaking audits to understand the number of catheters in the community and current management of these**,** with a particular focus relating to Catheter associated urinary tract infections. Includes joint working with social care and public health teams

Antimicrobial Stewardship

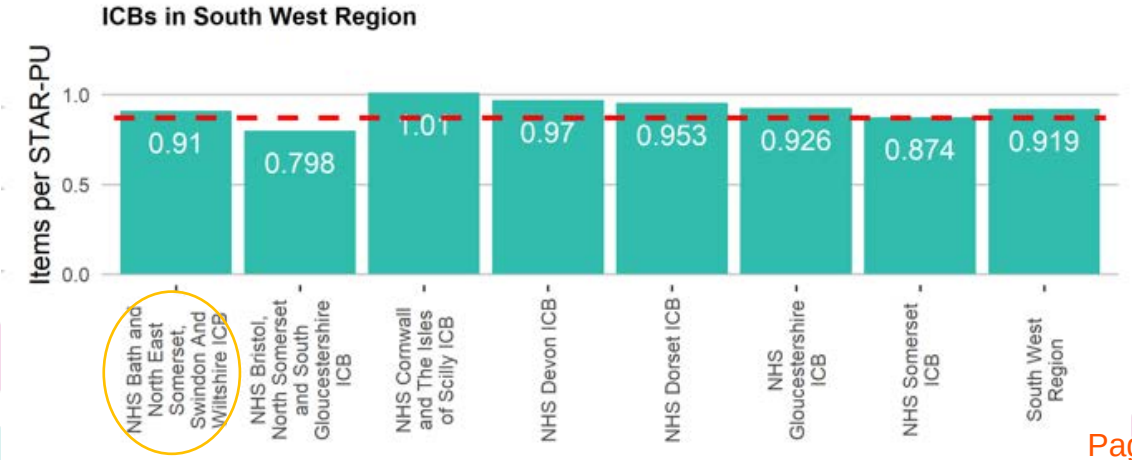
- Oversight and management for antimicrobial prescribing remains critical to ensure that we reduce and manage our healthcare associated infections across BSW, in particular, broad spectrum prescribing and prescribing associated with skin and soft tissue infections (see antibiotic prescribing in primary care).

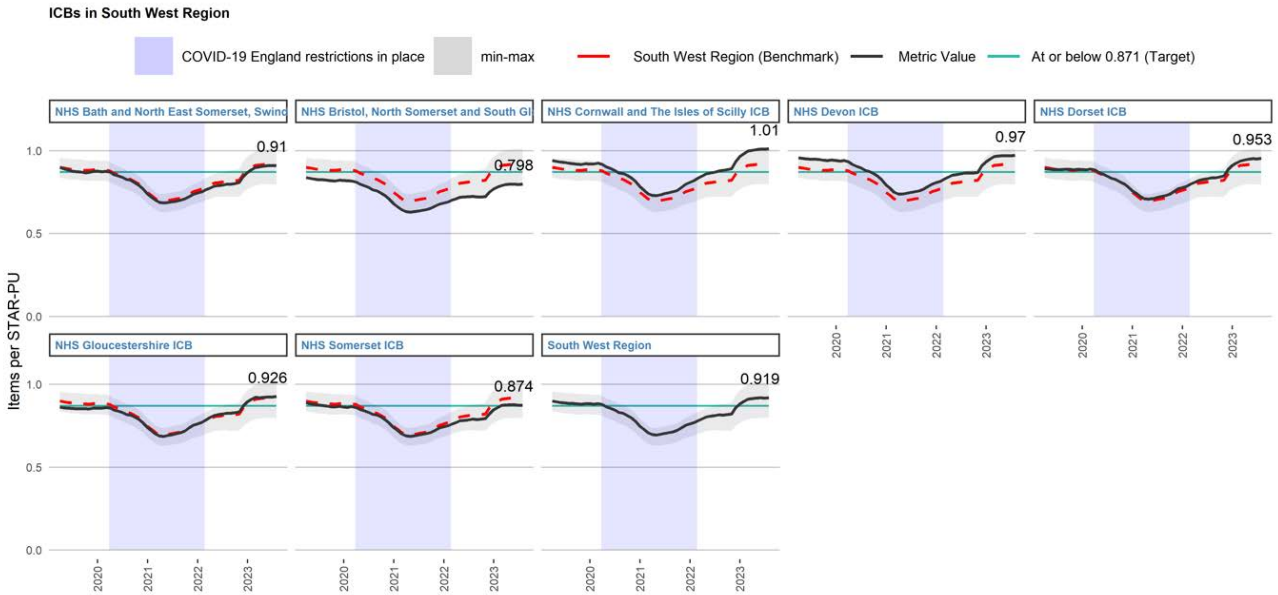
Antibiotic Prescribing in Primary Care: SOF Metrics

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

44a Anti-microbial resistance: total prescribing of antibiotics in primary care

Total prescribing of antibiotic items per STAR-PU in primary care.
Rolling 12-month rate to August 2023





Metrics 44a Data indicates:

- South West region is the 2nd lowest on total antibiotics prescribing in primary care among the 7 regions and
- In general, BSW total antibiotics prescribing (primary care) follows SW regional average trend.

Patient Advice and Complaints Team (PACT) Q2 Key Themes

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

South, Central and West Patient Advice and Complaints Team (SCW PACT) have produced the quarter 2 report for BSW ICB. This reports covers activity between 1st July and 30th September 2023.

During Q2, the ICB received a total of 35 formal complaints and 413 informal Patient Advice and Liaison Service (PALS) enquiries. This is an increase from Q1 (19 formal complaints and 278 enquiries).

The key area themes for complaints are in relation to:

- Primary Care
- Acute Care Pathway – including delays that patients have experienced

The key themes for concerns / queries are:

- Patient Transport Advice Centre (PTAC) – extended waiting times to get through to the service.
- Lack of available dentists
- Access to FreeStyle Libre 2 continuous glucose monitoring for people with type 2 diabetes.
- Covid-19 Autumn Vaccination Programme – mainly enquiries regarding access to vaccinations for people who are housebound

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	10
Date of Meeting:	18 January 2024		

Title of Report:	BSW ICB & NHS Integrated Care System (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 M8

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

Purpose:	Description	Select (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	x

Previous consideration by:	Date	Please clarify the purpose
ICB Finance & Investment Committee	10 January 2024	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 £18.4m deficit. This is £11.1m behind the planned deficit of £7.3m.
- The ICS breakeven position is dependent on achievement of £96.3m of efficiencies representing 5.0% of system allocation.
- Nearly half of identified schemes are non-recurrent in nature impacting our underlying position into next year.
- Agency Limit to date of £22.5m has been exceeded by £1.8m with a forecast of £0.7m (2.0%) below the £33.8m threshold. Controls to achieve this are being supported by the Workforce Group.

- Implementation of protocols including reviews of investments over £50k continue through the Financial Recovery Group who are also supporting delivery of efficiency targets and triangulating efforts to maximise productivity benefit in year.
- The formal reforecast is expected at M9. The system has agreed a £9.9m deficit forecast position.

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.	

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

NHS BSW ICS Finance Report

November 2023 (Month 8)

1. ICS Financial Position - Reported

BSW NHS ICS reported financial position at month 8 is an **adverse variance of £11.1m**. This is driven by:

- Prescribing price £6.8m (offset by underspends in delegated primary care, delegated dental and community health services)
- Industrial Action £1.2m
- Efficiency shortfall £0.5m
- Other £2.6m

This is a **favourable movement of £11.5m** month on month driven by the receipt of industrial action funding for H2 of £10.8m.

In the ICB other includes Elective Recovery funding income for providers accrued at plan values but costs to date have been reflected on an actual basis and exceed income.

The reported forecast at month 8 remains to breakeven.

	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	0.3	0.1	(0.2)	(67.0%)		0.0	0.0	0.0	0.0%	
Royal United Hospital	(6.7)	(9.9)	(3.2)	(47.3%)		0.0	0.0	0.0	0.0%	
Salisbury Hospital	(0.9)	(5.0)	(4.1)	(448.6%)		0.0	0.0	0.0	0.0%	
Provider surplus / (deficit)	(7.3)	(14.7)	(7.4)	(101.6%)		0.0	0.0	0.0	0.0%	
BSW ICB surplus / (deficit)	**0.0**	**(3.7)**	**(3.7)**	**(0.3%)**		0.0	0.0	0.0	0.0%	
ICS surplus / (deficit)	**(7.3)**	**(18.4)**	**(11.1)**	**(151.7%)**		**0.0**	**0.0**	**0.0**	**0.0%**	

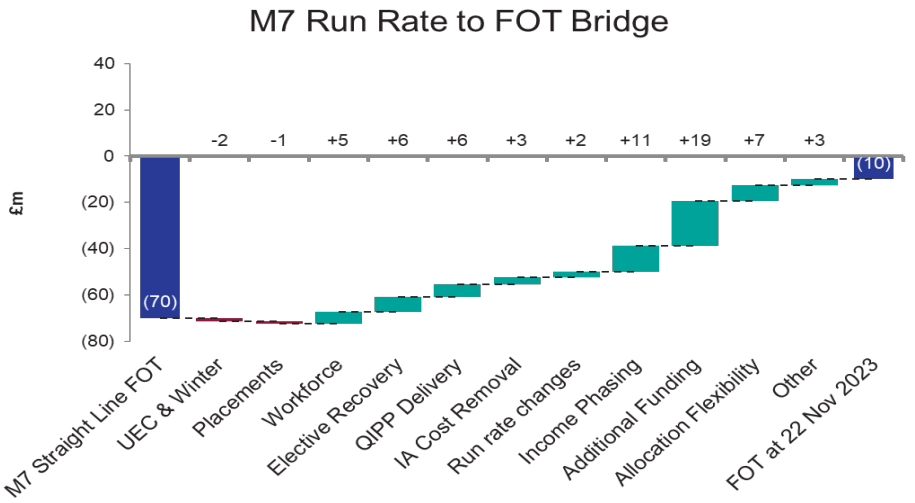
1. ICS Financial Position – Run Rate

		Month 1 - 8 £m's	Month 9 £m's	Month 10 £m's	Month 11 £m's	Month 12 £m's	Total £m's
Surplus / (Deficit)	GWH	**0.1**	**(0.5)**	**(0.5)**	**(0.1)**	**1.0**	**0.0**
Income	GWH	(325.9)	(40.3)	(40.3)	(40.3)	(40.3)	(487.2)
Pay	GWH	201.9	25.1	25.1	24.8	24.8	301.7
Non-Pay	GWH	111.6	14.2	14.2	14.1	13.0	167.1
Non-Operating Items	GWH	12.3	1.5	1.5	1.5	1.5	18.4
Surplus / (Deficit)	RUH	**(9.9)**	**0.7**	**2.0**	**1.8**	**1.9**	**(3.5)**
Income	RUH	(351.3)	(43.7)	(44.4)	(44.6)	(43.9)	(527.9)
Pay	RUH	231.3	27.0	27.4	27.5	26.8	339.9
Non-Pay	RUH	124.8	14.3	13.2	13.5	13.4	179.1
Non-Operating Items	RUH	5.1	1.9	1.9	1.9	1.9	12.5
Surplus / (Deficit)	SFT	**(5.0)**	**(1.2)**	**(0.3)**	**0.8**	**1.3**	**(4.3)**
Income	SFT	(241.9)	(29.4)	(29.8)	(30.5)	(31.0)	(362.5)
Pay	SFT	155.8	19.4	18.9	18.3	18.4	230.9
Non-Pay	SFT	85.8	9.3	9.3	9.5	9.5	123.4
Non-Operating Items	SFT	5.2	1.8	1.8	1.8	1.8	12.5
Surplus / (Deficit)	ICB	**(3.7)**	**0.4**	**0.4**	**0.4**	**0.4**	**(2.0)**
Surplus / (Deficit)	**ICS**	**(18.4)**	**(0.6)**	**1.6**	**3.0**	**4.7**	**(9.8)**

The ICS has agreed an out turn position of £9.9m. The table above shows the rate we need to make in order to achieve this total. A formal forecast will be delivered in month 9.

1. ICS Financial Position – Forecast Outturn

BSW is reliant upon £22m of run rate improvements and £26.2m of additional/reallocated funding and recovery actions to deliver (£10m) deficit



	GWH	RUH	SFT	ICB	ICS
	£m	£m	£m	£m	**£m**
M7 Straight Line FOT	(8.5)	(23.7)	(13.7)	(24.1)	**(70.0)**
Improvements	2.6	14.7	5.5	12.5	**35.4**
Investments				(1.6)	**(1.6)**
Additional Funding	5.7	5.5	3.8	4.4	**19.4**
Allocation Flexibility				6.9	**6.9**
FOT at 22 Nov 2023	(0.1)	(3.5)	(4.3)	(2.0)	**(9.9)**

Trust Improvements Backed by Plan	GWH	RUH	SFT
	£m	£m	£m
ERF Contribution	1.3	2	
Theatre Improvements		1.4	0.5
Industrial Action	1.4	1.4	1.1
Meds Management		0.4	
Agency		1	
Workforce		1.7	2
Cleaning		0.7	
RMNs		0.4	
PDC		1.5	
Non-Pay		2	1.1
Other QIPP	-0.1	2.2	0.8
Total	**2.6**	**14.7**	**5.5**

Provider improvements from M7 run rate are backed by plans but risks remain to delivery.

RUH comprises internal plans of £11.7m in-year with a risk of £3m

1. ICS Financial Position – Actions to Remedy

Funding and income

- Dental benefit taken in full
- Capital to revenue fully assessed and benefit taken
- SDF funding – fully reviewed against national guidance and underspends taken into the position
- Cancer alliance – underspend taken as per dame Cally Palmer email to Cancer Alliances
- Reviewed Non-NHS income profiling in the 2nd half of the year

ERF and elective activity

- Advice and guidance – benefit is included in the position
- Estimate of impact of ERF changes and target recognised
- Elective activity – reviewed no premium tariff on Independent Sector
- Outsourcing / insourcing – ongoing review (formal submission required)

Workforce

- System vacancy freeze
- System vacancy control panel
- Clear workforce analysis and understanding undertaken
- Providers - workforce, costing of staffing freeze to be quantified
- Agency – controls in place
- Workforce review with NHSE regional team on 9 Nov 2023

Investment

- Triple lock in place
- Reviewing all planned investments for the remainder of the year

Balance sheet / Income

- Full balance sheet review undertaken with NHSE regional team

Other areas

- Provisions released
- CHC – review of backlog and timing
- MHIS – all areas reviewed whilst maintaining MHIS standard

Governance / supporting actions

- Voluntary adoption of forecast protocols from Qtr 2 2023
- Grip and Control Templates populated for all organisations
- Run-rate review undertaken
- Each organisation has completed a financial recovery plan
- HFMA checklist update to audit committees in Qtr 3 2023

2. ICS Risks and Mitigations - Reported

Gross Risks	Total £m	ICB £m	GWH £m	RUH £m	SFT £m
Additional cost risk	(37.1)	(11.5)	(9.1)	(6.9)	(9.6)
Additional inflation	(8.0)	0.0	(3.9)	(4.1)	0.0
Contract risk (excl. ERF)	(2.0)	(2.0)	0.0	0.0	0.0
COVID risk	(0.5)	0.0	(0.5)	0.0	0.0
Efficiency risk	(13.4)	(2.0)	(8.4)	(3.0)	0.0
Income risk	(2.7)	0.0	(2.0)	(0.7)	0.0
BSW ICS Gross Risks	**(63.6)**	**(15.5)**	**(23.9)**	**(14.6)**	**(9.6)**

Mitigations	Total £m	ICB £m	GWH £m	RUH £m	SFT £m
Additional cost control	**13.0**	0.0	9.1	3.9	0.0
Risk share	**8.7**	8.0	0.0	0.7	0.0
Transformational / Pathway changes	**9.9**	0.0	6.9	3.0	0.0
Unmitigated: COVID	**0.0**	0.0	0.0	0.0	0.0
Efficiency mitigation	**0.0**	0.0	0.0	0.0	0.0
Mitigations not yet identified	**1.0**	0.0	1.0	0.0	0.0
BSW ICS Mitigations	**32.5**	**8.0**	**16.9**	**7.6**	**0.0**

Net Risk	Total £m	ICB £m	GWH £m	RUH £m	SFT £m
Additional cost risk	**(18.4)**	(3.5)	0.0	(5.3)	(9.6)
Additional inflation	**(5.7)**	0.0	(3.9)	(1.8)	0.0
Contract risk (excl. ERF)	**(2.0)**	(2.0)	0.0	0.0	0.0
COVID risk	**(0.5)**	0.0	(0.5)	0.0	0.0
Efficiency risk	**(3.5)**	(2.0)	(1.5)	0.0	0.0
Income risk	**(1.0)**	0.0	(1.0)	0.0	0.0
BSW ICS Net Risk	**(31.1)**	**(7.5)**	**(6.9)**	**(7.1)**	**(9.6)**

NB tables do not read across as each gross risk may have more than one mitigation category or mitigations not yet identified

Recovery plans are in development and national protocol controls and assurance processes have been adopted voluntarily within the system. All organisations are carrying risks in the delivery of their “Best Case”. These will be set out and discussed at each organisational Board.

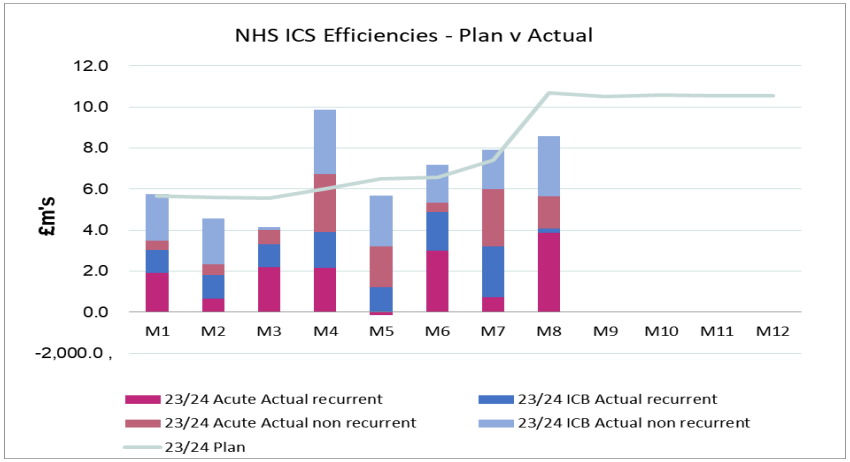
The most significant risk for providers is that of additional costs; **continued industrial action (£1.2m);** temporary staffing costs to meet demands in services combined with slippage on efficiencies (£11.4m) and under delivery of the elective recovery programme. They are managing these risks through internal programmes.

The largest ICB Risk is driven by ARRS funding for ICB primary care roles (£8.0m). This is **fully mitigated** by a shared risk that we may receive funding from NHSE to cover. Year-to-date caseload growth in Continued Health Care and Mental Health has exceeded planned mortality assumptions and CIP schemes are not yet delivering as expected leading **to £2.5m remaining net risk with a further net risk within this year’s contracts of £2.0m** remaining unresolved.

3. ICS Efficiency Schemes - Reported

Overall efficiencies within the 2023-24 NHS system plan to enable the required breakeven position total £96.3m. This represents 5.0% of the overall NHS system allocation. We are currently forecasting to achieve only 4.9%, **0.1% below our planned target**.

Overall YTD ICS achievement has deteriorated to an **adverse variance of 0.9% (£0.5m)** with non-recurrent achievement improving to balance slippage in recurrent schemes. The forecast has improved but the adverse variance of 30.2% on planned recurrent schemes with the exception of SFT continues to deteriorate creating further pressures in 24/25.



	Year-to-date					Forecast Outturn				
	Plan	Actual	(Under)/over delivery			Plan	FOT	(Under)/over delivery		
	£m	£m	£m	%		£m	£m	£m	%	
BSW ICB	21.1	10.9	(10.2)	(48.2%)	↓	31.7	16.2	(15.5)	(48.8%)	↓
Great Western Hospital	5.6	4.2	(1.4)	(25.0%)	↓	9.9	8.3	(1.6)	(16.4%)	↓
Royal United Hospital	7.5	4.3	(3.2)	(42.4%)	↓	23.5	17.3	(6.2)	(26.6%)	↓
Salisbury Hospital	6.7	5.8	(0.8)	(12.4%)	↑	10.8	11.2	0.5	4.2%	↑
Recurrent Efficiencies	**40.9**	**25.3**	**(15.6)**	**(38.1%)**	↓	**75.8**	**52.9**	**(22.9)**	**(30.2%)**	↓
BSW ICB	6.0	17.0	11.0	181.5%	↑	9.1	22.3	13.2	145.5%	↑
Great Western Hospital	3.6	5.3	1.7	46.0%	↑	6.8	8.4	1.6	23.8%	↑
Royal United Hospital	0.0	3.2	3.2	100.0%	→	0.0	6.2	6.2	100.0%	→
Salisbury Hospital	3.5	2.8	(0.7)	(19.9%)	↑	4.6	4.1	(0.5)	(10.0%)	↓
Non Recurrent Efficiencies	**13.1**	**28.3**	**15.1**	**115.3%**	↑	**20.4**	**41.0**	**20.6**	**100.9%**	↑
Total Efficiencies	**54.0**	**53.6**	**(0.5)**	**(0.9%)**	↓	**96.3**	**94.0**	**(2.3)**	**(2.4%)**	↑

4. ICS Workforce - Reported

	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	168.7	178.8	(10.1)	(6.0%)	↓	250.3	250.2	0.1	0.0%	↓
Healthcare Scientists and Techincal Staff	62.2	60.9	1.3	2.1%	↑	93.4	93.1	0.2	0.3%	↓
Qualified Ambulance Service Staff	0.7	1.1	(0.3)	(47.6%)	↑	1.1	1.6	(0.6)	(51.1%)	→
Support to Clinical Staff	71.7	81.0	(9.2)	(12.8%)	↓	107.1	119.1	(12.0)	(11.2%)	↓
Consultants	94.2	96.4	(2.1)	(2.3%)	↓	139.8	135.9	3.9	2.8%	↓
Other Medical staff	57.0	69.6	(12.7)	(22.2%)	↓	85.4	97.9	(12.5)	(14.7%)	↓
Non-medical/Non-clinical	97.2	100.5	(3.2)	(3.3%)	↓	143.6	142.9	0.7	0.5%	↓
Other Employee Benefit costs *	0.8	1.5	(0.8)	(102.3%)	↑	1.1	2.2	(1.1)	(97.5%)	↓
Total Provider Workforce Expenditure	**552.6**	**589.7**	**(37.1)**	**(6.7%)**	↓	**821.7**	**843.0**	**(21.3)**	**(2.6%)**	↓

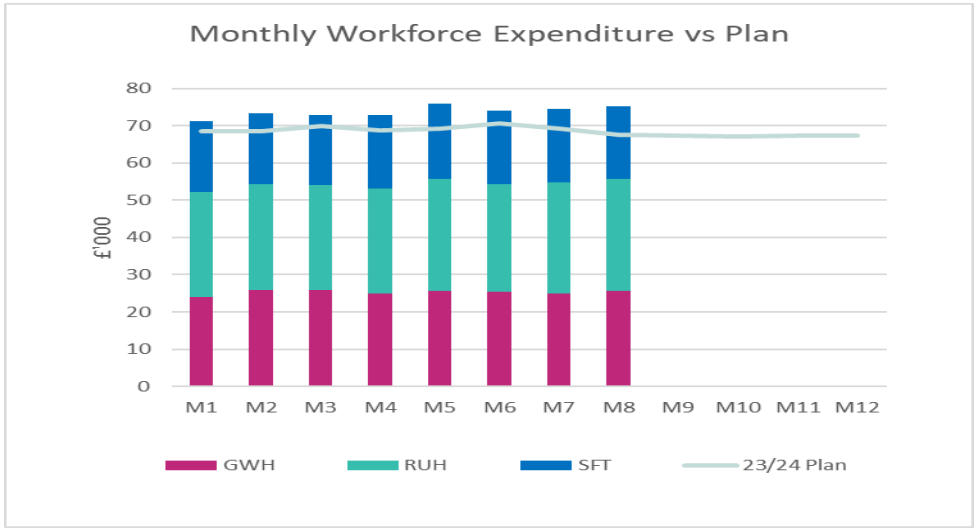
*Aprenticeship levy

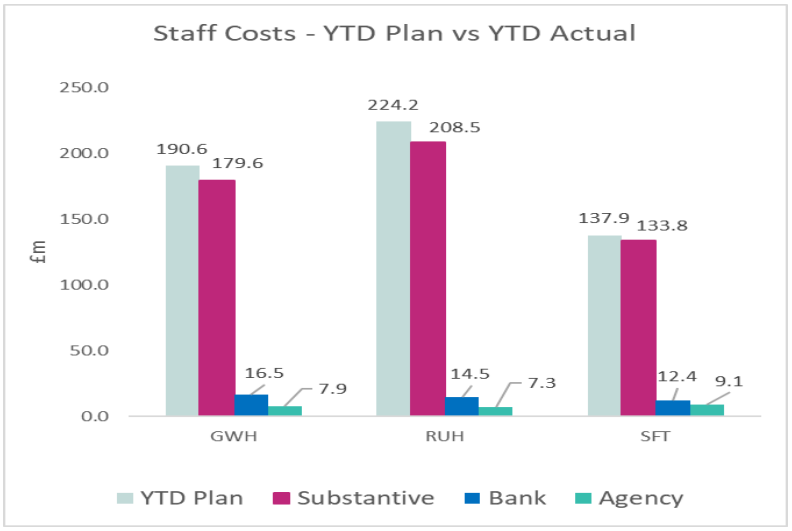
The **overall YTD position** in percentage terms has **deteriorated by a further 0.6%.** Staff costs exceed the year-to-date plan in part due to industrial action. £10.8m of funding to support this has been received leaving a **shortfall of £1.2m** with further industrial action expected over the winter period which will not be funded. The forecast has deteriorated **to 2.6% behind plan (-2.1% on M7).**

Use of **Bank** staff remains steady at **20.2% above the YTD planned level (+1.9% on M7)** as controls on the use of Agency and new rostering systems take effect The reported forecast has deteriorate significantly to an **overspend of £24.9m (-22.1% on M7).**

After a dip in M5, use of **Agency YTD** has fallen back to **£1.8m above the limit** of £22.5m**.** This has impacted the forecast position which now stands at £33.1m, **£0.7m (2.0%) below the agency limit** of £33.8m.

4. ICS Workforce – Delivery vs Plan



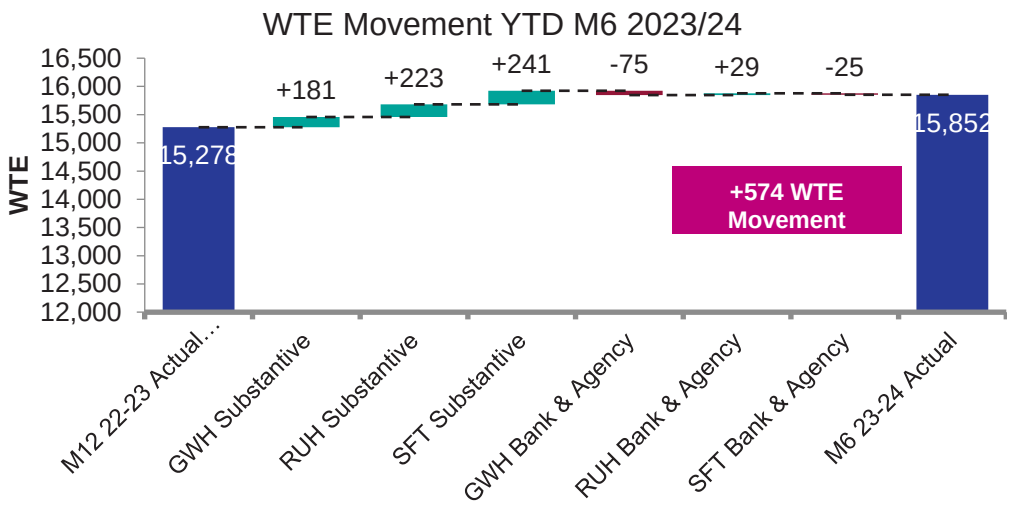


Year-to-date	Substantive				Bank				Agency			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%	£m	£m	£m	%
Registered Nursing Midwifery and HV's	147.2	153.0	(5.7)	(3.9%)	9.4	14.3	(4.9)	(52.6%)	12.1	11.5	0.6	5.0%
Healthcare Scientists and Techincal Staff	61.1	58.4	2.7	4.5%	0.5	0.6	(0.1)	(17.2%)	0.6	1.9	(1.3)	(218.4%)
Qualified Ambulance Service Staff	0.7	0.9	(0.3)	(37.3%)	0.0	0.1	(0.1)	(392.8%)	0.0	0.0	0.0	100.0%
Support to Clinical Staff	68.0	71.0	(2.9)	(4.3%)	3.6	9.8	(6.2)	(173.5%)	0.1	0.2	(0.0)	(43.7%)
Consultants	88.7	86.7	2.0	2.2%	2.4	4.3	(1.9)	(78.4%)	3.1	5.3	(2.2)	(72.2%)
Other Medical staff	48.9	57.0	(8.1)	(16.6%)	2.9	9.6	(6.6)	(226.9%)	5.2	3.1	2.1	40.5%
Non-medical/Non-clinical	91.5	93.5	(2.0)	(2.2%)	4.3	4.6	(0.4)	(8.4%)	1.4	2.3	(0.9)	(61.5%)
Other Employee Benefit costs *	0.8	1.5	(0.8)	(102.3%)								
Total Provider Workforce Expenditure	**506.9**	**522.0**	**(15.0)**	**(3.0%)**	**23.1**	**43.4**	**(20.2)**	**(87.6%)**	**22.5**	**24.4**	**(1.8)**	**(8.1%)**

*Aprenticeship levy

4. ICS Workforce – Acute WTE movement

The Acute Trust WTE growth since M12 2022/23 to M6 2023/24 is an additional 574 WTE. This is a significant growth given the financial position.



	M12 22-23 Actual	M6 23-24 Actual	Growth / (Reduction)
Non-Medical - Clinical Substantive Staff	9,592	8,943	(650)
Non-Medical - Non-Clinical Substantive Staff	2,562	3,614	1,052
Medical and Dental Substantive Staff	1,684	1,927	243
Total WTE Substantive Staff	**13,838**	**14,483**	**646**
Bank Staff	1,093	1,060	(33)
Agency Staff (including, agency and contract)	347	309	(38)
Total WTE all Staff	**15,278**	**15,852**	**574**

Org	Growth (WTE)
GWH	106
RUH	252
SFT	216
Total	574

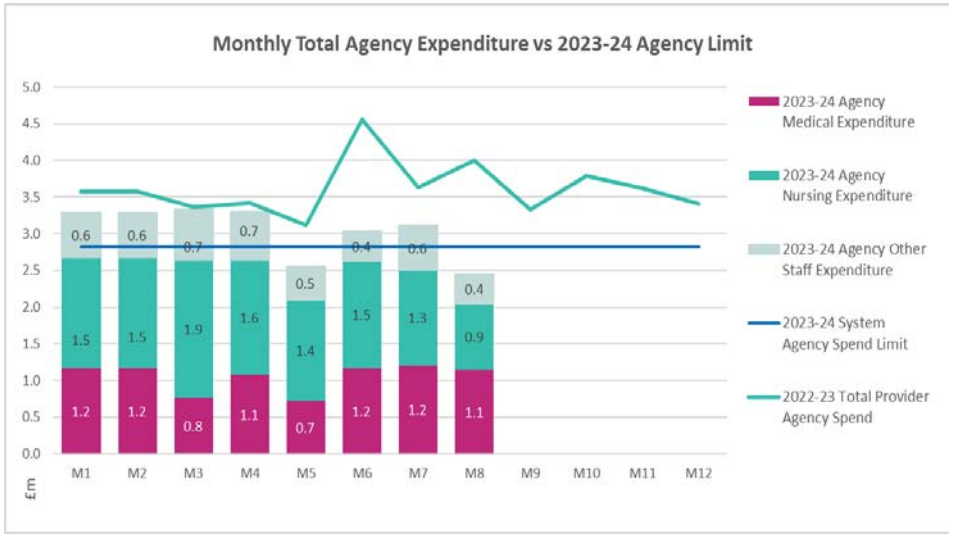
In 23/24, GWH and RUH have recategorized staff groupings, improving workforce data integrity. This relates to admin & estates staff working on the ward being included in clinical roles in 22/23 and then classified as non-clinical support in 23/24.

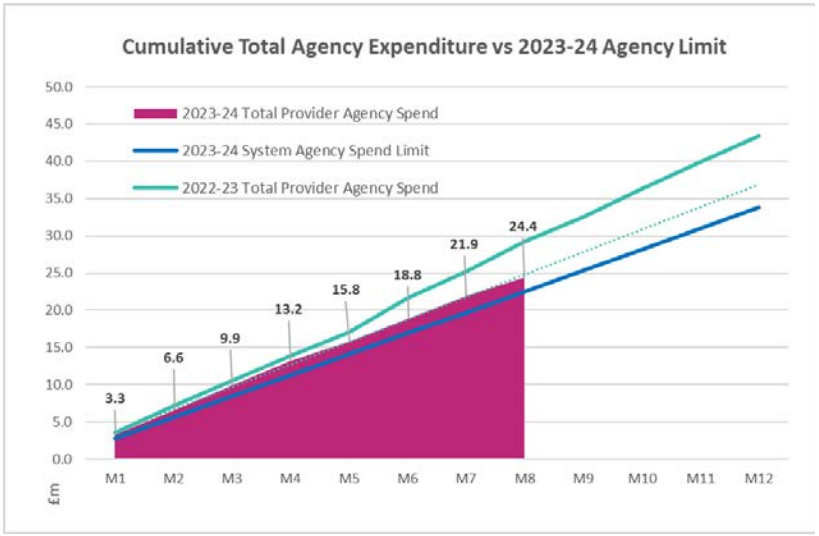
GWH used 93 WTE more than plan to deliver services in M7 with successful hiring reducing the vacancy rate to 233 WTE. Despite this, temporary staff utilisation remains above the vacancy position with 338 WTE used in-month. Above establishment use continues to be scrutinised, with reduction workstreams underway for Nursing and Medical usage. Agency nursing has seen a positive reduction, with improvement focus now on bank nursing and Medical & Dental.

RUH WTE growth has been driven by elective recovery and increased acuity – bringing workforce levels up to adhere to safe staffing requirements. Actions are underway to reduce head count including reviewing all planned increases and holding where appropriate, review of fixed term contracts, holding vacancies, rostering changes, reducing use of bank and agency.

SFT have pressures due to low staff availability on wards requiring temporary staffing and are taking action on rostering and fill rate to improve this position.

4. ICS Workforce – Acute 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	0.7	1.2	1.2	1.1					8.4	4.2	2.0	2.2
2023-24 Agency Nursing Expenditure	1.5	1.5	1.9	1.6	1.4	1.5	1.3	0.9					11.5	3.1	3.2	5.2
2023-24 Agency Other Staff Expenditure	0.6	0.6	0.7	0.7	0.5	0.4	0.6	0.4					4.4	0.6	2.2	1.7
2023-24 Total Provider Agency Spend	**3.3**	**3.3**	**3.3**	**3.3**	**2.6**	**3.0**	**3.1**	**2.4**	**0.0**	**0.0**	**0.0**	**0.0**	**24.4**	**7.9**	**7.3**	**9.1**
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**	**22.5**	**9.1**	**7.5**	**6.0**
Variance to planned Limit (over)/under	**(0.5)**	**(0.5)**	**(0.5)**	**(0.5)**	**0.3**	**(0.2)**	**(0.3)**	**0.4**	**2.8**	**2.8**	**2.8**	**2.8**	**(1.8)**	**1.1**	**0.1**	**(3.1)**
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**	**29.2**	**11.8**	**9.7**	**7.8**
Variance to previous year Spend (over)/under	**0.3**	**0.3**	**0.0**	**0.1**	**0.6**	**1.5**	**0.5**	**1.5**	**3.3**	**3.8**	**3.6**	**3.4**	**4.9**	**3.8**	**2.3**	**(1.3)**

5. ICS ERF Performance

ERF performance at month 8 is still heavily impacted by 'above average' rates of uncoded inpatient activity, resulting in higher volumes of zero tariff spells. Month 8 uncoded inpatient activity is at 36.4% (35.2% Daycase, 45.4% Ordinary admission) and ↓ 3.1% from month 7.

The below highlights uncoded activity levels by POD and provider for month 8. A backlog of uncoded activity now looks to be resolved, with month 8, now the only affected month, across system acutes.

Org	Daycase	Ordinary	Total
ICB	***35.2%***	***45.4%***	***36.4%***
Salisbury Hospital	**75.1%**	**92.5%**	**76.8%**
Great Western Hospital	**55.7%**	**84.5%**	**59.0%**
Royal United Hospital	10.5%	8.2%	10.3%
Independent Sector	1.7%	4.9%	2.2%

Nb provider splits are ICB commissioned, not trust total)

Month 8 activity has been cost adjusted to estimate performance, as per 'normal' levels of uncoded activity.

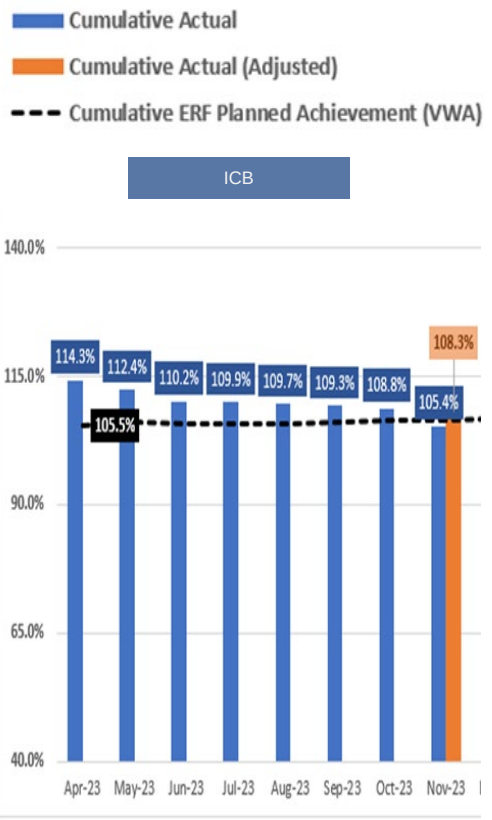
A reflective percentage of uncoded activity has been costed at an average POD price, however adjusted performance should be used with caution as performance is likely to be overstated.

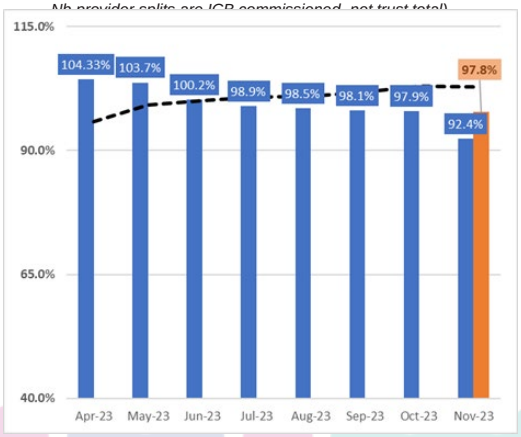
All activity is currently costed at 22/23 tariff.

Performance is monitored against the NHSE Op plan baseline target of 107.1%

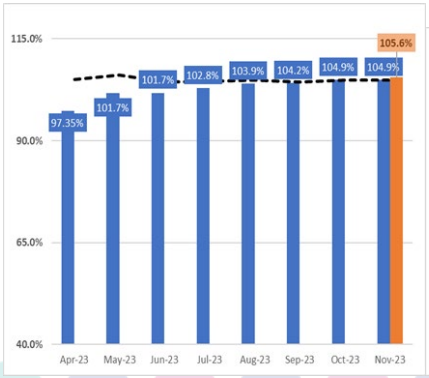
The below highlights adjusted and non-adjusted performance by organisation, against ytd cumulative plan.

Org	Plan	Non-Adj	Adj
ICB	***106.4%***	***105.4%***	***108.3%***
Salisbury Hospital	95.4%	93.0%	98.8%
Great Western Hospital	102.8%	92.4%	97.8%
Royal United Hospital	104.8%	104.9%	105.6%
Independent Sector	121.6%	124.6%	124.8%

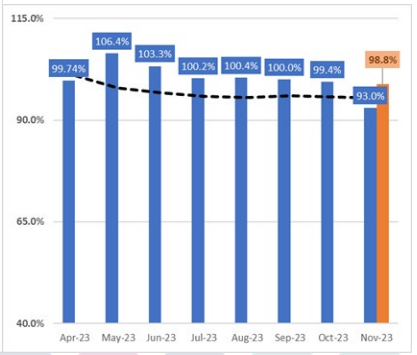




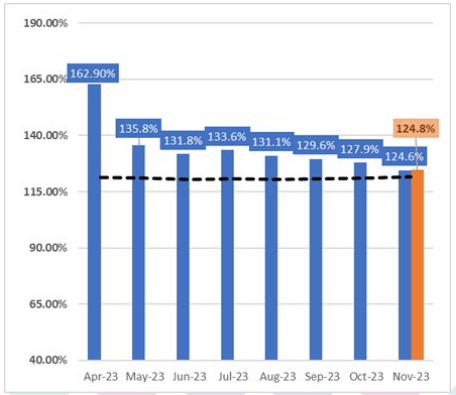
Great WesternHospital



Royal United Hospital



Salisbury Hospital



Independent Sector

Report to:	BSW ICB Board - Meeting in Public	Agenda item:	11
Date of Meeting:	18 January 2024		

Title of Report:	Annual Emergency Preparedness Resilience and Response (EPRR) Assurance Report
Report Author:	Louise Cadle Head of Emergency Preparedness Resilience and Response
Board / Director Sponsor:	Rachael Backler Chief Delivery Officer
Appendices:	

Report classification	Please indicate to which body/collection of organisations this report is relevant.
ICB body corporate	
ICS NHS organisations only	X
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	X
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	X

Previous consideration by:	Date	Please clarify the purpose
BSW ICB Audit and Risk Committee Meeting	7 December 2023	Assurance
BSW ICB Executive Management Meeting	20 December 2023	Assurance

1	Purpose of this paper

The purpose of the report is to:

- Outline the current position of BSW ICB against its requirements under the NHS England Annual EPRR Core Standards in support of the legal

requirements under the Civil Contingencies Act 2004 and Health and Social Care Act 2012.
- Confirm that BSW ICB has been assured as *Substantially Compliant* and set out the compliance status of BSW NHS funded providers.

2	Summary of recommendations and any additional actions required
The Board is asked to accept this report and note the assurance and feedback provided by NHS England.	

3	Legal/regulatory implications
Statutory duties as a Category One responder detailed within the Civil Contingencies Act 2004.	

4	Risks
The key risk is that the ICB will not be able to fulfil its role in supporting the local health economy in its response to an emergency incident whilst maintaining high levels of service for the local population.	

5	Quality and resources impact
Effective arrangements for the management of any emergency within the health economy will support the ongoing provision of high-quality care for patients, minimise any financial consequences following an incident.	
Finance sign-off	

6	Confirmation of completion of Equalities and Quality Impact Assessment
The planning arrangements gives the assurance that the ICB is prepared and can react in any major incident situation supporting all protected characteristics with a positive impact intended by giving staff and the public assurance that the ICB has clear plans in place to react to any type of major incident or emergency.	

7	Communications and Engagement Considerations
None.	

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

Annual Emergency Preparedness Resilience and Response (EPRR) Assurance Report

1. Introduction

1.1. This assurance report sets out the work that Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board have carried out in fulfilment of our responsibilities as part of the NHS England EPRR Core Standards Assurance Process.

1.2. The paper sets out the following:

- Provider assurance levels
- Standards that are partially compliant only
- Areas of notable EPRR best practice
- Local Health Resilience Partnership considerations for EPRR improvement/development activity

2. Background and wider context

2.1. The purpose of the annual EPRR assurance process is to assess the preparedness of the NHS, both commissioners and providers against common nationally agreed standards. The ICB has a key role to provide annual assurance against the NHS EPRR Core Standards, including monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable Core Standards.

2.2. We note that the period to which this assurance covers (2022/23) saw organisations working to support the continued covid-19 response, ongoing demand and capacity challenges and planning for and responding to industrial action. Several unions implemented industrial action around 40 days of industrial action since December 2022. This has ranged from paramedics, nursing, junior doctors, consultants, radiologists, and physiotherapists.

