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

BSW Partnership Board

Friday 1 October 2021, 9:00-12:00, Zoom meeting in public

Agenda

Time	Item no	Item title	Lead	Action	Paper ref.
9:00	1	Welcome and apologies	S Elsy		
	2	Declarations of interests	S Elsy	Note	
	3	Minutes of the previous meeting	S Elsy	Approve	ICSPB/21-22/020
	4	Action Tracker	S Elsy	Note	ICSPB/21-22/021
9:10	5	Questions from the public	S Elsy		
9:20	6	Chair's report	S Elsy	Note	verbal
9:25	7	SRO report	T Cox	Note	ICSPB/21-22/022
9:35	8	BSW Performance, quality and finance report	T Cox, J-A Wales	Note	ICSPB/21-22/023
10:00	9	Deep dive: People and workforce	S Flavin, V Ongley	Note	ICSPB/21-22/024
10:25		Break			
10:35	10	Greener BSW – *How are we as partners responding to the greener agenda, what is our collective ambition*	S Yeo, N Watts	Note	ICSPB/21-22/025 (slides on the day)
11:00	11	ICS development • ICB governance blueprint – first iteration • transfer of CCG statutory functions to ICB • update from ICS development programme work streams	T Cox, B Irvine	Discuss Note Note	ICSPB/21-22/026a ICSPB/21-22/026b (slides on the day) ICSPB/21-22/026c (slides on the day)
11:25	12	Transformation work streams updates	R Smale	Note	ICSPB/21-22/027
11:40	13	AOB • BSW Partnership Board forward plan 2021/22	S Elsy		ICSPB/21-22/028

Date of next meeting: 19 November 2021, 9:00-12:00, virtual

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/
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.
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.
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.

Acronym /abbreviation	Term	Definition
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.
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 will 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.
	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.
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.

Acronym /abbreviation	Term	Definition
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/
MDT	Multi-Disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. psychiatrists, social workers, etc.), each providing specific services to the patient.
	Non-elective care	Non-elective care is admitted patient care activity which takes place in a hospital setting where the admission was as an emergency.
OD	Organisational Development	Organisational development is a planned, systematic approach to improving organisational effectiveness and one that aligns strategy, people and processes. To achieve the desired goals of high performance and competitive advantage, organisations are often in the midst of significant change.
OPEL	Operational Pressures Escalation Levels	Framework system implemented by NHSE to provide a consistent approach in times of pressure.
	Primary Care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists,

Acronym /abbreviation	Term	Definition
		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.
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.
	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.
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

Bath and North East Somerset, Swindon and Wiltshire Partnership
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BSW Partnership Board

Friday 28 May 2021, 9:00-12:00, virtual Zoom meeting in public

DRAFT Minutes

Present

Members:
Stephanie Elsy, BSW ICS Chair
Tracey Cox, BSW ICS SRO
Alison Ryan, Chair, RUH
Cara Charles-Barks, CEO, RUH
Charlotte Hitchings, Chair, AWP
Sarah Constantine, AWP (for Dominic Hardisty, CEO, AWP)
Liam Coleman, Chair, GWH
Simon Wade, CFO, GWH (for Kevin McNamara, CEO, GWH)
Nick Marsden, Chair, SFT
Stacey Hunter, CEO, SFT
Stephen Ladyman, Chair, Wiltshire Health and Care (WHC)
Liz Rugg, CEO, Medvivo
Sue Wald, Director Adult Social Services, Swindon Borough Council
Jane Davies, Cabinet Member for Adult Social Care, SEND, Transition and Inclusion, Wiltshire Council
Gillian Leake, Chair, Healthwatch Wiltshire
Andrew Girdher, Chair, BSW CCG
Ian James, Lay Member, BSW CCG Governing Body
Ruth Grabham, Chair, BSW Population Health and Care Group
Gareth Bryant, CEO, Wessex LMC
Natasha Swinscoe, Managing Director, WEAHSN
Tony Fox, Executive Lead, SWASFT
Suzanne Tewkesbury

Attending Officers:
Caroline Gregory, CFO, BSW CCG
Ben Irvine, Programme Director ICS Development
Richard Smale, Director for Strategy and Transformation, BSW

In attendance and presenting specific items:

for item 8, from Oxford Health: Andrea Shand, Associate Director Mental Health; Debbie Richards, Executive Managing Director of mental health, learning disabilities and autism

services; James Fortune, Head of Service for BSW CAMHS; Agnieszka Pasek, Service Change Manager; Vikki Laakkonen, Deputy Medical Director Oxford Health; also Lucy Baker, BSW CCG Director of Planning and Transformational Programmes
for item 11, Julie-Anne Wales, Director of Corporate Affairs BSW CCG

Apologies
Andy Smith, ED SWASFT
Bernie Marden, Medical Director RUH
Kevin McNamara, CEO, GWH
Douglas Blair, Managing Director, WHC
Dominic Hardisty, CEO, AWP
Brian Ford, Cabinet Member for Adults & Health, Swindon Borough Council
Steve Maddern, Director Public Health, Swindon Borough Council
Kate Blackburn, Director Public Health, Wiltshire Council
Lucy Townsend, Director Adult Social Services, Wiltshire Council
Becky Reynolds, Director Public Health, B&NES Council
Kevin Peltonen-Messenger, CEO, The Care Forum
Sheridan Flavin, Co-Chair, BSW Social Partnership Forum
Val Scrase, Managing Director, Virgin Care Wiltshire and BaNES

1. Welcome and Apologies

1.1 The Chair welcomed members and officers to the meeting and noted apologies; the Chair welcomed members of the public who attended the meeting as observers.

1.2 The meeting was declared quorate.

1.3 The Chair announced a re-order of the agenda to accommodate presenters' availabilities. The minutes record item numbers per the original agenda, and in the order these items were taken.

2. Declaration of Interests

2.1 None declared.

3. Minutes of the BSW Partnership Board meeting 28 May 2021 (PB/21-22/011)

3.1 The Committee reviewed the minutes of its previous meeting and **approved** them as a true and accurate record of the meeting.

4. Actions and Matters Arising (PB/21-22/012)

4.1 The Partnership Board reviewed the action log and noted all actions from previous meetings closed / complete.

5. Questions from the public

5.1 None received.

9. ICS development: Provider collaboratives – Acute Hospital Alliance (AHA) update on current collaborative working and intended developments (ICSPB/21-22/015)

9.1 The RUH CEO presented an overview of the AHA provider collaboration progress, in the context of national policy and expectations re provider collaboratives' purpose and role within integrated care systems, as articulated in the Health and Care Bill and the ICS Design Framework. The presentation outlined the current state and intended future development for collaboration of the acute hospitals' corporate and clinical functions and teams. The presentation highlighted that no change of organisational form had been required; instead a re-focus on acute providers' role, and collaborative ways to discharge it, had achieved transformational outcomes for the benefit of the population.

9.2 The collaborative approach had already produced patient benefit, for example:

- through the collaborative approach, a BSW system waiting list for pediatric dental operations had been created across the system, capacity identified, and treatment offered within a short period of time, clearing 400 cases of the pediatric waiting list and benefitting elective care waiting lists overall;
- enablers of effective collaboration had been identified e.g. joined-up governance, joined-up IT and procurement, and mutually agreed quality principles; some of the corporate efficiencies could be made available to other system partners in due course;
- integration with neighbourhood and place occurred through collaboration with primary care and local community services; through the alliance, a consistent approach was enabled for the dissemination of learning, adoption of good practice, and continuous involvement of local partners in identifying demand and appropriate responses at place;

Action (C Charles-Barks, B Irvine): To build up real life examples where patients have benefitted from the provider collaborative approach, for public dissemination. This would support the public discourse re benefits of the ICS development.

9.3 The Partnership Board **noted** the report.

8. Deep dive: Children and Adolescent Mental Health Services across BSW (ICSPB/21-22/014)

8.1 The Associate Director Mental Health, Head of Service, and Deputy Medical Director Oxford Health NHS Foundation trust presented an overview of CAMHS transformation in the region, based on the THRIVE model which provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and families.

8.2 The presentation and subsequent discussion highlighted the following:

- the emphasis of CAMHS services was on prevention and early intervention, the latter increasing the success of recovery; greater integration and flexibility at the interface of children's and young people services, and adult services was a strategic priority, to ensure continuity of care;
- while there was increased funding in CAMHS, nationally there was a challenge to understand and unpick what was driving the increase in prevalence of mental illness in the UK;
- the principle of involving patients in service design and service review was embedded via a CAMHS participation team in BSW who link with Healthwatch and local authority participation groups;
- the BSW care model aimed for the majority of patient care to take place in the community, which required close collaboration between the lead mental health services and primary care; enablers such as IT infrastructure and data sharing were crucial to achieve transformation of services;
- the BSW Academy would play a key role in ensuring that BSW had the workforce to support and sustain expected levels of growth for CAMHS; the AHA provider collaborative model proposed collaborative rather than competitive approaches to workforce expansion, also closer working with voluntary sector and wellbeing practitioners needed to be considered, as well as a national re-think concerning the currently required academic criteria for entry into the profession which created barriers for potential candidates.

6. Chair's report (verbal)

6.1 The Partnership Board received and **noted** the Chair's verbal report about engagements and developments since the last meeting.

6.2 The report highlighted the following:

- system pressures arising from continuing Covid response, increase in demand for services, and the recovery programme inform the BSW approach to progressing and prioritising elements of the ICS development; this approach was supported by indications nationally that there was some flexibility;
- since the last meeting, the Chair had conducted meetings with local MPs, Local Authority Leaders and CEOs, and stakeholders incl. in the voluntary sector to brief them on implications of the Health and Care Bill for BSW transitioning towards a formally established BSW Integrated Care Board in April 2022;
- the Health and Care Bill had achieved its second reading on 14 July 2021 and would move to committee stage in September; minor amendments were expected.

6.3 The Chair reiterated the offer to visit partners and attend / observe meetings. Swindon officers took a report re legislative changes to their Health and Well Being Board and elected members are keen to understand more. Further reports will be presented to Cabinet, HWB and elected members in due course.

7. SRO report (ICSPB/21-22/013)

7.1 The BSW ICS SRO presented her report on activities and developments since the last meeting. The Partnership Board **noted** the report, in particular:

- the entire BSW health and care system was facing significant pressures with regard to demand for services, workforce shortages, Covid-19 response and recovery, and financial constraints;
- the BSW operational plan for October 2021 to March 2022 (the H2 plan) would set out the BSW responses to these challenges and resulting significant risk in the health and care system; Libby Walters, Director of Finance at the RUH, would be the Senior Responsible Officer for the production of the BSW H2 Plan;
- nationally, it had been recognised that systems' positions had deteriorated over the past two weeks and would continue to do so over the summer;
- work was underway, via the System Architecture and Local Ways of Working (SALSW) group, to develop the governance and assurance framework for the BSW ICB from April 2022, in view of the Health and Care Bill.

10. ICS development programme update (ICSPB/21-22/016)

8.1 The Partnership Board received and **noted** an update on the latest developments with regards to the transition to a statutory ICS. The focus was on currently known national expectations regarding the governance of ICSs, including potential composition of the statutory ICS NHS Body Board, and the statutory ICS Partnership Forum. National guidance on significant aspects of the transition was delayed.

8.2 The Partnership noted that the development of the ICB governance structures, led by the CCG per the Health and Care Bill, was a collaborative enterprise that required and invited all partners' input, and closely involved partners' governance leads. It was expected that the nationally developed ICB Model Constitution would be tailored to local circumstance, including alignment with partners' governance and assurance frameworks as appropriate.

11. Integrated system performance report (PB/21-22/006)

9.1 The Partnership Board received and **noted** the BSW system performance, quality and finance report to March 2021, which set out the system's performance against statutory targets and agreed prioritisations in view of performance data. The report highlighted areas of continuing challenge and concern.

9.2 The Partnership Board noted the report, which provided a picture of the system running hot, with demand for and pressures high on all services:

- Covid – there was an expectation that the number of Covid patients in hospital would increase exponentially over the next few weeks. New guidance to staff was expected to limit the adverse effects of the 'pingdemic' on staff;
- Urgent care – the focus was on getting in a good position for autumn and winter while ensuring the recovery piece remained on track and all areas of work that have been stood back up continued. Staff wellbeing remained a priority incl. ensuring colleagues took annual leave;

- Elective care – there had been a 34% reduction in 52-week waiters due to an increase of activity, including activity undertaken by the independent sector; activity levels remained below levels of the 2019/20 comparator period; BSW would gain a windfall from the Elective Recovery Fund, however this would be less than expected as the parameters for accessing the Fund had changed.
- Finance – no financial performance issues to report, the system was planning a breakeven position for H1; risks and mitigations noted, including expected reduction of Covid allocations, national expectation that the NHS would part-fund the 3% pay award, continued lack of clarity re the financial regime for H2, and continued uncertainty (until after the autumn spending review) whether BSW capital programmes would receive additional funding – recognised that the resultant delay of key estate improvements and developments had significant financial implications.

12. Transformation work streams, update report (PB/21-22/007)

11.1 The Partnership Board received highlight reports from the BSW Transformation programmes. Each highlight report provided more granular detail about transformation programme work underway per the BSW system operating plan, updated on delivery over the reporting period, and provided a headline assessment of risks, progress and key milestones per programme. Going forward, the report format would be adapted to highlight exceptions. The Partnership Board **noted** the reports.

Action (Secretariat): To send the slides as a separate pack to all, and request for all members to disseminate the information.

13. Any Other Business

13.1 The Partnership Board received for information the Partnership Board forward plan of business items. The Chair invited members to identify other items.

13.2 There being no other business, the Chair closed the meeting at 12:00.

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

Item 4

BSW ICS Board Action Log business year 2021-22

updated following meeting on 23 July 2021

OPEN actions

Meeting Date	Item no. and title per agenda	Action	Responsible	Progress/update
23/07/2021	9. ICS development: Provider collaboratives – Acute Hospital Alliance (AHA) update on current collaborative working and intended developments	To build up real life examples where patients have benefitted from the provider collaborative approach, for public dissemination. This would support the public discourse re benefits of the ICS development.	C Charles-Barks, B Irvine	
23/07/2021	12. Transformation work streams, update report	To send the slides as a separate pack to all, and request for all members to disseminate the information.	Secretariat	30/07/2021: Complete, slides circulated

Bath and North East Somerset,
Swindon and Wiltshire Partnership
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Report to:	**BSW Partnership Board Meeting**	**Agenda item:**	**7**
Date of Meeting:	**1 October2021**		
Title of Report:	**SRO Update Report**		
Author:	**Tracey Cox** **Chief Executive BSW CCG & SRO BSW Partnership**		
Appendices	**None**		

1. National, Regional and Local Developments

1.1 Update from BSW Executive Meeting 10th September 2021

The group met and considered the following items:

- Integrated Performance Update
- Update on the ICS Development Programme
- Our proposed approach to Financial Sustainability across BSW
- Tobacco Dependency Strategy & Action Plan – Approval of the business case, and approach to utilisation of a ring fenced allocation of £211,000 for the management of tobacco dependency in acute settings. (The sign off of the plan and business case would also trigger the release of an additional 20% of funding, to be targeted on treating tobacco dependence in maternity and mental health.
- Procurement Update – an update on proposed changes to future procurement guidance and future local requirements over the next 12 months

1.2 ICS Guidance

A significant amount of national guidance has been published in recent weeks. An overview of the key documents has been communicated via the weekly BSW ICS Programme Sprint report which is being distributed widely across partners.

1.3 Health Infrastructure Plan 8 New Hospital Programme

On the 9th September we submitted a number of Expressions of Interest (EOI) in response to the governments' next phase of implementation of its health infrastructure plan identifying a further 8 new hospitals to deliver on its commitment to fund and build a total of 40 new hospitals by 2030. This is the first of a two-stage selection process, starting with an 'Expression of Interest' phase, followed by a more detailed process for long-listed schemes later in the year with a final decision expected in spring 2022.

Across BSW we have backlog maintenance costs totalling £111m and unfunded capital schemes of £954m. For the EOIs we have included some proposals that are "shovel ready" and have put forward 7 EOIs:

1) Mental Health Bid – a single EOI including new builds and major refurbishments in Bath, and Swindon @ c.£120m
2) Community Hospital Bid – two EOIs for new build schemes to enable further 'out of hospital' care in Chippenham @ c.£79m and Melksham @ c.£25m

3) SFT Bid – a single EOI focused on a new elective care centre @ c.£40m, but also covering the wider SFT campus project at an additional c.£130m
4) GWH Bid – two EOIs for new build surgical assessment unit @ c.£10m, integrated rehabilitation facility @ c.£60m, and sterile services unit @ c.£20m
5) RUH Bid linked to New Hospitals Programme (NHP) – a single EOI with a focus on immediate commitments @ c.£110m, but also covering the full RUH NHP project totalling c.£470m

Nationally they are particularly keen to receive applications from trust types currently under-represented in the new hospitals programme, such as mental health and community trusts.

Note : Above values accurate as of 3rd September 2021.

1.4 ICS Developments – Working with Voluntary Community and Social Enterprise Sector

In recent months we have been working with representatives from the VCSE across BSW to discuss their involvement in the ICS working arrangements. There is already good engagement and involvement at place level with our three Integrated Care Alliances, but ICSs are being encouraged to ensure that our governance and decision-making processes support close working with the VSCE sector as key strategic partners at all levels.

We have been successful in access a national support programme and development funding (£25k) to help us to establish a VSCE sector alliance that can operate at system level and support the VSCE's role involvement in both the ICS NHS Board and future ICS Partnership Forum. Working with 3SG (BaNES), Voluntary Action Swindon and Wessex Community Action we have co-produced an Expression of Interest to set out how we will begin to develop these arrangements.

This will provide some much needed infrastructure and capacity to help the VSCE sector across BSW further engage in the work of the ICS. Given the diversity and complexity of VSCE sector across our geography and given the potential of their contribution, advice and support to the objectives of the ICS, we have provided a further £10k worth of funding from the ICS's infrastructure budget to help further this work. We will continue to brief system partners as this programme of work progresses.

1.5 Appointment of BSW Academy Director

Following a competitive recruitment process involving representatives from across Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership we have recently announced the appointment of Dr Sarah Green to the role of Director for the BSW Academy.

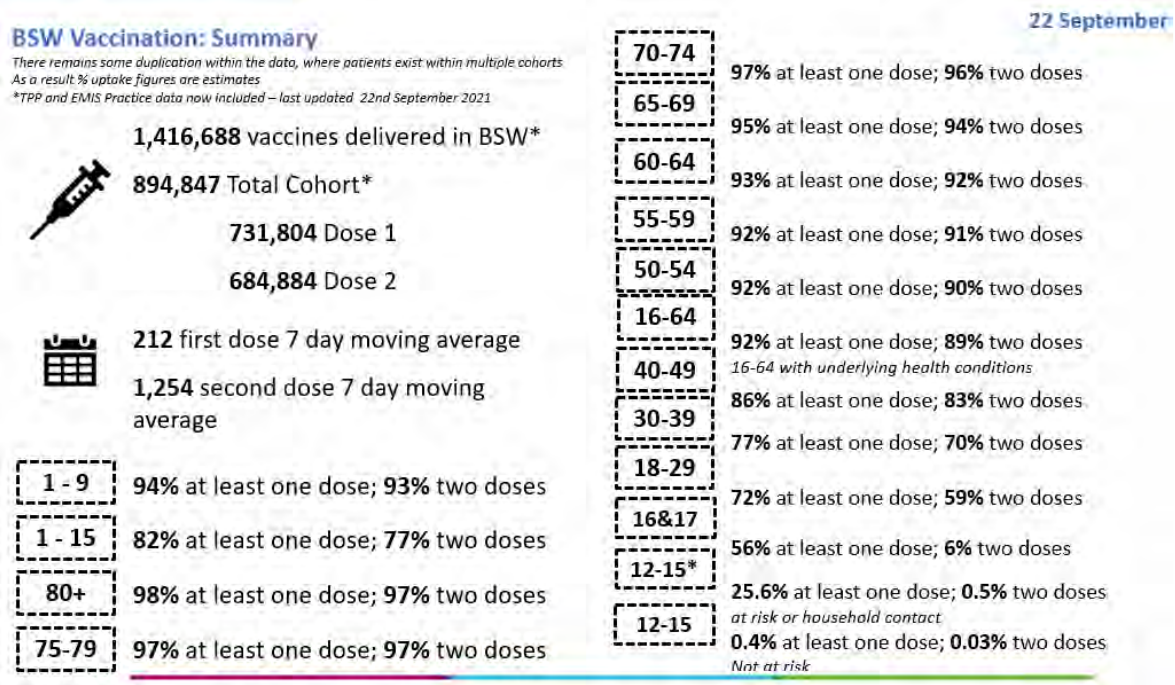
Since 2018 Sarah has been the Associate Director of Education at University Hospitals Bristol and Weston NHS Foundation Trust and has been the Senior Responsible Officer for the Bristol, North Somerset and South Gloucestershire (BNSSG) Learning Academy. Sarah has had an extensive career across both education and health and social care which has included partnership working and being awarded professional/academic qualifications and scholarships, culminating in a professional doctorate in 2019.

Sarah initially started her career through a clinical background as an adult nurse and midwife. Following a number of senior university positions, Sarah became Head of Nursing

and Midwifery at the University of the West of England (UWE), Bristol. Sarah moved from this role to return to the NHS in the drive to lead, influence and further support employer led workforce priorities.

Sarah will take up her new role from 1 November 2021.

1.6 BSW Mass Covid Vaccination Programme



1.7 Re-procurement of Primary Care Training Hubs

For a number of years BSW has been in receipt of non-recurrent funding from Health Education England for the provision of Training Hubs designed to support the delivery of high quality training and education for primary and community care. Training hub activity is funded by NHSE, CCG and HEE monies. We have been notified of the need to respond to a procurement process for specifically the component of the Training Hub activity that is HEE funded.

The service specification was issued on the 13th September 2021 with an intention to move to contract awards by around Jan 2022. The proposal is to create a Multiyear contract 3+1+1 which will provide stability and the ability to forward plan.

Current service arrangements are provided by some CCG staff (seconded or in addition to other roles) and we would like to submit a proposal on behalf of the BSW ICS to continue to deliver these arrangements.

The Training Hub team presented recently at ICS system capability group and have strong links into the work of the BSW Academy. We would envisage these future arrangements being a core component of the BSW Academy.

Ends

Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

BSW Performance, Quality and Finance Report – September 2021

BSW Partnership Board

01/10/2021

Timing of information in this report:
Please note the information used in this report is the latest available information from each source at the point the report was collated.
This can mean similar data from different sources will not be from the same period.
Managing the pandemic has driven the creation of new local data sources for some data but we will also use the national validated data sources for more detailed reporting where available.

Development of this report:
This report is being developed alongside the BSW System Oversight Framework (SOF).
The report now includes a phase 1 oversight framework which has taken currently available metrics from the NHS oversight metrics for 2021/22 system oversight framework. Metrics for Social Care will be added when agreed and available.
Further phases of development will be agreed in-line with the development of the BSW SOF.

Executive Summary 1 of 3

Area	Key Area	Key Action	Accountability
Elective Care Recovery	• Long waiters	• Additional capacity to Horton & Circle Reading. • Mutual aid arrangements for Maxillofacial, Ophthalmology, Urology and Orthopaedics including use of Sulis Hospital.	Elective Recovery Programme of Elective Care Board
Cancer	• Support continued recovery of: - NHS constitutional performance standards for: 2 week wait, 31 day, 62 day and 28 day faster diagnosis standard; - activity volume recovery; • Continue work to identify inequalities and actions to address (including links to PCN DES (cancer)) • Finalise details for GP Practice cancer Leads and Practice Nurses education events • Macmillan Nurse Facilitator (Swindon) begins • Re- advertise Macmillan Nurse Facilitator (Salisbury) • Initiate Macmillan Nurse Facilitator (Bath) proposals • Confirm future funding arrangements from 1/4/22 for Bath & Wilts Macmillan GP cover	• Expansion of Non Site Specific Rapid Diagnostic Service (NSS RDS) pathways: by end Sep go-live Minerva/Keynsham; expansion of Devizes to cover Melksham; continued development of SFT model • Prepare for transition of teledermatology advice and guidance from Consultant Connect to Cinapsis. Operationalise the mutual aid option from RUH for SFT footprint (awaiting finance agreement) • Further develop Swindon/GWH Thames Valley Cancer Alliance targeted lung health check pilot proposal if signed-off by NHSE • Increase recording of Quantitative Faecal Immunochemical Test (QFIT) scores on Lower Gastrointestinal 2 week wait referrals • Education events for non-clinicians NHS, Local Authority and community leaders) – cancer awareness	Elective Care Board
Urgent care	• Demand pressures and flow – we continue to see increases in demand and minor acuity continues to be challenging across the system • Considerable workforce challenges in all parts of the system due to vacancies, sickness and annual leave • Increasing Covid numbers in the acute trusts and across the community. Leading to challenges in flow across the system	• Demand and capacity work ongoing through the Urgent Care and Flow Board • Minor acuity workstream continues to progress • Workforce Hub being developed • Risk assessment review to enable system approach to workforce returning to work following Covid contacts in line with national protocols • Communication and public messaging ongoing with emphasis on appropriate access to healthcare	Patient Flow- Lisa Hodgson Minor Acuity- Heather Cooper Demand and capacity- Urgent Care and Flow board. Urgent Care and Flow Board work- Stacey Hunter and Heather Cooper

Area	Key Area	Key Action	Accountability
All age Mental Health	• Increasing activity and acuity. Increased bed pressures and system delays. Out of Area increase to 27 • Children and Young People access continues to be challenged – activity increase, acuity and workforce challenges • Eating Disorder particular area of activity and acuity growth continued increase • Adult ADHD waiting lists continue to increase.	• Additional clinical bed management approved for AWP in principle from national discharge funds to support system flow. Adult and CYP MH, LDA and Eating Disorder multi-agency discharge event (MADE) workshops occurring monthly. • BSW system MH surge plan to be developed by Sept with focus on pathways and capacity • BSW Complex Case Escalation Hub mobilising Sept. • ADHD pathway and WL improvement group developing recovery plan	BSW Thrive Programme Board – next meeting 08/09
All age Learning Disabilities /Autism Spectrum Disorder	• Annual health checks continue below trajectory • Adult inpatient numbers above trajectory	• Pathway improvement working group mobilised. • BSW LD / ASD Multi agency discharge events (MADE) now taking place monthly to review all patients. Focus on both discharge and admission avoidance	BSW LD/ASD Programme Board
Maternity	• Maternity in national contingency for first time in July. Request received for mutual aid from Bristol • Workforce issues with increased demand • Increased numbers of pregnant women with moderate to severe COVID-19	• BSW LMNS lead midwife on regional group exploring mutual aid pathways and policies • Temporary closure of midwife led units at times to maintain safe staffing and specialist midwives supporting clinical workload • Daily Sit reps to SW team sharing information across SW maternity unit, SW Diversion Policy in place,. • National 8 point plan received and actions underway for BSW maternity to reduce impact.	BSW Local Maternity and Neonatal System (LMNS)
Primary Care	• Continued demand and workforce challenges • Ongoing Covid Vaccination clinics delivered via 11 PCNs and now offering 16 &17s and 12-15 clinically extremely vulnerable • Impact of Covid changes in secondary care – additional service transfers / support • Impact of blood tube shortage	• Targeted communications campaigns • Flexible pool of staff to support vaccinations and continued work on recruitment under the additional roles reimbursement scheme (ARRS). • Continued block payment & reduced reporting arrangements for Q2 locally commissioned services • Developing additional support e.g. phlebotomy collections and RSV	Primary Care Commissioning Committee

Area	Key Area	Key Action	Accountability
Workforce	• Sickness Absence (and Covid-19 isolation) has remained high through August (4.4% to 4.8%; 50% higher than long term monthly average). • Decreasing retention is slowing workforce growth. (82% - Jun 2021; 85% - Dec 2020). This has had strongest implication within the lowest paid segment of the workforce. • BSW has historically had high levels of end of career activity. Recent modelling suggests that this is expected to be amplified in 2021/22 and 2022/23 by up to 250 wte.	• 7th flexibility workshop held with BSW managers. Themes have informed draft 'flexibility principles' for BSW to support later career retention and attraction of staff. • System wide bid commencing to support international recruitment of midwives and retention. • System bid written, submitted and accepted by HEE subject to modification for placement expansion to support increase in pipeline – concentration on mental health/ Learning Disabilities and adult nursing as priority areas. • Approx. 40 kickstart posts across the system identified to enhance pipeline and skills for Health and Social Care careers.	
Quality	• Increasing demand in the system has impacted on patient flow and the requirement to open additional beds in the system • Slight rise in Clostridium Difficile Infection (CDI) • Flu season campaign in line with BSW action plan • Reduction in incident reporting (SWAST), although recognised harm as a result of significant and constant demand pressures • Ambulance demands and System Serious Incidents will be passed to local systems for investigation and reporting onto STEIS with participation from SWASFT • Learning From Patient Safety Events rollout to Primary Care • Pressure remains across AWP challenging the resilience of Business Continuity plans- concerns identified in several service areas of note: Adult PICU and PCLS (Wiltshire)	• EQIAs completed to support beds to open in Care Homes • System agreed SOP and risk assessment to support returning of staff who have had contact with a Covid +ve case, and to open beds with less social distancing • 4 actions agreed by CDI collaborative • focusing on reducing inequalities and increasing flu vaccination uptake within at-risk populations • Implementing telephone line to encourage incident reporting • BSW CCG to liaise with other systems who have already instigated system investigations to identify process followed. For further discussion through Urgent care and flow board • BSW CCG discussing with Devon CCG who have undertaken a number of actions and improved incident reporting I primary care. • Assurance has been given in relation to PICU and the CCG is encouraging AWP to seek external support to help develop a positive ward culture. Audit and action plans are in place to support improvement in PCLS. Quality visit to be arranged to PCLS (South Wiltshire) with particular attention on caseload management/ review.	Quality and Performance Committee (QPAC) Quality Surveillance Group (QSG) Elective Care Board Urgent Care Board BSW Thrive Board Primary Care Commissioning Committee (PCCC)

Workforce

Workforce Exception reporting (Aug 21)

Exceptions Analysis

- Development of BSW workforce intelligence infrastructure and dashboard is on going.

What did we achieve in the past month?

- Flexibility principles to support retention by offering flexibility of when, where, and how we work by default drafted and sent to partners for BSW agreement
- 40 posts identified across BSW and commencing of recruitment process for kickstart to supply pipeline into high turnover HSC careers
- Exploration and spec development for a BSW international recruitment portal and draft processes and supporting admin under development
- Oversupply of international recruits resolved by coordination of a system wide approach – leading to sharing of supply with partners as supported by NHSEI
- Commitment to adopt a BSW approach and roll out **itchy feet conversations** across BSW to increase retention
- Development and provisional approval of a bid to support the increase of placements for preregistration pipelines across BSW targets key supply shortage areas
- The System Leadership Development Programme was launched on Friday 20th August. Nominations are now open for the first cohort and a briefing has been shared with the BSW Partnership Chief Executive, Locality COOs and Locality Chairs. Further cohorts are planned for early 2022.
- Structural Dynamics Cohort groups have met in advance of the second sessions in September/October.
- OD facilitator support to BSW Ophthalmology team strategy development (July – October).

Plans in the coming Month

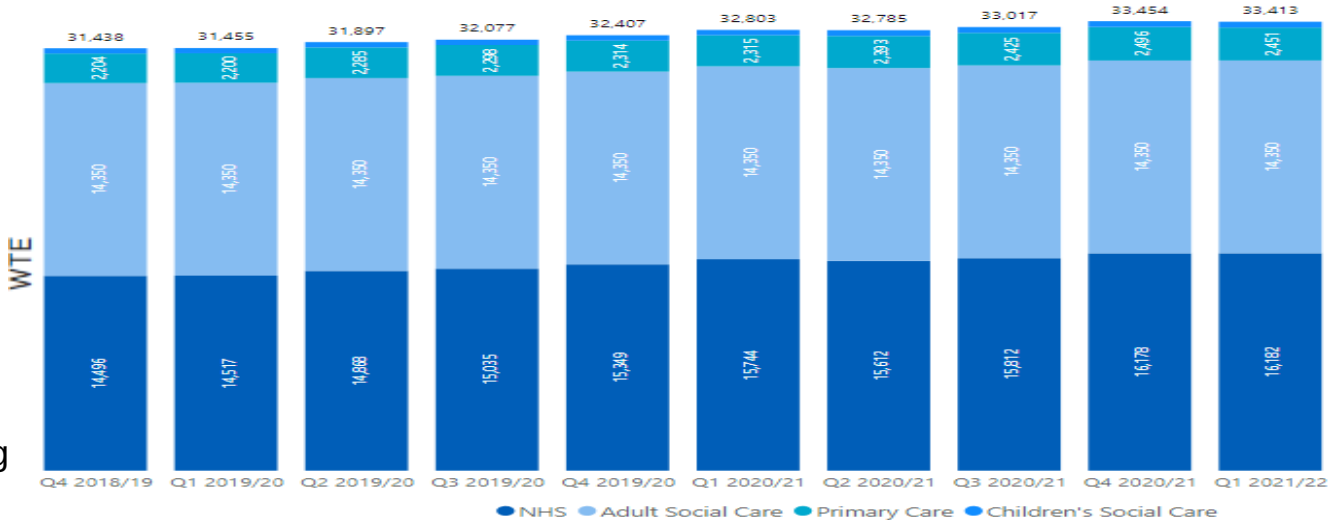
- Development and agreement of a process , portal and key resources for a BSW collaborative international recruitment to reduce costs and improve pipeline and support for IR for smaller partners.
- Devise and agree a plan for the roll of out of the NHS cadets scheme across BSW supporting disadvantaged young people into NHS and HSC careers
- Development and agreement of the concept of a talent pool for older staff, in response to the feedback from staff 55yrs + stating they would work longer if they could move to a less physically demanding role.
- Compilation and consideration of comments from BSW partners on the draft flexibility principles for finalisation and presentation at OPDG mid October
- First Community of Practice across BSW to support better work experience and support to promote healthcare careers using virtual methods
- Agreement of placement expansion bid and commencement of recruitment to key posts to support this
- Continued planning of first cohort for the System Leadership Development Programme.
- Structural Dynamics second sessions to take place in late September/early October. Shadowing opportunities to be identified.
- Planning for further Structural Dynamics workshops with key groups.

How will you address any quality and inequalities?

