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

BSW Partnership Board

Friday 19 November 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/21-22/029
	4	Action Tracker	S Elsy	Note	ICSPB/21-22/030
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/21-22/031
9:35	8	BSW H2 plans	J-A Wales, D Jobbins	Note	ICSPB/21-22/032
10:05	9	BSW Urgent and Emergency Care Strategy	H Cooper, E Smith	Agree	ICSPB/21-22/033
10:40		Break			
10:50	10	Deep dive – Digital	J Young	Note	ICSPB/21-22/034 (slides on the day)
11:10	11	ICS development • outcomes of engagement with first draft ICB constitution • update from ICS development programme work streams	T Cox, R Smale, B Irvine	Note	ICSPB/21-22/035
11:25	12	BSW Performance, quality and finance report	T Cox, J-A Wales	Note	ICSPB/21-22/036
11:40	13	Transformation work streams updates	R Smale	Note	ICSPB/21-22/037
11:50	14	AOB • BSW Partnership Board forward plan 2021/22	S Elsy		ICSPB/21-22/038

Date of next meeting: 28 January 2022, 9:00-12:00, virtual

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, virtual Zoom meeting in public

DRAFT Minutes

Present

Members:
Stephanie Elsy, BSW ICB Chair Designate
Tracey Cox, BSW ICS SRO
Alison Ryan, Chair, RUH
Cara Charles-Barks, CEO, RUH
Charlotte Hitchings, Chair, AWP (till 11:30)
Dominic Hardisty, CEO, AWP
Liam Coleman, Chair, GWH
Kevin McNamara, CEO, GWH
Nick Marsden, Chair, SFT
Stacey Hunter, CEO, SFT
Stephen Ladyman, Chair, Wiltshire Health and Care (WHC)
Douglas Blair, Managing Director, WHC
Liz Rugg, CEO, Medvivo
Val Scrase, Managing Director, Virgin Care Wiltshire and BaNES
Suzanne Westhead, Director of Adult Social Care, BaNES Council
Brian Ford, Cabinet Member for Adults & Health, Swindon Borough Council
Jane Davies, Cabinet Member for Adult Social Care, SEND, Transition and Inclusion, Wiltshire Council
Kevin Peltonen-Messenger, CEO, The Care Forum
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 (till 10:30)
Gareth Bryant, CEO, Wessex LMC
Natasha Swinscoe, Managing Director, WEAHSN
Sheridan Flavin, Co-Chair, BSW Social Partnership Forum
Tony Fox, Chair, SWASFT
Suzanne Tewkesbury, Director of Workforce and OD (South West), NHSE

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, Julie-Anne Wales, Director of Corporate Affairs BSW CCG;
for item 9, Vanessa Ongley, Interim BSW Education and RRS Project Lead and Wiltshire Health and Care Learning and Development Lead
for item 10, Nick Watts, NHSE Chief Sustainability Officer; Simon Yeo, BSW Assistant Director of Estates

Apologies
Andy Smith, ED SWASFT
Bernie Marden, Medical Director, RUH
Becky Reynolds, Director Public Health, B&NES Council
Steve Maddern, Director Public Health, Swindon Borough Council
Kate Blackburn, Director Public Health, Wiltshire Council
Lucy Townsend, Director Adult Social Services, Wiltshire Council

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.

2. Declaration of Interests

2.1 None declared. Noted that re item 11, ICB governance blueprint, all Partnership Board members were inherently conflicted.

3. Minutes of the BSW Partnership Board meeting 23 July 2021 (ICSPB/21-22/020)

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

4. Actions and Matters Arising (ICSPB/21-22/021)

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.

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:

- recruitment of the ICB CEO was underway. Ten applications had been received by the closing date, shortlisted down to three candidates. On 12 October, a stakeholder panel will be held, followed by interviews on 13 October;
- CCG staff would be transferred into the ICB under the employment promise; this did not apply to the members of the CCG Governing Body, and individual conversations were underway with these individuals to retain their commitment and expertise for BSW;
- The Partnership Board recognised that this was a particularly challenging time for the senior leaders of the CCG and put on record their appreciation for all their hard work and commitment particularly during the last 18 months of the pandemic

7. SRO report (ICSPB/21-22/022)

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 CCG Governing Body would hold a development session focussed on positioning the creation of the ICB as a new beginning; it was recognised that the period of transition would continue beyond April 2022 and would include evolving new approaches to commissioning;
- The BSW Partnership Executive had agreed a plan for Treating Tobacco Dependence in BSW. This addressed part of the NHS Long Term Plan and prevention, and was a positive development for BSW;
- BSW had submitted seven bids to the national Health Infrastructure Plan; recognised that the work to develop the bids had consolidated thinking re BSW priorities;
- Good working arrangements with the VCSE sector were developing at place; BSW wished to strengthen this, was seeking to establish a VCSE alliance across BSW, and had successfully bid for national funding for this work;
- The BSW Academy Director had been appointed and would take up post on 1 November; this was a critical development as part of the system plan to strengthen BSW's approach to the workforce agenda;
- Pressures across the system remained high with excessive pressures and demand; media coverage especially re the volume of face-to-face appointments not being fully restored had attracted increasing pressure on primary care, and primary care reported significant levels of abuse and complaints against primary care colleagues. BSW had launched a campaign to communicate to the public that primary care was not back to its full volume of service delivery, and to signpost the public to other available alternatives for health and care appointments in the community.

8. BSW Performance, quality and finance report (ICSPB/21-22/023)

8.1 The Partnership Board received and **noted** the BSW system performance, quality and finance report to end September 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.

8.2 Discussion highlighted the following:

- Elective, long waiters – a significant proportion of the long waiters were due to patients' choice to postpone treatment;
- Covid – as of 30 September 2021, there were 72 confirmed Covid-19 cases in BSW, with 8 patients in ICU; overall, there was a slow decrease in case numbers;
- Social care – Swindon Adult Social Care was forecasting an overspend against its budget due to a significant increase in demand for home care and 1 to 1 support in care homes; B&NES was forecasting that they would meet their budgets; Wiltshire Adult Social Care was forecasting an underspend of £2.9m;
- Finance – steer nationally was for a soft financial close of H1, more detail about H2 was becoming available; BSW had received its system allocation on 30 September, which resulted in less challenging efficiency saving targets than expected; BSW system leads were in conversation with the regional team regarding the continuous financial challenges for BSW, and seeking an approach to address BSW's underlying deficit.

  Action (C Gregory): To circulate a briefing note summarising the financial allocation to BSW for H2, and implications of policy steer for H2.
- Risks – remain in particular around the Hospital Discharge Programme (HDP); contrary to expectations, there would be no further income on ERF due to changes in national policy.

8.3 The Partnership Board recognised the challenges and pressures on the system, and the need for forward-looking, anticipatory reporting.

9. Deep dive: People and workforce

9.1 The Partnership Board received an in-depth report on workforce development work underway across BSW. The report focussed in particular on the recruitment / retention / supply workstream.

9.2 The Partnership Board noted the report. Discussion highlighted the following:

- Primary care – analysis uncovered a high percentage of the primary care workforce wishing to leave; this was recognised and intended to be addressed incl. through a roll-out of talent pools; recognised that data was reliant on self-reporting from primary care and national data sources and may therefore not convey a full picture for BSW – **Action (RRS workstream): Develop and conduct a BSW primary care workforce survey**.
- Mental health – providers like AWP, spanning two or more systems, needed to be enabled to participate in workforce development in each system they operate in;
- Enabling carers to remain active workers – recognised that BSW needed a comprehensive approach / policy to enable employees with caring responsibilities to remain active in the workforce;
- Social care – recognised that there was a disparity in job attractiveness when comparing similar roles offered by different employers; greater awareness of the employment market place was needed, and could be gained and addressed through the Integrated Care Partnership (ICP, to be developed / established)
- Recruitment – recognition that health and care often competed unsuccessfully with private sector high entry offers when recruiting to non-registered / early

career post; closer working with Local Enterprise Partnerships could remedy this.

10. Greener BSW

10.1 Dr Nick Watts, NHSE Chief Sustainability Officer, gave a stimulus presentation setting out the rationale for an NHS response to climate change. The Partnership Board then discussed the imperative to articulate / consolidate BSW's level of ambition, and how / where the ICS could add value by aligning and galvanising individual partner organisations' green ambitions and strategies. Discussion highlighted:

- there was significant value in resourcing coordination across all BSW partner organisations, and in articulating a shared vision that comprised all partners while recognising their individual ambitions / targets;
- the ICS working together would give all organisations and sectors clout to make changes across the entire system and help organisations address and deliver their social responsibility;
- clarity of aims and ambitions, and consistent measurement of achievements / performance against these, was crucial;
- recognition that 'green' excites the workforce and that this needed to be harnessed e.g. in recruitment;
- recognised that 'green' required investment, which competed with other priorities e.g. ensuring the safety of health and care infrastructure;
- recognised that changed approach to outpatients – i.e. shift to virtual appointments adopted during Covid – could be retained and contribute to reduction of traffic;
- community services delivering care at home – the impact on staff efficiency / effectiveness needed to be considered, also the accessibility / affordability of electric vehicles for the population and NHS staff alike.

10.2 The Partnership Board agreed to develop a galvanising kick-off event to put a 'Greener BSW' firmly on the agenda, and to develop a system strategy (**Action S Yeo**). Partners were asked to identify sustainability champion/s who would actively support the strategy development.

11. ICS Development

11.1 The Partnership Board considered a first draft of the ICB Constitution. 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. Per the national ICB establishment timeline, CCGs are to conclude engagement with partners re ICB Board size and composition by 17 November 2021, and to agree size and composition of ICB Board with NHS region by 19 November 2021.
The ICB will be a statutory NHS organisation reporting into NHSE.

11.2 The BSW Partnership Executive's System Architecture and Local Systems Working (SALSW) Group had considered the proposals also in the past days. It had considered that the proposed ICB Board options were open to some interpretation regarding acute NHS Trust membership, and should be clearer re the need for acute provider expertise.

11.2 Initial feedback from the Partnership Board

- focussed on how the role of 'place' as load-bearing should be enabled through the governance arrangements, and how local democratic structures such as Health and Wellbeing Boards and / or Scrutiny Committees should and could be utilised to enable both accountability, and public involvement;
- underlined local authorities' view that B&NES, Swindon Borough Council, and Wiltshire Council should all be included in the ICB Board membership;
- recognised the national steer that the ICB Board should not be a representative forum, yet emphasised the perceived need for balanced representation of sectors on the ICB Board;
- emphasised the need to ensure that the public voice is heard; further exploration of the role that Healthwatch could play to drive and ensure public involvement with the ICS would be desirable;
- underlined the desire to streamline governance and decision-making arrangements.

11.3 To further the development and consolidation of the ICB and system governance arrangements, an LGA-facilitated workshop would be held with local authorities in October. Healthwatch was keen to explore how it could best support the ICS. The Partnership Chair and SRO reiterated their offer to meet partner organisations' Boards.

11.4 Partner organisations were now invited to feedback on the draft ICB Constitution. A formal invite to engage with this would be issued in the next days.

12. Transformation work streams, update report (PB/21-22/027)

12.1 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. The report format now increasingly highlighted exceptions and focussed on evidence of impact.

12.2 The Partnership Board **noted** the reports, in particular the Acute Hospital Alliance's progress in meeting the provider collaborative agenda; and progress made with developing an urgent care strategy. Noted that operational pressures were impacting on transformation.

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.

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	30/09/2021: Development underway; the programme Team is working on a series of real-life examples / patient stories related to our Paediatrics, Dermatology, Ophthalmology BSW virtual teams work, and also our procurement collaboration
01/10/2021	8. BSW Performance, quality and finance report	To circulate a briefing note summarising the financial allocation to BSW for H2, and implications of policy steer for H2.	C Gregory	
01/10/2021	9.Deep dive: People and workforce	Develop and conduct a BSW primary care workforce survey.	RRS workstream	
01/10/2021	10.Greener BSW	To develop a galvanising kick-off event to put a 'Greener BSW' firmly on the agenda, and to develop a system strategy	S Yeo	
01/10/2021	10.Greener BSW	To identify sustainability champion/s who would actively support the strategy development	All	

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BSW H2 Plans including Winter Resilience and Elective Recovery 2021-22

BSW Sponsorship Board

19th November 2021

Introduction

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The winter plan aims to demonstrate that the BSW system:

1. Reflects a whole system approach to the delivery of services over the forthcoming winter period
2. Understands the demand on all sectors and their dependency on one another
3. Has a system escalation plan, using the SHREWD system, which is explicit about the expectations of each organisation, particularly in periods of heightened escalation
4. Will ensure that seasonal infection demand will not compromise patient care, experience and service standards. Planning in addition for further Covid-19 surge and agreeing a system response
5. Has robust policies and procedures in place to ensure that patients remain safe in our health and care services
6. Has identified the potential risks and has actions in place to mitigate against them

The 21/22 plans consider the following:

- Lessons learnt from 20/21
- UEC 10-point Recovery plan (Microsoft PowerPoint - UEC Recovery 10 Point Action Plan.pptx (england.nhs.uk))
- H2 Planning Submission
- Utilising the existing Demand & Capacity analysis completed in 2021

10 point UEC Recovery Plan

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1. Supporting 999 and 111 services
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of Urgent Treatment Centres (UTCs)
4. Increasing support for Children and Young People
5. Using communications to support the public to choose services wisely
6. Improving in-hospital flow and discharge (system wide)
7. Supporting adult and children's mental health needs
8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
9. Reviewing staff COVID isolation rules
10. Ensuring a sustainable workforce

BSW Winter Plan Contributors

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- All contributors are represented on the BSW Urgent Care and Flow board

Area	Contributors
BaNES ICA	Royal United Hospital Bath (Acute), Virgin Care (Community), BaNES Council (Local Authority), Age UK (Third Sector), in-hours Primary Care, BEMs+
Swindon ICA	Great Western Hospital (Acute), Great Western Hospital (Community), Swindon Borough Council (Local Authority), Age UK (Third Sector), in-hours Primary Care
Wiltshire ICA	Salisbury Foundation Trust (Acute), Wiltshire Health and Care (Community), Wiltshire Council (Local Authority), Carers' Support Wiltshire (Third Sector), in-hours Primary Care, Wilcodoc
Mental Health, AD & ASD	Adults – AWP, Children's – Oxford Health
Ambulance service	SWASFT, + coordinate a response from SCAS
111/ IUC Provision	Medvivo
Transport	BSW co-ordinate with E-ZEC (note: Discharge Transport in Trust Plans)
Flu Planning & EPPR	IPC Flu - BSW CCG to co-ordinate. Public Health - Outbreak Planning. EPRR – Severe Weather - BSW CCG to co-ordinate
Communications Plan	BSW Communications and Engagement team

Planning approach

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- Similar to previous years, to ensure that the BSW system has stability and preparedness for winter, the winter planning process has been achieved by embedding multiple lines of defence building upwards from provider level, assurance at system then regional and national level
- Our approach to Winter planning started earlier than 20/21, with a dedicated demand and capacity planning group established with key partner representatives in April 21 to develop our Acute and Community Hospital Bed D&C model
- This model has been used to support with planning at locality and building on from initiatives and progress made in 20/21 with the introduction of the Hospital Discharge Policy and the H1 guidance for 21/22
- A system wide lessons learnt session was held on 24th June 21, in conjunction with BSW UEC strategy development session
- The outputs of these plans and session, and in conjunction with separate workstreams, have cumulated in our final system plan
- This plan is owned by all members of the BSW Urgent Care and Flow Board, and was presented and accepted at the 14th October 21 meeting in conjunction with our initial self RAG assessment against the final national key lines of enquiry (KLOEs) that were published on 5th October 21
- The final winter plan was approved at the BSW Oversight and Delivery Board on 22nd October 21

BSW Processes and timescales

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- The timescales to achieve the BSW system and regional assurance deadlines are outlined in the table below

Level	Planning and assurance processes	
Provider(s) and partners	Internal assurance boards / Contract meetings / Locality alliance tactical and operational meetings / standalone system workstreams e.g. Flu and Vaccination planning, Demand and Capacity	Apr 21 – Oct 21
System	System wide lessons learnt session	24th Jun 21
Provider / ICA	Final provider and ICA Winter plans shared	6th Oct 21
BSW Urgent Care	Urgent Care team to collate final winter plans and KLOE evidence	6th – 13th Oct 21
UCFB / System	Urgent Care and Flow board to review and agree final plan and KLOE submission	14th Oct 21
CCG	BSW CCG Governing Body	21st Oct 21
System	BSW Oversight and Delivery Board to approve final system plan and KLOE submission	22nd Oct 21
System	Final BSW System Winter Plan and KLOE Assessment submission	31st Oct 21
Region	Subject Matter expert KLOE reviews	21st Oct 21
Joint	System feedback	28th Oct 21

Identifying winter capacity and additional actions

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- The priority action areas identified are as follows:
  - Increasing discharges and flow alongside social care and community response
  - Admission avoidance
  - Virtual wards
  - Workforce

(Links to UEC 10 Point Recovery Action Plan Section 2, 6,10)

Ongoing BSW Urgent Care and Flow Work programmes

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1. Think 111 First (UEC 10 Point Recovery Action Plan Section 1)
2. 999 / Keeping people at home (UEC 10 Point Recovery Action Plan Section 1)
3. Ambulance Handover delays (10 Point Recovery Action Plan Section 1)
4. Same Day Emergency Care (UEC 10 Point Recovery Action Plan Section 6)
5. Emergency Care Data Set
6. Discharge to Assess and Flow (UEC 10 Point Recovery Action Plan Section 6)
7. Minor Acuity (UEC 10 Point Recovery Action Plan section 3)

Other areas covered within BSW Winter plan

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- **IP&C** – plans to increase vaccination update rates and minimise impact of circulating flu viruses. Mitigations to support and address seasonal outbreaks in community and care homes etc. **(UEC Recovery action plan section 8)**