2.3. There were also several other work areas which our EPRR teams have been supporting including humanitarian repatriation efforts (Afghanistan Relocation Assistance Programme, and Asylum Seeker Hotels).

2.4. South West ICB Chief Executives are looking at ways of working and it was agreed that BSW ICB lead on EPRR streamlining processes – how can we work more collaboratively, do things once rather than 7 times and ensure each ICS EPRR processes complement each other. This has enabled a more cohesive regional structure for EPRR with the implementation of a Regional Health Resilience Partnership jointly chaired by NHS England and UK Health Security Agency.

2.5. The focus of the Deep Dive this year was training and exercising and BSW ICS used this an opportunity to reinvigorate EPRR awareness following protracted response to Covid-19.

2.6. Training programmes have been developed aligned to national standards – Principles of Health Command and Loggist training which have been rolled out across ICS bringing together key personnel involved in incident response in a safe environment.

2.7. BSW ICS also took part in a national 3-day live exercise testing the response to a national power outage exploring the impacts of such a scenario on organisations, patients, and the local community.

3. Outputs of assurance process

3.1. The table below sets out the results of the assurance process for organisations that are assured by BSW ICB:

Organisation	2021	2022	2023	
BSW ICB	Substantial	Substantial	Substantial	↔
Great Western Hospital NHS Foundation Trust	Substantial	Substantial	Full	↑
Royal United Hospitals Bath NHS Foundation Trust	Substantial	Partial	Substantial	↑
Salisbury NHS Foundation Trust	Full	Full	Substantial	↓
Medvivo	Full	Full	Full	↔
HCRG Care Group (formerly Virgin Care BaNES)	Substantial	Substantial	Substantial	↔
HCRG Care Group (formerly Virgin Care Wiltshire)	Substantial	Substantial	Full	↑
Wiltshire Health and Care	Substantial	Substantial	Full	↑

3.2. The following providers are commissioned by BSW ICB but were assured by other ICBs:

Organisation	Assuring body	Assurance level 2022	
Avon & Wiltshire Mental Health Partnership NHS Trust	BNSSG ICB	Full	↔
E-MED formerly E-ZEC	South West ICBs	Non-compliant	↓
Oxford Health NHS Foundation Trust	Buckinghamshire, Oxfordshire and Berkshire West ICB	Full	↔

3.3. Great Western Hospital, HCRG Care Group Wiltshire and Wiltshire Health and Care have improved their assurance rating now fully compliant with the core standards relevant to their respective organisations.

3.4. Salisbury Foundation Trust has moved down from full compliance to substantial by 1 core standard. They have seen several staffing changes in those who have been trained to respond to a Chemical, Biological, Radiological Nuclear incident meaning they are not able to confirm 24/7 adequate levels of rostered staff. However, a training programme is in place, and this will be rectified in the next quarter.

3.5. E-MED were assured by the 6 ICBs across the SW who commission them and unfortunately the evidence provided was not sufficient to be able to assure them. A reflection on their support to incidents has meant that they have been able to deliver during an incident however their governance, plans and work programmes need to be updated and aligned to guidance. A recovery plan is in place with the ICBs working with E-MED to improve their ratings.

4. Areas where further work is required.

4.1. For each provider who is reporting substantial compliance overall, an action has been developed to ensure the required standards are met ahead of next year's annual EPRR assurance. This work will be overseen by the ICB and reported to BSW Local Health Resilience Partnership. Follow-up meetings have also been put in place with ICB/Provider EPRR Leads to monitor progress against actions.

5. Areas of Notable EPRR Good Practice

5.1. There are several areas where we have seen good EPRR practice across our system.

5.2. **BSW ICB** has continued to forge strong relationships across health and social care and with both Avon & Somerset Local Resilience Forum (LRF) and Wiltshire & Swindon LRF. Several incidents have been coordinated by the ICB over the last year enabling demonstration of strong leadership supporting the ICS.

5.3. **GWH** are developing an online training package for EPRR which will enable the team to reach a wider audience and embed as part of a corporate responsibility.

5.4. **HCRG Care Group** have worked hard to maintain their assurance level and have carried out several exercises locally to test response arrangements with local authorities. They are currently 4 core standards from being fully compliant.

5.5. **Medvivo** provided a strong EPRR submission detailing good governance around how the EPRR and business continuity is managed. They have also

changed NHS 111 provider who in turn has been able demonstrate full compliance.

5.6. **RUH** have worked hard to move to substantial compliance. Work is underway to embed EPRR across services with training sessions in EPRR being delivered across all levels of the trust and being part of a trust wide gold standard initiative.

5.7. **SFT** may have dipped to substantial however this is an honest reflection because of loss of staffing in ED meaning new staff are being trained in CBRN – use of equipment.

5.8. **WHC** experienced a power outage and generator failure which impacted Chippenham Community Hospital over 3 days but was coordinated successfully to ensure patient safety and continued delivery of services.

6. Conclusion and recommendations for board

6.1. The Board is asked to note the findings, the work undertaken to ensure preparedness and resilience and the planned actions to address partial compliance.

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	12
Date of Meeting:	18 January 2024		

Title of Report:	BSW ICB Corporate Risk Management
Report Author:	Yvonne Knight, Head of Risk & Information Governance
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	Appendix 1 – BSW ICB BAF Appendix 2 – BSW ICB Corporate Risk Register

Report classification	BSW ICB
ICB body corporate	Yes
ICS NHS organisations only	No
Wider system	Yes - BAF

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	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	x
2. Fairer health and wellbeing outcomes	x
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
ICB Executive Management Meeting	15/11/2023	Consideration of the ICB Corporate Risk Register
ICB Audit and Risk Committee	07/12/2023	Consideration of risk appetite; consideration of the BSW ICB corporate risk register
ICB Board (development session)	14/12/2023	Consideration of risk appetite; consideration of the BAF

ICB Executive Management Meeting	20/12/2023	Approval of Risk Management Group ToRs

1	Purpose of this paper

We have been continuing to make arrangements to strengthen the BSW ICB's risk management work and processes.

Executives agreed in December 2023 to establish a Risk Management Group (RMG) and approved its Terms of Reference. The RMG is envisaged as an advisory group to the Executive Group, and its focus will be the in-depth scrutiny of local risk registers and recommendations to Executive Group regarding the inclusion or de-escalation of risk to / from the corporate risk register. The RMG is expected to meet for the first time in January. The formal consideration of risk, by the RMG and Executive Group, is moving to a bi-monthly cycle, with the day-to-day management of risk undertaken at local levels.
The ICB's Risk Management Framework has been updated to reflect these arrangements. The document is available to Board members.

The Audit and Risk Committee, and the Board, both considered proposed risk categories and an ICB risk appetite statement, which will underpin the ICB's risk management approach going forward. The Board, during a development session in December 2023, applied the proposed risk appetite statement to its consideration of the Board Assurance Framework. We are now asking the Board to approve the risk appetite statement, for inclusion into the ICB's Risk Management Framework; and to approve the updated Board Assurance Framework.

We further present the latest approved BSW ICB corporate risk register which was considered by the Executive Group in November.

2	Summary of recommendations and any additional actions required

The Board is asked to:

- Approve the risk appetite statement, for inclusion in the BSW ICB Risk Management Framework;
- Note that the BSW ICB Risk Management Framework has been updated to reflect the amended operational risk management arrangements that have been introduced;
- Approve the latest version of the BAF, as updated following the Board's discussions in December 2023;
- Note the BSW ICB corporate risk register.

3	Legal/regulatory implications

The ICB is required to have, and is committed to maintaining, a sound and effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities, which supports the achievement of the ICB's objectives. Robust processes to identify and manage strategic and operational risks are an inherent part of such arrangements.

4	Risks
The absence of robust processes for the identification and management of risk will leave the organisation exposed and likely unprepared / incapable to deal with and respond to risks of any nature.	

5	Quality and resources impact
Please outline any impact on Quality, Patient Experience and Safeguarding: Finance: Workforce: Sustainability/Green agenda: All of the above could be impacted by a lack of robust processes to identify and manage operational and strategic risks.	
Finance sign-off	N/A

6	Confirmation of completion of Equalities Impact Assessment
N/A	

7	Statement on confidentiality of report
The Corporate Risk Register is not considered to be a confidential document. However, there may be specific risks that are considered confidential.	

Risk appetite

1. Risk appetite informs the target risk rating and identifies the amount of risk that we are prepared to accept, tolerate or be exposed to at any point in time. The ICB's risk appetite helps the ICB establish a threshold of impacts it is willing and able to absorb in pursuit of its objectives. Risk appetite – by defining how much exposure the organisation is willing to accept for the different categories of risk – provides a framework which enables the ICB to make informed management decisions.

2. Ultimately it is for the ICB to decide which risks it is prepared to accept. The Board of the ICB will agree the ICB's risk appetite; the Board will also agree the ICB's strategic objectives, identify the risks to achieving / fulfilling them, and agree its appetite for each risk identified to the achievement of the ICB's strategic objectives.

3. The Board will annually review the ICB's risk appetite. This review will result in a risk appetite statement. Risks throughout the ICB – whether these are risks to achieving strategic or corporate objectives, or risks relating to the ICB's daily operations – should then be managed within the ICB's risk appetite as stated in the risk appetite statement, or where this is exceeded, action should be taken to reduce the risk to within the ICB's risk appetite.

BSW ICB Risk Appetite Statement

4. We propose the following risk appetite statement for the Board's approval, and subsequent inclusion in the BSW ICB's Risk Management Framework:

    - The ICB will endeavour to adopt a mature[1] approach to risk-taking where the long-term benefits could outweigh any short-term losses and will work with strategic partners across the BaNES, Swindon and Wiltshire system to develop and review its risk appetite.

    - Such risks will be considered in the context of the current environment in line with the ICB's risk tolerance and where assurance is provided that appropriate controls are in place and these are robust and defensible.

    - The ICB will seek to minimise risks[2] that could impact negatively on the quality of commissioned services, health outcomes and safety of patients, or in meeting the legal requirements and statutory obligations of the ICB. We will also seek to minimise any undue risk of adverse publicity, risk of damage to the ICB's reputation and any risks that may impact on our ability to demonstrate high standards of probity and accountability. It is

[1] Good Governance Institute Risk Appetite for NHS Organisations – definition of 'mature' is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.
[2] Good Governance Institute Risk Appetite for NHS Organisations – definition of 'minimise' is preference for ultra-safe delivery options that have a low degree of inherent risk.

expected that the levels of risk the ICB is willing to accept are subject to regular review.

Category of Risk	Appetite
Performance and Delivery	Medium
Engagement and Partnership Working	Medium
Workforce	Medium
Finance	Medium
Quality	Low
Safety	Low
Regulation and Governance	Low

5. We propose that this risk appetite statement is supplemented by more detailed risk appetite statements for the individual risk categories. We seek the Board's support for the statements over the page, and will append these to the BSW ICB's Risk Management Framework.

Risk Appetite by Risk Category

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
Quality	Risks to maintaining and improving quality, and risks to compliance with quality standards including regulatory and performance standards. Risks to the quality of the patient experience.	We have a **LOW** appetite for quality risk. We will always seek to reduce the quality risks of any action and will usually choose actions that have low levels of quality risk. In some circumstances we are prepared to accept the possibility of a short-term / low level impact on some quality outcomes if there is the potential for longer-term / higher level benefit. For example, we may make a decision that could have an impact on service user experience if we believe it will result in improved health outcomes. We will actively manage risk and contribute to the evidence base for quality improvement. We will prioritise meeting patient safety and regulatory standards.	Low
Safety	Risks to patient safety, and effectiveness of treatment and care. Risks to staff safety.	We have a **LOW** appetite for risks to patient safety, and staff safety. We will always seek to reduce the risk by focusing on the issues that lead to decreased safety. We accept that on occasion this may mean adopting approaches that may have an impact on performance. We are prepared to seek innovative approaches to improving the effectiveness of treatment and care. determinants	Low

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
		of health where this has the potential to meet our objectives.	
Regulation and Governance	Risks to compliance, and the ability to demonstrate compliance, with regulatory standards; legal standards; standards of business conduct and governance (including Information Governance); statutory duties including those related to delegated functions.	We have a **LOW** appetite for risks to governance and regulation. We will always seek to reduce the risk by acting in an open and transparent way and with integrity. We will prioritise transparency in decision making and identify and manage conflicts of interest to ensure probity in all aspects of our operation. We recognise that delivering our objectives may requires us to challenge orthodoxies around regulatory requirements in the interests of "doing the right thing." We expect to have very clear and proactive communication with regulators to secure their support. We will ensure we put in place the culture, systems and processes that enable us to take an innovative approach whilst meeting regulatory and governance standards and delivering our statutory duties.	Low
Finance	Risks to all areas pertaining to finance and financial control including financial sustainability.	We have a **MEDIUM** appetite for financial risk. We will seek to minimise these risks by operating robust financial controls, harnessing the benefits of joint working and looking at improving utilisation of assets and resources across the system. We are prepared to accept some financial risk when this is associated with actions that could improve productivity and value for money and/or capitalise on opportunities to accelerate or increase benefits.	Medium

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
		We are willing to invest differentially to target initiatives and reduce inequalities and we understand that implementation of innovations needs to be adequately resourced. We also understand that adequate time needs to be allowed before assessing the implementation as there may be a lag between the implementation and the desired results. We are willing to address difficult conversations about finances openly and directly, engaging with implications and risks connected to finances in an integrated way. We are looking for joined up system financial management, which takes account of the differing financial requirements and constraints of system partners.	
Workforce	Risks to capacity and capability, and to sustaining a skilled and effective workforce. Risks related to staff recruitment and retention, training and development (including succession planning) and organisational morale and culture.	We have a **MEDIUM** appetite for workforce risks. We would always seek to minimise workforce risks by focusing on actions that could improve the effectiveness, resilience and morale of our workforce and people's satisfaction with their experience of using health and care services. We are prepared to adopt innovative ways of working even where these require us to adopt new employment practices or challenge cultural norms which may carry high workforce risks. We are particularly interested in approaches that:	Medium

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
		• Encourage multi-disciplinary and cross organisations working e.g., creating joint posts • Create sustainable ways of recruiting, training and retaining staff across organisations/sectors • Enable us to align services with population needs and address inequalities e.g., by moving services into the community, • Increase efficiency, productivity and value for money	
Performance and Delivery	Risks to developing robust plans and / or delivering agreed system plans / priorities, including the required transformation programmes that ensure the delivery of equitable and improved outcomes for the citizens of BaNES, Swindon and Wiltshire. Risks to the commissioning of appropriate services that meet the population's needs.	We have a **MEDIUM** appetite for performance and delivery risk. We will seek to minimise these risks by using data and modelling, and by operating robust system planning processes, and equally robust system performance and delivery controls. We will encourage partners to use / adopt outcomes of research as well as innovations where this supports and drives delivery and performance. We are prepared to accept some delivery risk when this is associated with actions that could improve performance and productivity in the longer term.	Medium
Engagement and	Risks to effective engagement, involvement and communication with patients, carers, the public,	We have a **MEDIUM** appetite for risks to our relationships and engagement with partners and stakeholders, and our involvement of the public.	Medium

Risk category	Descriptor	Risk appetite - narrative	Risk appetite - summary
Partnership working	clinicians and all other stakeholders. Risks to partnership working with wider ICS partners.	We will seek to minimise these risks by working proactively with our citizens and our partners to develop our priorities and co-design and deliver transformation. We are prepared to lead difficult discussions and / or making decisions which may be unpopular, and which may carry a high risk of affecting our reputation, where this is in the interest of “doing the right thing” and delivering benefits to our population.	

Appendix 1

BSW ICB Board Assurance Framework

Summary view

BAF Risk	Current risk score	Target risk score
SO1.1, BSW ICS is unable to create the right conditions and incentives for all BSW residents to stay healthy	16	9
SO2.1, BSW ICB does not put reducing inequalities at the heart of all its activities	16	9
SO3.1, BSW ICB is unable to meet the additional healthcare demands and deliver our operational plan	16	12
SO3.2, BSW ICS is unable to recruit and retain suitably qualified staff	20	12
SO3.3, BSW ICS is unable to reduce its expenditure to address its underlying financial deficit	20	15
VE1.1, BSW ICB and partner health and care organisations in BSW do not work more effectively in partnership	12	6
VE1.2, BSW ICB and partner health and care organisations in BSW do not focus on those things that impact most on health outcomes	16	3
Risks removed from active BAF monitoring		

SO = Strategic Objective, numbered per the detailed BAF

Risk scoring matrix underpins BAF and corporate risk register.

	Likelihood				
Impact	**1 Rare** *will probably never happen/ recur*	**2 Unlikely** *not expected to happen but possible*	**3 Possible** *might happen / recur occasionally*	**4 Likely** *will probably happen / recur, but it is not persisting*	**5 Certain** *will undoubtedly happen / recur, possibly frequently*
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Insignificant	**1**	**2**	**3**	**4**	**5**

BSW ICB BAF

The BSW Integrated Care System (ICS) vision is “Working and listening effectively together to improve health and wellbeing.”

The BSW ICS strategic objectives (set over the five years 2023-2028) are:

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

As a key partner and enabler in the ICS, BSW ICB adopts the ICS strategic objectives as BSW ICB strategic objectives. This BSW ICB BAF articulates risks, from the ICB’s perspective, to achieving the ICB strategic objectives, and to the achievement of the BSW ICS vision as set out in the BSW Integrated Care Strategy .
We recognise that over time, it may be appropriate to develop a BSW ICS Assurance Framework to identify and oversee system risks to the achievement of the ICS strategic objectives.

Risk ref	Key risk to achieving strategic objective	Accountable (in bold)/ responsible* (See note)	Assurance committee	Current risk score	Target risk score & date	Controls	Assurance	Gaps in controls and assurance	Planned actions and target completion date
Strategic objective 1: Focus on prevention and early intervention									
SO1.1	There is a risk that BSW ICS is unable to create the right conditions and incentives for BSW residents to stay healthy – including through actively addressing the wider determinants of health. This means that we will not prevent disease, injury or ill-health, or avoidable complications associated with long-term conditions. This will then lead to increased and additional healthcare demands, and jeopardise BSW’s ambitions and plans for sustainable, equitably accessible, high-quality health and care services, and will continue to lead to long waits for treatment and poorer outcomes.	**Chief Medical Officer** CMOs of NHS Trusts Non-NHS partners e.g. LAs	Quality & Outcomes Committee	**16**	**9** 31/03/2027	Implementation of our Integrated Care Partnership Strategy through appropriate delivery mechanisms that include all partners. Development of our System Implementation Plan that sets out the things we plan to achieve for the next five years. Development of our Primary and Community Care Delivery Plan. Agreement and clarity which partners lead on the delivery of the elements of our strategy and plans. Monitoring of work undertaken to deliver our strategy and plans, including through the appropriate existing ICB and partner governance arrangements.	**First Line of Assurance** • Prevention and early intervention activities report • Workforce report • Routine Quality Monitoring and Triangulation by Quality Team • Performance Dashboard • Monthly Key Lines of Enquiry for areas of underperformance / concern **Second Line of Assurance** • Reports to ICB Quality and Outcomes Committee: o Integrated Performance Report o Integrated Provider Report • Reports to ICB Finance and Investment Committee o Performance Report o Annual Operating Plans **Third Line of Assurance** • National System Oversight Framework • NHSE Quarterly System Review Meetings	• Quality Strategy • Quality Assurance Framework	• Develop Quality Strategy • Develop Quality Assurance Framework
Strategic objective 2: Fairer health and wellbeing outcomes									
SO2.1	There is a risk that BSW ICB does not put reducing inequalities at the heart of all its activities, and work closely with partners in order to deliver on its plans. This will mean that we will continue to see reduced opportunities and outcomes for	**Chief Medical Officer** LA DPHs CIOs of NHS Trusts	People and Community Engagement Committee Quality & Outcomes Committee	**16**	**9** 31/03/2027	Implementation of our Health Inequalities Strategy and Plan, and of the Population Health Roadmap 2022-27, through appropriate delivery mechanisms that include all partners. System and partners’ strategies and plans support the delivery of	**First Line of Assurance** • Routine progress reports from key workstreams, such as Population Health Management • Regular Population Health Management Workstream Update to the Population Health Management Group		

Risk ref	Key risk to achieving strategic objective	Accountable (in bold)/ responsible* (See note)	Assurance committee	Current risk score	Target risk score & date	Controls	Assurance	Gaps in controls and assurance	Planned actions and target completion date
	our population incl. re prevention and early intervention.	LA DAS/DCS leads for BCF				the Health Inequalities Strategy and Plan. Joint Strategic Needs Assessments inform any recalibrations of plans and delivery. Monitoring of work undertaken to deliver strategy and plans, including through the appropriate existing ICB and partner governance arrangements. Population health data, and wider relevant population indices and data, provide objective measures to check achievement of strategies and plans.	• Regular Inequalities Workstream Update to the Population Health Management Group **Second Line of Assurance** • Population Health, Inequalities and Prevention Programme Report to Quality and Outcomes Committee		
Strategic objective 3: Excellent health and care services									
3.1	There is a risk that we are unable to meet the additional healthcare demands and deliver our operational plan, causing patients and residents to wait longer for treatment, and this will result in poorer outcomes	**Chief Delivery Officer** COOs of NHS Trusts	Quality & Outcomes Committee	**16**	**12** 31/12/2026	Implement our System Development Plan and Winter Plan through appropriate delivery mechanisms that include all partners. Agree deliverables, and monitor work undertaken through the appropriate existing ICB and partner governance arrangements. Performance data and population health data provide objective measures to check achievement of strategies and plans.	**First Line of Assurance** • Routine Quality Monitoring and Triangulation by Quality Team • General Practice Appointment Data Monitoring • Performance Dashboard • Monthly Key Lines of Enquiry for areas of underperformance / concern • Monthly Oversight System Review Meetings • Monitoring and oversight by command structure **Second Line of Assurance** • Reports to ICB Quality and Outcomes Committee: o Cancer and Planned Care Report o Urgent and Emergency Care Report o Integrated Performance Report o Learning Disability and Autism Assurance Report o Local Maternity and Neonatal System Report o Integrated Provider Report • Reports to ICB Finance and Investment Committee o Performance Report o Annual Operating Plans **Third Line of Assurance**	• CQC System Assessment • Quality Strategy • Quality Assurance Framework	• Develop Quality Strategy • Develop Quality Assurance Framework

Risk ref	Key risk to achieving strategic objective	Accountable (in bold)/ responsible* (See note)	Assurance committee	Current risk score	Target risk score & date	Controls	Assurance	Gaps in controls and assurance	Planned actions and target completion date
							• National System Oversight Framework • NHSE Quarterly System Review Meetings		
SO3.2	There is a risk that the ICS is unable to attract, recruit and retain suitably skilled staff so that we will be unable to deliver our desired levels of care and the future transformation to our services.	**Chief People Officer** LA workforce leads CPOs NHS Trusts	People Committee	**20**	**12** 31/03/2026	Implementation of our People Strategy, and our Short- and Long-Term Strategic Workforce Priorities. Delivery through appropriate delivery mechanisms that include all partners. Monitor work undertaken through the appropriate existing ICB and partner governance arrangements. Workforce data provides objective measures to check achievement of strategies and plans.	**First Line of Assurance** • Workforce dashboard **Second Line of Assurance** • Strategic Workforce Priorities Progress Report to the ICB People Committee **Third line of Assurance** • NHSE workforce data and assurance meetings	• System-wide Strategic Workforce Priorities	• Develop Strategic Workforce Priorities and implement monitoring arrangements • Develop focus and interventions to encourage and enable collaborative working on system-wide workforce challenges amongst CEO's, CNO's, CPO's and Workforce Leads across the system
SO3.3	There is a risk that we are not able to reduce our expenditure to address our underlying financial deficit. This means that we will not be financially sustainable and will be unable to meet the health and care requirements of its patients. This will then impact our ability to deliver more joined-up, preventative, and person-centred care for our whole population, across the course of their life.	**Chief Finance Officer** CFOs NHS Trusts CFOs LA	Finance and Investment Committee	**20**	**15** 31/03/2026	Implementation of our System Financial Strategy, Financial Revenue Plan, Financial Capital Plan, Efficiency and Transformation Plans, and Estate Programme. Arrangements to control system spend are in place; also NHSE monitoring and SOF. Monitor work undertaken through the appropriate existing ICB and partner governance arrangements. Financial data provides objective measures to check achievement of strategies and plans.	**First Line** • Monitoring delivery of System Financial Strategy and Financial Plan • Standing Orders, Standing Financial Instructions and Delegated Financial Limits • Financial Accounting Performance Metrics • HFMA Financial Sustainability Checklist • Better Payment Practice Code • Productivity review informed by: o Getting It Right First Time (GIRFT) o Model Health System **Second Line** • Finance Report to Finance and Investment Committee • Integrated Performance Dashboard to the ICB Board **Third Line** • Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE • Quarterly NHSE Financial Stocktake	• Integrated Care System Estates Strategy • Efficiency and Transformation Programme Plans	• Develop Integrated Care System Estates Strategy through the ICB governance via Finance and Investment Committee • Develop Efficiency and Transformation Programme Plans

Risk ref	Key risk to achieving strategic objective	Accountable (in bold)/ responsible* (See note)	Assurance committee	Current risk score	Target risk score & date	Controls	Assurance	Gaps in controls and assurance	Planned actions and target completion date
							• NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning		
Vision element 1: Working and listening effectively together									
VE1.1	There is a risk that ICB and partner health and care organisations in BSW do not work more effectively in partnership, and that we will fail to deliver joined-up support across our health and care services that better meets the needs of the population.	**CEO** CEOs partner organisations	People and Community Engagement Committee	**12**	**6** 31/03/2027	All partners engage and involve the BSW population in the development of strategies and plans. Partners share and align, where possible, learning and outcomes from public engagement and involvement. The ICP is the key forum for exchange, learning, and agreement of system vision and strategy – for partners and key stakeholders alike.	**First Line of Assurance** • Ongoing involvement with Healthwatch as well as the Voluntary Community and Social Enterprise • Joint Strategic Needs Assessments **Second Line of Assurance** • Population Health, Inequalities and Prevention Programme Report to ICB • Quarterly Communications and Engagement update to ICB People and Community Engagement Committee	System people and community involvement and engagement strategy and plan System stakeholder engagement strategy and plan	Develop System people and community involvement and engagement strategy and plan Develop System stakeholder engagement strategy and plan
Vision element 2: Improve health and wellbeing, and reduce inequalities									
VE2.1	There is a risk that BSW ICB and partner health and care organisations do not focus on those things that impact most on health outcomes and we will not make a significant difference in the health and wellbeing of the people of BSW. This will then impact our ability to deliver more joined-up, preventative, and person-centred care for our whole population, across the course of their life.	**CMO** LA partners with housing, economic development, education portfolios LA DPHs	People and Community Engagement Committee	**16**	**3** 31/03/2027	Implementation of our Integrated Care Partnership Strategy through appropriate delivery mechanisms that include all partners. Agreement and clarity which partners lead on the delivery of the elements of our strategy and plans. The ICP holds all partners to account for the delivery of the Integrated Care Partnership Strategy.	**First Line of Assurance** • Ongoing involvement with LAs and LEPs as well as the Voluntary Community and Social Enterprise • Joint Strategic Needs Assessments **Second Line of Assurance** • Quarterly Communications and Engagement update to ICB People and Community Engagement Committee		

***Note: Accountable /** Responsible**:**
‘Accountable’ in bold font = usually an ICB Executive and occasionally more than one.
‘Responsible’ in normal font = could be an ICB Executive and/or a partner and may often be more than one.