- Dates advertised and booking commenced for unconscious bias/ recruitment without bias/ awareness of bias in disciplinary cases training to be delivered in the autumn
- DPS framework for procured CPD completed to increase choices and range of CPD and reduce costs

		3 August 2021				10 August 2021				17 August 2021				24 August 2021			
QGroup_1	System_Name	Absences	% Absence	% Differe...	Net Dif	Absences	% Absence	% Differe...	Net Dif	Absences	% Absence	% Differe...	Net Dif	Absences	% Absence	% Differe...	Net Dif
All staff absences (sickness or self-isolation)	Bath And North East Somerset, Swindon And Wiltshire STP	801	4.8%			799	4.8%	0%	-2	804	4.8%	1%	5	768	4.6%	-4%	-36

The chart represents the first BSW view of a unified workforce position for BSW, inclusive of all of the NHS Providers, Primary Care, Local Authorities, Adult Social Care Providers and Children's Services. This is a complex set of data with a very high number of data sources from local providers and national sources and will take time to make consistent. In particular the mapping to staff groups is challenging.



The table below shows progress towards delivering the H1 plans for September 21 (phase 4) at the end of Q1.. Assumed vacancies, the difference between staff in post and phase 4 workforce plans , show a low overall rate of 3.1% (1,048 wte). Vacancies remain highest across Adult Social Care Providers, particularly within additional clinical services (a time series of this intelligence is under development). Quarter 1 workforce growth has been neutral, with a minor retraction in the primary care workforce balanced with minor growth in NHS Trusts.

Staff Group	Supply (June 2021)	Demand (June 2021)		Assumed Vacancies	
	Staff In Post (WTE)	Long Term Plan Workforce Plan (2019 to 2024)	Phase 4 Workforce Plans	WTE	Rate (%)
Add Prof Scientific and Technic	1,275	1,210	1,335	60	4.7%
Additional Clinical Services	13,282	13,714	14,335	1,052	7.9%
Administrative and Clerical	6,099	5,939	5,856	-243	-4.0%
Allied Health Professionals	1,238	1,344	1,283	45	3.6%
Estates and Ancillary	800	755	679	-120	-15.0%
Healthcare Scientists	411	418	405	-6	-1.3%
Medical and Dental	2,280	2,306	2,232	-48	-2.1%
Registered Nursing and Midwifery	5,522	5,891	5,709	187	3.4%
Balancing Value	*2,508*	*2,637*	*2,628*	120	4.8%
BSW	*33,413*	*34,214*	*34,462*	*1,048*	*3.14%*

Please note: this is a new data collation and still in development. As it is better understood the mapping may change.
Some roles, particularly, non-health are not yet mapped to the staff groups. These are currently showing in the balancing value.

The BSW NHS people plan metrics are from the NHS system oversight framework . These metrics are currently defined based on NHS sources and will need to be developed further to cover all BSW system partners. The grey tiles represent the metrics that are still under development nationally. E.g. “People Promise Index” is yet to be defined by NHS England.

Quality

Patient Experience

Current Performance:

SWAST are seeing an increase in complaints. Resource delays remain prevalent for complaints particularly with the ambulance service and long waits for elderly patients who have fallen. Data lag due to quarterly board reports for SWAST however increasing complaints cited in Harm papers

Vaccinations continue to be a theme for contacts through BSW Patient Advice and complaints teams (PALS and PACT):

- patients asking if walk-ins mean they can be seen earlier than eight weeks for the second vaccination, outside clinical exemptions (e.g. for travel).
- People who had the vaccine abroad, or in the UK outside of England, needing PACT and the CCG to arrange second jabs direct with the vaccine sites
- NHS APP, vaccine passport: errors, e.g. second jab not showing, wrong brands showing. Compounding issue: patients coming to PACT as other agencies, GP, NHS Digital, NHS England are unable to help

Commissioning complaints hotspot- out-patient waiting times

Actions and Recovery:

Urgent care risk summit planned for w/c 13/9 or 20/9

Patients advised that this is strict national protocol; walk-in centres monitored by the CCG to ensure only those at 8+ weeks are seen; PACT/vaccines team wrote an FAQ to this effect

Scotland and Wales data became available on English systems in June 2021– issue resolved. Vaccines abroad – national issue with NHS Digital; ongoing resolution sought. PACT/vaccines team wrote an FAQ to this effect

Plans for a national NHS England resolution centre

Monitoring of Healthcare Associated Infections - impact on urgent and primary care:

Zero incidence of MRSA during July.

We continue to see a slight rise in the number of cases of Clostridium difficile infection (CDI) . Most cases of CDI are within the community setting, work is underway to understand the learning, themes and trends from these cases in collaboration with the medicine's optimisation team. BSW CDI collaborative met in mid August and had identified 4 key actions to drive forward to support reduction in these cases.

- Reduce inappropriate antibiotic prescribing
- Correct and timely diagnosis
- Patient record coded and flagged at time of diagnosis
- Appropriate antibiotic for treatment of CDI. Getting It Right First Time.

Work progresses towards Flu season inline with the BSW system action plan, focusing on reducing inequalities and increasing uptake within the at- risk populations.

Small pilot project around the reduction of E-coli and gram-negative blood stream infections is currently being worked up in the Swindon area to look at how we can reduce the community onset cases.

Patient Safety

Current Performance:

- Increasing demand in the system has impacted on patient flow and the need to open additional beds in the system
- No serious incidents relating to urgent and emergency care reported in July. Second consecutive month and is reflected Trust-wide.
- SWAST undertaking 2 further potential harm audits in July and August. BSW granular detail due imminently.
- Medvivo have seen an increase in safeguarding referrals for child mental health from 26 in Q4 to 39 in Q1 (50% increase). This is for self harm and overdoses and OOH contacts for immediate advice regarding mental health concerns in children and young people.
- Learning From Patient Safety Events (LFPSE) is a new system rolled out from July 2021 (primary care), as the successor to the previous National Reporting and Learning System (NRLS). Currently BSW CCG does not have access to patient safety events occurring within BSW via LFPSE; NHSEI are currently implementing an enhancement to give this access automatically (expected September)
- MH pressures continue in Adult Psychiatric Intensive Care Unit (Wiltshire). PCLS pressures identified (Wiltshire).
- AWP Serious Incident backlog position improving.
- LeDeR - Learning Disability mortality reviews - on track for completion within expected timeframe
- Measuring level of harm whilst waiting for elective care
- SWASFT have demand related serious incidents with no identifying failures or concerns within SWASFT

Actions and Recovery:

- EQIAs completed to support beds to open in Care Homes
- System agreed SOP and risk assessment to support returning of staff who have had contact with a Covid +ve case, and to open beds with less social distancing
- SWAST have implemented a telephone line to encourage incident reporting
- Medvivo are in contact with OH CAMHS around staff education and support
- AWP have Increased quality monitoring in place, assurance provided on internal senior oversight and mitigating actions. Encouraging AWP to seek external support to implement and maintain cultural change.
- Trust-wide review of PCLS services underway. Seeking additional assurance via action plan and quality visit.
- AWP now have regular meetings in place to review trajectory and collaboratively support improvement.
- BSW LeDeR 3-year strategy in development in line with NHSE requirement. To be presented to QPAC Oct 2021
- Plan with RUH to undertake an audit to gain assurance of processes in managing waiting lists. This will be further rolled out in SFT and GWH. This will be monitored at the Elective Care Board sub-meeting (Performance).
- System serious Incidents will be passed to local systems for investigation and reporting onto STEIS with participation from SWASFT

Urgent Care and System Flow

Urgent Care – July and most of August have continued to see significant Urgent and Emergency care demand pressures, in all partners (111, 999, Emergency departments). SWAST remain in critical incident level at REAP (Resource Escalation Action Plan) level 4 - Surge Black and challenges in flow across system within acute, community and social care. Workforce continues to be significantly impacted as a result of absences; test and trace, holidays, and vacancies, resulting in red flags in a number of providers for staffing levels and rota fill which has lead to reduced opening hours of Urgent Treatment Centres and MIUs in particular.

Minors update: . Task and finish group established. Agreed what's in and out of scope for the workstream. Mapping has been done, which has created a list of symptoms/ conditions that are likely to be redirected at 111 - this is proving difficult to implement with the incumbent 111 provider. Work is underway to give minor injury units the ability to request x-rays into the main acute trusts. Discussion around setting up rotational posts for nurses between UTCs, MIUs and EDs to support workforce development. Wound care provision is an area that need to be addressed at PCN level. Comms around self care is being developed further with involvement from clinicians. Detailed scoping work around providing a prescribing pharmacist rota is well under way-the costed plan will be available within weeks

Updates against 6 priority workstreams (H1 21/22 priorities) – Metrics for each work stream to monitor and track progress to be agreed with SROs and BI leads still to be finalised.

1. **111 – (AMBER / GREEN) –** *SRO Michelle Reader* **-** impact of demobilisation of existing 111 provider causing concern and preventing quicker development opportunities. System buy-in to a local Category 2 validation pilot on 2 dates in September with dedicated senior clinicians and SWAST to oversee pilot. Impact to be shared across South West region. Pathway Clinical Consultation Support (PaCCS) roll out in September and will increase direct booking into ED from Medvivo MCAS.
2. **999 – (RED) -** *SRO tbc* **-** No further updates on workstream. SRO planning event in September due to lack of availability in August. However, Mental Health Programme board have approved Mental Health clinicians within ambulance hub pilot based on successful impacts in BNSSG and Somerset on non-conveyance of mental health patients.
3. **Hospital Handovers - (AMBER)** – *SRO Simon Sethi* - Co-horting areas and processes established in each trust following July South West GOLD call. No updates on alternative transport provider for low acuity Health Care Professional requests. However, Urgent Care and Flow Board recommendation for recurrent funding for Hospital Ambulance Liaison Officers at GWH and RUH has been approved internally by At Scale Commissioning Committee and Director's of Finance during August. Next Ambulance workshop being planned for mid September.
4. **Same Day Emergency Care (SDEC) – (AMBER**) – *SRO Andy Hyett* - Second workstream meeting held in August. Each of the acute trusts are progressing internal conversations and plans to increase SDEC capacity. Still need to complete the SDEC opportunities tool at acute trust. SRO to discuss with other community partners around SDEC opportunity outside of Acute footprints.
5. **Emergency Care Data Set (ECDS) – (AMBER) -** *SRO Al Sheward* **-** further clarity provided nationally on quantifying clinically ready to proceed and specialty pathways. Support required for SDEC coding and counting. IT upgrade planned for September at GWH to improve data collection; further work to be done around Minor Injury Unit activity and next month, building narrative against metrics to demonstrate impacts
6. **Discharge to assess (D2A) – (AMBER) –** *SRO Lisa Hodgson* – Report shared at UCFB. Focus of July has been carrying out data gathering and self assessment exercise against the Discharge policy. SRO has met with each ICA to identify what we are currently doing, what are the quick wins and starting to enact these. Highlighted potential financial implications of a complete 7 day service. Expecting detailed project plan with timeframes of actions to be reported back next month.

Urgent Care Exception reporting (Aug 21)

Exceptions Analysis

Percentage of 111 patients booked into an arrival timed ED Slot:

Data only includes percentage of patients that called 111, and not direct bookings from 111 online.
Reasons why the current percentage is around 30.7%;

1. Clinicians validating ED dispositions off of NHS pathways do not currently have the right software to enable direct booking in the CAS. Medvivo are currently implementing new software (PACCs) to enable staff to book directly. Clinicians are currently being trained
2. a mis-alignment of the time dispositions from pathways against the slots available, if there is no slot available patients will be advised to attend and information sent over – so they will still be heralded.
3. GWH Paediatric ED is not taking direct referrals
4. MIU – no updates on any planned IT solution for MIUs. However Medvivo noted that incumbent 111 provider has some experience in their normal area which we may be able to adopt. Current workaround process to enable referrals to be sent over still in place.

In July 87% ED dispositions were validated of which 33% downgraded, 63% remained same and 3.7% upgraded .

Handover delays over 30 mins:

- Hours lost to Handover delays in July have deteriorated in each of the 3 acute trusts however actual numbers slightly less compared to June as a result of lower conveyance rates – 42% in July versus 48% August. Noticeable increase in Hear and Treat – cause likely due to implementation of the standard operating procedure.
- No clear change on the identified themes for the reasons for handover delays from the BSW Hospital Handover delays July workshop (which were : Increasing demand in ED with less space, Non Criteria to reside bed occupancy, workforce constraints.)
- Aware not all delays at ED, delays happening in other front door areas – e.g. GWH's Covid Assessment Unit. Ongoing work to train and educate staff to ensure timely handover completion on CAD.(computer aided dispatch)
- SFT have updated their internal escalation SOP for Handover delays; RUH working on handover process for direct to CT scanning.
- Workforce challenges within ED departments, and less experienced staff confident in decision making process.
- Departments also struggling to meet with peak arrivals in short time periods e.g. insufficient cubical space to meet all ambulance conveyance.

How will you address any quality and inequalities?

- No serious incidents relating to urgent and emergency care reported in July. Second consecutive month and is reflected Trustwide. SWAST have implemented a telephone line to encourage incident reporting
- Two further potential harm audits being undertaken in July and August. BSW granular detail due imminently.
- Patient experience feedback and complaints remains a deteriorating picture
- Increasing children's mental health safeguarding referrals relating to self harm and overdose reported by Medvivo. Medvivo linking in with Oxford Health for staff training for clinician support for these cases

Plans in the coming Month

Percentage of 111 patients booked into an ED Slot:

- Rollout of PACCs in IUC service – Confirmed early September
- Implementation of Barn door profiles – subject to technological changes
- Review of 111 online ED activity with plans to consider capacity required to validate journeys
- Review of EDDI slot availability to understand if insufficient demand for booking

Ambulance handover delays / demand reduction:

- BSW pilot to validated NHS 111 Cat 2 dispositions by senior clinicians in the Medvivo CAS. Working with NHSEI leads and SWAST to ensure strict governance and oversight of an initial pilot.
- SWAST increasing Clinical Hub resource with additional NHSE investment for remainder of 21/22
- Dorset CCG working with SWAST to identify reporting and quality review process for patients with long waits
- Other actions:
- Co-location of AWP mental health clinicians in Bristol ambulance hub
- Create capacity in IUC CAS to support with 999 cat 3 /4 validation
- HALO posts to be built into SWAST rota for RUH and GWH

Other

- Outcome of BSW Citizen panel feedback for UEC strategy
- Further patient engagement exercise for UEC strategy

What did we achieve in the past month?

IUC

- PACCs training within Medvivo planned and being completed during August
- Further planning around Cat 2 pilots

Ambulance

- All 3 acutes have completed Co-horting risk assessments and areas utilised as required.
- BSW Hospital Handover July workshop chaired by Simon Sethi

B&NES

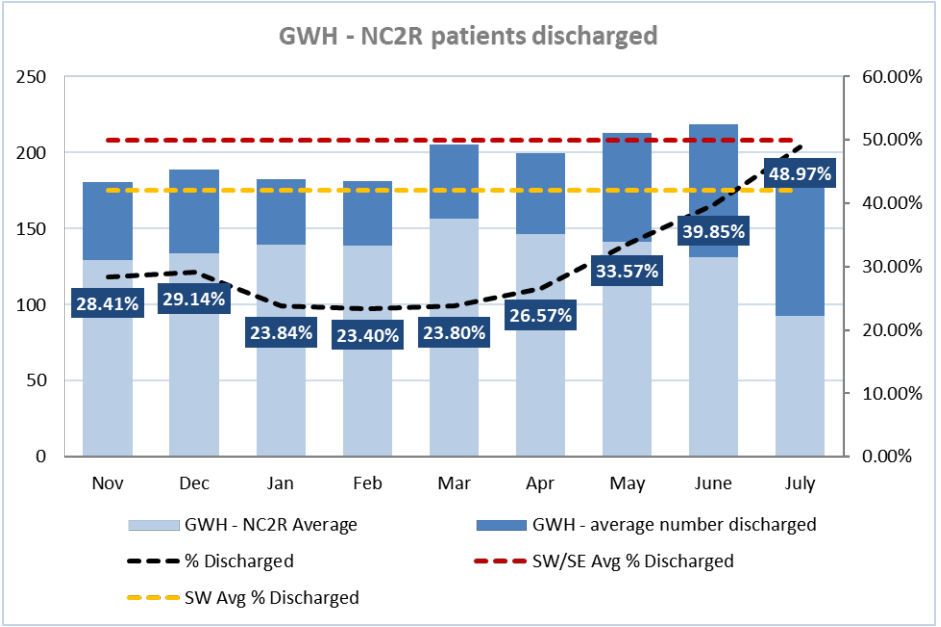
- Increased demand at RUH front door and Covid cases. Reablement service remains challenged with more high acuity patients. Care home closures remain due to Covid.
- Front door rapid improvement event at the RUH planned for 1 September.
- Significant delays in sourcing home care due to lack of availability impacting reablement service and patient flow.
- Transformation plan, demand and capacity analysis being finalised via Reablement Steering Group with QIAs.
- Process mapping session completed with partners continuing to work through issues highlighted
- System support for live-in care project, ART+, hospital@home pilot, and provision of intermediate care beds to compensate for P1 challenges
- Local Authority and CCG finalising options for in-housing home care provision
- Local Authority / Virgin Care developing plans for care team to support P1 position.
- Plans to recruit Wellbeing Advisers to support P1 discharges / Age UK calling P0 discharges to ensure community support / potential pilot of Third Sector navigator in A&E
- 29 beds are open at Sulis and Paulton has re-opened 18 beds as from 24/5/2021.
-

Swindon

- Capacity an issue at the beginning of the month for discharge into Wiltshire, however now improved. Seeing an increase in pathway 1 patients requesting 4 visits a day of double handed care which has a significant impact on capacity in all areas.
- We are continuing to see a peak in referrals mid-week and towards the end of the week which has an impact on the community capacity, this is due to limited or lack of senior review in the hospital over the weekend, or not using criteria led discharge. Deputy Chief Operating Officer has acknowledged this and is working on a plan.
- GWH UTC remains closed overnight due to staffing issues, with no significant impact seen in A&E, the Urgent Care Centre or partners.
- Trusted Assessor start to be confirmed this week.
- Task and Finish group to review all wound care services across Swindon to look at opportunities of integrated working.
- Swindon locality check in call arranged for weekly, to enable all partners to come together to look at the areas where there are challenges and working through alternative options of reviewing and reducing care where appropriate to do so.
- Estates work to be carried out in Swindon Intermediate Care Centre (SwICC) from October. Updates to follow nearer the time.

Wiltshire

- Flow challenges - Demand in pathway 1 with increased complexity for large packages of care averaging 50% requesting 3 + daily visits
- Continuing to see Care sector staffing pressures, as seen across NHS services
- Plan agreed and pending final approval to expand Wilts Council in-house domiciliary care capacity
- Trialling a new triage process for large packages to consider best pathway for the patient and reducing delays waiting for care
- In-reach staffing to acutes challenged, looking at future options to improve
- Spot purchased beds at 30 in August, IR & D2A beds
- Introduced 3 x weekly MADE events for RUH flow into Wiltshire, aiming to expand to GWH in September
- Rapid Response service continues to increase coverage across Wiltshire
- Wiltshire Bed Review – action plan has been finalised and being implemented
- ICA Demand and capacity modelling is nearing completion, working across all partners.
- Pathway 1 efficiency opportunities rapid improvement project scope agreed via ICA, which aims to reduce length of stay through improving discharge process efficiency. To be delivered in September.


GWH - NC2R patients discharged
250
200
150
100
50
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60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
28.41%
29.14%
23.84%
23.40%
23.80%
26.57%
33.57%
39.85%
48.97%
Nov
Dec
Jan
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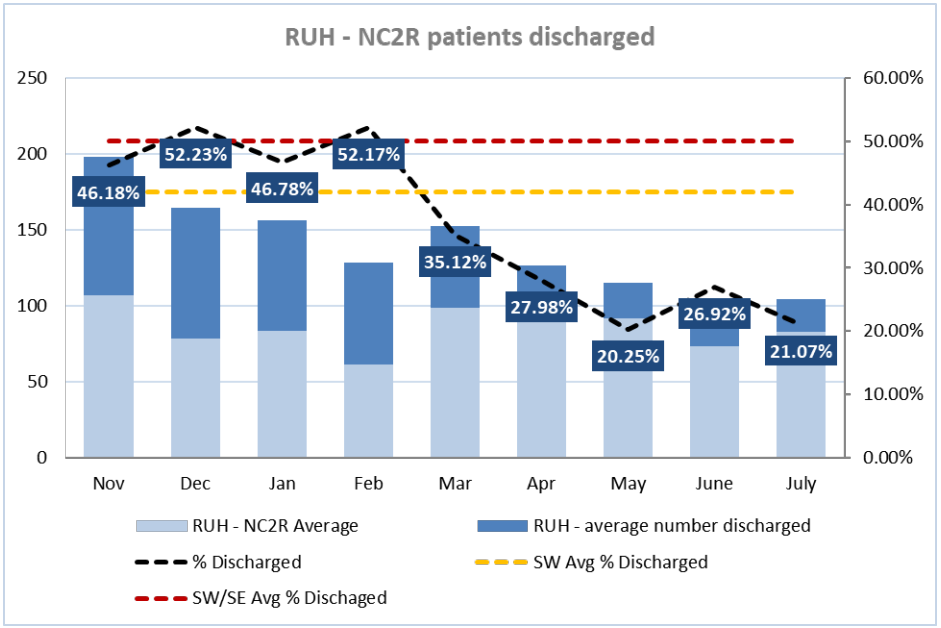
June
July
GWH - NC2R Average
GWH - average number discharged
% Discharged
SW/SE Avg % Discharged
SW Avg % Discharged


RUH - NC2R patients discharged
250
200
150
100
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60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
46.18%
52.23%
46.78%
52.17%
35.12%
27.98%
20.25%
26.92%
21.07%
Nov
Dec
Jan
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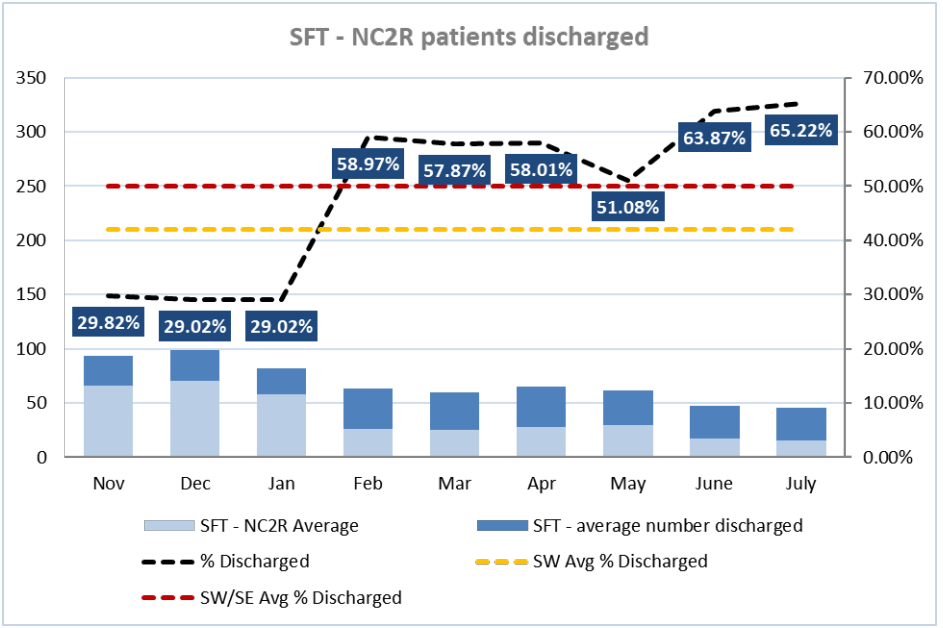
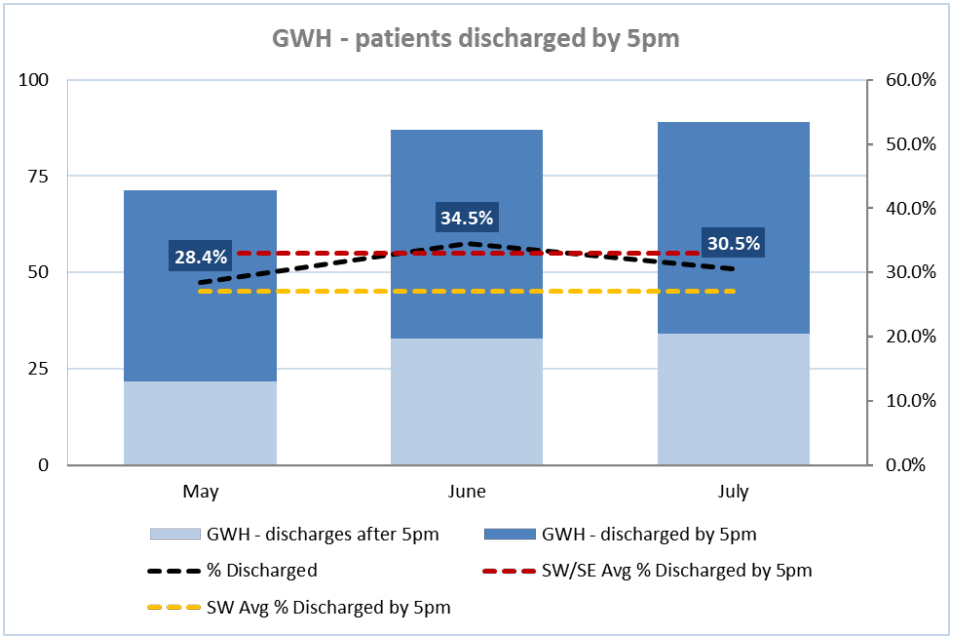
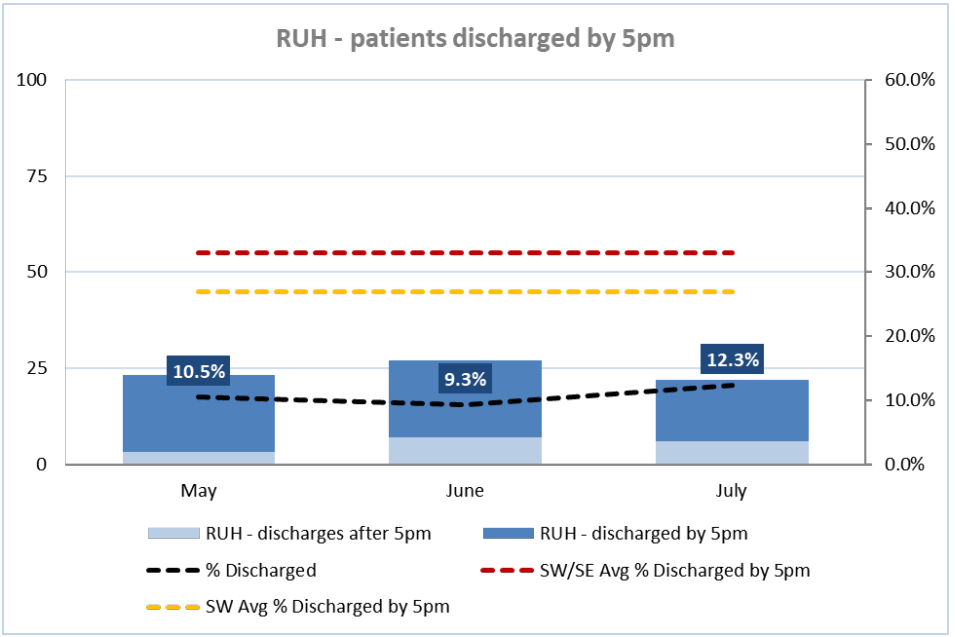
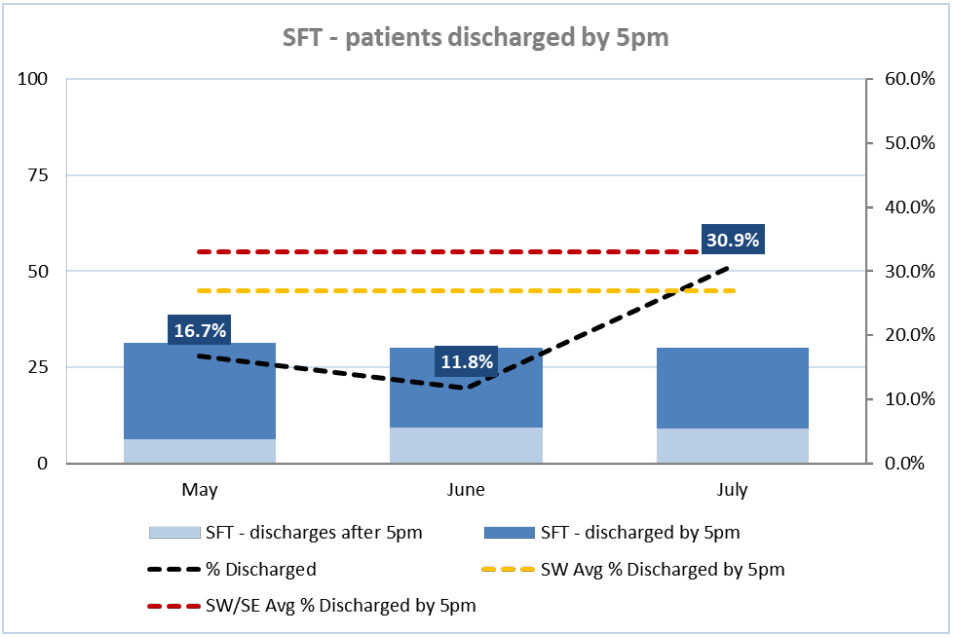
July
RUH - NC2R Average
RUH - average number discharged
% Discharged
SW Avg % Discharged
SW/SE Avg % Dischaged


SFT - NC2R patients discharged
350
300
250
200
150
100
50
0
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
29.82%
29.02%
29.02%
58.97%
57.87%
58.01%
51.08%
63.87%
65.22%
Nov
Dec
Jan
Feb
Mar
Apr
May
June
July
SFT - NC2R Average
SFT - average number discharged
% Discharged
SW Avg % Discharged
SW/SE Avg % Discharged


GWH - patients discharged by 5pm
100
75
50
25
0
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
28.4%
34.5%
30.5%
May
June
July
GWH - discharges after 5pm
GWH - discharged by 5pm
% Discharged
SW/SE Avg % Discharged by 5pm
SW Avg % Discharged by 5pm


RUH - patients discharged by 5pm
100
75
50
25
0
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
10.5%
9.3%
12.3%
May
June
July
RUH - discharges after 5pm
RUH - discharged by 5pm
% Discharged
SW/SE Avg % Discharged by 5pm
SW Avg % Discharged by 5pm


SFT - patients discharged by 5pm
100
75
50
25
0
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
16.7%
11.8%
30.9%
May
June
July
SFT - discharges after 5pm
SFT - discharged by 5pm
% Discharged
SW Avg % Discharged by 5pm
SW/SE Avg % Discharged by 5pm

Planned Care

Planned Care – There has been continued reduction in over 52 week waits, however people waiting over 78 weeks remains higher than planned requiring further focus on booking patients based on both clinical priority and length of time waiting.

Elective Care Recovery remains above the national expectations of delivery overall, compared to 19/20, but below 100% in some areas including ordinary electives (inpatients) and there has been a significant drop in outpatient follow ups. Changes to the payment of the elective recovery fund (ERF) have reduced the forecast income planned for use on additional activity. However additional contracts targeting long waiters remain in place. Plans to further increase the use of capacity in independent sector hospitals are being developed in preparation for the expected changes to the elective recovery fund for the second half of the year

Cancer waiting times performance compares well nationally but in some cases remains below the constitutional standards. BSW continues to deliver more activity versus pre-Covid baseline than most other systems in SW and nationally, this is partly at the expense of achieving required timeliness of service delivery per the national performance standards. The CCG is working with regional colleagues to refine the monitoring to focus on key tumour types where there is higher risk of harm from timeliness of treatment (within the overall ambition of improving the faster treatment times standard).

Work continues analysing the waiting list to identify health inequalities and to inform recommendations and actions. Additionally we are investigating whether there is any correlation between long waiters and urgent care demand and emergency department presentations by mapping the datasets.

Planned Care Exception reporting (Aug 21)

Exceptions Analysis

Cancer – people waiting over 62 days for treatment:

- The national target is to be at or below Feb 2020 number of people waiting over 62 days by 31/3/22. BSW CCG target was set as 180; this includes erroneous under-reporting for SFT. True BSW target is 217.
- The Oversight framework above shows the number of people waiting over 62 days at the 3 local Acute trusts as 328 versus target of 256.
- Latest weekly update (15 Aug 21) shows people waiting at the Trusts has reduced to 297, meaning 6.6% of the WL has waited 62d or more – this is within best quartile nationally (GWH 3.4%, RUH 7.3%, SFT 9.2%, England average 8.7%).

Elective activity levels have dropped compared to 19/20 with impact from urgent care pressures and a continued use of an elective green ward at RUH for urgent care impacting orthopaedics volumes.

How will you address any quality and inequalities?

- Working with Quality Leads in the acute hospitals to ensure that processes are in place to monitor people on waiting lists and identify any harm
- The CCG Quality Team are identifying is any concerns or issues are raised through serious incidents or complaints
- Due to current system pressures, some elective surgery is being postponed and the impact of this will need to be monitored

Plans in the coming Month

- Review report by Community First into rural isolation and digital exclusion for Wilts and B&NES cancer patients to confirm recommendations and next steps
- Continue to deliver education in key cancer screening and signs/symptoms to non-clinical NHS staff and Local Authority and community influencer leaders
- Share PCN DES (cancer) reporting framework with PCNs to allow early consideration ahead of year-end reporting requirement showing impact of efforts to improve screening uptake on under-represented groups
- Monitor recovery of breast and prostate new cancer treatment activity volumes/identify any additional actions required
- By end Sept - continued development of NSS RDS plans for SFT; go-live of NSS RDS for Minerva/Keynsham and expansion of Devizes to cover Melksham

What did we achieve in the past month?

- Number of new cancer treatments initiated in June 21 exceeded pre-Covid benchmark by over 10% - best in SW.
- Volume of urgent cancer referrals seen in June 21 exceeded pre-Covid benchmark by over 10% (+363 vs June 19, when working-day adjusted)
- 6.6% fewer urgent cancer referrals seen, Mar 20-Jun 21 cumulative versus benchmark – smallest shortfall across the SW (England overall average shortfall 10.4%).
- Volume of GP 2ww referrals in June 21 exceeded pre-baseline volume.

Mental Health / Learning Disabilities / Autism Spectrum Disorder

BSW H1 System Status – Mental Health

Mental Health

- Out of area placement numbers remains at the exceptional level of 27 (highest number for two years)
- Pattern of female PICU continues. Eating Disorder rates for both children and young people (CYP)
- and adults continue to increase, with a small cohort requiring treatment within Acute hospitals. We are working through alternative system solutions as part of transformation work and a single point of access escalation hub is being scoped to start by Oct 21.
- Mental Health surge planning has commenced, system co-production meetings commence late Aug. Through this system level service continuity plans will develop.
- Waiting times for adult ADHD diagnostic services remain a significant concern, with approx. 1270 individuals waiting for an average of 756 days.