- **Paediatric Surge** – actions cover demand including RSV, self care, primary care, secondary care and monitoring at system level **(UEC Recovery action plan section 4)**

- **Critical Care, elective and specialist capacity** – includes current capacity, additional capacity through reconfiguration and spot purchasing beds

- **EPRR** – including ICC coordination, daily battle rhythm for support and escalation, severe weather planning, mortuary capacity and on call

- **Communication and engagement programme** **(UEC Recovery Action Plan Section 5)**

- **Inclusion health** – Homeless health plans over winter **(UEC Recovery Action Plan Section 6)**

BSW Winter 21/22 Constraints and Risks

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Constraint / Risk	RAG	BSW Mitigation
Health and Social Care workforce	RED	• Workforce hub being explored • Dom care support – learning from other systems • System wide Operational People Group working on recruitment and retention plans • System wide discussions as to how to support dom care capacity – recruitment fairs, expanding in house dom care capacity, • Vaccination programmes – influenza and Covid –19 • Review of isolation processes for staff • MOU being explored amongst clinical teams to support cross organisational working • Redirecting staff to virtual working when isolating
Infection surge (Covid and Influenza)	AMBER	• Influenza plan and vaccination plan for public and staff • IP&C network reviewing daily • System outbreak management plans • Point of care testing and lateral flow to support patient placement decision • Review of elective pathways and relevant IP&C measures • Exploring cohorting areas for contacts • PHE advice ref local messaging
Paediatric surge (RSV and non-RSV demand)	AMBER	• Commencement of Paediatric surge clinical group • Developing dashboard to review situation • Paediatric hot hubs being set up • Pulse oximetry for paeds to be available • Use of Handi App and comms and engagement plan being worked up • Tabletop exercise to stress test Paediatric surge plans
Change in public behaviours and comms	RED	• System wide comms plan being implemented • Exploring further options for messaging • PHE advice ref local messaging
System Flow incl. SWASFT	RED	• UC&FB programmes • ICA improvements in admission avoidance and Urgent community response actions • Demand and capacity modelling and schemes to mitigate the risk • 12 and 24 hr disposition review • Category 2 clinical validation pilot

BSW Winter 21/22 Constraints and Risks

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Constraint / Risk	RAG	BSW Mitigation
Governance	AMBER	• Review of UC&FB and reporting structures underway • Review of work programmes within UC&FB • Outline of winter business rhythm submitted as part of the winter planning process • Functional mapping ongoing
Data and Information	AMBER	• Demand and capacity information completed and understanding of the key areas of risk – bed gap identified and relevant schemes to mitigate risk • SHREWD Programme Manager to be appointed to develop system to full potential
Escalation and Comparison of Risk	AMBER	• Review of BSW system escalation plans • ICA plans mirror and align • Develop SHREWD in order to ensure system visibility of rising pressures and demands • Acute alliance risk review • Regional OPEL framework review to be updated in local plans
Minor acuity and presentations	RED	• Minor workstream as part of the UC&FB • Enhanced clinical validation • Work with SWASFT to reduce conveyance and provide earlier system interventions
Primary Care demand	RED	• Action plan developed following a primary care leads call • System Communications plans • Change in 111 provider – Nov 21 leading to improvements in service levels • Winter Access Fund letter actions • Community pharmacy – further develop information as an alternative to primary care

Areas in yellow identified through the risk summit

Summary and next steps

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- At a recent assurance meeting with NHSE/I we were challenged regarding the deliverability of our winter plans – were they realistic and address system challenges; did they reconcile with elective plans and had we triangulated with financial and workforce plans?

- Given current urgent care system pressures and concerns about risk shared by the Acute Alliance, further work is needed to:

    1. Review Demand and capacity work using expected levels of demand over winter and higher COVID levels and asses impact on urgent care system
    2. Reconciliation of urgent care assumptions against elective plan – derived occupancy levels suggest over 100%+
    3. Financial analysis of planned investment and projection for H2 expenditure
    4. Stress test of all winter plans and current priority areas

- The outputs will be fed into the Urgent Care and Flow Board on 16th November. We expect there to be a projected acute bed gap.

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Elective Recovery

NHSE Expectations

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- 89% of clock stops versus 19/20
- 12 advice and guidance requests per 100 new outpatients
- At least 5 specialities using Patient Initiated Follow Ups and incremental increase in use
- Zero 104 week breaches by 31/3/22 except for patient choice (P5/P6)
- Maintain number of 52 week waiters as at September 21 number
- Identify our risk areas to the above for planning submission
- No specific target on total incomplete waiting list number but expectation that targeting non-admitted pathways will reduce overall number waiting
- No potential over 104 week breaches without a Decision To Admit by 31 November 21
- No over 52 week breaches as at 31/3/22 without a Decision To Admit
- Cancer – 62 day standard improved to a set number of breaches

Planning submission draft

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- Exceeding the 89% of clock stops versus 19/20
- Advice and guidance standard being met at system level
- Already achieving patient initiated follow ups and we are under reporting activity progress
- Plan has no 104 week breaches from Feb 22 onwards
- 52 week position is stabilised
- Waiting list grows by 4% (before validation impact)
- Exceeds expectation for 62 day cancer standard improvement
- Forecast additional income earned through elective recovery fund - £8.7m

Targeted Investment Funds (£3.9m capital, £3.1m revenue, £3.9m digital)

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Two programmes submitted made up of many initiatives:-

- Critical and urgent care to support elective resilience
- Additional elective care (equipment, locums, insourcing, mobile diagnostics, validation and customer care teams)
- Plus 7 digital bids
- Additional activity in H2
  - 1,076 day cases and electives
  - 2,326 outpatients
  - 3,192 diagnostics

2021/22 H2 Workforce Planning

Workforce Position Summary

Workforce Planning for NHS Workforce as at 30 September 2021

A draft plan has been submitted against an establishment of 13,995wte at the end of H2 in respect of the NHS workforce in line with the planning requirements

Work is ongoing to capture the overall workforce data to include social and primary care, recognising that the level of granularity of this data is difficult to obtain and if it exists

H2 plans indicate an overall vacancy level in substantive staff of 455wte at the end of March 2022

The breakdown of these vacancies is;

Total Clinical Staff (non medical)	201wte
Medical and Dental Staff	54wte
Non Clinical/Non Medical	200wte

Workforce by Staff Group

H2 plans indicate an overall vacancy level in substantive staff of 455wte at the end of March 2022

Total Clinical Staff (non medical)		**201wte**
Registered Nursing	79wte	
AHP	21wte	
Health Care Scientists	24wte	
Support to Nursing staff	26wte	
Support to STT & HCS staff	58wte	
Medical and Dental Staff		**54wte**
Consultant	35wte	
Career/staff grades	51wte	
Trainee Grades	-32wte (over-delivery)	
Non Clinical/Non Medical		200wte

Schemes to support workforce plan – Retention

- Commencement of NHS Cadets in 3 sites across BSW in January 2022
- Further 2 – 3 Sector based Academy programmes with the DWP (45 attendees)
- Kickstart to create 30 roles by end December 2021
- T-level support for 23 students where programmes have commenced across BSW Further Education institutes
- Targeted project by the BSW AHP faculty to focus on the AHP support worker role and explore how the role can be expanded to reduce skills gaps and can provide a reliable pipeline for registered training via apprenticeships etc.
- Increase in apprenticeships to build on 17% improvement in 2021 (compared to 2020)
- Clinical Placement expansion (CPEP) programmes have commenced – at least 60 more registrants
- Two BSW Nurse Training hubs developed in partnership with UWE and OBU with 100% BSW placement support with the majority of students placed in Community and Primary Care (18 additional Student nurses recruited).
- Inclusive recruitment and delivery of equality, diversity and inclusion initiatives

Schemes to support workforce plan – Retention

- Recruitment of a dedicated system lead for retention - £75k Retention Support Offer funding (subject to approval)
- Implementation of ‘Itchy feet/ Stay’ or ‘talk before you walk’ conversations
- Line managers training / coaching programme for ‘people first’ conversations
- Eroster review and ‘rethinking’ based on projects to support self-rostering and unlimited shift requests
- Flexibility in working pattern for all, particularly for maternity returners
- Standard talent management and succession planning processes across BSW (Scope for Growth)
- In Primary Care, continue with the implementation of a GP Flexible Pool, offering practices a staff rostering system for efficiency, enabling more staff to join a Primary Care bank and increase flexible options for working within BSW
- +55 career flexibility – less demanding role opportunities, reduced hours, flexibility and flexible retirement approach

Schemes to support workforce plan – Health & Wellbeing

Continued development of the BSW Wellbeing Matters Hub that currently delivers:

- Specialist assessment for the person contacting the team to signpost them on to appropriate services as required
- Provide interventions for individuals (up to 2 sessions)
- Consultations for teams and/or organisations across BSW to discuss the stresses and pressures affecting their staff
- Training and support for BSW services in order to support their wellbeing at work
- Delivering a series of webinars that are accessible to all colleagues across BaNES, Swindon and Wiltshire i.e. understanding anxiety, managing stress in your workplace
- Colleague helpline, confidential email and website: http://www.awp.nhs.uk/advice-support/bsw-wellbeing-matters/
- Organisation level interventions and specialist support, including OH and EAP services

Risks

Risks
Absence due to Covid 19 and households self isolating
Wearying of the workforce and high sickness absence related to post covid exhaustion
McCloud pension judgement and impact on number of leavers and retirements
National staff shortages in some professions and high demand leading to an inability to recruit to hard to fill / shortage occupation posts
Reduction in pipeline from HEI's of newly qualified clinical candidates
System, health and care pressures
Social Care – no jab no job impact
GP attrition and aging workforce
Aging workforce and predicted retirements
Level of maternity leavers who do not return to any contractual commitment

Opportunities

Opportunities
International recruitment pipeline open
International Nurse Recruitment Funding Offer 2021/22
Retention Support Offer funding
BSW Academy and related pillar activities – Leadership, Learning, Innovation, Improvement, Inclusion
Apprenticeship funding from HEE for Trainee Nurse Associates and Registered Nurses
Greater BSW system collaboration
ICS structure and 10 people function outcomes for greater alignment
New care model and modelling of workforce to support

2021/22 H2 Financial Planning

Financial Position Summary

Bath and North East Somerset, Swindon and Wiltshire Partnership
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- **Financial Position @ First Draft 21st October 2021**
  - Draft Plan have been submitted to NHSEI Regional team reflecting a break even position with £18m of risk.
  - Mitigations include use of ERF monies, slippage on SDF, accruals carried forward from 2022 and holding back the 0.5% fund for region
- Provider income and CCG BSW expenditure assumptions have been agreed for planning purposes only. Any adjustments will not effect the system total but may affect delivery of individual organisations positions.
- We will continue to work through the ERF modelling in order to get a robust plan for the final submission on the 16th November
- Appreciate we have not as yet set all organisations across the system a challenging efficiency target- we are considering how we tie this into next stages of our financial sustainability programme by focusing on specific areas and also redirecting our efforts toward productivity which we think we offer greater returns in the immediate future

Financial Risks and Opportunities

Risks	Opportunities
RUH NHP SOC costs - £4m	ERF Income assumption- £8.7m
Sulis costs for H2 - £1.6m	Benefits from prioritisation of Non Recurrent funding- £8.4m
Increase in staff absence due to sickness/burnout and annual leave- £2m	Increase non recurrent efficiencies- £6.5m
Covid and Winter Costs higher than expected- £5m	National funding including ERF opportunity of £100m – circa £15m based on capitation share. Primary Care to improve capacity and access - £4m

Underlying financial position

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BSW system undertook a DoD analysis early 19/20 to determine underlying financial position – this identified anticipated system deficit of £70m, representing a real, annual cash shortfall. Common themes for address were identified including:

- Workforce is a real constraint, evidenced by large agency usage across all providers
- The higher proportion of acute care is non-elective activity
- Good investment in community and primary care does not appear to have impacted upon the workloads of acute providers
- Back office functions are an opportunity (strategic system collaboration)
- IT/Digital maturity system wide is inconsistent and could stifle innovation.

Further work has been carried to determine the 2020/21 FOT Underlying Deficit which has increased to £117.3m, mainly driven by undelivered efficiency savings and increased covid costs. Agreement has been reached across SW that all systems work to a common set of assumptions to determine their underlying position as we exit 2122

Productivity

Bath and North East Somerset, Swindon and Wiltshire Partnership
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- Ongoing discussions, recognising this isn't cash releasing, therefore doesn't help directly reduce our underlying deficit or meet the cash efficiency targets in year.

- There is optimistic scope to deliver productivity savings which in turn will reduce the amount of money we need to spend on ERF and growth, but this is a stretch target from where we currently are.

- What we are doing:
  - Reviewing Covid costs- looking across the providers to benchmark where covid costs are higher, talking to clinical teams to identify IPC differences in practice to enable reduction in costs.
  - Opportunities to pool resources- GWH and SFT working together to pull together a financial analytics team, this includes what was the historical costing/contracting team, recognising we need different skills to apply to the way we work moving forward. Idea is to create a central team of high quality financial analysis which then underpins our financial management teams working directly with clinicians.
  - Looking at all the benchmarking data– GIRFT, Model hospital, we know we are inefficient. All three main providers challenged with theatres, looking how the improving together programme which all three acutes are doing can centre round theatre improvement to share cross learning and pathway changes.
  - Using what we can through patient choice framework to move patients round the system to ensure their opportunity for treatment has increased; working on a clinical strategy to underpin this
  - Have identified some inefficiencies are a result of the booking strictly within clinical criteria e.g. P1, P2 etc, where to ensure lists run efficiency we are looking at how we might be more flexible. Pragmatism around we use the criteria to take opportunities to treat patients quicker
  - Workforce one of the biggest challenges to operational efficiency, particularly in theatres, all three acutes challenged. Looking at overseas nursing.

Submission Timetable Milestones and Leads

Bath and North East Somerset, Swindon and Wiltshire Partnership
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2 November	Final system deadline for narrative content	Section Leads: As per 26/10/21
5 November	System Planning Group final review of all elements of 16/11 submission content	ALL Leads
12 November	Update to BSW Partnership Exec final sign off of submission understanding further work still to be completed	Julie-Anne Wales/Programme SROs
16 November (noon)	Final numeric submission: • Activity & performance • Workforce Final narrative submission Final narrative submission Excel template – elective recovery Finance: system submission Finance: Specialised commissioning/ direct commissioning refresh BCF Planning Submission and BCF narrative template	 Danni Harris Danni Harris (with support from Rupert Milsom) David Jobbins (with leads as per 26/10/21) Mark Harris Caroline Gregory/ Joss Convey Spec Comm Locality COOs
19 November	Overview of H2 submission at BSW Sponsorship Board	Programme SROs
25 November (noon)	Provider organisation finance plan submission	Submitted by provider

Risks and Opportunities within the plan

Bath and North East Somerset, Swindon and Wiltshire Partnership
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Risks	Opportunities
Workforce constraints	New Care Model and opportunities for system collaboration
Capacity shortfall due to increased demand/acuity/infection surge/paediatric surge/reduced system flow.	Stress testing of current plans and mitigations and reverse modelling of impacts and VFM
Elective activity volumes not met resulting in rise in overall numbers waiting and increased numbers waiting over 52 and 104 weeks and risk to urgent and cancer patients.	System collaboration to manage patients waiting in high risk specialties. Modelling of impact of worst case scenarios on P1 and P2 patients
Income below anticipated level and inability to cover costs incurred and winter delivery costs higher than anticipated.	National funding including ERF opportunity of £100m- BSW share TBC and Primary Care to improve capacity and access - £4m. Review of VFM of all schemes.

Bath and North East Somerset, Swindon and Wiltshire Partnership
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Meeting of the BSW Partnership Board

Report Summary Sheet

Report Title	Urgent and Emergency Care Strategy					**Agenda item**	9	
Date of meeting	19th November 2021							
Purpose	Note		Discuss and Agree	x	Inform		Assure	
Author, contact for enquiries	Emma Smith BSW CCG - esmith17@nhs.net Ruth Gazzane SCW CSU - ruth.gazzane@nhs.net							
Appendices	Appendix 1 – Feedback and Consultation Session (within the papers) Appendix 2 – Health Inequalities Information Appendix 3 – Citizens Panel Report							
This report was reviewed by	Urgent Care and Flow Board – 18th November 2021 Urgent Care CCG Clinical Lead Dr Nicola Jakeman Dr Mark Boothman Dr Louise Abson Dr Sarah Blaikley Urgent Care Strategy task group including patient and public engagement team and NHS E/I.							
Executive summary	The Urgent and Emergency 5 year strategy has been developed in order to help shape sustainable services of the future within BSW. The strategy contains the following areas to help provide the balance of back ground information that will inform the service changes and developments. • National and local UEC context • How the strategy can support closing the inequalities gap across BSW • The Urgent Care Model ambitions • Workforce developments needed • The links with existing BSW work programme / strategies • The changing landscape due to the pandemic							

Report Title	Urgent and Emergency Care Strategy	**Agenda item**	9
Equality Impact Assessment	Equality Impact assessments will be carried out during the individual service developments at the next stage.		
Public and patient engagement	Public and Patient engagement have been part of the strategy development team. In addition a citizens panel focusing on urgent care services took place in August 2021 - details and outcomes are within the strategy.		
Recommendation(s)	1. The Committee is asked to **approve** the Urgent and Emergency Care strategy. 2. The Committee is asked to **support** the next steps of development to ensure delivery of the strategy and support engagement across the different work programmes and strategies for achieve the best patient outcomes.		