BSW ICB Corporate Risk Register

Risk no.	Risk Category	Risk Entered Date	Risk name	Bodies affected by risk	Executive Risk Owner	Risk Manager	Reviewing Committee or Group	Date of last review	Likelihood	Impact	Latest risk score	Change in risk rating since last reviewed	Target risk score	Risk Treatment	Description of risk including event, cause and consequences	Existing controls	Assurances, and gaps in assurance	Mitigations	Mitigation owner	Target dates for mitigations to be in place	Mitigations RAG	Residual Likelihood	Residual Impact	Residual Risk Score
BSW ICB 01	Public, patient, and staff safety including clinical harm	23-Sep-22	Insufficient capacity across urgent and emergency care and flow leading to reduction in system flow.	ICS NHS organisations and partner organisations	Gill May, Chief Nurse Officer	Heather Cooper, Director of Urgent Care and Flow	Urgent Care & Flow Board; Quality & Outcomes Committee	11-Sep-23	5	4	20	↔	12	Treat	Demand and Capacity planning has identified there is a shortfall in capacity to safely meet the demand across health and social care resulting in continued periods of escalation, continued high numbers of patients who do not have a criteria to reside, delays in all parts of the system resulting in inadequate performance and sub optimal patient experience. Whilst there have been some improvements in NCTR numbers, this is attributable to seasonal variation.	* System Demand and capacity modelling through the System Demand and Capacity Steering Group. System wide escalation plans in place. Shrewd system alerts us with a live performance and use of capacity position. * Weekly UEC Tactical urgent care meetings, that are increased in frequency as required. *UEC recovery planning process. * KLOE assurance processes completed as required (UECBAF). Reporting to Quality and Outcomes Committee and Board as required.	Actions from the SD&CG fed to the localities and vice versa. Goes to Urgent Care & Flow Board. * Urgent care and flow board has oversight of all elements of urgent care and flow. Monthly reporting on all elements of urgent care and flow from localities to system, to Execs and the ICB Board. Winter Learning events to take place in April has identified learning opportunities and gaps to consider for Winter Planning 23/24. BSW wide Demand and capacity model in place which the localities use.	Locality discharge from hospital plans to deliver additional capacity supporting ASC discharge funding and discharge funding. UEC recovery plan for 2023/24 covering the 5 areas of focus: increasing capacity; increasing workforce size; improving discharge; expanding care outside hospital and; making it easier to access the right care reporting to UC&FB. Guidance and policies to support decision making for front line staff. Additional capacity been identified in Wiltshire to be presented to the ICB Recovery Board. BSW ICB have completed self assessment against the national 10 high impact interventions ahead of Winter to identify opportunities for further improvement. Now have the 4 areas of focus: ARI hubs; acute internal improvements; SDEC; and frailty.	Heather Cooper, Director of Urgent Care and Flow	National target to have plans in order by the end of September 2023. Plans will be iterative and will be monitored.	Amber	4	4	16
BSW ICB 02	Finance	28/10/2022	Non Delivery of the ICS NHS finance and operating plan for 2023/24 and that the ICS does not hit its statutory obligation to meet its annual control target.	ICS NHS organisations	Gary Heneage, Chief Finance Officer	Budget Holders	Finance & Investment Committee	05-Oct-23	5	4	20	↔	12	Treat	The risk is that the ICS (which includes the ICB, RUH, SFT and GWH and Place) are unable to deliver on the interventions to enab a break even position for 23/24. There has been a significant amount of non recurrent funding used to balance the 22/23 position and this will not be available in 23/24. Failure to meet a balanced control total could result in undertakings, SoF ratings, and further conditions imposed by NHSE. There continues to be uncertainty regarding the non consolidated 22/23 NHS pay award and the guidance concerning non-NHS organisations. The ICB continues to follow national guidance, which is not to pay, as the award only related NHS Employers.	System DoFs group Coordinated system planning process System Oversight group Provider membership of ICB Board Finance Committee discuss risks. Board escalation, by exception. NHSE Forecast Protocol in place (adopted voluntarily).	Regular and timely DoFs meetings to discuss finance across the system, which generates actions plan. System Planning Group in place to develop the Operating Plan for 2023/24. Finance Summit involving system CEOs and DoFs (January 2023). System partners are responsible for their own organisational plans. Annual Plan (balanced by system and by organisation) submitted by March 2023. External financial support has been engaged to support action plan 2 Year Recovery ICS Programme and signed off by Board. Financial Recovery Board set up.	1) 5 year planning process already started to understand what the financial position is over the next 3-years (best practice). 2) Understanding the underlying position and actions to be taken reported to Board meeting. 3) Agree system planning assumptions and instructions 4) Financial Recovery Specialist appointed and in place. 5) Financial Recovery Board, meets every 2 weeks, attended by all CFOs, CEOs, Programme Leads. 6) Financial Protocol conditions work is ongoing. Collated a system position, detail to be undertaken by Workforce Group.	System DoFs.	1) On-going refresh, updated regularly. First iteration expected during 2023/24.2023/24 Annual Plan submitted by March 2023. 2) On-going reporting. 3) On-going. 4) Q1 23/24 Appointed 5) Meets every 2 weeks, on-going reporting. 6) On-going.	Amber	5	4	20
BSW ICB 03	Capacity, Capability, Quality and Patient Experience	01-Dec-20	Hospital handover delays	ICS NHS organisations	Gill May, Chief Nurse Officer	Heather Cooper, Director of Urgent Care and Flow Emma Smith, Head of Urgent Care Helen Harris, Urgent Care Quality Lead	Urgent Care & Flow Board; Quality & Outcomes Committee	11-Sep-23	5	4	20	↔	6	Treat	There are significant ambulance handover delays at acute trusts due to challenges with system flow. The requirement is to offload patients within 15 minutes, which is not currently being achieved. This leads to long waits for patients on ambulances contributing to patient harm, along with delays in patients receiving a timely 999 response. The impact is sub optimal experience for patients, families and carers there is a delay in conveyance and a moral injury to staff, both ambulance crews and hospital staff. The UEC Recovery Plan has an ambition that systems support an Ambulance Cat 2 mean response of 30 minutes in 2023/24 and SWAST have indicated to achieve this mean, an average handover delay needs to be no more than 40 minutes. Whilst we are under our trajectory, as a result of improvements in flow due to the reductions in NCR, there are still variations in handover delay.	* SWAST Escalation Plan and associated SOPs. Providers have escalation plans in place to support. System Demand and Capacity modelling in place. Tactical meetings (see above). Implementation of care coordination to support non conveyance, business case being developed. Each acute offers a rest area for crews with refreshments, HALO in place for clinical prioritisation for patients who are queuing for offload. Patients waiting in ambulances are closely monitored and offered refreshments. Daily bed flow meetings with clear SOPs in place. 100 Day Challenge actions, implemented and monitored. BSW 2023/24 Ambulance handover trajectory has been developed and monitored on a weekly basis.	* Oversight of SWAST performance Ambulance Governance meetings - AJCC , FICSC, QASC, TIG, CAG. * BSW Urgent Care and Flow Board and QAC oversight at UEC Tactical. * Monitoring of harm through incidents, clinical harm reviews and end to end reviews. * EQIA accompanying all surge decisions.	1. BSW Care Coordination model extended until end of March 2024. 2. Revised SWAST Strategy being socialised in the UEC system and updated Transformation plan is being developed. This includes Cat 2 implementation plans. 3. Additional capacity has been funded nationally to improve Cat 2 response times. 4. Discharge to Assess Programme at UC&FB which will improve system flow. 5. Task & Finish Group to facilitate discharges across 7 days. Complete. 6. Ambulance co-horting areas established as a standard. 7. Regional Ambulance Handover Data Quality Improvement Group set up. 8. All providers to review their practices against good practice guidance and identify their own internal actions. 9. BSW ICB have completed self assessment against the national 10 high impact interventions ahead of Winter to identify opportunities for further improvement. Now have the 4 areas of focus: ARI hubs; acute internal improvements; SDEC; and frailty. 10. BSW Ambulance Working Group has been established and reporting to UCFB, which will explore further opportunities to reduce handover delays.	Heather Cooper, Director of Urgent Care and Flow Emma Smith, Head of Urgent Care Helen Harris, Urgent Care Quality Lead	Reviewed on a monthly basis at UCFB and also through AJCC. Score to be reviewed next month re: performance. We did not achieve the trajectory for June although we are expected to for July. There are lower levels of confidence to achieve the trajectories as we move into the Autumn and Winter.	Amber	4	4	16
BSW ICB 06	Capacity and Capability, Quality and Patient Experience	19-Jan-22	Workforce and Resilience	ICS NHS organisations and partner organisations	Jas Sohal, Chief People Officer	System HR Leads & ICB HR Leads	People Committee Strategic Workforce Group Recovery Board	25-Oct-23	5	4	20	↔	9	Treat	Staff vacancies are very high with a heavy reliance on temporary workforce, particulalrly agency staff, which could result in a lack o availability of staff to meet the high demand of services. There is also a national expectation to reduce premium spend associated with bank and agency staffing to 3.7% of total pay-bill 2023-24. This together with a difficulty to recruit and retention due to other industries able to pay higher wages and therefore attract a potential NHS workforce. Compounded by the current cost of living crisis. As a system we do not have a process to identify and deploy staff to maximise their impact according to patient need. Surge plans are based on individual organisation surge plans. System wide surge plans are not in place and this needs systemwide CEO commitment and drive to mitigate and achieve solutions, including system surge plans to allow for inter-organisation workforce flexibility. With staff sickness levels still remaining high, this is compounding the situation. The risk to the ICB is that services commissioned by the ICB fail to be delivered effectively. These risks affect all of the following sectors: Providers in Acute, Community, Mental Health and Primary Care Social Care / Domiciliary Care Virgin Care / Medvivo	**Short term controls:** Local risk management process for staffing. **Medium term controls:** Systemwide recruitment and retention initiatives including international recruitment. E.g. Career Navigators, wellbeing initiatives and development of middle managers. Plans to be developed in how to tackle staff absence. BSW NHS Employers have existing controls in place over agency and non-framework agency usage. Current system wide bank and agency usage programme being scoped. **Longer term controls:** Working alongside health and social care partners to develop more flexible career paths and consistent remuneration packages. Strategic workforce priorities to be developed systemwide. Programme plan in place to enact in order of priorities, as part of the recovery work. Priorities agreed and programme of work to be agreed with partners.	Surge planning, Community Hub approaches. Local Health & Wellbeing Support in organisations plus the BSW H&WH (Hub). Implementation of international recruitment progressing rapidly with recruitment process currently being finalised. Career navigators now recruited to support on-going retention initiatives and undertake / lead on 'itchy feet' conversations. Development of system wide surge plans. Working closer with the Nursing Directorate the Academy Group is looking at a talent pipeline and career opportunities. As a system the ICB Resourcing and Recruitment team have developed an NHS partner programme of work, to include grip and control, control of off-framework usage, an enhanced bank offer and a collaborative rate card. NHS Partner organisations assurance to system that their individual processes and controls are sufficient to meet 2023-24 National target of 3.7% for agency spend.	**Short / Medium term:** Strategic Workforce Lead in place who will identify workforce risks and gaps to support workforce mapping and planning. A System Workforce Plan as part of the Operating Planning Process and Narrative and Numerical Workforce Plans being developed. Identified hotspots will inform further inventions to mitigate against the risk. **Longer term:** Operational Working Groups reporting progress on workstream to the Strategic Workforce Group (SWG) which reports to the People Committee, which is a formal sub-committee of the ICB Board (on-going monthly activity). Participation in longer term workforce planning - 10 year plans, utilising supply tool. Due to the reliance on a collaborative approach to addressing workforce priorities, likelihood and impact of this risk will be reduced once programme agreed and implemented. NHS Partner Chief People Officers, PA Consulting meeting with ICB Leads to discuss and agree next steps to implement a system wide process.	Chief People Officer BSW Strategic Workforce and Intelligence Lead Chief People Officer	30/10/2023 31/03/2024	Amber	4	4	16
BSW ICB 12	Quality and Patient Experience	30-Mar-23	Community Services Commissioning	ICS system organisations	Fiona Slevin-Brown, Director of Place Wiltshire, Exec Lead Community Services	Anna Field Programme Director for Integrated Community-Based Care Programme	ICB	14-Aug-23	4	5	20	↔	9	Treat	There is a risk that the ICB Community Services recommissioning and transformation programme is not effectively organised or sufficiently resourced resulting in key timelines not being met with the potential for reputational, financial, quality, outcomes, legal challenge and delivery risks. There is a risk of misalignment between ICB and LA commissioning, governance and procurement approaches resulting in fragmented provision, delay in decision making with potential impacts on patient care. Lack of clear direction and pace with the programme may have an impact in the short term with uncertainty leading to delays or hindering of ongoing transformation activities, system-wide staff retention issues, and deterioration in performance standards	Current controls include: 1) Programme Structure in place including Programme Board chaired by ICB and reporting through ICB Governance arrangements 2) ICB executive leadership 3) Outsourcing of support for the completion of the Strategic Outline Business Case and September Decision paper 4) Collaborative commissioning arrangements with LA Commissioning partners underpinned by local arrangements 5) Access to legal advice to support decision making 6) Defined budget for the Programme to enable access to SME advice and input as needed 7) Additional leadership capacity recruited (new SRO) now started 8th May 23. 8) Close working between ICBC Programme team and Place teams, strengthened through new Commissioners Group 9) Full governance structure established to support the preparation for a provider selection process	Gaps in Assurance: Effective and robust communications and engagement activities are essential to the smooth running of the programme, and the delivery of the anticipated outcomes for the population and staff. Programme resourcing requires strengthening as this is a limiting factor in enabling delivery within the required timeframes. Recognised gaps in resourcing currently within the Programme team and also Comms and Engagement in particular.	1. Review of Comms and Engagement resources and plan in development 2. Programme resourcing being reviewed in discussion with the CSU to ensure best practice structures and sufficient capacity and capability to optimise success. Recruitment to permanent Project Manager post, with a view to starting September 2023. 3. Commissioning arrangements post April 2024 being determined with a proposal going to July ICB Board to ensure continuity of provision. 4. Use of business case process to support system alignment - need to secure extension of existing contract with external partner 5. Partner engagement within market engagement events 6. Public engagement as a part of Community Based Care Implementation Plan development 7. Place Directors are working with local authorities to work through timelines re: governance and collectively there will be careful wording of their recommendation for the ICB Board. 8. Making sure that the decision making paper and supplementary information is available for the ICBC Programme Board to consider and sign off. 9. Agreement with LAs of the principles that underpin our approach to this programme.	1 -7) Anna Field, Programme Director	1. August 2023 2. CSU from July 2023, permanent post September 2023. 3. July 2023 4. August 2023 5. Ongoing 6. August 2023 7. August 2023 8. September 2023 9. August 2023	Amber	3	5	15
BSW ICB 14	Finance	07-Aug-23	Sufficiency of capital funding for the ICB and system	ICS NHS organisations	Gary Heneage, Chief Finance Officer	Directors of Finance	Finance & Investment Committee	05-Oct-23	5	4	20	↔	12	Treat	Resources aligned by organisations to deliver system priorities. Failure could result in finite resource being spent on schemes that don't support the delivery of system objectives or create revenue pressures which add to the system underlying deficit and ongoing savings requirements. Need for system ownership, coordination and monitoring.	1) Capital plan 2) Assurance and decision making group 3) PID process 4) Capital plan (3yr-5yr) 5) Finance and Investment Committee oversight	1. ICB Finance capital role in place 2. Capital Group 3. Business cases now coming to ICB Finance Committee 4. Capital plan required as past of MTFP. Comprehensive capital report October F&I committee. 5. Developing system vs organisational monitoring and reporting capabilities	1) ICB capital role in place (to 2024) 2) Capital assurance group 3) Finance Committee oversight 4) Capital plan (3-5year) 5) In development	System DoFs.	Ongoing. Comprehensive capital report for September F&I committee.	Green	5	4	20
BSW ICB 19	Quality and Patient Risk	06-Oct-23	CHC Performance Targets	ICS system organisations	Gill May, Chief Nurse Officer	Sarah- Jane Peffers, Associate Director of Quality and Patient Safety	Quality and Outcomes	06-Oct-23	5	4	20	↔	8	Treat	There is a risk that the ICB will not achieved the expected national CHC targets. This is caused by insufficient capacity and limited systems and processes in place and would result poor patient experience and additional oversight by NHSE with an expected improvement plan to be agreed and delivered which may require additional resource.	Policies, Operational Leadership	Gaps- IT infrastructure to capture timely data to continually support performance 12 WTE vacancies Exhausted workforce SOPs agreed across all 4 CHC/ FNC functions Social work capacity	Improvement Plan developed: UB Healthcare to support capacity and demand gap Recruitment plan- All Vacancies agreed, advertised and recruitment has started Working with HR colleagues to design and deliver a focused OD programme. SOPs in development Business case for New IT E2E solution	Kirstie Jackman	Apr-24	Amber	5	4	20
BSW ICB 08	Capacity and capability	24/11/2022	There is a risk that we will not have sufficient MH trained staff to deliver effective and responsive core services across our system	ICS system organisations	Gordon Muvuti, Swindon Place Director	Jane Rowland/ workforce subgroup chair	Thrive Programme Board People Committee	08-Aug-23	4	4	16	↔	12	Treat	There is a risk that current vacancy rates across all providers will make it challenging to deliver and maintain effective and responsive core mental health provision. This is evidenced through high vacancy rates in Swindon CAMHS, within AWP (c. 1000 vacancies). A lack of trained staff means that we have had to implement business continuity arrangements in some services, B&NES intensive and crisis services. This impacts on our ability to provide consistent liaison cover to acute hospitals. Existing staff end up with higher caseloads and longer waiting times for treatment for patients.	Thrive Programme Board oversees all aspects of MH delivery BSW MH Workforce Planning Group established Regular review calls with partners to identify mitigations to existing challenges Business continuity arrangements in place for specific areas of challenge	Workforce Planning as part of Operational Plan in partnership with People Directorate colleagues. Business Continuity Plans shared with system partners. International Recruitment within AWP. AWP - 10 Trainee Nurse Associates joined from October 2022 (pan AWP) AWP - expanding Mental Health and Wellbeing Practitioner roles by a further 18 (pan AWP) in 2022/23 and in partnership with Health Education England through their training programme AWP - Clinical Associate Psychologist roles - further 8 roles to be recruited in 2022/23 to expand existing workforce. Registered Nurse Degree programme in place. Trainee Nursing support programme in place in partnership with Oxford Brookes and UWE.	New roles established to improve vacancy rates. This includes 1) AWP Multi-professional Approved Clinicians (MPAC). 2) AWP implementation of retention strategy with multiple support processes in place including wellbeing support offer (use of Wellbeing Hub for staff funded by NHSE) ongoing implementation. 3) AWP Healthcare Support Worker (HCSW) recruitment - 126 offers made on the day in May 2022, target number of posts to be filled by March 2023 is 211 (pan AWP so incl. BNSSG) 4) AWP - Scoping Physician Associate roles for plan to be implemented from 2023/24 5) Oxford Health - Vacancy rate of 31% as at October 2022 - new roles including social work and OT apprentices, clinical associate psychologists and nursing associates being piloted 6)Oxford Health - new supervisory roles being implemented during 2022/23 (Band 7s supervising teams of Band 4 staff) 7) Oxford Health - implementation of Healios (digital platform) to mitigate staff shortages and maintain access target	Julian Feasby, Director of HR, AWP. Andrea Shand, Associate Director for BSW CAMHS, Oxford Health.	1) On-going recruitment 2) On-going 3) On-going 4) March 2024 5) On-going 6) On-going 7) On-going	Amber	3	4	12
BSW ICB 09	Capacity and capability	12/05/2021	There is a risk that elective care capacity will not recover as planned.	ICS system organisations	Rachael Backler, Chief Delivery Officer	Mark Harris, Director of Commissioning	Elective Care Board & Elective Recovery Sub-Group	27-Oct-23	4	4	16	↔	8	Treat	There is a risk that elective care capacity will not recover as planned or to the extent required, where assumptions and actions do not deliver the impact anticipated; or where additional factors such as urgent care pressures impact on capacity. As a result there is a risk that the BSW system will not eliminate over 65 weeks waits by March 2024. There is a risk that the operational plan requirements related to additional capacity in 23/24 will not be met, resulting in under-achievement of ERF income versus financial plans. There is additional pressure on this target due to the ongoing industrial action. Additionally there is a risk that diagnostic performance will not achieve the regional target of 85% by March 2024 seen within 6 weeks.	Weekly long wait end of month forecasts submitted to NHSE for 65 week waits and reviewed to inform local response and mutual aid / capacity concerns. Mutual aid opportunities between acute providers and joint working of service teams in hot spot specialties reviewed fortnightly. Weekly elective care activity report. Elective Recovery Group (sub group of Elective Care Board) fortnightly review. NHSE and ICB joint assurance reviews of performance and action plans for diagnostics. Elective Care Board monthly review. Individual contractual discussions with Independent Sector Providers (not represented on Elective Care Board). Memorandum of Understanding in place within all IS provider contracts to support requests for mutual aid. All three acute providers participating in the new NHSE led Digital Mutual Aid (DMAS) process and supporting contract with IS providers for requested mutual aid transfers.	Operational performance report reported to Quality & Outcomes Committee ERF position and forecast reported to Elective Care Board and Finance and Investment Committee. Elective Care Performance and remedial action plans and progress reported to Elective Care Board supported by operational discussions and the Elective Recovery sub-group. Impacts of ongoing industrial action on forecasts not fully quantified.	1. Increased theatre productivity - actions from Four Eyes review (In place - Lead :Acute providers) 2. Completion of actions for High Volume Low Complexity (Lead : Acute providers) 3. Development and submission of business case for 2 additional theatres at Sulis Hospital - planned opening in 2024/25 4. Opening of 14th Theatre at GWH (Aug 23 - Lead GWH) 5. Introduction of system waiting list tool 6. Increased ASA grade activity at Sulis and day case arthroscopy 7. Diagnostic recovery action plans and NHSE site visits (Plans to be refreshed from Oct 23 visits Lead : Lucie Owens and Rob Gittens) 8. Regional diagnostic deep dives to review opportunities for adopt and adapt from other systems. 9. Additional mobile capacity being reviewed with InHealth for RUH on Bath Clinic pad 10. Reconfiguration of use of mobile vans between SFT and GWH to address pressure 11. Implementation of patient initiated digital mutual aid process 12. GWH Gastroenterology remedial action plan including additional weekend lists, validation and increased patient initiated follow ups 13. RUH Gastroenterology remedial action plan including prioritisation of long waits, validation and outsourcing. 14. RUH Cardiology remedial action plan including validation, use of junior doctors and additional consultant recruited. 15. GWH Diagnostic Ultrasound remedial action plan including insourcing to recover to 85% by March 24. 16. RUH Diagnostic Ultrasound remedial action plan including insourcing at weekends and waiting list initiatives to recover to 85% by March 24.	1) Acute Providers 2) Acute Providers 3) Victoria MacFarlane 4) GWH 5) Acute Providers 6) RUH 7) Lucie Owens and Rob Gittens 8) NHSE 9) RUH 10) Lucie Owens 11) Amber House 12) Felicity Taylor Drewe (GWH) 13) Niall Prosser (RUH) 14) Niall Prosser (RUH) 15) Felicity Taylor Drewe 16) Niall Prosser	1) Next review Dec 23 2) Next review Dec 23 3) Completed. 4) Completed 5) Completed 6) Completed 7) Refreshed plans Nov 23 8) Completed 9) Mid October for mobilisation 10) Completed 11) Cohort 1 goes live 31st Oct 23 12) Dec 23 13) Dec 23 14) Dec 23 15) March 24 16) March 24	Amber	3	4	12
BSW ICB 10	Capacity and capability	29/11/2019	There is a risk that cancer waiting times will not meet the NHSE target levels required	ICS system organisations	Rachael Backler, Chief Delivery Officer	Mark Harris, Director of Commissioning	Elective Care Board & Quality and Outcomes Committee	27-Oct-23	4	4	16	↔	9	Treat	There is a risk that patients may come to harm as a result of long waits for cancer diagnosis and treatment, specifically in relation to 62 day treatment target. This target is currently measured as the number of breaches versus a nationally set plan for systems. The associated measure is the national standard of achieving the target for 85% of patients.	Weekly oversight of trust level data on number of patients waiting over 62 days for start of cancer treatment -resubmission of trust level trajectories for remainder of FY22/23 -Bi-weekly situation updates at pan-BSW cancer forum -Regular cancer alliance activity, performance and capacity update and review meetings (SWAG and TVCA) where current position is reviewed and assurances provided -monthly update of current (2 months prior) performance (and mitigations for poor performance) into BSW ICB reporting process -Quarterly 1-1 cancer review meetings with each trust for more targeted discussions e.g. of recovery plans for specific tumour types, covering both activity volumes and performance -Clinical harm reviews of all long wait cancer patients for any evidence of harm resulting from the delay -Cancer is reportable to the Elective Care Board for governance and oversight	Harm review forms part of reporting to Elective Care Board and Quality & Outcomes Committee.	-Trusts running internal recovery projects, each with multiple strands, to address issues for what are currently the most challenged tumour types and pathways e.g. Skin at GWH: running WLI's; locum provision; deep dive RCA; additional Cancer Alliance funding for community-based independent sector provision for BCCs; use of insourcing for routine pathway patients; clinical summit task and finish group commenced Oct 23 including trust, ICB, TVCA as existing mitigations considered unlikely to resolve the ongoing demand/capacity gap. Urology at GWH: deep dive ongoing. LGI at RUH: additional 7 endoscopy lists weekly, prioritised for cancer patients; additional GI radiologist from Oct; additional colorectal surgeon from Sept; additional capacity in pathology, OP, and theatres for resulting increased surgical capacity. Prostate at RUH: additional lists and list capacity from oct as familiarity with robot delivered procedures continues to develop. Skin at RUH: locum sought for minor Ops capability; looking to run WLI's; investigating ability to employ GPwER for telederm A&G. Prostate at SFT: largely now resolved with improved pathway management and additional Band 6 role to help manage patient flow, STT for u/s or flexi. Skin at SFT: plastics locum in place now; additional trust clinician starts Oct; routine work - looking to provide insourced capability for routine work to alleviate from cancer work; further plans being developed. On-going monitoring in respect of 2023/24 for both performance and the number of breaches.		Monthly reports to Elective Care Board and Cancer Alliances to March 2024	Amber	3	4	12
BSW ICB 11	Public, patient, and staff safety including clinical harm	06/02/2023	Lack of capacity of suitable placements for BSW Children Looked After. Both within BSW and across England and Wales	ICS NHS organisations, local authorities and other partner organisations	Gill May, Chief Nurse Officer	Anne Gray Designated Nurse for Children Looked After	Quality and Outcomes	25-Oct-23	4	4	16	↔	8	Treat	There is a lack of suitable placements for Children Looked After particularly for children with complex needs. These placements ar Local Authority commissioned placements but this impacts on health hence the risk for BSW ICB. It means more children looked after are placed beyond 20 miles from their homes. There is an increased use of unregulated placements. The available placements may not be able to address all the child's needs leading to risk of unmet needs or placement breakdown. The risk to the ICB is that this could lead to increasing numbers of children being admitted to acute hospitals and placements are then giving immediate notice so when the child is fit for discharge there is no suitable placements available, and child remains in hospital, sometimes for weeks before a suitable placement is found. This is a national issue but having significant local impact where children with complex and challenging behaviour are in a secondary care setting. This also impacts on staffing and bed capacity in acute settings. This is a constant throughout the year. During July / August 2023, there was an increase in the number of children, not only from BSW children and young people, but oth local authorities CLA (of which we have a statutory duty to meet their health needs).	ICB has an established escalation process in place and the executive nurse and commissioners are kept aware of any cases were a child is fit for discharge but no placement is available. The three acute trusts in BSW ICB have put in place escalation processes and will inform the ICB if they have a child looked after who is fit for discharge but cannot be discharged because of lack of a placement. There are established processes in place between the ICB and Local Authorities with regard to multi-disciplinary meetings and case discussion with senior managers. As of April 2023, the designated professionals have maintained a database outlining which hospitals, local authority and days from admission to discharge for individual cases. Assurance received that each local authority has a policy to address placement sufficiency.	The ICB will facilitate a LEAP meeting and or CETR (multi-agency meetings) were appropriate. There is a Strategic Looked After Children's Group where issues are raised. This Group has the Chief Nurse, Designated Nurses, ICB commissioners and representatives from the three local authorities as members. The Designated Nurses meet with the Chief Nurse and the Associate Director of Strategic Safeguarding monthly. Concern raised at the Children & Young People's Transformation Board. Meeting to take place (11/07) to discuss collective oversight of all children currently residing in acute settings.	1. This is a national problem which the recently completed Care Review sought to begin to address. A Government response to the Care Review has been received with further details awaited. 2. The Designated Nurses will monitor the situation and will update Chief Nurse on any cases of children looked after who are in an acute bed and fit for discharge but unable to leave due to a lack of suitable placement on a one-to-one basis. If the child has a learning disability or autism a CETR will be considered 3. Corporate Parenting Board / Panels in each of the three local authorities will be made aware that the ICB has this issue on their Corporate Risk Register. 4. Paper to be taken to the Children & Young People's Transformation Board. 5. Early discussions and plans to meet with Somerset in September 2023 to look at a model they have developed between ICB and the Local Authorities. 6. The re-introduction of the Concordat Panels, led by Associate Director of Mental Health, from September 2023. 7. A C&YP Summit has been arranged for November to look at how as a system we reduce the number of CLA staying in acute hospitals due to lack of a suitable placement.	1 National 2, 3 Anne Gray 4. Gill May 5. Anne Gray /Jane Rowland 6. Georgina Ruddle	1. TBC 2. Monthly 3. End of 2023 4. End September 2023 5. October 2023 6. End September 2023 7. End of November 2023	Amber	3	4	12
BSW ICB 13	Quality and Patient Experience	18/04/2023	POD Quality and Performance risks are not fully known and understood	ICS system organisations	Fiona Slevin-Brown, Director of Place Wiltshire, Executive Lead for Primary Care	Jo Cullen, Director of Primary Care Victoria Stanley Programme Lead, POD.	Primary Care Executive Group	26-Oct-23	4	4	16	↔	12	Treat	The ICB is not yet in receipt of sufficiently detailed reporting of finance, performance and quality reports for POD. Without this it is challenging for the ICB to fully understand the key risks and issues relating to provision across BSW, and to plan effectively with ou population, IBC partners and neighbouring ICBs, and NHSE partners to address these issues and risks without this information. Th presents delivery, financial and reputational risks to the ICB.	1. BSW POD Delegation Transition Steering Group set up (from delegation preparation steering group) with named workstream leads, meeting monthly to manage the outstanding actions. 2. Engaged in the monthly NHSE SW Transition Group (monthly) with NHSE colleagues and PCCC/PCEG Chairs. 3. Share all documents and information with wider ICB team 4. BSW Operational Groups for pharmacy services, dental and primary eye care services now set up and all meeting for first time in June with attendance from Local Representative Committees, clinical leads, LA and NHSE. 5. A SW wide Task and Finish Group being established to review Risk Register - both risk management in transition, and managing risks of service delivery here and now. BSW reps engaged. 6. NHSE colleagues have supporting reported on dental position to Swindon and Wiltshire HOSC - BaNES in June after local elections. 7. Finance information obtained 8. Primary Care Quality and Oversight Group to include PODD reporting. 9. The complaints process transferred to the ICB on 1st of July and we are developing a process of complaints reporting into PCEG.	Finance and quality reporting to PCEG Highlight report from PODD Transition Group coming to Strategic PMO and PCEG monthly Revised ToR of PCEG to include PODD Regular review of finance, quality & performance issues through the operational groups. ICB representation Director rep on Commissioning Hub meetings and strategic transformation meetings. Transition Oversight Group meets monthly and reports Meetings with NHSE take place. NHSE are represented in Operational Groups Risk Register established around the operational groups PODD Risk Register reports onto PCEG Operational Groups set up and meeting from end June 2023. SW Task and Finish Group meeting from end of June 2023. POD Risk Management Framework adopted. Development Board session to discuss PODD October 2023.	DPA agreement now signed by the ICB Transition group and Project plan include development of future reporting arrangements Operational sub-groups being established with representation from NHSE. Transition Leadership role out to advert, now recruited. Quality, Finance & Performance dashboards to be developed. South West Task & Finish Group to be set up focusing on recovery of dental access. Dental access to be discussed at September's Executive Performance & Risk Meeting. Primary Care Exec Group reports to Exec Management Meeting, monthly.	Victoria Stanley Programme Lead, POD.	As per Transition timelines.	Green	3	4	12
NEW BSW ICB 25	Quality and Patient Experience	15-Nov-23	Long lengths of stay in acute mental health wards	ICS system organisations	Gordon Muvuti, Swindon Place Director	Jane Rowland/ workforce subgroup chair	Thrive Programme Board	03-Nov-23	4	4	16	New Risk	9	Treat	There is a risk that we cannot discharge patients who are medically fit from AWP inpatient capacity. This leads to long lengths of stay in acute mental health wards - as at August 2023 55.9%of older adult beds are occupied by people with a LoS of > 90 days; 20.3% of adult acute beds are occupied by people with a LoS of >60 days with consequent impact on flow both within AWP and from acute partners. This leads to people waiting for inpatient MH capacity in acute hospitals, delays in our S136 pathway and could adversely affect the improvement we have seen in our out of area position.	Thrive Programme Board oversees all aspects of MH delivery	ACPPO Programme established to oversee MH and LDA escalations. Review of ACPPO and associated issues developed September 2023. Comprehensive work plan agreed with locality commissioners to address identified issues. September 2023 Discussions underway with AWP to develop improvement plan for Inpatient Services t be concluded by January 2024 with work plan signed off through MH governance process. Mental Health Strategy in development which will inform this work. To be approved in March 2024.	- System wide escalation tool developed and implemented - October 2022 - System wide review meetings convened to support operational flow when required - with particular focus on working with Local Authority partners to address housing support needs - ongoing - Section 117 aftercare under review in collaboration with Local Authorities and AWP. Further work underway through the Community Rehabilitation programme. - Development of plan to implement the National Quality Improvement Programme for Inpatient Services underway with AWP partners. Anticipated that plan will be developed by Q4 2023/24 with phased roll out across 2024/25 and 2025/26. Programme will be presented to Thrive Programme Board in Q4 2023/24. This will build on the AWP Right Care programme.	Gordon Muvuti	Ongoing	Amber	3	3	9

BSW ICB 16	Cyber Risk	08-Mar-23	Cyber Attack	ICS system organisations	Multiple Organisations	TBC / Steve Mapleston	Cyber Technical Design Authority	25-Oct-23	3	5	15	⟺	8	**Mitigate**	There is a risk that a cyber incident has the potential to severely impact patient care system-wide due to malware affecting shared and individual computer systems, causing the loss of essential services including diagnostics devices and patient information systems. The ICB has a obligation under NIS to make sure appropriate measure are in place https://www.gov.uk/government/publications/network-and-information-systems-regulations-2018-health-sector-guide/the-network-and-information-systems-regulations-2018-guide-for-the-health-sector-in-england Any lack of adequate system wide funding also contributes to this risk due to the impact on the ability to deploy protective measures, however a suitable risk based balance is required. Examples of the types of factors causing this risk include but are not limited to: -Data loss via internal abuse -Lack of ICS Cyber lead -Ransomware breaching a ICS network -Phishing breaching a ICS network -Websites breach / DOS -Other Cyber Attack -Cyber Attack on 3rd Party Supplier (Recent 111 and SWAST issues as an example) -Out-dated Systems -Physical Security -Medical Equipment	-Use of Microsoft MDE (National NHS Microsoft defender antivirus and alerting tool) -Roll-out of MFA (Multi factor authentication i.e. one time codes) -Individual Trust Cyber Staff -National SOC (security operations centre) Cyber monitoring -National Respond to a Cyber alert requiring orgs to acknowledge and action high severity threats -Increasing willingness across the ICS to work together on cyber including formation of ICS wide cyber group (CTDA) -Monitoring of ICS wide cyber risk at ICS level via new ICS Cyber Group (CTDA)	DPST (NHS Data protection Security Toolkit) at individual org level More is needed to understand impact as system level	ICS wide mitigations to be discussed at future CTDA 3rd party suppliers need significant national work especially for suppliers that we do not contract with directly or are on national frameworks ICS Cyber Exercise to take place Nov 23	CTDA / Steve Mapleston	NB cyber will always be ongoing as significant work is required to just maintain current risk as cyber attacks become more advanced	**Amber**	3	5	15
BSW ICB 20	Quality and Patient Experience	06-Oct-23	PHB Management	ICS system organisations	Gill May, Chief Nurse Officer	Sarah- Jane Peffers, Associate Director of Quality and Patient Safety	ICB	06-Oct-23	5	3	15	⟺	8	**Treat**	There is a financial/ legal and patient safety/ experience risk that without a robust PHB management approach people will not have the required offer and support for PHB's when receiving CHC funding	Policies, Operational Leadership	Gaps- Resource, SOPs, IT infrastructure	Current Financial audit Interim funding for additional resource	Kirstie Jackman/ Sarah Corkery-Lloyd	Jan-24	**Amber**	5	3	15

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	13
Date of Meeting:	18 January 2024		

Title of Report:	BSW ICB Board – Declarations of Interests
Report Author:	Anett Loescher, Deputy Director of Corporate Affairs
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
Appendices:	Appendix 1 - ICB Board Member Conflicts of Interests Register Appendix 2 – ICB Board Attendees Conflicts of Interests Register

Report classification	Please indicate to which body/collection of organisations this report is relevant.
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	x

Previous consideration by:	Date	Please clarify the purpose
Deputy Director of Corporate Affairs	monthly	Regular maintenance review of registers
ICB Audit and Risk Committee	7 December 2023	Assurance

1	Purpose of this paper

The ICB Corporate Office holds and maintains the statutorily required corporate registers, including that for conflicts of interests.

We regularly present these registers to the Audit and Risk Committee for information and assurance that the ICB complies with statutory requirements and has in place a policy framework / key controls.

As required, the Declarations of Interests Register is also regularly shared with the ICB Board for assurance.

Register of Interests
The current register of Board members' interests is published on the ICB website, likewise the register of regular attendees' interests. Both registers are shared with the ICB Board for review and confirmation of accuracy. This will satisfy the requirement of the BSW ICB Standards of Business Conduct Policy for regular review of the Board members' register of interest, by the Board.

In compliance with the Health and Care Act 2022 and the BSW ICB Standards of Business Conduct policy, the Corporate Office maintains a comprehensive register of interests for all ICB Board and committee members, employees, and individuals working for / on behalf of the ICB. This full register is kept as an internal document, but is available to the public on request, per the Health and Care Act 2022.

2	Summary of recommendations and any additional actions required
The Board is asked to **note** this update, and to take assurance that the ICB has processes in place that enable it to comply with statutory requirements regarding transparency around, and management of, interests wherever and in whatever form they may arise.	

3	Legal/regulatory implications
The ICB is compliant with law and regulations by maintaining corporate registers for conflicts of interests; gifts, hospitality, and sponsorship; and procurement decisions. These registers must be made available to the public, and the ICB does so by publishing these registers on its website.	

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	Statement on confidentiality of report
The corporate registers (with the exception of the Policy Register) are published on the ICB website once reviewed by the Audit and Risk Committee.	

Appendix 1

Register of Interests for members of the BSW ICB Board, January 2024

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

Name	Role	Interest Type	Interest Description	Provider	Interest Category	Direct or In-direct	Interest ended	Mitigation
Alison Moon	Non-Executive Director for Quality	Declarations of Interest	Self-Employed Executive Coach		Financial	Direct		Noted on Register of Interests. Highlight at any relevant agenda items
		Declarations of Interest	Independent Non-Executive Member	Bristol, North Somerset and South Glos ICB	Financial	Direct		Noted on Register of Interests. Highlight at any relevant agenda items
		Declarations of Interest	Non-Executive Director	Gloucestershire Hospitals NHS Foundation Trust	Financial	Direct		Noted on Register of Interests. Highlight at any relevant agenda items
Amanda Webb	ICB Medical Director	Declarations of Interest	Salaried GP	Westrop Medical Practice	Financial	Direct		Declaration raised when required. No active involvement in discussions or decisions regarding Westrop Surgery.
		Declarations of Interest	Founder and member of Phoenix GP	Phoenix GP	Financial	Direct		Would remove myself from any discussions involving Phoenix GP
Claire Feehily	Non-Executive Director Audit	Declarations of Interest	Non-Executive Director and Audit Chair	Gloucester Hospitals NHS FT	Non-Financial Personal	Direct	31/07/2023	
		Declarations of Interest	Trustee, SID and Audit Chair	National Lottery Heritage Fund	Non-Financial Personal	Direct	30/11/2023	
		Declarations of Interest	Non-Executive Director Audit	Oxford Hospitals NHS FT	Non-Financial Personal	Direct		Specific declarations in business meetings as required.
		Declarations of Interest	Trustee and vice-chair of The Brandon Trust since 2021, a provider of services for adults with learning disability and autism across the South West. Currently commissioned by partners within BSW ICS	The Brandon Trust	Non-Financial Personal	Direct		Specific declaration of interest in business proceedings as required
		Declarations of Interest	Chair and Trustee	Stroud and Cotswolds Citizens Advice	Non-Financial Personal	Direct		Specific declaration made as necessary in business meetings
Dominic Hardisty	NHS Trusts & NHS Foundation Trust Partner Member - Mental Health Sector	Declarations of Interest	Chief Executive	Avon & Wiltshire Mental Health Partership	Financial	Direct		Will declare when relevant
Francis Campbell	ICB Partner Member - Primary Care	Declarations of Interest	GP Partner	Elm Tree Surgery	Financial	Direct		Would declare if decision directly affected this business or could be perceived to materially effect
		Declarations of Interest	Clinical Director	Brunel PCN	Non-Financial Professional	Direct		Declare where relevant. Ensure that actions taken do not - or could not be perceived to- afford preference to any one particular PCN
Gary Heneage	ICB Chief Finance Officer	Declarations of Interest	Family member is a sport and exercise consultant	Circle Hospital Reading	Indirect	Indirect		Declare as and when necessary, manage in accordance with BSW ICB Standards of Business Conduct Policy
		Declarations of Interest	Family member is a solicitor	DWF	Indirect	Indirect		
Gillian May	ICB Chief Nurse	Nil Declaration						
Pam Webb	Voluntary, Community & Social Enterprise Partner member	Declarations of Interest	VCSE Strategic Lead For Integrated Care	Voluntary Action Swindon	Financial	Direct		Would declare as necessary
Paul Miller	Non-Executive Director Audit	Declarations of Interest	I am both a Director and employee of Sparrow Healthcare Consulting Limited, which provides training, coaching, consulting and audit services to a wide range of clients.	Sparrow Healthcare Consulting Ltd	Financial	Direct		Sparrow Healthcare Consulting Limited will not provide any paid service, whether a contract or sub-contract, funded directly from Bath and North East Somerset, Swindon and Wiltshire ICB
		Declarations of Interest	Family member is a retired senior NHS finance professional and volunteers for Hampshire Hospitals NHS Foundation Trust	Hampshire Hospitals NHS Foundation Trust	Indirect	Indirect		No mitigation required, unless a specific conflict of interests arises in the future and then that would be declared and appropriate mitigations agreed.
Stacey Hunter	NHS Trusts & NHS Foundation Trusts Partner Member	Declarations of Interest	Chief Executive	Salisbury NHS Foundation Trust	Financial	Direct		would declare as relevant
Stephanie Elsy	BSW Independent Chair	Declarations of Interest	I am an adviser	Impower Consulting Ltd	Financial	Direct	31/07/2023	Declaration when relevant
	BSW Independent Chair	Declarations of Interest	Shareholder and Director	Stephanie Elsy Associates Ltd	Financial	Direct		Declaration when relevant
	BSW Independent Chair	Declarations of Interest	NHS NED	Peninsular Acute Provider Collaborative	Non-Financial Professional	Indirect		Declaration when relevant
	BSW Independent Chair	Declarations of Interest	Non Executive Director	Solent NHS Trust	Non-Financial Professional	Direct		Declaration when relevant
Suzannah Power	Non-Executive Director Remuneration & People	Outside Employment	Member of the Approvals and Oversight Board, CVD-COVID-UK Project	British Heart Foundation Data Science Centre			01/09/2023	
	Non-Executive Director Remuneration & People	Declarations of Interest	I have been appointed as Deputy Chair of the HDR Public Advisory Board.	Health Data Research UK - the national institute for health data science	Non-Financial Personal	Indirect		Where there is a potential conflict of interest I will bring it to the attention of the committee or group involved. This would only be an issue were we as an organisation involved in commissioning healthcare academic research.
	Non-Executive Director Remuneration & People	Outside Employment		Penny Brohn UK				
Suzanne Harriman	BSW ICB CEO Designate	Nil Declaration						
Terence Herbert	ICB Partner Member - Wiltshire Council	Declarations of Interest	Chief Executive	Wiltshire County Council	Financial	Direct		Declaration when relevant
Will Godfrey	Local Authority Partner Member - BaNES	Declarations of Interest	Chief Executive	Bath and North East Somerset Council	Financial	Direct		Would declare when relevant
Vacant Post	Local Authority Partner Member - Swindon							
	(Susie Kemp former holder of post stepped down (30/08/2023: declared interests remain on register for 6 months	Declarations of Interest	Chief Executive	Swindon Borough Council	Financial	Direct		Would declare as necessary
Vacant Post	Community Provider Partner Member							
Historic register of interest of a previous Board member	Non-Executive Director - Quality							
	(Rory Shaw former holder of post , stepped down 20/09/2023:declared interests held on register for 6 months	Declarations of Interest	Family member is a solicitor in he Arbitration team	Freshfields	Indirect	Indirect		Only relevant if BSW entered a dispute to be settled by Arbitration involving the Team at Freshfields
		Declarations of Interest	Chairman of the Board	Feedback plc	Financial	Direct		Avoid any participation decision maing in relation to IT procurement in BSW ICS
		Declarations of Interest	Non-Executive Director on the Board	DIOSynVaX	Financial	Direct		The Company hopes to sell to National Governments, not to individual ICB's
		Declarations of Interest	Family member is a partner in the accountancy firm	BDO	Indirect	Indirect		She works in the international business arena, and does not participate in audit or activities relating to any healthcare business

Appendix 2

Register of Interests for attendees of the BSW ICB Board, January 2024

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

Employee	Role	Interest Type	Interest Description	Provider	Interest Category	Direct/In-Direct	Interest Ended	Mitigation
Fiona Slevin-Brown	ICB Place Director	Declarations of Interest	Family member has bank contract with a Primary Care Provider in East Berkshire and works for them on a part-time basis during University holidays	Primary Care Provider - East Berkshire	Indirect	Indirect		This provider does not provide services in BSW. They are local only to East Berkshire and Frimley ICS Declaration would be shared should a situation arise where this changes, and decisions would need to be made at a Committee or at the Board where I was present, and this would be managed appropriately by the Chair.
Gordon Muvuti	ICB Place Director	Nil Declaration						
	ICB Place Director	Declarations of Interest	Trustee	YMCA Southampton	Non-Financial Personal	Direct	27/06/2023	They have no interaction with BSW. If they did I would declare and leave the room
	ICB Director of Equalities & Innovation *(Jane Moore former holder of post stepped down: declared interests remain on register for 6 months)*	Nil Declaration						
		Declarations of Interest	Member of the advisory board	What works well - Wellbeing Programme (this is not an organisation but a programme funded by Government departments and other partners to bring together the evidence on wellbeing)	Non-Financial Professional	Direct	07/09/2023	
Jasvinder Sohal	ICB Chief People Officer	Declarations of Interest	A property company which my husband has set up and which has not current links to health and social care	Director of Big Rock Estates Limited	Non-Financial Personal	Indirect		No conflict of interest
	ICB Chief People Officer	Declarations of Interest	A property company which my husband has set up and which has no current links to health and social care	Director of Little Rock Estates Limited	Non-Financial Personal	Indirect		No conflict of interest
John Collinge	Chief of Staff	Declarations of Interest	Volunteer Community First Responder	South West Ambulance Service NHS FT	Non-Financial Personal	Direct		Declare interest at all meetings involving SWAST and allow Chair to determine appropriate steps to be taken.
Laura Ambler	ICB Place Director	Nil Declaration						
Rachael Backler	Chief Delivery Officer	Declarations of Interest	Husband is a board member of a charitable housing association.	Network Homes Limited	Non-Financial Personal	Indirect		Would declare in meeting although need to declare unlikely given geographical location (London and Hertfordshire)
	Chief Delivery Officer	Declarations of Interest	Family member works as Deputy Director of Finance at East Sussex Healthcare NHS Trust	East Sussex Healthcare NHS Trust	Non-Financial Personal	Indirect		Would declare as and when relevant in meeting.
	ICB Director of Strategy & Transformation *(Richard Smale former holder of post stepped down: declared interests remain on register for 6 months)*	Declarations of Interest	Family member working for Oxfam - commences 25 Sept 23	Oxfam	Indirect	Indirect		Avoid direct involvement in procurement decisions that could include Oxfam
		Declarations of Interest	Family member working for the Bristol Drugs Project	Bristol Drugs Project	Non-Financial Professional	Indirect		Avoid participating in any procurement activities in which Bristol Drugs Project are involved (unlikely due to Geography)
		Declarations of Interest	Volunteer member of the Football Foundation Funding Panel.	Football Foundation	Non-Financial Professional	Direct		Time commitment to attend Panel sessions (4 per year) will be recorded against voluntary activities as the focus is on community engagement, tackling inequalities and maximising value from investment in community assets.
		Declarations of Interest	Family member works for SILS (Supported independent Living Services)	SILS (Supported Independent Living Services)	Non-Financial Professional	Indirect	03/07/2023	Declare as and when necessary, manage in accordance with BSW ICB Standards of Business Conduct policy
		Outside Employment	Paid contribution to Mtech Symposium event. Possible further paid opportunities may occur	Mitech Access Ltd				
		Declarations of Interest	Volunteer Coach and Trustee of Keynsham Town Junior Football Club.	Keynsham town Juniors Football Club	Non-Financial Personal	Direct		Declare as and when necessary, manage in accordance with BSW ICB Standards of Business Conduct policy
Shirley-Ann Carvill	Community Provider Partner Member (Interim)	Declarations of Interest	Managing Director	Wiltshire Health & Care	Financial	Direct		Conflict of interest only when discussing the provider framework for BSW primary and community care delivery plan
Samantha Mowbray	Local Authority Partner Member Swindon (Interim)							
Richard Clewer	ICP Chair							

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

Report to:	BSW ICB Board – Meeting in Public	Agenda item:	14
Date of Meeting:	18 January 2024		

Title of Report:	Summary Report from Integrated Care Board (ICB) Board Committees
Report Author:	Sharon Woolley, Board Secretary
Board / Director Sponsor:	Rachael Backler, Chief Delivery Officer
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 December 2023 was chaired by the Non-Executive Director for Audit, Claire Feehily.

Received and Noted:

- External Audit Technical Update & Progress Report
- Internal Audit:
    - Progress Report and Action Tracking
    - Procurement Review Report
- Internal Audit Procurement Review Report and Action Plan
- Provider Selection Regime - Briefing
- Local Counter Fraud
    - Progress Report
    - Internal Audit and Local Counter Fraud Conflicts of Interest Review Report
    - Mandate Fraud Review Report
- Quarter Two Security Management Service Progress Report
- Risk Management
- BSW ICB Corporate Registers
    - Gifts, Hospitality and Sponsorship Register
    - Conflicts of Interest Register
    - Procurement Register
    - Policy Register
- Conflicts of Interest Report
- Exception Report from the Information Governance Steering Group
- Finance Update
- HMFA Checklist Update
- Integrated Care System and ICB Cyber Security
- Annual Emergency Preparedness Resilience and Response Assurance Report
- Single Tender Waivers
- Losses and Special Payments
- BSW ICB Audit and Risk Committee Forward Planner 2023-24

Items Escalated to Board:

- None

Endorsed / Approved:

- The Committee approved a change to the Internal Audit Plan for 2023-24 - the rescheduling of the Financial Recovery Plan review, to be replaced with a review of compliance with processes relating to the Community Services contract procurement, to be undertaken in quarters three and four.

1.4 The next meeting of the BSW ICB Audit and Risk Committee will be held on 29 February 2024.

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.

1.5 The meeting of the BSW ICB Quality and Outcomes Committee held on 7 November 2023 was chaired by the Non-Executive Director for Finance, Paul Miller.

Received and Noted:

- BSW Patient Safety and Operational Report
- Continuing Healthcare Quarter 1 Report and Current Position
- Patient Advice and Complaints Team Quarter 1 Report
- ICB Equality Quality Impact Assessment (EQIA) Revised Proposal
- BSW Population Health Board Update
- Maternity Deep Dive
- Consideration of Risk (Quality and Outcomes)
- Clinical Policies
    - Benign Skin Lesion Policy
    - Diastasis Recti Policy
    - Chalazion Policy
    - Blepharoplasty Policy
    - Breast Surgery Cosmetic Statement

Items Escalated to Board:

- Maternity Deep Dive - The Committee was assured by the presentation shared, and noted the importance of wider use of the presentation for meetings such as a future ICB Board development session.

Endorsed / Approved:

- ICB Equality Quality Impact Assessment Revised Proposal - The Committee noted the ICB Equality Quality Impact Assessment Revised Proposal and were assured that the review ensures a robust EQIA process.

2.3 The next meeting of the BSW ICB Quality and Outcomes Committee will be held on 9 January 2024.

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 meeting of the BSW ICB Finance and Investment Committee held on 6 December 2023 were chaired by the Non-Executive Director for Finance, Paul Miller.

Received and Noted:

- Month 7 ICB Position
- Month 7 Integrated Care System (ICS) Position
- BSW ICB Capital Prioritisation
- Update on addressing the significant financial challenges created by industrial action in 2023/2024 and actions to take
- BSW Productivity of Medium-Term/Financial Plan breakdown of calculation
- Commissioning and Business Case - Ophthalmology
- Operational Planning Paper
- Finance Risk Register
- BSW ICB Finance and Investment Committee Forward Planner
- Community Provider Update

Items Escalated to Board:

- Operational Planning Paper

Endorsed / Approved:

- *Referenced in the private committee report, due to commercial sensitivities.*

3.3 The next meeting of the BSW ICB Finance and Investment Committee will be held on 10 January 2024.

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 There have been no further meetings of the BSW ICB Remuneration Committee since the November report. The next meeting of the BSW ICB Remuneration Committee is scheduled for 30 January 2024.

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 There have been no further meetings of the BSW ICB Public and Community Engagement Committee since the November report. The next meeting of the BSW ICB Public and Community Engagement Committee will be held on 23 January 2024.

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 meeting of the BSW ICB People Committee held on 13 December 2023 was chaired by the Non-Executive Director for People and Remuneration, Suzannah Power.

Received and Noted:

- BSW People Plan Update
- BSW Training Hub Update
- Workforce – Financial Recovery Briefing
- NHS System Workforce Plan (as part of the annual business plan)
- ICB Corporate Risk Register - Workforce

Items Escalated to Board:

- None

Endorsed / Approved:

- Annual ICB Equality, Diversity and Inclusion Report

6.3 The next meeting of the BSW ICB People Committee will be held on 13 March 2024.

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) was 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 A new lead commissioner model approved by all seven ICB's came into practice from 1 October 2023. The final meeting of the AJCC was held on 26 September 2023. The new commissioning governance arrangements see the establishment of the Ambulance Partnership Board, to meet quarterly and attended by ICB and South Western Ambulance Service NHS Foundation Trust (SWASFT) Chief Executive's.

7.3 The first meeting of the Ambulance Partnership Board is scheduled for 15 January 2024.

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 12 December 2023 considered the following business:

- Arrangements for Review of Joint Specialised Services Committee Terms of Reference
- Joint Directors Group Business Matters
- Joint Directors Group Update on Developing Arrangements for 2024 and 2025
- Principles/Risk share from Finance Working Group
- 2023/24 Specialised Financial Position
- Delegation Work Programme
- Feedback from key national meetings
- Specialised Commissioning operational performance
- Finance report
- Provider Collaborative Update

8.5 The next meeting is scheduled for 23 January 2024.

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

Report to:	BSW ICB Board - Meeting in Public	Agenda item:	15
Date of Meeting:	18 January 2024		

Title of Report:	The Case for Change and Using Population Health Analysis to Drive Our Decision-Making
Report Author:	Sam Wheeler, Assistant Director of Business Intelligence, BSW ICB
Board / Director Sponsor:	Rachael Backler, BSW ICB Chief Delivery Officer Kate Blackburn, Director of Public Health, Wiltshire Council
Appendices:	Appendix 1: The Case for Change and Using population health analysis to drive our decision-making - Presentation for Board Appendix 2: Case for Change Analysis

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	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	x
2. Fairer health and wellbeing outcomes	x
3. Excellent health and care services	x

Previous consideration by:	Date	Please clarify the purpose
ICBC Programme Board	July 2023	Noting
BSW ICB Executive	December 2023	Noting and discussion of implications

1	Purpose of this paper

The purpose of this paper is to allow the Board to review and consider the implications of the BSW Case for Change.

In our ICP Strategy we set out a clear commitment to investing more of our funding in prevention and to reduce inequalities. We also produced an ICS Implementation Plan which aimed to set out how we would make that happen. A key plank of our delivery strategy is our approach to integrated community-based care and in support of that, we have developed a set of supporting analyses which demonstrate the compelling reasons why we must start to invest our monies differently.

This Case for Change is presented because as well as informing the commissioning decisions we are making as part of the ICBC programme, it also provides compelling reasons for us to re-think how we approach decision-making across all of our programmes of work in the coming months and years.

The Case for Change begins to quantify the do nothing challenges in BSW and there can act as a backdrop to whether our ICP Strategy is addressing these issues and help us make sure that the actions we set out in our refreshed implementation work are sufficient.

To do this we would need to better quantify the programmes and actions set out in our Strategy and Implementation Plan, testing them back against the Case for Change.

The supporting slides set out a set of recommended actions to do this, building on work underway to review and refresh our Implementation Plan. This work has been developed and led by our Business Intelligence team and we are now looking for wider involvement and engagement to make this thinking part of everything we do

2	Summary of recommendations and any additional actions required

On reviewing the supporting slides and the fuller BSW Case for Change the Board is asked to:

- Note the work on the BSW Case for Change, what it's telling us regarding the challenges faced in BSW, and implications for the further development and delivery of our Strategy.
- Note and support the related next steps on development of our Strategy, specifically:
  - To complete the outcomes work started as part of the Implementation Plan, to quantify our strategic objectives (outcomes) by adding defined levels of ambition to existing outcome measures.

- Refreshing our implementation plan, using the case for change to test our plans and ask ourselves whether our proposed actions target the right areas. The proposal is to use logic models for each programme to help us do this, linking the actions (outputs) we propose to the outcomes we're aiming for.
- Through the Implementation Plan renew our focus on how we quantify the impact of prevention and early intervention on key outcomes so we can reflect the impact of this work within our Operational and Financial Plans

- Support the work underway to strengthen our Population Health intelligence capability across the system, particularly within the Primary and Community Care Delivery Programme, to support delivery of the changes within our communities which impact on the prevention and early intervention aspects of our Plan
- Support the proposal to embed population health analysis and evidence into our business cases as part of our decision-making process.
- Note there will be changes needed to the way we work together as a system to achieve these aims, and to provide a mandate to develop plans and update at a future Board.

3	Legal/regulatory implications

Whilst the BSW Case for Change does not directly relate to any legal or regulatory implications, the challenges set out within the 'do nothing' analysis have significant implications for future performance, financial sustainability and outcomes for our populations.

4	Risks

The Board Assurance Framework sets out risks relating to the achievement of our strategy. The approach set out in this paper will help to mitigate some of these risks in particular regarding seeking to provide a better evidence base for our decision-making and make sure we are targeting a reduction in inequalities and improved outcomes.

5	Quality and resources impact

Quality, Patient Experience and Safeguarding: The Case for Change highlights the likely impacts on quality, patient experience, access and outcomes through the expected growth in demand for services, driven by changing demographics, in the do-nothing scenario.

Finance: The Case for Change highlights some of the expected costs pressures driven by the changing needs and demands of our population.

Workforce: The Case for Change highlights challenges for our future workforce to manage changing needs and demands of our population, as well as the direct implications as the workforce itself ages. **Sustainability/Green agenda:** N/A

Finance sign-off	N/A

6	Confirmation of completion of Equalities and Quality Impact Assessment
Any relevant service change proposals would need to have an EQIA completed – an EQIA has not been completed for this piece of analysis.	