LD/ASD

- LD inpatients adults - BSW LD/ASD remains on track; stabilised at 19.
- LD Annual Health Checks – improving uptake rate, exceeding Q1 20/21 position 1.7%; Q1 21/22 7.6% (This is a cumulative measure across the 4 quarters and previously has been heavily skewed towards Q4.)

Mental Health Exception reporting (Aug 21)

Exceptions Analysis

- CYP access rates remain challenged and below the long-term plan target, although access is starting to improve. This remains affected by reduced flow associated with covid, and workforce pressures. BSW CAMHs recovery actions plans are in place and being reviewed fortnightly. Risk stratification continues
- SMI annual health checks (AHCs); Our pilot to deliver an holistic model in partnership across nursing teams and the third sector has been extended into Q3. Uptake remains low, with many patients declining. Work in progress to mobilise Third Sector Outreach Practitioners focused on engagement with AHCs and after care, including positive health behaviour change interventions.
- Out of Area numbers remain at 27. This is following a national trend, current national MH bed shortage, planned work to local wards with temporary reconfiguration causing a small number of displacement. Supporting escalation for MH patients waiting in acutes with co-creation of single BSW escalation hub

Plans in the coming Month

- Mobilisation of 6m proof of concept pilot BSW Ambulance Control Room Mental Health Practitioner, to advise Paramedics responding to MH calls.
- Commencement of BSW data and outcomes group.
- Co-production of all age MH LDA system surge plans.
- Development of the operational model and mobilisation plan for AWP discharge and patient flow team.
- Mobilisation of the CYP Avoidant and Restrictive Food Intake Disorder Specialist Practitioners.
- Phased launch of BSW CCG Complex Case Escalation hub.
- BSW Mental health school support team evaluation – to be completed Oct.
- BSW CYP KHLOE self-assessment - informs H2 roadmap.
- SMI and LD AHC evaluation completion by University of Bristol to inform future pathway.
- BSW LeDeR 3 year strategy in development in line with NHSE requirement.

How will you address any quality and inequalities?

- Review of annual health check for rough sleepers with an SMI to be expanded.
- Staff wellbeing hub mobilisation – normalising support-seeking relating to mental wellbeing across key worker staff groups.
- Risk stratification of people to reduce preventable attendances and admissions.
- Pressures continue in Adult PICU (Wiltshire). Increased quality monitoring in place, assurance provided on internal senior oversight and mitigating actions. Encouraging AWP to seek external support to implement and maintain cultural change.
- Primary Care Liaison Services (PCLS) pressures identified (Wiltshire). Trust-wide review of PCLS services underway. Seeking additional assurance via action plan and quality visit.
- AWP Serious Incident backlog position improving, regular meetings in place to review trajectory and collaboratively support improvement.

What did we achieve in the past month?

- LDA Programme manager commenced in post.
- Initial BSW Adult Eating Disorder Multi-agency discharge event workshop held.

Primary Care –

- Continued demand and pressures across General Practices – all ages but specifically children and mental health issues and managing long term conditions
- 11 PCN sites continuing to deliver Covid Vaccinations C10-12, and now 16&17s and clinically extremely vulnerable 12-15s.
- Pandemic Standard Operating Procedures (SOP) for general practice removed but Infection prevention & control guidance remains.
- BSW reporting total appointments of 375,250 in July 2021 compared to 353,860 in July 2020, with 53.6% face to face appointments in July 2021 (as % of the total appointments) compared to 50.4% in July 2020.
- To enable nationally consistent GP appointment reporting all areas were requested to map appointment slots and by 01/08/21 overall BSW have 99% of slots mapped.
- Supporting the messaging and public communications - CCG meetings in public, MP briefings and social media.
- Preparation for RSV surge and Phase 3 – 24 of 25 PCNs have opted into Covid booster programme; and influenza from September.

Primary Care

Primary Care Exception reporting (Aug 21)

Exceptions Analysis

- Standard Operating Procedure for General Practice during the pandemic withdrawn from 19th July but Covid infection prevention & control guidance remains in place.
- Contractually all general practices should continue to offer a blended approach of face to face and remote appointments with digital triage where possible.
- The appointment data for July shows the number of appointments and the mode in which they were conducted, demonstrating that across BSW offering more face to face than telephone appointments. There is some variation across the three localities so working with all PCNs and Practices.
- BSW appointments:
  - July 2020 – 353,860
  - July 2021 – 375,250

How will you address any quality and inequalities?

- Continued close working with CQC regarding performance concerns and the Quality team has commenced engagement and scoping work to agree an appropriate quality oversight framework through discussions at PCCC and with CQC.
- Refresh of primary care quality metrics
- Ongoing inequalities work on Covid Vaccination Cohort penetration by outreach services (homeless, bus and boat)
- Incident reporting remains low. In July a PCCC patient safety workshop took place to gain understanding and awareness of the roll out of the patient safety strategy across Primary care.

Plans in the coming Month

- Managing continued demand across General Practices and across whole system. Ongoing work to pull meaningful data on reasons for attendance and by age cohorts and outcomes.
- Continuing to deliver Covid Vaccinations (11/25) PCNs continuing to deliver for people in the Cohorts 10-12; and now 16 &17 years old and 12 -1 5 clinically extremely vulnerable.
- 24 of 25 PCNs opted into Phase 3 Booster Programme (as signed off by JCVI) to start beg of September.
- Launched coding of children with respiratory illness in practices (as part of RSV planning) – 13 practices submitting in first week.

What did we achieve in the past month?

- Continue to deliver Covid Vaccination programme
- Plans for phase 3 vaccination programme and PCN opt in aligned to flu planning; plans for Covid vaccination for 12-16 clinically extremely vulnerable; and plans for RSV surge out of hospital.
- Address concerns re blood tube shortage and impact on primary care
- Ongoing support for additional roles reimbursement scheme (ARRS) recruitment and alignment to Integrated Care Alliance plans and priorities to neighbourhood level
- Focus on sign up to Primary Care OPEL score as a metric for measuring workload pressures – to ensure we have the same level of detail evidencing the pressures faced by primary care to share as we have for secondary care and other services, specifically workforce challenges.

Covid – 19

COVID19 Focus (21st Sept 2021) 1 of 3

COVID-19 Capacity Thresholds and Triggers - Acute Providers

System/Locality
BSW

OPEL Status

	11 Sep	12 Sep	13 Sep	14 Sep	15 Sep	16	17	18	19	20	21
GWH	4	4	3	4	4	3	4	3	2	3	4
RUH	4	4	3	4	4	4	4	4	4	4	4
SFT	3	4	3	3	3	3	3	3	3	3	3

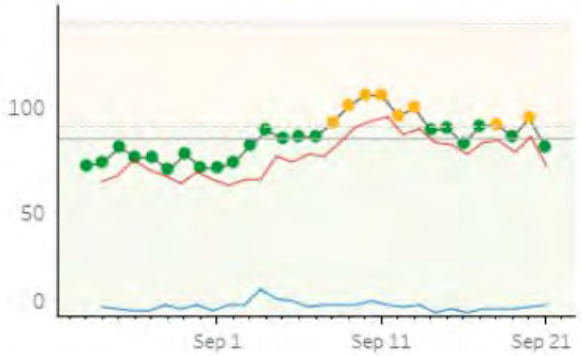
COVID-19 Capacity Thresholds and Triggers (Acute)

Confirmed & Suspected COVID Cases (Acute) 21 Sep: 81

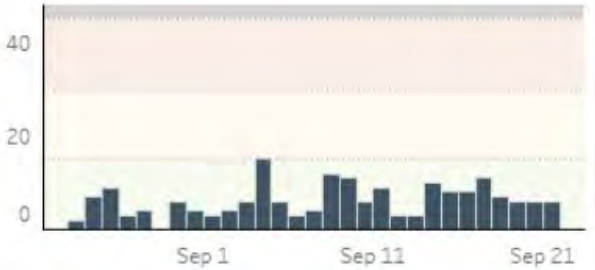
Total No of confirmed COVID cases (Acute): 76

Total No of suspected COVID cases (Acute): 5

% COVID Bed Base	5%	5-10%	10-15%	>15%
No of Beds	91	141	211	>211

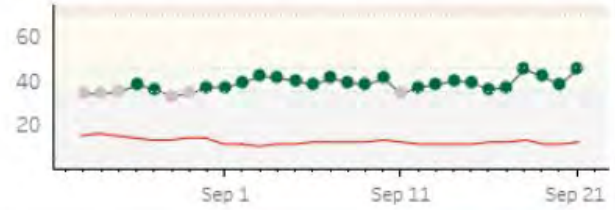


Inpatients diagnosed with COVID 21 Sep: 6

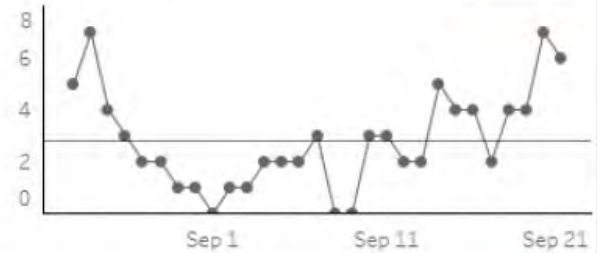


Total No of patients in ITU 21 Sep: 45

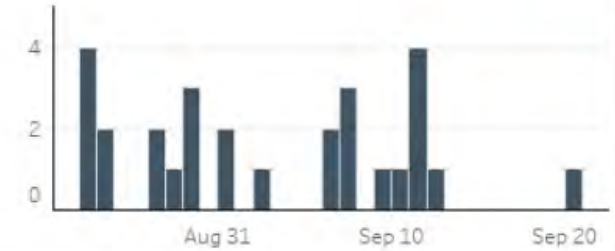
Total No of confirmed COVID patients in ITU: 12



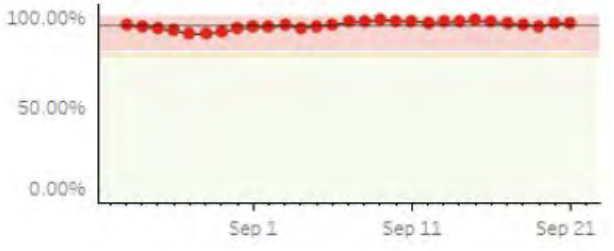
Number of COVID-19 patients on non-invasive ventilation 21 Sep: 6



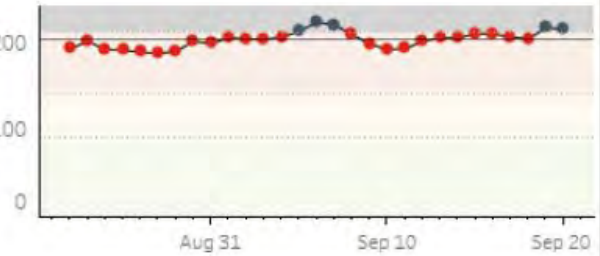
No of Deaths from COVID 20 Sep: 1



Acute Bed Occupancy 21 Sep: 95.23%



Super-Stranded (Acute) 20 Sep: 215



COVID19 Focus (21st Sept 2021) 2 of 3

COVID-19 Capacity Thresholds and Triggers - Community Providers

System/Locality
BSW

OPEL Status (Community)

Confirmed & Suspected COVID Cases (Community)

21 Sep **5**

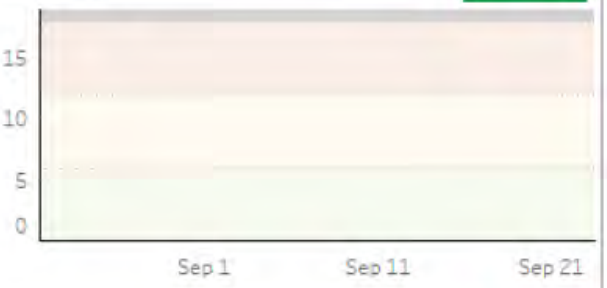
Total No of confirmed COVID cases (Community) **1**

Total No of suspected COVID cases (Community) **4**

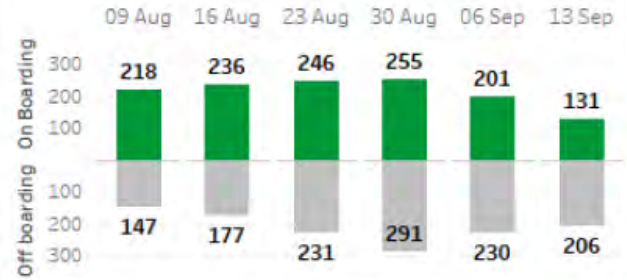
% COVID Bed Base	5%	5-10%	10-15%	>15%
No of Beds	11	22	33	>33

Community Inpatients diagnosed with COVID

21 Sep **0**

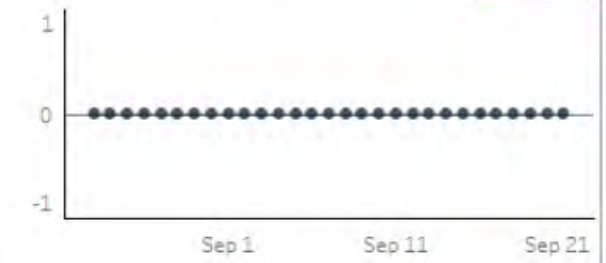


Oximetry (BSW)



Number of COVID-19 patients on non-invasive ventilation

21 Sep **0**

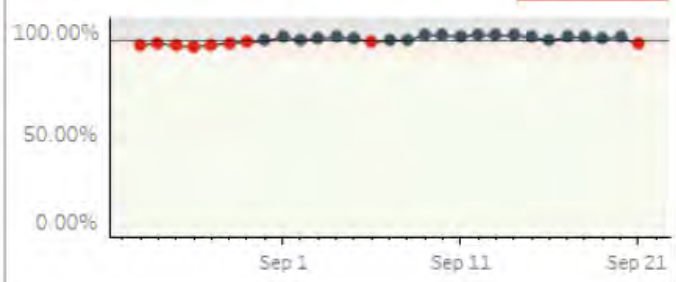


No of Deaths from COVID

20 Sep **0**

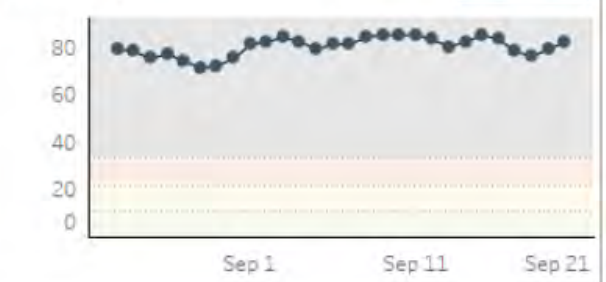
Bed Occupancy (Community)

21 Sep **93.72%**



Super Stranded (Community)

20 Sep **82**



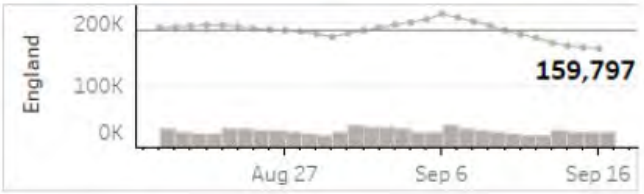
COVID19 Focus (21st Sept 2021) 3 of 3

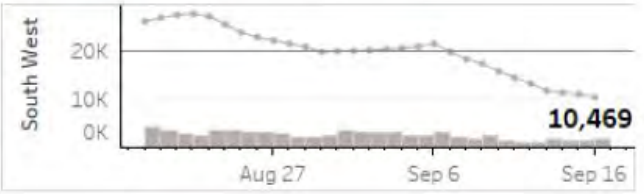
Cases and Prevalence

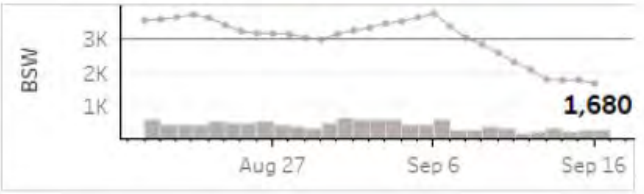
Data shown are cases by specimen date and because these are incomplete for the most recent dates, the period represented is the seven days ending 5 days before todays date. Inline with how its reported on the Gov.UK website.

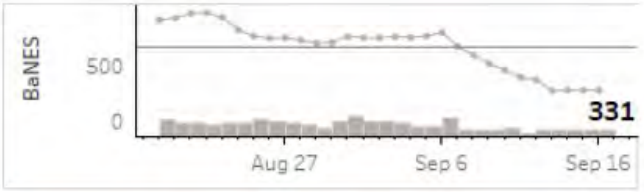
Number of cases in the last 7 days (Line Graph) & Daily cases (Bar Graph)

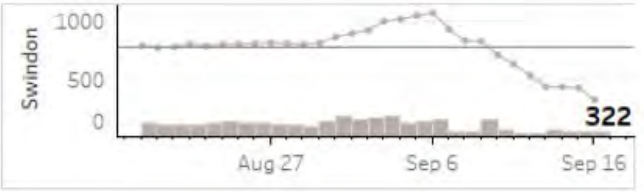
September 16, 2021

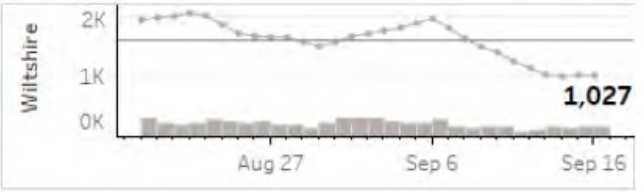












Rate of cases in the last 7 days per 100,000

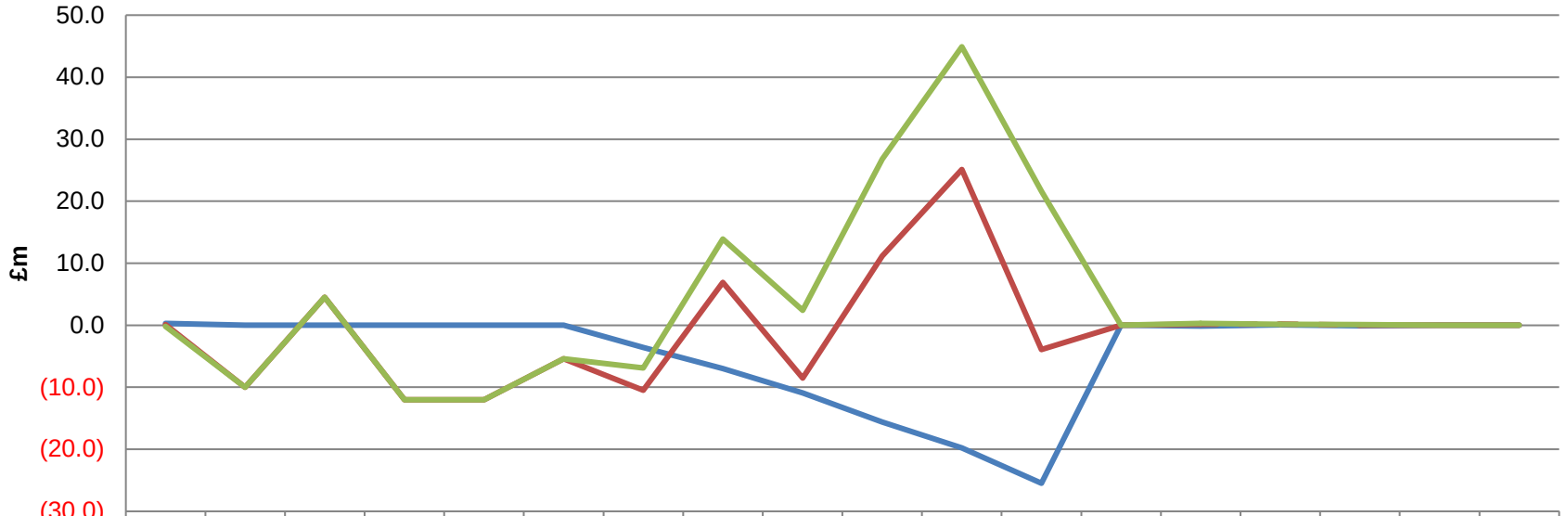
	02 Sep	03 Sep	04 Sep	05 Sep	06 Sep	07 Sep	08 Sep	09 Sep	10 Sep	11 Sep	12 Sep	13 Sep	14 Sep	15 Sep	16 Sep
England	372.84	376.93	376.07	382.59	407.77	413.58	399.42	386.75	369.82	349.90	340.28	344.30	326.69	318.08	312.62
South West	416.67	414.68	407.88	410.05	431.57	420.10	387.50	369.11	337.82	302.04	280.02	268.51	239.09	231.32	228.01
Bath and North East Somerset	365.79	369.41	366.82	372.00	384.93	333.71	301.63	270.59	246.27	220.40	211.09	170.22	172.29	172.29	171.25
Swindon	418.56	452.76	460.41	475.26	485.61	421.71	376.25	374.90	321.34	284.89	241.68	195.78	194.88	192.18	144.92
Wiltshire	343.78	354.58	363.78	378.98	393.98	363.38	326.58	300.79	281.99	251.59	229.99	207.19	201.59	205.99	205.39
Bournemouth, Christchurch and Poole	291.40	295.20	301.01	303.04	313.16	300.76	292.92	282.80	262.82	248.65	239.04	219.56	213.24	213.24	217.29
Bristol, City of	395.57	398.60	398.60	405.93	413.49	373.35	332.13	302.78	263.93	239.33	207.17	168.55	153.01	142.22	116.97
Cornwall and Isles of Scilly	396.78	393.62	388.18	386.43	391.17	369.40	354.47	334.81	311.99	294.43	283.37	263.88	254.05	244.22	250.54
Dorset	311.75	316.77	322.58	327.60	331.83	319.94	303.03	285.86	268.42	256.01	244.91	240.15	227.74	227.74	236.72
Devon	354.95	354.20	349.09	349.71	353.95	337.00	320.17	305.97	284.41	268.83	258.23	243.40	234.06	221.72	217.11
Gloucestershire	323.51	345.96	353.49	356.95	367.31	324.30	289.14	273.44	235.14	200.92	169.68	139.55	137.03	133.27	109.56
North Somerset	350.61	358.05	375.26	397.11	430.59	384.09	351.08	341.31	302.72	269.24	219.95	154.85	151.13	136.25	99.51
Plymouth	440.29	436.09	440.67	450.97	462.42	437.62	424.27	401.37	367.04	340.33	314.77	293.02	286.15	270.89	264.78
Somerset	371.03	372.09	368.00	382.76	398.24	358.75	327.98	317.84	295.97	276.58	249.01	213.08	208.99	205.61	182.67
South Gloucestershire	356.73	355.32	348.31	356.37	363.39	321.65	278.51	270.09	236.41	215.02	179.24	154.34	143.81	137.85	103.12
Torbay	366.20	369.87	401.43	404.36	427.11	428.58	419.04	389.68	361.80	318.50	315.56	304.56	281.07	284.74	290.61

Finance

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

BSW System
2020/21 MONTH 4 Financial Overview

NHS System 18 Month Plan vs Actual/Forecast incl. Financial Support (PSF/FRF/Top-Up/etc.)



	20/21 M1	20/21 M2	20/21 M3	20/21 M4	20/21 M5	20/21 M6	20/21 M7	20/21 M8	20/21 M9	20/21 M10	20/21 M11	20/21 M12	21/22 M1	21/22 M2	21/22 M3	21/22 M4	21/22 M5	21/22 M6
NHS System YTD Plan	0.3	0.0	0.0	0.0	0.0	0.0	(3.6)	(7.0)	(10.9)	(15.6)	(19.8)	(25.5)	0.0	(0.1)	0.1	(0.1)	0.0	0.0
NHS System YTD Actual / Forecast	0.1	(10.0)	4.5	(12.0)	(12.0)	(5.4)	(10.5)	6.9	(8.5)	11.2	25.1	(3.9)	0.0	0.2	0.2	0.0	0.0	0.0
NHS System YTD Variance Against Plan	(0.2)	(10.0)	4.5	(12.0)	(12.0)	(5.4)	(6.9)	13.9	2.4	26.8	44.9	21.6	0.0	0.3	0.1	0.1	0.0	0.0

Financial Summary

At this stage in the financial year there are no financial performance issues to report, the NHS system is planning a breakeven position for H1 and is reporting delivery against this position with a small surplus YTD against a planned YTD deficit of £0.1m. We have now received national estimations of ERF income for Q1 along with changes to the thresholds for Q2. There is a risk that ERF costs could be greater than income potential as we may not achieve activity to generate income in Q2 creating a financial risk.

The Local Authorities have different methods for reporting their YTD positions therefore to ensure consistency we are no longer reporting their YTD positions. Swindon Adult Social Care is forecasting that is will overspend against its budget by £2.2m due to a significant increase in demand for home care and 1 to 1 support in care homes. B&NES is forecasting that they will meet their budgets and Wiltshire Adult Social Care is forecasting an underspend of £2.9m. Wiltshire's figures do not include the estimated cost of supporting the ongoing support needs of the Hospital Discharge cohort once the 4/6 week HDP funding finishes, as they are accounted for separately at present, and these are estimated to be at least £2m.

Risks and Mitigations

The key risks are:

- There are key operational risks being faced by the NHS Acute Providers around ED and Urgent care activity demands and ability to meet these due to staff vacancies and sickness
- Due to the change in the ERF thresholds, ERF costs could be greater than income potential as we may not achieve activity to generate income in Q2.
- BSW is expecting to overspend by £8.1m against notified capped funding for the Hospital Discharge Programme. CCG assumption is this will be funded.
- The financial regime for H2 is not currently known and it is anticipated that the income envelope for the system will be significantly reduced.

2021/22						
Organisation	**Planned YTD Outturn at Month 4**	**Actual YTD Outturn at Month 4**	**Variance from YTD Plan at Month 4**	**H1 Planned Outturn**	**H1 Forecast Outturn**	**Forecast Variance from Plan**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
BSW CCG	0	0	0	0	0	0
Total CCGs	**0**	**0**	**0**	**0**	**0**	**0**
Great Western Hospitals FT	0	4	4	0	0	0
Royal United Hospitals FT	(5)	0	5	0	0	0
Salisbury NHS FT	(76)	27	103	0	0	0
Total Acute Providers	**(81)**	**31**	**112**	**0**	**0**	**0**
Total BSW NHS Position	**(81)**	**31**	**112**	**0**	**0**	**0**
Avon and Wiltshire MH Partnership @ 45%	0	0	0	0	0	0
Total NHS	**(81)**	**31**	**112**	**0**	**0**	**0**
B&NES Adult Social Care			0	0	0	0
Swindon Adult Social Care			0	0	(2,157)	(2,157)
Wiltshire Adult Social Care			0	0	2,878	2,878
Total Adult Social Care	**0**	**0**	**0**	**0**	**721**	**721**
Total Health & Adult Social Care	**(81)**	**31**	**112**	**0**	**721**	**721**

AWP is being reported separately as they are aligned to BNSSG for Reporting

Due to differences in YTD reporting, Adult Social Care can only provide forecast figures

Wiltshire Adult Social Care figures are @ Month 3 due to reporting timescales

Oversight Framework

1C (1a) - Clients receiving self-directed support
2A(1) - Permanent admissions to residential care homes: people aged 18-64. Permanent admission to nursing care: people aged 18 - 64
2A(2) - Permanent admissions to residential care homes: people aged 65+., permanent admissions to nursing care people aged 65+
1F - Adults in contact with mental health services who are in paid employment.
Satisfaction of social care service users with services they receive - annual indicator based on survey
Number of people receiving reablement services each month
Number of hours of domiciliary care delievred per week per 100k population for all ages
Number of people in residential care 65+ per 100k population at the end of each month
Number of people in nursing care aged 65+ per100k population at the end of each month
NI 133 - Waiting time for care packages
NI 135 - Carers assessed / reviewed who receive servs or info & advice as a % of clients receiving comm servs
D40 - Clients who received a service who have received an annual review of need

Awaiting sign off from Wiltshire and Swindon Local Authority. BSW Performance Working Group reviewing for recommendations to BSW Partnership Board in Sept

BSW Oversight Framework

Phase 1- Initial 23 Indicators agreed for August 21 Report. Phase 2 – to start in October Report.

Oversight Framework

Deterioration
Improvement
No Change

Below Standard ✗
Meets Standard ✓

Acute emergency care and transfers of care

	Indicator	Organisation	Frequency / Latest Period	Previous value	Current value	Change from Previous	Target or Standard	Meets Target / Standard?
Implementation of Agreed Waiting Times	% of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend	BSW CCG	Monthly 2021 07	32.30%	30.70%	↓	75%	✗
	30-Minute Ambulance Handover Breaches	BSW CCG	Monthly 2021 07	982	1,382	↑	0	✗
Transforming Community Services and Improving Discharge	% of Discharges by 5pm	GWH	Monthly 2021 07	62.40%	63.50%	↑		N/A
		RUH	Monthly 2021 07	73.70%	74.30%	↑		N/A
		SFT	Monthly 2021 07	69.20%	78.20%	↑		N/A
	% of Patients Meeting the Criteria to be Discharged that are Discharged	GWH	Monthly 2021 07	39.90%	44.30%	↑		N/A
		RUH	Monthly 2021 07	26.90%	28.00%	↑		N/A
		SFT	Monthly 2021 07	63.90%	59.40%	↓		N/A

Delivering safe, high quality care overall

Patient experience of GP services	Percentage of people who report that their overall experience of GP services was 'very good' or 'fairly good' (Annual GP Survey)	BSW CCG	Annually 2021 03	84.70%	86.70%	↑	85%	✓
Quality	Clostridium difficile infection rate	BSW CCG	Monthly 2021 07	22	22	→		N/A
	E. coli bloodstream infections	BSW CCG	Monthly 2021 07	50	48	↓		N/A
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	BSW CCG	Monthly 2021 07	3	0	↓	0	✓
	Serious Incidents	BSW CCG	Monthly 2021 07	16	20	N/A		N/A

BSW Oversight Framework Scorecard 2 of 4

Oversight Framework

Deterioration
Improvement
No Change

Below Standard ✗
Meets Standard ✓

Finance

	Indicator	Organisation	Frequency / Latest Period	Previous value	Current value	Change from Previous	Target or Standard	Meets Target / Standard?
Performance Against Financial Plan	BSW System Variance Against Plan YtD	BSW CCG	Monthly 2021 07	(+)£134,000	(+)£112,000	↓	(-)£81,000	✓

Primary Care & Community Services

Improvements for people with conditions such as diabetes, CVD and obesity	Number of Referrals to the NHS Diabetes Prevention Programme	BSW CCG	Monthly 2021 07	338	563	↑	337	✓
Primary and community services including new community services response times	2-Hour Urgent Response Activity	Wiltshire Locality	Monthly 2021 04			→		N/A
	Access to general practice – number of available appointments	BSW CCG	Monthly 2021 06	429,859	464,310	↑	428,842	✓

Screening and vaccination programmes

Screening and vaccination programmes meet base levels in the public health agreement or national goals	COVID Vaccination: % of adults vaccinated	BSW CCG	Monthly 2021 07	81.70%	85.90%	↑	90%	✗

BSW Oversight Framework Scorecard 3 of 4

Oversight Framework

Deterioration
Improvement
No Change

Below Standard ✕
Meets Standard ✓

Mental Health

	Indicator	Organisation	Frequency / Latest Period	Previous value	Current value	Change from Previous	Target or Standard	Meets Target / Standard?
Deliver the mental health ambitions outlined in the NHS Long Term Plan, expanding and transforming core mental health services	CYPMH Access - Patients having at least 1 contact (Rolling 12 mths)	BSW CCG	Monthly 2021 06	6,910	6,900	↓	6,038	✓
	IAPT Access - Patients entering treatment	BSW CCG	Monthly 2021 05	3,035	3,200	↑	23,266	✓
	LD Inpatients Adults CCG Funded	BSW CCG	Quarterly 21-22 Q1	22	19	↓	21	✓
	LD Inpatients Adults NHSE Funded	BSW CCG	Quarterly 21-22 Q1	7	7	↑	5	✕
	LD Inpatients Children NHSE Funded	BSW CCG	Quarterly 21-22 Q1	4	5	↑	4	✕
	Out of Area Admissions (Count of OBDs)	BSW CCG	Monthly 2021 05	300	345	↓	0	✕
	The percentage of people with SMI on GP Registers to receive the complete list of physical health checks in the preceding 12 months.	BSW CCG	Quarterly 21-22 Q1	15.60%	21.20%	↑	60%	✕
Learning disability and autism: reducing inpatient rate and increasing learning disability physical health checks	The percentage of people with a learning disability on the GP register receiving an annual health check	BSW CCG	Quarterly 21-22 Q1	56.00%	7.60%	↓	12%	✕

BSW Oversight Framework Scorecard 4 of 4

Oversight Framework

Deterioration
Improvement
No Change

Below Standard ✗
Meets Standard ✓

Restoration of elective and cancer services*

	Indicator	Organisation	Frequency / Latest Period	Previous value	Current value	Change from Previous	Target or Standard	Meets Target / Standard?
	Cancer 31 day treatments. Number of patients receiving first definitive treatment following a diagnosis (decision to treat) within the period, for all cancers.	BSW CCG	Monthly 2021 06	395	490	↑	469	✓
	RTT Incomplete 52+ wks	BSW CCG	Monthly 2021 06	2,590	2,224	↓	0	✗
	Numbers of patients seen in a first outpatient appointment following urgent referrals	BSW CCG	Monthly 2021 06	3,350	3,730	↑	3,582	✓
	The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral.	GWH	Monthly 2021 08	67	63	↓	57	✗
		RUH	Monthly 2021 08	142	151	↑	114	✗
		SFT	Monthly 2021 08	119	114	↓	85	✗
Diagnostic Activity Levels	Diagnostic Activity Against Plan	BSW CCG	Monthly 2021 08	5,954	5,717	↓	5,525	✓
Elective Activity Levels	Daycase Activity Against Plan	BSW CCG	Monthly 2021 08	1666	1584	↓	1565	✓
	Elective Activity Against Plan	BSW CCG	Monthly 2021 08	245	269	↑	249	✓
	Outpatient Activity Against Plan	BSW CCG	Monthly 2021 08	17,182	16,377	↓	15,195	✓

Where the latest period is 2021 08.

Cancer 62 day pathways are a snapshot as at 9th August, the target is from the H1 plan for July 2021. Diagnostic and Elective Activity is the average weekly activity from the 4 weeks to 15th Aug. The target is from the H1 provider plans for Aug 2021.