Risk (associated with the proposal / recommendation)	High		Medium	x	Low		N/A	

Key risks	The key risks for the strategy are: • Lack of delivery of ambitions within the strategy life span. • Limited engagement across BSW work programmes impacting on UEC. • Workforce to deliver the required changes across BSW. • If the strategy is not implemented as a whole system across BSW.
Impact on quality	The strategy contains a section regarding quality and patient safety which clearing sets out the impacts within this area and the quality ambitions.
Resource implications	No costs have been identified within the strategy however further work will take place during the development stage.
Conflicts of interest	No conflicts of interest have been identified at this point however this will be revisited during the development stage.
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

Do not embed documents / appendices, submit these separately as individual documents

Bath and North East Somerset, Swindon and Wiltshire Partnership

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Bath and North East Somerset, Swindon and Wiltshire Urgent and Emergency Care

5 Year Strategy

2021 – 2026

"Ensuring people access the right care, in the right place, first time"

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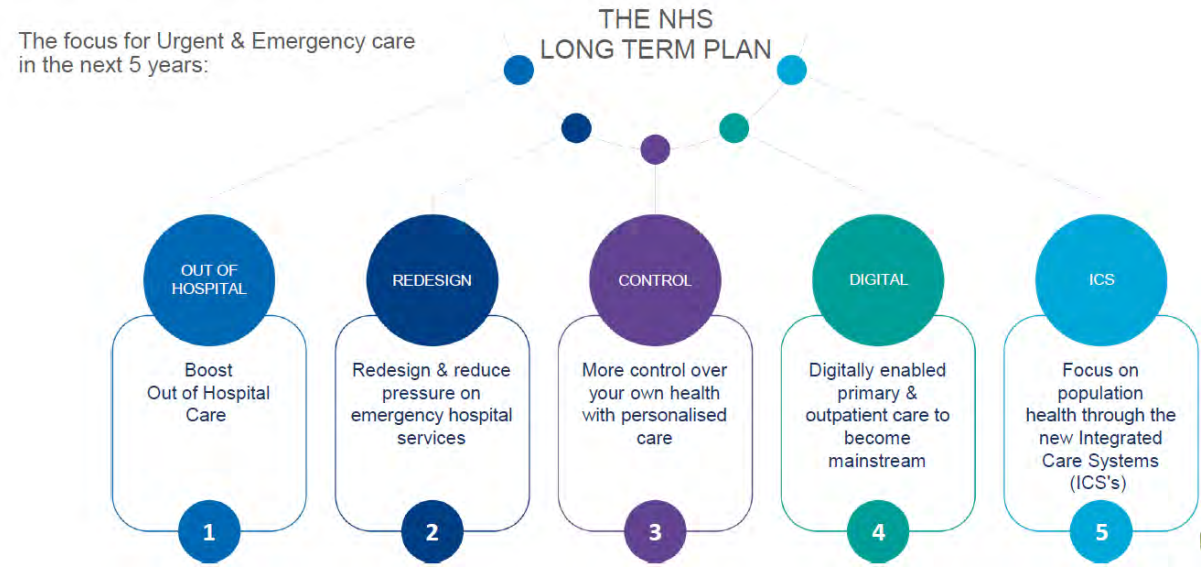
National Context to Urgent and Emergency Care

In January 2019 the long-term ambitions for the NHS were set out in *The NHS Long Term Plan*, which included the plans for urgent and emergency care and this is considered in this strategy.

The key areas of focus that need to be incorporated into future planning for the Bath and North East Somerset, Swindon and Wiltshire (BSW) system are set out in *Chapter 1 – A New Service Model for the 21st Century*.



A critical part of the urgent and emergency care pathway development is to ensure sustainable services to meet rising demand and keeping care closer to home. Arguably the most important area is to boost 'out of hospital' care working in partnership with community and primary care services. The Long Term Plan will be asking systems within the 5 years the plan encompasses to ***improve the responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate. In addition, all parts of the country should be delivering reablement care within two days of referral to those patients who are judged to need it.*** The aim of this is to reduce admissions both in secondary care and residential care when appropriate and ultimately freeing up 1 million hospital bed days.

All emergency care systems are under pressure both pre and post the covid 19 pandemic, the LTP states that the number of patients within the accident and emergency department successfully treated within four hours is 100,000 per month higher than five years ago. However, reforming the urgent and emergency care services will ensure patients receive a quick response to their needs reflecting in a reduction in A&E attendances particularly over the period of peak demand during winter.

The key **milestones** that have been set out in the NHS Long Term Plan for urgent and emergency care are:

- *In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.*

• *All hospitals with a major A&E department will:*
• *Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20*
• *Provide an acute frailty service for at least 70 hours a week. They will work towards achieving clinical frailty assessment within 30 minutes of arrival;*
• *Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020.*
• *Test and begin implementing the new emergency and urgent care standards arising from the Clinical*
Standards Review, by October 2019
• *Further reduce DTOC, in partnership with local authorities.*
• *By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.*

The LTP sets out in detail the expectations of each system in the development of urgent and emergency care services in order to support their population and will need to be taken into consideration for the BSW Urgent and Emergency Care Strategy.

Pre-hospital urgent care – in order to help patients, navigate the urgent care system effectively each area will require a clinical assessment service (CAS) that is embedded within its NHS 111 service, as well as ambulance dispatch and out of hours GP services that will provide specialist advice, treatment and referral from a wide array of healthcare professionals, encompassing both physical and mental health. This will enable access to medical records supporting better care. The CAS will also support health professionals working outside hospital settings, staff within care homes, paramedics at the scene of an incident and other community-based clinicians to make the best possible decision about how to support patients closer to home and avoid unnecessary trips to A&E.

Urgent Treatment Centres to be established at place level to offer out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. These centres will work alongside primary care, community pharmacy, ambulance and community services to ensure they are locally accessible to patients and become the service of choice rather than A&E.

Ambulance services are at the heart of the urgent and emergency care system. Systems need to ensure that the recommendations as set out in the **Lord Carter report** are implemented to ensure optimal clinical and operational performance is achieved. It is critical that the Urgent and Emergency Care systems provides flow to ensure that ambulance handover delays are eliminated and where there are long delays immediate action is implemented to address them.

Same Day Emergency Care - This is a model co-developed by the Royal College of Physicians and the Society of Acute Medicine, providing a service that reduces the need for hospital admission by providing rapid diagnostics and treatment within a few hours and as a result, reported growth in non-elective hospital 'admissions' are now disproportionately being driven by so-called 'zero-day admissions' (patients who are not actually admitted to an inpatient overnight acute bed). Whilst developing an SDEC service the inclusion of an acute frailty service should be considered so that patients can be supported by a skilled multi-disciplinary team (MDT) delivering a comprehensive geriatric assessment in A&E and acute receiving units.

NHS clinically led review of UEC standards is aiming to develop new ways to look after patients with the most serious illness and injury, ensuring that they receive the best possible care in the shortest possible time frame. For people that arrive in A&E following a stroke, heart attack, major trauma, severe asthma attack or with sepsis, pathway improvements will ensure a timely assessment and treatment in order to reduce the risk of death and disability. Clinical experts have been working with patient groups nationally to ensure that these pathways

deliver improvements in patient outcomes, so that the NHS continues to lead the world in the quality of care that it provides for those with the greatest need.

The new "bundle of ten standards" as set out in the clinical review aimed at helping patient flow and improved outcomes are set out below:

Pre-hospital

- Response times for ambulances
- Reducing avoidable trips (conveyance rates) to emergency departments by 999 ambulances
- Proportion of contacts via NHS 111 that receive clinical input

A&E

- Percentage of ambulance handovers (from ambulance to A&E) within 15 minutes
- Time to initial assessment — percentage within 15 minutes
- Average (mean) time in department — for non-admitted patients

Hospital

- Average (mean) time in department — for admitted patients
- Clinically ready to proceed (time from when decision is made to admit or discharge, and patient is admitted or discharged)

Whole system

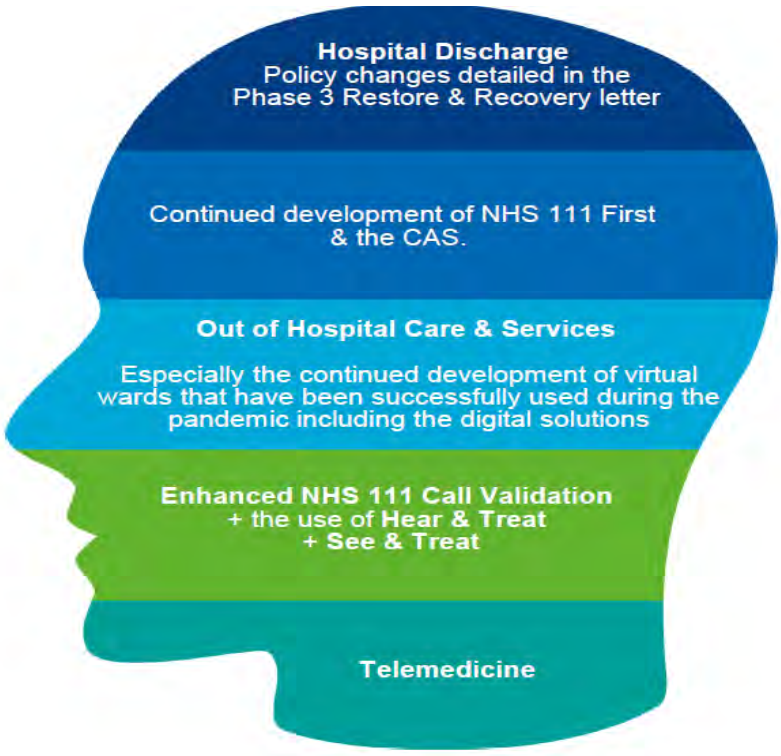
- Patients spending more than 12 hours in A&E
- Critical time standards — aimed at ensuring the highest priority patients get care within a set timeframe such as an hour

Accurate and timely data - The new Emergency Care Data Set will enable a better understanding of the needs of the patients currently accessing A&E departments. UTCs and SDEC services were embedding in the ECDS from 2020. An equivalent ambulance data set that will, for the first time, bring together data from all ambulance services nationally in order to follow and understand patient journeys from the ambulance service into other urgent and emergency healthcare settings.

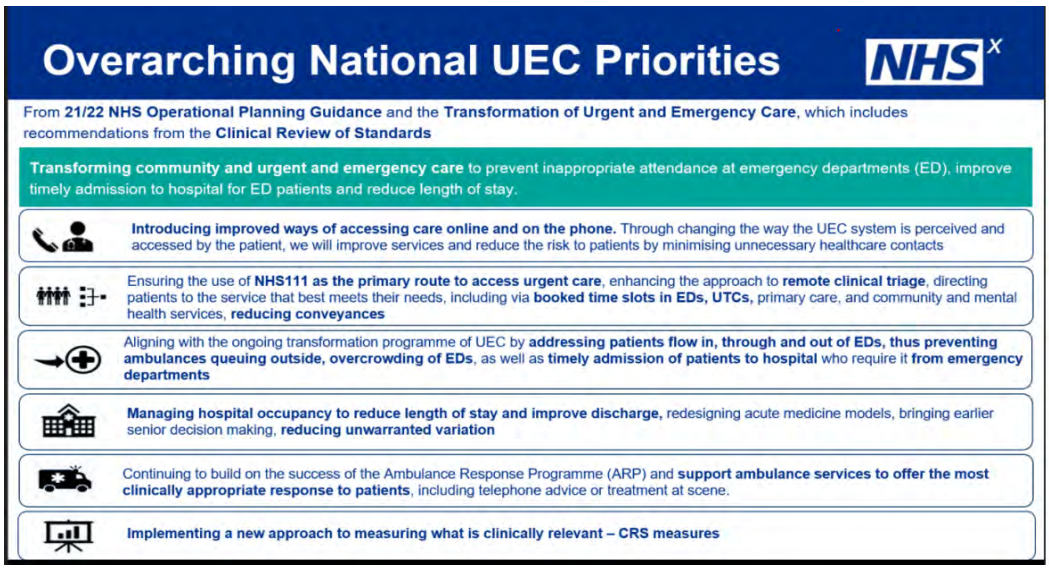
The NHS and social care will continue to improve performance at getting people home without delay when ready to leave. This reduces the risk of harm to patients from deconditioning during this delay period. The aim being to achieve an average DTOC figure of 4,000 or fewer delays with the longer term ambition to reduce this even further. This will be achieved by placing both therapy and social work teams at the beginning of a patient's journey,

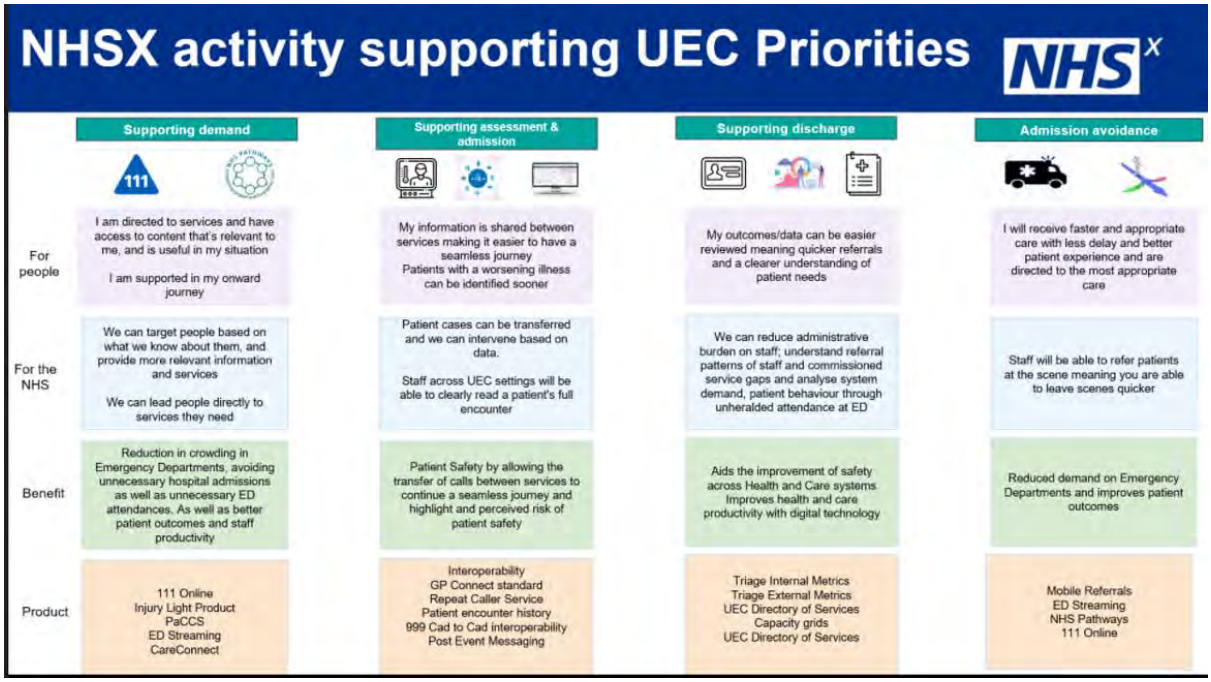
expected discharge dates set at this stage and the implementation of the SAFER patient flow bundle and multidisciplinary team reviews on all hospital wards every morning.

Something to think about



In July 2021 NHS X shared at the Transforming Urgent Care and Patient Flow Conference: Improving access and indicators conference shared the national drivers and priorities as set out in the 21/22 NHS Operational Planning Guidance including the recommendations from the Clinical Review of Standards.





Together with the ambitions set out in the NHS Long Term Plan this will provide the backdrop for the context for the BSW strategy, the developments required to reach the ambitions to ensure a sustainable service for the future is built to support the population of BSW.

Whilst developing the strategy all future ambitions need to ensure a Green NHS is considered and that BSW as a system is focused on the contribution contributions to Net Zero ambitions.

Why a Greener NHS?

- Climate change poses a major threat to our health as well as our planet
- The pace of environmental deterioration is accelerating, and this has direct and immediate consequences for our patients
- By tackling climate change we reduce causes of ill health from air pollution, heatwaves and extreme weather
- Reaching the UK's ambitions under the Paris Climate Change Agreement could see across the UK:
    - 5,700 lives saved each from improved air quality
    - 38,000 lives saved through more active lifestyles
    - Over 100,000 lives saved through healthier diets

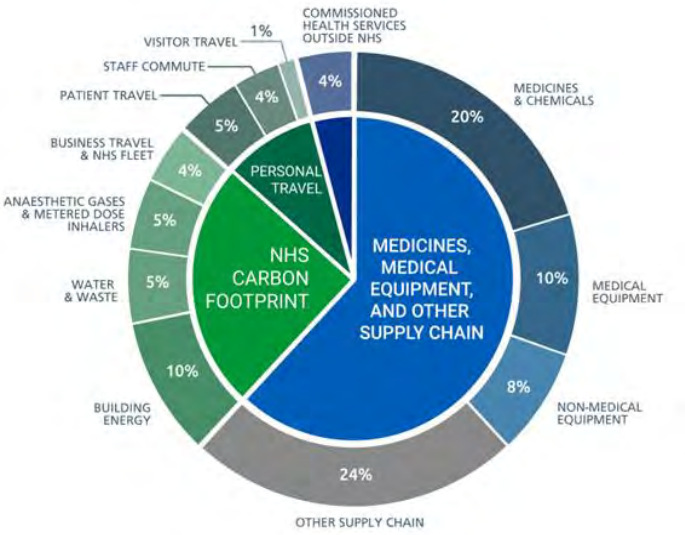
The NHS in England is responsible for an estimated 4% of the country's carbon footprint, and 40% of the total public sector footprint.

With 1.3 million staff we have a huge opportunity to make a difference

NHS Net Zero Strategy, published in October 2020, set out a vision to become the world's first net zero carbon health service and respond to climate change, improving health now and for future generations.

24% of NHS carbon emissions we directly control (the NHS Carbon Footprint). Net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.

76% of NHS carbon emissions we can influence (our NHS Carbon Footprint Plus). Net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039, and net zero by 2045.



Local context - Bath and North East Somerset, Swindon and Wiltshire

The BSW Sustainability and Transformation Partnership was formed in 2016 and, in December 2020 the BSW Partnership was formed that will become an Integrated Care System (ICS) from April 2022. This is underpinned by our Integrated Health and Care Strategy and delivery model within which our local population is at the centre, surrounded by our different services.