7	Communications and Engagement Considerations
N/A at this stage	

8	Statement on confidentiality of report
This report is not confidential.	

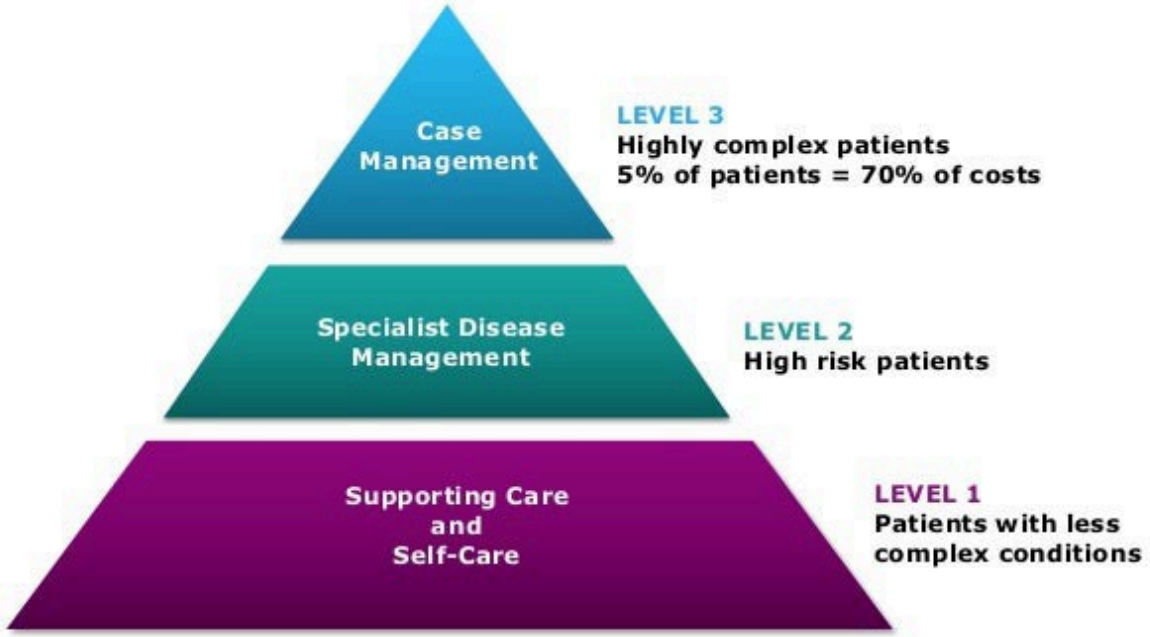
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

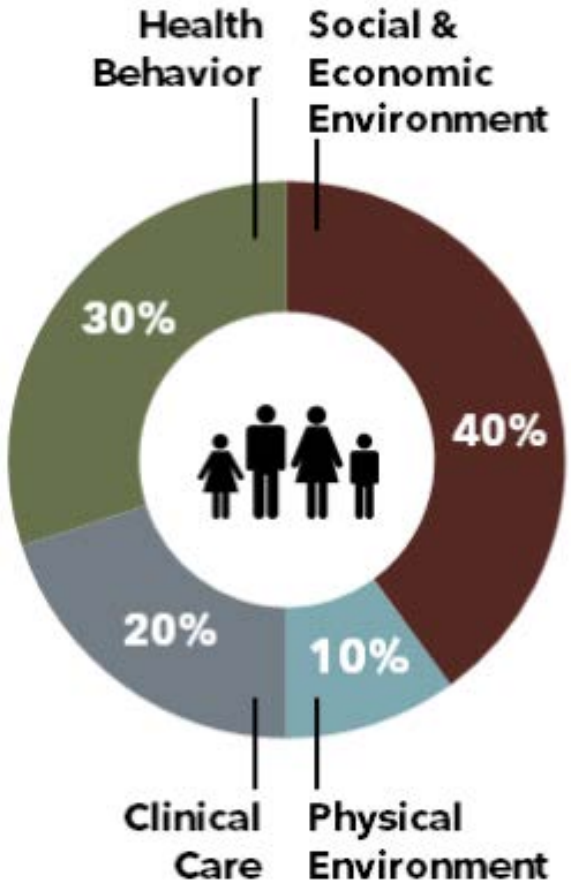
The Case for Change, and Using Population Health Analysis to Drive Our Decision-Making

Presentation for ICB Board Meeting
18th January 2024

Population Health (Analytics)

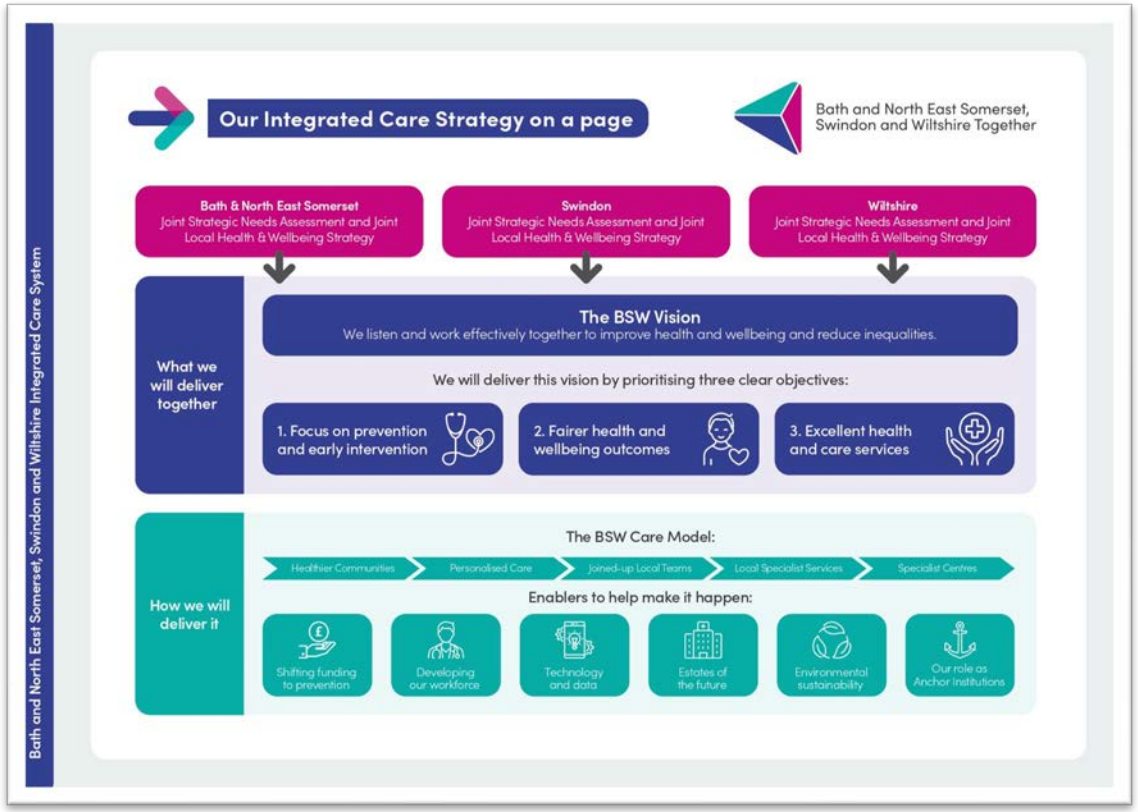
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

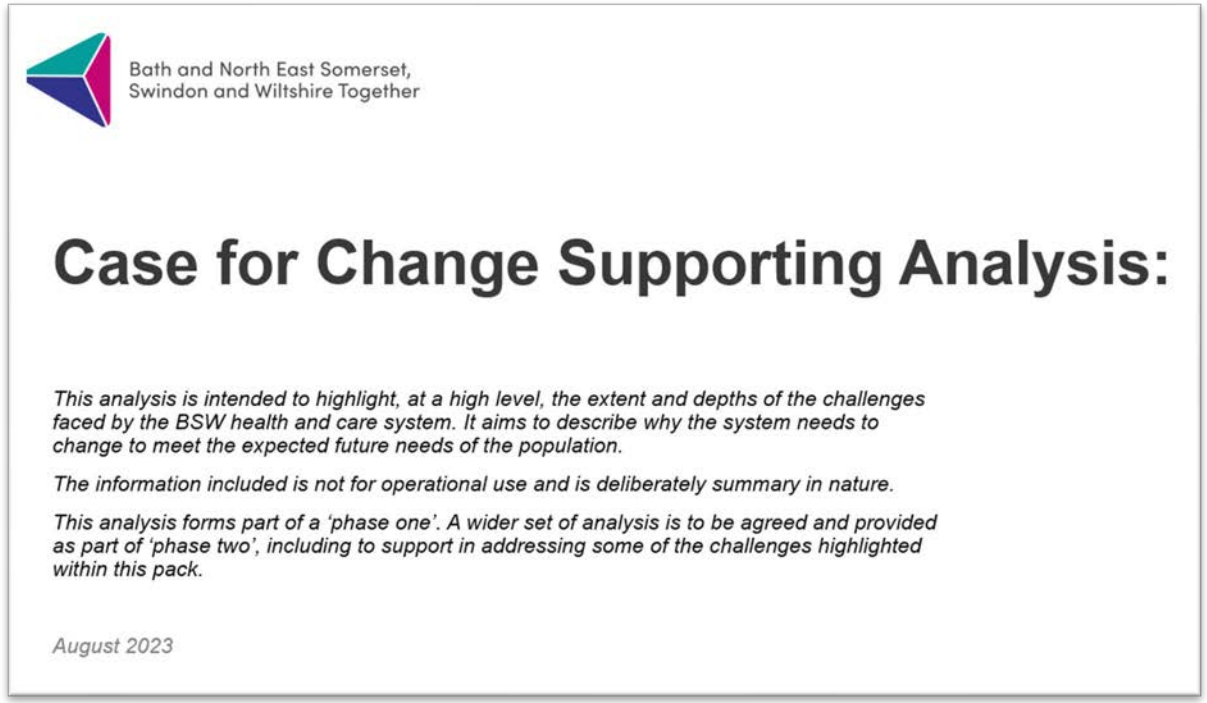




Our Strategy and the Case for Change

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





There is a compelling case for change… (adults)

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

6% Population growth in 15 years

35% Growth in the over 60 population

£5M Per year cost pressure on acute ‘activity’ through demographics alone

115 Additional acute bed demand in 5 years driven by demographic changes

57% Increase in adults over 65 requiring care in 15 years

There is a compelling case for change… (children)

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

12-18 Year-olds are our biggest children's cohort. They are the Covid generation who will transition to adulthood in the next 5 years

3,000 Children and Young people with 2 or more long-term conditions

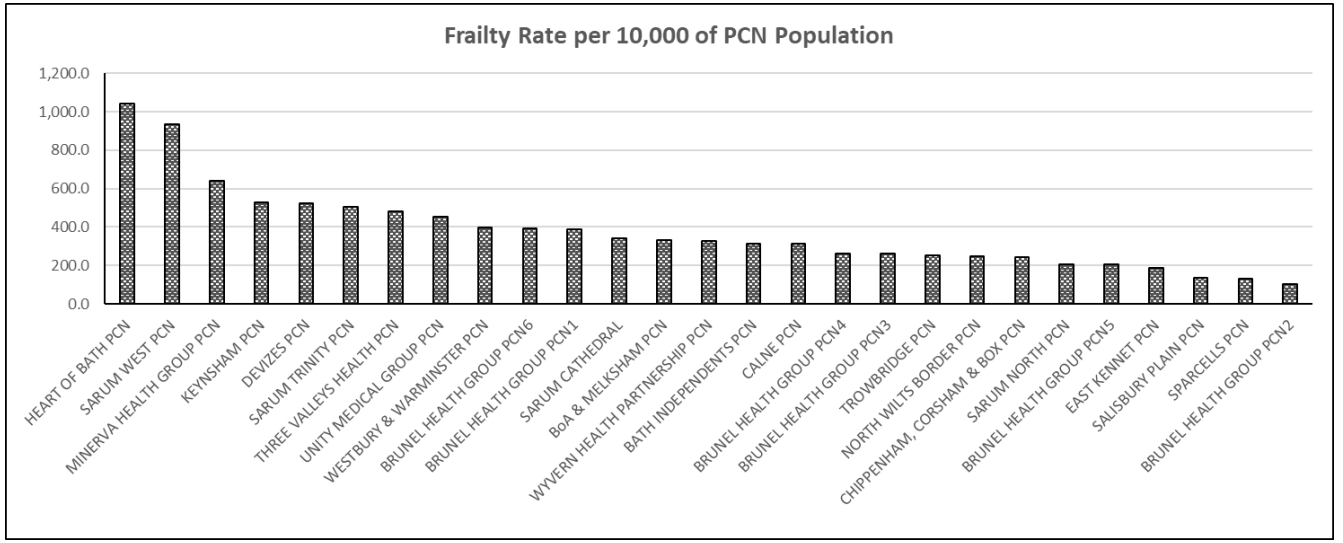
300% Increase in Neurodiversity caseloads in some parts of BSW during the pandemic

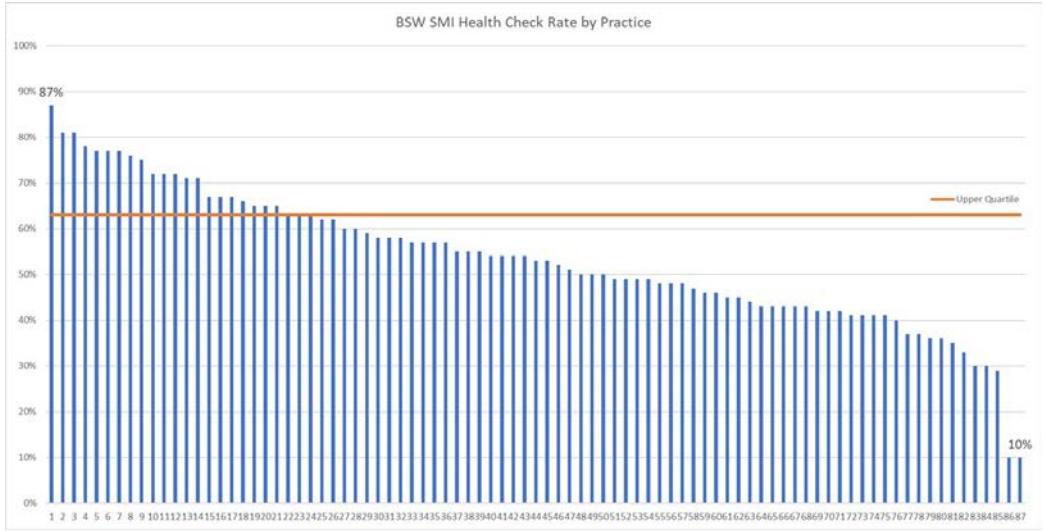
33% Of year 6 children in BSW are overweight or obese

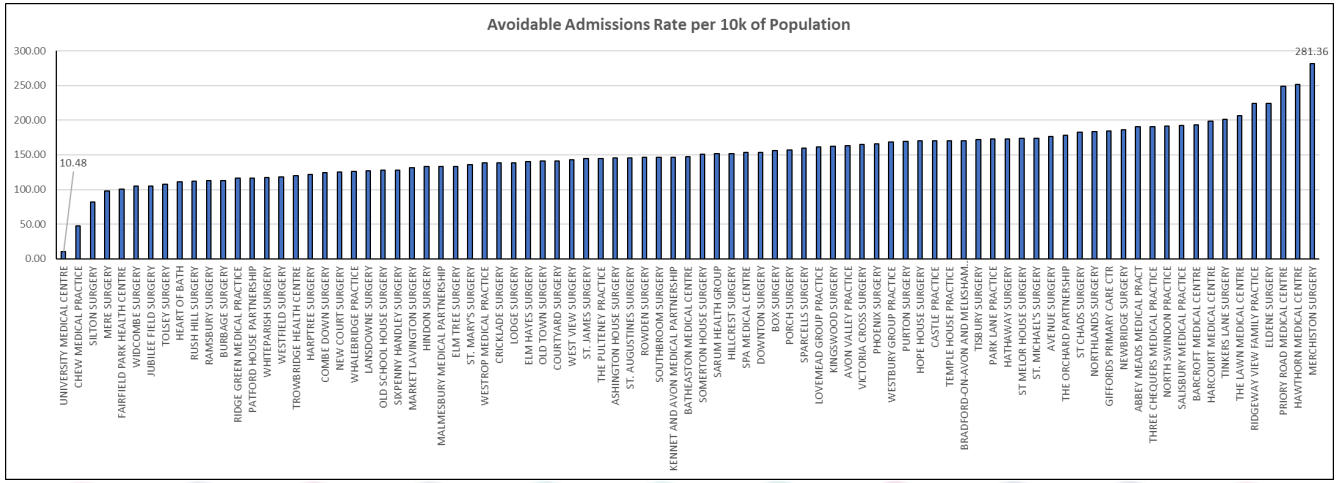
But we must also respond to the significant variation…

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

- Our populations look different and so we should tailor our approach based on need (top right)
- Performance is different across BSW and so we should drive a levelling up to improve outcomes and efficiency (below left)
- This variation plays through into secondary care (below right).
- Addressing the variation out with our communities, and in primary and community care, will help address secondary care demand and outcomes







And there is evidence on what we should do…

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

We already have work underway to respond to some of these key issues, but there is more we can do using evidence on what works well – this may involve spending our BSW pound differently. For example….

Evidence suggests **early detection** of deteriorating health in **heart failure** patients reduces absolute hospitalisations by **45%.**

This could total approximately **£1.7m** in savings per year in BSW.

Identifying **high-risk patients** with recurrent admissions for **heart failure** (due to social vulnerability) using a population health management approach in primary care, saves around **£7,500** per person per year in non-elective admissions.

BSW have an estimated **1,486** such patients, equating to theoretical savings of **£11.1m** (including the £1.7m noted above)

Lowering blood pressure reduces the incidence of stroke by 35%–40%, heart attacks by 20%–25% and heart failure by 50%.

Over 10 years a reduction in the population average **blood pressure** by 5mmHg through improved prevention, detection and management could save an estimated **716** quality adjusted life years (QALYs) and save **£13.5m** on related health and social care costs in BSW.

Source: B1590-cvd-high-impact-interventions.pdf (england.nhs.uk)

Some of this evidence describes the opportunity….

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

25,000 bed days each year (10%) for **Ambulatory Care Sensitive Conditions** are **potentially avoidable** with improved out of hospital care.

31,000 ED attendances each year in BSW (15%) are **potentially 'inappropriate' or 'avoidable'**

Child Health Hubs could reduce demand for Paediatric outpatients, ED attendances and admissions. Crude opportunity to save an estimated **£11M** (over 10 years) in BSW by repeating models from elsewhere.

Mental Health (MH) services users make up 5% of the population but account for 15% of ED attendances and emergency admissions. Around **£18M** of this activity is considered 'amenable to change' via improved out of hospital care.

Some of this evidence informs how we commission and design services, together, to realise the opportunity

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

The BSW opportunity for Secondary Prevention in **CVD** and **Respiratory Disease**

Intervention	Estimated BSW Opportunity
Cardiac Rehab for Acute CVD	1,000 deaths 3,000 admissions (over 10 years)
10% improvement in Hypertension management / diagnosis	140 CVD events
Heart Failure Annual Reviews	£1M on admissions (per year)
Identifying High Risk patients using a PHM approach, and intervening	£7,500 per patient

Intervention	Estimated BSW Opportunity
Preventing CYP Asthma Exacerbations	£200k
Meeting LTP objectives for Pulmonary Rehab	1,500 admissions
Accurate diagnosis of COPD and Asthma	£27-£140k
Early diagnosis of COPD	16% cost reduction per patient (over 2 years)

B1590-cvd-high-impact-interventions.pdf (england.nhs.uk)
B1590-respiratory-high-impact-interventions.pdf (england.nhs.uk)

We should use the data to drive our community engagement to make real, sustainable change

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

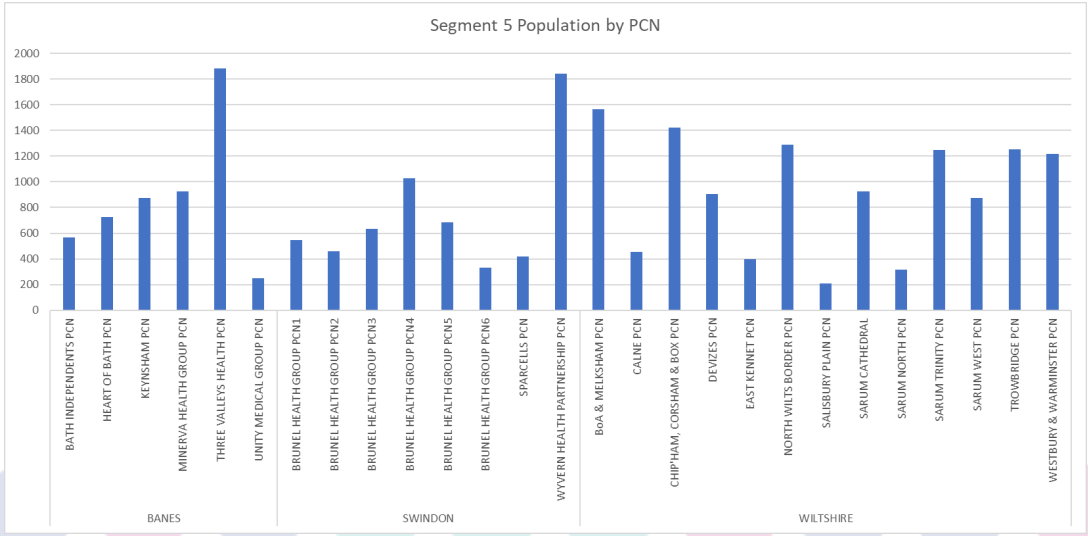
25,000 bed days each year (10%) for **Ambulatory Care Sensitive Conditions** are **potentially avoidable** with improved out of hospital care.

Through Population Health Analytics we know **40%** of these avoidable bed days are from **22,000** people, or **2.5%** of our population ('segment 5')

We know who segment 5 are, and in which communities they live……

The data can tell us which of them are in receipt of the **evidence-based interventions**, and which aren't…..

For example, 3 in 4 people in BSW have not had all 8 care processes for diabetes. Meeting all eight process is associated with a 25% reduction in acute admissions.



Q: How do we organise ourselves together, around this data, to properly engage with our communities to remove the barriers to making these changes?

We want to use population health analysis more comprehensively to inform our delivery plan and decision-making

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

- Complete the outcomes work we started as part of the Implementation Plan, to quantify our strategic objectives (outcomes) by adding defined levels of ambition to existing outcome measures

- Refreshing our implementation plan, using the case for change to test our plans and ask ourselves whether our proposed actions target the right areas. We propose using logic models for each programme to help us do this, linking the actions (outputs) we propose to the outcomes we're aiming for.

- Through the Implementation Plan renew our focus on how we quantify the impact of prevention and early intervention on key outcomes so we can reflect the impact of this work within our Operational and Financial Plans

- Strengthen our Population Health intelligence capability, including within the Primary and Community Care Delivery Programme, to support delivery of the changes within our communities which impact on the prevention and early intervention aspects of our Plan

- Embedding population health analysis and evidence into our business cases as part of our decision-making process.

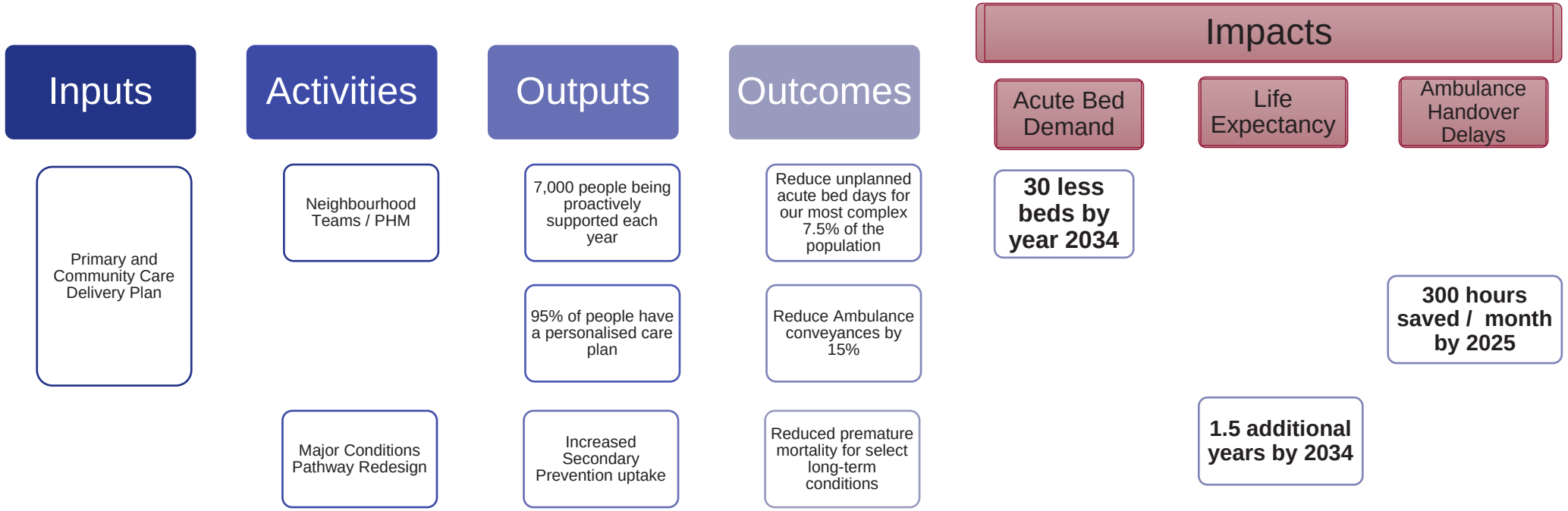
What would this look like? An example:

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

ALL FIGURES ARE ILLUSTRATIVE AT THIS STAGE

Through updating the outcomes within our strategy, supported by the case for change, we are likely to identify ambitions like ‘improve life expectancy by X years by 2034’ or ‘mitigate the expected growth in demand for 200 acute beds by 2034’.

Through the refresh of our implementation plan we will develop logic models for our priority programmes, like the example shown below, which properly assess the impact of our work on our stated outcomes.



Next Steps

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

The Board is asked to:

- Note the work on the BSW Case for Change, what it's telling us regarding the challenges faced in BSW, but also our approach to the delivery of our Strategy
- Support the proposals set out in slide 11 to embed population health analysis within our implementation plan and the work of our priority programmes
- Support the proposal to better embed intelligence into our decision-making processes
- Note there will be changes needed to the way we work together as a system to achieve these aims, and to provide a mandate to develop plans and update at a future Board

Bath and North East Somerset,
Swindon and Wiltshire Together

Case for Change Supporting Analysis: Adults

This analysis is intended to highlight, at a high level, the extent and depths of the challenges faced by the BSW health and care system. It aims to describe why the system needs to change to meet the expected future needs of the population.

The information included is not for operational use and is deliberately summary in nature.

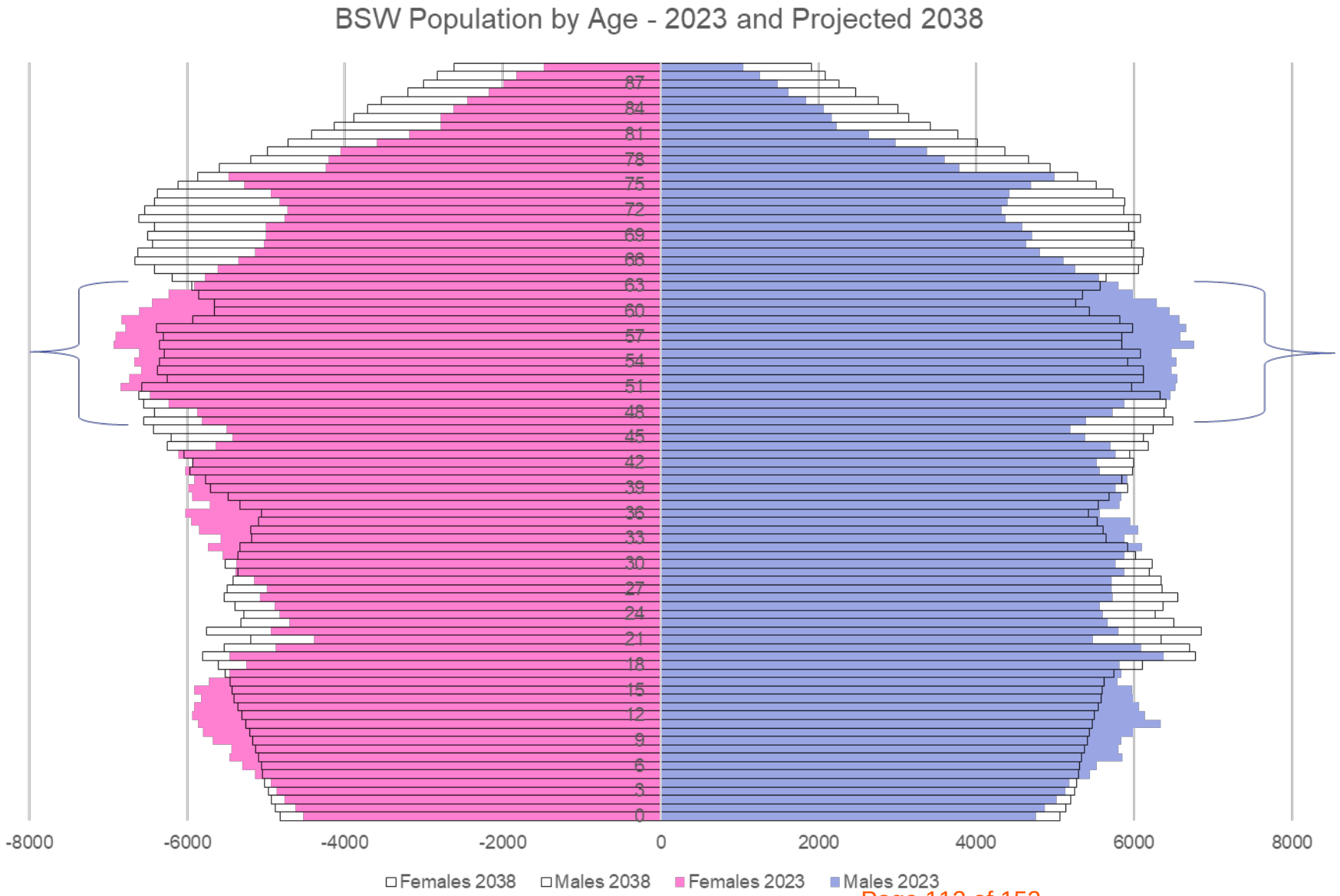
This analysis forms part of a 'phase one'. A wider set of analysis is to be agreed and provided as part of 'phase two', including to support in addressing some of the challenges highlighted within this pack.

August 2023

BSW Case for Change – Exec Summary

- The BSW population is projected to grow by 6% over the next 15 years, meaning there'll be an extra 60,000 BSW residents by 2038
- The number of people aged under 60 will remain stable. All of this growth is in the over 60s, meaning a 35% growth in our population aged 60+.
- Multimorbidity increases with age. These population changes mean there will be an additional 32,000 people with two or more long-term conditions by 2038.
- These population changes mean the ratio of people over 65 to those of 'working age' will decline, impacting upon the ability of the general population to support those with dependencies as they age, but also an ageing NHS workforce
- The cost of Acute Inpatient, Outpatient and A&E activity in BSW is currently £340M. In 15 years, demographic changes alone will see this rise to £410M – or by £5M per year (before inflation or new treatments)
- BSW health services are currently stretched, in particular urgent and emergency services. In 5 years' time our ageing population will require an additional:
    - 115 acute beds
    - 40 ambulance journeys per day
    - 51 additional ED attendances per day
- Many services for Children and Young People are under extreme pressure, with growing demand post-Covid and long waiting times. Improving the health of our CYP population now will make a difference for future health and use of services.
- Nationally and locally, the additional demand on Mental Health services since the pandemic is putting tremendous pressure on mental health and other services, and is increasing waiting times, especially for those needing more routine care
- Social Care services for adults and children are under pressure locally and nationally. Recent national trends have seen requests for support rise and people accessing support fall, and demographic changes will see large increases in demand.

The BSW population is ageing



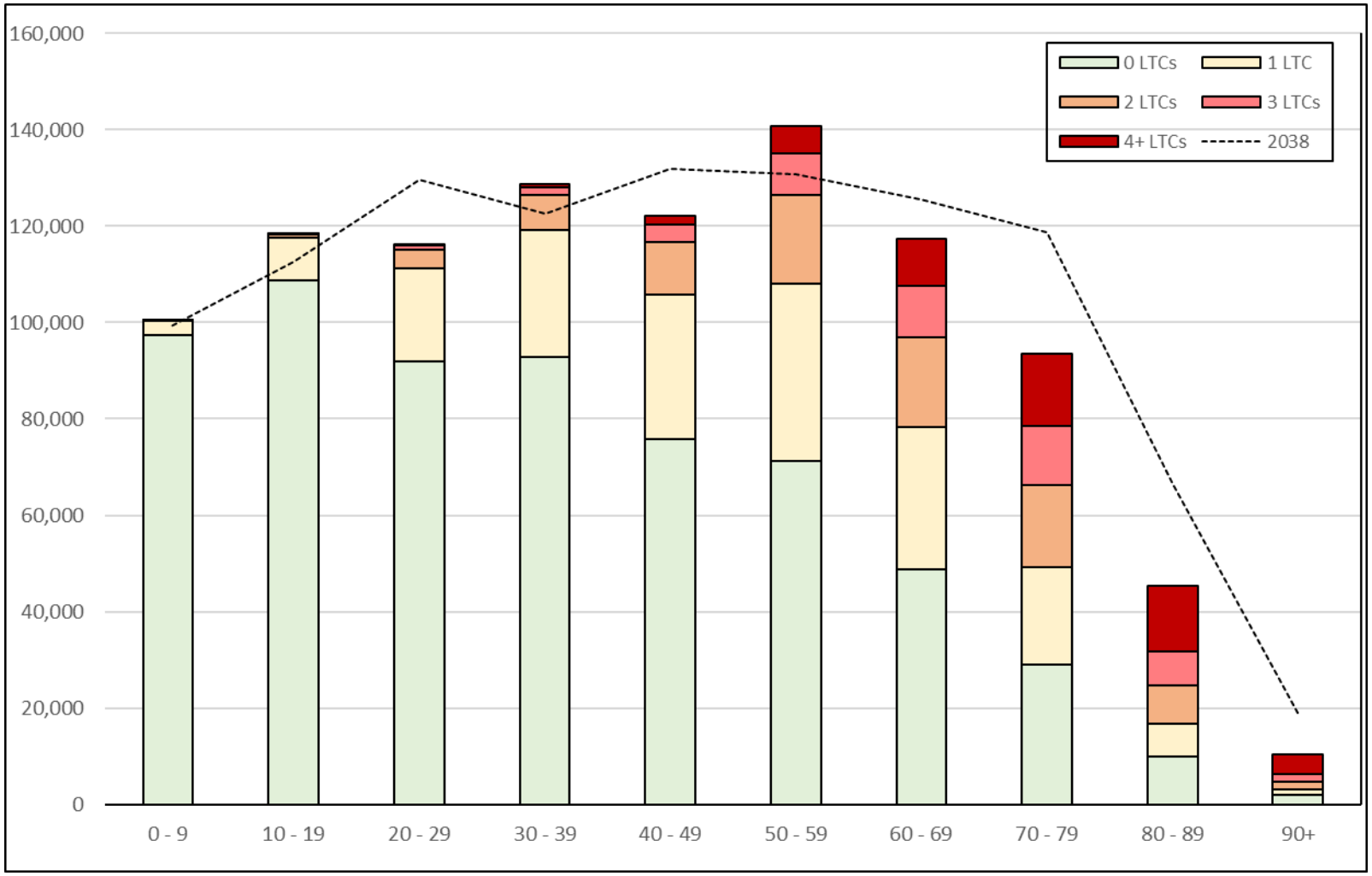
ONS projects the BSW population to grow from 947k to 1.1m over the next 15 years

This is overall growth of around 6%, however our population numbers under 60 will remain unchanged. The number of people over 60 in BSW will grow by 35% over the next 15 years.

BSW has a large population currently aged 50-59. As this group in particular ages, it's likely to put increasing pressure on services in BSW over the coming decade.

BSW also has a large population currently aged 12-18, and those reaching adulthood in the next 5 years are those of the Covid generation, with evidence suggesting substantial impact to their mental health and wellbeing. As this group reaches adulthood, it's likely to put increasing pressure on services in BSW over the coming decade.

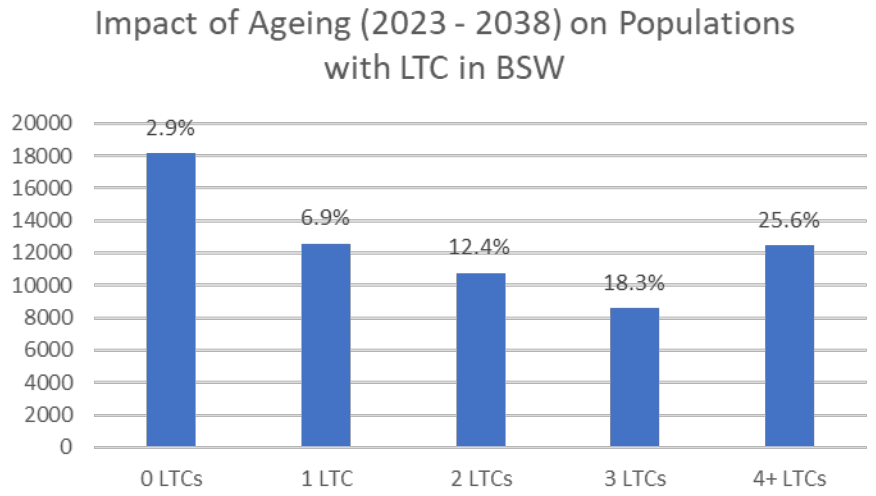
More older people means more multi-morbidity



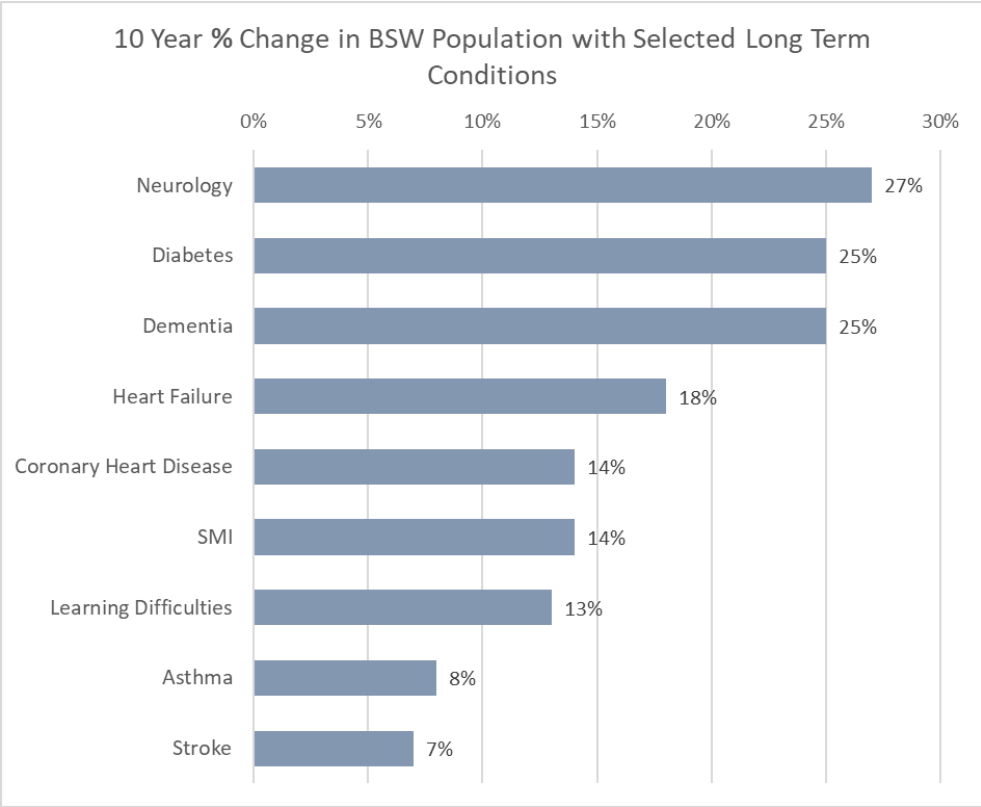
Multimorbidity increases with age. This chart shows the current BSW population by age and number of long-term conditions (LTCs).

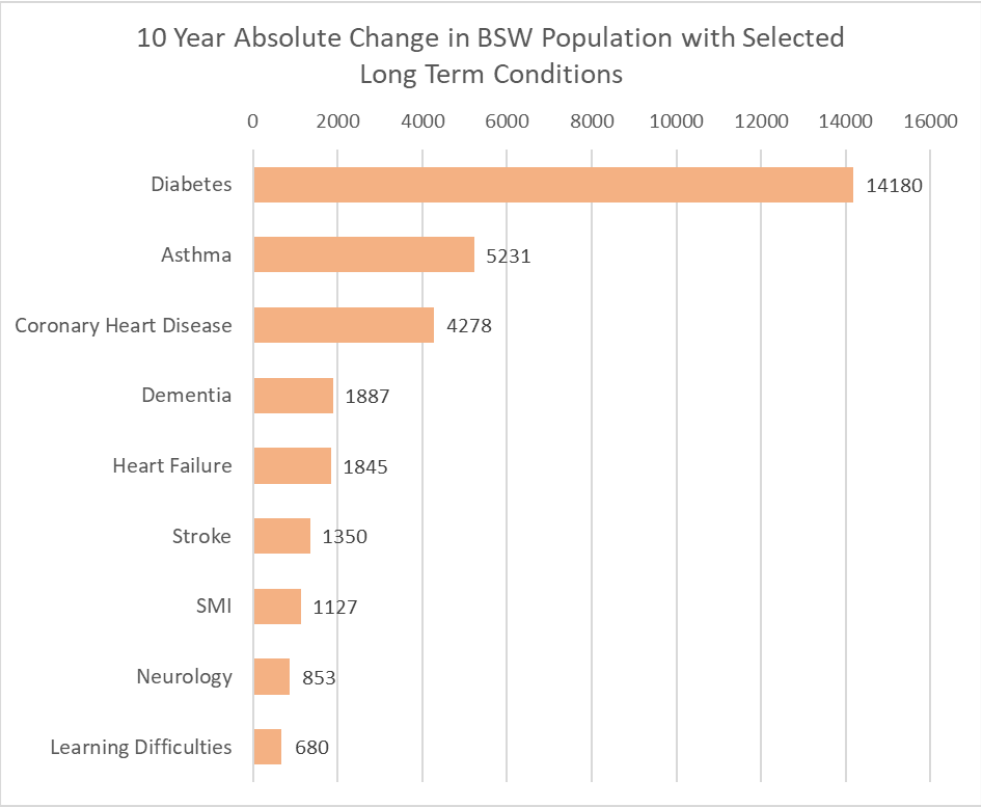
The dashed line represents the population for that age group in 2038. The projected growth in older age groups in BSW mean there will be significantly more people with multiple LTCs by 2038.

The chart below summarises the growth expected in the BSW population by number of LTCs. In 15 years, there will be an additional 32,000 people with more than 1 LTC.



A look at specific conditions





These charts highlight the scale of growth projected for selected long-term conditions taken from BSW modelling.

The % and absolute rises are significant and are compounded by the fact many patients will be multimorbid.

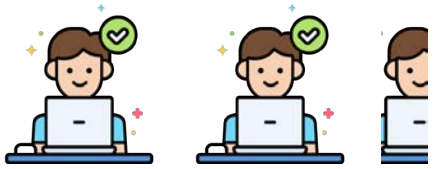
The modelling also shows that in 10 years BSW will have 25,000 more people with **frailty** than we do today.

Source: QOF and the BSW WSP Population Cohorts model

There will be less working age people to support an ageing population

For every BSW person over retirement age there are currently 3.1 people of ‘working age’.