Urgent Care
Urgent Care & Flow Board ..\..\..\..\Urgent Care\Routine reports\Urgent Care and Flow Board Report Monthly\Final Slides
SHREWD https://e-shrewd.com/resilience/

Planned Care
Elective Care Board ..\..\..\Routine Reports\Final Reports\Weekly Activity Report\Acute Reports
RTT K:\Analytics\Planned Care\Performance\RTT\2020-21
Diagnostics K:\Analytics\Planned Care\Performance\DM01\2020-21
Cancer K:\Analytics\Planned Care\Performance\Cancer Wait Times\2020-21

COVID
K:\Analytics\COVID-19\Slides - COVID SITREP
K:\Analytics\COVID-19\Triggers and Thresholds Report\Slides

Mental Health
Opel status dashboard K:\Analytics\Ad Hoc Requests\AH195 - MH OPEL Status Dashboard\MH OPEL Status Dashboard Draft v2.xlsx

Primary Care
Flu Vaccination K:\Analytics\Primary Care\Routine Reports\Flu Vaccinations\Published Reports
Primary Care Appointments K:\Analytics\Primary Care\Routine Reports\Weekly Summary Report\BSW PDF

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

Meeting of the BSW Partnership Board

Report Summary Sheet

Report Title	Deep dive: People and Workforce					**Agenda item**	**9**	
Date of meeting	1 October 2021							
Purpose	Note	x	Agree		Inform		Assure	
Author, contact for enquiries	Vanessa Ongley – v.ongley@nhs.net							
Appendices	BSW Recruitment/workforce data pack							
This report was reviewed by	Alison Kingscott and Sheridan Flavin - Interim BSW Executive Director for People and OD							
Executive summary	Recruitment, Retention and Supply (RRS) of the BSW workforce is recognised as a key priority in 2020-21 aimed at supporting the BSW system to improve the stability of the workforce available to provide health and care service to the BSW population. The RRS work stream aims to embed the principles of the BSW People Plan to deliver its actions resulting in positive recruitment and retention outcomes around vacancies and voluntary turnover, improved WRES/staff survey results, workforce recovery and support post-COVID, equality and diversity, local phases of People plan action plans and SW/national initiatives and priorities. The RRS network, directed by BSW partner organisation recruitment leads, has identified four main categories of work for the period of 2021-22. The structure of this paper covers each of these categories separately providing a series of charts and data to assist the reader to understand the extent of the RRS issues across BSW, including areas of highest and lowest risk, and to outline the associated RRS work and projects to mitigate risks and improve the ongoing supply of a skilled and experienced workforce across the BSW system. A. Increase supply to reduce BSW vacancies B. Retention of essential skills an staff resource post age 55							

	C. Increase retention of workforce across BSW (aligned to workforce plan defined risks) D. Ensure the diversity of our staff reflects the diversity of our communities In 2020-21 4 broad priorities are being addressed: • Increase workforce supply to reduce BSW vacancies • Retention of essential skills and staff resource post 55yrs • Increase retention of staff across BSW (aligned to workforce plan defined risks) • Ensure the diversity of our staff reflects the diversity of our communities
Equality Impact Assessment	The intention is that some of this work will help us attract a diverse workforce that reflects our local communities and foster a culture of inclusion and belonging.
Public and patient engagement	N/A.
Recommendation(s)	The Partnership Board is asked to: 1. Note the report and the progress made to date. 2. Provide comments and feedback on the format and content of this document that could further strengthen future reporting. 3. Recognise the resource constraints as a result of being dependent on year-on-year HEE funding.
Risk (associated with the proposal / recommendation)	High | Medium **x** | Low | N/A
Key risks	Failure to retain the existing BSW workforce and attract new staff, with the right skills, will directly impact on capacity, the quality of health and care delivery, and will have significant financial implications for BSW Stakeholder organisations (agency costs).
Impact on quality	Working collaboratively, the activities undertaken within this work stream will influence future BSW workforce numbers and ability to deliver services, providing consistent quality in health and care delivery system-wide now and in the future.
Resource implications	• Resourcing for this workstream is dependent on HEE workforce Development funding (year on year) which limits the level of capacity available to successfully embed work stream projects • Resistance from BSW stakeholders to approve a devolved approach to project delivery
Conflicts of interest	None recognised
This report supports the delivery of the following BSW System Priorities:	☒ Improving the Health and Wellbeing of Our Population ☒ Developing Sustainable Communities ☒ Sustainable Secondary Care Services ☒ Transforming Care Across BSW ☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan

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

BSW Partnership Board, 1 October 2021, item 9

BSW Workforce – Deep Dive Data Pack

Sheridan Flavin - Interim Director for People and OD, BSW CCG

Vanessa Ongley - RRS Workstream Project Lead, BSW Strategic Workforce Programme

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Key Points	This data pack provides a deep dive into BSW workforce metrics and activities currently underway within the BSW, Recruitment, Retention and Supply workstream to address current and long-term pressures, focusing on four priority areas: • Increase supply to reduce BSW vacancies • Retention of essential skills an staff resource post age 55 • Increase retention of workforce across BSW (aligned to workforce plan defined risks) • Ensure the diversity of our staff reflects the diversity of our communities Supported with existing BSW data an overview of current projects lead by the BSW recruitment, retention and supply workstream, informed by the Long Term Plan and the BSW People Plan to improve system-wide workforce practices and address capacity on an ongoing basis.
Recommendations	The Partnership Board is asked to : 1. Note the report and the progress made to date. 2. Provide comments and feedback on the format and content of this document that could further strengthen future reporting. 3. Recognise the resource constraints as a result of being dependent on year-on-year HEE funding.
Key risks	Key risks identified include: 1. Continued support, by BSW partners of collaborative approach to implementing workforce projects. 2. Workstream activities dependent on year on year funding. 3. Implications on workstream activity as a result of Covid-19.
Resource implication(s)	Resourcing for the Recruitment, Retention and Supply Project is funded by HEE on a year on year basis on a fixed term basis. The current secondment arrangements are unable to be extended and OPDG are currently exploring options to appoint a new RRS Project Lead, however funding arrangements are having an adverse impact on securing a replacement. A business case is currently being prepared to convert this temporary funded post to a permanent ICS funded post from April 2022.

Please note: The data enclosed is provided by the BSW Strategic Workforce Planning workstream, sourced from a number of national, regional and partner organisations (through dashboard reporting):

NHS Data Sources

1. Health Education England System Information pack is updated quarterly and includes NHS data only, next pack expected early October 2021.
2. Flow analysis/year-on-year retention data is informed by the BSW workforce Intelligence dashboard - updated on an ongoing basis. In addition to the dashboard the data reported is supplemented by the National Electronic Staff Record (ESR) data warehouse which is updated on a monthly basis.
3. Vacancies data is reliant on a number of sources including those detailed above. Whilst not all of the below are updated on a monthly basis it is possible, at a system level, to provide a reliable BSW vacancy position at any given time utilising a combination of:
    - Department of Education Workforce Statistics
    - NHS England System data sharing platform
    - NHS Digital Workforce Statistics
    - BSW PCN ARRS Claim Portal
    - NHS Bench Marking Network
    - NHS Model Health System
    - Nationally Collated Workforce Returns
    - Locally Collated Workforce Returns

Primary Care Data Sources

1. Primary Care data is obtained from National Workforce Reporting System (also known as NWRS) and is now collected/reported monthly basis.

Social Care Data Sources

1. Social Care data is obtained from Workforce Data Set for Adult Social Care (WDS-ASC) and is collected/reported on an annual basis.

Children's Social Care Data Sources

2. Social Care data is obtained from Department of Education Workforce Statistics and is collected/reported on an annual basis.

Introduction

There are approximately 41,000 people employed across BSW in Health and Social Care. It is recognised that retaining and growing workforce is one of our biggest challenges.

This data pack provides a deep dive into the workforce metrics across BSW Health and Care through the lens of several aspects; staffing numbers, turnover, retention, age demographics and diversity.

Through the work of the BSW Recruitment and Retention and Supply (RRS) Workstream a number of projects have progressed to make a positive impact on the workforce across BSW. These system projects are focussing on both attracting workforce into BSW as well as retaining those individuals within our system. The RRS workstream is a subgroup of the BSW Operational People Delivery Group (OPDG) which is attended by senior HR leads from across all BSW organisations to discuss and drive the workforce agenda on behalf of the whole system.

The OPDG group has four workstreams set up to support strategic workforce development and for the purposes of this deep dive into BSW workforce, the focus is on elements of workforce information and data that drive growth and retention of workforce across BSW.

Each sovereign organisation has their own workforce challenges and has put in place actions or projects to mitigate these challenges. Where BSW can add value is the power of collective effort and collaboration on workforce projects for the benefit of the system. The projects described in this data support this approach.

The RRS workstream priorities, projects and areas of focus were identified following the publication of the NHS Long Term Plan followed by the NHS People Plan that provides a clear overall vision of the workforce transformation requirements to underpin required changes to service delivery and ways of working and to deliver the triple aims of improvement in health, quality and financial sustainability. Delivered through a system of sustainability and transformation plans (STP) and now Integrated Care Systems (ICS's), a critical component is the creation and delivery of an enabling BSW workforce strategy for health and care.

In addition the NHS People plan set out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care. The BSW People Plan sets out how BSW will develop and deliver the local NHS workforce with system wide approach and address the key themes of;

- *Looking after our people*

- *Belonging in the NHS*
- *New ways of working and delivering care*
- *Growing for the future.*

The BSW People plan does not replicate the work of the NHS Trusts and other employers within the BSW system. It sets out plans that will be undertaken at system level. System level actions are defined as:

- *Those that the NHS People Plan makes explicit as requiring to be managed at system level*
- *Actions that BSW workforce development leaders have agreed can be better planned and/or delivered collectively rather than at employer level.*

The RRS network is a key enabler in delivering the system wide actions of the BSW People plan. The membership of the BSW RRS Leads Network includes health and care, local authority and charities organisations (stakeholders), this is not exclusive and will support sub-groups of services deemed to have specific RRS needs. Working collaboratively the network is focused on; improving the quality of RRS delivered across BSW footprint, optimising the utilisation of resources and research for all partners and supporting the delivering of the BSW People Strategy.

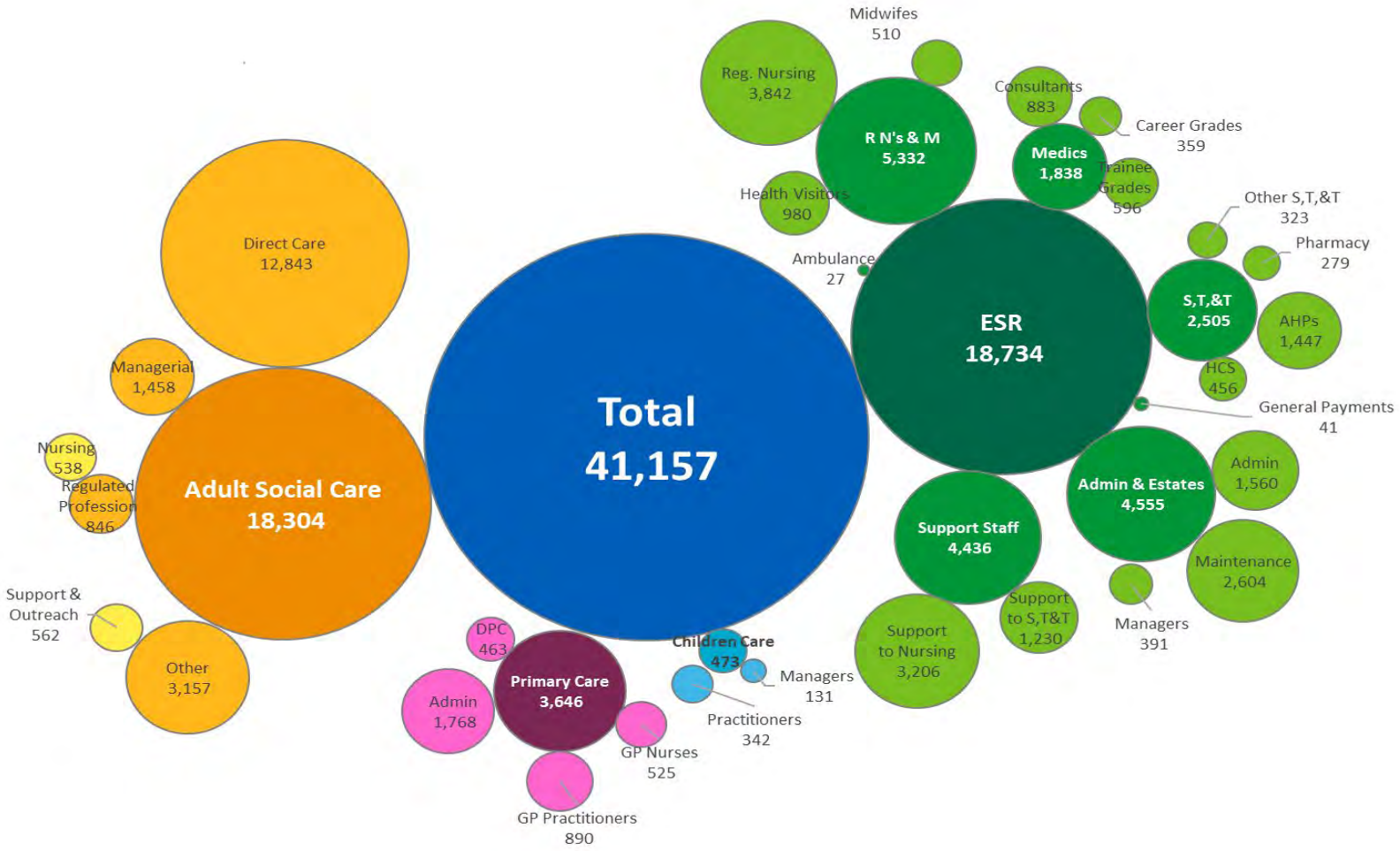
The information contained in this report covers the period from September 2020 to September 2021 and includes workforce data, by organisation where it is available. It should be noted that some historical data prior to April 2021 is not available and was not collated prior to system workforce planning leads coming into post.

The RRS network has identified four main categories of work and this paper is structured to cover each of these separately with a series of charts and data to help the reader understand the extent of the RRS issues across BSW, including areas of highest and lowest risk and to outline the associated RRS work and projects to mitigate risks and improve the supply of a skilled and experienced workforce.

A. Increase supply to reduce BSW vacancies
B. Retention of essential skills an staff resource post age 55
C. Increase retention of workforce across BSW (aligned to workforce plan defined risks)
D. Ensure the diversity of our staff reflects the diversity of our communities

The shape of BSW Workforce:

As at March 2021 : source HEE data pack



A - Increase supply to reduce BSW Vacancies

The following table provide an overview of the numbers and types of vacancies that are known at this time, these have been modelled using the data provided throughout the Phase 4 workforce plans:

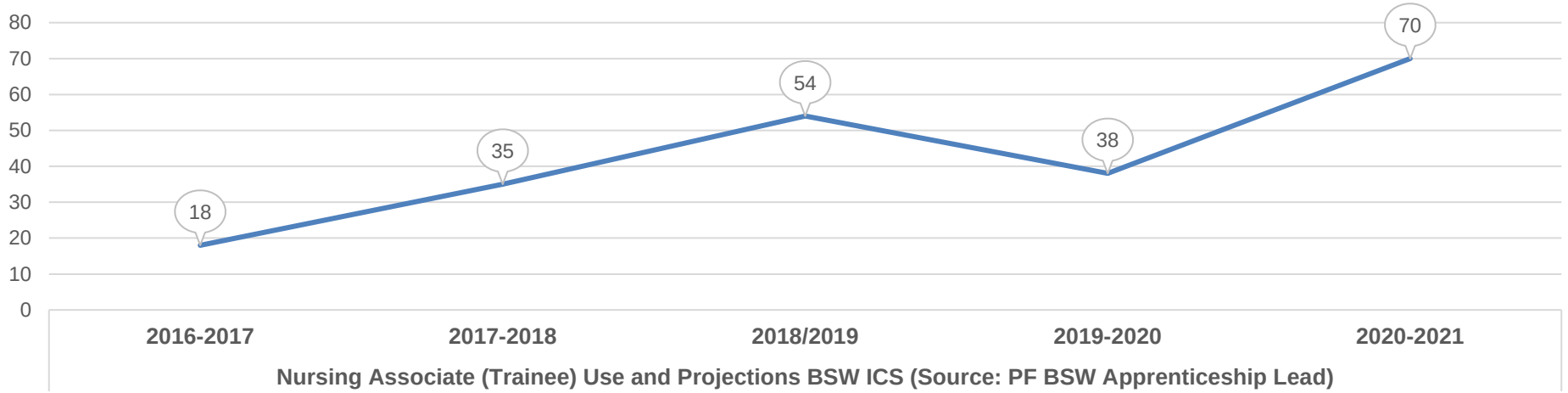
1. BSW Vacancies

Staff Group	Supply (June 2021)	Demand (June 2021)		Assumed Vacancies	
	Staff In Post (WTE)	Long Term Plan Workforce Plan (2019 to 2024)	Phase 4 Workforce Plans	WTE	Rate (%)
Add Prof Scientific and Technic	1,275	1,210	1,335	60	4.7%
Additional Clinical Services	13,282	13,714	14,335	1,052	7.9%
Administrative and Clerical	6,099	5,939	5,856	-243	-4.0%
Allied Health Professionals	1,238	1,344	1,283	45	3.6%
Estates and Ancillary	800	755	679	-120	-15.0%
Healthcare Scientists	411	418	405	-6	-1.3%
Medical and Dental	2,280	2,306	2,232	-48	-2.1%
Registered Nursing and Midwifery	5,522	5,891	5,709	187	3.4%
Balancing Value	*2,508*	*2,637*	*2,628*	120	4.8%
BSW	*33,413*	*34,214*	*34,462*	*1,048*	*3.14%*

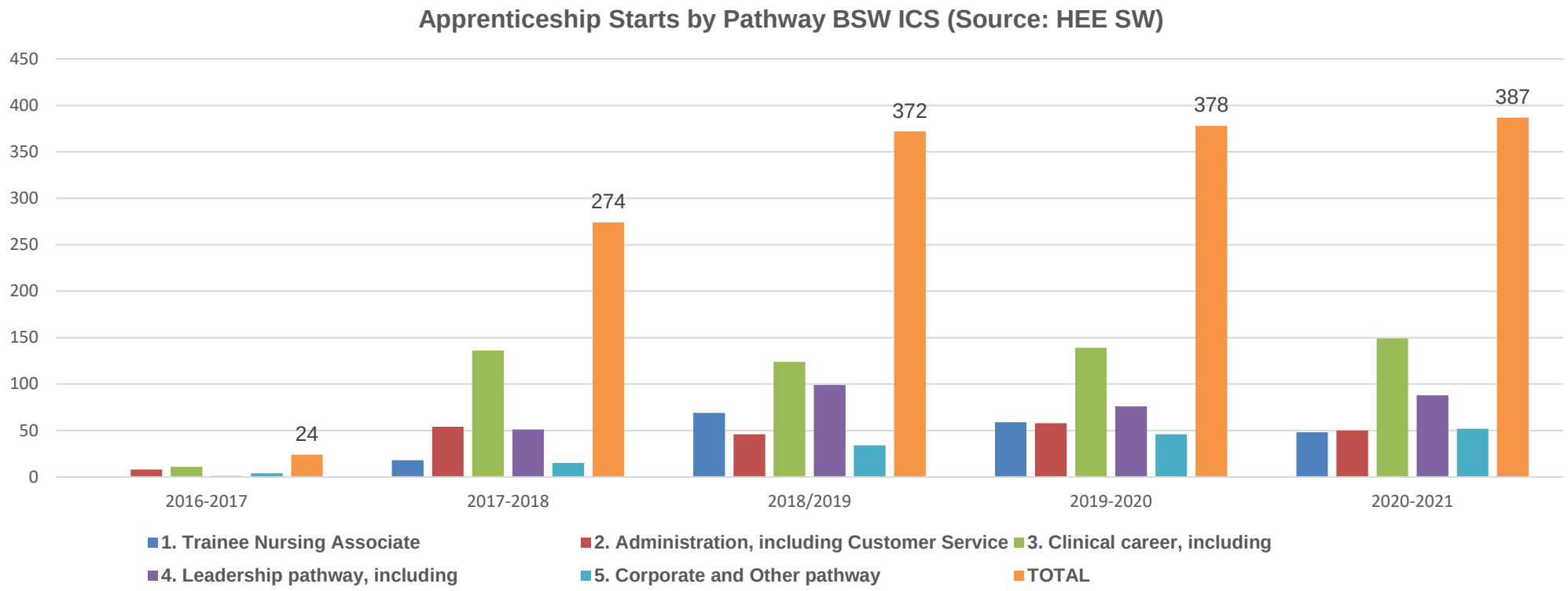
The date provided above does not include, Primary Care, Local Authorities, Adult Social Care Providers and Children's Services.

Tables 2, 3 & 4 provide information on supply routes for BSW Workforce for Nursing Associates and Apprenticeships, as well as the spend on the apprenticeship levy which is viewed as a whole system opportunity to grow workforce through this route.

2. Nursing Associate (trainee) numbers incl. planned numbers for 2020-21

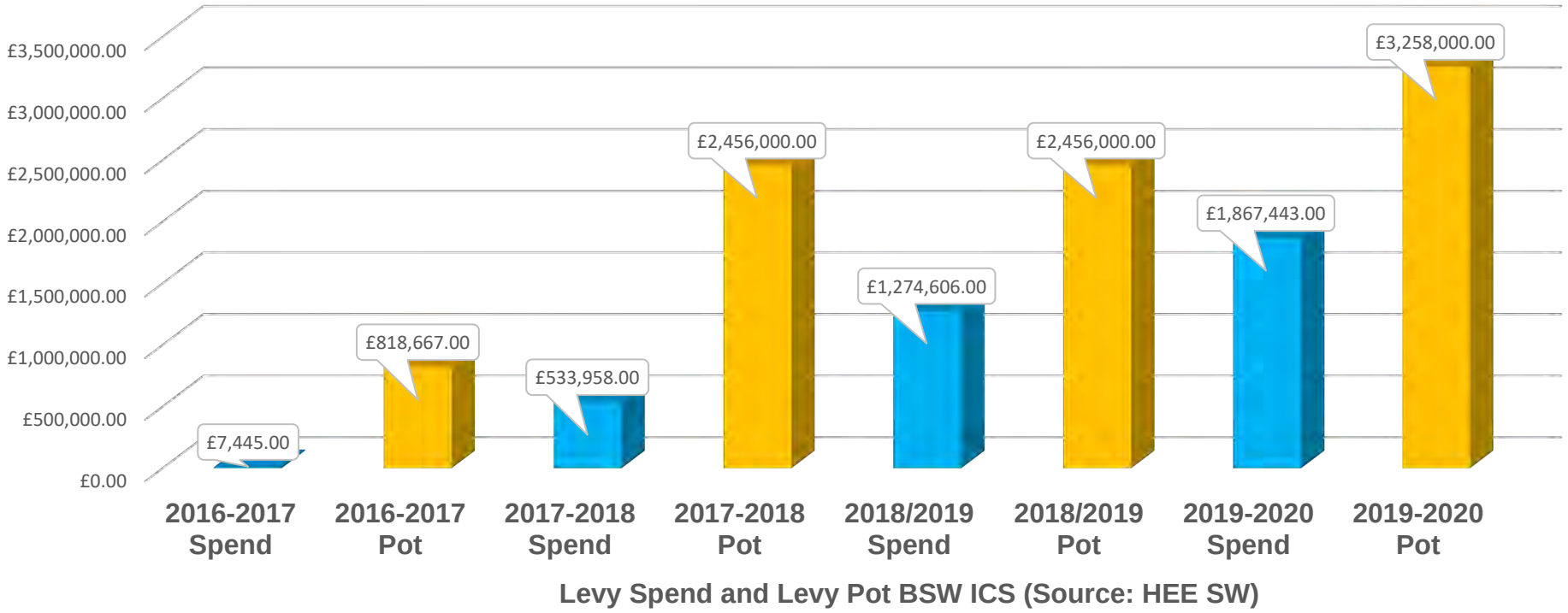


3. **BSW Apprenticeship start numbers 2016-2021** shows that apprenticeship starts across BSW have risen year on year since the introduction of the levy, with leadership and clinical apprenticeships underpinning succession planning and pipeline development to more senior or registered careers. Apprenticeships starts in the past year were fewer than predicted as a result of COVID-19 and employer/HEI's pausing apprenticeship programmes, support and study time for candidates for 6-12 months, in some cases to free up operational capacity.



4. **Apprenticeship levy spend across BSW** 2016-2020 shows that the BSW levy pot has grown year on year with more funding available to support the education costs of apprenticeships. This also defines an increase in year-on-year spend however, there is approximately £1.4 million of unspent levy across our providers that could be utilised to support apprenticeship thus providing a workforce pipeline over the next 2-5 years into high turnover and high vacancy roles. Apprenticeships provide an opportunity to utilise our support worker role as development and training posts for our higher risk registered professions potentially.

The BSW Academy, working with Partner Organisations, will focus on ensuring how the ongoing BSW Apprenticeship Levy underspend can best be reinvested across the BSW health and care system, building on a home-grown BSW workforce for the future.



Levy Spend and Levy Pot BSW ICS (Source: HEE SW)

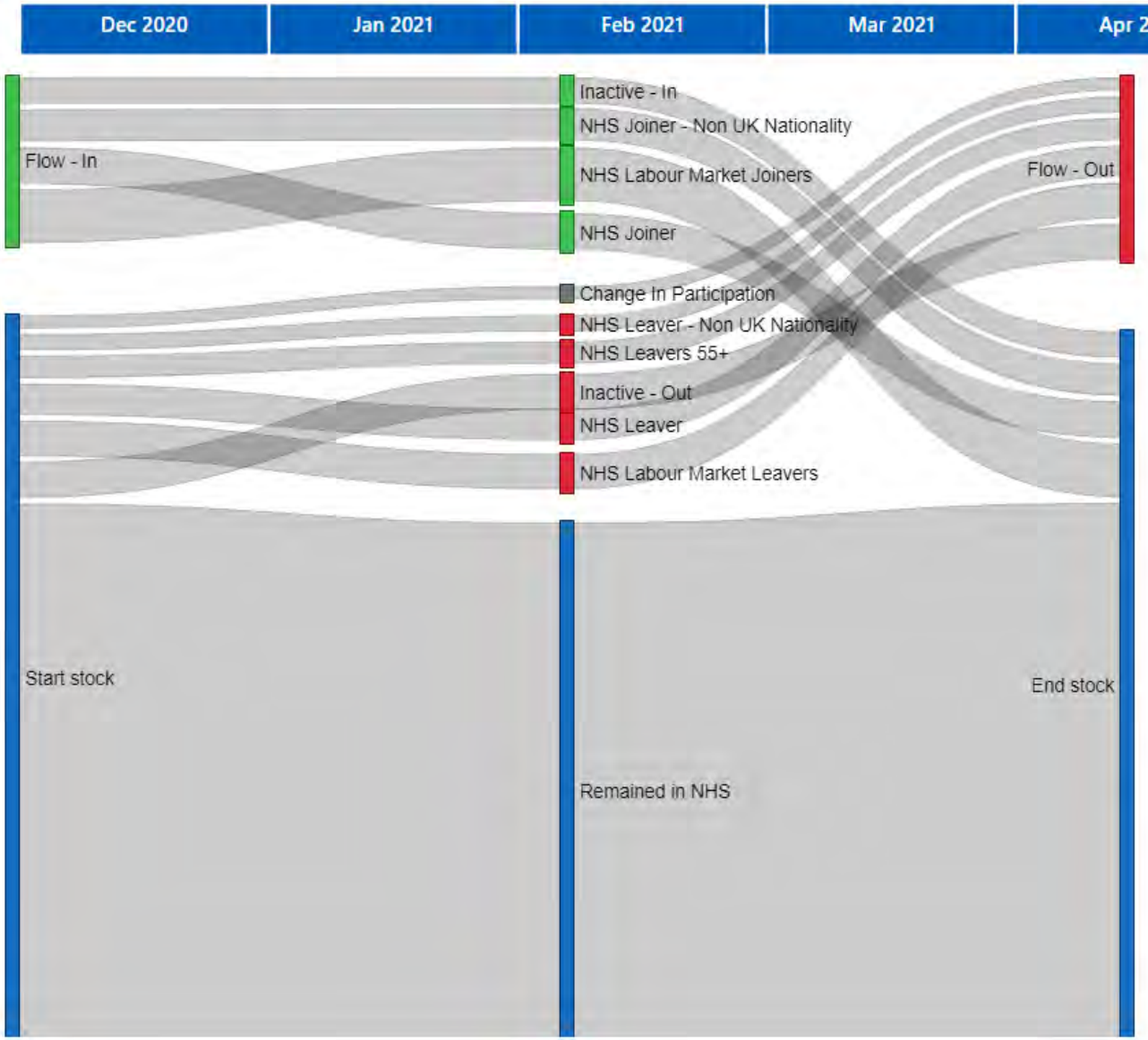
Tables 5 &6 below provide an overview of flow of registered nurses within BSW NHS Trusts, demonstrating the flow of nursing in and out of the BSW footprint. Overall, this data shows a greater number of starters than leavers (Registered Nurses and Midwives between December 2020 and April 2021) but again, must be viewed in the context of an extraordinary recruitment associated with COVID-19 and vaccine delivery services.

5. Flow Analysis of Registered Nurses within NHS Trusts in BSW (YoY)

NHS only - YoY comparison i.e. Jun 21 is the 12 month period from Jun 20 to Jun 21

Workforce Flows	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
NHS Labour Market Leavers	-3.4%	-3.58%	-3.64%	-3.72%	-3.95%	-4.03%	-4.04%
NHS Labour Market Joiners	6.16%	6.00%	5.72%	5.43%	6.96%	7.55%	7.02%
Net NHS Labour Market Activity	*2.77%*	*2.42%*	*2.08%*	*1.71%*	*3.01%*	*3.52%*	*2.98%*
NHS Leaver	-3.68%	-3.60%	-3.50%	-3.27%	-3.18%	-3.31%	-3.36%
NHS Leaver - Non UK Nationality	-0.76%	-0.83%	-0.93%	-0.83%	-0.86%	-0.89%	-0.87%
NHS Leavers 55+	-1.85%	-1.71%	-1.56%	-1.66%	-1.81%	-1.86%	-1.87%
NHS Joiner	7.15%	6.93%	6.54%	6.45%	4.53%	3.76%	4.21%
NHS Joiner - Non UK Nationality	3.14%	2.80%	2.75%	2.15%	2.49%	2.88%	3.50%
Net Wider Labour Market Activity	*1.62%*	*1.62%*	*1.48%*	*1.51%*	*-0.46%*	*-1.41%*	*-1.02%*
Net Non-UK Nationality Activity	*2.38%*	*1.97%*	*1.82%*	*1.32%*	*1.63%*	*1.99%*	*2.63%*
Change In Participation	-0.08%	0.00%	-0.07%	-0.34%	-0.39%	-0.42%	-0.41%
Inactive - In	2.78%	2.64%	2.43%	2.47%	2.50%	2.49%	2.54%
Inactive - Out	-4.17%	-4.15%	-4.15%	-3.98%	-4.09%	-4.16%	-4.13%

6. Nursing Flow Analysis (June 2020 vs. June 2021)



Staff Group

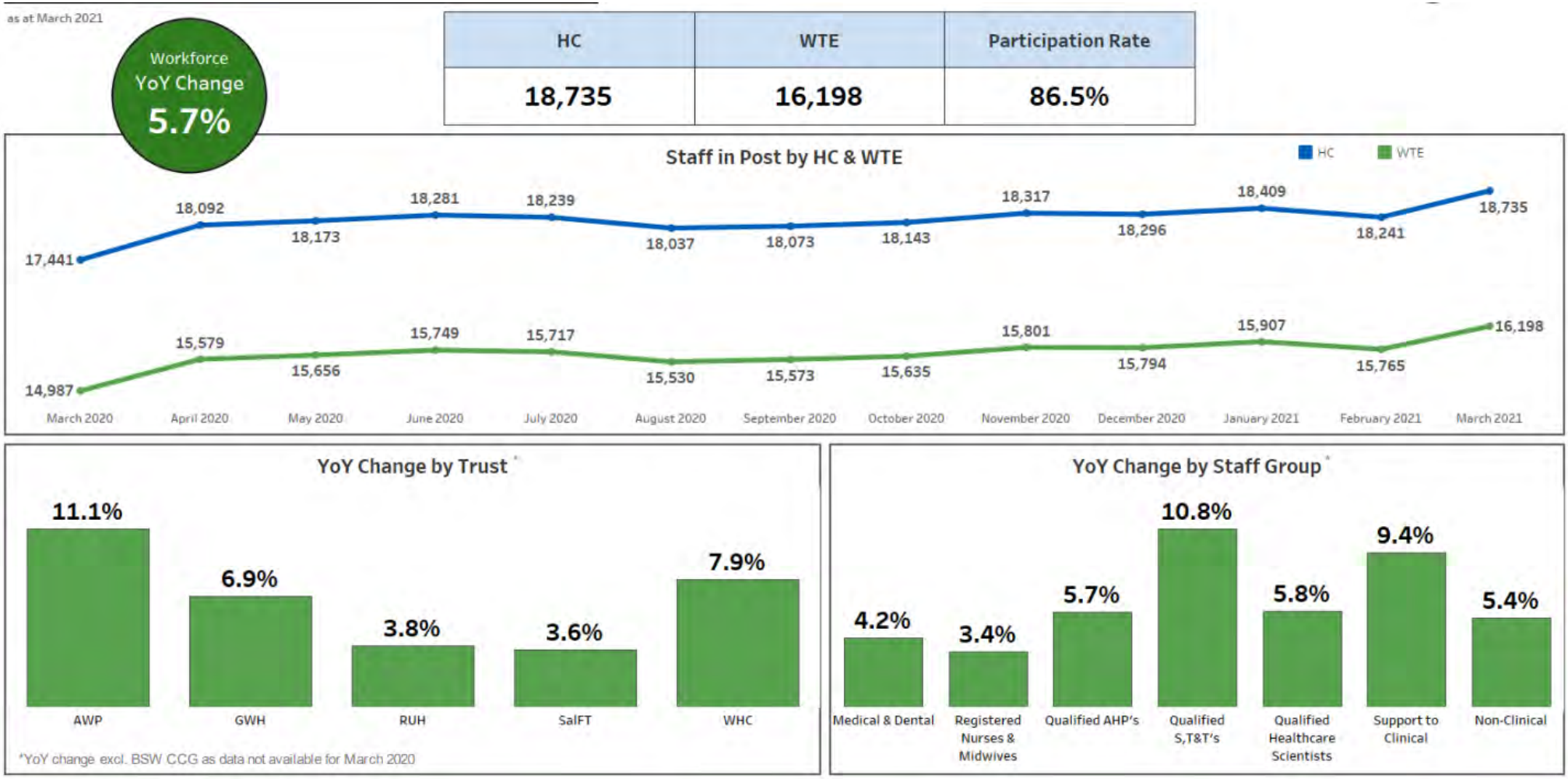
- All Staff Groups
- Add Prof Scientific and Technic
- Additional Clinical Services
- Administrative and Clerical
- Allied Health Professionals
- Estates and Ancillary
- Healthcare Scientists
- Medical and Dental
- Registered Nursing and Midwifery
- Students

Flow	Rate	Actual WTE
NHS Labour Market Joiners	7.02%	306
NHS Labour Market Leavers	-4.04%	-176
Net NHS Labour Market Activity	**2.98%**	**130**
NHS Leaver	-3.36%	-147
NHS Leaver - Non UK Nationality	-0.87%	-38
NHS Leavers 55+	-1.87%	-81
NHS Joiner	4.21%	184
NHS Joiner - Non UK Nationality	3.50%	153
Net Wider Labour Market Activity	**-1.02%**	**-44**
Net Non-UK Labour Market Activity	**2.63%**	**115**
Change In Participation	-0.41%	-18
Inactive - In	2.54%	111
Inactive - Out	-4.13%	-180

Source: ESR

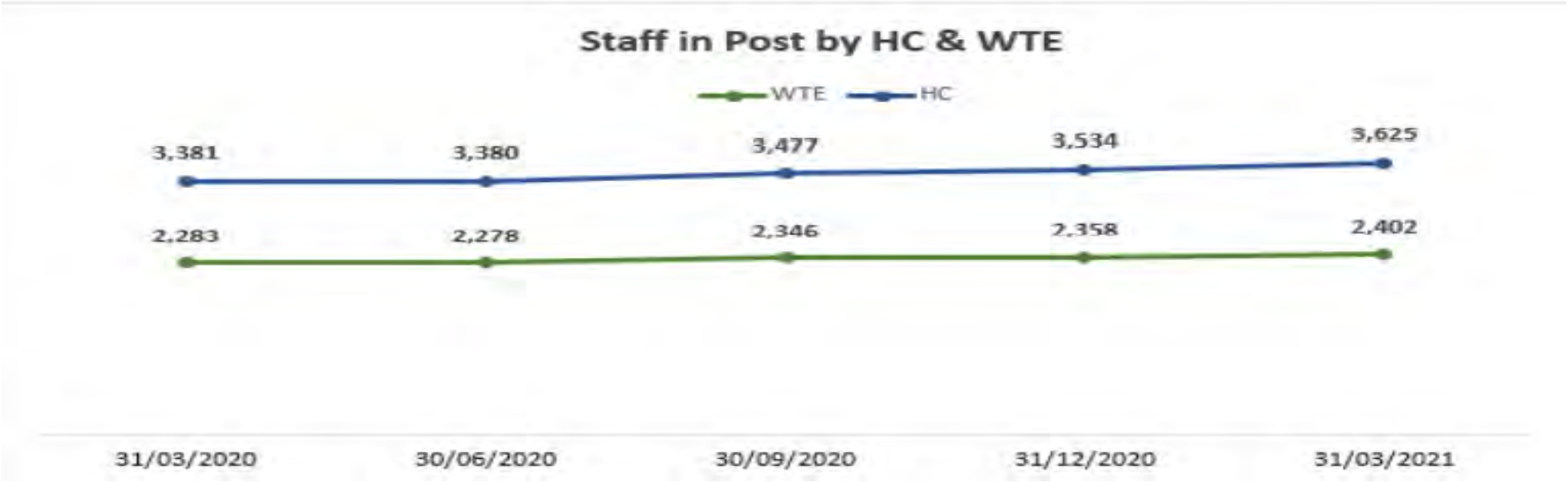
7. Workforce change (growth March 2020-March 2021)

This information is supplied by HEE which shows our Headcount (HC) and WTE growth with 1,294 additional staff (HC) recruited in the system between March 2020 and March 2021, with the largest growth of 11.1% in AWP followed by 7.9% growth in WHC.