The BSW Partnership has a combined population of c.940,000 and is served by three local authorities- Bath and North East Somerset Council, Swindon Borough Council and Wiltshire Council, and a single Clinical Commissioning Group. A range of partners contribute to the urgent and emergency care landscape locally and these can be found here.

Overall BSW is less deprived than other parts of England though there are pockets of deprivation where people do not live as long and are more likely to have health issues sitting alongside more wealthy communities. For example, in some areas of Wiltshire, the gap in life expectancy between the most and least deprived is 11.7 years. One of our goals, working across geographical boundaries and with better collaboration, is to reduce this variation in outcomes and to provide an equitable service offer across BSW.

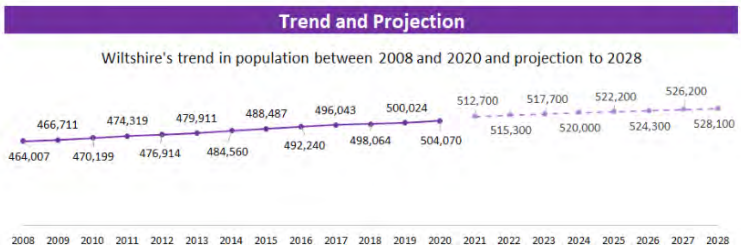
Cancer, cardiovascular disease and respiratory disease are the main causes of death here, but we know that people in deprived areas will suffer more from these diseases. A focus for our system is to help people to improve their outcomes, or prevent disease, by making healthier choices about smoking, over-eating and alcohol use.[1]

Some areas of BSW (such as Wiltshire) have a larger proportion of older people than the England average and this proportion is likely to greatly increase in the future. In the coming years, we expect the BSW older population to grow considerably with an increase of c.30 percent between 2020 and 2024 – with over 100,000 people being aged over 75 in the area by 2024. Many of these people have multiple long-term illnesses[1].

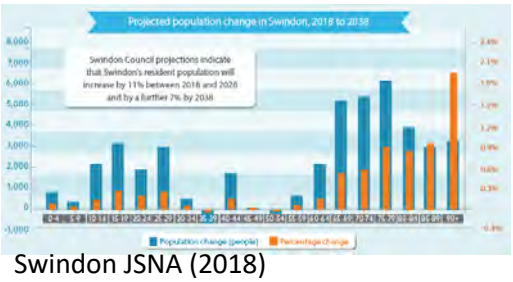
We also expect significant population growth in Wiltshire because of an on-going programme to relocate army personnel into the authority and a number of large-scale housing developments planned or underway.

[1] Our plan for health and care 2020-2024 (2020), Bath and North East Somerset, Swindon and Wiltshire Partnership https://bswccg.nhs.uk/docs-reports/strategies-and-reports/335-bsw-our-plan-for-health-and-care-2020-2024-full-version/file

Overall, the BSW population is increasing at a rate higher than the national average. This increase in population, as well as other interdependent factors, are impacting on the activity levels[2] [3].



Wiltshire Intelligence (2020)
https://www.wiltshireintelligence.org.uk/population/population-overview/

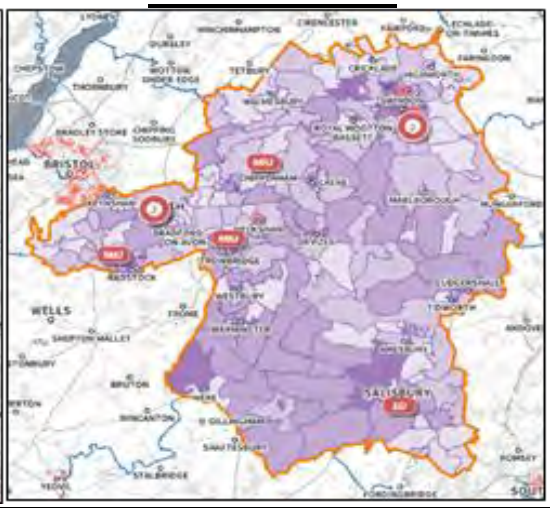


Swindon JSNA (2018)
https://www.swindonjsna.co.uk/pictures

There are 33 local areas in BSW that have been identified with the highest areas of multiple deprivation, and a further 59 local areas that have second highest levels of deprivation. Map 1 below highlights areas in BSW that are classified as being in the two highest quartiles with deprivation – with the 20% of high deprivation highlighted in red. Map 2 below shows the location of the A&Es, UTCs and MIUs in BSW together with the multiple deprivation areas shown in deep purple.

Map 1

Map 2



[2] Wiltshire Intelligence (2020) https://www.wiltshireintelligence.org.uk/population/population-overview/

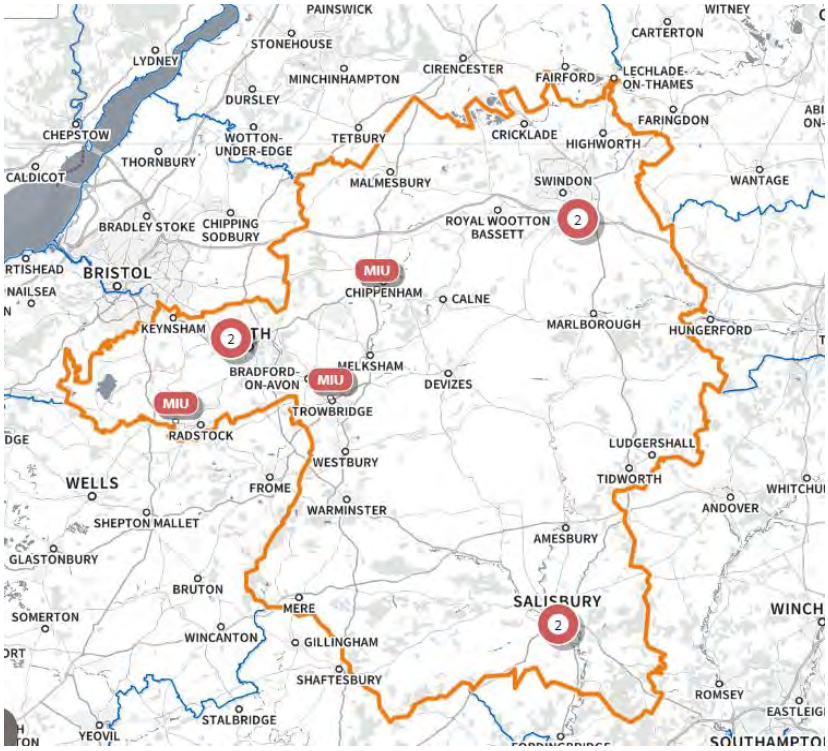
[3] Swindon JSNA (2018) https://www.swindonjsna.co.uk/pictures

As can be clearly shown in the maps above Swindon has the highest cluster of the top 20% of deprivation areas in the ICS footprint, however when understanding patient flows the wider determinants of health need to be taken into consideration such as availability of A&E alternatives, public transport links and service preference particularly in certain BAME groups. The impact and outcomes of the Covid Pandemic has exposed the health inequalities especially for patients from a black and ethnic background (BAME)[4]. It is therefore critical when developing services within this strategy to ensure that there is improvements in access, experience and outcomes for BAME communities to actively reduce health inequalities.

In BSW, 5.46% of the population density from BAME ethnic group based on the ONS census of 2011 (Appendix 2). Asian/Asian British is 2.81%, Black/African. Caribbean/ Black British is 0.86%, Mixed /Multiple ethnicity 1.48% and 0.3% as Other Ethnic group. The maps below show the areas in BSW that represent the 2 highest quartiles for BAME populations in our footprint.

Asian/ Asian British

Black/African/Caribbean/ Black British



The Urgent and Emergency Care Landscape

The information detailed in the map and the table below demonstrate the range of providers within BSW that are currently supporting the urgent and emergency care system.

(Type 1 and Type 3 Attendance Locations)
3 Emergency Departments
Great Western Hospital, Swindon Royal United Hospital Bath, Bath Salisbury Foundation Trust, Salisbury
2 Urgent Treatment Centres
Great Western Hospital (co-located) Royal United Hospital Bath (co-located)
3 Minor Injury Units
Chippenham Community Hospital Paulton Memorial hospital Trowbridge Community Hospital

Other Key Partners delivering care in the wider UEC landscape				
148 Pharmacies	**3 Community Providers (Adults and Children's)**	**1 Adult Mental Health Provider**	**3 Local Authorities**	
94 GP Practices	Virgin Care, Wiltshire Health & Care, Great Western Hospital,	Avon and Wiltshire Mental Health Partnership NHS Trust	Wiltshire Council, Swindon Borough Council Bath & North East Somerset Council	
22 Primary Care Networks	**3 Hospices**	**1 Child and Adolescent Mental Health Provider**	**Numerous 3rd sector partners**	
(200+) Care Homes	Dorothy House, Prospect, Salisbury	Oxford Health Foundation Trust	SWASFT	

Other Key UEC Providers
1 Integrated Urgent Care service (NHS 111, clinical assessment service and out of hours primary care)

Current activity volumes and performance levels

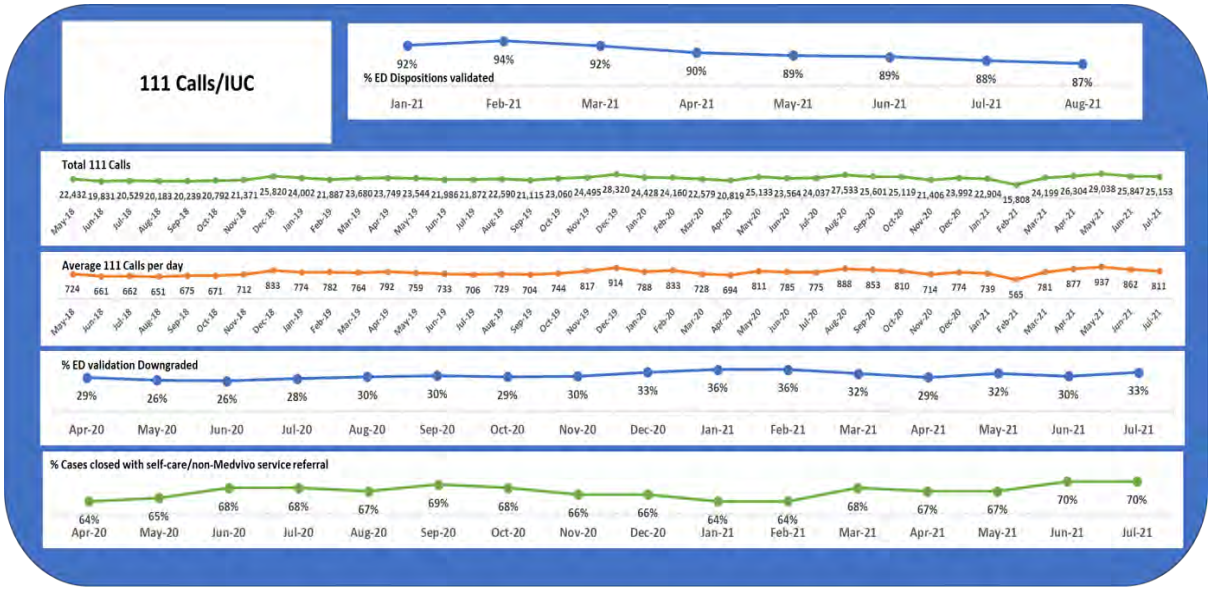
The current activity levels and performance within the BSW area are detailed below, please note the variance in activity for 20/21 this is due to the change in service provision during the pandemic.

Pre- Hospital performance (111 and Ambulance)

BSW has started shadow reporting the new urgent care standards in 21/22, and the table below covers the first section which captures key pre-hospital metrics against the current standards. The data shows that ambulance response times, have significantly deteriorated across all of the 4 main categories and 6 metrics. The proportion of NHS 111 calls receiving clinical input is above the national target and has been achieved since the start of the Integrated Urgent Care (IUC) contract, but the percentage has been decreasing over the first 5 months of this year.

New Urgent Care Standards			National Standard	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Pre-Hospital	Response times for ambulances	Cat1 Mean	7 mins	7.4 mins	7.8 mins	8.2 mins	9.7 mins	9.2 mins
		Cat1 90th Percentile	15 mins	14.2 mins	14.1 mins	14.9 mins	18.0 mins	17.6 mins
		Cat2 Mean	18 mins	25.8 mins	31.7 mins	35.3 mins	47.9 mins	41.5 mins
		Cat2 90th Percentile	40 mins	52.8 mins	64.8 mins	73.4 mins	107.0 mins	87.8 mins
		Cat3 90th Percentile	120 mins	170.1 mins	272.2 mins	316.3 mins	453.4 mins	356.9 mins
		Cat4 90th Percentile	180 mins	244.9 mins	268 mins	486.4 mins	339.5 mins	378.8 mins
	Reducing avoidable trips (conveyance rates) to emergency departments via Ambulance		tbc	46.80%	49.92%	51.46%	57.24%	54.54%
	Proportion of contacts via NHS 111 that receive clinical input		≥50%	71.60%	69.90%	68.20%	68.20%	66.70%

This deterioration in performance reflects the current level of demand, which is higher than it has been at any point since the start of the contract with the current provider which commenced in 2018. The data shows that a high proportion of cases being closed with self-care or referral to another community service.



The Think 111 initiative introduced in December 2020, saw an increased focus on additional clinical triage and validation of NHS 111 calls which came out with a disposition of an A&E. In BSW this was supported by senior A&E clinical staff providing an additional enhanced clinical assessment and re-directing patients or providing self-care advice if appropriate. The national target for validating A&E dispositions is 50%, which has been achieved consistently. But there has been a drop the number of cases validated in recent months as the number of patients with an initial A&E disposition has increased post lock-down 3 phases.

The service also validates patients that have an initial 111 disposition of Ambulance Category 3 and 4, exceeding the national target of 50% of Category 3 and 4 patients validated within 30 mins. BSW is one of 3 CCGs in the Southwest with the lowest percentage of answered calls resulting in an ambulance dispatches[4].

Equally, demand into the ambulance service has been rising year on year within BSW. The diagram above shows the number of incidents seen during the period April 2018 to August 2021 – it clearly shows an increase of an average 335 incidents per day to 420 incidents per day equating to a 20% increase in daily incidents during this period. This summer the Ambulance service across the entire Southwest area has seen activity in some days and weeks similar to that of what it would be normally expected over a Christmas and New Year period. This has resulted in the Ambulance service declaring it's highest ever escalation status and introduction of new standard operating procedures to respond to how it manages patients to prioritise those with the highest acuity (Category 1 and Category 2).

[4] South West Ambulance Commissioning Appendix I – Revalidation of category 3/4 ambulance dispositions (Commercial in Confidence, February 2021)

The increased demand has caused significant challenge to the Ambulance service to respond to patients in a timely way as per the national ambulance response standards which is evident in the performance metrics. There has also been an increase handover delays in over 15 minutes, which is reported in the new urgent care standards.

A&E Performance

The proposed new urgent care standards for A&E focus on three key aspects of A&E, and whilst the national standards are yet to be confirmed, however all of the indicators for this year are reflecting a deterioration in performance in our 3 main acute trusts. The next section will explore the activity and trends behind some of these increases.

New Urgent Care Standards			National Standard	Apr-21	May-21	Jun-21	Jul-21	Aug-21
A&E	Percentage of ambulance handovers within 15 mins		tbc	62.47%	61.36%	61.84%	54.00%	58.86%
	Time to initial assessment - percentage within 15mins	RUH	tbc	71.61%	69.46%	61.78%	67.02%	62.57%
		SFT	tbc	39.84%	45.46%	34.76%	32.79%	34.35%
		GWH	tbc	38.57%	33.35%	30.09%	28.26%	38.34%
	Average (mean)time in department - non admitted	RUH	tbc	175 mins	176 mins	182 mins	190 mins	181 mins
		SFT	tbc	169 mins	170 mins	192 mins	180 mins	189 mins
		GWH	tbc	172 mins	180 mins	193 mins	202 mins	164 mins

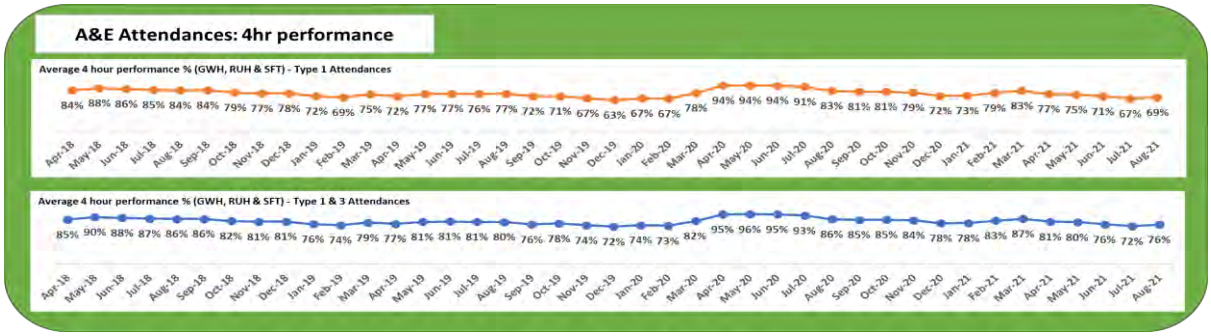
A type 1 A&E department is defined as "*A consultant led 24- hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients"* with a type 1 attendance being *"All unplanned attendances in the reporting period at type 1 A&E departments, whether admitted or not"* [5].

A type 3 A&E department is defined as "*A&E department / urgent care centre = other type of A&E/minor injury units (MIUs)/walk-in centres (WiCs)/urgent care centre, primarily designed for the receiving of accident and emergency patients*" with a type 3 attendance describing all unplanned attendances to a type 3 department [6].