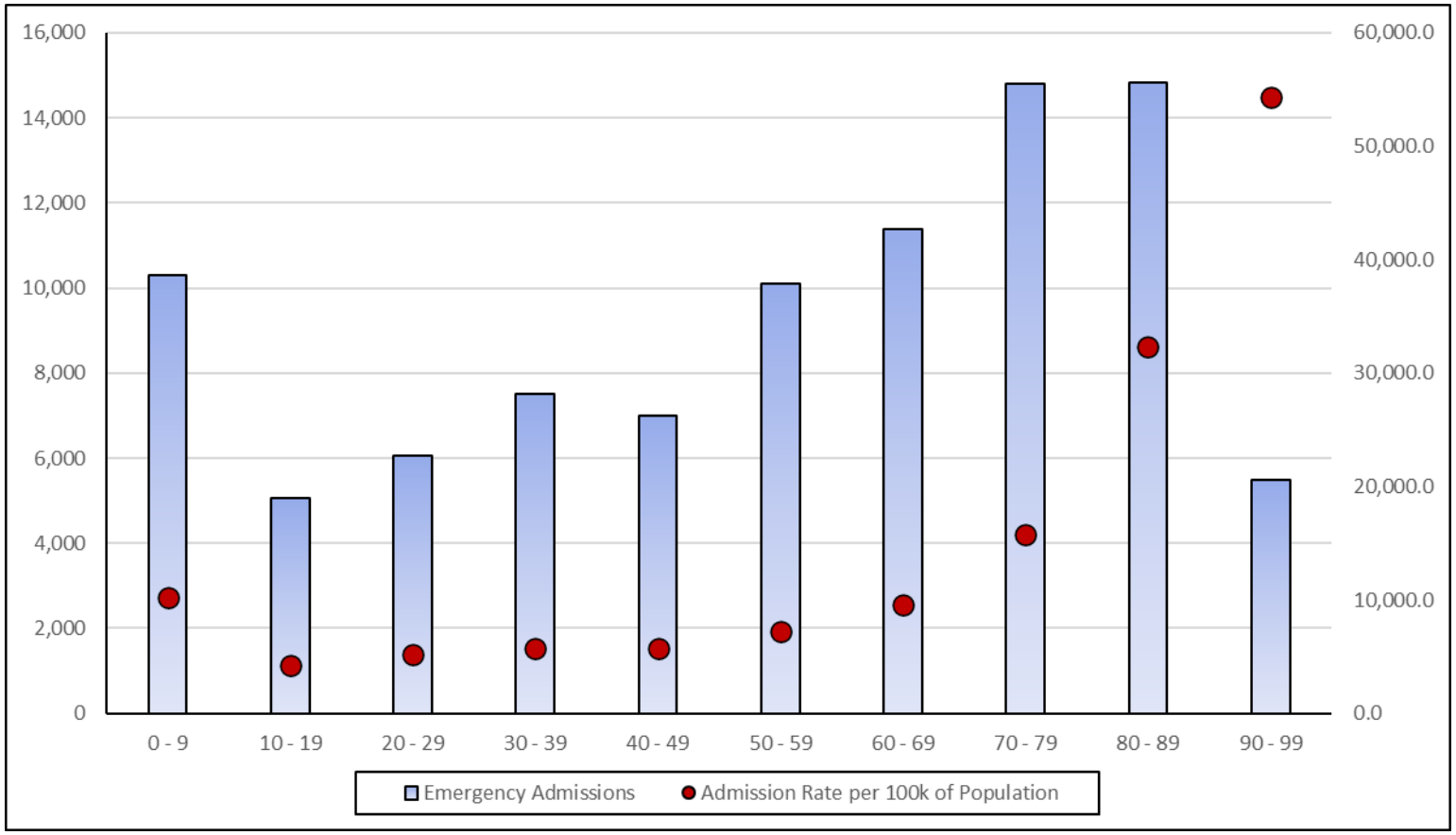
In 15 years, this will have dropped to 2.3



This is also reflected in our workforce. Around 30% of GPs in BSW are over 50.

Assumes retirement age as 66 based on State Pension age (although age increases to 67 around 2027)

With age and multimorbidity come emergency admissions



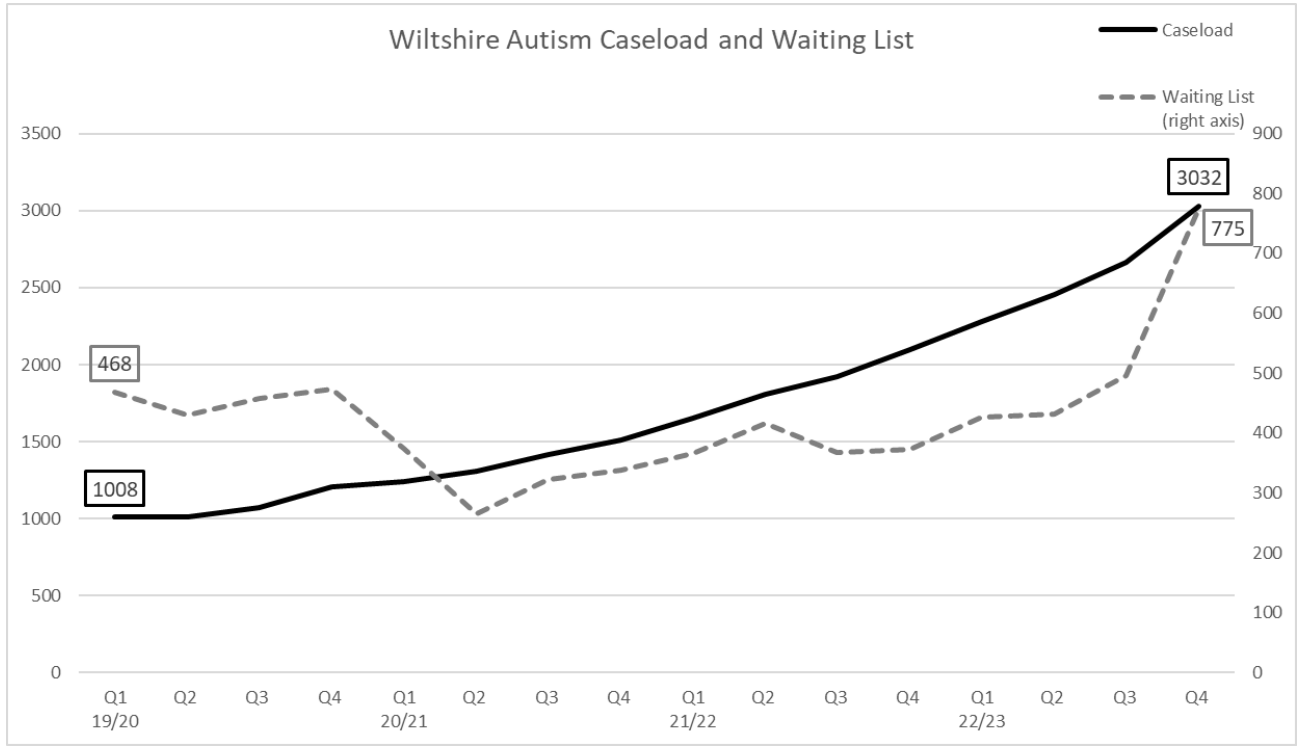
This chart shows BSW emergency hospital admissions by age group – both totals and rates. Emergency admission rates start to rise sharply from the 60-69 age group in line with rises in multimorbidity shown on slide 5.

Emergency admission numbers for 0-9 year-olds show a need to consider prevention measures for this cohort.

Over the next 15 years projections show the BSW population aged under 60 remaining relatively flat, whereas the population over 60 is projected to grow by 61,000.

This will result in a continued demand for emergency beds if services operate as they currently do.

Children's Services (Autism)



The needs and demands of our CYP population are growing. Many services are under extreme pressure post-pandemic, and the impact of our care will be carried forward by this group into adulthood.

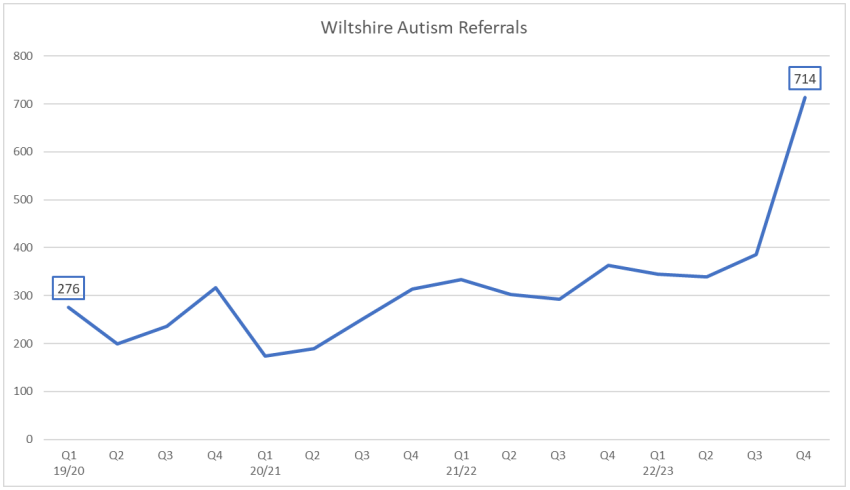
The example shown here is Autism in Wiltshire, however this picture is reflective of wider pressure on CYP services across BSW.

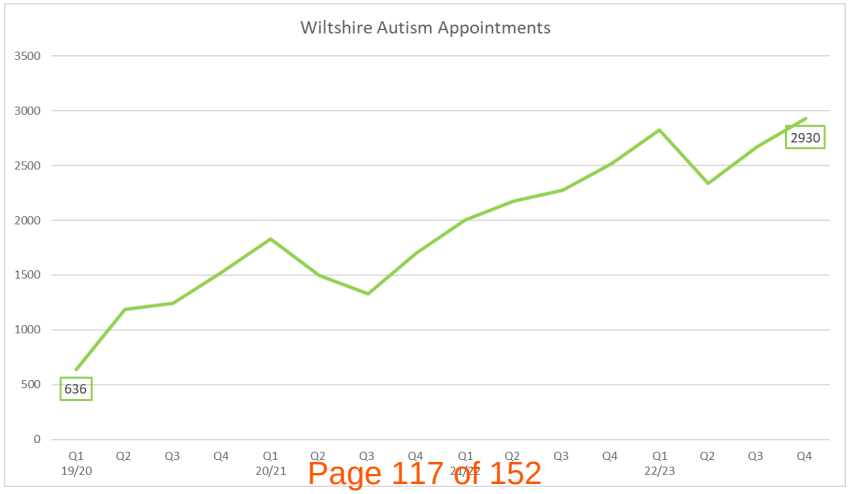
Both the Autism waiting list and caseload have grown significantly in recent years (left). The caseload is triple pre-pandemic levels, and the waiting list has trebled since its low point in 21/22.

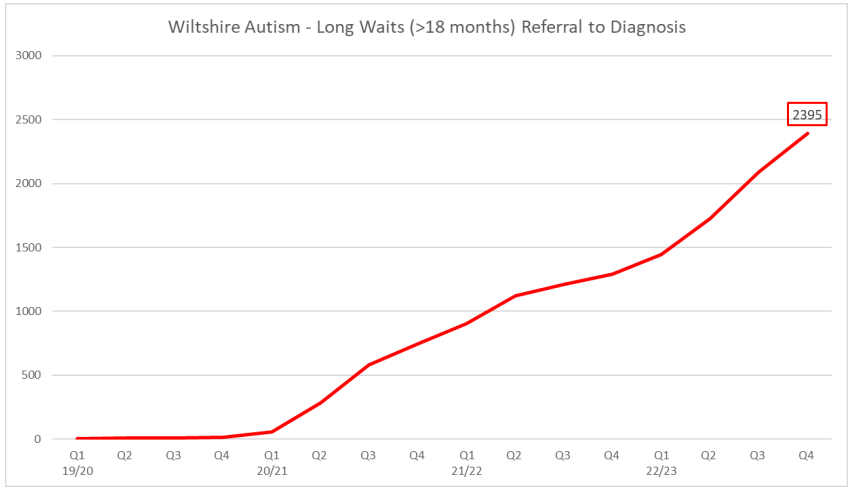
Demand for these services is increasing sharply (below left), and despite increases in appointments (below), waiting lists and times continue to grow. Referrals into the service are increasingly complex. Resources for those most in need is being diluted, and service user anxiety is increasing as a result.

It was historically rare to wait longer than 18 months from referral to diagnosis, however there are now thousands who wait this long (below right).

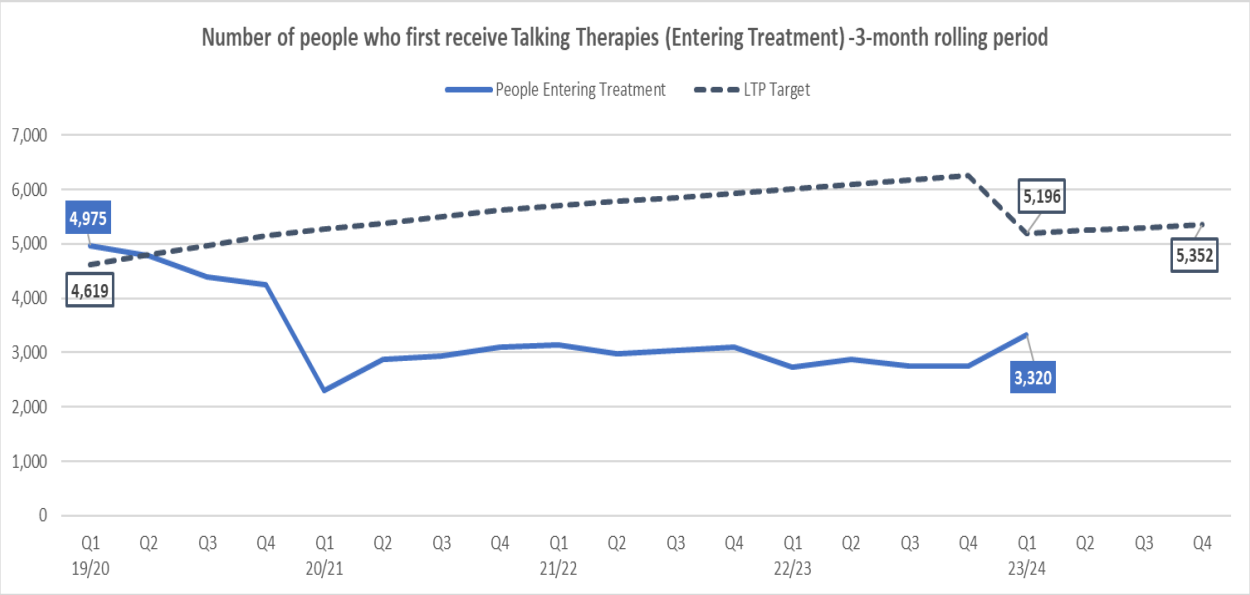
There is opportunity to work differently to address some of these huge challenges, including offers of early help prior to referral to children and their families.







Mental Health Services – Talking Therapies



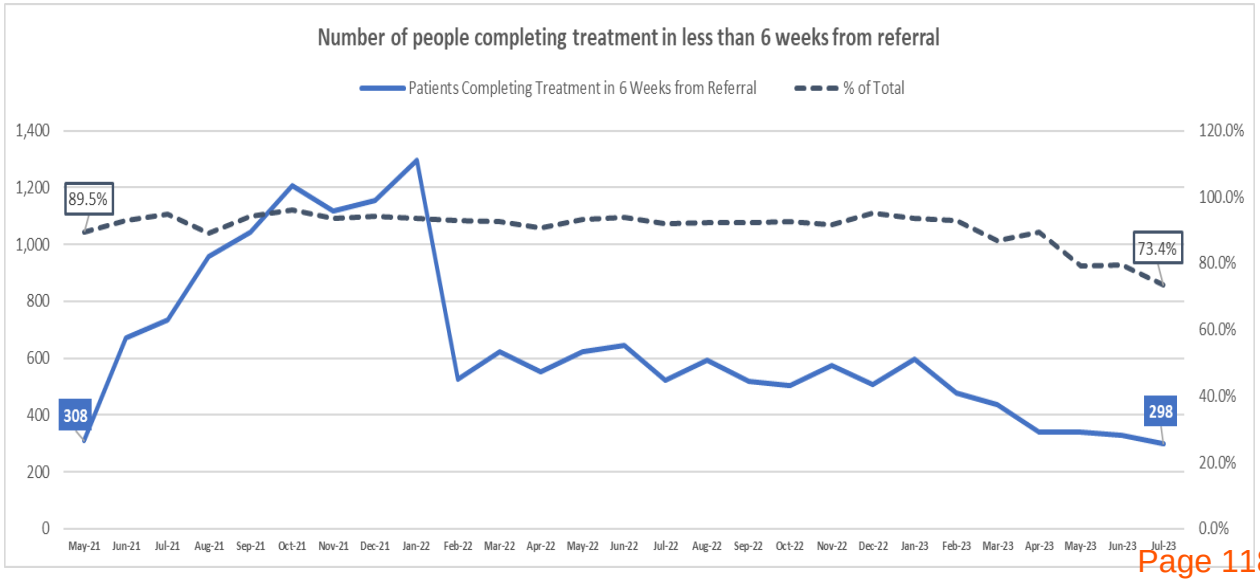
The chart to the left highlights the volume of people entering treatment for talking therapies, which BSW is currently under-delivering on, against its long-term plan targets.

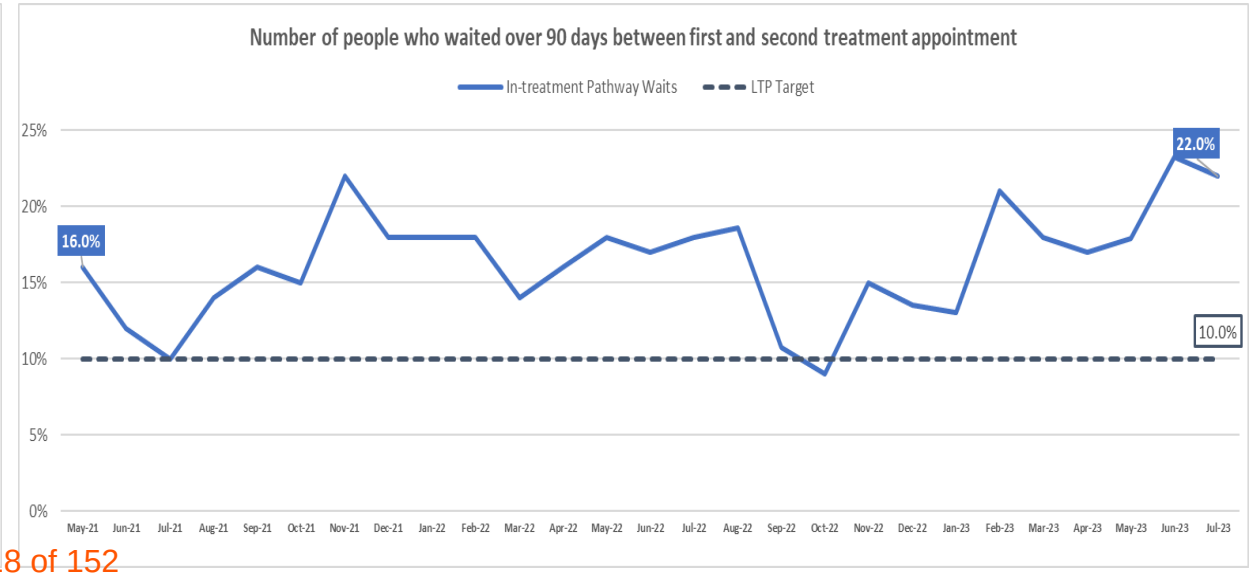
In addition, BSW has a large population currently aged 12-18, and those reaching adulthood in the next 5 years are those of the Covid generation, with evidence suggesting substantial impact to their mental health and wellbeing.

The data shows that there are now more people receiving talking therapie, who are waiting longer between first and subsequent treatments, and fewer patients that are completing first treatment within 6 weeks of referral.

An indication of more complex cases or increased demand/pressure with insufficient capacity. A risk if demand is likely to increase over the next 5-10 years within one of BSW's largest population cohorts.

BSW is beginning to work differently to address the challenges. To address underperformance against the nationally set KPIs, BSW Talking Therapies service converted its operational model in July 23 to align with NICE and the national IAPT/TT model; compliance with these standards will result in sustainably improved KPIs. Whilst not currently meeting the national targets, the service is performing above the proposed recovery trajectory for access and recovery rates.



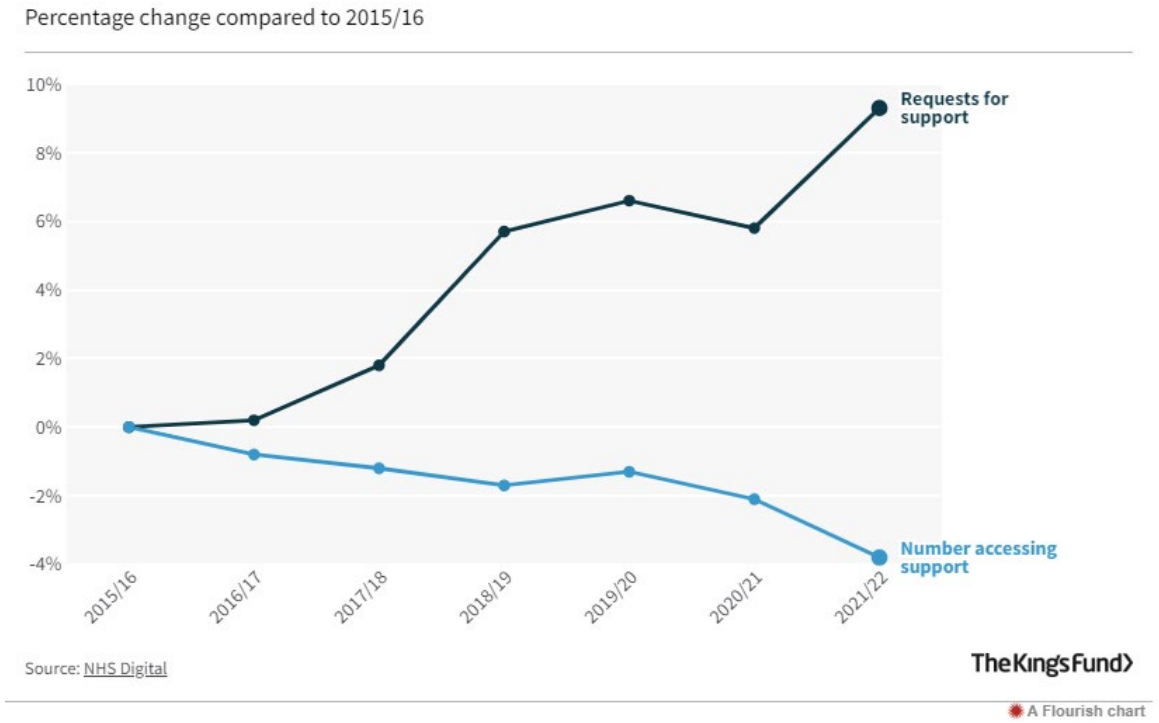


Social Care

The national evidence highlights pressure on social care both now, and the projected future demand pressures from a growing / ageing population.

‘Compared to 2015/16, more people in England are requesting social care support but fewer people are receiving it’

(The Kings’ Fund, 2023)

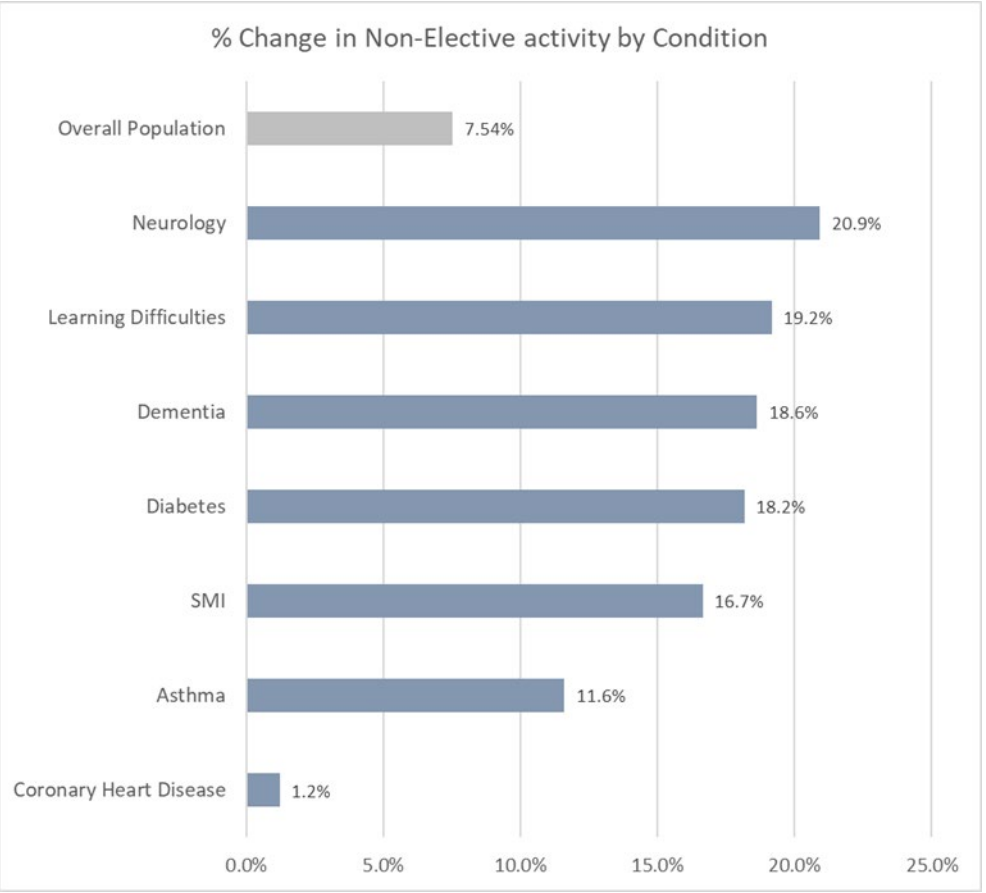


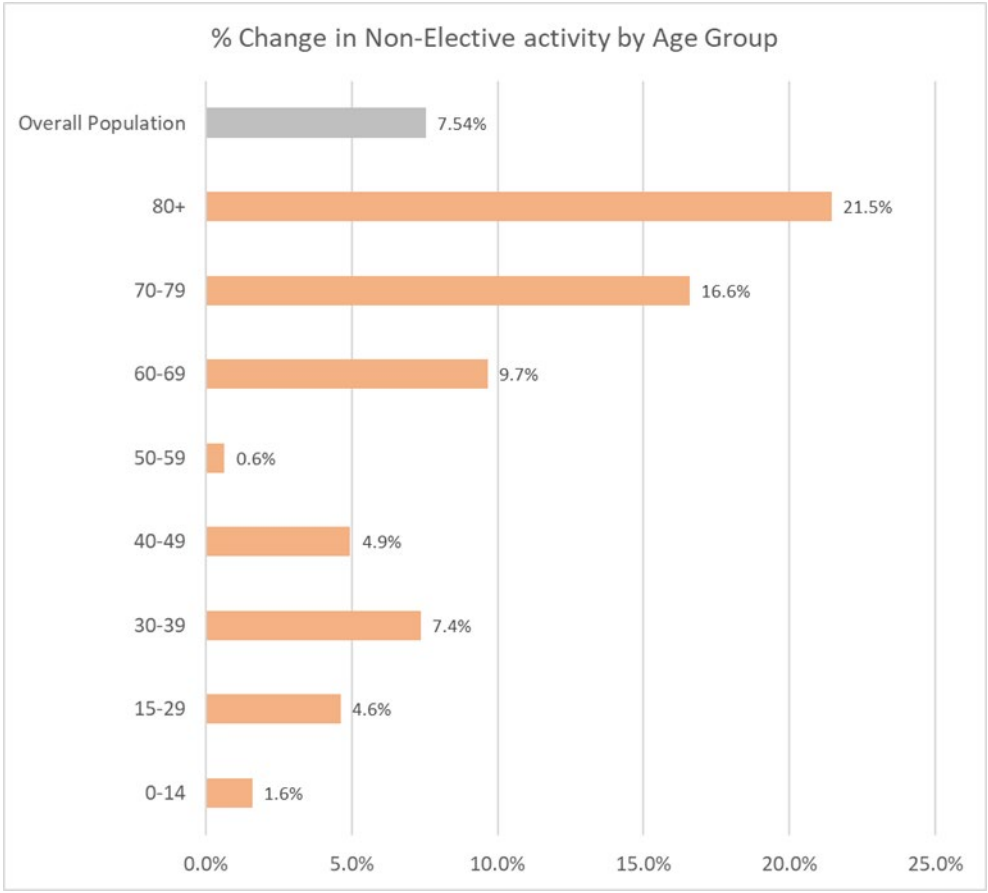
‘Based on long-term forecasts there will be large increases in future demand for care and therefore cost’

(National Audit Office, 2021)

29%	projected forecast increase in adults aged 18 to 64 requiring care by 2038 compared with 2018
90%	projected forecast increase in costs of care for adults aged 18 to 64 by 2038 compared with 2018
57%	projected forecast increase in adults aged 65 and over requiring care by 2038 compared with 2018
106%	projected forecast increase in total costs of care for adults aged 65 and over by 2038 compared with 2018

A look at emergency admissions by condition





BSW modelling allows us to projected emergency (non-elective) admission growth by condition, as well as by age band, from demographic changes over 10 years.

Emergency admissions are expected to grow by around 7.5% overall, however specific condition groups will see sizable growth in demand for emergency beds.

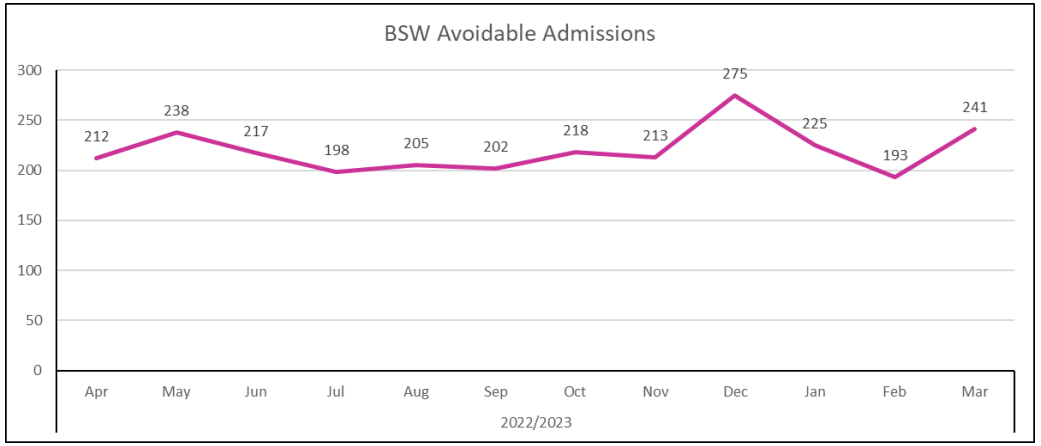
Source: QOF and the BSW WSP Population Cohorts model

Many admissions remain ‘avoidable’

There are several areas where there is opportunity to reduce demand for services in an ageing population.

Avoidable Admissions are emergency admissions for people aged over 75 with specific long-term conditions, which should not normally require hospitalisation.

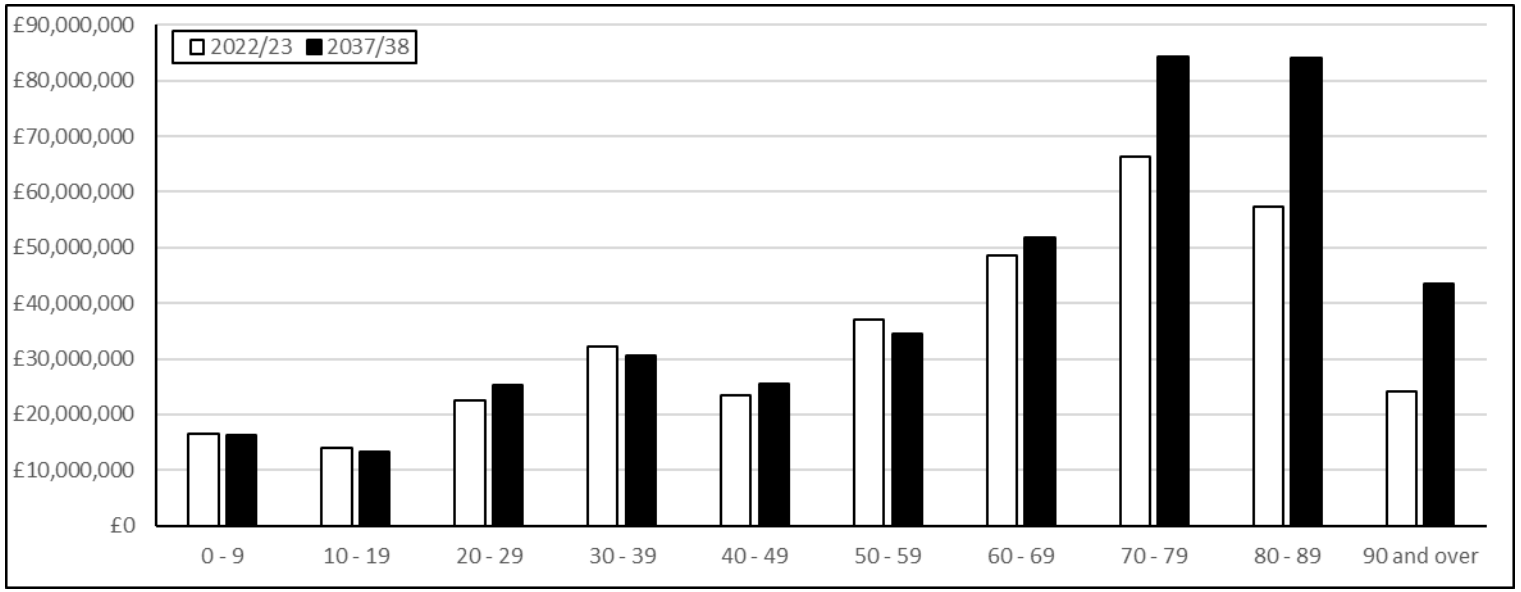
Measured as part of the Better Care Fund these include things like High Blood Pressure, Constipation and Gastro-oesophageal reflux disease.

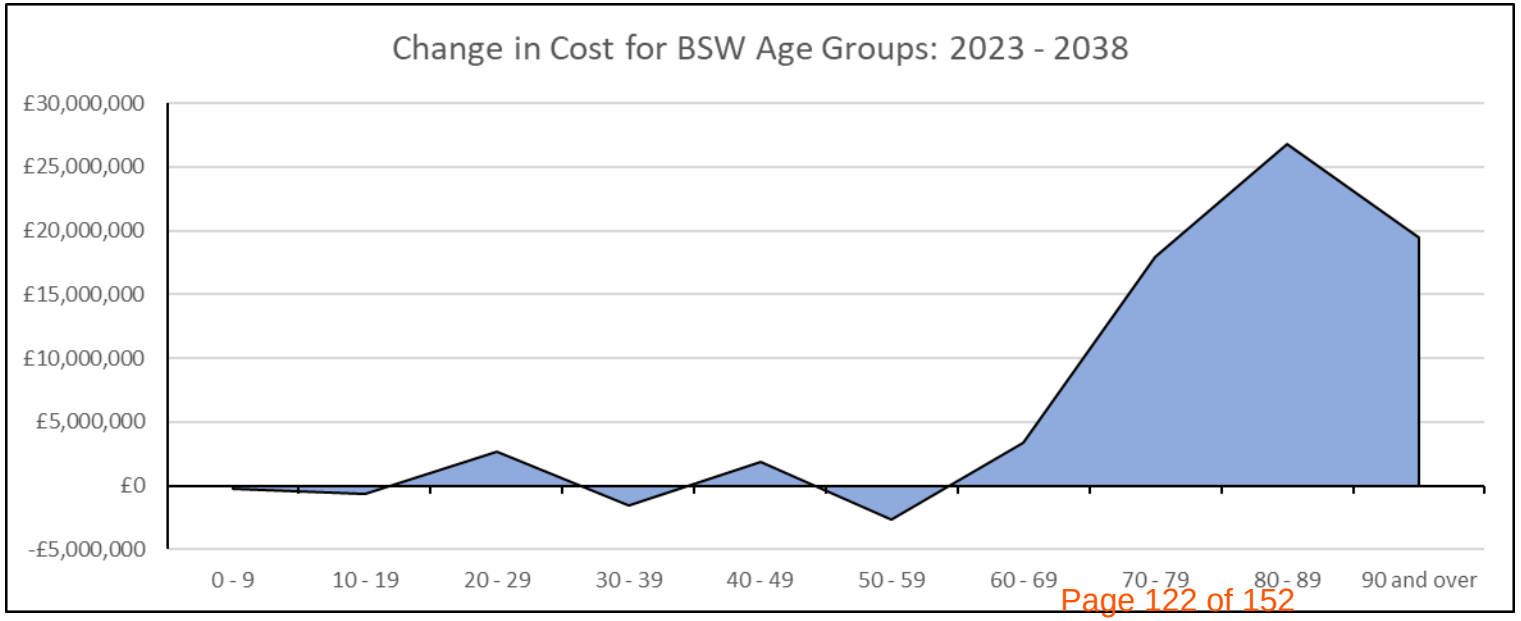


On average there were over 200 ‘avoidable’ admissions of over 75s per month in BSW during 22/23.

At any given time, these patients occupied around 50 acute hospital beds.

Our changing population will bring huge cost pressures



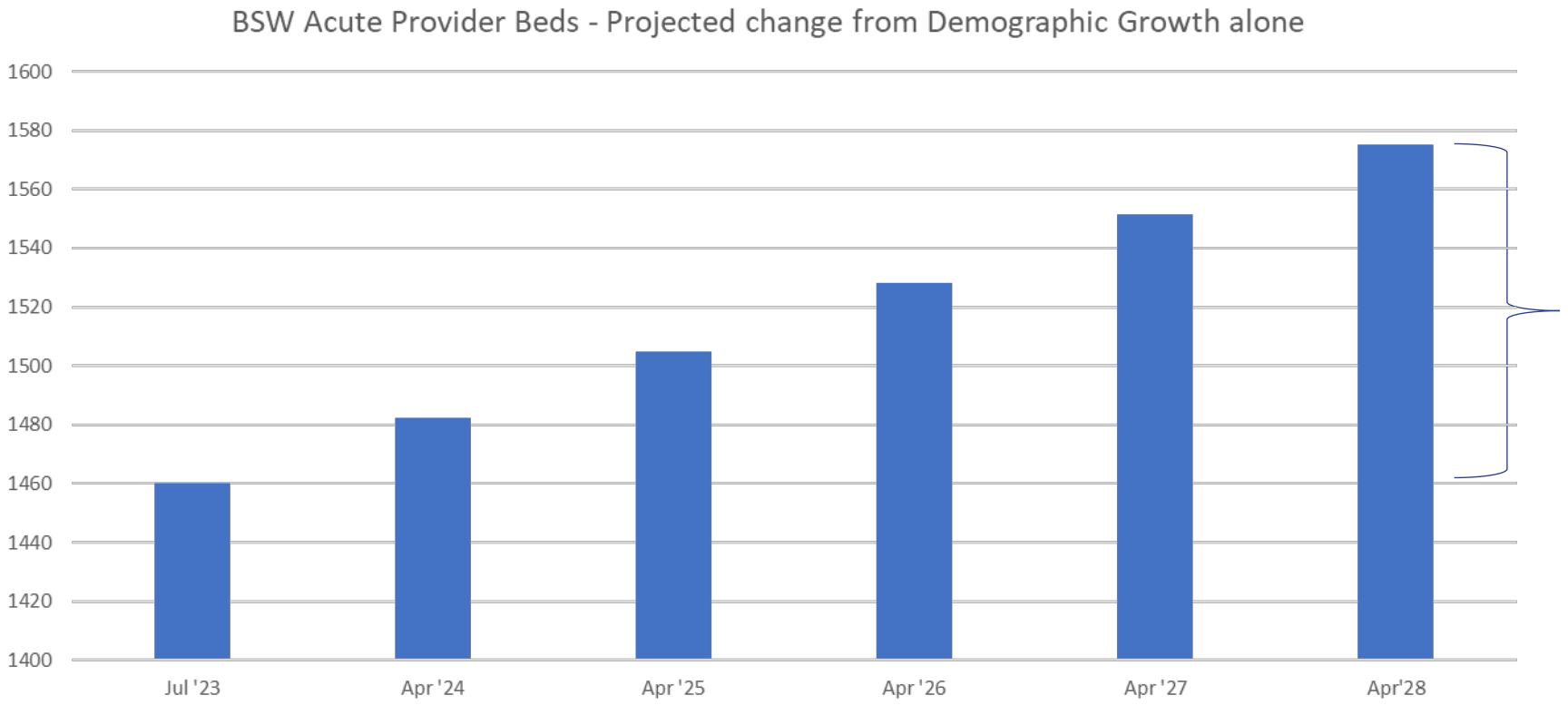


SUS data shows BSW spends around £340M annually on Acute Inpatient, Outpatient and A&E activity.

Demographic change alone is projected to increase this cost by £70M over the next 15 years, or around £5M per year. This is without adjusting for things like inflation, or the cost of new technologies and treatments.

The chart below shows how changes in the over 60s population are driving these cost increases.

Already stretched acute beds will see further demand



Acute beds are under enormous pressure with the BSW system.

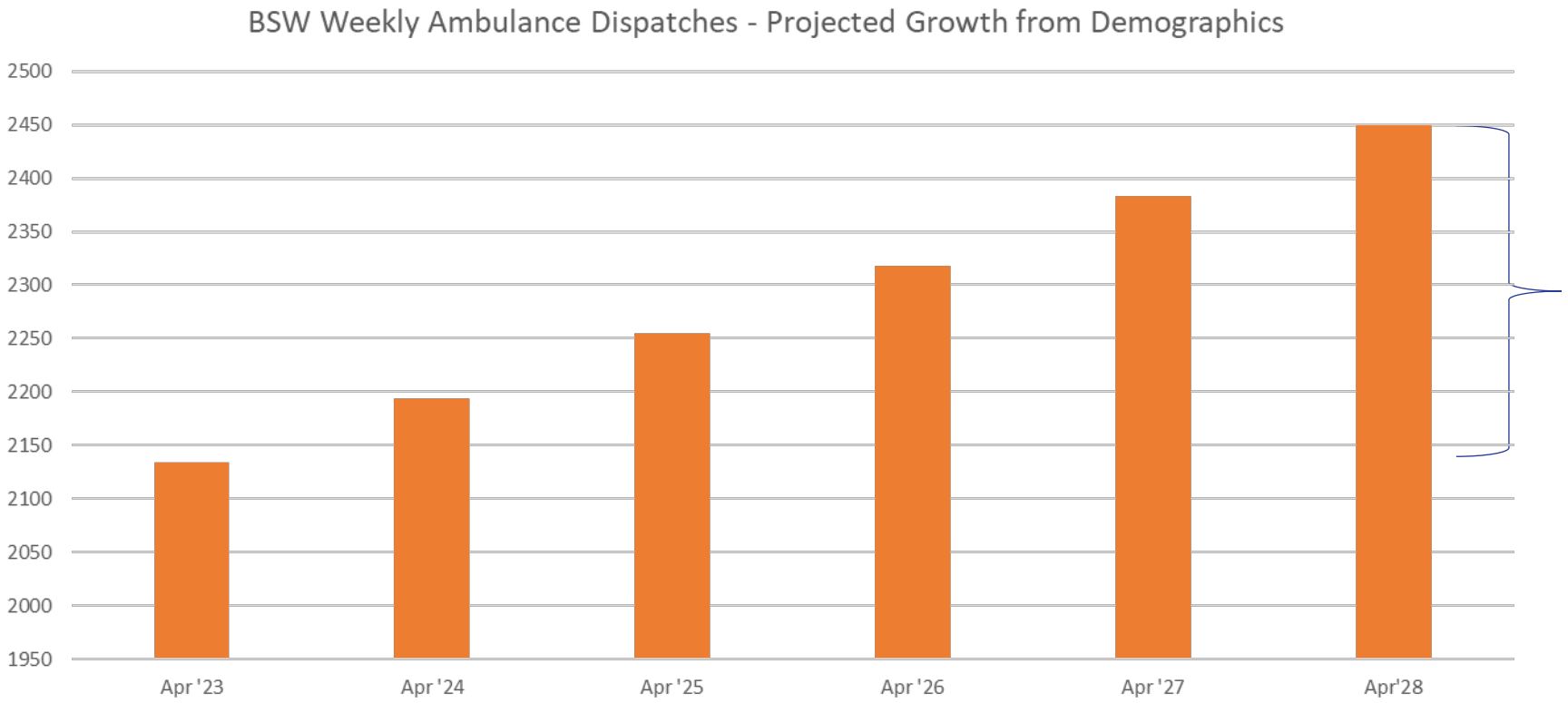
Bed occupancy in BSW is regularly around 95% leaving little headroom to maintain flow through hospitals.