7.1 BSW Primary Care

Table 7.1 shows that workforce growth was also notable in primary care with a growth of 244 (HC) recruited over the same period.



8. 50, 000 more nurse promise (50k project) – BSW trajectory.

In 2019 the government announcement the nursing promise to increase the registered nursing workforce by 50,000 nurses by 2024 and the target for BSW is 4,123 by March 2022. BSW is currently above the agreed delivery trajectory at 4,107 which is 16 short of the target and an increase of 26 since figures were reported in June 2021.

Projects that are supporting this aim of 'Increasing the supply to reduce BSW Vacancies' include:

Project 1: Increased Supply (domestic)

Aim - to increase the pipeline of registered nurses/ who will train and then go on to work in BSW

Actions	Outputs
1. BSW based Blended Learning programmes with University of Gloucester developed (delayed due to COVID until Sept 21).	1. 22 Additional students in the system who are completing their learning in BSW rather than moving away to undertake training which we know will improve the "placement to employment" conversion rate and provide training for those who otherwise may not be able to undertake training due to lower access requirements.
2. Two BSW Hubs developed with 100% placement support. Majority of students placed in community and Primary Care (PC) (18 additional Student nurses recruited).	2. Increased number of students (18) with expansion of placements aligned to new model of care with greater training opportunities close to or at home elevating pressure on saturated acute providers who traditionally are required to support up to 85% placements.
3. Registered Nurse apprenticeships with co-ordinated business cases (2019/20 (4), 2020/21 (25), 2021/22 (planned 88).	3. Increased nursing apprenticeship opportunities within BSW. Total since 2019 = 29 plus additional 88 planned in this year (117 total)
4. Development of more NA roles – targeting Social Care and PC with support and supporting placements.	4. Increased numbers or of Nursing Associate roles and new employers embracing role (45% increase / 32 WTE additional NA's).
5. Successful placement expansion Bid to Health Education England to support additional 60 Nurses and AHP students in BSW from Oct 21.	5. HEI's to increase students in BSW and overall recruitment of students in line with BSW workforce planning predictions (60 additional students recruited aligned to placement expansion). This would use £234,000 award to support the following additional placements; 10 MH, 18 PC and community, 5 PVI, 5-10 social care and 18 acute.

6. COVID response workers – employment substantive / bank	6. To assist in recruitment where there is short term 1 year funding as FT posts are not attractive, BSW indicative agreement to recruit band 5 therapists substantively from 3 employers so far and then second the long COVID services for a year, with preceptorship package and rotational approach to support skills building and career aspirations.
7. Shared suitable shortlisted but not appointed application forms for roles from Health to Social Care.	7 Exploration, design and agreement of a process to allow sharing of suitable unsuccessful applicants to NHS roles with Social Care to create a new recruitment pipeline.

Project 2: Increased supply (international)

Aim – To meet People plan action to collaborate when recruiting internationally

Actions	Outputs
1. Forming the BSW International Recruitment Steering Group.	1. Smaller employers participate in IR using a collaborative approach to reduce vacancy and service pressures in smaller organisations.
2. Use learning from areas of good practice to set gateway questions during procurement to ensure certain criteria (such as language requirements), are met before recruitment offer is made.	2. Reduce on boarding timeframe consistently from 13 months to 3-6 months and ensure an improved offer to start prediction allowing for more accurate planning and less chance of over or under supply.
3. Procurement collaboratively using the bulk demand and over a 3 year contract to secure lower agency costs of approx. £1000 per recruit (previous cost up to £2,800 per recruit)	3. Reduce costs by up to £1000 per recruit against spot purchase costs / existing costs.
4. Align recruitment offer through consistent offers being made and BSW partners therefore not bidding against each other and driving up rates	4. A consistent attractive BSW offer to attract good quality candidates
5. Ensure experience of nurses is considered in a standard way when commencing on Agenda for Change considering experience in a standard way	5. BSW is considered a fair and attractive employer by assigning AfC increment according to experience and knowledge in a standard way across all employers.
6. Ensure possible oversupply is managed / prevented.	6. Align allocation/supply to areas of key risk via central allocation of cohorts using level of vacancies as one of the agreed allocation criteria.
7. Ensure that all agency suppliers used are of high quality and recruit ethically.	7. Agencies used are approved on framework suppliers.
8. Write operating procedure and other underpinning documents using existing example of best practice where they exist.	8. Ensure all process/procedure and recruitment offers are accessible, standardised and agreed across all BSW employers leading to a clear, smooth recruitment pathway for employers and recruits.

Project 3: New to NHS pipeline

Aim – to meet People Plan action to create pipelines and widen participation

Actions	Outputs
1. Introduce SWAP[1] programme to Health – as a pipeline into NHS careers.	1. Increase in the number of young people considering a career in health and social care. 12 SWAP places identified and filled May 2021, a further 15 SWAP places identified for a further November 2021 start/course.
2. Introduce Kick start as a pipeline into NHS careers.	2. Supporting our communities into jobs and careers with our employers – 35 Kickstart places identified for recruitment by December 2021
3. Support T Levels students with placements and entry into NHS careers.	3. T level strategy devised and agreed to illustrate roles and responsibilities to ensure attractive, smooth and high quality experience for learners across BSW. 23 T level students who commenced Health Care T level in Swindon and Bath commitment to support on placement from Sept 2021
4. Placement expansion – using models that create high quality experiences and BSW connection.	4. A larger pool of students who are keen to work in BSW post registration (BSW Community, Social Care and Primary Care placement hubs created/ 2 x blended learning cohorts created). Coaching model of placement support for students introduced to new areas – a proven method of increasing placement numbers whilst giving a positive placement experience for students.

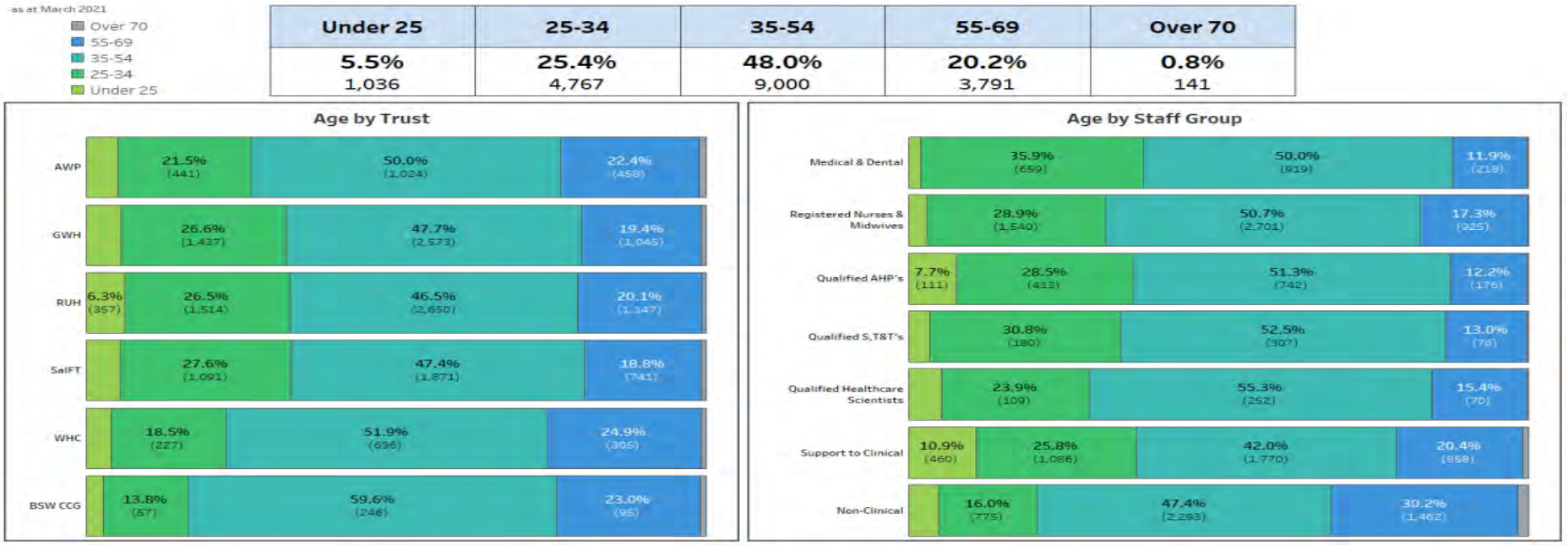
[1] Sector-based work academy programme (SWAPs) is an opportunity to offer job seekers a placement in employment to learn new skills and is fully funded.

5.	Increase apprenticeships – widening access and participation and creating attractive career pathways.	5.	Support more support workers to become registrants (45% increase in Trainee Nursing Associates and overall rise in numbers of apprenticeships).
6.	Identify a work experience virtual offer across BSW.	6.	Web platform to be explore, agreed and commissioned with a timetable and collaborative virtual events to be confirmed by March 2021.
7.	Introduce NHS cadets' scheme to BSW.	7.	Identify at least 1 pilot site for BSW to set up the NHS cadet scheme in conjunction with St John's Ambulance aimed at promoting health and social care careers to young, disadvantaged students via speakers, work experience/volunteering opportunities.
8.	Explore becoming a pilot site for NHS reservist scheme.	8.	Initiative explored and no lead employer identified at this point. To await outputs of pilots across South West however, all NHS organisations are currently working towards silver award by March 2022 (with some already having achieved a silver award).
9.	Support, promote and introduce Medical Support Workers to BSW workforce.	10.	MSWs introduced to RUH and GWH x 10 (increase of 10 from 2020-21).

B - Retention of essential skills and staff resource post 55 years old

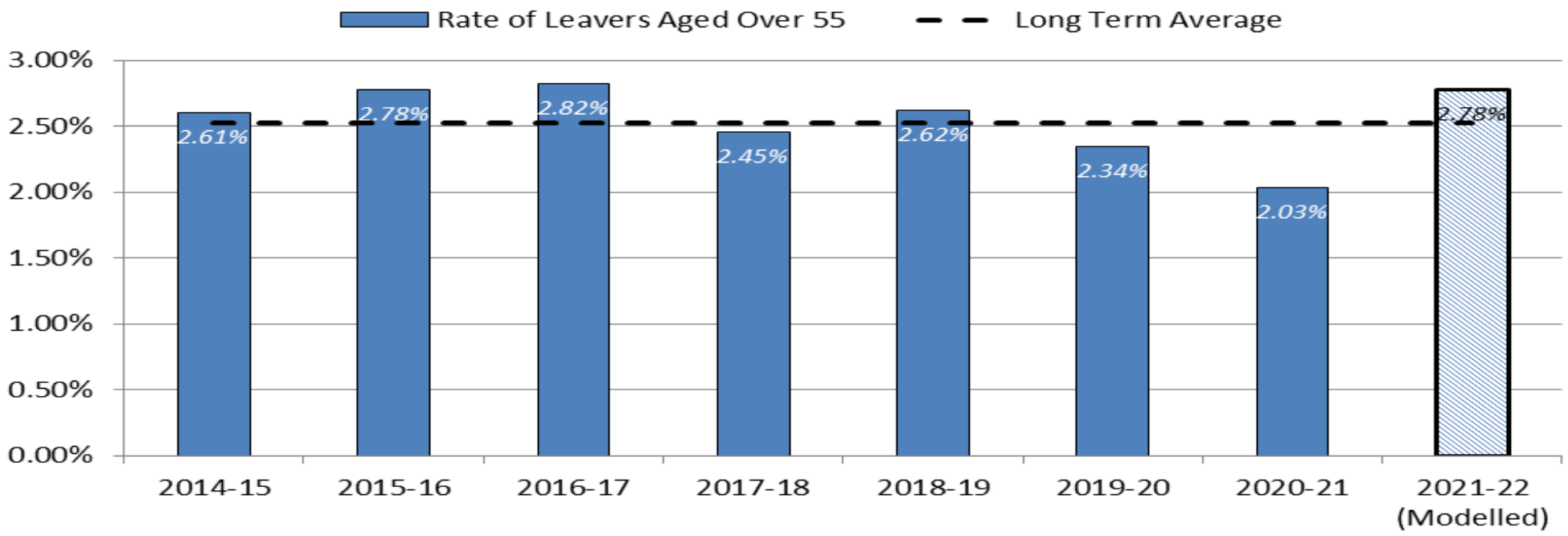
The workforce within BSW and, particularly across some staff groups are aging and the level of retirements are predicated to increase as per data tables, 1 & 2 below. Whilst this is NHS only data there is an even higher pattern across social care with 26% of staff aged over 55 as of March 2020 and in primary care where 33% are aged over 55.

1. Age profile of BSW staff overall, by NHS Trust and by staff group (NHS only)



Under 25	25-34	35-54	55-69	Over 70
5.5%	25.4%	48.0%	20.2%	0.8%
1,036	4,767	9,000	3,791	141

2. Retirements March 2020-2021 and potential retirements by Trust and by staff group (NHS only)



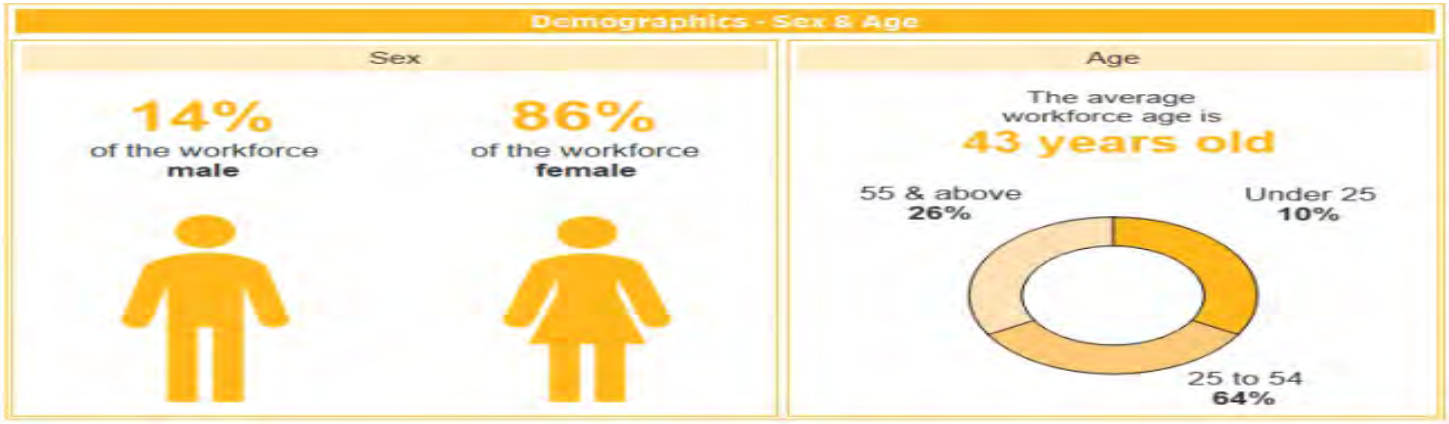
HEE data provided (below) on workforce tenure in the NHS in BSW at 31st March 2021 states that whilst over 30% of our workforce has less than two years tenure (which could indicate a healthy supply) it also sets out that 7.7% of our workforce has over 20 years tenure, indicating we have an increasing number of staff heading towards the time when they can make choices about continuing to work within healthcare

< 2 years	2-5 years	5-10 years	10-20 years	> 20 years
30.8%	26.7%	17.0%	17.8%	7.7%

The rate of leavers of over the age of 55 is modelled to increase above the long term mean in 2021-22. This modelled uptake is a result of expiring protection from 1995 NHS Pension Scheme, reducing entitlement to special class status and pent up attrition from 2020-21. The increase in attrition estimated in 2021-22 may result in 0.75% worsening in retention in the year, the loss of an additional 140 wte vs 2020-21.

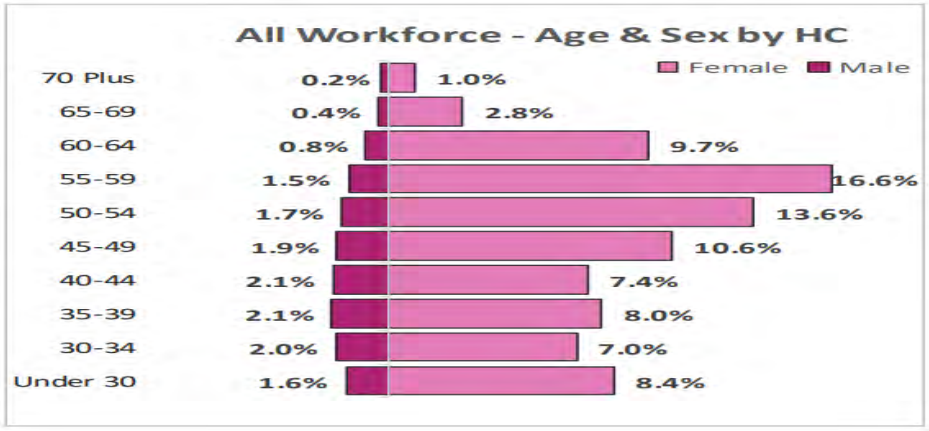
3. Adults Social care workforce demographic as of March 2020

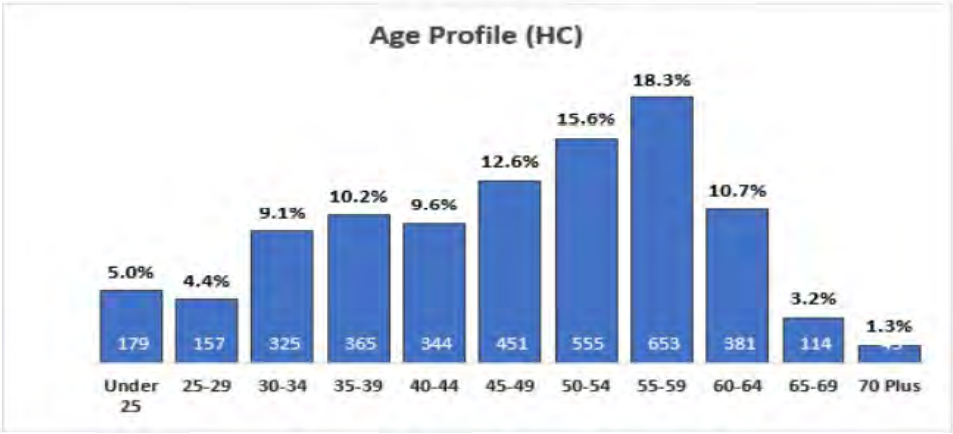
Data for Social Care workforce is captured differently to NHS Data which is captured through ESR. However, the BSW strategic workforce team have been pulling together data available in order to present an overall BSW Workforce position. The following table (3) provides an overview of the adult social care workforce as at March 2020 which demonstrates that it has a largely female workforce with 26% of the workforce aged over 55. A refresh of this data is due in October 2021 (the next official data capture) and is expected to show that the average age may rise.



4. Primary Care workforce demographic March 2021

Data for Primary Care Workforce is captured differently to NHS and Social Care and the following tables (4 & 5) provide an overview of the primary care workforce and demonstrate a workforce with over 30% aged 55 or over. The graphs show the % of staff in each age category with a peak between 55 and 60 and the distribution across gender.





Projects that are supporting this aim of 'Retention of essential skills and staff resource post 55 years include:

Project 1: Support staff to work more hours for longer post 55

Aim (Sep 2020-March 2021) - to understand what would support staff to work longer within BSW

Aim (Apr 2021 – March 2022) - to use the intelligence provided above to deliver actions that will support staff to work longer where they wish to

Actions	Outputs
1. Investigate what would encourage out older staff to work more and longer via a BSW survey aimed at all staff across HCS in BSW.	1. Survey devised, cascaded and completed across BSW – themes identified across 3 broad areas: • Flexibility • Ability to transfer into less demanding role • Positive and proactive approach required to flexible retirement
2. Flexibility workshops with BSW managers and principles developed.	2. Flexibility workshops x 8 facilitated across BSW involving over 150 line managers from health and social care. Workshop outputs used to produce BSW draft flexibility principles to underpin flexibility by default. The workshops have also initiated essential culture change by identifying and spreading best practice and challenging and showing the consequences and less flexible practice., which includes;
3. Itchy feet conversations explored – agreement to roll out.	3. Scoping confirmed that there were workshops for staff but not for managers and often managers felt uninformed and believed that were 'not allowed' to initiate retirement conversations. Policies reviewed best practice identified and shared – policy review across BSW undertaken

4.	Talent pool' across BSW - concept agreed. Retirement / flexible retirement approach BSW scoping completed. Policy investigation to understand if a positive approach is taken and flexible retirement actively promoted.	4.	Talent pool for over 55s - investigation into IG progress informed draft process / SOP to be agreed. Policies scoped and shared with review of policies undertaken using AWP best practice example of positive approach.

C - Increase retention of our staff (aligned to workforce plan defined risks)

In order to ensure we can deliver our services effectively and with pipeline in some professions less than demand, it is crucial that we retain our staff. We know that staff resign from the NHS for reasons that we could address - for example between 2011 and 2018 more than 56,000 people left NHS employment citing work-life balance as the reason.

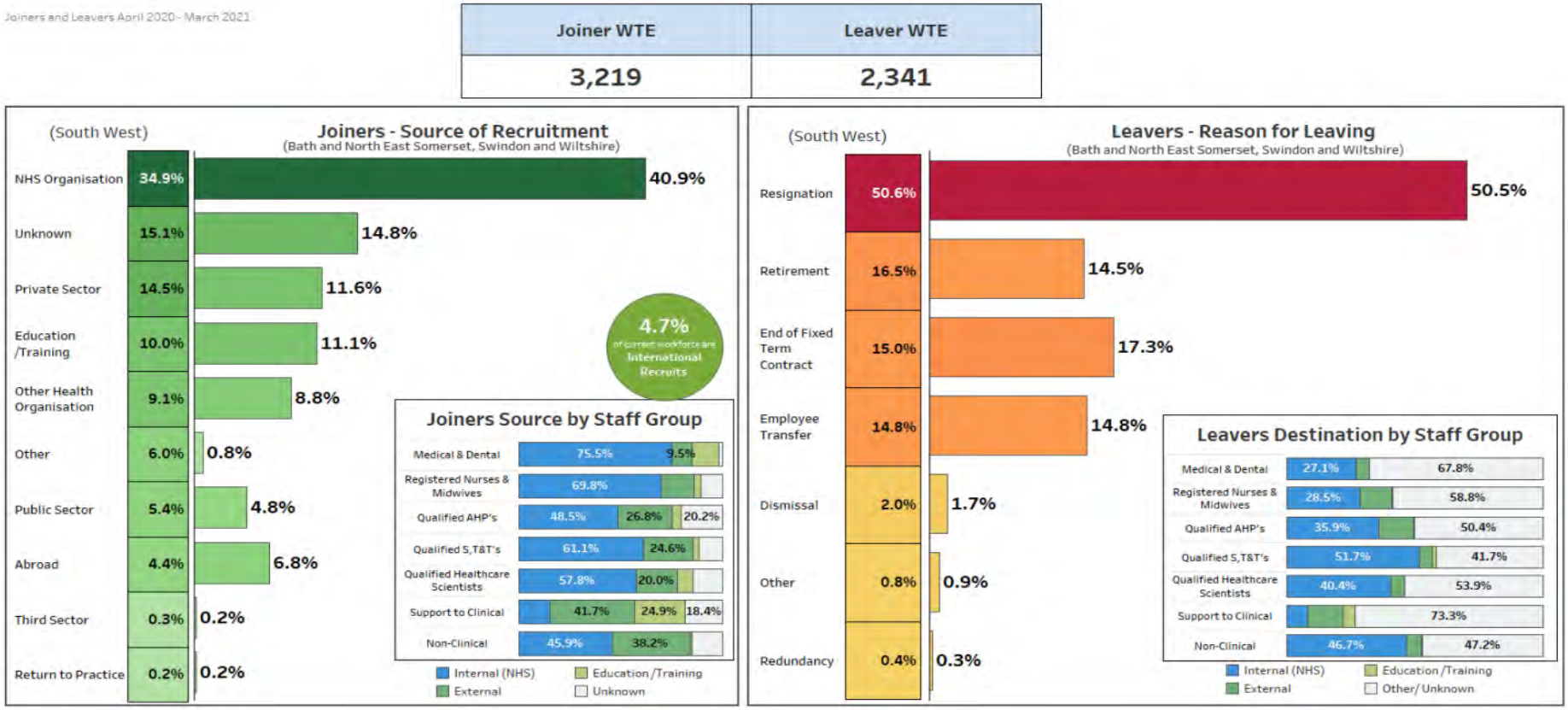
1. Retention - NHS only – Year on Year comparison i.e. June 21 is the 12 month period from June 20 to Jun 21

The table below shows that between December 2020 and March 2021 our retention of staff across BSW remained fairly static. However, between March 2021 and June 2021 there has been approximately an overall 3% decline noted particularly in Additional clinical services, AHPs and Medical and dental.

Year on Year (YoY) Retention Rates								
Staff Group	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Trend
Add Prof Scientific and Technic	85.69%	85.17%	84.45%	84.52%	86.47%	86.38%	86.35%	
Additional Clinical Services	81.52%	81.00%	81.25%	79.68%	76.06%	74.14%	72.93%	
Administrative and Clerical	87.33%	87.49%	87.61%	87.65%	88.08%	87.13%	86.68%	
Allied Health Professionals	88.03%	88.15%	87.90%	88.27%	88.08%	87.76%	86.45%	
Estates and Ancillary	90.46%	90.74%	91.52%	91.92%	91.90%	91.97%	90.90%	
Healthcare Scientists	92.41%	92.84%	93.35%	93.25%	94.34%	93.98%	93.33%	
Medical and Dental	71.07%	70.94%	70.64%	70.27%	68.57%	68.59%	69.21%	
Registered Nursing and Midwifery	90.25%	90.27%	90.31%	90.18%	89.81%	89.48%	89.45%	
Students	9.09%	20.00%	20.00%	20.00%	20.00%	1.35%	0.62%	
BSW	85.52%	85.46%	85.55%	85.20%	84.23%	83.39%	82.83%	

Although the level of attrition in 1 above is of concern, table 2 below demonstrates that we had more joiners than leavers (equating to 878 WTE), between April 2020 and March 2021 showing that we are currently attracting more staff than are leaving.

2. Joiners and Leavers Apr 2020 – March 2021



Projects that are supporting this aim of 'Increase retention of our staff (aligned to workforce plan defined risks) includes:

Project 1: Retain our staff*

Aim: To retain our staff by responding to what matters to them most:

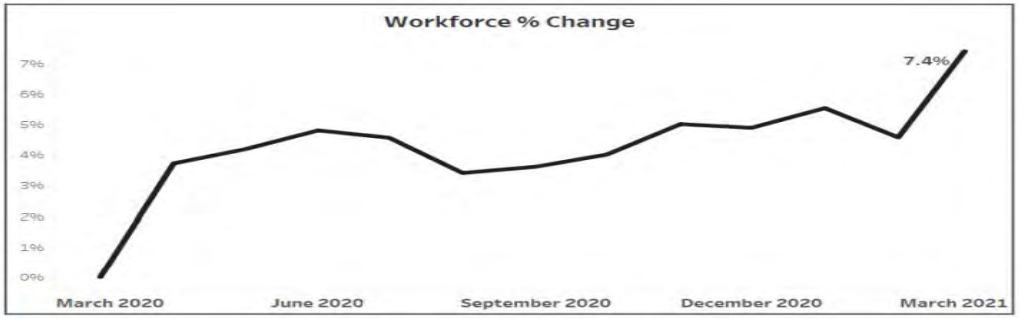
Actions	Outputs
1. Flexibility workshops with BSW managers and principles developed.	1. Flexibility workshop x 8 facilitated across BSW involving over 150 line managers from health and social care. Workshop outputs used to produce BSW draft flexibility principles, which will support employers to offer flexibility by default.
2. Itchy feet conversations explored – agreement to roll out across BSW.	2. Itchy feet/ stay conversations – agreement in principle to rolling out project across BSW. Itchy feet draft process designed using SFT Stay process and BNSSG itchy feet vanguard project – for agreement. Itchy feet conversation template designed – draft for agreement.
3. 'Talent pool' across BSW - concept agreed to share details of staff who require or would like new career opportunities available across the wider BSW area to allow them to be retained in a health and social career in BSW.	3. Process mapped out with IG lead to ensure compliance due to implications of data sharing across organisations and outside NHS. Specific BSW talent pool data sharing agreement required – Talent pool process to be agreed and commenced by March 2022.

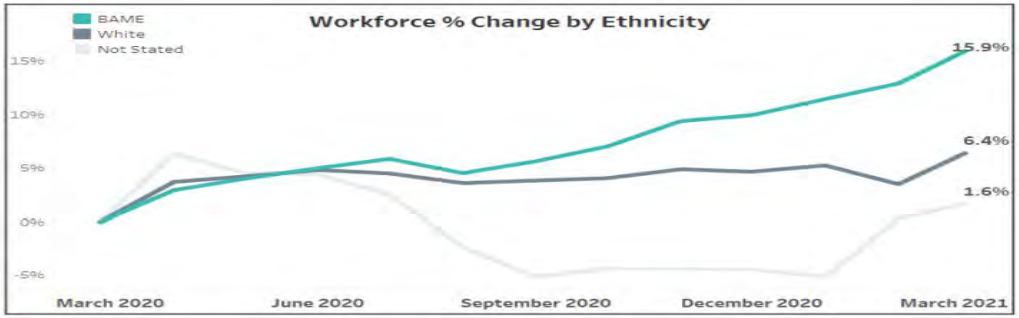
*****Other projects related to retention are also included in the Education and Development workstream, another subgroup of OPDG*

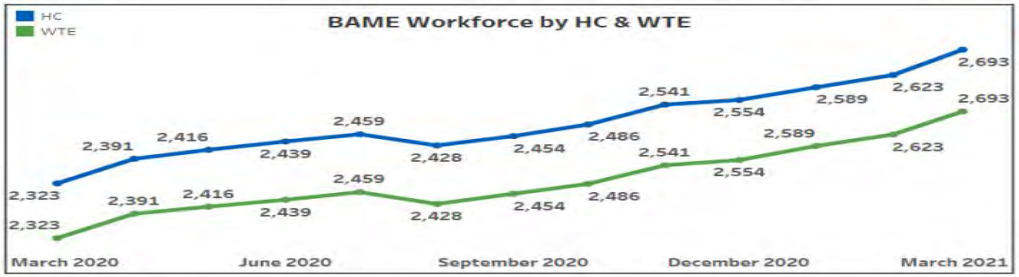
D - Ensure the diversity of our staff reflects the diversity of our communities

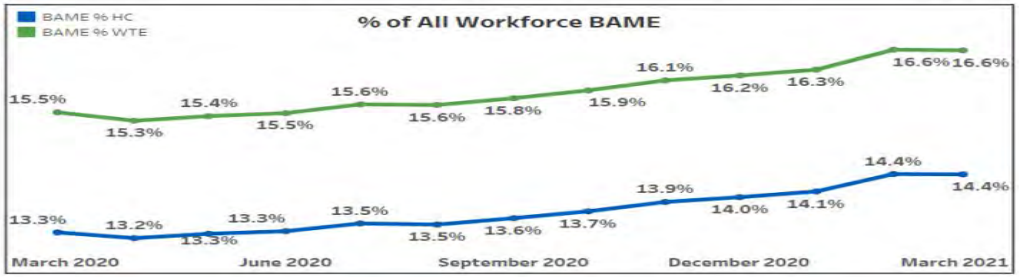
A key objective set out in the NHS People plan is to ensure that our workforce reflects the diversity of the communities they serve. The Model Employer goals focus us particularly on ensuring our leadership teams reflect the diversity of our staff and communities as well as challenging us to reduce the inequality between the number of minority and other staff entering disciplinary processes. Whereas we have data for our NHS employers on ESR and Social care this is not a complete picture as we currently do not have data for primary Care and those non NHS organisations delivering NHS contracts who do not use ESR.