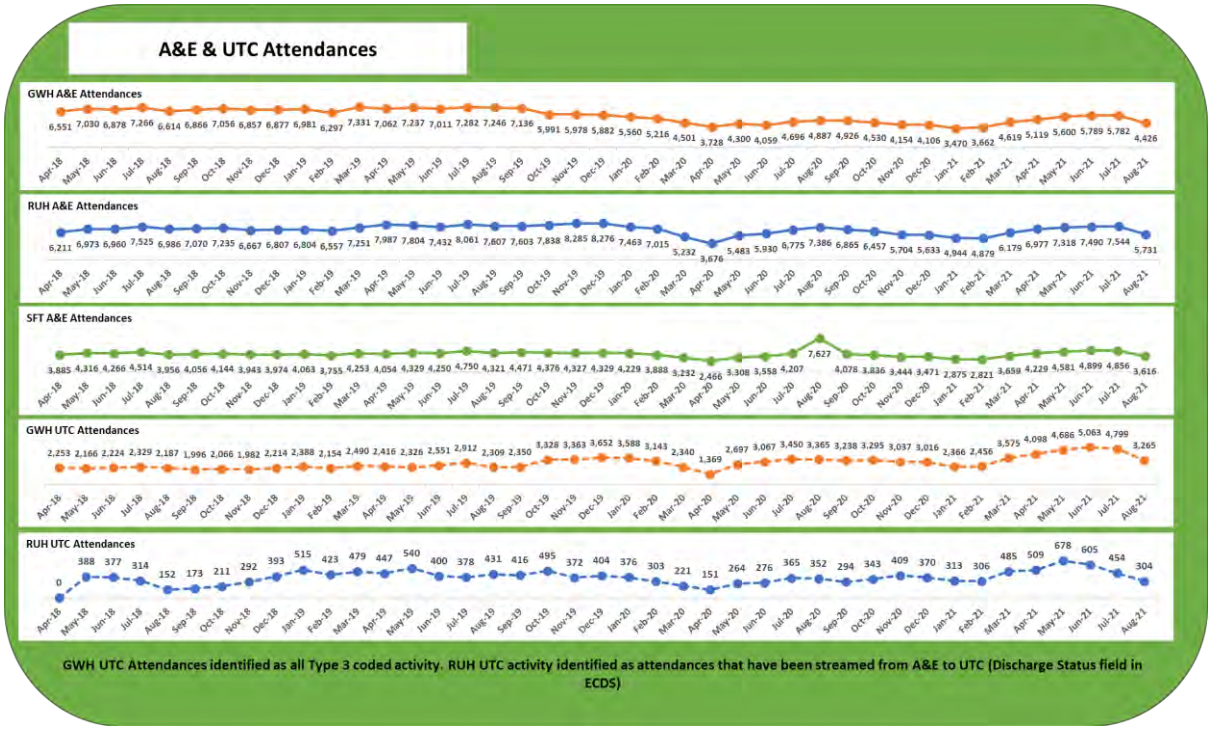
Since 2010, all major NHS A&E departments are meant to discharge, admit or transfer at least 95 percent of patients within four hours of arrival. The diagram below shows that for combined activity across our main sites, the 4-hour target has not been achieved since April 2018, with the exception of the initial Covid lockdown in April 2020-June 2020 accounting for combined Type 1 and Type 3 performances when there was a significant drop in the number of attendances during those months.

[5] A&E attendances and emergency admissions monthly return definitions (NHS England, 2015) https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

Nationally the 4-hour standard has not been met since July 20156 and in August 2021 the percentage of all attendances in 4 hours or less (all) was 77%, Type 1 was 66.2% and Type 3 was 96.9%. However, this measure will be phased out and replaced by the new urgent care standards.

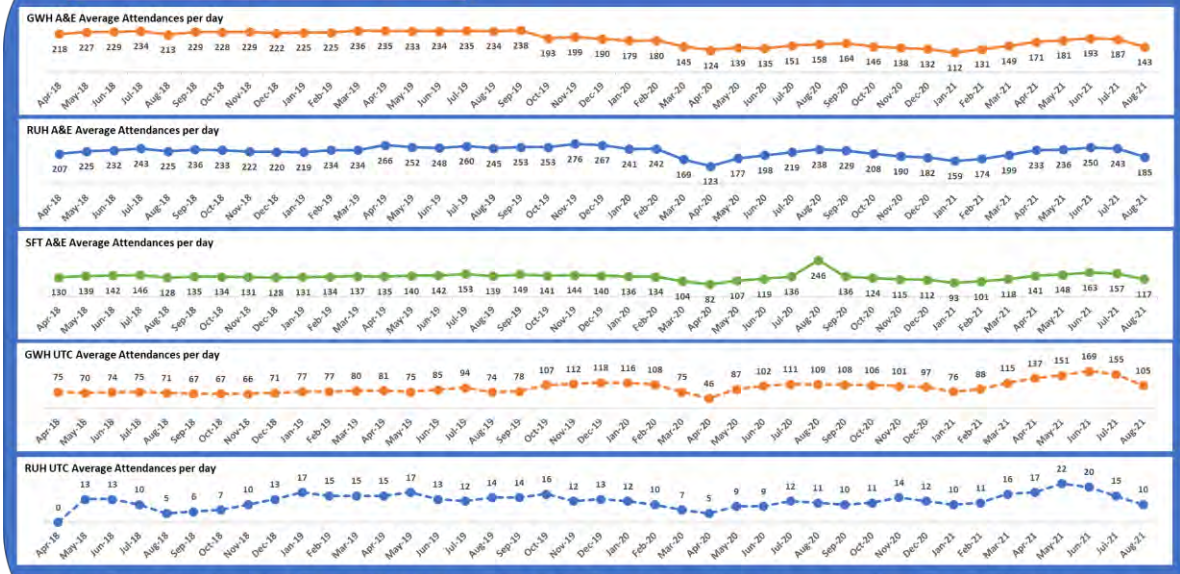


The next three diagrams show the total and average daily numbers of A&E, UTC and MIU attendances across our main locations since April 2018. The changes in the Minor Injury Units (MIU) activity reflect the s periods where the service was suspended as a result of the initial covid lockdown and then the gradual phased return of services from change in opening times and moving towards a booked only approach.



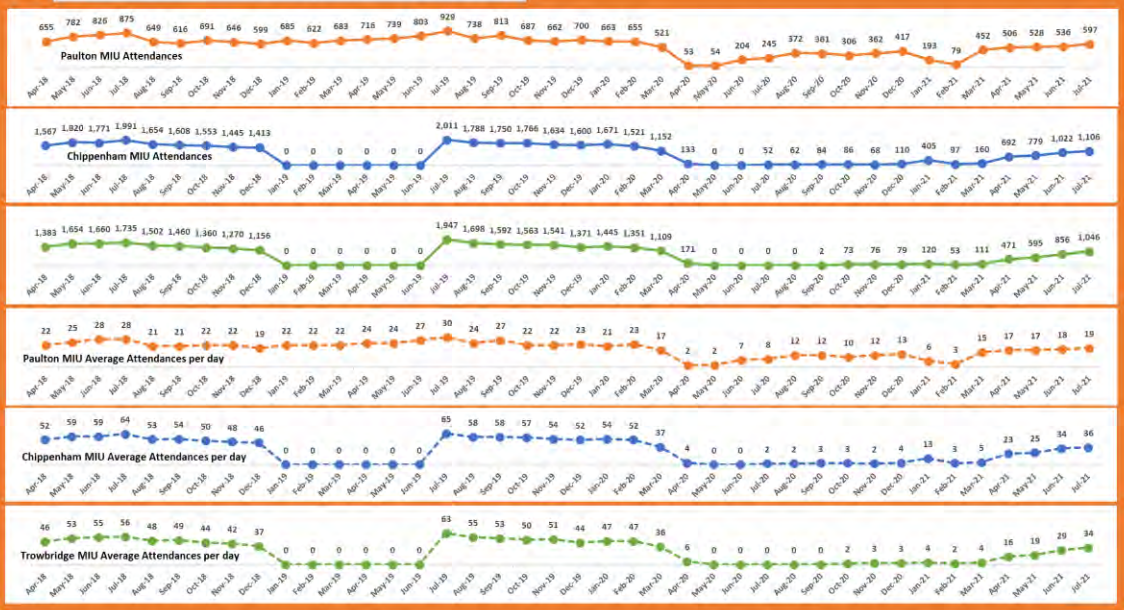
[6] Statistics » A&E Attendances and Emergency Admissions 2021-22 (england.nhs.uk)

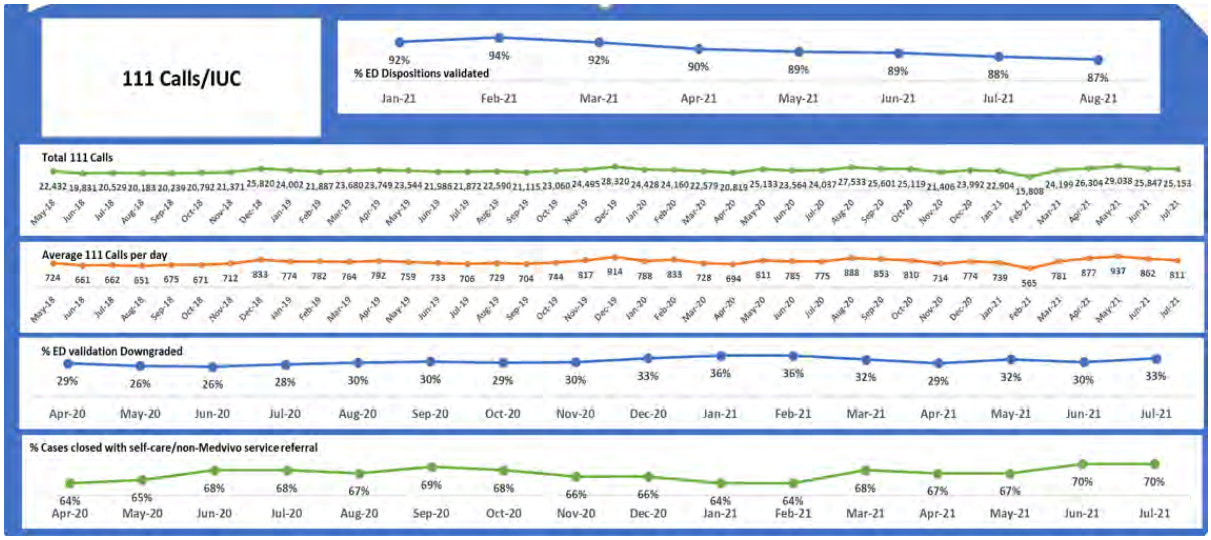
A&E & UTC Average Attendances per day



GWH UTC Attendances identified as all Type 3 coded activity. RUH UTC activity identified as attendances that have been streamed from A&E to UTC (Discharge Status field in ECDS)

MIU Attendances and Average Attendances per day

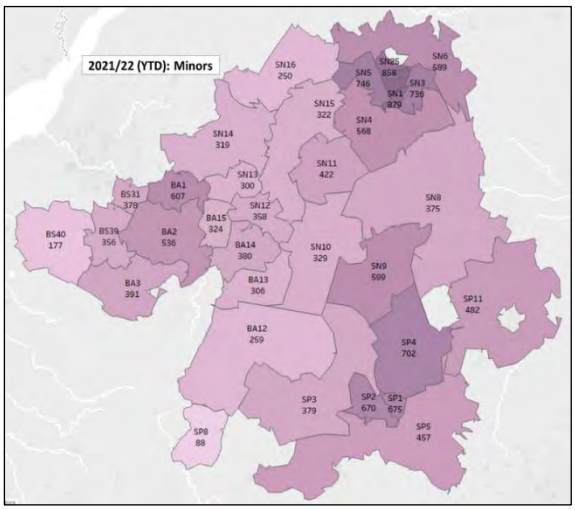


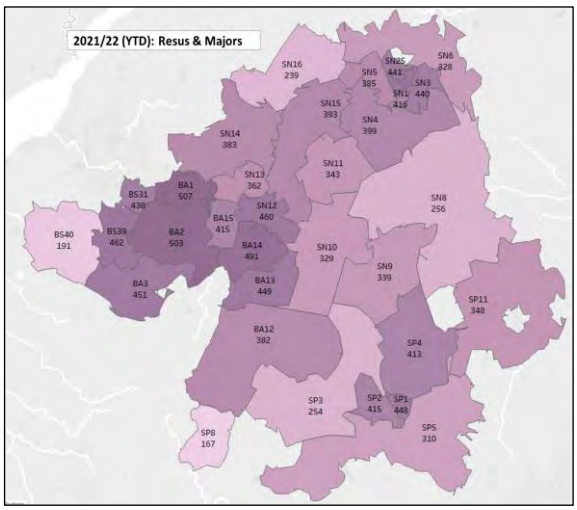


Geographical mapping has been developed to show the minor and majors' activity into the three acute trusts within BSW by GP practice. These maps enhance the systems understanding of areas of unmet need and service inequality for example where a patient may not be able to access care close to home. Interestingly the maps (see below) suggest a slightly different perspective of location and demand – for minor acuity attendances, the highest rates are in areas where the patient is registered with a GP Practice which is in close proximity to one of the three acute trusts. This suggests that proximity is likely a key motivator for those local to an acute to arrive at an A&E department seeking care for minor acuity symptoms. More rural areas have much fewer minor acuity attendances per 10,000 registered patients which suggests that residing at a greater distance from an acute hospital means that patients are less likely to attend A&E for a minor acuity presentation.

This trend is less evident for those patients with resus/major acuity illness. Medium to high rates of attendances per 10,000 population have a greater geographical spread across GP practice postcode sectors. Ambulance conveyance may contribute to this trend with higher acuity presentations likely to be more appropriate for acute hospital care.

Overall, the data and maps are indicating that Swindon GP Practice postcode areas have consistently higher rates of attendances at A&E than other areas.





These graphs and activity presented above do not reflect any patient attendances to service outside of BSW footprint. The data table below from April 2018 to Jun 2021, shows that some

of our patients access minor injury units that are in neighbouring healthcare systems as their services are closer geographically and more accessible to reach than some of emergency departments. For instance, patients will travel to Frome and Shepton Mallet within Somerset, Andover in Hampshire, Tetbury and Cirencester in Gloucestershire, Shaftesbury in Dorset. The map below shows the range of travel time to these locations in car (between 15-30 mins).

There are differences in some of the service offered at these locations compared to BSW, including times of opening. For instance, Somerset and Gloucestershire MIUs also will see patients with minor illnesses as well as injury; where was in BSW our MIUs are nurse-lead and only see injury and have limited diagnostic provision (e.g. X-ray).

Some of this activity has reduced during covid as the services have adopted similar response to the initial phase of the covid pandemic and how to respond to the Think 111 approach.

% Minors Activity (BSW Patients)				
	In Area Acute A&E	2019/20	2020/21	2021/22 (YTD)
1	RUH, BATH, BA1	32.94%	28.37%	31.58%
2	GWH, SWINDON, SN3	31.13%	30.23%	25.28%
3	SFT, SALISBURY, SP2	15.94%	22.26%	20.85%
	In Area MIU			
4	PAULTON MIU, BS39	5.80%	3.23%	3.53%
5	TROWBRIDGE MIU, BA14	1.48%	0.06%	0.72%
6	CHIPPENHAM MIU, SN15	1.52%	0.25%	1.08%
	In Area WIC			
7	SALISBURY WIC, SP1	-	-	-
	Out Area Acute A&E			
8	SOUTHMEAD, BRISTOL, BS10	0.47%	0.38%	0.52%
9	BRI, BRISTOL, BS1	1.70%	1.38%	1.95%
10	YEOVIL HOSPITAL, BA21	0.18%	0.20%	0.19%
	Out Area MIU			
11	SHEPTON MALLET MIU, BA4	-	0.53%	0.63%
12	FROME MIU, BA11	-	6.54%	6.79%
13	SHAFTESBURY MIU, SP7	0.59%	0.96%	0.29%
14	ANDOVER MIU, SP10	1.12%	0.11%	0.22%
	% of Minors Attendances:	92.87%	94.50%	93.63%
	Other Providers:	7.13%	5.50%	6.37%

The only alternative walk-in service available for minor illnesses in Salisbury is the Walk in Centre, which operates during the traditional out of hours period during the week (18:30-22:00) and weekends and bank holidays 08:00-20:00. The service is a GP led service, offering additional primary care and as such the data is not reported through ECDS so this activity is reflected within the graphs and table above.

Who is attending BSW A&E departments?

The largest volume of A&E attendances during each financial year featured patients residing within average to low deprivation areas (Index categories 7 - 10). It is important to note that the figures have not been standardised according to population density within each Deprivation Category area. This means that the percentages shown are potentially skewed depending on population volumes. In terms of acuity, the proportion of attendances coded as 'Minor' acuity has increased during 2021/2022 (YTD) compared to previous years. This increase in Minor acuity attendances is consistent across all Deprivation categories. However, the figures shown include UTC attendances, type 3 activity and may include MIU attendances for some Providers who may have only recently started to submit data. Overall, this may bias the percentages shown.

On the whole, ethnicity has been coded within an average of 93% of attendances across all years shown. An average of 79% of attendances feature patients who identify as White British. This would suggest a disproportionate representation of BAME individuals attending A&E. As with the Acuity and Deprivation table, minor acuity activity has increased as a proportion of all attendances across all ethnicity groups.

As a system, we need to understand who is accessing all the Urgent Care services and ensure that the system are tackling any health inequalities that are evident.