BSW modelling shows that, with no changes to the current service model, demographic changes alone would increase demand for acute beds by 115 in five years - on top of an already stretched system.

This is the equivilent of 6 20-bed wards.

Basic growth projections taken from BSW Population Cohorts model and UEC model

We'll need to dispatch more ambulances



Ambulance services in BSW are under enormous pressure.

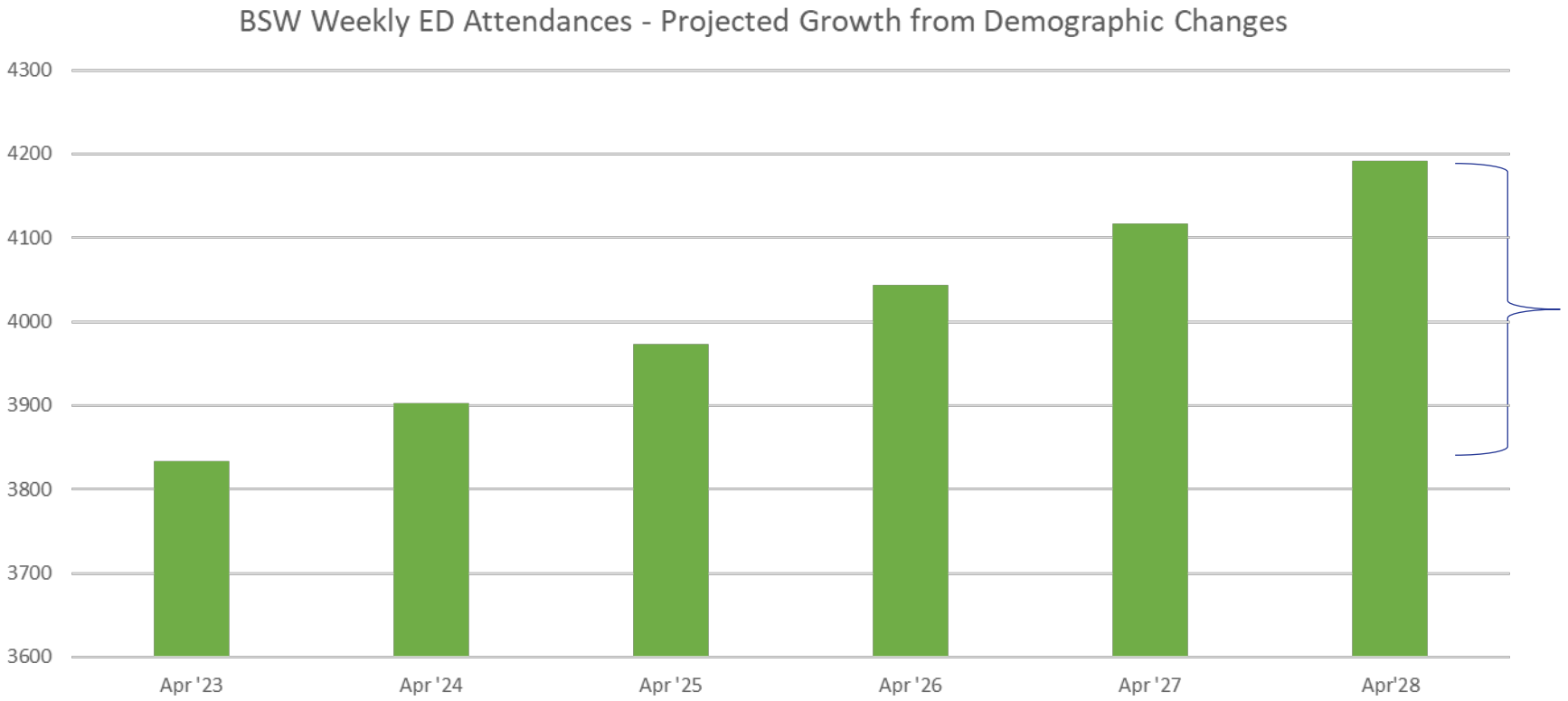
At the extreme end, in several days in December 2022 BSW regularly lost over 300 hours of ambulance time due to ambulances queuing outside hospitals.

BSW modelling shows that demographic changes alone would lead to an additional 280 ambulance dispatches per week in BSW in five years - on top of an already stretched system.

This is the equivilent of 40 extra ambulances journeys per day.

Basic growth projections taken from BSW Population Cohorts model and UEC model

And more people will put pressure on our ED departments



Emergency Departments (ED) in BSW are under enormous pressure.

Around 30% of BSW people attending ED wait longer than 4 hours.

Modelling shows that demographic changes alone would lead to an additional 360 attendances per week at BSW Acute A&E departments - on top of an already stretched system.

This is the equivilent of 51 additional attendances per day, or around 17 extra at each trust ED department.

Basic growth projections taken from BSW Population Cohorts model and UEC model

Bath and North East Somerset,
Swindon and Wiltshire Together

Case for Change Supporting Analysis: Children & Young People

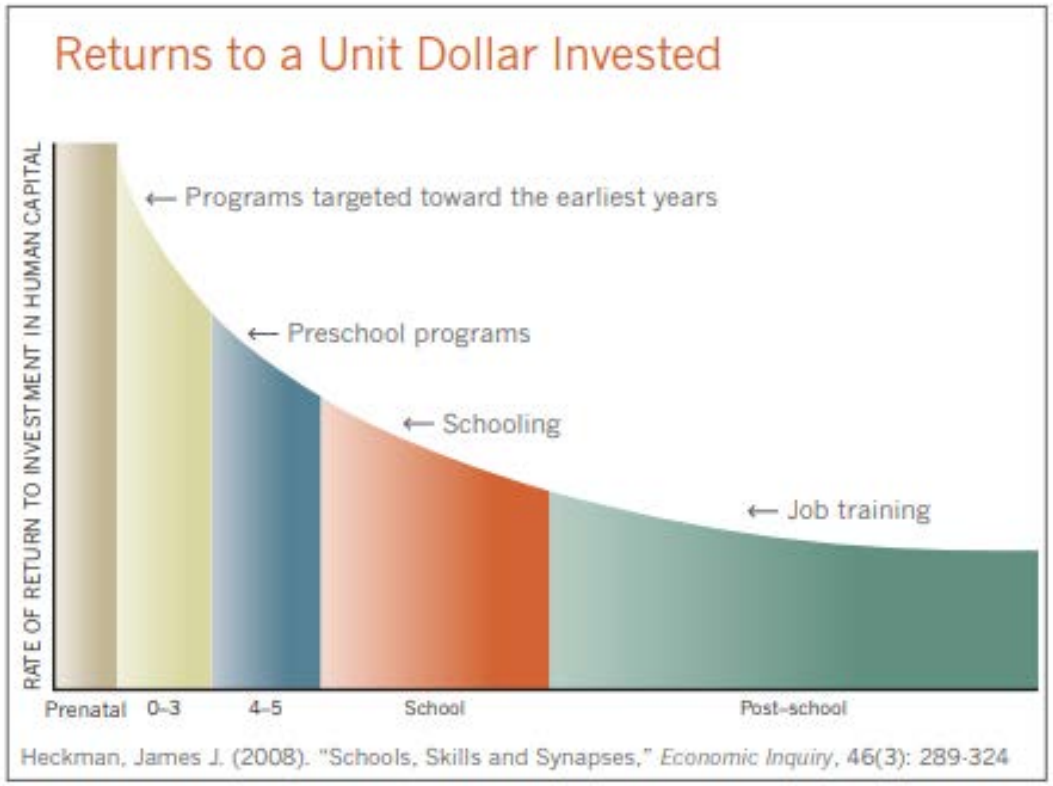
This analysis is intended to highlight, at a high level, the extent and depths of the challenges faced by the BSW health and care system relating to the Children and Young People Population. It aims to describe why the system needs to change to meet the expected future needs of the population.

The information included is not for operational use and is deliberately summary in nature.

BSW Case for Change – Exec Summary

- The BSW population is projected to grow by 6% over the next 15 years, meaning there'll be an extra 60,000 BSW residents by 2038.
- In BSW, CYP aged 0-25 account for 29.5% of our total population. BSW has a large population currently aged 12-18, and those reaching adulthood in the next 5 years are those of the Covid generation, with evidence suggesting substantial impact to their mental health and wellbeing. As this group reaches adulthood, it's likely to put increasing pressure on services in BSW over the coming decade.
- Circa 25k CYP in BSW have at least 1 LTC and of those, 2,643 have 2 and a further 496 have 3. A large segment of this cohort will have significant health needs which are likely to become increasingly complex. Compared to adults living with major conditions, children and young people have a much longer life span compared to the adult population.
- The likelihood of a person being in the most deprived 20% of the population ('Core20') decreases with age, meaning CYP are more likely to be deprived than adults of working age or over 65s. CYP with major conditions are then more likely still than their peers to be in the most deprived group.
- On average, for CYP there was a relative 10% increase in risk of death between each decile of increasing deprivation (as defined by the Indices of Multiple Deprivation (IMD)). The cost-of-living crisis will push more families into poverty, which is likely to exacerbate existing inequalities for children and young people.
- Mental health conditions have become more common among children and young people. Among those aged 6 to 16 in England, one in six had a probable mental health condition in 2021, up from one in nine in 2017. Current figures are especially concerning for adolescent girls aged between 17 and 19: one in four had a probable mental health condition in 2021.
- Many services for Children and Young People are under extreme pressure, with growing demand post-Covid and long waiting times. Improving the health of our CYP population now will make a difference for future health and use of services.
- Approximately 33% of children in 2021/22 were either overweight or obese, a measure which deteriorates across the Primary School Years. The 2021/22 increase in numbers and prevalence is particularly stark among those classified as severely obese.
- Covid has had a significant impact. 83% of young people with mental health needs agree that the Covid-19 pandemic has made their mental health worse. Persistent absence (defined as missing 10% of lessons) has doubled from 8% at primary and 13.7% of secondary school children to 17% and 28%.

Ensuring that babies, children and young people have the chance to live healthy lives will radically improve population health, economic prosperity and value for money for the NHS



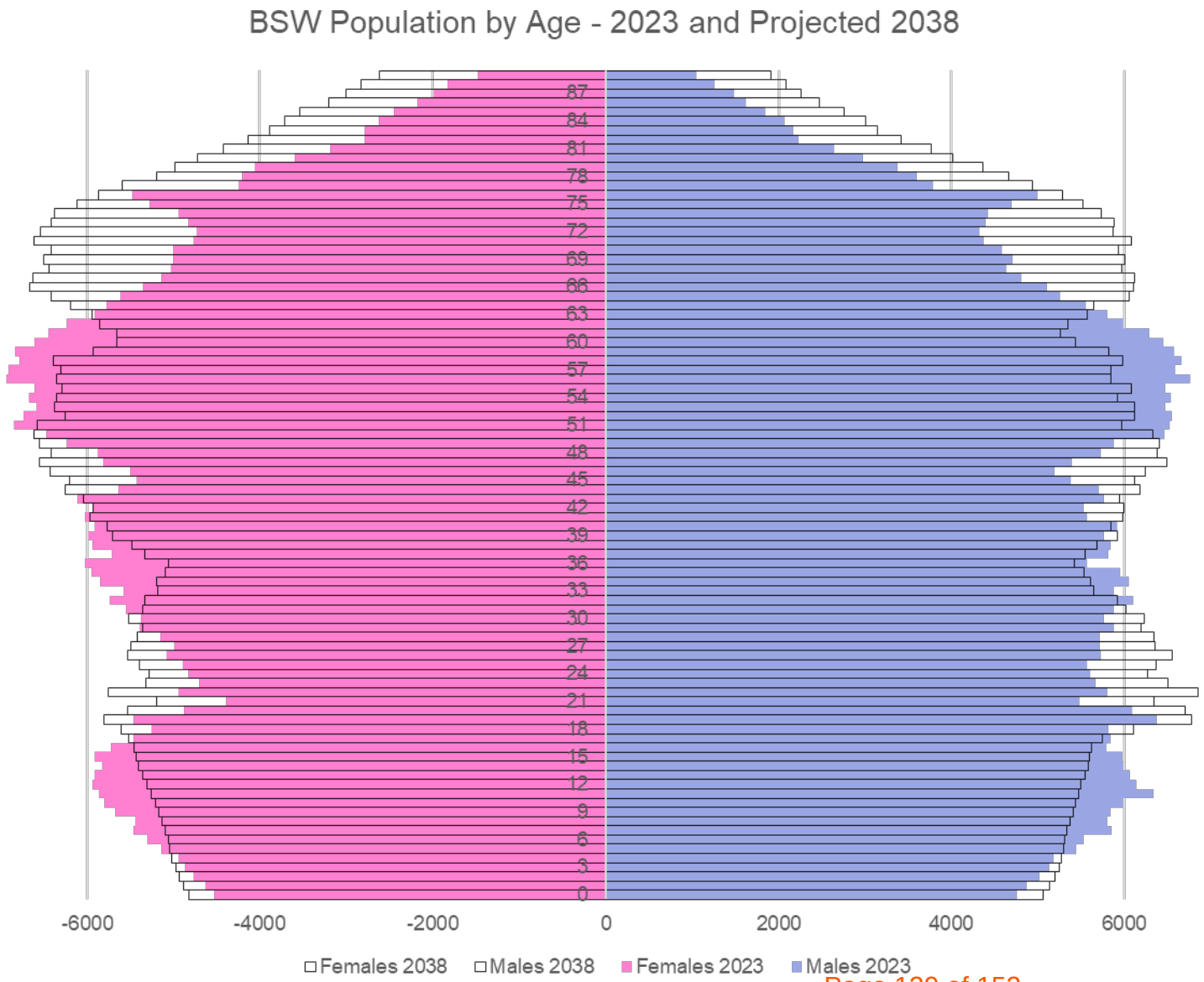
Making greater investments in children's health sets in motion favourable demographic changes, and shows that safeguarding health during childhood is more important than at any other age because poor health during children's early years is likely to permanently impair them over the course of their life.
Investing in children's health: what are the economic benefits? Belli PC, Bustreo F, Preker A.

Level of funding and investment in early years remains below OECD and EU averages. In 2016, Early Intervention Foundation estimated that the national cost of 'late intervention' (the acute, statutory and essential benefits and services that are required when children and young people experience significant difficulties in life that might have been prevented) was £16.6 billion. Investment in the early years, the stage at which the most significant changes can be made to people's long-term outcomes, is the most cost-effective and equity-effective time to invest.
The Marmot Review 10 Years On; Michael Marmot

Data shows that one of the most effective strategies for economic growth is investing in the developmental growth of at-risk young children.
Short-term costs are more than offset by the immediate and long-term benefits through reduction in the need for special education and remediation, better health outcomes, reduced need for social services, lower criminal justice costs and increased self-sufficiency and productivity among families.
A critical time to shape productivity is from birth to age five, when the brain develops rapidly to build the foundation of cognitive and character skills necessary for success in school, health, career and life.
Invest in early childhood development: Reduce deficits, strengthen the economy; James J. Heckman (Henry Schultz Distinguished Service Professor of Economics at The University of Chicago, a Nobel Laureate in Economics and an expert in the economics of human development)

Slide credit: NHS Medium Term Plan Children and Young People 15062023

The BSW population is changing



ONS projects the BSW population to grow from 947k to 1.1m over the next 15 years

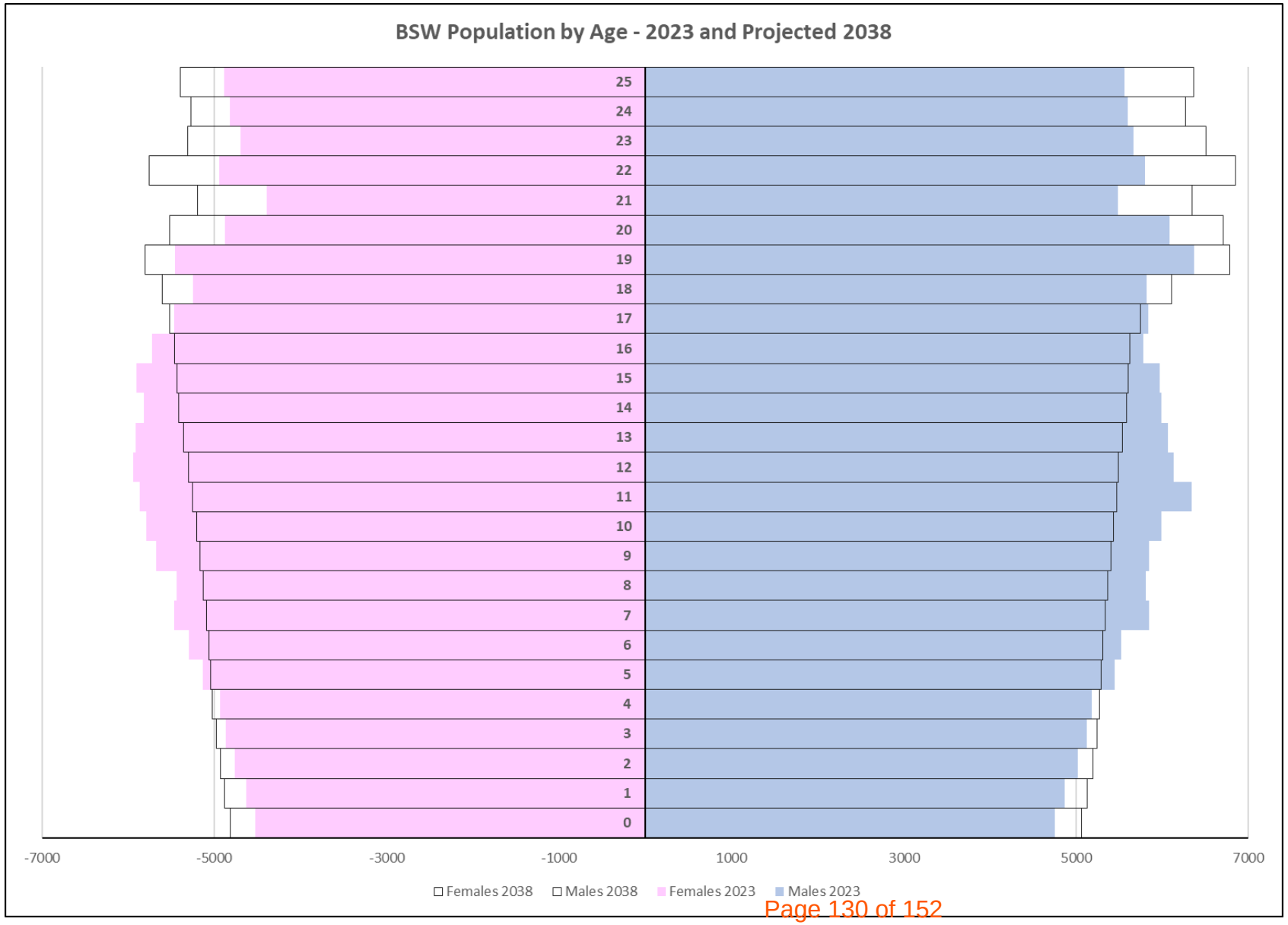
Under the Health and Care Act 2022[1], Integrated Care Boards (ICB) must demonstrate how they will 'address the particular needs of children and young persons under the age of 25'.

In BSW, CYP aged 0-25 are 29.5% of our total population. Babies, children and young people, working age adults and older people all have specific needs and preferences to be considered in our models of prevention and treatment.

BSW children with major conditions, mental health issues, living with excessive weight, learning disabilities and autism, special educational needs and disability are already facing a sense of crisis.

1Health and Care Act 2022

The BSW CYP population



The Children and Young People population (CYP) is defined as those aged 0 to 25 years old.

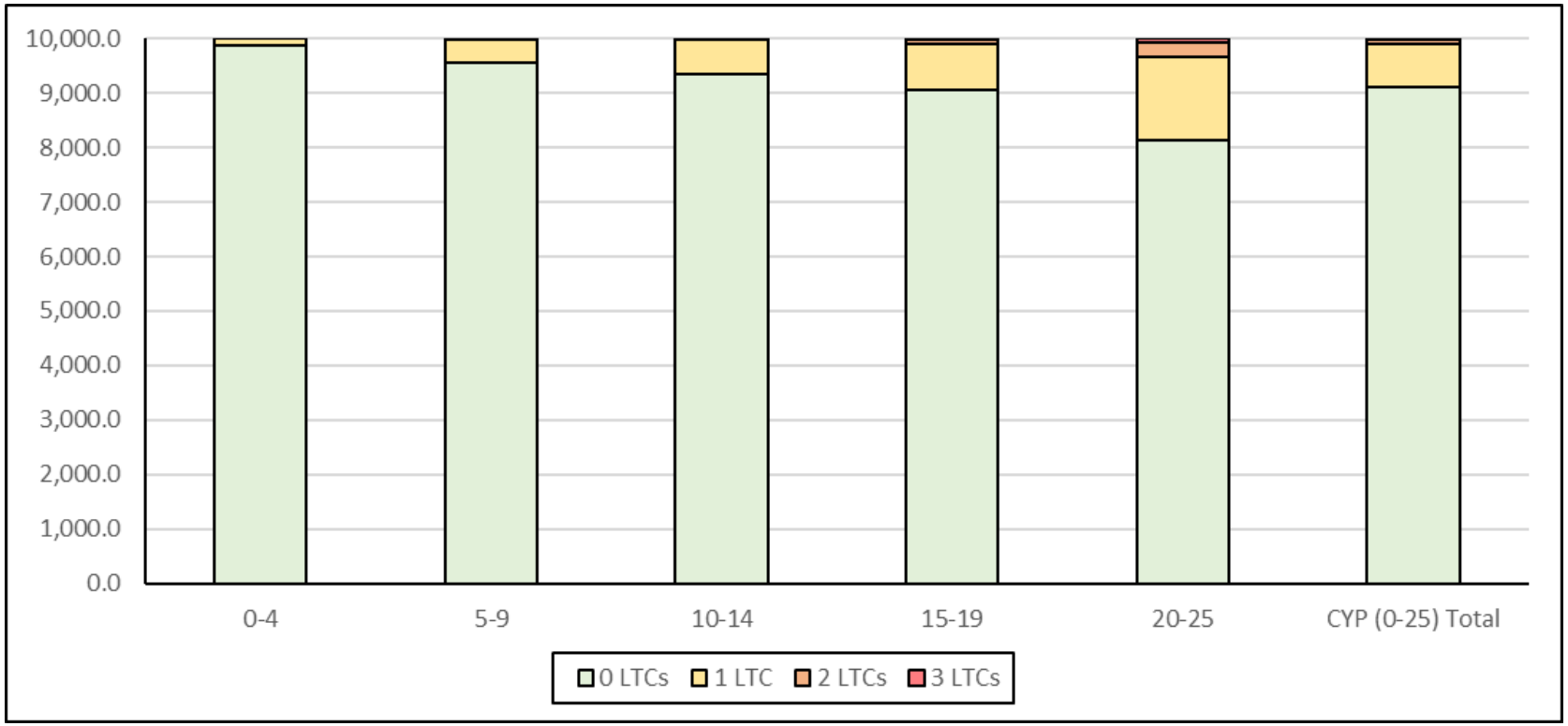
ONS projects the BSW population to grow from 947k to 1.1m over the next 15 years, including growth of 1.7% among the CYP population.

BSW has a large population currently aged 12-18, and those reaching adulthood in the next 5 years are those of the Covid generation, with evidence suggesting substantial impact to their mental health and wellbeing. As this group reaches adulthood, it's likely to put increasing pressure on services in BSW over the coming decade.

The CYP populations in each LA area are reasonably varied, with a large university population in B&NES, the BAME population in Swindon, and the decreasing CYP population in Wiltshire.

The BSW CYP Population and Major Conditions

Number of LTCs	0-4	5-9	10-14	15-19	20-25	CYP (0-25) Total
0	44,425	52,847	56,570	52,262	55,631	**261,735**
1	572	2,444	3,741	4,989	10,473	**22,219**
2	12	60	159	471	1,941	**2,643**
3+		5	6	63	422	**496**



The table opposite details the absolute numbers of each CYP age group in BSW, shown by these populations' number of major, or 'long term' conditions (LTCs).

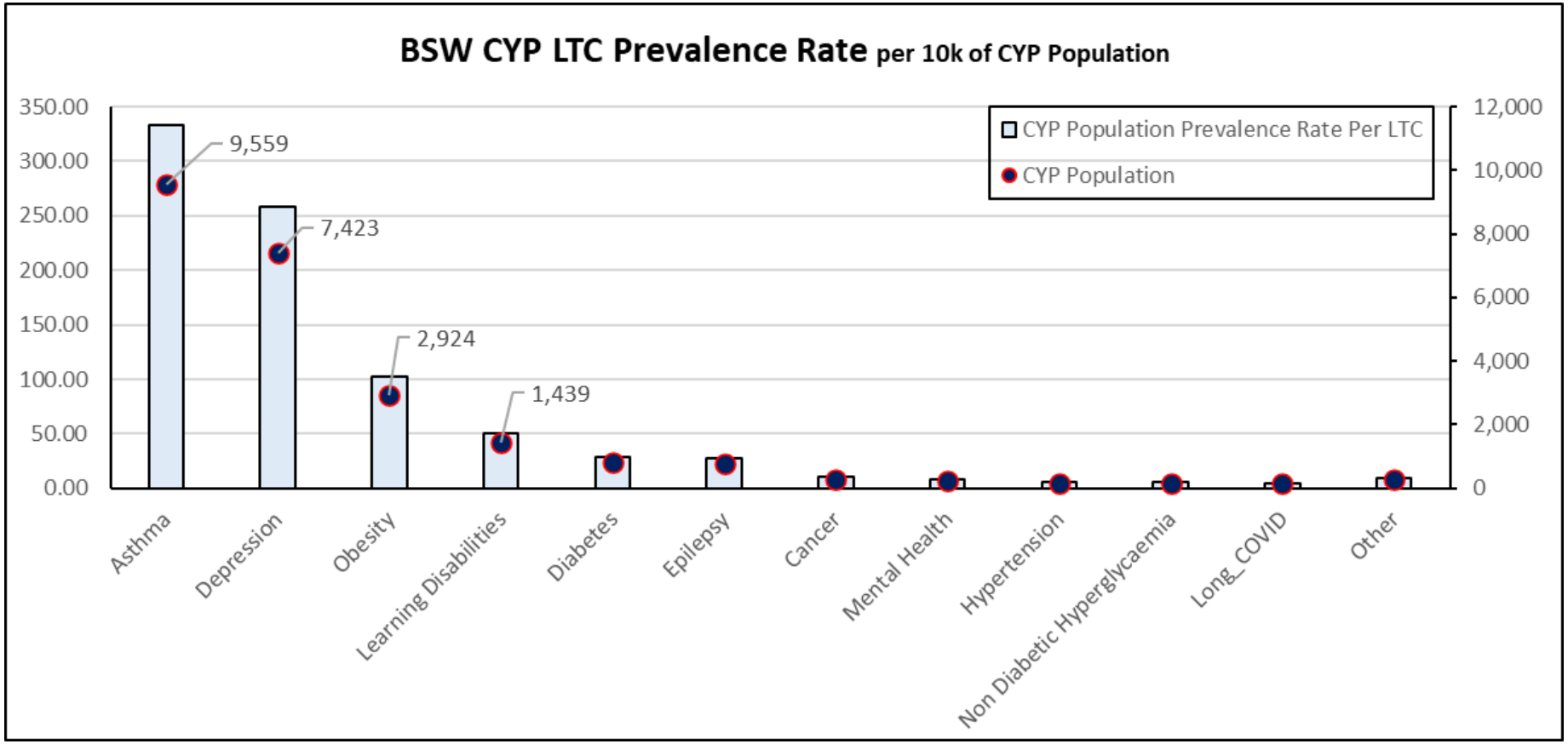
The graph opposite demonstrates the LTC count as a rate per 10k of each age group's population.

Circa 25k CYP in BSW have at least 1 LTC and of those, 2,643 have 2 and a further 496 have 3. A large segment of this cohort will have significant health needs which are likely to become increasingly complex. Compared to adults living with major conditions, children and young people have a much longer life span.

The complex interplay between factors means there are some children that are extremely vulnerable and impacted as a result.

For example, Children Looked After (CLA) and care-experienced young people have an increased likelihood of having a learning disability, autism, higher mental health needs and are more likely to live with excessive weight or obesity[1]. The complications arising from this are compounded further by having a major condition.

A look at specific Long-Term Conditions

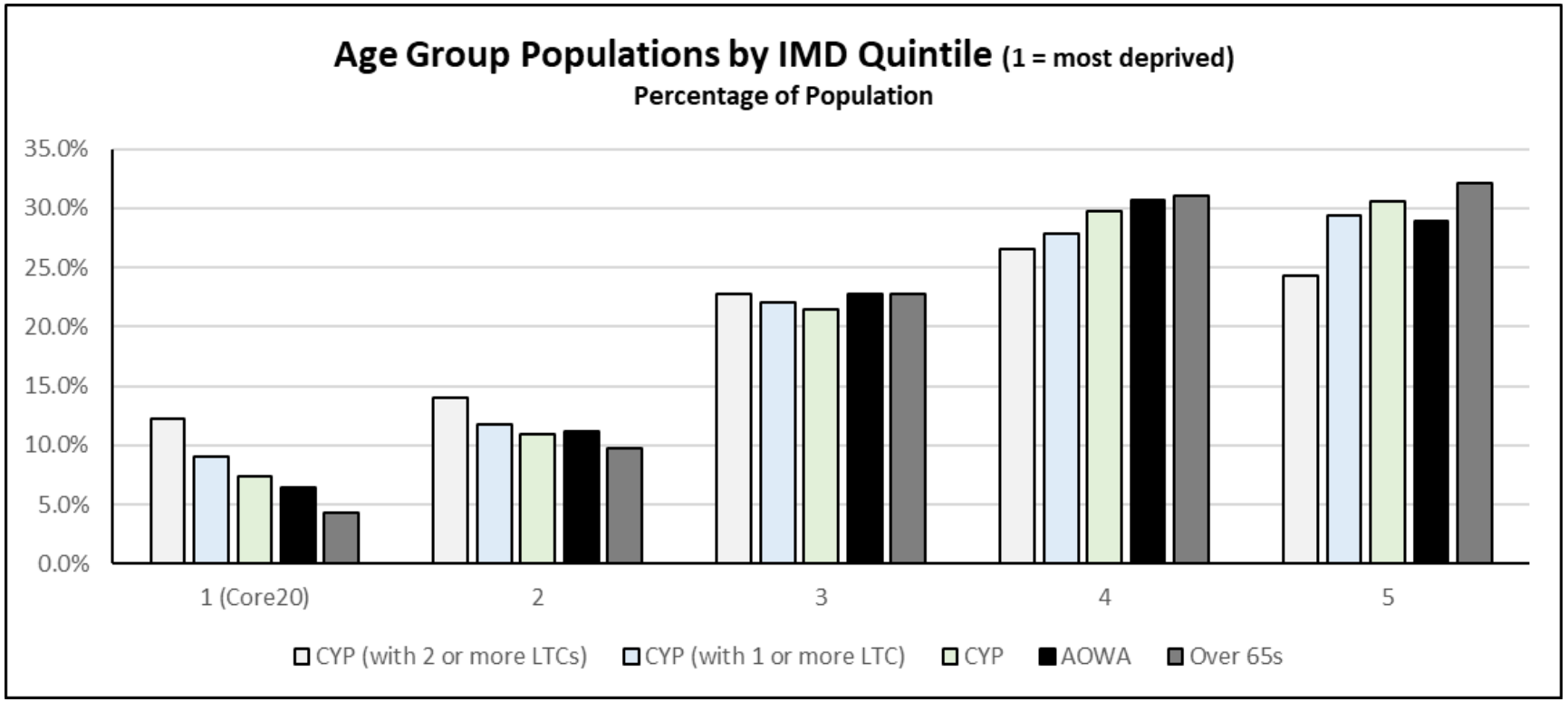


The graph opposite demonstrates the long-term conditions prevalence (selected QOF conditions) and absolute population numbers in BSW.

Among the 0 to 25-year-olds in BSW, Asthma and depression are the most prevalent conditions. For example, there are around 340 with a diagnosis of asthma and 250 with depression per 10k of the population. There are also a significant number living with obesity or with learning disabilities.

Although BSW's prevalence benchmarks relatively well nationally, this is at least partly due to the relative deprivation of the BSW population. Conditions such as asthma, depression, and obesity are strongly linked to deprivation and socio-economic factors, thus creating a health inequality.

The CYP Population and major conditions (LTCs)



The graph opposite demonstrates the link between age and deprivation and highlights the link between health and deprivation among the CYP population.

Using the Indices of Multiple Deprivation (IMD) as the method of defining deprivation, the likelihood of a person being in the most deprived 20% of the population (IMD quintile 1, 'Core20' Population) decreases with age, meaning CYP are more likely to be deprived than adults of working age or over 65s. CYP with major conditions are then more likely still than their peers to be in the most deprived group.

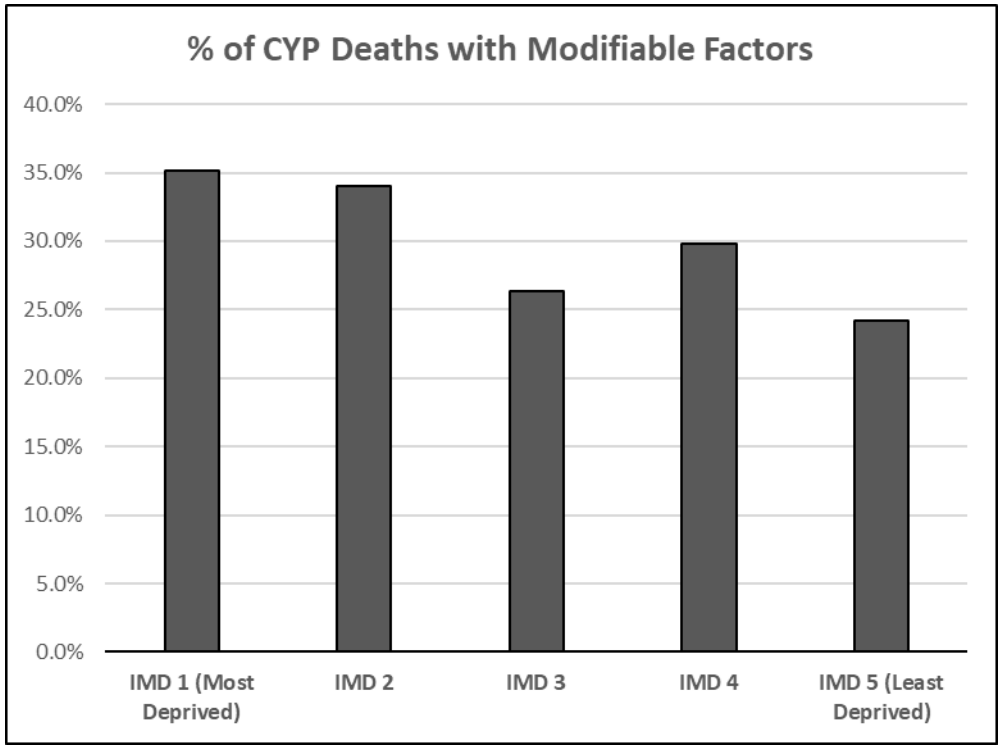
The decreasing bars in IMD categories 1 and 2 demonstrate this, and the increasing bars under IMD categories 4 and 5 reflect the same trend, but reversed – those in the least deprived categories are less likely to be CYP and even less likely to be CYP with major conditions.

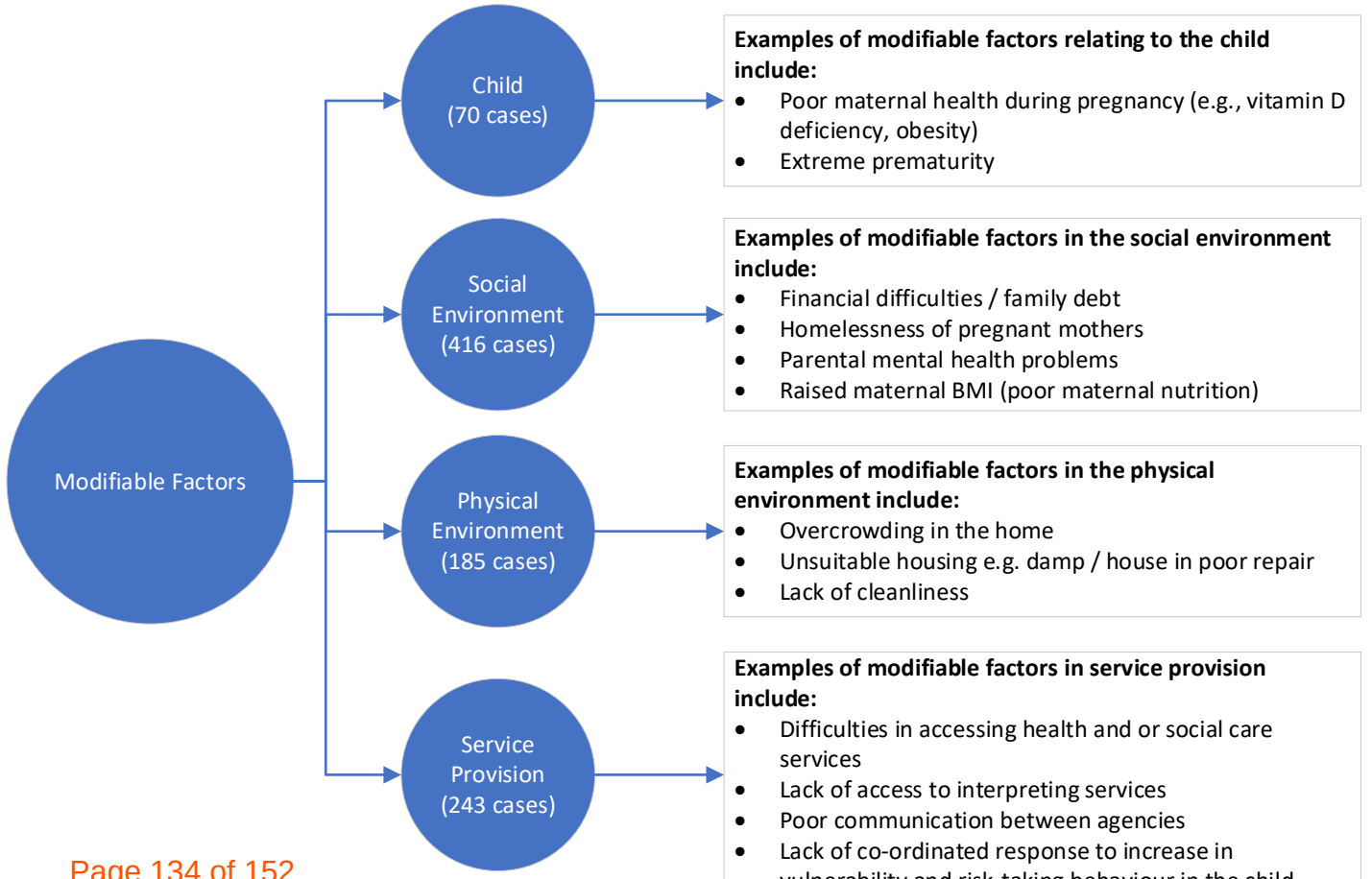
With the exacerbating effects of these inequalities, the needs of these CYP will continue to grow and develop into adulthood. Along with the increasing needs for the 12-18 age group identified (slide 5), we are likely to see a significant increase in complexity and added pressure to BSW services over the next five years.

CYP Mortality and Inequality

The pandemic and cost of living crisis will have long-lasting effects on the health of children and young people. On average, for CYP there was a relative 10% increase in risk of death between each decile of increasing deprivation (as defined by the Indices of Multiple Deprivation (IMD)). The cost-of-living crisis will push more families into poverty, which is likely to exacerbate existing inequalities for children and young people.

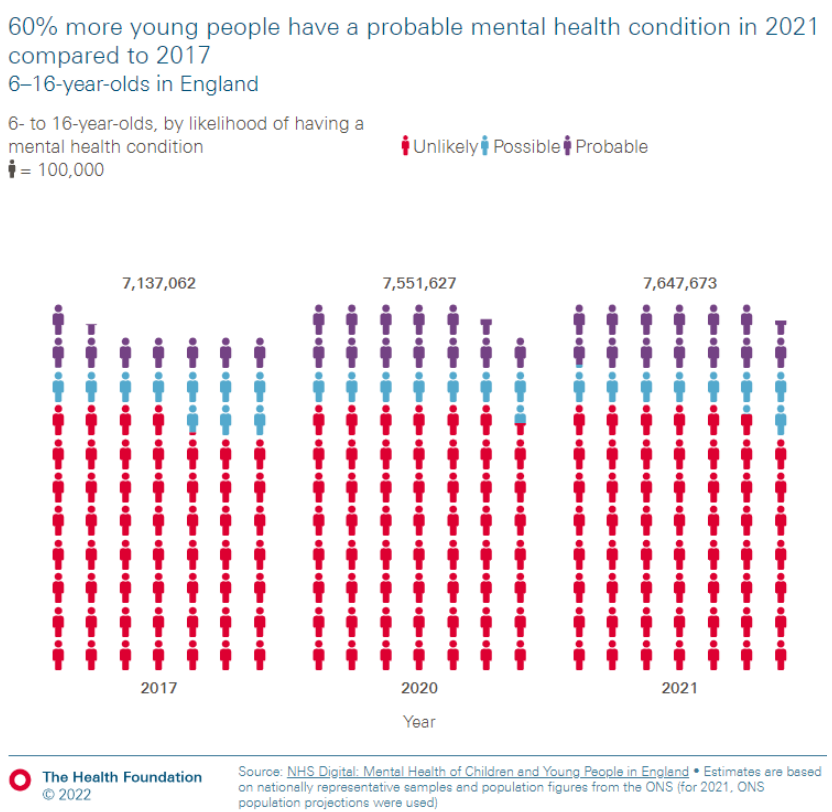
This National Child Mortality Database study highlights the link between CYP mortality and 'modifiable factors' linked to deprivation. A modifiable death is defined where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. https://www.ncmd.info/publications/child-mortality-social-deprivation/

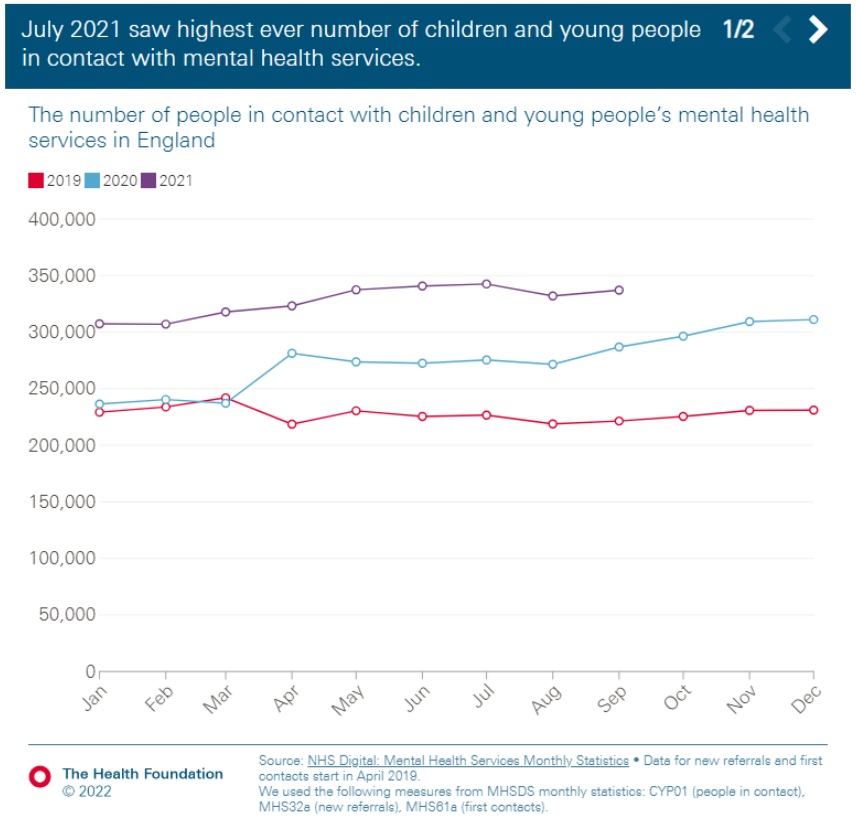




National CYP Mental Health

- Mental health conditions have become more common among children and young people.
- Among those aged 6 to 16 in England, one in six had a probable mental health condition in 2021, up from one in nine in 2017. Current figures are especially concerning for adolescent girls aged between 17 and 19: one in four had a probable mental health condition in 2021.
- This rise in prevalence since 2017 corresponds to an additional 500,000 young people between 6 and 16 with a probable mental health condition, who may need support from children and young people's mental health services (CYPMHS).
- The underlying causes are complex, but increased recognition of mental health issues, social isolation and disruptions to home and school routines during the pandemic likely played a role.
- After schools closed due to COVID-19 and ways of accessing GPs changed, new referrals to CYPMHS fell sharply (by 35% in April 2020 compared with the year before). However, about a year later, these reached a new high of 100,000 per month.
- In 2021, 24% more patients were in contact with CYPMHS compared with 2020, and 44% more than in 2019 (based on the January to September period). This includes patients waiting to be seen, suggesting CYPMHS may be struggling to meet demand.