1. **BSW NHS Workforce change in terms of ethnicity – March 2020 to March 2021** shows that over the year March 2020 – 21 we have increased the diversity of our workforce over our NHS employers by 370 (HC).







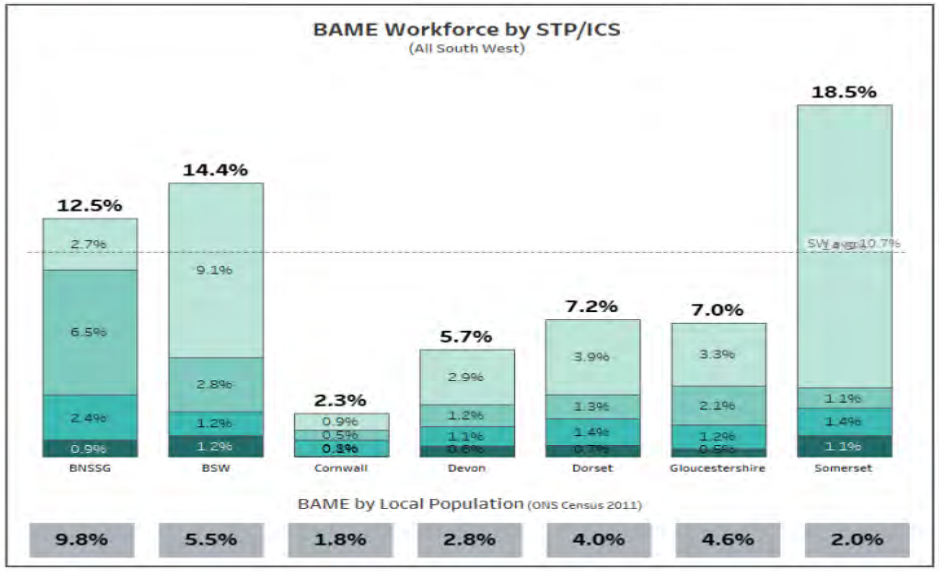


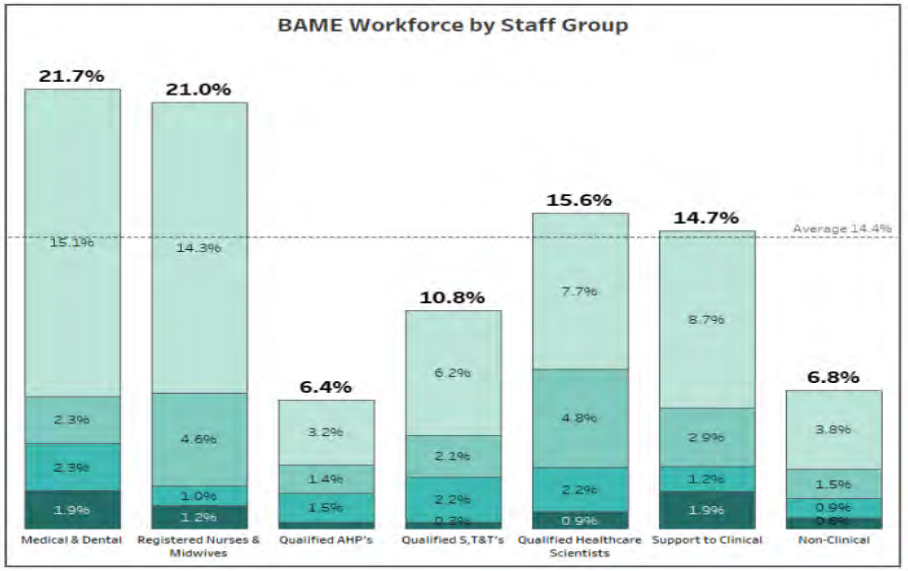
2. **Workforce ethnicity proportion NHS –** By ICS and by role shows that across all the SW systems/ICSs, BSW is the second most diverse in terms of workforce with 14.4% of staff categorised as BAME with the highest proportion of diversity within Medical and Dental and Nursing professions. In contrast AHPs have the least diverse workforce with more work needed to attract minority groups to the profession (this may however be influenced by international recruitment priorities).

as at March 2021

Asian/ Asian British
Black/ Black British
Multiple Ethnic Groups
Other Ethnic Group

White	Asian/ Asian British	Black/ Black British	Multiple Ethnic Groups	Other Ethnic Group	Not Stated
80.9%	9.1%	2.8%	1.2%	1.2%	4.7%
15,162	1,712	531	234	216	880





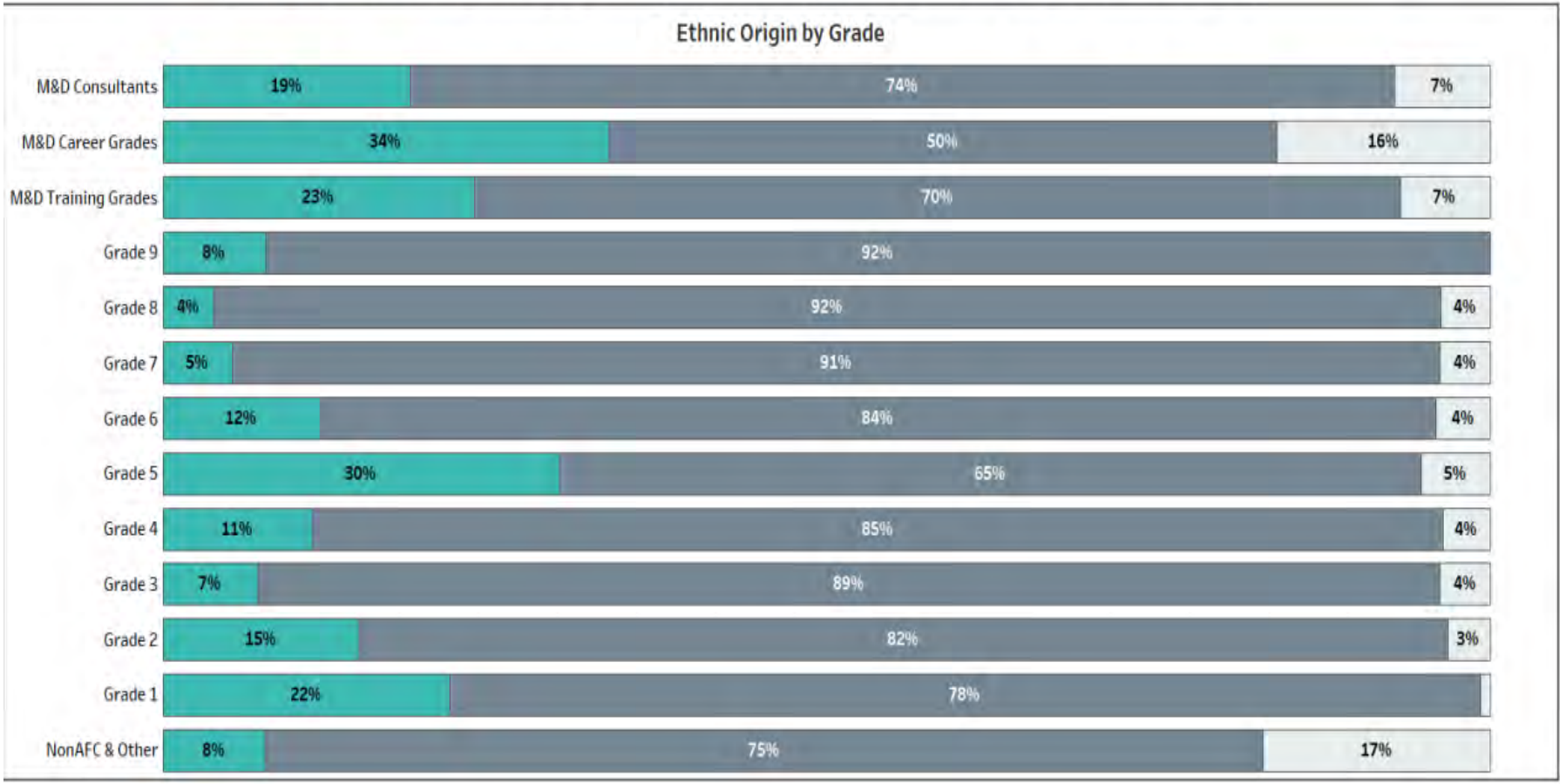
3. The following two tables outlined the workforce diversity by band as at December 2020 and March 2021. The data demonstrates that within NHS Agenda for Change bands there has been a slight improvement in the % of staff from minority groups occupying roles at bands 7 and above so gradually the diversity of our leadership groups are improving.

December 2020

as at December 2020

BAME
White
Not Stated

% of BAME Representation by Grade						
M&D Consultants	M&D Career Grades	M&D Training Grades	Grade 7-9	Grade 5-6	Grade 1-4	NonAFC & Other
18.6%	33.6%	23.4%	4.7%	21.3%	11.5%	7.7%

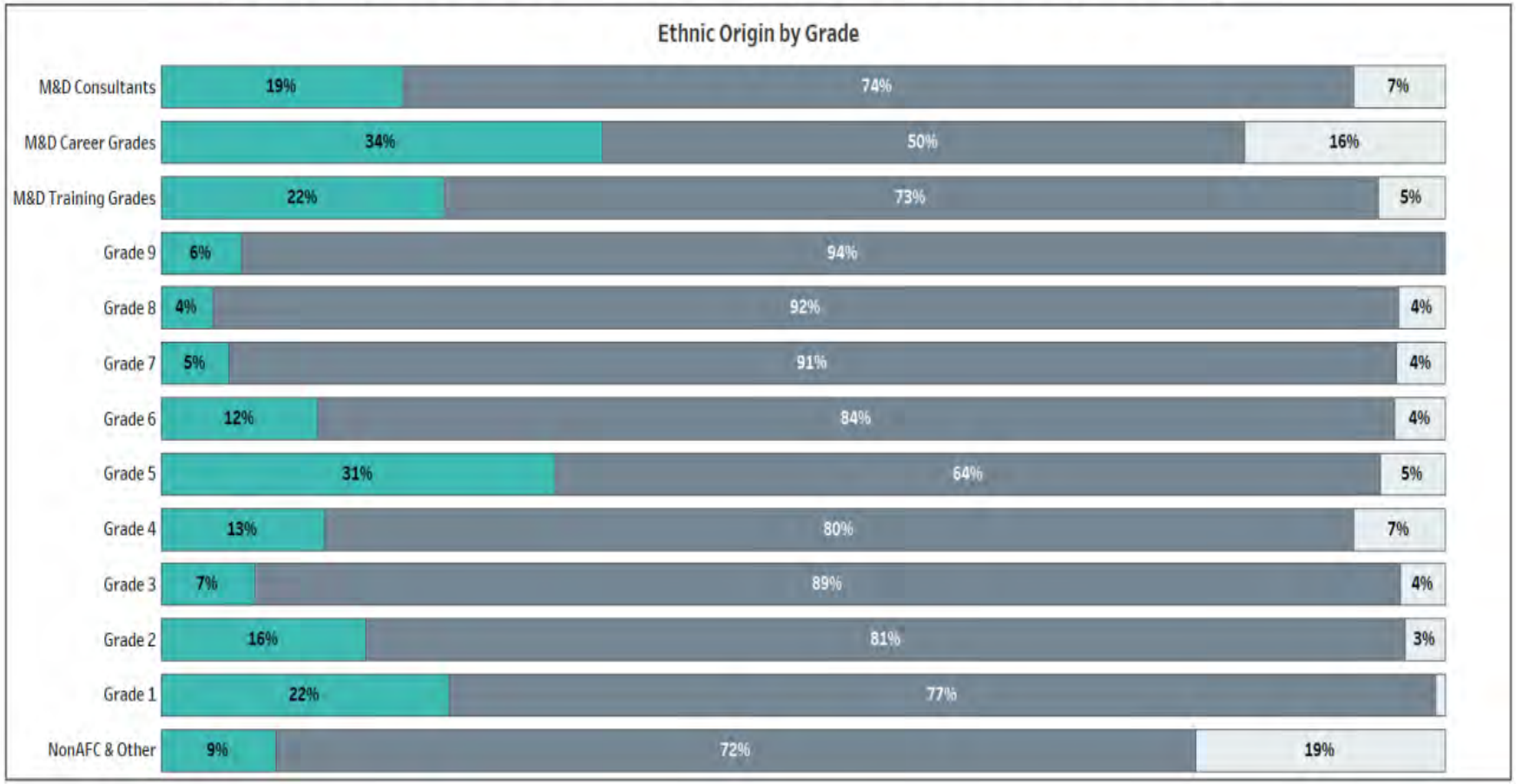


March 2021

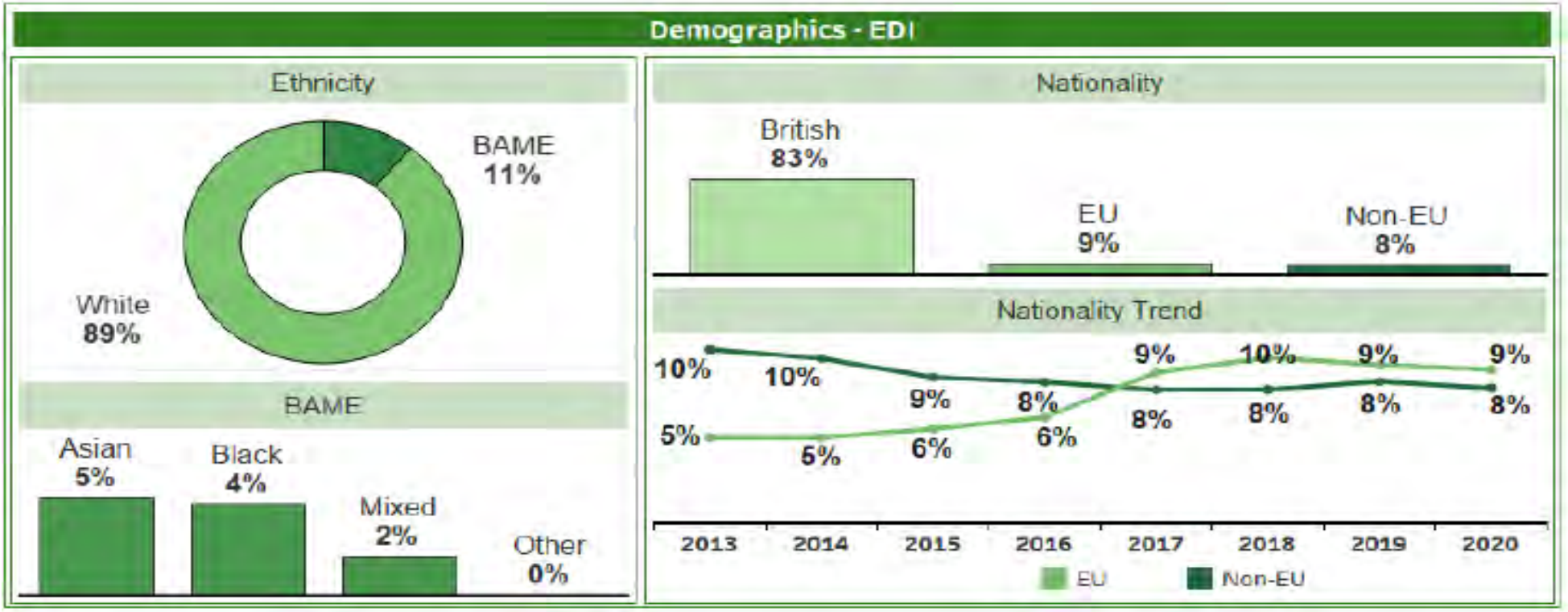
as at March 2021

BAME
White
Not Stated

% of BAME Representation by Grade						
M&D Consultants	M&D Career Grades	M&D Training Grades	Grade 7-9	Grade 5-6	Grade 1-4	NonAFC & Other
18.9%	34.4%	22.0%	4.8%	21.8%	12.4%	9.0%



BSW Social Care ethnicity data as at March 2020 shows that there is comparatively fewer staff (45), identified as BAME employed in BSW Social Care than in the NHS



Projects that are supporting this aim of 'Ensure the diversity of our staff reflects the diversity of our communities' include Projects:

Project 1: Increase diversity of our workforce

Aim: In line with People Plan actions improve the diversity of our teams including senior leadership and reduce the inequality between those entering disciplinary procedures.

Actions	Outputs
1. Procure and market Level 7 Senior Leaders apprenticeships for minority groups using EDI networks	1. BSW Managers training session on unconscious bias have been developed, funding obtained and training procured, for an initial 200 place aimed at colleagues in health and social care.
2. Education for managers in unconscious bias.	2. Level 7 Senior Leaders Apprenticeship procured with targeted marketing.
3. Values based recruitment – BSW toolkit and approach developed to be used by all partners.	3. Values based recruitment approach help eliminate opportunity for biased decision making. Values based recruitment toll kit including a question bank and scoring matrices.
4. Delivery of enhance recruitment action plan across BSW.	4. BSW enhanced recruitment 3 year action plan devised and agreed – using WRES data to benchmark. System monitoring and reporting arrangements defined and agreed.

Conclusion

As a system and workstream focused on staff recruitment, retention and supply we have attempted to use our workforce data included in this document to identify key risks and prioritise actions to mitigate or reduce risks. Furthermore, we have identified baselines and in some areas are able to identify improvements across the course of the BSW workstreams (since September 2020). We have also been able to identify key gaps in the data – such as data from Healthcare providers not on ESR. Development of the BSW workforce intelligence infrastructure and dashboard is ongoing and we continue to engage with system-wide providers to strengthen our intelligence in both coverage and accuracy.

The data demonstrates that the identified four main areas of focus for RRS, some of which were instigated by the People Plan actions, aligns to data and is substantiated. In all projects highlighted a process of scoping and survey has helped us identify, in more detail where we are as a system, where best practice areas are and could be shared, and where the areas of improvement are.

A. **Increase supply to reduce BSW vacancies** – the data demonstrates that the vacancy rate has reduced and the number of staff in post has increased during the project timeframe so far however we need to continue and embed some of these new initiatives further if we are to continue this trend, whilst recognising that we have an ageing workforce who may retire over the next 0 - 10 years.

B. **Retention of essential skills and staff resource post 55 years** – The data shows the extent of this risk and confirm that the dedicated projects that started in March this year are required to ensure we support our staff to continue to have fulfilled and long careers, which provide them with job satisfaction and the flexibility they desire. Our over 55s survey has helped our staff to understand that we are listening and we want to hear and respond to what they want. The dedicated work in this area also needs to be set against the backdrop of the McCloud judgement on pensions where we could see more staff choosing to retire before April 2022.

C. **Increase retention across BSW of our staff (aligned to workforce plan defined risks)** - The data in this pack demonstrates that we saw a steady decline in retention from March 2021 to June 2021. Our projects to address this and to increase retention have been chosen both for the evidence base of success where similar projects have been introduced – e.g. Itchy Feet conversation and using the views and feedback of our staff – e.g. talent pools and flexibility initiatives. These projects not only will provide processes to address retention but also aim to start essential cultural change that considers the needs and wants of our staff by default.

D. **Ensure the diversity of our staff reflects the diversity of our communities** – the data demonstrates small improvements in the diversity of the workforce and shows that BSW has as a system started to address this well in comparison with other systems. The projects and current programme of education for managers aim to build this positive start in the next 1-3 years as there is more to do on this important agenda.

The scoping and use of data has allowed us to focus on actions for BSW that are having a positive impact on our workforce challenges in an extremely busy operational environment where there are multiple initiatives and projects suggested and available to deliver. However, whilst we can see improvement in some areas which is encouraging, we must view this as just the start of our journey to address our workforce challenges.

Item 10, Greener BSW: presentation on the day

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

Meeting of the BSW Partnership Board

Report Summary Sheet

Report Title	ICB Governance Blueprint					**Agenda item**	10	
Date of meeting	1 October 2021							
Purpose	Note		Discuss	x	Inform	x	Assure	
Author, contact for enquiries	Anett Loescher, BSW CCG Deputy Director of Corporate Affairs							
Appendices	Draft ICB Constitution							
This report was reviewed by	Stephanie Elsy, Chair designate of the BSW ICB Tracey Cox, BSW ICS CEO System Architecture and Local System Working Group							
Executive summary	In March 2022 each ICB CEO designate and their relevant regional director will be asked to co-sign a 'readiness to operate statement' (ROS) to confirm that: • all legally required and operationally critical elements are in place ready for the establishment of the ICB as a statutory body on 1 April 2022; • arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership with the relevant Local Authority/ies. In order to give this confirmation, we are progressing the development of an overall ICS governance blueprint, setting out the key governance, decision-making, and assurance arrangements for the BSW system from April 2022 onwards. Key discussions are underway, including re • transition of current system governance and assurance structures into proposed arrangements for the ICS from April 2022 onwards; • shape, functions and roles of the place-based partnerships; • assurance arrangements, incl. effective and non-duplicative performance oversight and reporting. A key component of the overall ICS governance is the Integrated Care Board (ICB), the statutory NHS body to be established on 1 April 2022.							

	The Health and Care Bill mandates that the CCG proposes the constitution of the initial ICB to NHS, and that before it makes this proposal, the CCG consults all it considers relevant on this constitution. This paper presents the context for the draft ICB constitution, in particular the anticipated functions of the ICB. Against the background of the Health and Care Bill and ICS development guidance, this papers also presents possible configurations of the ICB Board (the ICB's governing body); an agreed determination of the ICB Board membership will be enshrined in the ICB constitution. This paper also presents initial thinking regarding the ICB Board's committee structure. All these are subject to further development, in view of legislation, feedback from our stakeholders, and final design of operating models and ICS governance arrangements. The paper refers to, but does not cover, the Integrated Care Partnership (ICP). This will be covered separately in due course.
Equality Impact Assessment	The ICB will need to have an effective understanding of different sectors, groups and networks and the needs of diverse populations.
Public and patient engagement	N/A
Recommendation(s)	The BSW Partnership Board is invited to: • consider, and comment on, the draft ICB Constitution, in particular size and composition of the ICB Board; • socialise the draft ICB Constitution to their respective Boards, and identify any calibrations / amends that may be necessary to organisations' schemes of delegations in particular, in order to ensure that ICB Board members coming from organisations can fully participate in ICB Board decision-making; • consider, and comment on, the proposed emerging governance and decision-making arrangements for the BSW ICB.
Risk (associated with the proposal / recommendation)	High | Medium **x** | Low | N/A
Key risks	Components of the Readiness to Operate framework are not developed / in place in time, jeopardizing sign-off by NHSE and establishment of the ICB on 1 April 2022.
Impact on quality	The ICB will need to have a strong focus on quality and patient safety with robust oversight and monitoring mechanisms and a continuous focus on quality improvement.
Resource implications	None at this stage. The development of the ICB and Constitution is being managed within existing CCG resources.
Conflicts of interest	The members of the BSW Partnership Board are inherently conflicted with regards to the ICB Constitution, and the proposals for

	the ICB Board membership in particular. This is true also for the Board and governing bodies of the BSW Partner organisations
This report supports the delivery of the following BSW System Priorities:	☒ Improving the Health and Wellbeing of Our Population ☒ Developing Sustainable Communities ☐ Sustainable Secondary Care Services ☐ Transforming Care Across BSW ☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan

Policy background

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined-up services, and to improve the health of people who live and work in their area.
ICSs exist to achieve four aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

The government has set out plans to put ICSs on a statutory footing.

Statutory component parts of an Integrated Care System (ICS)

Statutory component parts of an ICS are an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).

The ICP is a statutory committee established locally and jointly the ICB and the Local Authorities in the ICB's area. It has a specific responsibility to develop an 'integrated care strategy' for the area's whole population, covering health and social care, and addressing health inequalities and the wider determinants which drive these inequalities. We envisage this to be the key body for developing the overarching vision and strategy for health and care in BSW – a forum that brings together a wide range of partners and organisations who each contribute their respective expertise, and leverage their influence, to develop a holistic strategy that articulates a longer-term view of how partners – local authorities, the VCSE sector, the NHS, anchor institutions, education, housing to name a few – will each contribute to the improvement of outcomes in population health and healthcare, and tackle inequalities in outcomes, experience and access.

The ICB is a statutory NHS body / organisation that will bring partner organisations together in a new collaborative way with common purpose; and will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. In that sense, the ICB is a key delivery vehicle for the ICP strategy.

The ICB can only be formally established if we meet the requirements of the Readiness to Operate framework (ROS), among them the requirement to have in place the ICB Constitution, including the Standing Orders and agreed ICB name, approved by NHS England before 1 April 2022, and ready to be adopted on 1 April 2022.

As a joint committee of the ICB and the local authorities in the ICB area, the ICP can only be set up once the ICB is formally established. There is thus an implied timeline which gives priority to the formal steps we need to take to establish the ICB on 1 Aril 2022. In contrast, there is a more developmental approach to the ICP: the national expectation is that we have initial ICP arrangements agreed, including principles for operation from 1 April 2022, with further iterative steps following from April 2022 to consolidate the ICP.

We will provide regular updates to the Partnership Board on progress with the ICP development.

The draft BSW Integrated Care Board (ICB) Constitution

The key formal step toward establishing the ICB in the BSW area is the creation of the ICB Constitution. NHSE have issued a model ICB Constitution and accompanying supporting notes; the model is aligned with the Health and Care Bill and subject to further amends as the Bill progresses through the legislative process. There is a clear national expectation that the model constitution is adopted, and that ICBs-to-be apply a 'comply-or-explain approach', i.e. provide a rationale for any deviations from the model.

We present today a first draft of the ICB Constitution. This is a live document and will evolve over the next weeks. Notes to readers as well as highlighted proposals set out our thinking. In particular, we invite feedback and responses from all members of the Partnership Board to the draft and the proposals contained within. We also invite you to socialise the draft with your organisations' Boards and Governing Bodies, and to seek feedback and responses there. This engagement with our partners and stakeholders forms the consultation that the Health and Care Bill requires CCGs to undertake before formally proposing the constitution of the ICB to NHSE[1].

Anticipated functions of the ICB[2]

Per national guidance and legislation, the BSW ICB (the statutory NHS organisation) will have the following functions:

- Developing a plan to meet the health and healthcare needs of the population (all ages) within BSW, in view of the ICP's integrated health and care strategy;
- Allocating NHS resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital);

[1] Health and are Bill, Part 1, 14Z26 Process for establishing initial integrated care boards.
[2] cf. Interim guidance on the functions and governance of the Integrated Care Board; and Interim guidance on the functions and governance of the Integrated Care Board. Statutory CCG functions to be conferred on ICBs, which includes a full list of CCGs' statutory functions

- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan
- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
- Arranging for the provision of health services in line with the allocated resources across BSW through a range of activities, incl. putting contracts and agreements in place to secure delivery of its plan by providers; convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes; support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships; working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people;
- Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers;
- Leading system-wide action on data and digital;
- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes;
- ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability;
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability;
- Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement;
- Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services.

Subject to the legislation, most CCG statutory functions will likely be conferred on ICBs in April 2022, along with the transfer of all CCG assets and liabilities (including commissioning responsibilities and contracts), when they are established.

Under the proposed legislation the ICB will have more flexibility than the CCG has currently to delegate certain functions, in particular to NHS trusts and Foundation Trusts, so that these organisations can exercise the function on behalf of the ICB. The ICB will continue to be held to account for the way in which the function has been discharged, and will have to continue to monitor how the delegation is operating and whether it remains appropriate. It is important to note that individual NHS provider organisations will remain as accountable and statutory bodies in their own right. However from the delegation of ICB

functions to providers, and the ICB's ability to allocate resource arise significant authority and influence, for the ICB, to operate in the best interests of the system.

This informs the role and functions of the ICB Board, as the ICB's governing body. The ICB model constitution is silent on the functions of the ICB Board. The Interim guidance on the functions and governance of the integrated care board[3] sets out typically expected functions of an ICB Board.

Membership of the ICB Board

First and foremost, legislation will stipulate the statutory members of the ICB Board. The current Health and Care Bill determines that an ICB Board must comprise:

- the Chair (independent)
- the Chief Executive (must be employed by / seconded to the ICB)
- one member nominated jointly by the NHS trusts and NHS foundation trusts that provide services in the ICB area
- one member nominated jointly by those providing primary care services in the ICB area
- one member nominated jointly by the local authorities in the ICB area

National guidance determines that the following are also members of an ICB's Board:

- a minimum of two other independent non-executive members
- Chief Finance Officer (must be employed by / seconded to the ICB)
- Director of Nursing (must be employed by/seconded to the ICB)
- Medical Director (must be employed by/seconded to the ICB)

All of the above are voting members. An ICB can appoint additional members to its Board (with voting rights).
What is more, the ICB Board can also determine and invite regular attendees to its meetings. Such regular attendees do not have voting rights, but will typically be in positions of significant influence and therefore critically inform the ICB Board's business and decisions.

It is important to note that the ICB Board is not a representative forum – its members are expected to bring the specific expertise and perspective of NHS trusts, local authorities, primary care etc, but they must not act as representatives of these sectors.
To note also that once agreed and enshrined in the constitution, the ICB Board configuration is not easy to amend.

In presenting two possible configurations of the ICB Board, we have taken into account:

- statutory requirements and national expectations for ICB Boards as outlined above;
- good governance practice re the size of a Board, to ensure it can make and take decisions effectively;
- 'what is right for BSW' – our system's specific local context, challenges and outlook should inform the ICB Board membership;

[3] Interim guidance on the functions and governance of the integrated care board

- how membership on other bodies, in particular the ICP, may influence membership of the ICB Board;
- the value of diversity;
- the potential ICB Board committee structure to support the ICB Board in discharging its functions, and implications of that on ICB Board membership.

The below sets out initial thinking, as well as a summary of pros and cons for each permutation.

We invite feedback and comments from Partnership Board members.

Possibility 1 –
22 members, meeting the minimum requirements as prescribed by Health and Care Bill, meeting national expectations set out in guidance, and reflecting BSW

Statutory members:	**NHS guidance:**	**What's right for BSW – additional members**
• the Chair • the Chief Executive • one member nominated jointly by the NHS trusts (guidance: expect this will often be the chief executive) • one member nominated jointly by primary care providers (guidance, draft legislation: neither articulates expectations re seniority, though PCN Clinical Director or similar level seems appropriate) • one member nominated jointly by the LAs (expect this will often be the chief executive of their organisation or in a relevant executive-level local authority role (*note: a member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland can not be a member of the ICB Board, cf. ICB model constitution*)	• NED* (Audit) • NED** (Remuneration and People) • Director of Finance • Director of Nursing • Medical Director	• two members from LAs (i.e. all 3 LAs on the Board) • one member nominated by the VCSE sector • one member nominated by community providers • one member nominated by mental health providers • one member representing provider collaboratives • the three Chairs / Convenors of the three place-based partnerships • one NED (Finance) • one NED (Quality; clinical experience) • one NED (Lived experience and public engagement)
6 regular attendees (no voting rights, can inform and participate in discussions): Place COOs; the ICP Chair; ICB Director People / Workforce; ICB Director Communication; Healthwatch		
Meetings normally held in public, meeting papers published on ICB website, and members of the public welcome to observe meetings (i.e. no participation in proceedings)		

Pros:
- Representative of all key stakeholders in BSW
- Quite large number of clinical leaders (7), reflecting the importance we attach to clinical leadership
- No member is expected to 'wear multiple hats' (e.g. the member jointly nominated by the NHS trusts would not need to represent both the trust sector and the provider collaboratives)
- The number of NEDs means there is a good pool of independent leadership (to chair Board committees and tie in with governance at place), and a good proportion of independent perspective and challenge

Cons:
- A representative, large Board (good practice is ca. 12 members) that may find it hard to make and take decisions effectively and efficiently
- A cautious model of Board composition that
  - focusses on being representative of BSW – note that the national steer is clearly away from Boards as representative forums towards Boards as oversight and decision-making bodies; consider how this Board composition could lead to membership overlap and mission creep between ICB and ICP
  - could be seen as reflecting a system that is still progressing towards, rather than having reached, maturity

* It is a statutory requirement for ICBs to have an Audit Committee. This must be chaired by a NED with relevant expertise. It is therefore a given that the ICB Board must have a NED (Audit)
** One NED (not the one fulfilling the role as Audit Chair, and not the ICB Chair) should fulfil the role of Senior Independent Director (SID), who would take a role in the Chair's appraisal. This NED could be appointed Chair of the Remuneration Committee, which the ICB is required to have. In BSW, they could also lead a People and Workforce Committee (if created). This NED would need to have experience / skills in HR and OD.