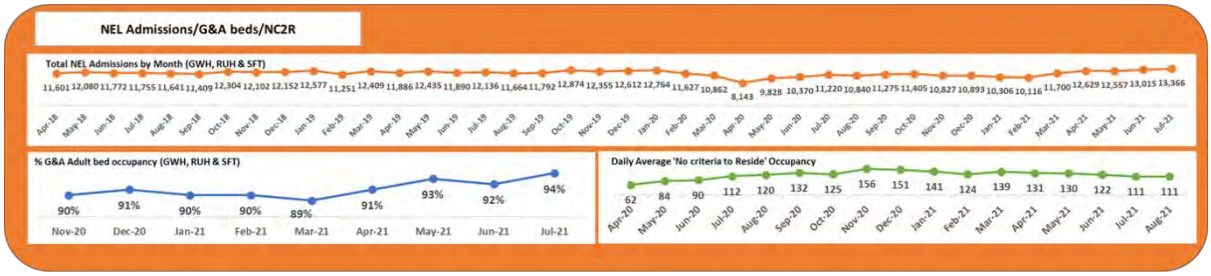
Hospital and Whole System performance

The two other main areas of the new urgent care standards capture the impact of wider hospital flow on A&E performance on patient's experience within the department.

The new UEC standards data shows that patients are waiting longer to be admitted into the hospital and more patients are spending a total of 12 hours in the emergency department. The average wait times are longer than the traditional 4 hour target

New Urgent Care Standards			National Standard	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Hospital	Average (mean)time in department - admitted	RUH	tbc	255 mins	260 mins	260 mins	309 mins	318 mins
		SFT	tbc	285 mins	283 mins	305 mins	314 mins	356 mins
		GWH	tbc	319 mins	373 mins	327 mins	402 mins	405 mins
	Clinically ready to proceed	RUH	tbc	162 mins	160 mins	150 mins	183 mins	206 mins
		SFT	tbc	105 mins	104 mins	107 mins	194 mins	234 mins
		GWH	tbc	No data	(no data)	(no data)	No data	(no data)
Whole system	Patients spending more than 12 hours in A&E	RUH	tbc	352	351	373	611	556
		SFT	tbc	15	13	24	25	40
		GWH	tbc	148	329	192	401	434
	Critical time care standards	RUH	tbc	(no data)	(no data)	(no data)	(no data)	(no data)
		SFT	tbc	(no data)	(no data)	(no data)	(no data)	(no data)
		GWH	tbc	(no data)	(no data)	(no data)	(no data)	(no data)

Activity data on our non-emergency admissions shows an increase in the number of patients being admitted month on month since April 2018, and in particular an increase in adult bed occupancy in our 3 acute trusts since November 2020. The average number of patients with a 'non-criteria' to reside has been particularly high which impacts on beds being available for those patients who need to be admitted from A&E.

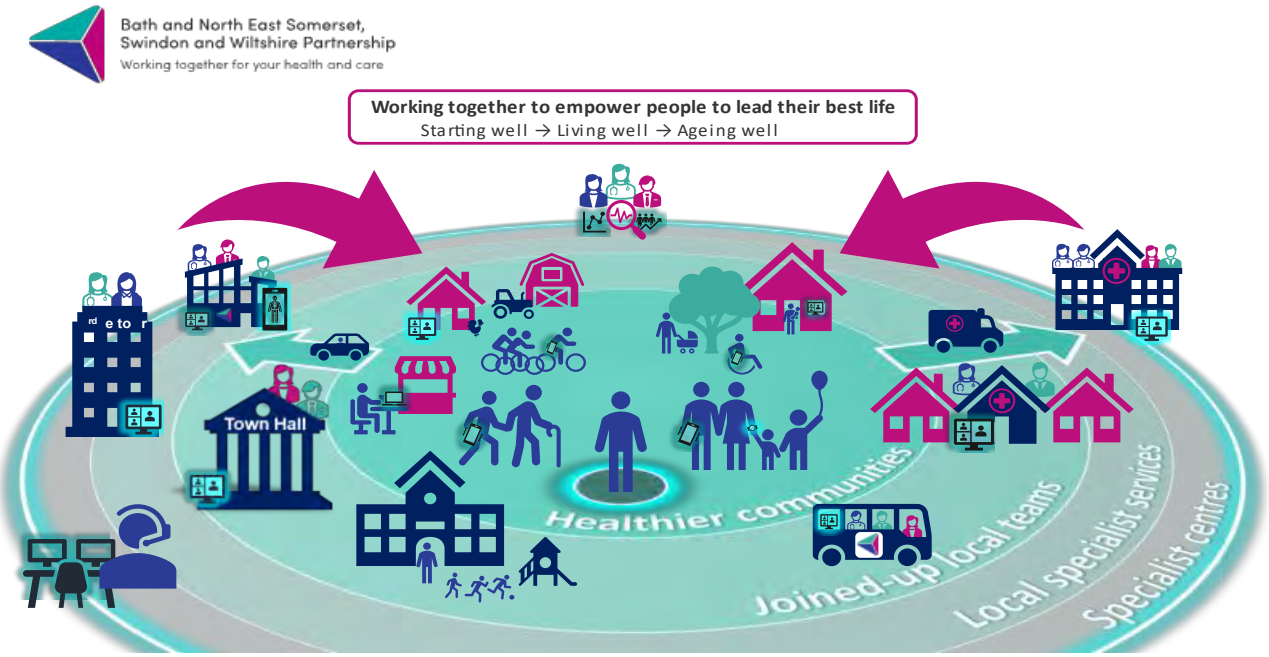


The new UEC standards do not capture wider community activity demands, but health and care services have a significant part to play in terms of the system response to Urgent Care and face similar challenges particularly in 20/21 with increased demand.

The general increase in Urgent and Emergency care demand and performance data have led to the development of this system wide strategy incorporating all partners within the UEC landscape.

Aligning the UEC Strategy with the wider BSW strategic context

Within this strategy, in order to meet the changing population needs in BSW over the next 5 years, a new model of care is set to address the strategic ambitions that will be the bedrock of any system developments and transformation during this period.



- Starting with the individual and placing prevention at the heart of everything the system does.

- Promoting self- care and self-management, including the use of technology to enhance the patient experience.
- The urgent treatment centres (UTCs), walk-in centres and minor injury units will see those that need urgent medical attention for minor health issues, freeing up A&E for the most serious cases.
- Mental health liaison services for adults, children and young people in the A&E department will help to make sure people get the right care at the right time.
- Building on the foundations of the inter-connected Primary Care Networks offering a wider range of roles including clinical pharmacists, social prescribers, paramedics and physiotherapists in order to develop the workforce and BSW becoming the employer of choice.
- Acknowledging the role which all agencies have to play including:
    - specialist services,
    - community groups,
    - health and wellbeing ambassadors,
    - palliative care,
    - rapid assessment services,
    - mental health services,
    - social care,
    - palliative care,
    - community nurses,
    - multi-disciplinary teams,
    - ambulance service,
    - bed based provision and nursing homes.
- Ensuring services are available to people near to where they live[7].

In addition to the shared aspirations listed above within the BSW model of care, there will be Integrated Care Alliances (ICA's) with locality-based priorities for each of the respective areas – BaNES, Swindon and Wiltshire – which align with one another, and the ICS Plan. The table below shows the key priorities for the ICA's that can be seen in their individual Health and Wellbeing strategies.

Swindon	**BaNES**	**Wiltshire**
Swindon's Health and Wellbeing Strategy 2017 -22[8]	*Bath and North East Somerset Health and Wellbeing Strategy 2015-2019*[9]	*Wiltshire Health and Wellbeing Strategy 2019-2022*[10]
1. Every child and young person in Swindon has a healthy start in life	Theme 1 Preventing ill health by helping people to stay healthy	1. Prevention

[7] Our plan for health and care 2020-2024 (2020), Bath and North East Somerset, Swindon and Wiltshire Partnership https://bswccg.nhs.uk/docs-reports/strategies-and-reports/335-bsw-our-plan-for-health-and-care-2020-2024-full-version/file

[8] Swindon_s_health_and_wellbeing_strategy_2017_2022.pdf (ims.gov.uk)

[9] banes_health_and_wellbeing_strategy_2015_-_2019.pdf (bathnes.gov.uk)

[10] D19025-HW2018-strategy-vFINAL.pdf (wiltshireintelligence.org.uk)

2. Adults and older people in Swindon are living healthier and more independent lives	Theme 2 Improving the quality of people's lives	2. Tackling Inequalities
3. Improved health outcomes for disadvantaged and vulnerable communities	Theme 3 Tackling health inequality by creating fairer life chances	3. Localisation
4. Improved mental health, wellbeing and resilience for all		4. Integration
5. Creation of sustainable environments in which communities can flourish		

There are a range of other supporting and/or interdependent strategies and plans. These focus on a broad number of subjects ranging from prevention, transport and access to services, to mental health. A full list of strategies can be found here.
The BSW Ageing Well programme development over the life time of this strategy will provide some of the key foundations for the urgent care development and help support the change in shifting more activity in the community closer to home than within the acute trusts.

The Ageing Well programme will include development in areas such as: -

- Hospital to Home services.
- Community Geriatric Assessment co-creation to enhance frailty management in the community.
- Implementation of a single ReSPECT form across BSW.
- Trusted assessment and a shared risk approach.
- Virtual ward development.
- Enhanced Falls service.
- Enhanced Care Home programme.

The BSW Mental Health Thrive strategy has seen significant development in several early intervention services during 2020/21 that will enable these needing this support to access it at the earliest opportunity, rather than reaching for urgent and emergency care services as often the only service available 7 days a week.

Examples of the services being implemented and will held patients receive the right care in the right place at the right time are: -

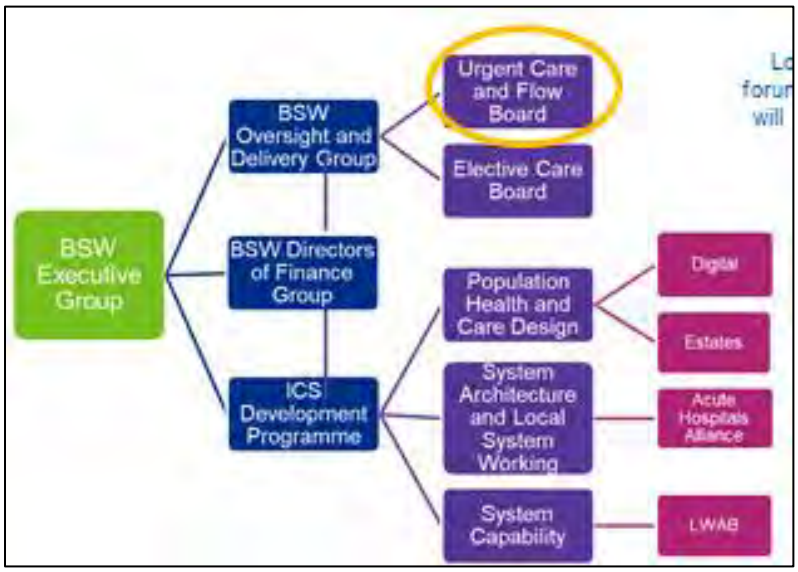
- A new BSW personality disorder service was launched in April 2020.
- Three new Places of Calm were established, led by third sector providers working virtually during Covid-19 to provide wrap-around support to people out of hours.
- Mental health support lines run by our third sector partners and 24/7 crisis lines were co-created and began operating in April 2020 to provide a uniform approach to early intervention and prevention and improve access across BSW.
- A BSW-wide mental health early warning system has been developed to identify hot spots and proactive actions across partners as part of a co-developed mental health

operational escalation plan. We have used this model to support the continuity of mental health support during the pandemic.

The BSW Diagnostics programme is a 5-year national programme, following the publication of the Mike Richards report prior to the COVID-19 pandemic. The aim within the report is to shift diagnostic activity from the current acute sites into newly created Community Diagnostic Centres (CDC) which will help the population access the services needed and to also address the current inequity of services across the area particularly for those reliant on public transport. The development of this work programme will allow increased accessibility to rapid diagnostics in the community, streamlining of operational processes across BSW, workforce development to form a BSW diagnostics workforce to support the whole population than attributed to a single organisation and development of BSW estates to support the CDCs in the most appropriate locations within BSW.

Governance and delivery

To ensure alignment with wider strategic objectives, and timely delivery, a robust governance and oversight structure is in place. Progress on this UEC Strategy will be reported through the Urgent Care and Flow Board, which reports to the BSW Oversight and Delivery Group enabling clear system oversight and support. Governance arrangements are as shown and the BSW Executive reports into the CCG Governing Body.



Within the Urgent Care and Flow Board there are a number of workstreams focusing on the key areas such as ambulance handover delays and same day urgent care. The aim of the groups is to ensure that the BSW Partnership are embracing examples of good practice to enable service development across the system to best effect, unblocking areas of greatest need, ensuring flow within the urgent care pathway and enabling patients to be seen in the right place, at the right time by the right person to ensure the best outcomes and experience.

Post Pandemic – How has the pandemic changed UEC?

The first systematic review (SR) of studies reporting on pandemic-related changes in overall healthcare utilisation found internationally consistent major reduction in visits to A&E departments across multiple studies. The largest absolute reduction involved people presenting with abdominal pain in a large national US study from the Centres for Disease Control and Prevention. In terms of age group, the largest reduction (−72 percent) was seen for children 10 years and under.

The SR found the percentage change in the number of hospital admissions with a median reduction of 28.4 percent. For example, a large study of the weekly admission rates for acute coronary syndrome in England showed a substantial reduction by the end of March (−40 percent) which partly rebounded by the last week of May 2020 (−16 percent). The percentage reduction in diagnostics ranged from 10 percent to 85 percent, with a median 31.4 percent reduction.

Changes in healthcare utilisation according to the disease severity of the service user were also noted. Despite the considerable heterogeneity in settings and services, many studies found larger reductions in utilisation among populations with milder or less severe illness.

The authors of the SR propose that this unprecedented pandemic-induced natural experiment in reduced healthcare utilisation provides a genuine opportunity to learn more about what services populations and healthcare systems came to regard as lesser priorities, when redistribution of resources towards more essential services was needed to minimise mortality in a crisis. Greatly reduced A&E attendances around the world for non-urgent complaints indicate an opportunity to inform and implement new strategies and models of care that maximise the appropriateness of visits in the future.

In the UK, a review/opinion piece by the Nuffield Trust (June 2020) explored the factors that might influence the use of emergency health care services during the pandemic. The author concurs with the findings of the SR that most of the drop in A&E use was in lower acuity groups and that the rate of presentation of seriously ill patients also fell, albeit to a lesser extent.

During the time period in question, there were reductions in the most common causes of trauma; road traffic accidents (which usually account for around 30 percent of trauma calls), high falls (approximately 15 percent) and assault (around 8 percent) . A reduction has also been noted for A&E admissions due to drug and alcohol use. While the drop in trauma could have been predicted by the nature of the lockdown, there was expectation that those presentations due to drugs and alcohol would rise, with people turning to substance abuse in response to the stressors of the pandemic. However, in England, there has been a police crackdown on drug dealing in the quest to keep the streets safe, making illegal substances more difficult to obtain. And while retail sales of alcohol appear to be up, long queues and restrictions on the amount that any one person can buy could have helped to limit heavy binge drinking at home.

The report by the Nuffield Trust also explored the health-related behaviour of patients with chronic diseases and noted that there was an increase in engagement with all aspects of self-care, particularly medication compliance and exercise, a positive result of concern about attending hospital. It has been reported that patients have been making minor adjustments to their own medications themselves or with the support of their GP, rather than waiting until the next routine hospital appointment. Given the rates of chronic illness, even marginal

improvements in medication compliance and engagement with self-care are likely to impact on A&E presentations. The numbers of patients with intermittent conditions, such as back pain, migraine and cyclical vomiting, who often attend the A&E for symptomatic relief also fell during early stages of the pandemic. Some patients report better use of medication and increasing their use of proven alternative therapies, such as physiotherapy, cognitive behavioural therapy and exercise. The author concludes that the drop in A&E attendances is likely to reflect a combination of real decreases in the prevalence of certain types of presentations and exacerbations of chronic disease, as well as pointing to more appropriate routes of accessing care.

There have also been substantial changes in how ambulance crews treat patients. The number of patients transported to A&E by ambulance in April 2020 was 29 percent lower than in April 2019. This is a reduction of 4,000 patients per day or 120,000 across the whole month. There has been a corresponding increase in the number of people who are treated at the scene or by telephone without needing to be transported to hospital.

The Health Foundation report (May 2020) examined the impact of COVID-19 on access to and use of health care services for people with pre-existing health conditions. Their survey found that access to health services for people with pre-existing conditions was 20 percent lower during the COVID-19 peak period. Some of the largest falls were in the use of health services for mental health conditions and cancer. While many patients (47 percent) reported that they did not need access to health care, 10% said that they were unable to get an appointment and 22 percent cited concerns over contracting/transmitting the virus or worries about breaking the lockdown. The survey data is mirrored in data from NHS Digital, which show a substantial fall in GP appointments in early pandemic.

During the pandemic, there has been increased NHS use of both established and newer technologies to reduce face-to-face contact and manage demand. Around three-fifths of UK adults who used the NHS during the early phase of the pandemic said that in doing so they used technology either in a new way or more than before.

The Health Foundation Report (March 2021) notes that among members of the public and NHS staff who reported increased use of technology, the overwhelming majority said they had positive experiences. Slightly higher proportions of negative experiences were reported by those aged 55 and older, those with a carer and unemployed people.

In the Opinions and Lifestyle Survey carried out in August 2020, 68 percent of people said they would be ‘comfortable’ or ‘very comfortable’ attending an online appointment. This decreased for people aged 70+ (61 percent) and for those with a specific health condition (62 percent). The Royal College of General Practitioners (RCGP, May 2021) highlights that face-to-face consulting is an essential element of general practice and remote consulting should be an option but not the ‘automatic default’ for GP care. Currently around half of consultations in general practice are being delivered face to face. At the peak of the pandemic, the ways in which patients accessed their GP reversed from around 70 percent face to face and 30 percent by phone, video or online pre-pandemic to around 30 percent face to face and 70 percent remote. However, the report acknowledges that a number of patient groups have recently highlighted a lack of satisfaction with remote access to general practice and the RCGP is calling on the Government to invest £1 billion in digital infrastructure and capabilities for general practice by 2024. This would include significant investment for ongoing upgrades to digital technology and supporting infrastructure.