BSW CYP Mental Health

- **BSW:**

Mental Illness*:* Across BSW, rates of hospital admissions for mental health conditions in those U18 years is consistently higher than national average. Hospital admissions due to mental health conditions in U18 in Wiltshire rose to their highest in 5 years in 2020/21 (~108.2 per 100,000 population).

Self-harm*:* admissions due to self-harm 10-24yo in Wiltshire were also at a 5 year high in 2020/21 (600+; ~751.3 per 100,000 population). In B&NES admissions have been consistently higher than the National average since 2011/12 with 240* in 2020/21. *U18 admissions for alcohol* B&NES currently highest in the South-West. *Core20PLUS5*: Wiltshire is a large, rural area and rurality is identified as a 'PLUS' group (for adults) due to the difficulties in accessing appropriate services.

- **B&NES:**

Mental illness. The Mental Health of Children and Young People (MHCYP) national survey found rates of probable mental disorder in 6–19-year-olds increased between 2017 and 2021 from one in nine (11.6%) to one in six (17.4%) in 6–16-year-olds and from one in ten (10.1%) to one in six (17.4%) in 17–19-year-olds. This would give an estimated 5,750 children and young people with a probable mental disorder in B&NES. Rates of hospital admissions for mental health conditions in those under 18 years is higher than the national rate.

Self-harm The rate of hospital admissions as a result of self-harm in 10–24-yearolds have been consistently higher in B&NES than the National average since 2011/12 with 240* admissions in 2020/21. Females consistently have higher rates than Males both nationally and in B&NES with 205* female and 35* male admissions in 2020/21. Female rates in B&NES have generally been significantly worse than the national female rate since 2012/13. The rate of hospital admissions for self-harm is significantly higher in B&NES compared to England.

Deprivation: The rates in a number of wards in B&NES are significantly higher than the national rate, namely: Twerton, Radstock, Moorlands, Westfield, Weston, Keynsham North, Combe Down, Peasedown, Keynsham South and Midsomer Norton Redfield. These areas overlap with our most deprived areas.

- **Swindon:**

Mental Illness: Hospital admissions rate for mental health conditions in 0-17 years old has been on a rising trend since 2013/14, with Swindon and the South-West at much higher levels than England. In 2020-21, rates for Swindon dropped to settle at a lower level than the South-West.

Self-harm: In 2020/21, there were 735 emergency hospital admissions in Swindon for intentional self-harm. This is a higher rate than other areas across the South-West and England (340.7 per 100,000 compared with 249.4 and 181.2 per 100,000 respectively). Trends show that Swindon's rate has been consistently higher than England since 2010/11 with some fluctuations year on year.

- **Wiltshire:**

Mental Illness***:*** Hospital admissions due to mental health conditions in under 18-year-olds in Wiltshire rose to their highest recorded rate for five years in 2020/21 following a period of fluctuation between 2016/17 – 2019/20. In Wiltshire, rates of hospital admissions due to mental health conditions have been notably and consistently higher in young females compared with young males since 2017/18. The gap also looks to be widening with admission rates in young females markedly rising between 2018/19-2020/21. Conversely rates amongst young males have consistently declined over the same time frame. In 2020/21, just over 80% of hospital admissions of this nature involved females compared with just over 50% in 2016/17.

Self-harm: Hospital admissions as a result of self-harm in 10–24-year-olds in Wiltshire rose to their highest rate in five years in 2020/21 following a period of sustained, gradual increase between 2016/17 – 2019/20. In 2020/21, almost 600 hospital admissions were recorded relating to self-harm in 10–24-year-olds in Wiltshire, equivalent to a rate of 751.3 per 100,000 population. This is significantly higher than rates reported in both the South-West as well as England.

BSW CYP Hospital Admissions due to Mental Health

Hospital admissions for mental health conditions (<18 yrs) 2021/22

Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	11,740	99.8	98.0	101.6
South West region	–	1,670	153.6	146.3	161.2
North Somerset	–	115	268.4	219.5	319.6
Somerset Cty	–	200	182.7	160.0	211.9
Devon	–	260	179.3	159.4	203.9
Cornwall	–	185	175.8*	151.4	203.0
Plymouth	–	80	154.9	126.3	197.1
Bath and North East Somerset	–	55	153.8	113.5	197.1
Bournemouth, Christchurch and Poole	–	105	143.2	117.1	173.4
Torbay	–	35	139.0	93.5	188.7
Gloucestershire	–	175	137.6	119.4	161.2
South Gloucestershire	–	80	135.1	105.6	166.2
Dorset	–	85	128.7	100.1	155.8
Swindon	–	65	126.4	99.3	163.3
Bristol	–	115	125.5	105.6	153.1
Wiltshire	–	110	106.6	87.6	128.5
Isles of Scilly	–	-	*	-	-

Mental health problems often start early in life. Half of all mental health problems have been established by the age of 14, rising to 75% by age 24[1]. This is why intervening as early as possible is essential. Nationally and locally, we know that the impact of Covid and the wider social determinants are affecting the health and wellbeing of our young people. We are seeing high and increasing levels of under 18 hospital admissions for mental health conditions, eating disorders, self-harm, and alcohol. This includes Children and young people who display significant emotional and behavioural disturbance resulting in highly dysregulated behaviour characterised by self-harm or harm to others that results in admission and/or placement breakdown. Children Looked After and Care Experienced young people are disproportionately represented in this cohort.

B&NES

Rates of hospital admissions for mental health conditions in those under 18 years is higher than the national rate but has shown reduction in 2020/21 compared to 2018/19 & 2019/20. Admissions increased from 33 in 2016/17 to 50* in 2018/19 and 2019/20, reducing to 40* in 2020/21.

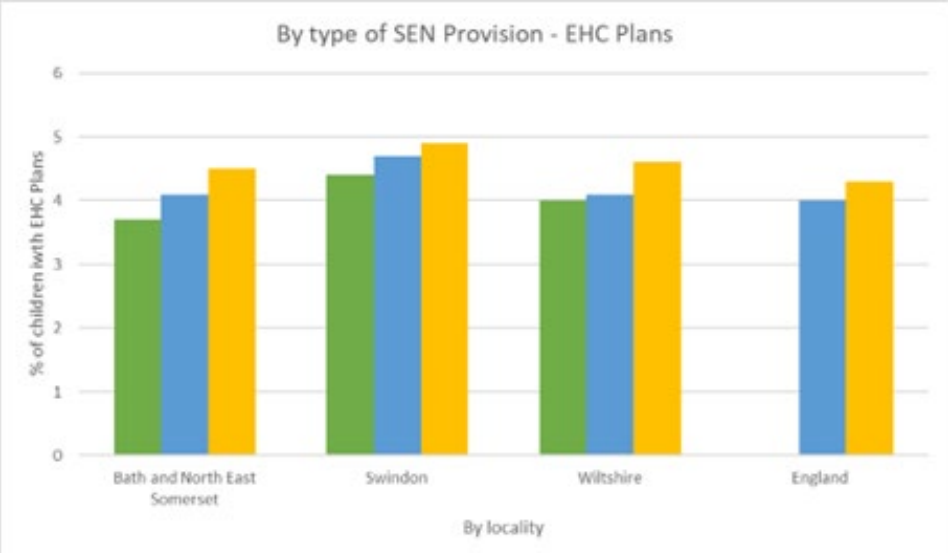
Swindon

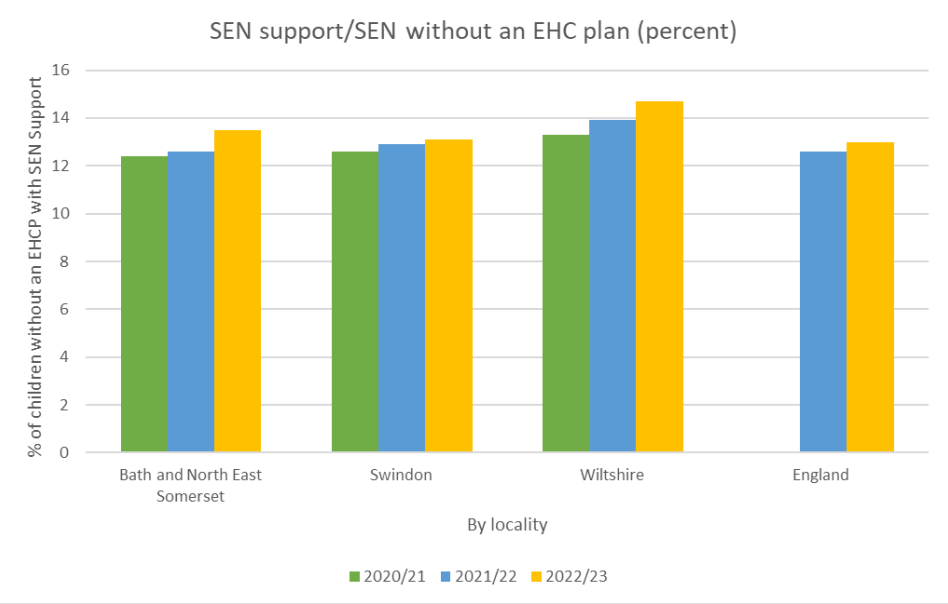
Hospital admissions rate for mental health conditions in 0-17 years old has been on a rising trend since 2013/14, with Swindon and the South-west at higher levels than England. In 2020-21, rates for Swindon dropped to settle at a lower level than the Southwest. Hospital admissions caused by self-harm amongst children and young people have been declining from around 2018/19, although levels in Swindon have been consistently higher than the Southwest and England. Reported levels of high anxiety have risen and are higher than the national average. Rates of hospitalisation are also up and comparatively high, particularly for young women and girls.

Wiltshire

Hospital admissions relating to self-harm in Wiltshire's overall population and the 10–24-year age group have increased annually since 2016/17. In 2020/21, admissions of this type were significantly higher than both the South-west and England. Also, Hospital admissions for 2020/21 caused by unintentional and deliberate injuries has increased and higher than the rates recorded in the South-west, by statistical neighbours and across England in the same year. (Child and Maternal Health - Data - OHID (phe.org.uk))

Special Educational Needs and Disability (SEND)



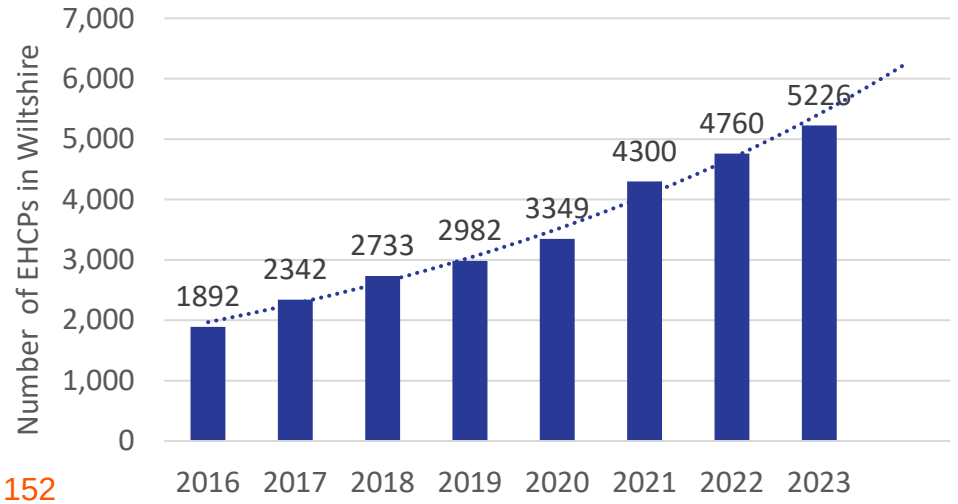


A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support, we shorten this to SEND. This includes Autism and neurodiversity.

The BSW footprint is above the national average for children with Education Health and Care Plans (EHCP) and SEN support. Since 2014 there has been a sharp rise in EHCPs following the introduction of the Children and Families Act 2014, figures have steadily risen over the last 6 years. This upward trend is expected to continue across the BSW footprint.

As an example of BSW need, in Wiltshire there were 4760 EHCPs in place in Wiltshire at the end of the 2022 Calendar Year which has increased by 10.7% from the previous year. This represents a rate of 330 EHCPs per 10,000 population compared to 270 across England, 292 for the southwest region and 299 amongst our statistical neighbours.

Current high needs provision in Wiltshire is made up of a combination of special schools, resource bases and enhanced learning provision (ELP). Although Wiltshire has a higher percentage of our learners with an EHCP than national average, it has a significantly lower number of special school places, but when combined with Resource Base and ELP places the amount of specialist provision is a little higher than our statistical neighbours and the national picture.



Learning Disability, Autism and Neurodiversity

It is estimated that **15-20%** of children and young people* in the UK are neurodivergent. https://mentallyhealthyschools.org.uk/risks-and-protective-factors/vulnerable-children/neurodiversity/

Neurodiversity is an umbrella term that encompasses a range of differences in how our brains function. It includes conditions such as **ADHD**, **autism**, **dyslexia,** among others. These conditions are often present from a young age and can have a lasting impact throughout a person's life

BSW has historically had long autism assessment waiting times for children and young people. This mirrors the national position. A revised model of assessment has been implemented in 2022 and is still in a live transformation phase, which is reducing these waits. Co-produced work continues on a new end to end pathway with a focus on need not diagnosis

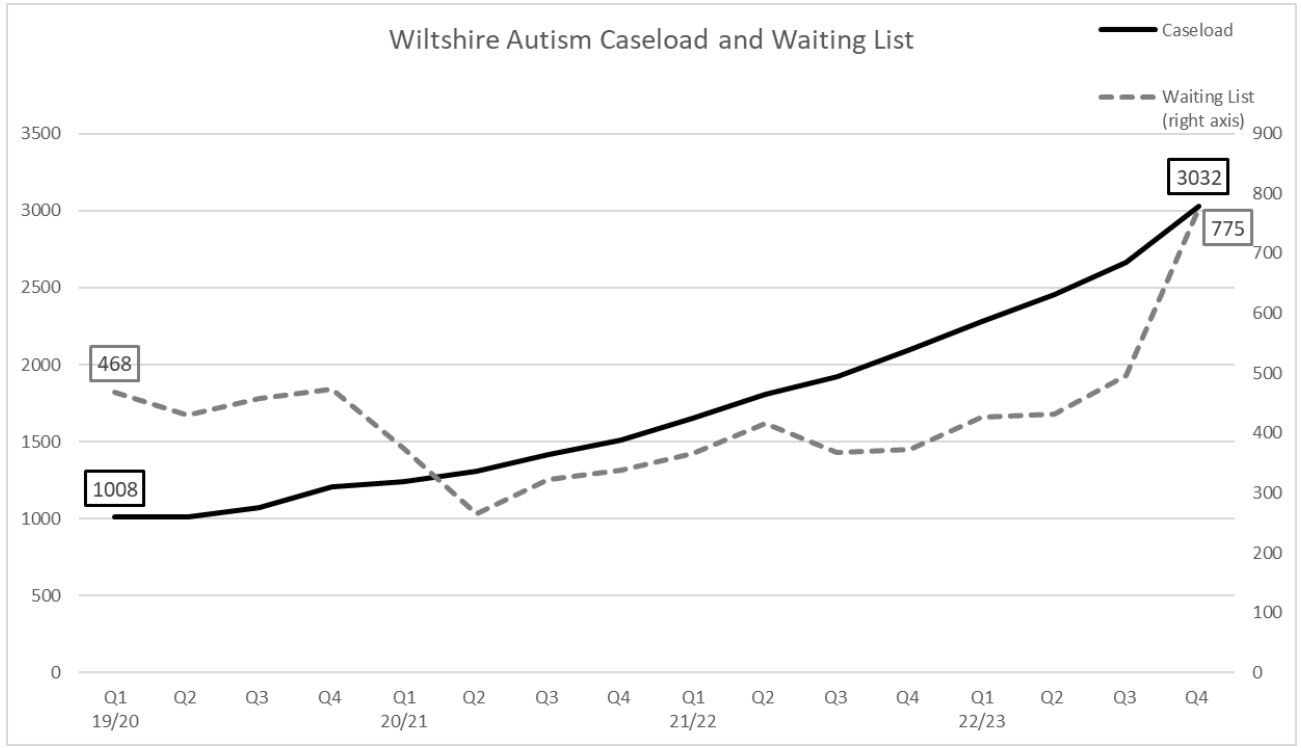
It is estimated that **351,000 children** and young people in the UK have a Learning Disability. https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/children-research-and-statistics

Increasing number of babies born at low gestational age are now surviving, this is leading to increasing numbers of children with life long needs. Some of the long-term health outcomes that preterm babies may experience include behavioural and social-emotional problems, learning difficulties and increased risk of neurodiverse conditions. Source: BMJ.

The need to provide early intervention and prevention support for CYP with LD, A or neurodiversity is well recognised. BSW has mirrored the national picture with an increase in CYP and adults with autism presenting in crisis and requiring inpatient care. Nationally, the keyworker programme has been developed to provide targeted support to CYP, families, carers and supporters and goes lives in BSW Oct 2023

Neurodiversity and Autism

Source: *HRCG's BSW Scorecard*



The needs and demands of our CYP population are growing. Many services are under extreme pressure post-pandemic, and the impact of our care will be carried forward by this group into adulthood.

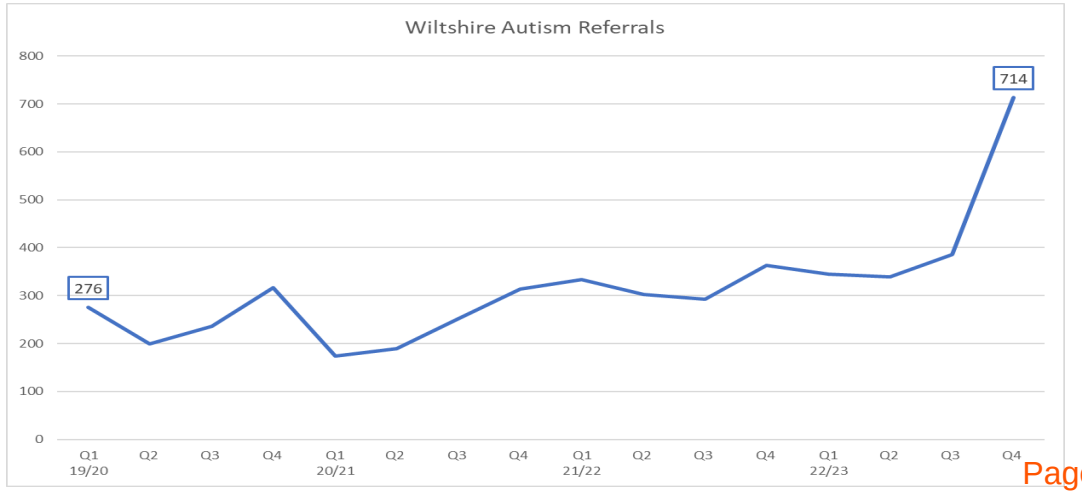
The example shown here is Autism in Wiltshire, however this picture is reflective of wider pressure on CYP services across BSW.

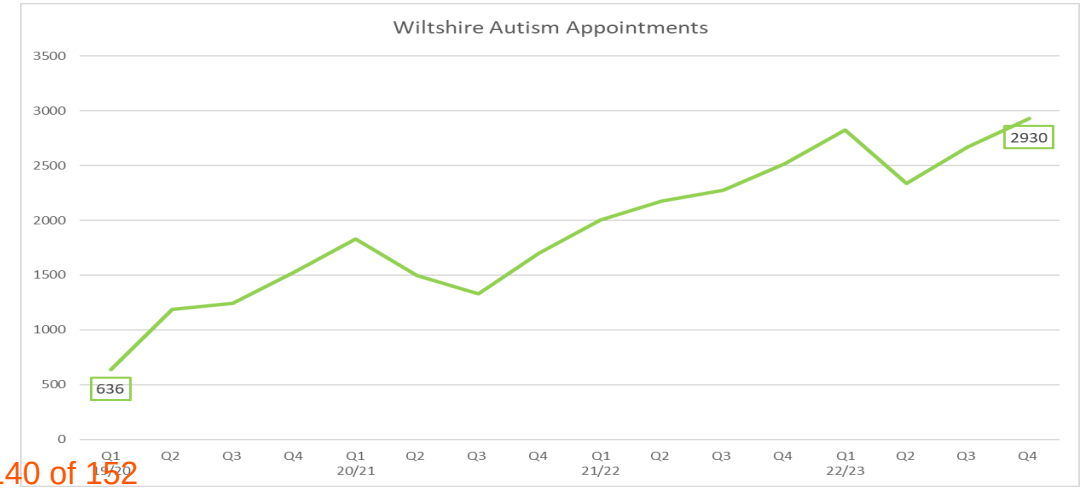
Both the Autism waiting list and caseload have grown significantly in recent years (left). The caseload is triple pre-pandemic levels, and the waiting list has trebled since its low point in 21/22.

Demand for these services is increasing sharply (below left), and despite increases in appointments (below right), waiting lists and times continue to grow. Referrals into the service are increasingly complex. Resources for those most in need is being diluted, and service user anxiety is increasing as a result.

The dedicated Waiting List Initiative service is helping to support with additional capacity for these patients. This services currently provides an additional 500 – 600 contacts per month (across all commissioned patients, not only Wiltshire).

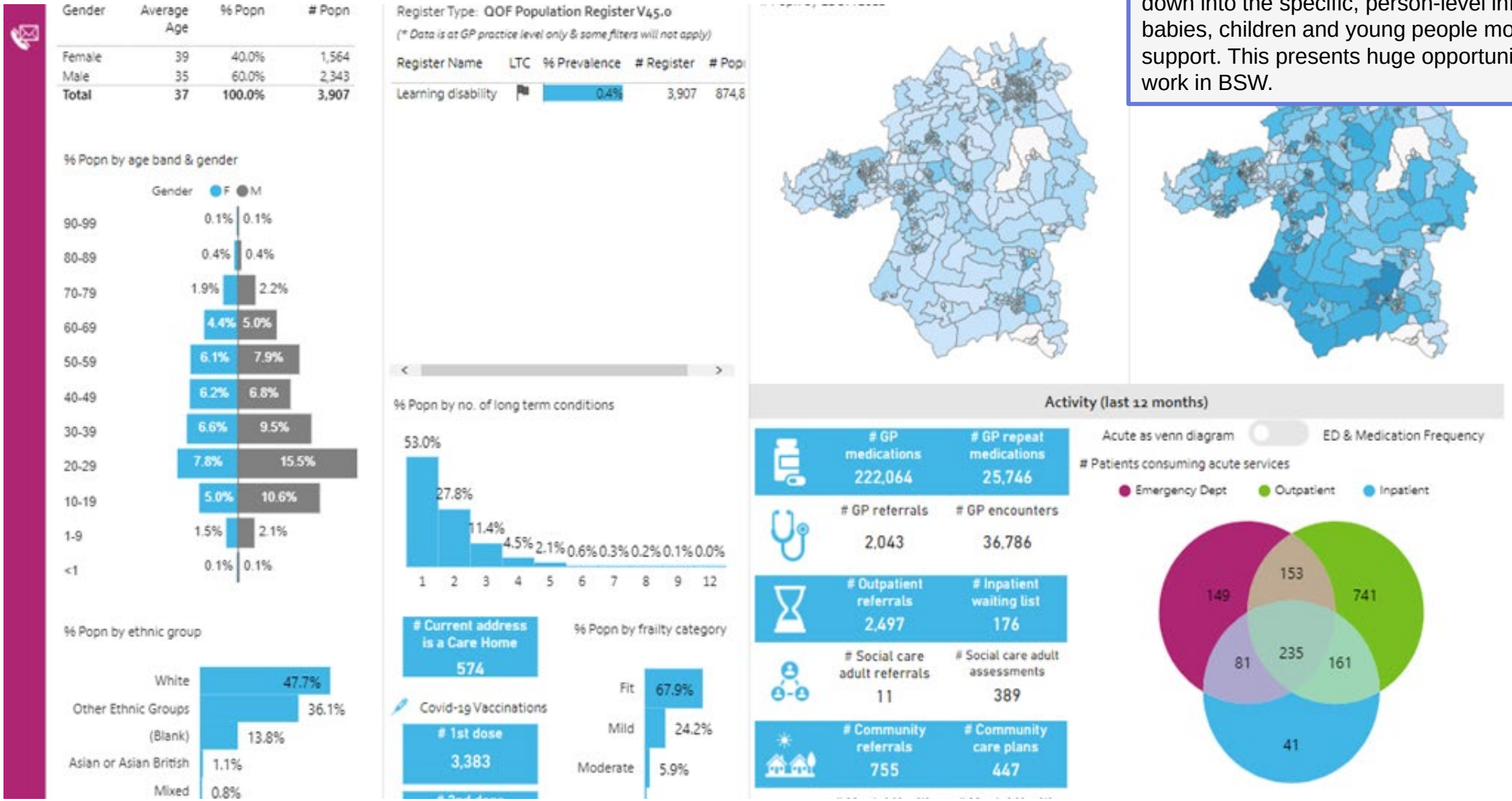
There is opportunity to work differently to address some of these huge challenges, including offers of early help prior to referral to children and their families.





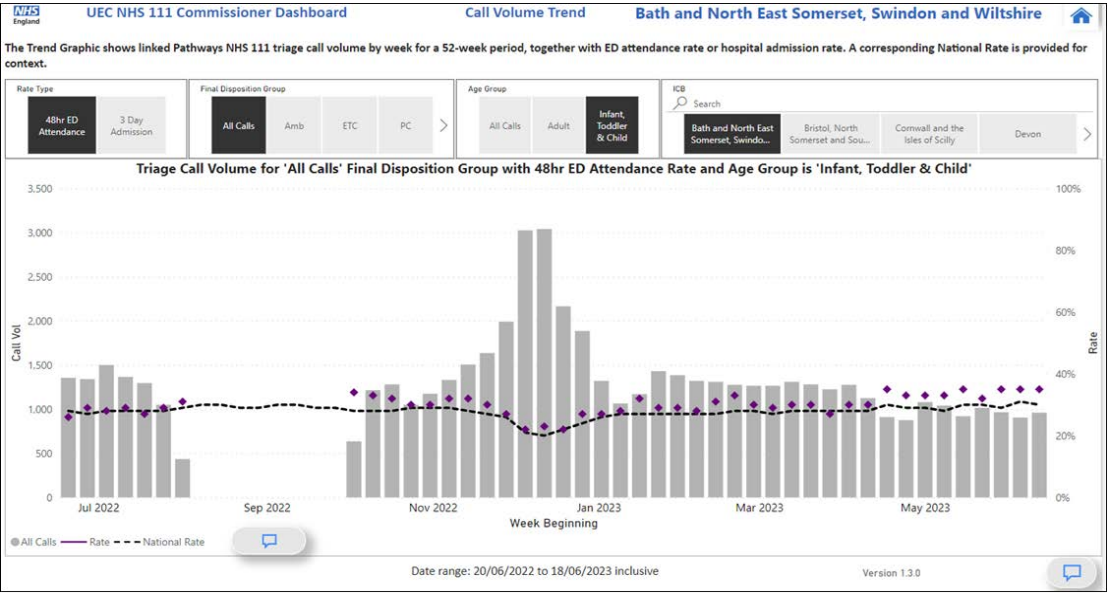
BSW LDA Population Health Management

Our linked data sets now provide us with a better holistic understanding of our CYP population. The tools (like this one) developed within our Integrated Care Record give us the potential to take this high-level insight and drill-down into the specific, person-level information about our babies, children and young people most in need of support. This presents huge opportunity for the way we work in BSW.

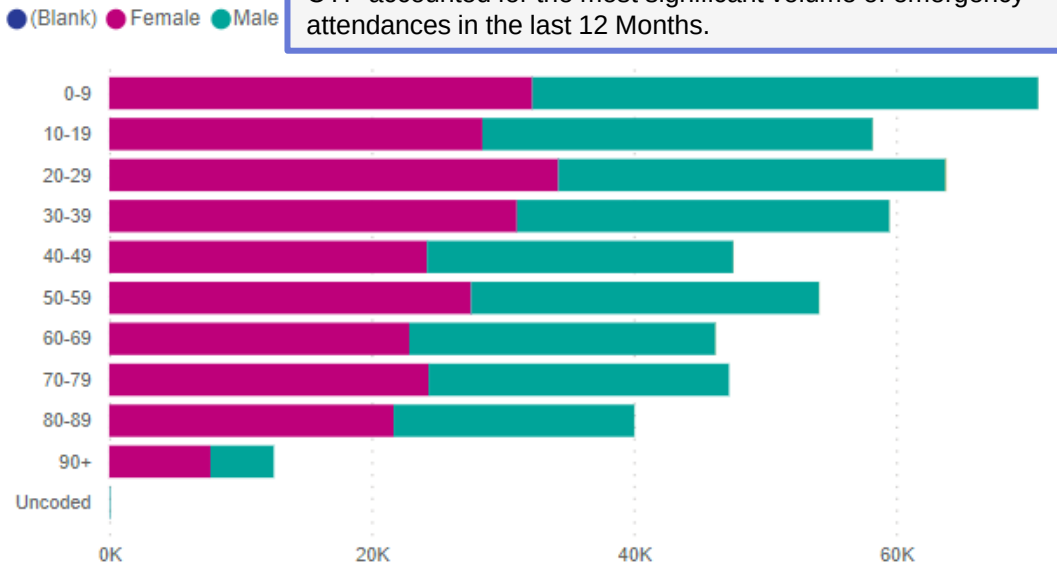


CYP Urgent & Emergency Care

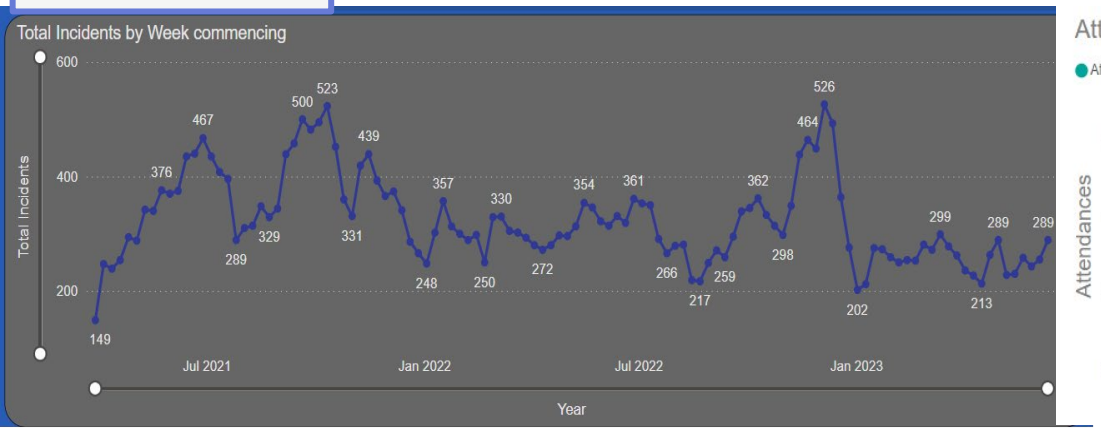
CYP NHS111 Calls

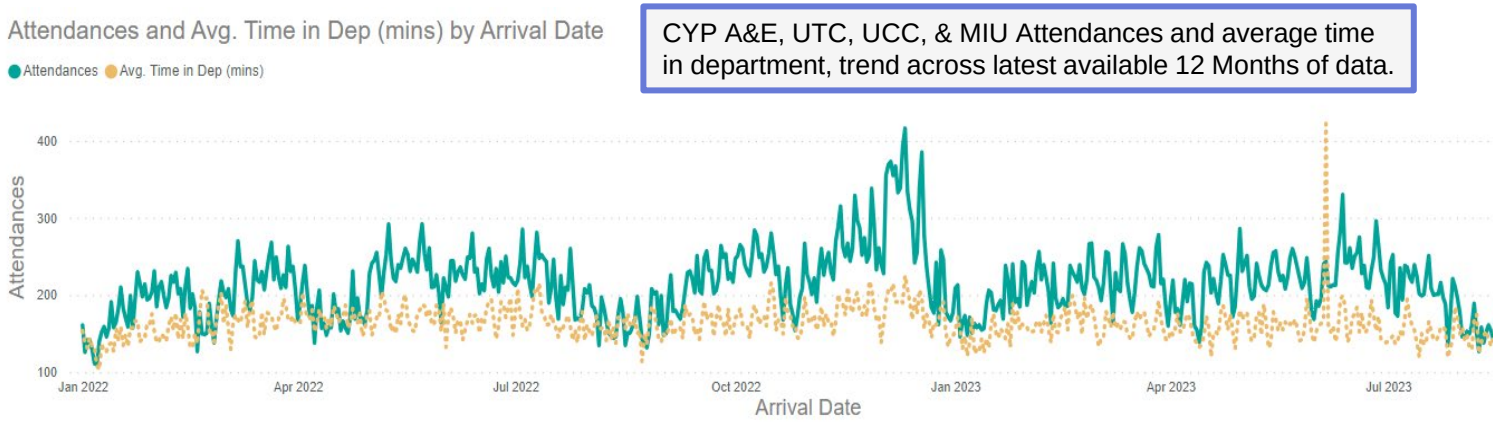


A&E, UTC, UCC, & MIU Attendances, latest available 12 Months of data.
CYP accounted for the most significant volume of emergency attendances in the last 12 Months.



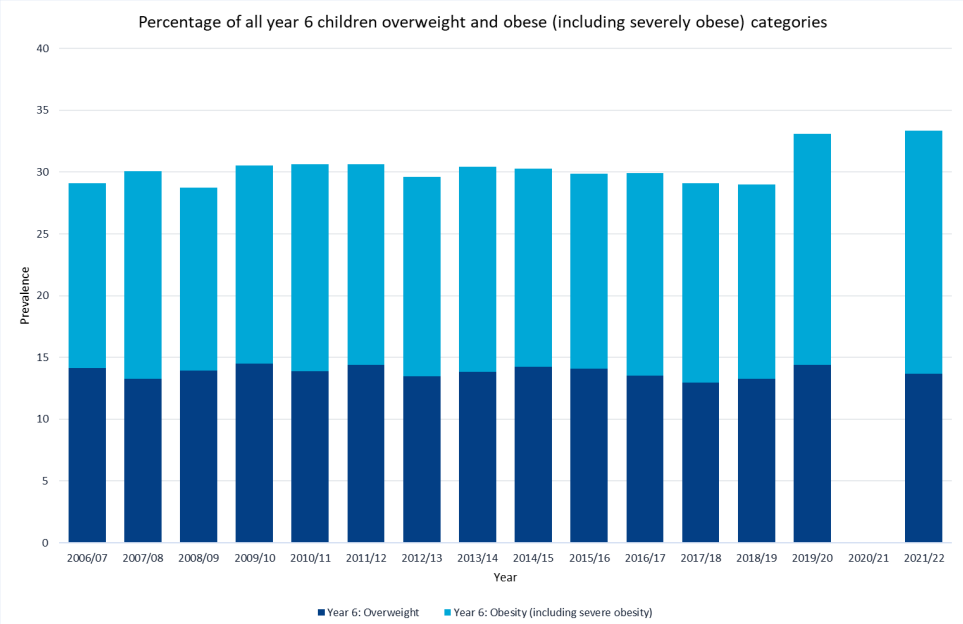
CYP SWAST Incidents





CYP A&E, UTC, UCC, & MIU Attendances and average time in department, trend across latest available 12 Months of data.

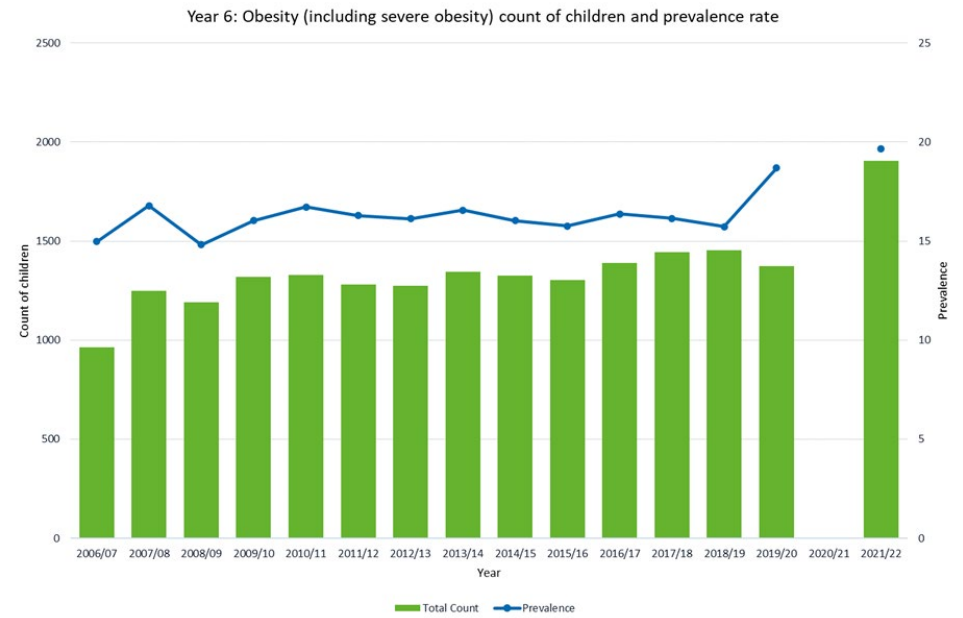
Annual Prevalence of children living with excessive weight and obesity in Year 6

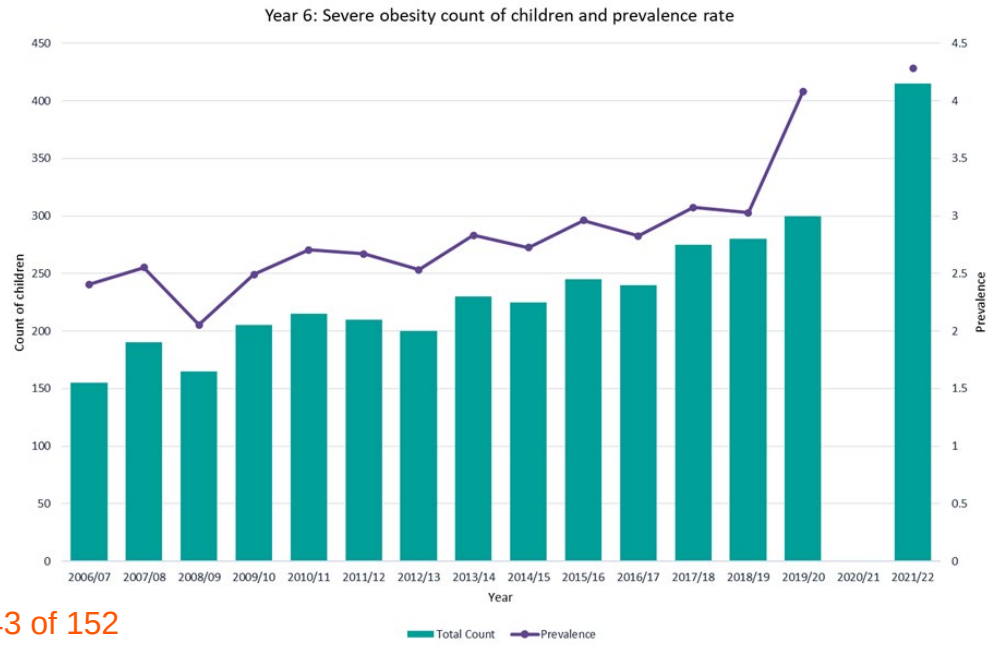


The bar chart shows the prevalence of year 6 children in BSW who are both overweight and obese. The totality of these two bars equates to the overall prevalence. Approximately 33% of children in 2021/22 were either overweight or obese.

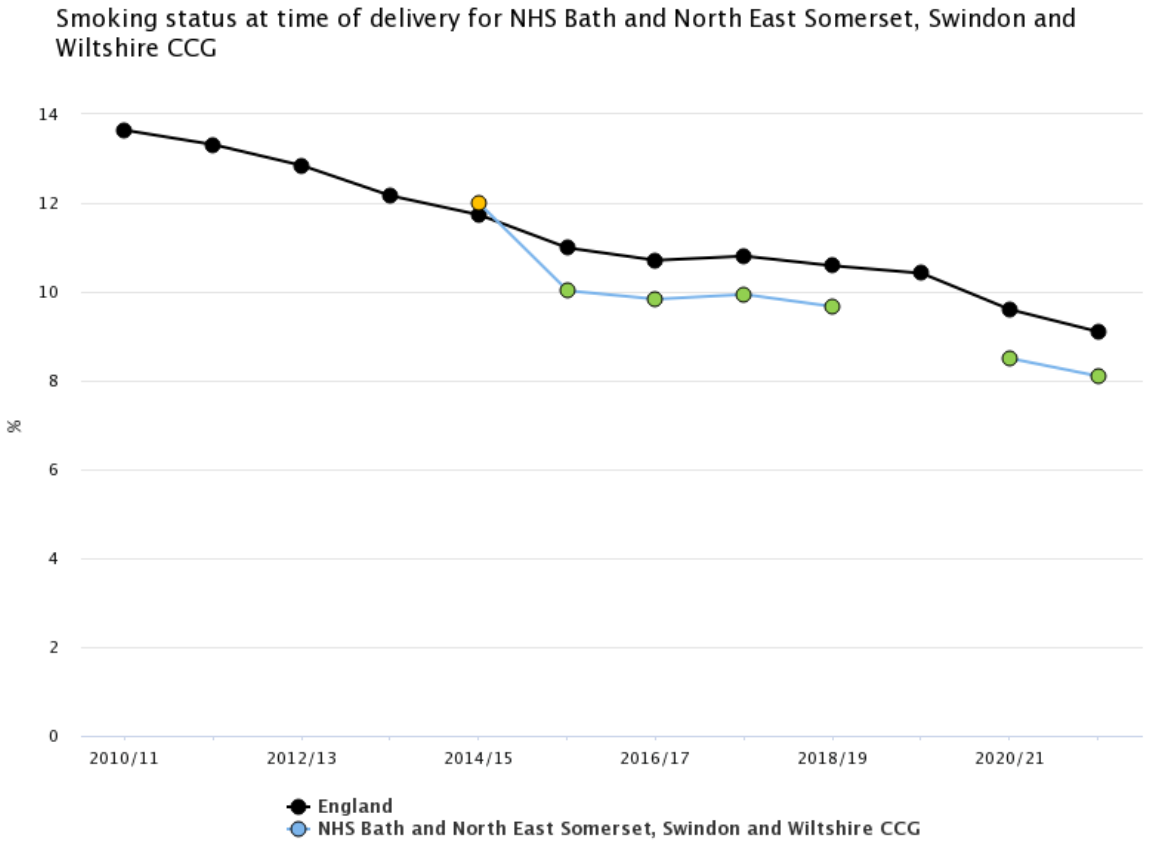
When compared to the latest data for reception aged children, there is a noticeable decrease in the percentage of children who are at a healthy weight, meaning that the position deteriorates across the Primary School Years.
The 2021/22 increase in numbers and prevalence is particularly stark among those classified as severely obese.

Deprivation is a significant factor in the number of those living with obesity among Year 6 children, both in BSW and nationally, and this is even more marked for Year 6 boys.
In Year 6 there is a higher proportion of boys living with obesity than girls.