Possibility 2 –
15 members, meeting the minimum requirements as prescribed by Health and Care Bill, meeting national expectations set out in guidance, and reflecting BSW

Statutory members:	**NHS guidance:**	**What's right for BSW – additional members**
• the Chair • the Chief Executive • one member nominated jointly by the NHS trusts (guidance: expect this will often be the chief executive) *and also serving as representative of provider collaboratives* • one member nominated jointly by primary care providers (guidance, draft legislation: neither articulates expectations re seniority, though PCN Clinical Director or similar level seems appropriate) *and also serving as representative of 'place'* • one member nominated jointly by the LAs (expect this will often be the chief executive of their organisation or in a relevant executive-level local authority role (*note: a member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland can not be a member of the ICB Board, cf. ICB model constitution*)	• NED* (Audit) • NED** (Remuneration and People) *and also bringing lived experience* • Director of Finance • Director of Nursing • Medical Director	• two members from LAs (i.e. all 3 on the Board) *and also serving as representatives of 'place'* • one member nominated by the VCSE sector • one member from mental health provider/s *and also serving as representative of community providers* • NED (Finance)
At least 6 regular attendees (no voting rights, can inform and participate in discussions): Chairs of the Place-based Partnerships (3); the ICP Chair; ICB Director People / Workforce; ICB Director Communication; Healthwatch; representatives from community providers and provider collaboratives		
Meetings normally held in public, meeting papers published on ICB website, and members of the public welcome to observe meetings (i.e. no participation in proceedings)		

Pros:
- A smallish Board (good practice is ca. 12 members) that may find it easier to coalesce around decisions effectively and efficiently
- A Board that demonstratively moves away from representing all stakeholders, which would signal maturity of the system and focus of the Board on oversight and decision-making

Cons:
- Some stakeholders may feel alienated by not being members of the ICB Board, or feel 'demoted' if invited to attend as regular attendees without voting rights
- Some members are expected to 'wear multiple hats' which may be hard to manage for the individuals, and also re conflicts of interest

* It is a statutory requirement for ICBs to have an Audit Committee. This must be chaired by a NED with relevant expertise. It is therefore a given that the ICB Board must have a NED (Audit)
** One NED (not the one fulfilling the role as Audit Chair, and not the ICB Chair) should fulfil the role of Senior Independent Director (SID), who would take a role in the Chair's appraisal. This NED could be appointed Chair of the Remuneration Committee, which the ICB is required to have. In BSW, they could also lead a People and Workforce Committee (if created). This NED would need to have experience / skills in HR and OD.

We are currently working through potential ICB Board committee structures. Much of this depends on how much the ICB Board itself wishes to delegate to any committees that it wishes to establish. Other factors are current work to design the ICB's future operating model; relationships between the ICB and partner organisations / forums, in particular with the ICP and the place-based partnerships; statutory requirements – we know that an ICB Board is required to have a Remuneration Committee, and an Audit Committee (this is also enshrined in the model ICB Constitution).

As with the governance design for the ICB and the ICS overall, we are guided by the principle of 'form follows function', and are mindful that the chart overleaf is a first outline of potential structures that will evolve.

Next steps

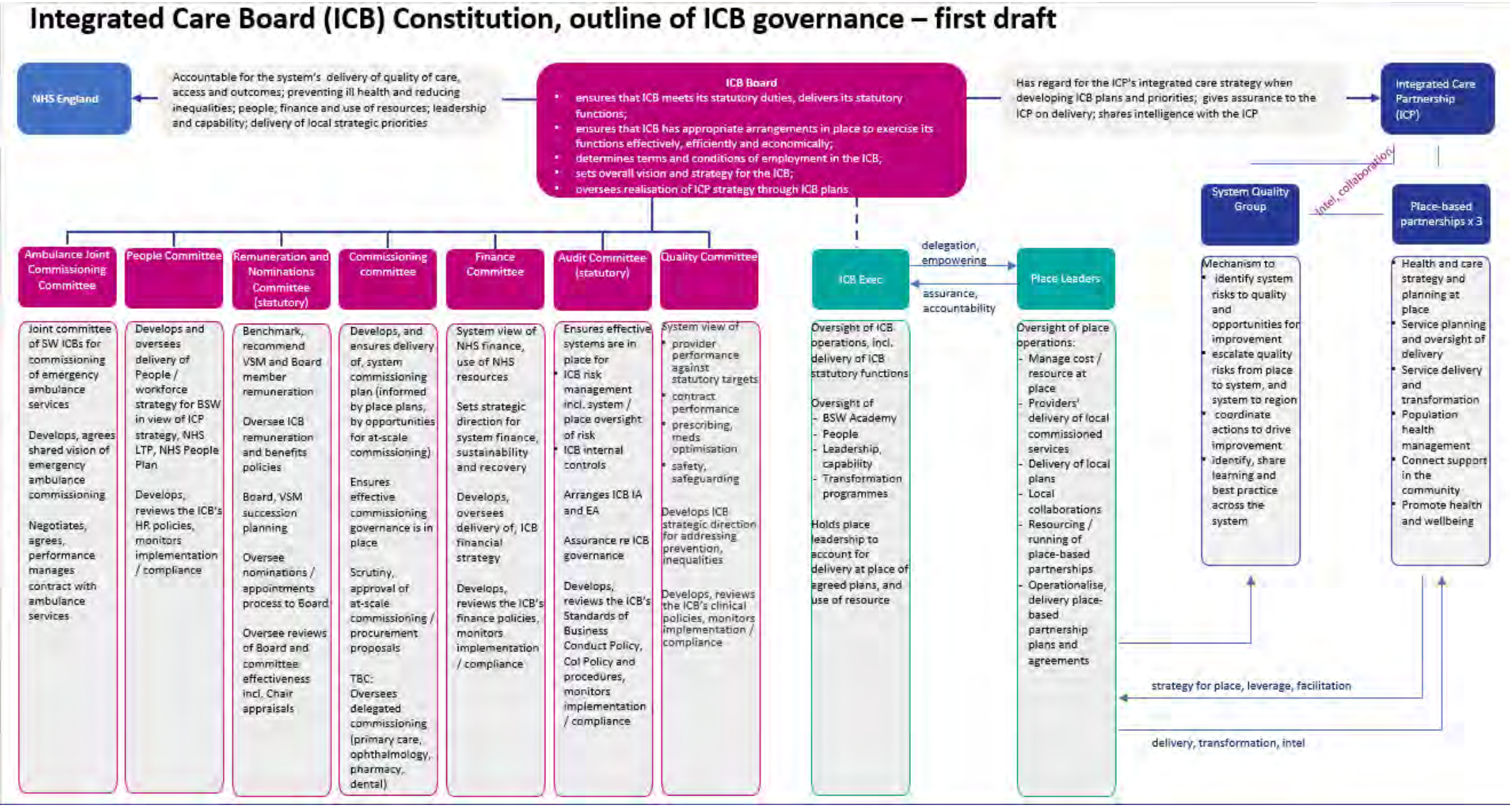
NHSE published an updated ICB establishment timeline on 23 September 2021.
Per this timeline, next steps include:

- conclude engagement with partners re ICB Board size and composition by 17 November 2021;
- agree size and composition of ICB Board with NHS region by 19 November 2021 (with input from CCG and designate ICB CEO);
- conclude engagement with partners re all other aspects of the Constitution, incl. nomination process for Partner Members by 30 November 2021;
- submit draft constitution to NHS region 3 December 2021, region to feed back by 21 December 2021;
- submit final draft Constitution to regional team by 11 March December 2022, for NHS region sign-off by 18 March 2022.

We wish to continue our engagement with the Partnership Board as we continue to develop the ICB's governance, as part of the wider ICS governance and assurance architecture.
We will therefore bring further iterations of the ICB Constitution to the Partnership Board in November 2021.

We will also seek the Partnership Board's input into our development of arrangements for the ICP, and anticipate to bring a first draft to the Partnership Board in November 2021.

Integrated Care Board (ICB) Constitution, outline of ICB governance – first draft



Notes for readers

This draft BSW Partnership ICB Constitution is prepared in the template provided by NHSE in August 2021. We have produced this draft with close reference to the supporting notes that NHSE issued alongside the model constitution – these supporting notes can be made available on request.

Superscript numbers in red indicate the relevant applicable supporting note.

Text in black indicates a legal or policy requirement and should be retained unless we agree this otherwise with NHS England.

Text in green indicates a clause which is optional, or which requires local completion. The supporting notes explain more about what is required and also provide examples.

We have inserted orange boxes that draw readers' attention to particular nuances, questions for further discussion, or points of note that may have an impact on the way in which we phrase provisions in this Constitution.

We welcome feedback from Partnership Board members on this draft, and endeavour to integrate it in future iterations of this draft. We will maintain a log of feedback and changes made, to document our consultation activity with our partners in the course of developing this Constitution, as required.

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

NHS Bath and North East Somerset, Swindon and Wiltshire Partnership

Integrated Care Board

CONSTITUTION

Version	Effective Date	Changes	Approval by
V0.1	n/a	First draft BSW ICB Constitution, for discussion (BSW Partnership Board, 1 October 2021)	n/a

CONTENTS

1. Introduction

The template suggested an optional introduction to set the context for the ICB, describe how the ICB differs from organisations that have preceded it, introduce the partners taking part in the local arrangements, or draw out the mutual. accountability agreed between the partners. None of this is legally required for inclusion in the constitution.

Proposal:

We propose to focus the constitution on the set-up and decision-making arrangements of the ICB. The proposed introduction text therefore only briefly describes the purpose of the ICB.

Other contextual and background information could be more appropriately presented in other documents, incl. the mandatory Governance Handbook

1.1 Purpose

1.1.1 The Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board ("the ICB") was established to arrange for the provision of services for the purposes of the health service in England in accordance with the National Health Service Act 2006.

1.1.2 The ICB exists to support the delivery of the BSW Integrated Care System's (ICS) core purposes:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

1.2 Name

1.2.1 The name of this Integrated Care Board is [2] NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB[3] is coterminous with Bath and North East Somerset Council, the Borough of Swindon plus Shrivenham, and Wiltshire Council.[4]

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).[5]

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at [insert link on ICB website]

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the EU General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—

h) section 14Z34 (improvement in quality of services),
i) section 14Z35 (reducing inequalities),
j) section 14Z38 (obtaining appropriate advice),
k) section 14Z43 (duty to have regard to effect of decisions)

l) section 14Z44 (public involvement and consultation),
m) sections 223GB to 223N (financial duties), and
n) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z58 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z59).

1.5 Status of this Constitution

1.5.1 The ICB was established on [date] by [name and reference of establishment order], which made provision for its constitution by reference to this document.

This can only be completed on receipt of the establishment order, following NHSE's approval of the Constitution. Expect establishment date of 1 April 2022.

1.5.2 Changes to this constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 14 of Schedule 1B to the 2006 Act this constitution may be varied in accordance with the procedure set out in this paragraph. The constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure[6] and that application is approved; and

b) where NHS England varies the constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the constitution is as follows:[7]

a) The Accountable Officer may periodically propose amendments or variations to this Constitution which shall be considered and approved by the ICB Board through a simple majority vote, for submission to NHS England, unless:
   i. changes are thought to have a material impact;
   ii. changes are proposed to the reserved powers of the Board

   In case of i. or ii. above, a 75% majority of votes must be cast in support of the proposed amendments or variation.

b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a constitution:

a) Standing Orders– which set out the arrangements and procedures to be used for meetings and the selection and appointment processes for the ICB committees.

1.7.3 The following do not form part of the constitution but are required to be published.

a) The Scheme of Reservation and Delegation (SoRD)[8]– sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the constitution. The SoRD identifies where / who functions and decisions have been delegated to.

b) Functions and Decision Map[9]- a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs.

d) The ICB Governance Handbook[10]– which includes:

- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions[11].
- Delegation arrangements[12] for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to

a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.

- [Add other key contents].

Proposal:

The required content of the Governance Handbook as outlined in the three bullet points above is extensive.

We propose that this Constitution does not reference other key content of the Governance Handbook, as this would commit the ICB to indeed include and publish such additional content. Instead, we propose that we maintain some design freedom – we can include further content in the Governance Handbook without stating this here in the Constitution. Examples of such additional content are MoUs of place-based partnerships.

e) Key policy documents[13] **-** including:

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement

Proposal:

We expect that statutory guidance regarding Conflicts of Interest management for ICBs will be quite similar to that currently applicable to CCGs.
The CCG's Standards of Business Conduct Policy can relatively easily be updated and adapted to become the ICB's Standards of Business Conduct Policy, and the ICB's Conflicts of Interest Policy.

The Policy for public involvement and engagement is recognised as a new requirement, and work is planned to develop such a policy (ready by April 2022).

Proposal:
To insert the following section and provisions. The ICB Model Constitution is silent on the role and functions of the ICB Board. Including the proposed section in the BSW ICB Constitution may support clarity of purpose and functions vis-a-vis the Integrated Care Partnership and other component parts of the ICS.

2 The Board of the ICB: its role and functions

2.1.1 The Board has responsibility for:

a) ensuring that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the ICB's principles of good governance; and for

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the ICB and the allowances payable under any pension scheme established.

2.1.2 The SoRD sets out the functions that the Board reserves for itself.

2.1.3 The detailed procedures for the Board, including voting arrangements, are set out in the Standing Orders.

3 Composition of The Board of the ICB (section 2 in the model Constitution)

3.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in the Standing Orders.

3.1.2 ~~Further information about the individuals who fulfil these roles can be found on our website [add link].~~[14]

Proposal: To omit provision 3.1.2.

The ICB will have to meet the requirements of the Freedom of Information Act 2000. We propose to follow the Information Commissioner's Office model publication scheme and the specific expectations for health bodies in England, and to publish information about the ICB Board members on the ICB website.

3.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary members.

3.1.4 The Ordinary[15] Members include at least three members who will bringing knowledge and a perspective from their sectors. These members (known as Partner Members) are identified and appointed in accordance with the procedures set out in ~~Section 3 below~~ the Standing Orders**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are or a prescribed description
- the local authorities whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

3.1.5 The ICB has [3][16] Partner Members.

3.1.6 As per NHS England Policy[17], the ICB has appointed the following additional Ordinary Members:

a) three executive members, namely:
- Director of Finance
- Medical Director
- Director of Nursing

b) Two[18] independent non-executive members, namely:

3.1.7 The ICB has also appointed the following further Ordinary Members to the Board[19]

a) List locally agreed additional members

Cf. ICSPB-21-22-026a for possible configurations of the ICB Board – the agreed form will be inserted into the Constitution.

3.2 Regular Attendees at Board Meetings[20]

3.2.1 The Board may invite other person(s) to attend all or any of its meetings, in order to inform its decision-making and the discharge of its functions as it sees fit.

3.2.2 Such regular attendees[21] will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

Note:
The Constitution need not set out the regular attendees.
By stating regular attendees in the Constitution, the ICB commits to issue standing invitations to the identified individuals, and it will require a change of Constitution to amend arrangements.

3.2.3 ~~The Board may admit observers[23] will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.~~

Proposal:
Omit the optional clause 3.2.4 (2.2.4 in the model constitution)
Admittance of observers, in particular members of the public, to Board meetings is regulated through the Standing Orders. Inserting this into the Constitution main text potentially confuses matters.
We envisage a continuation of current practice of advertising meetings through the website and inviting members of the public to observe meetings.

3 Appointments Process for the Board

Provision 3.1, Eligibility for Board Membership, through to provision 3.14, Terms of Appointment for Board members

Proposal:
To move Section 3, i.e. the procedural description of Board members' eligibility and appointment, in its entirety from the Constitution main text into the Standing Orders, see Standing Orders section 4, p.31ff.

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance in the way it conducts its business. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

~~4.1.2~~ ~~The ICB has agreed a code of conduct and behaviours[64] which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.~~

Proposal:
To omit the optional provision 3.1.2.
Instead of a separate ICB code of conduct, the ICB Standards of Business Conduct Policy could serve as the vehicle to set out expected behaviours of Board and committee members, and employees of the ICB also.
Behaviours and expectations could include:

- Adherence to the Good Governance Standard for Public Services
- Adherence to the NHS Constitution

- ICB has in place standards and procedures that facilitate speaking out and the raising of concerns, including a freedom to speak up guardian
- Framework for speaking on behalf of the ICB, the ICP, the ICS

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care;
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England;
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) its Board;
b) any of its ~~members or~~ employees;
c) a committee or sub-committee of the ICB;
d) any other individual who may be from outside the organisation and who can provide assistance to the ICB in delivering its functions.

Proposal:
To add point a), for clarity that the ICB Board may act on behalf of the ICB.
To delete 'members' from point b) – the ICB is not a member organisation, and therefore cannot authorise members to act on its behalf.
Point c) captures the ICP, which is a joint committee of the ICB and the local authorities.
To add point d).

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for

the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

Proposal:
Insert the following provision, for clarity and avoidance of doubt.

4.3.4 The extent of the respective bodies' and individuals' authority to act and of the powers delegated to them by the ICB is expressed through:

a) the Standing Orders;
b) the Standing Financial Instructions and Delegated Financial Limits;
c) the CCG's SoRD; and
b) Committees' and sub-committee's Terms of Reference.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full [to be added – link to ICB website]

4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the Board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published [to be added – link to ICB website]

4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB;
b) Commissioning functions delegated to committees and individuals;
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

Note:
There is an expectation that a model functions and decisions map will be issued, for ICBs to adopt.
Meanwhile, we use the SoRD and governance charts to express a) to d) above.

4.6 Committees and Sub-Committees[65]

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference and membership agreed by the Board[66]. All terms of reference are published in the Governance Handbook.

Proposal:
The ToRs for committees of the ICB Board should set out that these committees may form sub-committees and approve these sub-committees' ToRs.
A Board-agreed framework should set tight parameters around the creation of committees and sub-committees, incl. regular review of the committee- and sub-committee structure to mitigate 'mushrooming' of committees.
The Standing Orders to regulate this is agreed.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB will be required to:

a) Have in place Terms of Reference that are approved by the relevant parent body, and align with the ICB's Constitution, Standing Orders, and Scheme of Reservations and Delegations;
b) Provide regular decision or assurance reports to the Board;[67]

c) Comply with internal audit findings and committee effectiveness reviews.

4.6.5 Any committee or sub-committee established in accordance with clause 3.6.4 may consist of, or include, persons who are not ICB members or employees.

4.6.6 All members of committees and sub-committees are required to act in accordance with this constitution, including the standing orders as well at the SFIs and any other relevant ICB policy.

4.6.7 The following committees will be maintained:

a) **Audit Committee[68]:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by an independent non-executive member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee[69]:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by an independent non-executive member other than the Chair or the Chair of Audit Committee.

Note:
Provisions 4.6.7a) and 4.6.7b) make clear that the ICB Board will at least have two independent NED members, and implies the required skills, experience and knowledge of those two NED roles.

Specifically re the Audit Committee:

- the AC should be made up of independent people – this may include the ICB Board's non-executive members but not the ICB Chair;
- not all members of the Audit Committee should be members of the ICB Board (this links with provision 4.6.5, permitting persons who are not ICB members or employees to be committee members;
- the Audit Chair should be an independent NED, and should not chair any other ICB committees; they may be the ICB's conflicts of interest guardian and freedom to speak up guardian

4.6.8 The terms of reference for each of the above committees are published in the governance handbook[70].

4.6.9 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published[71] in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

Note:
This concerns the delegation of ICB functions, i.e. delegation arrangements with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's [statutory] functions to be exercised by or jointly with that other body, or for the functions of that other body to be exercised by or jointly with the ICB.
The ICB and the other body can arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions.
Under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund

4.7.1 As per 3.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation[72]. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published [specify where - probably the governance handbook]

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions[73]

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders[74] is included in Appendix 2 and form part of this constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs are published in the ICB's Governance Handbook [insert relevant link to ICB website]

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest[75]

[DN: subject to change in line with NHS England guidance[76]]

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB website [insert link].[77]

6.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include, but not be limited to, declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy, and the Standards of Business Conduct Policy[78].

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian[79]. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;

e) Provide advice on minimising the risks of conflicts of interest.

Proposal:
To include a provision that
6.1.7 The ICB ensures that all ICB Board members, employees and other relevant individuals receive training on the identification and management of conflicts of interest, and that relevant employees undertake the NHS England Mandatory training.

6.2 Principles[80]

6.2.1 In discharging our functions the ICB will abide by the following principles:
a) Xxx
b) xxx

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers[81] of the interests of:
a) Members of the Board
b) Members of the Board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website [insert link][82].

6.3.3 All relevant persons as per 5.1.3 and 5.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 5.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

~~6.3.7 Interests[83] (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.~~

6.3.8 ~~Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be~~

~~managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed~~.

Proposal:
To omit provisions 6.3.7 and 6.3.8. This is articulated in the Conflicts of Interest / Standards of Business Conduct policies, incl. detail of processes and procedures, and linkage with other relevant policies such as data protection.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;

b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);

c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

~~**7.2 Principles**[84]~~

~~7.2.1 Add local principles~~

Proposal:
To omit provision 7.2.
Principles can be articulated, and translated into practice and actions via e.g. the ICB's Policy for public engagement and involvement

7.2 Meetings and publications

7.2.1 Board and committee meetings will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

Proposal:
To elaborate a little on provision 7.2.4, to clarify the scope of such complaints process, e.g. whether this means a route to complain about the ICB as an organisation; about specific ICB processes e.g. application of IFR or EFR policies; or about the ICS.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The constitution and governance handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests[85]
- ~~Key policies~~
- ~~add further documents.~~

Proposal:
To not include a list of publications in the Constitution beyond what is required per the model constitution. Other provisions detail already the documentation that the ICB must publish in order to ensure transparency, cf. 1.7.3, 4.4.1, 4.5.2, 4.6.3, 5.2.2, 6.2.1, 6.2.3, 6.4.

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z43 (have regard to effect of decisions)
- section 14Z44 (public involvement and consultation), and
- sections 223H and 223J (financial duties).

And

b) proposed steps to implement the XXX joint local health and wellbeing strategy(s)[86]

7.3 Scrutiny and Decision Making

7.3.1 At least three independent non-executive members will be appointed to the Board including the Chair; and all of the Board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

c) ensure that there are decision-making structures within the ICB that allow for decisions around arranging healthcare services line with the NHS Provider Selection Regime; [87]

d) ensure that there are appropriate governance structures to address any challenges that may follow decisions about provider selection;

e) ensure that local audit arrangements are capable of auditing the decisions made under the NHS Provider Selection Regime;

f) publish intentions for arranging services in advance;

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.4 Annual Report

7.4.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year and in particular how it has discharged its duties under sections

a) 14Z34 (improvement in quality of services),
b) 14Z35 (reducing inequalities),
c) 14z43 (have regard to the effect of decisions)
d) 14Z44 (public involvement and consultation), and

7.4.2 The annual report will also review the extent to which the ICB has exercised its functions in accordance with the plans published under section

a) 14Z50 (Integrated Care System plan), and
b) 14Z54 (capital resource use plan), and

7.4.3 The annual report will also review any steps the Board has taken to implement any joint health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee[88] which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.2.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) Add local arrangements e.g. HR advisers being in attendance or appointment of independent HR advice to the Rem com.

8.2.4 The Board may appoint independent members or advisers to the Remuneration Committee that are not members of the Board.

8.2.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board set out the duties of

the Remuneration Committee and are published in the Governance Handbook [add link on ICB website].

8.2.6 The duties of the Remuneration Committee include[89]:

a) Add local points

Proposal:
Omit provision 8.2.6, as this is duplicative of the more detailed Terms of Reference for the Remuneration Committee.
Provision 3.6.7 summarises the duties of the Remuneration Committee.

8.2.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z44(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board;
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z52 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) Add local arrangements – [to be added in light of the draft ICB Policy on public engagement and involvement]

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities[90].

b) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
c) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

d) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working.

e) Build relationships with excluded groups – especially those affected by inequalities.

f) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

g) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

h) Use community development approaches that empower people and communities, making connections to social action.

i) Use co-production, insight and engagement to achieve accountable health and care services.

j) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

k) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

~~In addition the ICB has agreed the following:~~[91]

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements include[92]:

l) ICB to specify other local arrangements [to be added in light of the draft ICB Policy on public engagement and involvement, and the policy expectations per ICS Design Framework and implementation guidance on working with people and communities] [93]

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB Board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
	ICBs should add local definitions as required and should always include any local terms that refer to legally prescribed roles or functions.

Appendix 2: Standing Orders

Note to readers:

Text in black is provided through the model ICB constitution, with the expectation that it is retained

Text in green is for local determination

Text in orange is lifted from the BSW CCG constitution and proposed for inclusion, for providing further clarity, detail, and avoidance of doubt.

1. Introduction[94]

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution[95].

1.2. These Standing Orders, together with the ICB's Scheme of Reservation and Delegation and the ICB's Standing Financial Instructions, provide the procedural framework within which the ICB discharges its business. They set out:

a) The arrangements for conducting the business of the ICB;
b) The procedure to appoint members of the ICB Board, and members of ICB committees and sub-committees;
c) The procedure to be followed at meetings of the ICB, the ICB Board and any committees or sub-committees of the ICB or the ICB Board;
d) The process by which powers are delegated.

1.3. These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate of any relevant guidance.

1.4. The 2006 Act provides the ICB with powers to delegate the ICB's functions and those of the ICB Board to certain bodies (such as committees) and certain persons. The ICB's Scheme of Reservations and Delegations (SoRD) sets out matters reserved, and delegations to committees, sub-committees and individuals. The SoRD is provided in the ICB Governance Handbook, but does not form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from xx [96]

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6 in the Constitution.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB constitution and will not be implemented until the constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from [add title for senior governance adviser,] will provide a settled view which shall be final.

3.5. All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit Committee for review.

The following section 4 was originally section 3 in the Constitution main text.
It describes processes and procedures, and so is proposed to sit here in the Standing Orders rather than the Constitution main text.

4 Appointments Process for the Board

4.1 Eligibility Criteria for Board Membership:

4.1.1 Each member of the ICB must:

a) Comply with the criteria of the “fit and proper person test”[24]

b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles) and will adhere to the ICB’s Standards of

Business Conduct Policy which includes the ICB's approach to identifying and managing conflicts of interest;

c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

4.2 Disqualification Criteria for Board Membership[25]

4.2.1 A Member of Parliament, or member of the London Assembly.

4.2.2 A member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland.

4.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or

b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

4.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Orde 1989 (which relate to bankruptcy restrictions orders and undertakings).

4.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

4.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office

b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,

c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or

d) of misbehaviour, misconduct or failure to carry out the person's duties;

4.2.7 A health care professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the

profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

4.2.8 A person who is subject to—

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

4.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

4.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under—

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

4.3 Chair[26]

4.3.1 The ICB Chair[27] is to be appointed by NHS England, with the approval of the Secretary of State.

4.3.2 In addition to criteria specified at 4.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.
b) Add any local criteria

4.3.3 In addition to criteria specified in 4.2, individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 4.2 apply
c) Xxx

4.3.4 The term of office for the Chair will be four years and the total number of terms a Chair may serve is two[28] terms. For the avoidance of doubt, the Chair may not serve more than two consecutive terms or a maximum of eight years.

4.3.5 [Provision required re if / how the Chair can a) give notice and resign, and b) re the removal of the Chair. The Chair is appointed by NHSE with approval of the Secretary of State, so assume powers for removal lie there, and resignations would need to be directed to NHSE.]

4.4 Chief Executive

4.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.[29]

4.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England[30]

4.4.3 The Chief Executive must fulfil the following additional eligibility criteria
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Specify any further local criteria[31]

4.4.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role
c) Specify any further local exclusions

4.4.5 The Chief Executive
- is an employee of the ICB on a substantive appointment, and for the duration of that appointment they shall be a member of the Board (ex officio appointment);
- will cease to be members of the Board if their contract of employment is terminated.

4.4.5 The Chief Executive is appointed into their substantive role following an open, formal, standard recruitment process during which competency against the respective role and person specification is assessed.

4.4.7 Processes to appoint the Chief Executive into their substantive role will be pursuant of NHS England guidance on senior appointments (including accountable officers) that applies at the time of recruitment and appointment.

4.5 Partner Member(s) - NHS Trusts and Foundation Trusts [add which[32] NHS Trusts and FTs provide services within the ICB area]

4.5.1 This Partner Member *description to be inserted in accordance with the regulations*[33]:

a) [*list trusts*]

4.5.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area[34]

b) Specify any other criteria as may be set out in any NHS England guidance

c) Specify any other criteria agreed locally by the ICB

4.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) add any exclusion criteria set out in NHS E guidance

c) Add any locally determined exclusion criteria

4.5.4 This member will be appointed by[35] the Board subject to the approval of the Chair.

4.5.5 The appointment process will be as follows[36]:

a) the Boards of the NHS Trusts or FTs in the ICB's area identify, through processes of their own choosing, an individual who they wish to jointly nominate as this Partner Member of the ICB Board; these processes will provide for the selection of the nominee that is best suited to the specific requirements of the role;

b) in making their nomination, the Boards of the NHS Trusts or FTs in the ICB's area will take account of the role specification and eligibility criteria for this Partner Member;

c) the Chairs of the Boards of the NHS Trusts or FTs in the ICB's area will formally notify the ICB Chair, via the Secretariat, of their nomination;

d) the ICB Chair will cause the Remuneration Committee to undertake an eligibility and a fit and proper person check of the nominee;

e) the Remuneration Committee will present any nomination and the outcomes of the eligibility and the fit and proper person checks to the Board, with a recommendation to appoint as appropriate;

f) the Board will appoint this Partner Member subject to the approval of the Chair.

4.5.6 The term of office[37] for this Partner Member will be four years and the total number of terms an individual may serve in the office of this Partner Member is two terms. For the avoidance of doubt, an individual may not serve more than two consecutive terms or a maximum of eight years in the office of this Partner Member.

4.5.7 Upon expiry of the first of two terms, the ICB Chair shall ascertain with the Boards of the NHS Trusts or FTs in the ICB's area if they wish to jointly re-nominate the office holder for a second term, or if they wish to replace the incumbent by jointly nominating another individual.

4.5.8 This Partner Member shall give three months' notice in writing to the Board, via the Secretariat, of their resignation from office at any time during their term of office. The ICB shall give three months' notice in writing to this Partner Member, via the nominating parties.

4.6 Partner Member(s) - Providers of Primary Medical Services.

4.6.1 This Partner Member is *description to be inserted in accordance with the regulations*].

4.6.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Specify any other criteria set out by NHS England's guidance
b) Specify any other criteria agreed locally by the ICB[38]

criteria could e.g. be:

Must work in a GP practice in the ICB area (be that as a partner, salaried GP, or locum);
Must / must not be a Primary Care Network (PCN) Clinical Director;
Must be a Healthcare Professional as defined in Appendix 1 of the Constitution;

4.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any criteria set out in NHS E guidance
c) Add any locally determined criteria

4.6.4 This member will be appointed by[39] the Board subject to the approval of the Chair

4.6.5 The appointment process will be as follows[40]:

a) [for local determination and must include both nomination and selection elements]
Propose to adopt a similar process as outlined under 4.5.5 above

4.6.6 The term of office[41] for this Partner Member will be three years and the total number of terms they may serve is two terms. For the avoidance of doubt, an

individual may not serve more than two consecutive terms or a maximum of eight years in the office of this Partner Member.

4.6.7 Upon expiry of the first of two terms, the ICB Chair shall ascertain with the providers of primary care in the ICB's area if they wish to jointly re-nominate the office holder for a second term, or if they wish to replace the incumbent by jointly nominating another individual.

4.6.8 This Partner Member shall give three months' notice in writing to the Board, via the Secretariat, of their resignation from office at any time during their term of office. The ICB shall give three months' notice in writing to this Partner Member, via the nominating parties.

4.7 Partner Member(s) - local authorities

4.7.1 This Partner Member *description to be inserted in accordance with the regulations* from the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) [*insert list of those LAs*]

4.7.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or relevant Executive level role of one of the bodies listed at 3.7.1
b) Specify any other criteria set out by NHS England's guidance
c) Specify any other criteria agreed locally by the ICB

4.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) [Add any locally determined criteria
c) and any criteria set out in NHS E guidance]

4.7.4 This member will be appointed by[42] [x] subject to the approval of the Chair

4.7.5 The appointment process will be as follows[43]:

a) [for local determination and must include both nomination and selection elements]

4.7.6 The term of office[44] for this Partner Member will be four years and the total number of terms they may serve is two terms. For the avoidance of doubt, an individual may not serve more than two consecutive terms or a maximum of eight years in the office of this Partner Member.

4.7.7 Upon expiry of the first of two terms, the ICB Chair shall ascertain with the local authorities in the ICB's area if they wish to jointly re-nominate the office holder for a second term, or if they wish to replace the incumbent by jointly nominating another individual.

4.7.8 This Partner Member shall give three months' notice in writing to the Board, via the Secretariat, of their resignation from office at any time during their term of office. The ICB shall give three months' notice in writing to this Partner Member, via the nominating parties.

4.8 Medical Director[45]

4.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB[46] or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner
c) Specify any other criteria set out by NHS England's guidance
d) Specify any other criteria agreed locally by the ICB

4.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any locally determined criteria
c) and any criteria set out in NHS E guidance

4.8.3 The Medical Director

- is an employee of the ICB on a substantive appointment, and for the duration of that appointment they shall be a member of the Board (ex officio appointment);
- will cease to be a member of the Board if their contract of employment is terminated.

4.8.4 The Medical Director is appointed into their substantive role by the Chief Executive following an open, formal, standard recruitment process during which competency against the respective role and person specification is assessed.

4.8.5 Processes to appoint the Medical Director into their substantive role will be pursuant of NHS England guidance on senior appointments (including accountable officers) that applies at the time of recruitment and appointment.

~~4.8.6 This member will be appointed by~~[47] ~~[x] subject to the approval of the Chair.~~
Propose to delete this provision, or seek clarification.
As it stands, it suggests that the ICB Chief Executive cannot make this senior appointment without having to seek the Chair's approval.

4.9 Director of Nursing[48]

4.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee[49] of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse or Midwife
c) Specify any other criteria set out by NHS England's guidance
d) Specify any other criteria agreed locally by the ICB

4.9.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply
b) Add any locally determined criteria
c) and any criteria set out in NHS E guidance

4.9.3 This member will be appointed by[50] [x] subject to the approval of the Chair.

Propose to include provisions similar to 4.8.3 to 4.8.5

4.10 Director of Finance[51]

4.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria
a) Be an employee of the ICB[52] or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Specify any other criteria set out by NHS England's guidance
c) Specify any other criteria agreed locally by the ICB

4.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply
b) [Add any locally determined criteria
c) and any criteria set out in NHS E guidance]

4.10.3 This member will be appointed by[53] [x] subject to the approval of the Chair

Propose to include provisions similar to 4.8.3 to 4.8.5

4.11 [Two[54]] Independent Non-Executive Members[55]

4.11.1 The ICB will appoint [Add number] independent Non-Executive Members

4.11.2 These members will be appointed by[56] the Board subject to the approval of the Chair.

4.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria
a) Not be employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area

c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
e) Specify any other criteria set out by NHS England's guidance
f) Specify any other criteria agreed locally by the ICB[57]

4.11.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area
c) add any locally determined criteria
d) and any criteria set out in NHS E guidance

4.11.5 The term of office for an independent non-executive member will be four years and the total number of terms an individual may serve is two[58] terms. For the avoidance of doubt, an individual may not serve more than two consecutive terms or a maximum of eight years in office.

4.11.6 Initial appointments may be for a shorter period[59] in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

4.11.7 Subject to[60] satisfactory appraisal by the Chair, to the individual continuing to meet the eligibility criteria set out in 3.1, and to the disqualification criteria in 3.2 not applying, the Chair may approve the re-appointment of an independent non-executive member up to the maximum number of terms permitted for their role.