Uncertainties remain over the safety and clinical effectiveness of remote appointments, and it is unknown which patient groups will benefit or lose out from these ways of working. Exploration by The Nuffield Trust (December 2020) on remote care and its impacts and

attitudes revealed a sudden increase in prescribing of new medication for remote GP appointments, alongside a fall in the rate of prescribing for face-to-face appointments.

The proportion of patients who were discharged following a telephone or telemedicine appointment fell from 25 percent in February to 18 percent in April, where it remained through to September. There was also an increase in appointments that resulted in another being needed at a later date. The same could not be said for face-to-face appointments, where the proportion of patients discharged remained consistent at around 22 percent. The reduction in discharges following remote appointments could lead to pent-up demand for outpatient care, in a system that is already struggling to cope with a large backlog of cases.

At the start of the pandemic, all ambulance service providers implemented a national protocol, referred to as Protocol 36. This is based on internationally tested algorithms and ensured that any patients with ineffective breathing were prioritised for response. Non-emergency patient transport providers also worked with the ambulance service to offer support and transport low acuity patients to hospital for assessment and treatment, to allow for ambulance services to prioritise higher acuity calls. This was stopped towards the end of phase 2 when elective services including outpatient appointments started to return to resume.

Our out of hours service reduced the number of operational face to face bases used across the footprint and increased the number of virtual triage appointments through the use video technology (Good Sam) for patient consultations. Patients still needing to be seen face to face appointment were seen in more traditional GP surgeries out of hours, moving out some of the previous locations of RUH UTC and MIUs to enable see potential covid patients and non-covid patients separately; or if still needed, patients were seen in their own home.

A Covid Oximetry at home service to support the remote monitoring of patients of suspected or confirmed covid patients was implemented in November 20 following the learnings out of phase one of covid. Our BSW service is managed and overseen by our Integrated Urgent Care provider, 24 hours a day, using a pulse oximeter, patients submit readings to the service and are escalated for treatment if required. In January 2021, the Covid Virtual Ward was also added, to clinically oversee patients began providing the Covid virtual ward for patients who have either been in hospital with a primary diagnosis of Covid-19 and have an improving clinical position or have been assessed by hospital or ambulance crews and do not need an admission, but their blood oxygen levels need to be monitored to indication any deterioration in their clinical condition.

Urgent care partners also worked collaboratively to introduce the Think 111 approach by 1st December 2020, to encourage patients to contact NHS 111 (either online or through phone calls) and if patients needed to be seen in an accident and emergency department that they were given an arrival time slot in a new national booking system. This initiative was aimed to limit the number of patients in waiting rooms. BSW ED clinicians joined the clinical assessment service to offer their expertise and provide telephone or virtual consultations, enhancing the existing workforce of GPs, paramedics, advanced nurse practitioners and pharmacists.

Strategic demand and capacity modelling

The ICS are embarking on a strategic transformation project centred around the development of a new model of care. Whole Systems Partnership (WSP) have been commissioned to support the ICS in development a series of modelling projects that aim to support strategic decision making and evaluation of transformational changes including new model of care and across U&EC described in this document.

The modelling programme sets out several modelling projects, that are designed to have a 'golden thread' and provide a single version of the truth across the transformation. The outputs will provide a view on the impacts the transformation will have across the U&EC system across BSW. The work is underway, unfortunately will not be available for the development of this document, and therefore this section acts as placeholder for the work to be presented when it is completed.

Population health modelling

Outputs for this document will be able to inform:-

1. Current breakdown of the population across BSW by health cohort (healthy, frail, multiple morbidity etc)
2. Breakdown by locality (PCN if required)
3. Forecasts of how these will change over time, including percentage change
4. Forecasts following impacts of key prevention and public health measures

Urgent and Emergency Care Demand and Capacity

Outputs for this document will be able to inform:-

1. A view on the future demand across U&EC key points of delivery (PODs) if the system does no transformation, and the impacts of population health and demographic changes (previously provided within this document)
2. What the effects across those key PODs could be if transformation occurs
3. The functions of care included within the modelling that affect change.
4. Provide a view and insight that Covid 19 has had on the health of the population across BSW, and what impact that has on the future demand of U&EC services.

What are the population of BSW saying about our services?

The CCG has a Citizens' Panel – Our Health Our Future which is one of the ways for the CCG to engage with those living in BSW to get their views on health and care issues.

The online panel is made up of a representative panel of the population from across our region. Panel members take part in regular surveys throughout the year.

From 26 July to 23 August 2021 a survey was undertaken which included questions about urgent care and primary care. The response rate was 38% which is higher than other similar panel surveys.

The key themes from the survey were:

Overall, panellists consider that a healthcare scenario that can wait for 2 or more days is a routine one. Something needing attention in 4 to 24 hours becomes an urgent need and if help is needed within 2 to 3 hours it becomes an emergency

- Those aged 75+ escalate from routine to emergency more slowly (only 24% say urgent at 1 days and 58% at 6 to 12 hours)
- Those aged 25-44 years, escalate much more quickly (33% say urgent at 2-3 days)
- Males escalate more quickly than females (51%of males say emergency at 4 hours)
- BAME participants escalate to emergency more quickly (73% say emergency at 4 hours)
- Those with LTC's also escalate more quickly than others (24%say emergency at 1 day)

If experiencing an URGENT HEALTHCARE NEED, just over one third would be happy to use online healthcare services first for advice. Just under one half would prefer telephone or video advice first. One fifth would prefer to walk directly into a service without prior contact.

- Using online healthcare services (e.g. NHS 111 or Doctorlink or via an NHS app) 54% of those aged 16-44 years would be happy to with this option but only 8% of those aged 75+
- Wanting to talk to someone first by telephone or video consultation - 55% of those aged 65+ would want this option. As would 75% of BAME panellists.
- Wanting to go directly to the service that they think best suits their needs without contacting anyone first - one third of those aged 75+ would want this option. As would one third of those with LTC's

If experiencing an urgent healthcare need, just under one half would want to be able to walk in without an appointment following advice. Just over one half would want a booked arrival time at a service location following advice.

If experiencing an urgent healthcare need the most popular locations for being seen/ assessed are GP practices (81%) and MIU/ UTC's (69%). 30% would visit a pharmacist.

- 40% of 25-44 year olds would go directly to an hospital emergency department

If experiencing an urgent healthcare need the most popular healthcare professional to see or speak to is a GP (93%), followed by a nurse (63%).

- 64% of 25-44 year olds selected a paramedic
- 33% selected a pharmacist

If experiencing an urgent healthcare need the average time and distance panellists are prepared to travel (if advised to do so) is 8 miles or 16 minutes.

- This average rises to 10 miles and 20 minutes for the under 45 age group and drops to 7 miles and 14 minutes for those with LTC's

If experiencing an urgent healthcare need, having confidence in the advice that is given to them is the most critically important factor, followed by being in the right/best place for the treatment needed.

- Telling one's story once only is of particular importance to those with LTC's, 40% very and 36% quite

Other factors (not already mentioned) that are important to people in their subsequent treatment of an urgent healthcare need *(unprompted)*

- Communication of information between departments/staff, sharing of information (21%)
- HCP's must be appropriately experienced (20%)
- Concerns being taken seriously, being believed, not feel I'm being a nuisance, non-judgemental HCP's, being treated with respect (19%)
- Follow-up treatment -consistency, appropriate information given to me/updates, appropriate waiting time, ability to phone/ email for further advice (14%)
- Being able to understand the diagnosis, advice is properly discussed/ delivered (plain English/ written down) (9%)

Increasing the public's knowledge about health services and accessing these services

- Online / websites (reading or video) - 81% of 16-44 year olds and 83% of males selected this option
- Via an NHS app - 81% of 16-44 year olds selected this option
- Information leaflets in the community e.g. doctor's surgery, library - 69% of 75+'s and 49% of females selected this option
- Ads/ info on social media – 2% selected this option

The full survey results are in Appendix 3.

The insights gathered from the Citizens' Panel will be used to develop a communications campaign which will target the key cohorts identified, for example 25-44 year olds and those with long term conditions. Specific messages and channels of communication used will be relevant to each cohort as one size does not fit all.

Quality and Patient Safety in Urgent and Emergency Care

Quality is defined as safety, clinical effectiveness, and patient experience. Across the system, including Urgent and Emergency care, the challenge of rising demand and costs means that quality must be the organising principle of our services. Quality is what matters the most to service users and it is what unites all that work in Health and Social care. People have told us that having confidence in the advice given and being in the best place for the treatment needed are the most important factors in urgent care. (Our Health Our Future 2021) This is conjunction with equipping people with the skills and resources to care for themselves or their family member at home will frame the delivery of quality of urgent care in BSW.

Patients rely on urgent and emergency care for accessible, timely and high-quality care and to provide a safety net at time of need. When things go wrong in urgent, and emergency care the outcomes can range from poor patient experience to catastrophic outcomes. The patient should receive the right care at the right time in the right place. And when things go wrong there will be a focus on being open and honest (Duty of Candour) with patients and their families, maximising learning, and continuous improvement.

BSW Integrated Care System (ICS) is committed to setting out a single vision of quality that includes the delivery of high-quality care for all. The ICS, including the delivery of Urgent and emergency care services will play an important role to ensure that inequalities and variation in the quality of care and outcomes are addressed, that serious quality concerns are managed effectively and that learning, intelligence and improvement are shared across the system and beyond to inform on-going improvement. The urgent and emergency care system in its support of delivering the three quality functions; quality planning, quality improvement and quality control will:

- Identify and monitor early warning signs and quality risks
- Plan and coordinate transformation locally and at system level
- Deliver on-going improvement and quality experience and outcomes

And through the adoption of the key principles:

1. Quality is a shared commitment	1. A designated executive clinical lead for quality, including safety, in the ICS, and clinical and care professional leadership embedded at all levels of the system.
2. Population focussed vision	2. A clear vision and credible strategy to deliver quality improvement across the ICS, which draws together quality planning, quality control, quality improvement and assurance functions to deliver care that is high quality, personalised and equitable.
3. Coproduction with people using services, the public and staff	3. A defined governance and escalation process in place for quality oversight – covering all NHS commissioned services and those commissioned jointly by the NHS and local authorities (included devolved direct commissioning functions) and formally linked to regional quality oversight arrangements (Quality Committees / Joint Strategic Oversight Groups)

4. Clear and transparent decision making	4. An agreed way to measure quality, including safety, using key quality indicators triangulated with intelligence and professional insight, which is reported publicly and transparently at Board-level to inform decision-making and effective management of quality risks. Evidence must show that this is also mirrored by tracking of local metrics within services to inform progress and improvement.
5. Timely and transparent information sharing	5. A defined way to engage and share intelligence on quality. Including safety – at least quarterly and delivered through a System Quality Group

(National Quality Board 2021)

Patient Safety and Quality Ambitions for Urgent and Emergency Care will support the delivery of quality care for all:

Ambitions

- **Patient Safety and Quality Metrics –**A set of Urgent and Emergency Care metrics will be established by working with organisational partners and service users to develop quality metrics that can inform learning, quality improvement and service development. Equality, Quality impact Assessments (EQIAs) will be completed for all service transformation proposals.

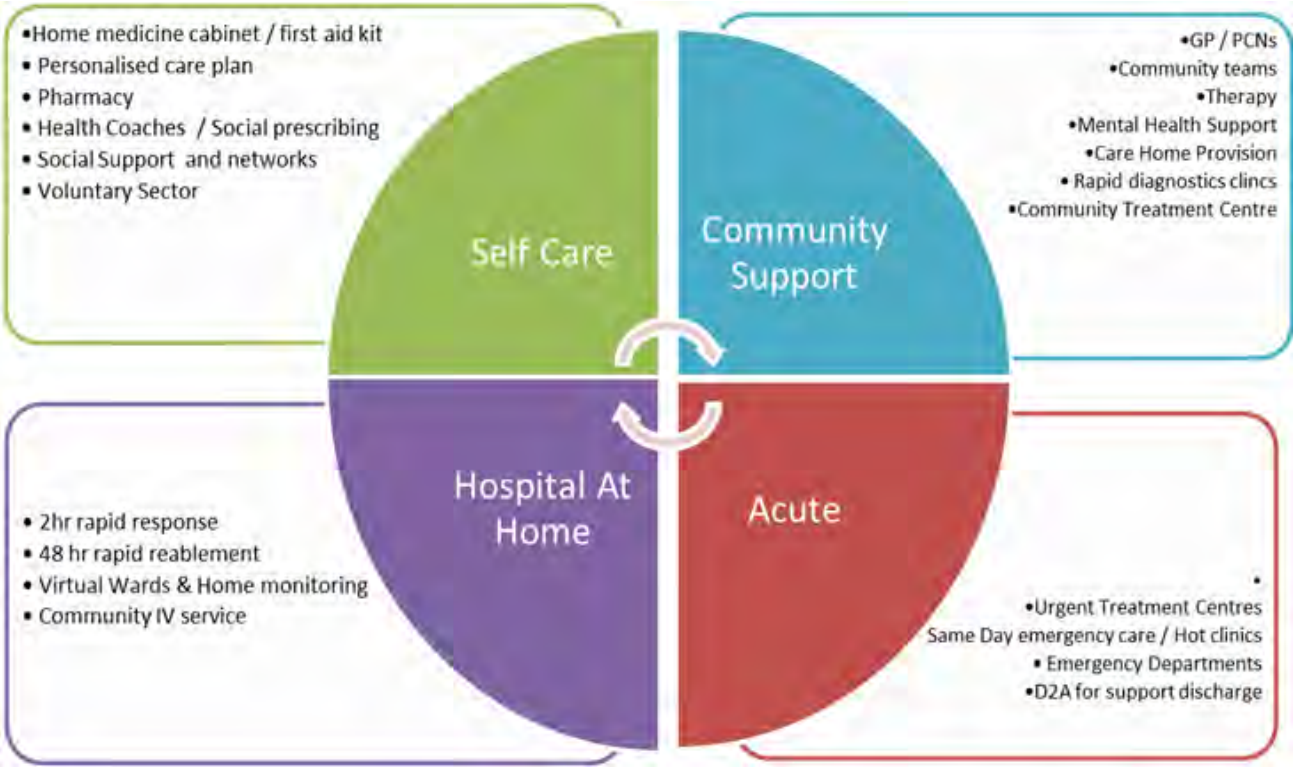
- **Patient Experience -** Patient experience data collection will be developed across the urgent and emergency care system to ensure we capture the whole patient experience. Whilst still utilising 'tested' approaches such as Friend and Family, we will increase our ability to enrich the information, through collating data and narrative using different methodology and including all partners and most importantly service users.

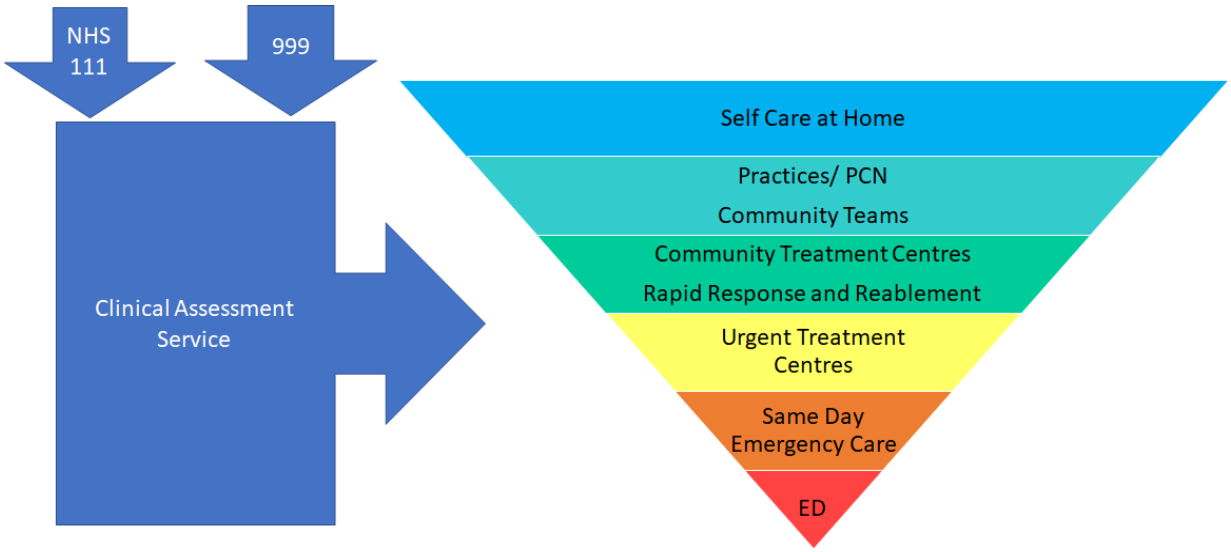
- **Deteriorating patient, NEWS/PEWS and Sepsis Six –** NEWS/ PEWS, combined with the Sepsis six care bundle will be a focus for quality improvement for urgent and emergency care providers supported by the ICS. The management of deteriorating patients, the use of National Early Warning Score (NEWS2/ PEWS (paediatric)) scoring and diagnostic bias are themes in patient safety incidents in urgent and emergency care. NEWS2 is a nationally recognised scoring tool mandated for use in secondary care to assist clinicians in the recognition of the sick and deteriorating patients.

- **Patient Safety Incident Response Framework and Just Culture – System partners will work collaboratively to embed the Patient Safety Incident Response Framework and a Just and Learning Culture, this will ensure we are maximising organisations and the system to learn from incidents.** All organisations will transition to a new reporting framework for incidents from April 2022. The experience for those affected will be brought sharply into focus and expectations will be clearly set for informing, engaging and supporting patients, families, carers and staff involved in patient safety incidents and investigations. In accordance with a just culture, staff involved in incidents are treated with equity and fairness.