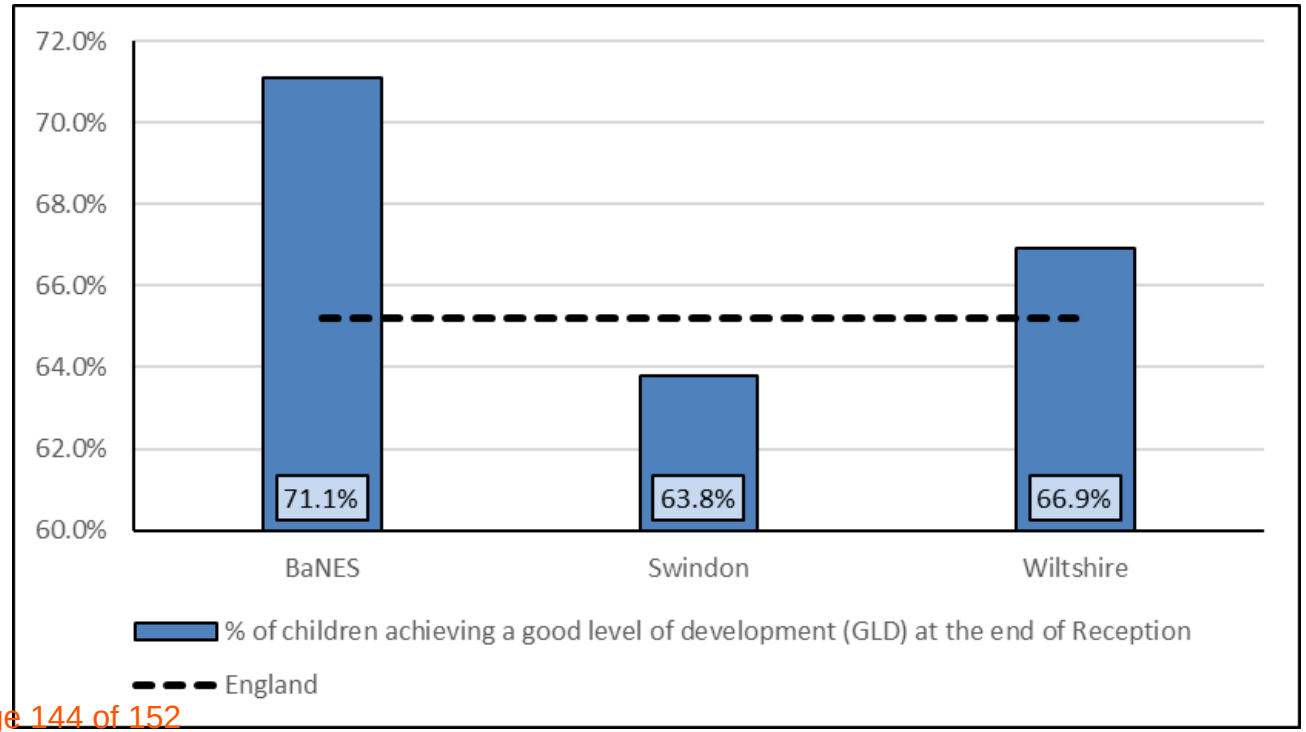




Maternity and Early Years Development



Smoking in pregnancy is also a key indicator due to the link with stillbirths and low birth weight babies, which in turn increases risks for the child longer term, eg cognitive developmental. Although BSW performs better than the national average and the percentage continues to improve, continued focus on this area is key.



Good level of development (GLD) achievement rate is below the England average in Swindon.

Across BSW, the gap between all children and disadvantaged children (FSM) at the end of reception highlights issues that need to be addressed during the earliest years.

Impact of Covid on CYP and “The Covid Generation”

The cost-of-living crisis and Covid have increased poverty figures and levels, affecting CYP and families.

In 2021/22 the national disadvantage gap index increased to their highest levels since 2012 for both KS2 and KS4 suggesting that disruption to learning during the Covid-19 pandemic had a greater impact on disadvantaged pupils.

1 in 6 children aged five to 16 were identified as having a probable mental health problem in July 2020.

Less than 1 in 3 young people with a mental health condition get access to NHS care and treatment.

83% of young people with mental health needs agree that the Covid-19 pandemic has made their mental health worse.

Persistent absence (defined as missing 10% of lessons) has doubled from 8% at primary and 13.7% of secondary school children to 17% and 28% respectively in the most recent year. This is more likely to affect children eligible for school meals, with special educational needs and those from ethnic minority backgrounds.

Neurodivergent and disabled children are missing twice as much school as those who are neurotypical and abled.

Only 53.5% of secondary and a scant 26.6% of primary schools have access to mental health support.

The number of A&E attendances by young people aged 18 or under with a recorded diagnosis of a psychiatric condition more than tripled between 2010 and 2018-19.

Suicide was the leading cause of death for males and females aged between five to 34 in 2019.

Nearly half of 17–19-year-olds with a diagnosable mental health disorder has self-harmed or attempted suicide at some point, rising to 52.7% for young women.

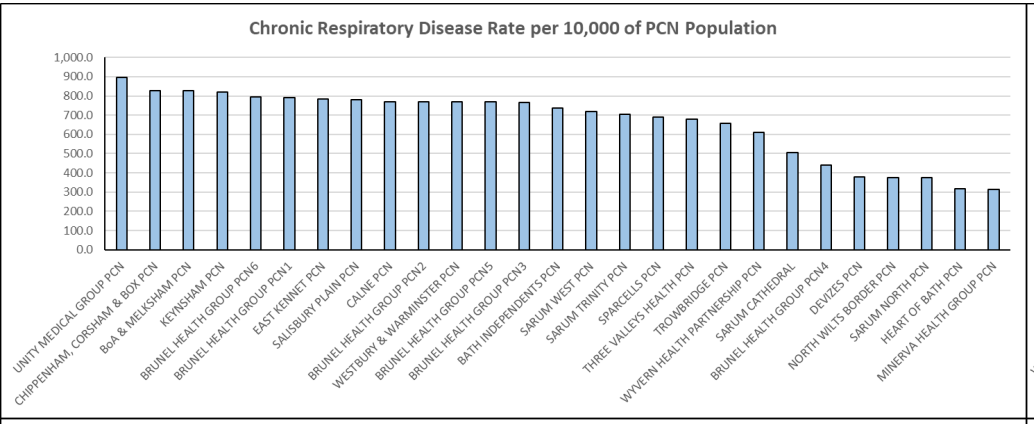
Bath and North East Somerset,
Swindon and Wiltshire Together

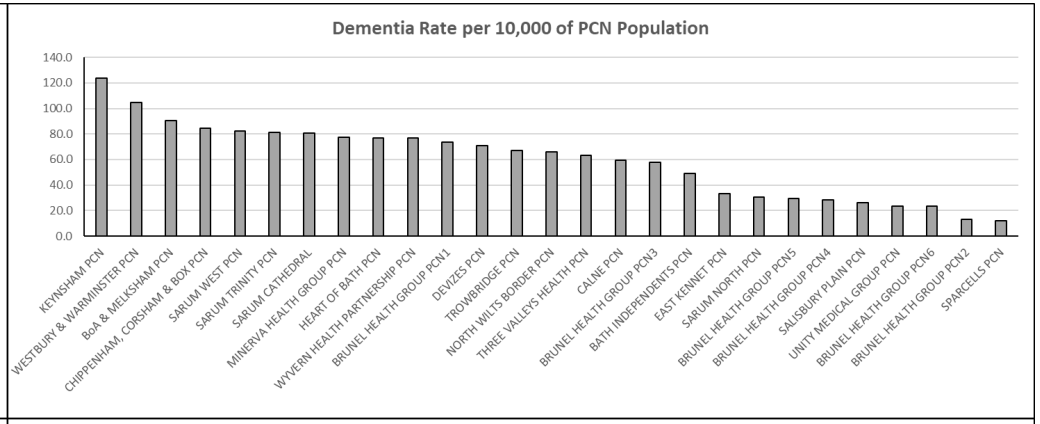
Variation in BSW

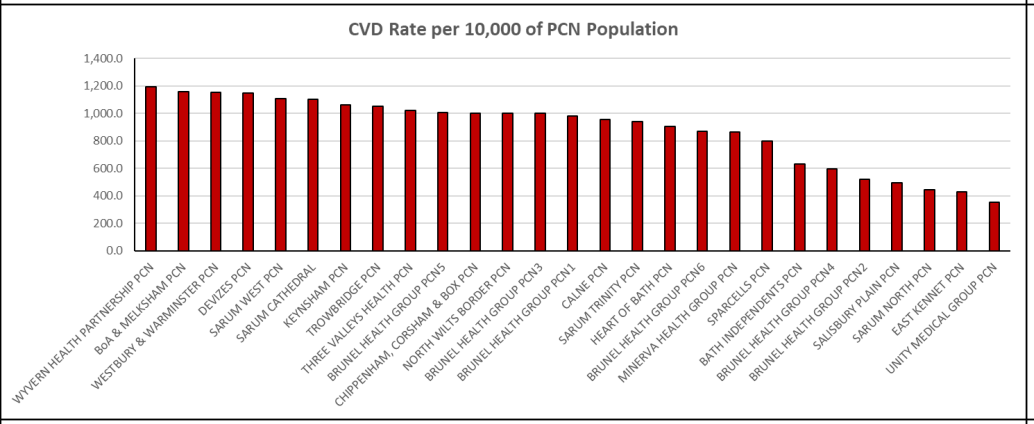
The following analysis builds on the Case for Change, starting to describe variation across BSW in some of the major conditions driving poor health outcomes with a view to supporting how we prioritise and address these together as a system.

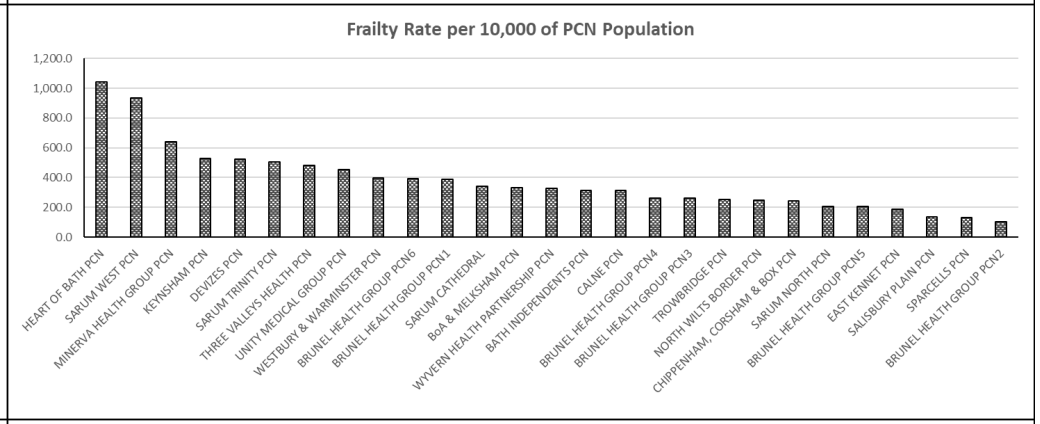
Further analysis will then seek to provide evidence for working differently and, in time, will start to quantify the opportunity and potential benefits for BSW and our populations.

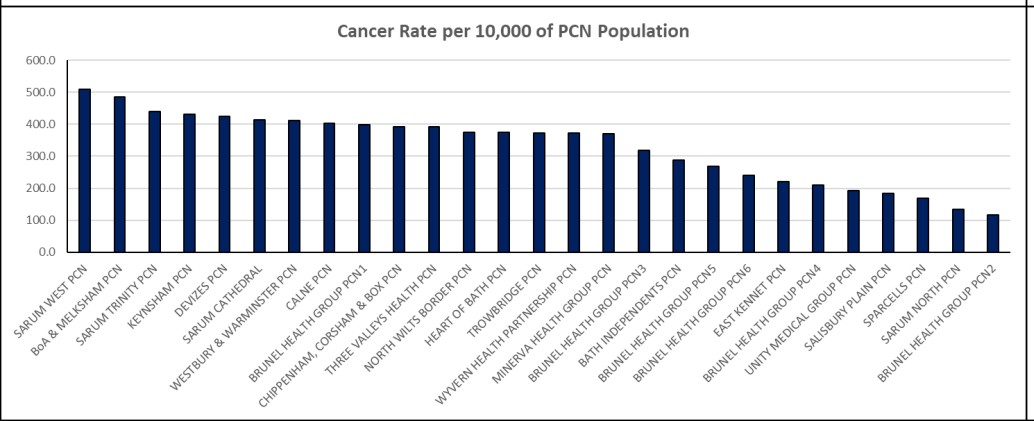
Variation for Major Condition Prevalence

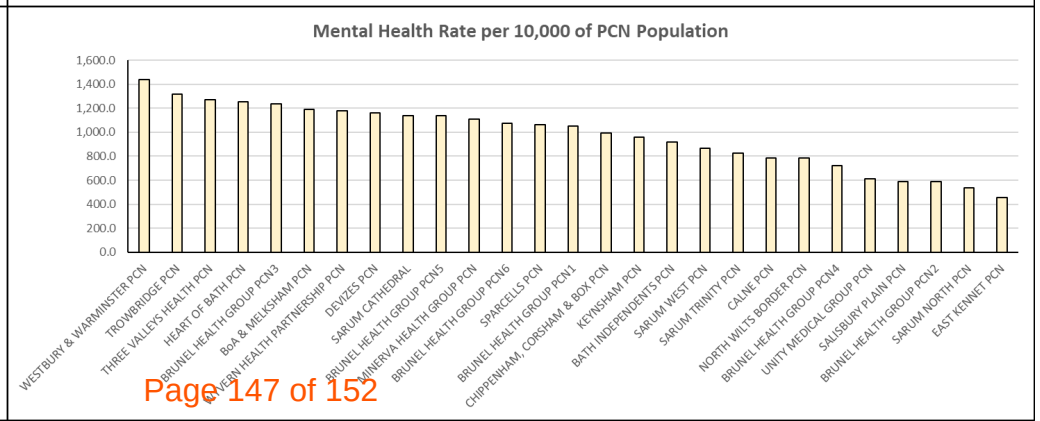






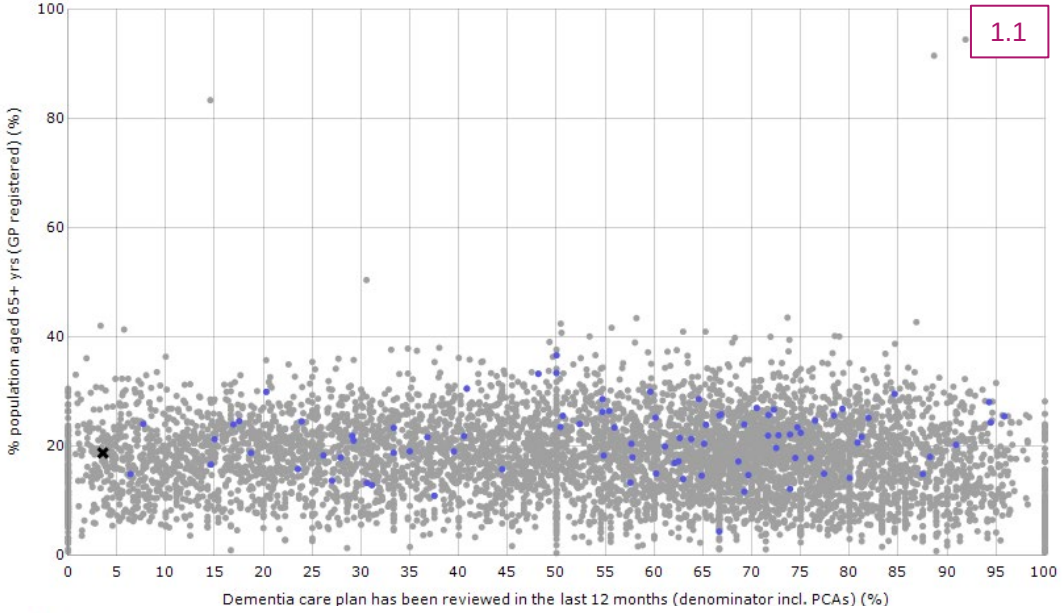


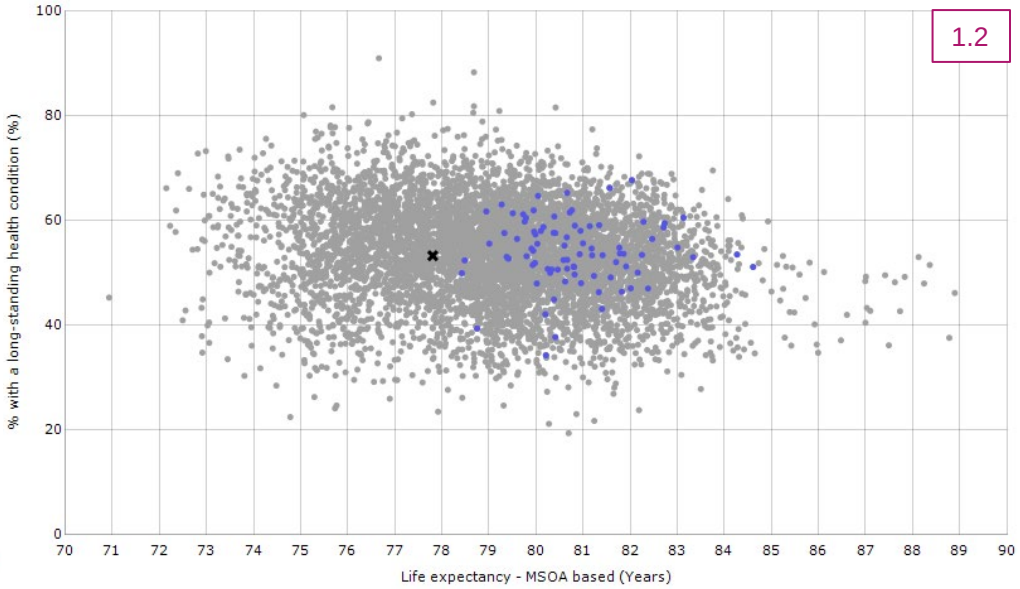


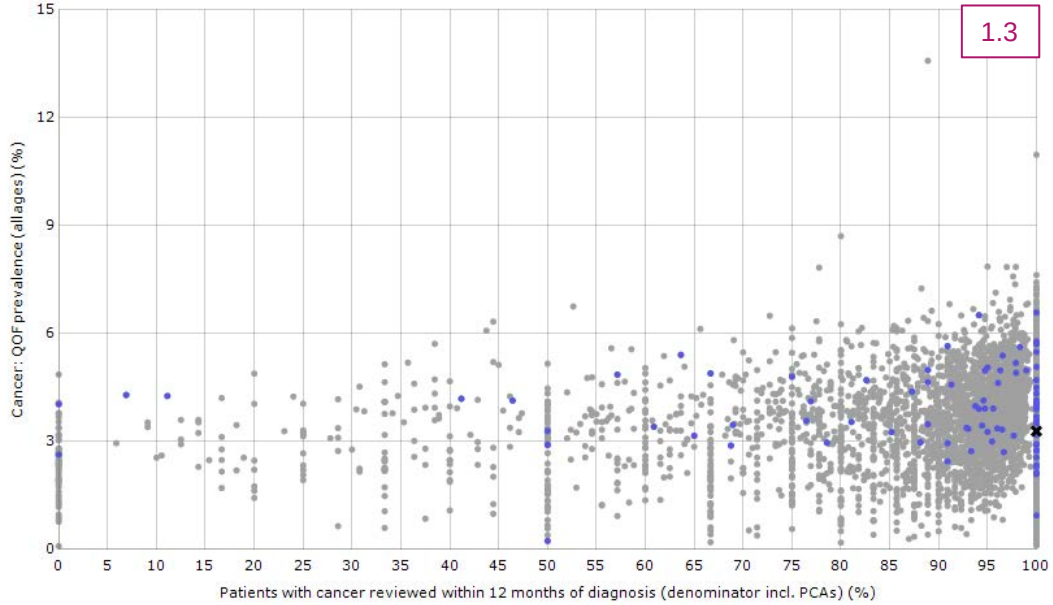


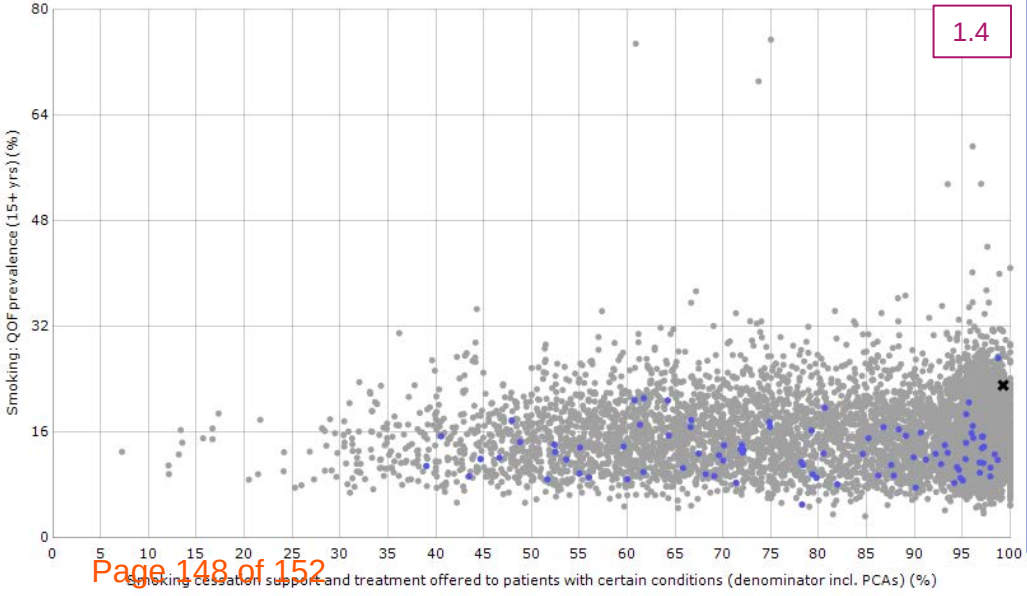
The variation in major condition prevalence across BSW is significant, influenced by the differing population characteristics within PCN populations and smaller geographies. For example, the age profile at certain PCNs is materially younger than others, creating expected variation in certain conditions. The dementia rate at Sparcells is a fraction of the rate among Keynsham's population, for example.
Similarly, variation in relative deprivation is linked to variation in some conditions' prevalence, such as CVD.

Variation of Major Condition Outcomes









- GP Practices across England
- BSW GP Practices

x Lowest/Highest Performing Practice

1.1) x axis: % of dementia care plans reviewed in the last 12 Months.
y axis: % of population aged 65+.

1.2) x axis: life expectancy in years. Y axis: % of population with an LTC.

1.3) x axis: % of cancer patients reviewed within 12 months of diagnosis. y axis: cancer prevalence.

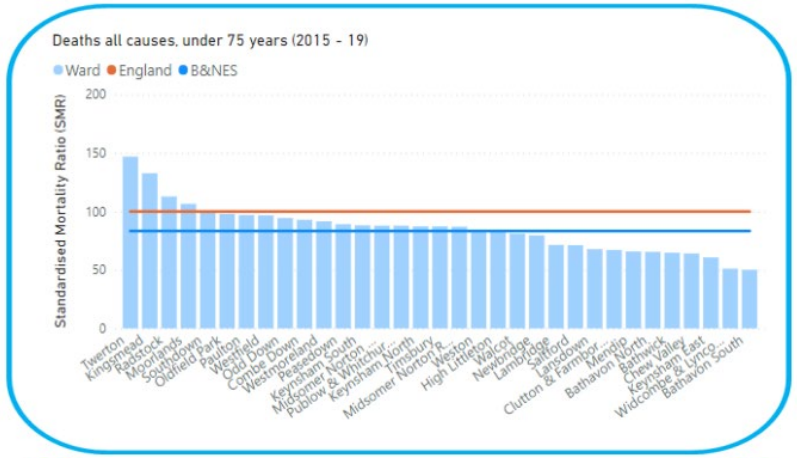
1.4) x axis: % of patients in applicable cohort offered smoking cessation services. y axis: smoking prevalence.

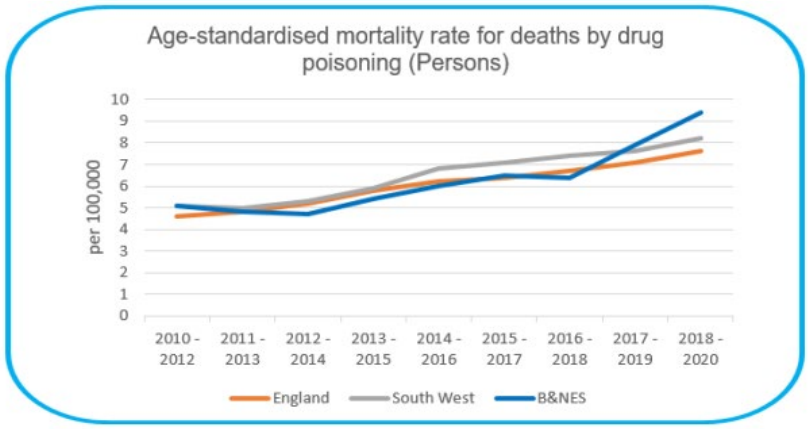
JSNAs: BaNES

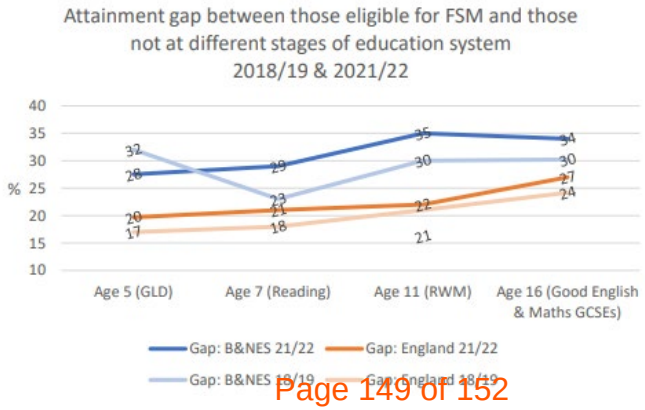
Strategic Evidence Base | Bath and North East Somerset Council (bathnes.gov.uk)
Updated source: (1) https://fingertips.phe.org.uk/profile/mortality-profile/data#page/1/gid/1938133009/pat/6/par/E12000009/ati/401/are/E06000022/yrr/1/cid/4/tbm/1/page-options/car-do-0

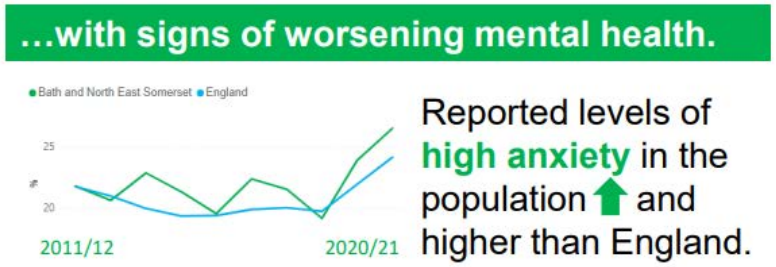
Highlights

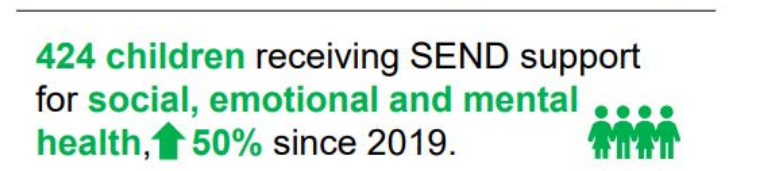
- Most LTC prevalence below the national average.
- **Compared to national, relatively high hospital admission rates** in:
  - u18 MH
  - Alcohol Specific Conditions
  - Eating Disorders
  - Self-harm
- The two main broad causes of premature death are cancer and CVD.
- Higher **premature mortality** rate compared to England for **Injuries to Males** (although the recent rise is linked to a rise in deaths from drug poisoning / misuse, which is significantly higher compared to England).[1] There are higher rates of premature mortality in wards with higher levels of deprivation.
- **Educational attainment gaps** across the school years between Free School Meal pupils and their peers are **higher** in B&NES **compared to national**.

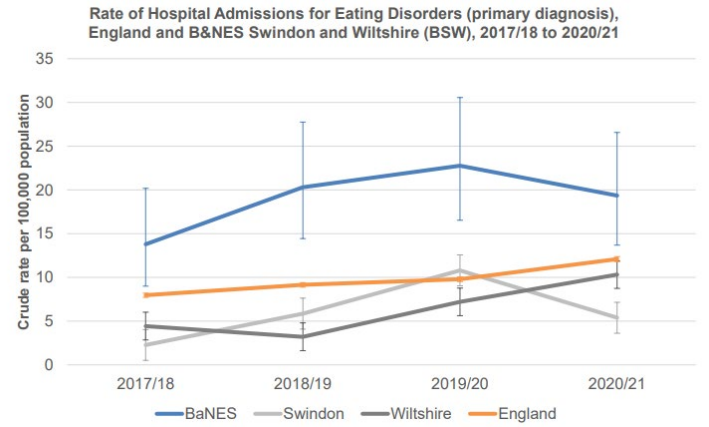








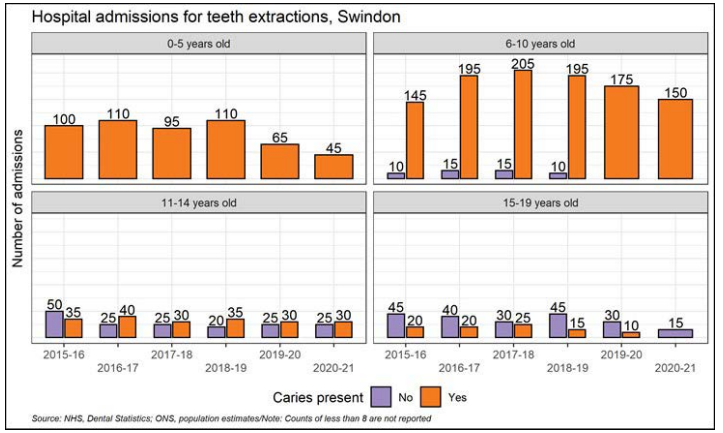


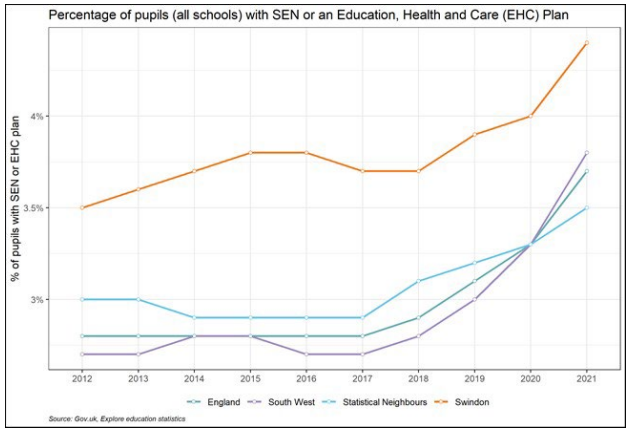


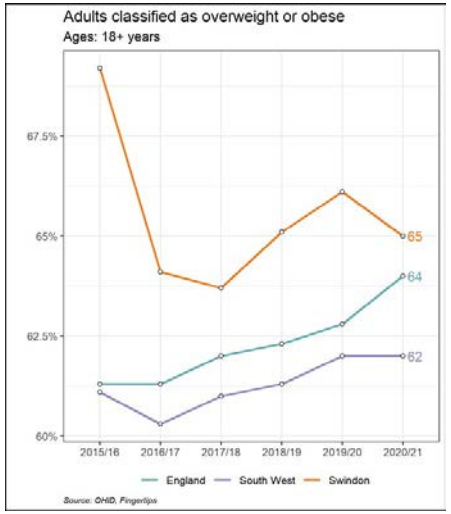
JSNAs: Swindon

Highlights

- High rate of smoking during pregnancy
- Higher rates of social, emotional or mental health needs in children (higher SEND and EHCPs) and adults
- Lower educational attainment for children in reception year
- Self-harm and substance misuse in young people
- Oral health concerns amongst 0-10 year olds
- Major causes of ill health similar to NHS Major Conditions strategy list
- Higher rates of obesity
- Dementia prevalence to increase with ageing population







Most prevalent conditions in Swindon's GP practices (2020/21)

Condition	Age	Prevalence	People	Recent Trend	Comparison with England
Hypertension	All ages	14.2%	35,070	↑	Higher
Depression	18+ years	11.9%	22,766	↑	Lower
Obesity	18+ years	8.7%	16,664	–	Higher
Diabetes	17+ years	7.9%	15,464	↑	Higher
Asthma	6+ years	6.9%	15,832		Higher
Non-Diabetic Hyperglycaemia (NDH)	18+ years	4.0%	7,582		Lower
Chronic Kidney Disease (CKD)	18+ years	3.3%	6,366	–	Lower
Cancer	All ages	2.8%	7,000	↑	Lower
Coronary Heart Disease (CHD)	All ages	2.7%	6,760	–	Lower
Atrial fibrillation (AF)	All ages	1.9%	4,652	↑	Lower
Chronic Obstructive Pulmonary Disease (COPD)	All ages	1.7%	4,299	–	Lower
Stroke	All ages	1.6%	3,917	↑	Lower
Epilepsy	18+ years	0.8%	1,621	–	Similar
Heart Failure	All ages	0.8%	2,009	↑	Lower
Mental Health	All ages	0.8%	1,939	–	Lower
Rheumatoid Arthritis	16+ years	0.7%	1,436	–	Not compared
Osteoporosis	50+ years	0.6%	560	–	Lower
Dementia	All ages	0.5%	1,295	↓	Lower
Learning disability	All ages	0.5%	1,186	–	Lower
HIV*	15+ years	1.6	284	–	Better

*diagnosed prevalence rate per 1,000 population for Swindon UA

Main causes of DALYs in Swindon for 2019 (GBD 2019)

Cause	DALYs	Percentage
Ischemic heart disease	3,873	6.4%
Low back pain	3,342	5.4%
Chronic obstructive pulmonary disease	2,441	4.0%
Tracheal, bronchus, and lung cancer	2,102	3.5%
Depressive disorders	1,956	3.2%
Diabetes mellitus	1,929	3.1%
Stroke	1,858	3.1%
Headache disorders	1,772	2.9%
Lower respiratory infections	1,494	2.5%
Falls	1,461	2.4%

Main causes of YLL and the percentage change in Swindon for both genders and all ages
(Global Burden of Disease Study 2019 (GBD 2019))

Cause	YLL		Percentage Change	Rate		Disease Burden (percentage of total)
	2010	2019	2010 to 2019	2010	2019	2019
Ischemic heart disease	3,567	3,727	4.3%	1,712	1,562	13.0%
Tracheal, bronchus, and lung cancer	1,839	2,070	11.2%	882	868	7.2%
Chronic obstructive pulmonary disease	1,478	1,588	15.9%	641	665	5.5%
Stroke	1,335	1,563	5.5%	709	655	5.5%
Lower respiratory infections	1,220	1,482	17.7%	585	621	5.2%
Colon and rectum cancer	930	1,112	16.4%	446	466	3.9%
Breast cancer	849	928	8.5%	407	389	3.2%
Alzheimer's disease and other dementias	745	907	17.9%	357	380	3.2%
Self-harm	759	770	1.4%	364	323	2.7%
Cirrhosis and other chronic liver diseases	703	760	7.5%	337	319	2.7%

JSNAs: Wiltshire

Highlights

- Projected 87% increase in 85+ population by 2040 (from 2021) = increases in dementia, falls etc
- Admission rates for self-harm in Wiltshire are at their highest level in 5 years.
- Prevalence of common MH disorders rising
- Significant deprivation-linked inequalities in admissions related to alcohol, in levels of smoking and in life expectancy

Population and deprivation: Ageing population

Our **65+ population currently** represents just over a **fifth** of Wiltshire's population, but **by 2040** this age group will make up nearly **a third** of the total population.

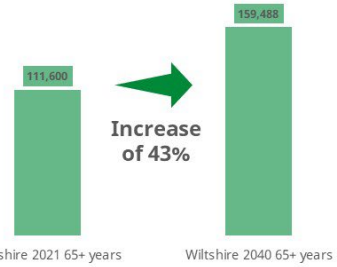
The increases expected to be seen in Wiltshire in both the 65+ and 85+ age groups are higher than the expected increases in the South West and England

By 2040 in Wiltshire...

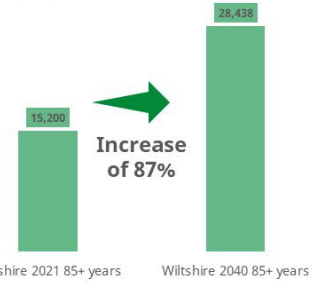
- **65+** population expected to have **increased** by ↑ **43%**
- **Under 65+** population expected to have **decreased** by ↓ **3%**
- **85+** population expected to have **increased** by ↑ **87%**

Ageing population: Projected percentage increase in population aged 65+ years and 85+ years from 2021 to 2040
Geographical comparison, 2021 and 2040

Wiltshire population aged 65 years and above: Number of people
Comparing 2021 census data and 2040 projections



Wiltshire population aged 85 years and above: Number of people
Comparing 2021 census data and 2040 projections



Wiltshire Health and Wellbeing JSNA 2022 — Wiltshire Council

Diseases and ill health: Key focus areas

Sensitively promoting healthy behaviours to lower the risk of preventable conditions associated with lifestyle factors. These include:

Hypertension: 15.4% of people in Wiltshire had a recorded diagnosis of hypertension in 2020/21, higher than levels in South West (14.8%) and England (13.9%).

Diabetes: 7.2% of Wiltshire's population aged 17 and over were recorded as having diabetes in 2020/21, similar to the South West (6.9%) as well as England (7.1%)

Coronary heart disease: In 2020/21 3.4% of people in Wiltshire were registered as having coronary heart disease, comparable with regional (3.5%) and national levels (3.0%)

Strokes: 2020/21 prevalence data shows that 2.2% of Wiltshire's population were recorded as having experienced a stroke or transient ischaemic attack, broadly in line with levels reported regionally (2.2%) as well as in England (1.8%)

Disease prevention and health protection with a specific focus on

Early childhood vaccine coverage: Meningitis B vaccinations for 2 year olds, Dtap/IPV boosters (protecting against diphtheria, tetanus, pertussis and polio) and the second MMR vaccine (both for 5 year olds) were below the national coverage target of 95% in Wiltshire in 2020/21.

Cervical and breast cancer screening: Levels of screening in these areas has reduced in Wiltshire over the last 2 years as a result of the pandemic. For both metrics, uptake is consistently lower in the most deprived areas of the county.

Wiltshire's ageing population and age related conditions, particularly:

Dementia: In 2022, the dementia diagnosis rate in over 65 year olds in Wiltshire is estimated to be 58.5%, equivalent to around 4,300 people. This indicates that there are in the region of a further 3,000 people in older age groups in the county that are undiagnosed.

By 2030, it is estimated that almost 11,500 people in Wiltshire aged 65 and above will be living with dementia, driven primarily by an aging population and increased life expectancy.

Supporting good mental health and emotional wellbeing.

The prevalence of common mental health disorders is rising in Wiltshire

In 2020/21, almost a quarter (24.6%) of persons aged 16 and over in the county were estimated to have higher levels of anxiety. Whilst this is similar to the South West (23.4%) and England (24.2%), it represents a 6% rise compared with the previous year (18.3%).

Almost 44,000 people in Wiltshire (18 and over) had a recorded diagnosis of depression in 2020/21, equivalent to 11% of the adult population. Levels have been steadily rising since prior to 2016/17.

Rates of hospital admissions for self harm in Wiltshire are now at their highest level for five years

Hospital admissions relating to self harm in Wiltshire's overall population and the 10-24 year age group have increased annually since 2016/17. In 2020/21, admissions of this type (in both age ranges) were significantly higher than both the South West and England. Admission rates for both metrics in Wiltshire are notably higher in women and young females.

Wiltshire Health and Wellbeing JSNA 2022 — Wiltshire Council

Life expectancy and causes of death: Key focus areas

Life expectancy

In 2018-2020 the average life expectancy for females in Wiltshire is 3.6 years more than males, with females expected to live to 84.5 years and males 80.9 years in Wiltshire .

Healthy Life expectancy

Male - Within Wiltshire, male healthy life expectancy is above that of its statistical neighbours and the South West; meaning that the time males spend in a healthy life extends into their state pension age at 66

Female - Wiltshire's female healthy life expectancy has been in continual decline and has dropped by 4.2 years over the past 4 years to 65.2 years and now sits below that of the region, whilst Wiltshire's comparators have remained largely stagnant.

All-age all-cause mortality - 2021

1.	Diseases of the circulatory system	26%
2.	Neoplasms (cancers)	25%
3.	Diseases of the respiratory system	9%
4.	Mental and behavioural disorders	9%
5.	Codes for special purposes (mainly Covid-19)	8%
6.	Diseases of the nervous system	7%
7.	Diseases of the digestive system	4%
8.	Other causes	11%

Trends in under 75 mortality

Cancer and CVD are the main causes of premature mortality in Wiltshire causing around 60% of premature deaths.

Gender inequality - Men have a higher rate of premature mortality than women (803 to 588 deaths in 2020), and the inequality is particularly evident in premature CVD deaths with 85.2 male deaths per 100,000 population compared to 32.3 deaths for females.

The gap between genders is smaller when looking at premature mortality from cancer. However, there is substantial variation between genders for preventable premature cancer mortality, with 52.3 male deaths per 100,000 compared to 30.8 for females.

Under 75 preventable mortality

In Wiltshire, under 75 preventable mortality is considerably lower than England and South West.

Yet, within Wiltshire preventable deaths were over 3x higher for men living in our most deprived areas than in our least deprived areas. For women it was 3.7x higher.

Identifying inequalities in life expectancy in Wiltshire

Healthy life expectancy – in years (England)

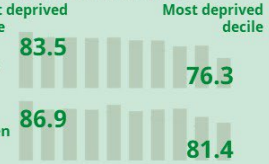
The areas of deprivation in England have a large variation in healthy life expectancy at birth:

	Least deprived decile	Most deprived decile
Men	70.5 years	52.3 years
Women	70.7 years	51.9 years

Nearly 120,000 people in Wiltshire live in in the most deprived 5 deciles (half) of areas in England, and face these inequalities in their healthy life expectancy.

Life Expectancy - in years

Wiltshire deprivation deciles



This difference in life expectancy among the different deciles is likely to worsen as a result of the cost of living crisis.

Wiltshire Health and Wellbeing JSNA 2022 — Wiltshire Council

Preventative ways of working - CVD

There is a strong rationale and an increasing evidence base for pivoting current ways of working towards preventative approaches in several areas. Cardiovascular Disease (CVD) is one such area, with several potentially high impact interventions, including:

Optimisation of hypertension treatment
Improving diagnosis and ensuring those with an existing diagnosis are receiving and adhering to the right medication to control their hypertension.

Systematic review of high BP on patient records: to achieve at least 73% control according to QoF, or 3% greater than pre-pandemic levels (whichever is greater) by March 2024. The clinical management of hypertension accounts for 12% of visits to primary care and up to £2.1 billion of healthcare expenditure. Lowering blood pressure reduces the incidence of stroke by 35%–40%, heart attacks by 20%–25% and heart failure by 50%.

Over 10 years a reduction in the population average blood pressure by 5mmHg through improved prevention, detection and management could save an estimated 716 quality adjusted life years (QALYs) and save £13.5m on related health and social care costs in BSW.

Optimisation of Heart Failure treatment through annual reviews
Managing blood pressure, atrial fibrillation, cholesterol and anticoagulant use to identify and address deterioration early.

Heart failure represents the only major cardiovascular disease with increasing prevalence and carries a poor prognosis for patients – 30-40% of people diagnosed with Heart failure will die within 1 year. Reviews are associated with a reduction in non-elective readmission and mortality in those diagnosed with HF, and are monitorable via QOF- HF007 - The percentage of HF Register patients who have had a review in the preceding 12 months.

Evidence suggests early detection of deteriorating health in heart failure patients reduces absolute hospitalisations by 45%. This could total approximately £1.7m in savings per year in BSW. Identifying high-risk patients with recurrent admissions for heart failure (due to social vulnerability) using a population health management approach in primary care, saves around £7,500 per person per year in non-elective admissions. BSW have an estimated 1,486 such patients, equating to theoretical savings of £11.1m, including the £1.7m noted above.

Source: B1590-cvd-high-impact-interventions.pdf (england.nhs.uk)