4.12 Other Board Members[61]

Local completion of all details for **any/ all other** members is required.

4.13 Board Members: Removal from Office

4.13.1 Arrangements for the removal from office of Board members is subject to the terms of appointment, and application of the relevant ICB policies and procedures.

4.13.2 With the exception of the Chair of the Board, members shall be removed from office if any of the following occurs:

a) If they become ineligible for their role as set out in this constitution, regulations or guidance;

b) If they no longer fulfil the requirements of their role;
c) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
d) in the written opinion of a registered medical practitioner, have become physically or mentally incapable of acting as a Governing Body member, and may remain so for more than three months.[62]

4.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.3 apply.

4.13.4 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

4.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

4.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:
i. terminate the appointment of the ICB's Chief Executive; and
ii. direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

4.14 Terms of Appointment of Board Members

4.14.1 With the exception of the Chair, Non-executive members and Chief Executive, arrangements for remuneration[63] and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published [say where] and any guidance issued by NHS England or other relevant body. Remuneration for Chairs, Non Executives and Chief Executives will be set by NHS England.

4.14.2 Other terms of appointment will be determined by the Remuneration Committee.

4.14.3 Terms of appointment of the Chair will be determined by NHS England.

5 Meetings of the Integrated Care Board

General Provision

5.1.1 These General Provisions apply to all meetings of the ICB's Board, and any committees and sub-committees of the ICB and the ICB's Board.

Constituting a meeting

5.1.2 As permitted and appropriate, a meeting is constituted when members of the ICB, its Board, or their respective committees and sub-committees, meet face-to-face, by telephone, by video-conference, by any other electronic means, or a combination of the above.

5.1.3 The Chair of a meeting may invite others to attend a meeting for particular agenda items, or issue a standing invitation, if their presence will assist the business of the committee. Individuals who are so invited may receive meeting papers and participate in discussion as appropriate and at the discretion of the Chair, however they cannot participate in any voting.

5.1.4 When members of the ICB, its Board, or their respective committees and sub-committees are not able to attend a meeting by any of the means described in Standing Order 5.1.2, they shall wherever possible give apologies in advance of the meeting.

5.1 Calling Board Meetings[97]

4.1 Meetings of the Board of the ICB shall be held at regular intervals[98] at such times and places[99] as the ICB may determine.

4.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two[100] days' notice by setting out the reason for the urgency and the decision to be taken.

4.2.1 A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it ~~at the offices of the ICB body and~~ electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.2.2 The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.3 Chair of a meeting

4.3.1 The Chair of the ICB shall preside over meetings of the Board.

4.3.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair of the committee shall chair the meeting. If the Deputy Chair is not present within 15 minutes of the scheduled start time of the meeting, or due to a conflict of interest needs to absent themselves from a meeting, the members shall nominate one of their midst to chair this meeting. For the duration of this meeting, the individual acting as Chair may exercise any of the powers, duties and responsibilities normally held by the Chair of the meeting. The meeting minutes shall record such arrangements. [101]

4.3.3 The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.4 Agenda, supporting papers and business to be transacted

4.4.1 The agenda for each meeting will be drawn up and agreed by the Chair[102] of the meeting.

4.4.2 Items of business for inclusion on the agenda of a meeting need to be notified to the Chair of the meeting, via the Secretariat, at least 10 working days before the meeting takes place. Agendas will be agreed between the chair of the meeting and the relevant executive and / or clinical lead.

4.4.3 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.4.4 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at [insert link].

4.4.5 For extraordinary and emergency meetings, the Chair of the meeting may relax the requirement for a formal agenda, and may relax the requirements regarding the timelines for the dissemination of agenda and meeting papers / materials.

4.5 Petitions

4.5.1 Where a petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board.

4.6 Nominated Deputies[103]

Note:
There is no requirement to allow deputies. The ICB can consider whether deputies will be allowed, for which roles, whether to permit them to vote or count towards the quorum.
Both ICB and its board members must understand that the accountabilities and liabilities associated with the role may not be delegated to a deputy – the officer holder "carries the can", not the deputy.

The nature of the unitary board means that there are potential implications for all board members when other members delegate to a deputy.

On balance, propose to omit provisions for nominated deputies.

4.6.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak and vote on their behalf.

4.6.2 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.7 Virtual attendance at meetings[104]

4.7.1 The Board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

Note:
General provisions above cover this – propose to omit.

4.8 Quorum[105]

4.8.1 The quorum for meetings of the Board will be one third of members, including:

a) Either the Chief Executive or the Director of Finance
b) Either the Medical Director or the Director of Nursing
c) At least one independent member

d) At least one Partner Member

4.8.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.8.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.9 Vacancies

4.9.1 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

4.9.1.1 To determine locally

4.10 Decision making

4.10.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.10.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

b) In no circumstances may an absent member vote by proxy[106]. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional Participants and Observers[107] (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.10.3 if consensus cannot be reached, the Chair may make decisions on behalf of the Board where there is disagreement. Where necessary Boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

Urgent decisions

4.10.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.10.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees)[108] subject to every effort having been made to consult with as many members as possible in the given circumstances.

4.10.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.

4.11 Minutes

4.11.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.11.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.11.3 Draft records of meetings will be circulated to meeting members for information, and shall be approved at the next appropriate meeting.

4.11.4 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.11.5 Where providing a record of a meeting held in public, the minutes shall be made available to the public by way of publishing them on the ICB's website in accordance with the Code of Practice on Openness in the NHS and the Freedom of Information Act.

4.11.6 Where this is deemed to facilitate patient and public access to the ICB's proceedings, does neither compromise a meeting's nor individuals' effectiveness and confidentiality, and is agreed by the Chair, the ICB may

i) make a video or audio recording of the meeting;

ii) broadcast the meeting as a web cast, live stream, podcast or similar.

4.12 Admission of public and the press

4.12.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the ICB at which public functions are exercised will be open to the public.

4.12.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.12.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the ICB Board's business shall be conducted without interruption and disruption.

4.12.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting suppress or prevent disorderly conduct or behaviour.

4.12.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5 Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 2 other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6 Use of seal and authorisation of documents.

If the organisation has a seal, arrangements made for its safe keeping and authorisation of its use should be set out here:

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

BSW Partnership Board, 1 October 2021, Item 12

Transformation Workstreams – Update Report

David Jobbins

Interim Deputy Director – Planning & Programmes, BSW CCG

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

Report summary

Key points	This report presents the Highlight Reports from the following programmes: • Acute Hospitals Alliance • Digital Programme • Elective Care (to follow) • Integrated Care System (to follow) • Learning Disabilities & Autism • Maternity • Mental Health • Outpatient Transformation (to follow) • Urgent Care and Flow • Estates Each report updates on delivery over the reporting period (please note that this varies by report) together with a headline assessment of risks, progress and key milestones.
Recommendation(s)	The Partnership Board is asked to : **1.** **Note** the report and the progress made to date. 2. Provide **comments and feedback** on the format and content of the Highlight Reports that could further strengthen future reporting.
Key risks	Risks for escalation are identified in each Highlight Report. The Urgent Care and Flow programme is reporting as Red rated. The Learning Disability & Autism programme is reporting four workstream level red traffic lights identified which are: <u>Learning Disability & Autism</u> • BSW LDA inpatient pathway review • BSW LDA Intensive Service Model evaluation to commence • Refresh TCP Housing Action Plan as part of wider BSW Delivery Plan • Co-production of 22/23 BSW LDA Roadmap
Resource implications	Resource implications described in each Highlight Report

Highlight delivery report

Programme	Digital			**Delivery RAG**
Reporting period	August 21			
Executive Lead	Caroline Gregory	**Transformation Lead**	Jason Young	**On Track**

What has been delivered or changed? (headlines)

- Graphnet Integrated Care Record now extended to include all bar 9 Swindon & Wiltshire practices. AWP & GWH now both sharing data.
- Combined Intelligence for Population Health Analytics programme (CIPHA) PID agreed to extend reporting in Graphnet BI platform
- Maternity Personal Held Record app design complete and in test ahead of roll out at Chippenham birthing unit
- Comprehensive Geriatric Assessment shared plan in being tested by clinicians in Aging Well Programme
- Additional care homes live with TPP SystmOne
- £3.3m bid to NHSX for ICR funding submitted

- Digital board highlights:
  - Input into planning of BSW Care Model session
  - Video Consultation & appointment management joint procurement
  - Advice and Guidance go live planned for 31/10
  - Significant amount of national guidance published for digital including Unified Tech Fund bidding opportunity
  - Refresh of Digital Strategy planned in response

What risks and issues need escalation?

- A significant element of the IT programme has no identified funding source.

Over £90m of £130m is unfunded or only partially funded

Fundamentals of **IT estate** remain significantly underfunded. Estimated £4m gap to deliver PC/Laptops on a 6 year refresh cycle

EPR alignment will require significant external funding source

Unified Tech Fund includes bid opportunities with very short deadlines which may preclude BSW

Financial summary

5 year programme est. £130m+
£64m unfunded/ £23m partially funded/ £41m funded. Yr1= £30m

Highlight delivery report

Milestones	Target date	RAG
National milestone of "Minimum Viable Solution" for Shared Care Records	Sep 21	SFT planning for Oct 21
Review of ICS digital strategy	Dec 21	On track
Maternity PHR pilot commences	Sep 21	On track
Advice & Guidance contract transition	Oct 21	On track
NHSE Population Health Management Wave 3 Programme commences	Nov 21	On track
FBC for EPR Alignment	tbc	

Planned impact and progress

Digital strategy and component projects underpin the priorities below by providing a toolkit to enable transformation:

Recover non-Covid services
Strengthen delivery of local People Plans
Address the health inequalities that Covid has exposed
Accelerate the planned expansion in mental health services
Prioritise investment in primary and community care
Build on the development of effective partnership working at place and system level

Evidence of impact - data

"I could see the patient was being prescribed hydrocortisone by the GP regularly for secondary hypoadrenalism so avoided a phone call to the out of hours service".

Quote from Graphnet ICR user

900 different individuals have accessed the ICR to view over 10000 patient records in August

BSW Highlight delivery report

Programme	Acute Hospital Alliance	**Reporting period**	July - Sept 2021
Executive Lead	Cara Charles-Barks	**Transformation Team**	Ben Irvine

Delivery RAG

GREEN

What has been delivered or changed? (headlines)

AHA Programme readiness for Next Phase of Provider Collaboration

- In July a ***refreshed high-level work programme*** was approved**.**
- ***ICS Provider Collaboration & AHA Governance review.*** At the AHA Programme Board on 30th July 2021 a detailed formal proposal to establish a Committee in Common between the three Trusts was considered. The proposal aimed to provide a ***stronger framework to support successful delivery***. A draft AHA Memorandum of Understanding was approved at September AHA meeting, and will be considered by Trust Boards in October.
- ***Communications and engagement strategy*** developed to raise the profile of the AHA.
- Recruitment underway of **3 p/t Clinical Transformation Leads** and a **Programme Manager** to support delivery.

AHA Corporate Stream:

- The AHA ***Common Improvement Methodology*** programme is underway, with a joint sessions involving all three Trusts held.
- **EPR Alignment Programme –** OBC development has continued - supported by an external review of the draft OBC. Regular briefings with regional team are being planned. Resource plan approved for next stage.
- **Corporate Back-Office Programme – Finance team:** Good progress is being made in **procurement, Trusts have agreed to move to a single AHA team.** Other joint work on ledger, income, contracting, costing is being pursued, led by DoFs and their teams.
- Collaboration opportunity scoping is underway for a **range of back-office services [including estates; people; legal, library** services]. GWH team is sharing successful experience in adopting Robotic Process Automation in a range of back-office functions.

AHA Clinical Stream:

- **Secondary Clinical Services Strategy: Mandate defined.** The three Medical Directors and Trust strategy leads are shaping a review of secondary clinical services, designed to link closely with BSW care model work.
- **Elective Strategy –** a BSW MDT led by Peter Collins created an Elective Care Strategy. The strategy includes 'what good looks like' examples describing how the strategy will make experience of care different for our population. The team presented a draft of the Elective Strategy to the Population Health and Care Programme Board on 14th July and is now planning wider public engagement activity.
- **Virtual Clinical Teams –**The BSW paediatrics clinical team work has progressed well and has now transitioned into BAU. **Paediatrics** single waiting list pilot has been successful; opportunities to spread being sought. **Dermatology** work is ongoing with good progress now being made. Mutual aid for Advice & Guidance services between RUH and SFT is planned. **Ophthalmology** team has defined vision, strategy and priorities for change.

What risks and issues need escalation?

- A range of risks and issues are being managed by the programme team.
- In Q1 a lessons learnt exercise identified areas for focus in preparing for next phase (Engagement, Roles & Responsibilities, Resources, Programme Management, Programme Governance); these are being managed by Programme Director, CEOs and Programme Board.

Financial summary

- EPR OBC Digital Aspirant budget award (£250k); expenditure (c£200).
- Procurement Programme Saving target 21/22, £2.5m. Forecast to over-deliver @ £3.2m

BSW Highlight delivery report

Milestones	Target date	RAG
AHA Corporate Stream		
1. Procurement – Strategy, OBC Team plan, [plan complete] 2. 21-22 CIPs [Forecast to over-deliver]	Mar-June 21 Q1-Q4 21	In Progress
• EPR Alignment OBC. [Note: re-programmed in light of external review]	Nov 21	In Progress
• Back Office Finance programme defined	Feb 21	Complete
• Back Office Corporate Programme defined	October 21	In Progress
AHA Clinical Stream		
• BSW Elective Strategy complete.	July 21	Complete
• BSW Secondary Care Clinical Strategy	Jan 22	In Progress
1. BSW Ophthalmology Strategy [Complete] & Priority developments [underway]	Aug 21	Complete/ In Progress
1. BSW Virtual Clinical Teams [Phase 1, Paediatrics, Dermatology]	June 21	In Progress
1. BSW Microbiology [Phase 2]	Q3 21	In Progress
Programme Management and Governance		
• AHA Development as Provider Collaborative: next phase plan.	June 21	Complete
• Launch of Committee in Common arrangements	Oct/ Nov 21	In Progress
• AHA Communications Strategy	July 21	Complete

Planned impact and progress

Rationale for working at AHA level:

- Equity, Sustainability, Improvement
- Reduction in inequality.
- AHA as catalyst for horizontal collaboration as well as vertical integration.
- AHA provider collaboration as an effective contributor to BSW. With DGHs being effective system partners across health and care; making contribution as anchor organisations to local populations and enabling system financial sustainability.

BSW Highlight delivery report

Programme	Maternity Transformation	**Reporting period**	May 2021
SRO Lead	Lucy Baker	**Transformation Team**	Sandra Richards and BSW LMNS Programme Board

Delivery RAG

AMBER

What has been delivered or changed? (headlines)

- Alongside Midwifery Unit building work completed at SFT – furnishing in progress.
- Plans in place to implement4 month pilot project for AI assisted breastfeeding support app across BSW for women
- Maternal Mental Health AWP psychology teams members recruited. Recruitment to midwifery delayed
- Ockenden- Trust boards receiving monthly safety information in line with Ockenden requirements and shared with LMNS.
- Carbon monoxide monitoring recommenced in all three providers. Additional smoke free pregnancy team workers to be recruited following agreed funding through LRP money.
- Further rollout of Continuity of Carer models paused in all three providers due to significant staffing issues in maternity services over the summer period. Collaborative bid to national NHSE for international recruitment to support workforce. All trusts received a proportion of national workforce (Ockenden) money tp support birthrate plus staffing for midwifery (but not fully funded)
- Maternity Voices Partnership Sharing of quarterly survey results – positive feedback on caring staff and value of continuity of carer models with service user satisfaction
- Successful cross service BSW bid to PIMH training fund for funding to support mental health training across maternity, health visiting, mental health services and PH.
- PERIprem Quality improvement nominated for Patient safety award HSJ – (opimising outcomes for preterm babies) SFT are now joining with GWH and RUH to implement PERiPrem

Evidence of Impact- Data

- BSW have achieved target of 20% reduction in Stillbirths by 2020.
- RUH Bath have 45% women booked on Continuity of Carer Pathway with 5 teams in place and GWH Swindon continue to run 2 Continuity of Carer teams. Both areas prioritising women from Black, Asian, minority ethnicities and women from deprived areas. SFT have paused Continuity of Carer teams whilst additional recruitment is underway but plans in place to resume. Smoking at time of birth (delivery – SATOD) **BSW reduction from 9.7% of women 18/19 and 19/20) to 8.5% in 20/21** towards target of 6% by March 2022. (Note BaNES increase from 6.6 to 8.1% but Swindon decrease from 11.1 to 9.1% and Wilts decrease from 9.8 to 9.1% of women)
- Breast feeding initiation rates data not yet available for YTD
- Decrease in numbers of women smoking at time of birth in BSW from 9.7% to 8.5%

What risks and issues need escalation?

- Risk and issue to escalate that workforce absences (maternity leave) and staff vacancies impacting on implementation of Continuity of Carer models, personalised care and capacity to maintain normal services. Risk that COC outcomes will have decreased impact as COC teams supporting in escalation periods
- Decreased capacity of provider trusts business intelligence teams to support increasing data requirements requested by national teams

Finance Summary

Risk around Maternal Medicine network funding escalated at national level. Proposed top slicing of transformation funds for previous NHSE commissioned service

BSW Highlight delivery report

Milestones	Target date	RAG
Full resumption of pre-Covid maternity services	July 2021	In progress
Maternity Services Compliance with Ockenden IEA Assurance requirements	August 2021	In progress
Plan and building blocks in place for Continuity of Carer Pathway to be default model of care offered to women	March 2023	In progress
All women from Black, Asian, minority ethnicity and women from most deprived areas on Continuity of Carer pathway (appropriate caseloads)	March 2022	In progress
Smoking at time of birth to be below 6%	March 2022	In Progress
At least 40% expectant mothers on new LTP smoke free pathway	March 2022	In progress
All women to have personalised care and support plan	March 2022	In progress
AMU provision on SFT Site	Sept 2021	In Progress
AMU provision on RUH Site	March 2023	In progress
Embedded offer of Continuous Blood glucose monitoring for all pregnant women with type 1 diabetes in BSW	May 2022	Implemented
Agreed plan for implementation of blended payment for maternity services	Dec 2021	In progress
Maternal Mental Health clinics in place (trauma, tocophobia and grief)	Dec 2021	In progress
Each maternity provider to be compliant with Saving Babies Lives Care Bundle – Pre-term birth clinic and right place of birth for <27 week babies	June 2021	In progress
Stillbirths reduce to 2.4/1000	March 2024	
Neonatal deaths reduce to 0.9 /1000	March 2024	
Pre-term births reduce below 6%	March 2024	
Reduce brain injuries in neonates to 2.9/1000	March 2024	
LMNS Equity Analysis and co-produced action plan to meet national Perinatal Equity Strategy (not yet published)	Nov 2021	In progress
Implementation of Neonatal Critical Care Review improvement plan (SW ODN)	Ongoing	In Progress
All BSW maternity information system suppliers to be compliant with MISN (1 and s)	Nov 2021	In progress

Planned impact

- 50% reduction in stillbirths, neonatal deaths, maternal death and neonatal brain injuries by 2025
- Pre-term births to reduce to below 6% by Mar 2024
- Smoking at time of birth to be below 6% by March 2022.
- Improved outcomes and maternity experience for women from Black, Asian, Ethic minorities and women from the most deprived areas of BSW.
- Increased number of women having choice of birth in a midwife led setting.
- Improvement in women's experience in CQC Maternity Survey.
- Increase in number of women booked on Continuity of Carer Pathway
- Increase in number of women able to access psychological support and interventions

Highlight delivery report

Programme	Estates			**Delivery RAG**
Reporting period	June 2021 to August 2021			
Executive Lead	Caroline Gregory	**Transformation Lead**	Simon Yeo and Laurence Arnold	On Track

What has been delivered or changed? (headlines)

- BSW Expressions of Interest (EOIs) submitted in response to the governments' next phase of implementation of its health infrastructure plan, totalling circa £900m of EOIs for BSW, including mental health, community and acute
- BSW ICS Estates Strategy update nearing conclusion
- Future Delivery of Estates Functions: procurement process underway for external support to bring forward proposals for the future delivery of a single Estate function across BSW
- GWH UTC build commenced. Integrated Front Door GA plans in development
- RUH Cancer Centre build commenced July 2021
- RUH New Hospital Programme (Shaping a Healthier Future) Strategic Outline Case in development with a planned submission March 2022
- SFT Campus Programme – Strategic outline case for the first element to reprovide the current day surgery unit has been completed and has been approved by Trust Board. An initial review by NHSE/I Estates team has provided feedback and case is being amended
- New Devizes Health Centre (£11m), previously known as Devizes Integrated Care Centre under construction and due to be operational summer 2022
- New West Wiltshire Centre for Health and Care (£16m), previously known as Trowbridge Integrated Care Centre Full Business Case decision delayed until after the spending review
- Providing specialists Estates input into the BSW Care Model and Demand & Capacity Modelling

What risks and issues need escalation?

- Circa £900m of capital schemes without an identified funding route, which is anticipated to increase with the development of the BSW Care Model
- Backlog maintenance of circa £110m without adequate funding, and expected to increase as backlog maintenance for community and primary care is better defined
- An ambitious wide ranging Estates and Facilities programme across BSW, which isn't matched with adequate specialist skills and capacity
- The NHS nationally has ambitious Environmental Sustainability target ('Net Zero'), with BSW currently having a skills, capacity and funding gap to deliver the targets

Financial summary

- £108m of major schemes with a funding route
- Circa £900m of unfunded major schemes
- Circa £110m of backlog maintenance

Highlight delivery report

Milestones	Target date	RAG
BSW Estates Strategy	November 2021	On Track
BSW Estates and Facilities Management redesign	September 2022	On Track
Soft Facilities Management Services	March 2022	In progress
Environmental Sustainability Work Plan	September 2022	In progress
GWH Way Forward Programme	UTC target completion date Dec 21, IFD target completion date Winter 23	In progress
RUH Cancer Centre under construction		On Track
RUH New Hospital Programme Strategic Outline Case	March 2022	On Track
SFT Campus Programme Strategic Outline Case revised version	November 2021 (estimated)	On Track
Devizes Health Centre construction completion	June 2022	On Track
West Wiltshire Centre for Health and Care Full Business Case decision	May 2021	In Progress

Planned impact and progress

- Collective understanding of BSW wide estates needs and how they will be addressed aligned to future health and care model
- Integrated ICS estates function providing more comprehensive service to partner organisations
- Mitigation of poor infrastructure which is costly to maintain and increase exposure to clinical risks
- Fit for purpose estate responding to future sustainability agenda which can adapt to meet future agile ways of working

Evidence of impact

- Estates Strategies actively being developed
- ICS approved list of strategic estates schemes
- Reduction in costs of backlog maintenance through covid funded improvements
- Established Vaccination Sites across BSW
- Reduction in cost of backlog and estate alignment to care model through business cases being developed and approved
- BSW wide groups established for Agile Working, Environmental Sustainability, Soft FM and future Estates and Facilities redesign
- Active involvement in the Care Model design and Demand and Capacity Modelling

BSW Highlight delivery report

Programme	BSW All Age Learning Disabilities and Autism	**BSW Transformation Team**	Dr Sarah Blaikley (lead GP), Georgina Ruddle, Lucy Baker
Reporting Period	Aug/Sept2021		
Executive Lead	Claire Edgar		

Delivery RAG

AMBER

What has been delivered or changed? (headlines)

- BSW Learning Disability and Autism (LDA) three year strategic roadmap revised in light of funding constraints of the NHS E allocation.
- Task and finish group revision of the investment schemes BSW are able to mobilise in year, with five able to progress. Approved through an extraordinary LDA Programme Board;
    - BSW LDA Strategy Delivery Infrastructure and Enablers
    - Swindon & Wilts Forensic Risk Assessment [levelling up with BaNES]
    - Levelling up Swindon Adult Community Learning Disabilities Team for People with a Learning Disability
    - Levelling up Swindon Adult Autism Diagnostic Service
    - Phase two of the CYP Autism Diagnostic Pathway Transformation.
- Successful expression of interest for Creating ASD Friendly Health and Social Care Environments; to be delivered through a team of experts by experience.
- BSW LDA Programme Manager commenced in post.
- BSW LDA governance structure approved.
- Independent evaluation of Learning disability and Severe Mental Illness Annual Health Checks (AHC) pilot has received approval and is progressing qualitative interviews with people to understand their experiences and perspectives on how the annual reviews are completed.
- BSW LeDER action plan approved, implementation progressing.
- BSW NHS E Housing Metric self-assurance evaluation completed.
- BSW CCG launched mandatory e-learning package - All Age Autism Awareness.

What risks and issues need escalation?

- Breach of CYP and Adults 12 week wait for autism assessments [ongoing].
- BSW LDA AHCs remains behind operational plan (OP) target; month 4 (year to date) 11.2% (national target 75%).

Financial summary

Confirmation of expected NHS E LDA funding allocation 21/22;

- Community £410k
- C[e]TR £28k
- LeDER £33k
- ASD training £120k

BSW Highlight delivery report

Milestones	Target date	RAG
BSW MH LDA Escalation and Complex Case Hub to mobilise.	Sept 2021	In Progress
BSW task and finish group to form a system position statement regarding Pathological Demand Avoidance.	Dec 2021	In Progress
University of Bristol Evaluation of BSW LD Annual health checks pilot with First Option Health Care.	Dec 2021	In Progress
BSW LDA inpatient pathway review [inclusive of the Daisy model].	Q4 2021	
BSW LDA Intensive Service Model evaluation to commence.	Q4 2021	
Refresh TCP Housing Action Plan as part of wider BSW Delivery Plan.	Q4 2021	
Co-production of 22/23 BSW LDA roadmap.	Q4 2021	

Planned impact and progress

- Reduction of Adult LDA inpatient numbers
- Sustained reduction of CYP LDA inpatient numbers
- Improved rates of annual health checks
- Address health inequalities including those related to Covid-19

Evidence of impact - data

- LDA AHC pilot team activity (year to date):

Number of people contacted	Number of people booked	Number of actual attendances to date	Number who did not attend a booked appointment	Number of people who have declined
432	263	218	28	84

Highlight delivery report

Programme	BSW All age Mental Health – Thrive			**Delivery RAG**
Reporting period	Aug/Sept 2021			
Executive Lead	Dominic Hardisty	**BSW Transformation Team**	Dr Sarah Blaikely (lead GP), George Ruddle, Lucy Baker	In progress

What has been delivered or changed? (headlines)

- Mental Health ARRS model co-designed with primary care and 19 wte out to advert early October
- 40wte third sector wellbeing practitioner posts as part of the Community Mental Health Framework out to advert Sept 6th 2021 (posts starting in Nov)
- CAMHS access improvement schemes approved and recruitment to commence
- New third sector intensive outreach model being expanded at pace
- Revised LTP trajectories for all age MH agreed – additional oversight via BSW Thrive Programme Board
- 999 ambulance pilot agreed for BSW (mental health professionals in SWAST control) go live on track by end of Sept 2021
- BSW Staff Wellbeing Hub went live as planned in July. 16 referrals to date. Available to all key worker staff across health and social care. Communications plan in place to further promote service in October. Working with teams across BSW on bespoke offers of support
- Recruitment commenced for new BSW Complex Needs (Personality Disorder) Pathway
- BSW section 140 policy drafted in collaboration with BNNSG. This work forms part of our strategic workstream to review Health Based Place of Safety (HBPoS) pathways

What risks and issues need escalation?

- Continued increase in activity and acuity across all services. 100% increase in Health Based Place of Safety (HBPOS) activity
- Access to national tier 4 CAMHS beds particularly for eating disorder remains a significant challenge
- SMI annual health checks below target but continuing to increase (24% Aug)
- Out of area bed usage has reduced but remains high at 20 (as @23/09)
- Workforce challenges across service – hot spots include Wiltshire PCLS, Swindon CAMHs and BaNES Care home liaison. Risk mitigation actions plans co-developed

Financial summary

MHIS continues to be achieved. £1.6m risk linked to high cost placements and drug spend. Medicines Management working group to be setup. Mental Health Finance Oversight Group continue

Highlight delivery report

Milestones	Target date	RAG
ARRS MH roles to be co-designed and advertised Revised SMI AHC model with AWP to be co-developed	Oct 2021 End Oct 2021	In Progress
Community MH framework recruitment to commence for all partners (third sector/ AWP/ Oxford Health) Progress Check in workshop for implementation of community framework	Oct 2021 Oct 2021	In Progress
BSW complex case hub to be launched– including oversight of high cost placements	Oct 2021	In Progress
BSW system all age MH escalation process as part of co-created BSW surge plan	Go live end of Sept	In progress
Strategic review of local tier four support options for children and young people – co-creation workshop being developed	Nov 2021	In progress

Planned impact and progress

- Supporting people around their emotional wellbeing and mental illness in their local communities
- Reduction in preventable attendances and admissions
- Reduction in OOA placements
- Address health inequalities including those related to Covid
- Accelerate the planned expansion in MH services
- Collaboratively agreed BSW priorities – feature in the diagram below. Programme plan in place for each element

Evidence of impact

Third Sector Intensive Outreach case study

49 year old woman with EUPD and acute anxiety disorder discharged from Hillview lodge to Wellbeing House. Client unable to return home due to state of property and essential repairs required. Client needs range of interventions, not feeling confident to live independently and has ongoing issues with hoarding.

Referred to Bath Mind Intensive Outreach service at end of WBH stay for 10 hours support a week and continues seeing her Care Coordinator & psychiatrist.

Week 1 after WBH discharge: x 3 visits a week carried out by Support Worker. Support plan completed identifying service user's goals. Focus on house clearance, gaining essential items (cooker, washing machine, fridge freezer) and support with hoarding issues (referred to We Care and Repair). Service user signposted to Breathing Space as evenings identified as very difficult. Plan includes strategies to staying well.

Week 2 CPA review
Improvement seen although still a great need for ongoing support. Close collaboration with AWP to facilitate Care Act Assessment for ongoing support in community.

3 week CPA review: Further improvement with anxiety levels reduced, decision to continue frequency of visits due to vulnerability. Service user is now accessing community services, support groups independently but still requires reassurance making decisions and problem solving. Client is able to access support with hoarding and now has essential white goods. Service user has learnt coping mechanisms and is able to self soothe at times.

Final 2 weeks: Discharge from service planned and assessment with Supported Independence arranged for continuation of support as identified necessary in Care Act Assessment

Discharge: Service user leaves having learnt new coping mechanisms and with support in place from hoarding charity and Supported Independence.

BSW Highlight delivery report

Programme	Urgent Care and Flow Board	**Reporting period**	Aug /Sep 2021
Executive Lead	Stacey Hunter	**Transformation Team**	

Delivery RAG

RED

What has been delivered or changed? (headlines)

- Demand and capacity bed modelling – work completed to inform ICA seasonal/ winter resilience plans.
- UEC Strategy – several clinical and provider engagement sessions over the Summer and BSW Citizen panel survey completed during August. Citizen panel feedback with partners being arranged end of Sep.
- BSW UEC risk summit on 14th September following growing escalation pressure

1. 111 – Cat 2 validation pilots put on hold due to lack of national support and concerns around risk of delays. A system conversation around long term view of enhanced validations model as ED clinical staff volunteering additional on top of existing roles and need to consider all ED as speak to dispositions to make sure goes through enhanced clinical validation and Current model not sustainable. .
2. 999 - Workshops postponed due to availability and BSW internal critical incident. SRO to speak to local alliances separately and bring back outcomes to a workshop in October to address measures to reduce calls into 999 and conveyances
3. Hospital Handovers - Hospital handover delays continue to deteriorate, particularly at the RUH where IP&C bed related closures and non -criteria to reside numbers increased. GWH position has improved and no longer within top 6 areas of concern in southwest, BSW Gold action supported short term 4 -week alternative transport for HCP conveyance approach to support interim whilst impact and longer-term business case could be developed. Discussions at UCFB as to future overlap with 999 workstream
4. SDEC - Workstream meeting fortnightly, request to each trust to focus on Frailty SDEC options and exploring wider SDEC opportunities in Community and Mental health teams. Progress has been limited due to increased escalation pressures.
5. ECDS - Confirmation all Same Day Urgent & Emergency Care Providers (GWH, RUH, SFT, WH&C & Virgin) have systems and processes in place to record the core 10 data sets. Support required to help on reporting for WH&C & Virgin for MIU activity as not included in the national dashboards
6. Discharge to Assess - Following discussion at Urgent Care and Flow board, the scope of the workstream has been confirmed that it that D2A is the entirety of the discharge process. The D2A workstream will become the schemes that the ICAs have presented at Urgent Care &Flow Board and the Matrix/dashboard of these schemes will be reported to the Board by exception.

What risks and issues need escalation?

Identified in BSW Risk summit outcomes:

- Demand vs. Supply
- Governance structures and perception of risk
- Patient and public behaviour
- Risk sharing and mutual understanding of risk
- Escalation
- UEC Workforce risks
- Population needs
- Access
- Community response

Financial summary

* TBC

BSW Highlight delivery report

Milestones	Target date	RAG
UEC Strategy - Final	Oct 21	In progress
UEC Demand & Capacity planning	Jul 21	In progress
Priority Workstream 1 - 111	Sep 21	In Progress
Priority Workstream 2 - 999	tbc	delayed
Priority Workstream 3 – Ambulance to Hospital Handovers	Dec 21	In Progress
Priority Workstream 4 – Same Day Emergency Care	Mar 21	In Progress
Priority Workstream 5 – Emergency Care Data Set	Tbc	In progress
Priority Workstream 6 – Discharge to Assess	Mar 22	In progress

Planned impact and progress

- UEC strategy – intention to bring final draft to November meetings
- ICAs still identifying capacity to address gaps in D&C plans to inform Winter season, but initial bed/ pathway modelling completed
- Risks impacting on progress as a result of demand and workforce challenges

Evidence of impact - data

- 111 – Activity figures increasing. Booked arrival slots averaging 35%. August Unheralded patients = 49% versus a southwest ambition to be <30%
- 999 – Impact would be on ambulance response times and demand. However, increase in activity -10% up on August 20 and 25% against core contract. SWAST increased hear & treat rates but performance targets for all Categories deteriorating.
- Hospital Handovers – Over 30 minute and total handover time lost in August improved from July month but 800+ hours.
- SDEC – unable to report data consistently although meeting in BSW to agree common approach in line with national guidance. Should reduce patients conveyed to ED and improve LOS.
- ECDS – new standards still in draft form and shadow reporting as a number don't have targets. Deterioration in initial triage waiting times.
- Discharge to Assess – non-criteria to reside figures – which has seen some improvements in August from the acute trusts.