The Next 5 Years

Ambition: ***Helping to ensure people with urgent care needs "get the right advice in the right place, first time"***





Self-Care domain:

- Individuals will have the confidence to manage minor ailments and conditions from within or close to their place of residence, without the need to physically access urgent and emergency care services. **'Every home will have a home medi ine upboard and first aid kit'.**

- Individuals with long term health conditions will have **a personalised care plan** on how to manage their condition if it deteriorates or is exacerbated. The personalised care plans and shared care records will be digitally accessible to all healthcare professionals to be able to quickly support clinical decision making to ensure the right outcomes for their healthcare needs are achieved.

- Primary Care will remain the first point of entry for individuals that require either **advice and guidance or treatment** for a health condition that can be supported in the community setting.

- If unsure, an individual will be supported to be making the right decision for their healthcare need using **NHS 111 – which will be the single entry point for urgent care**; and if they self-present to the wrong healthcare setting for their need (wrong place wrong time) they will be **coached by the healthcare professional** on how to access the right services for their needs, for their current need and for any urgent and emergency need in the future.

- Working to develop key links at place level with the voluntary sector, encouraging community connectors to enable self-care and community support within neighbourhoods to reduce social isolation and increase ownership and control over individual health needs.

Community domain:

- If an individual needs to be seen by a healthcare professional, there will be a consistent offer of service to them wherever they reside within BSW, starting within **their own residence** then community neighbourhood and local network

- Our Minor injury unit service offer will be expanded to manage urgent minor illnesses to become a consistent '**Community Treatment Centres**', open 7 days a week for at least 12 hour a day that are integrated with local primary and community care teams to prevent people needing to travel further to a UTC or A&E for minor injuries and illness; and have access to community diagnostic hubs 7 days per week to enable rapid diagnostics such as near patient testing. The service will offer directly bookable appointments as well as a walk in facility to prevent A&E walk ins.

    - **Pharmacy of Excellence** to be developed across BSW to create an enhanced service supporting primary care with medicines advice, guidance and prescribing.

- **Rapid response crisis service** will provide an urgent care wrap around service in the community that manages patient need at home or usual place of residence in a timely way to provide crisis care to prevent avoidable hospital admissions and accelerate the treatment of people's urgent care needs.

    - Secondary Care clinicians providing enhanced community clinics within primary care to enhance knowledge sharing and enable increase clinical risk thresholds within the community.

Hospital at Home:

• If an individual needs enhanced support within the community due to an exacerbation of an existing condition or increased care needs the BSW Community **Rapid Response Service** will provide the wrap around care to manage the patient in their usual place of residence to prevent a hospital admission.

• The **enhanced community care pathways** led by a senior decision maker such as a community matron with physical assessment and clinical reasoning (PACR) and prescribing skills to manage the patient with the support from primary care, community IV service, therapies, Home Care step up facility and specialist services where required to mange the patient needs within the community and prevent a hospital admission or A&E attendance where possible.

• **Virtual wards** will be supported by a Multi-Disciplinary Team based around a locality aimed at managing short and long term care via a step up/step down pathway and meeting the needs of the patients including frailty pathways– this will include access to home monitoring and digital technology and residential beds where appropriate.

Emergency and Acute domain:

• There will be **Urgent Treatment Centres** within BSW, co-located or near to our main A&E departments to provide non-emergency on the day urgent treatment. The UTCs will be compliant with national UTC standards, with walk in and directly bookable appointments – the ambition is to have 80 percent of patients having a booked arrival time slot.

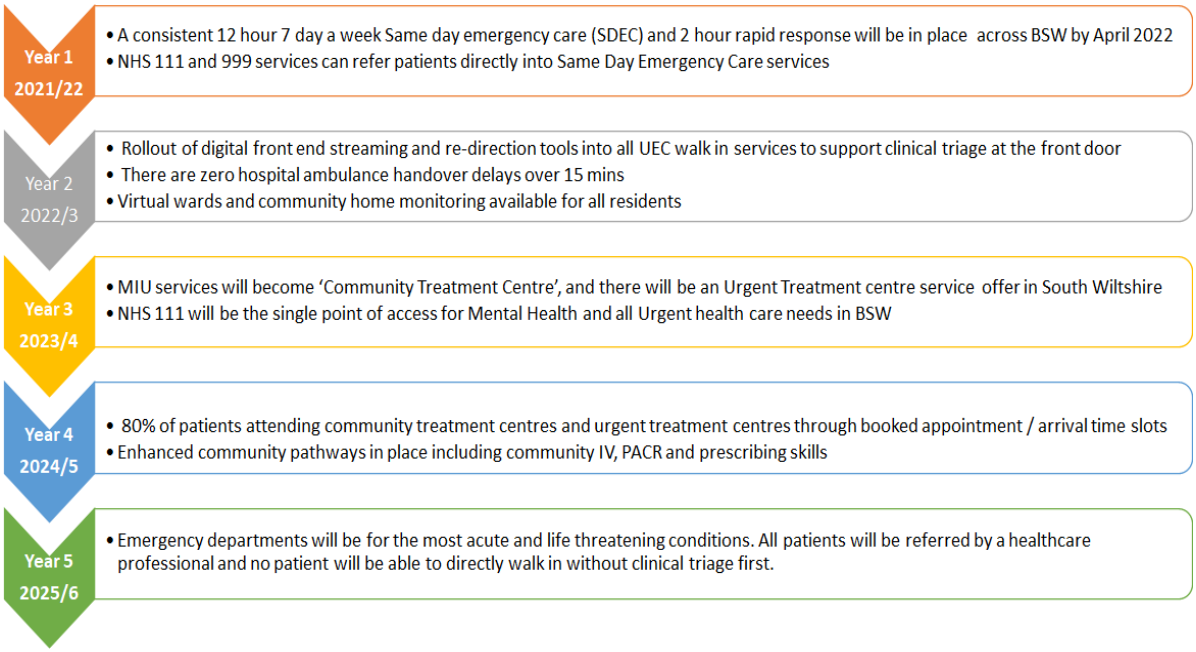
• Patients accessing 999 ambulance service with an urgent but not an emergency health need, will have the **same level of clinical assessment** via phone or video as patients using NHS 111 service before determining what response is needed.

• 999 Ambulance service will respond to **emergency 999 calls only (Cat 1-3**), and patients with less urgent healthcare needs will be signposted to alternative urgent care services. 111/999 services will work collaboratively using technological solutions in order to case share and enhance clinical validation to support the patient journey.

• If an individual needs specialist advice, they will be referred to the most appropriate clinician for their health care needs, which may be a geriatrician, paediatrician, surgical consultant or urology consultant as part of **Same Day Emergency Care** offer, which will be available 12 hrs a day, 7 days per week.

• By 2025, A&E departments should only be there for those with the most acute and life-threatening conditions. Individuals will be referred by a healthcare professional into A&E. **Patients will not be able to walk into an A&E department.**

- **Same Day Hot Clinics** to be accessible across BSW for a variety of suitable clinical pathways that are both easy to navigate and referrals accepted from all health care professionals.



Workforce

The BSW Partnership with a clear focus on building system capability focused on developing a culture to create the capacity and the capability required to make change. The ambition is to mobilise a BSW Academy centred around five pillars: Learning, Leading, Inclusion, Improvement, and Innovation. BSW will lead the way in workforce development supporting our workforce to deliver outstanding care to our communities. The challenges we face are:

- Low numbers of recruitment from education and training- 3.3 percent
- Retirement (23.5 percent of leavers) and those potentially due to retire (15.4 percent)
- No higher educational provider within the geographical footprint
- A mix of NHS and non-NHS providers
- Impact of COVID on learners and staff health and well-being
- COVID accelerating transformational changes and the need to be able to match workforce resource to support

Evidence clearly demonstrates that investment in the new ICS collective workforce's learning and development positively impacts these challenges by reducing turnover, upskilling staff, the development of pipeline, new roles and by sharing our collective resources intelligently, acknowledging the co-dependency of all parts of the system. By working together and building on the outputs of previous projects BSW can maximise funding, impact, accessibility and specialist knowledge.

BSW Partnership need to understand more detail regarding the Recruitment, Retention and Supply challenges faced with the system, such as high turnover on BSW social care staff, an aging workforce in some areas within BSW, persistent vacancies in some areas with the use of agency at high cost to respond to operational surges in pressure as well as fill persistent

vacancies for some roles. With the formation of a BSW specific workforce data set BSW can have a richer and more accurate understanding of our current and future needs. Through the future workforce projects, the new ICS intents to build an infrastructure / processes and systems, providing the ability to respond to issues in an agile manner.

The workforce leads will:

- Have oversight of the 50,000 nursing project to support senior nursing groups – responding to changes and shortfalls in future nurse pipelines
- Consider and assess the benefit of adopting some of the new national and regional schemes and support the implementation and evaluation of recommended schemes e.g. Reservists project.
- Realise the full benefit of some of the underpinning work on inclusive recruitment through a BSW approach and shared tools and a collaborative approach to international recruitment
- Maximize pipelines from new sources, supporting more apprenticeships, Kickstart, Student Work Aboard Programme (SWAP), T levels, volunteers and other new sources.
- Continue its work with the established BSW Equality and Diversity group to ensure that barriers are managed and removed and to support the build-up of more representative leadership teams via targeted programmes of leadership development, in line with the latest Workforce Race Equality Standard (WRES) report.
- Facilitate open discussion with social care to understand how working together can reduce turnover in support worker roles and explore innovative solutions.

By delivering the Peoples Promise and Peoples plan it will demonstrate that BSW:

- Has a clear ambition to be an area of inclusive and positive employment
- Can reduce current and predicted skills gaps and expected skills gaps created through reduced pipeline and aging profiles
- Offers flexible employment
- Is a great place to work where excellence is recognised and rewarded
- Works hard to retain its staff across the system using innovative approaches, learning from vanguard sites as well as tried and tested evidenced based approaches
- Allows and facilitates to capture of current activity and best practice and allow best practice to be shared across the system
- Delivers cost efficiencies that can lead to greater investment elsewhere in the system underpinning quality improvements.

Workforce development will be a critical part of the Urgent and Emergency Care Strategy success over the next 5 years. The BSW Academy will need to explore the different skills and competencies that are required for the workforce within the emerging specificity of urgent care. Existing staff within the system will require enhanced training and new staff coming to work within BSW will need new skills in order to support the population health needs over the coming years – for example implementing a new hybrid role including both health and social care skills.

Glossary

A&E - Accident and emergency	An accident and emergency department, also known as an emergency department (ED) is a medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment; either by their own means or by that of an ambulance. The A & E department is usually found in an acute hospital. Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.
BAME - Black, Asian and minority ethnic	Often used as a catch-all phrase to mean non-white people
BSW Partnership - Bath and North East Somerset, Swindon and Wiltshire	The health and care needs of people living in Bath and North East Somerset, Swindon and Wiltshire are changing, with more people living longer, often with multiple long term conditions. To tackle this and other health and care problems the NHS, local government and local third sector groups have formed a partnership to better meet the populations' needs now and in the future. The BSW Partnership brings together many organisations who work together as an integrated care system (ICS). Collectively, we take responsibility to improve the health and wellbeing of local people, ensure that health and care services are high-quality and to make the most efficient use of our resources. Further information is available here: https://bswpartnership.nhs.uk/about-us/
Care Connect	A system enabling access to patient information through open interfaces.
CAS - Clinical Assessment Service	A clinical assessment service is an intermediate service that allows for a greater level of clinical expertise in assessing a patient than would normally be expected of a referring clinician (such as a GP).
Community IV	Providing intravenous (IV) antibiotics in the community – in patients own homes, community hospitals and community outpatient clinics following referral by a GP, consultant or specialist nurse.
Community PACR -	Physical Assessment and Clinical Reasoning this is a training package for advanced clinical skills within the community.
CDC	Community Diagnostic Centres and Community Diagnostic Hubs (CDH) are key to transforming current models of care delivery

- Community Diagnostic Centre	by providing access to “right first time” diagnostics and treatment services, closer to patient's homes. Find out more: https://www.gov.uk/government/news/40-community-diagnostic-centres-launching-across-england
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.
ECDS - Emergency Care Data Set	The Emergency Care Data Set is the national data set for urgent and emergency care. ECDS allows NHS Digital to provide information to support the care provided in emergency departments by including the data items needed to understand capacity and demand and help improve patient care.
EQIAs - Equality and quality impact assessments	The EQIA examines the extent to which a “policy” may impact, either negatively or positively, on any groups of the community and, where appropriate, recommend alternative mitigation measures (ie avoiding or lessening impacts) to ensure equal access to services and opportunities. The impact assessment also ensures that consideration to quality issues are considered in decisions, at the design and scoping stage.
DTOC - Delayed Transfer of Care	A ‘delayed transfer of care’ occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.
ICA - Integrated Care Alliance	Integrated care alliances are NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.
ICS - Integrated Care System	Integrated care systems (ICSs) will take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area. Further information can be read here: https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems
IUCS - Integrated Urgent Care Service	The Integrated Urgent Care service combines the previously separate NHS 111 and GP Out of Hours services allowing for an improved and streamlined model of patient care.

LTP - Long Term Plan	The NHS Long Term Plan, also known as the NHS 10-Year Plan is a document published by NHS England on 7 January 2019, which sets out its priorities for healthcare over the next 10 years and shows how the NHS funding settlement will be used. Further information is available here: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
MDT - Multidisciplinary team	A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users. MDTs are used in both health and care settings.
MIU - Minor Injuries Unit	MIUs are run by experienced clinicians and are available to treat non-life-threatening injuries, such as: • sprains and strains • broken bones • wound infections • minor burns and scalds • minor head injuries • insect and animal bites • minor eye injuries • Injuries to the back, shoulder and chest
NEWS - National Early Warning Score	NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.
NHSX	NHS is a joint unit of NHS England and the Department of Health and Social Care, supporting local NHS and care organisations to: - Digitise their services - Connect health and social care systems through technology - Transform the way patients' care is delivered at home, in the community and in hospital.
Non-elective hospital admissions	A Non-Elective Admission is one that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a hospital bed in another health care provider.
Oximetry	Pulse oximetry is a test used to measure the oxygen level (oxygen saturation) of the blood. It is an easy, painless measure of how well oxygen is being sent to parts of your body furthest from your heart, such as the arms and legs. A clip-like device called a probe is placed on a body part, such as a finger or ear lobe. The probe uses light to measure how much oxygen is in the blood. This information helps the healthcare provider decide if a person needs extra oxygen.
PCNs - Primary care networks	Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan, with general practices being a part of a network, typically covering 30,000-50,000 patients. The networks will

	provide the structure and funding for services to be developed locally, in response to the needs of the patients they serve.
PEWS - Paediatric early warning score	Paediatric Early Warning Score (PEWS) system enables the early recognition of sick patients and management of any deterioration.
PODs - Key points of delivery across urgent and emergency care	The key points of delivery are any part of the health care system that delivers urgent care services such as an A&E or MIU.
ReSPECT form - Recommended Summary Plan for Emergency Care and Treatment -	ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Further information is available here: https://www.bswccg.nhs.uk/docs-reports/2292-respect-information-for-families/file
SAFER patient flow bundle	The SAFER patient flow bundle is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity). When followed consistently, length of stay reduces and patient flow and safety improves.
SDEC - Same Day Urgent Care	Same day emergency care (SDEC) is one of the many ways the NHS is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and hospital admissions, where appropriate.
Telemedicine	Telemedicine is the use of telecommunication and information technology for the purpose of providing remote health assessments and therapeutic interventions. This could include video or voice messaging services on mobile phones, computers and tablets.
UEC standards - Urgent emergency care standards	Urgent and Emergency Care standards are a way of measuring both performance and patient outcomes within an urgent care setting.
UTCs - Urgent treatment centres	Urgent treatment centres (UTCs) are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for.
Walk-in centre	For urgent medical attention, but it's not a life-threatening situation. The service is run by GPs and nurse practitioners. People can walk in and don't have to have an appointment.
WRES	The WRES was introduced in 2015 to ensure employees from black and minority ethnic (BME) backgrounds have equal access

- Workforce Race Equality Standard	to career opportunities and receive fair treatment in the workplace.

Appendix 1 :- Feedback & Consultation Sessions

Date	Slides	Output/ Notes
24th June 2021	210624 Winter Debrief and UEC Str	strategy info for 210715.pptx
20th July 2021	210720 UEC Strategy Event clinic	210720 Notes from the event
3rd August 2021	210720 UEC Strategy Event clinic	210803 notes from the event
4th August 2021	210804 YHYV panel	
July – August 2021	BSW Our Health Our Voice Panel	BSW OHOF Panel - Survey 6 Results Aug

Reference Links

Detailed below are the links to the different documents referenced within the strategy.

Lord Carter Report - https://www.england.nhs.uk/wp-content/uploads/2019/09/Operational_productivity_and_performance_NHS_Ambulance_Trusts_final.pdf

NHS Net Zero Strategy https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

Our plan for health and care 2020-2024 (2020), Bath and North East Somerset, Swindon and Wiltshire Partnership https://bswccg.nhs.uk/docs-reports/strategies-and-reports/335-bsw-our-plan-for-health-and-care-2020-2024-full-version/file

Wiltshire Intelligence (2020) https://www.wiltshireintelligence.org.uk/population/population-overview/

Swindon JSNA (2018) https://www.swindonjsna.co.uk/pictures

A&E attendances and emergency admissions monthly return definitions (NHS England, 2015) https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

Our plan for health and care 2020-2024 (2020), Bath and North East Somerset, Swindon and Wiltshire Partnership https://bswccg.nhs.uk/docs-reports/strategies-and-reports/335-bsw-our-plan-for-health-and-care-2020-2024-full-version/file

[1] Swindon_s_health_and_wellbeing_strategy_2017_2022.pdf (ims.gov.uk)

[1] banes_health_and_wellbeing_strategy_2015_-_2019.pdf (bathnes.gov.uk)

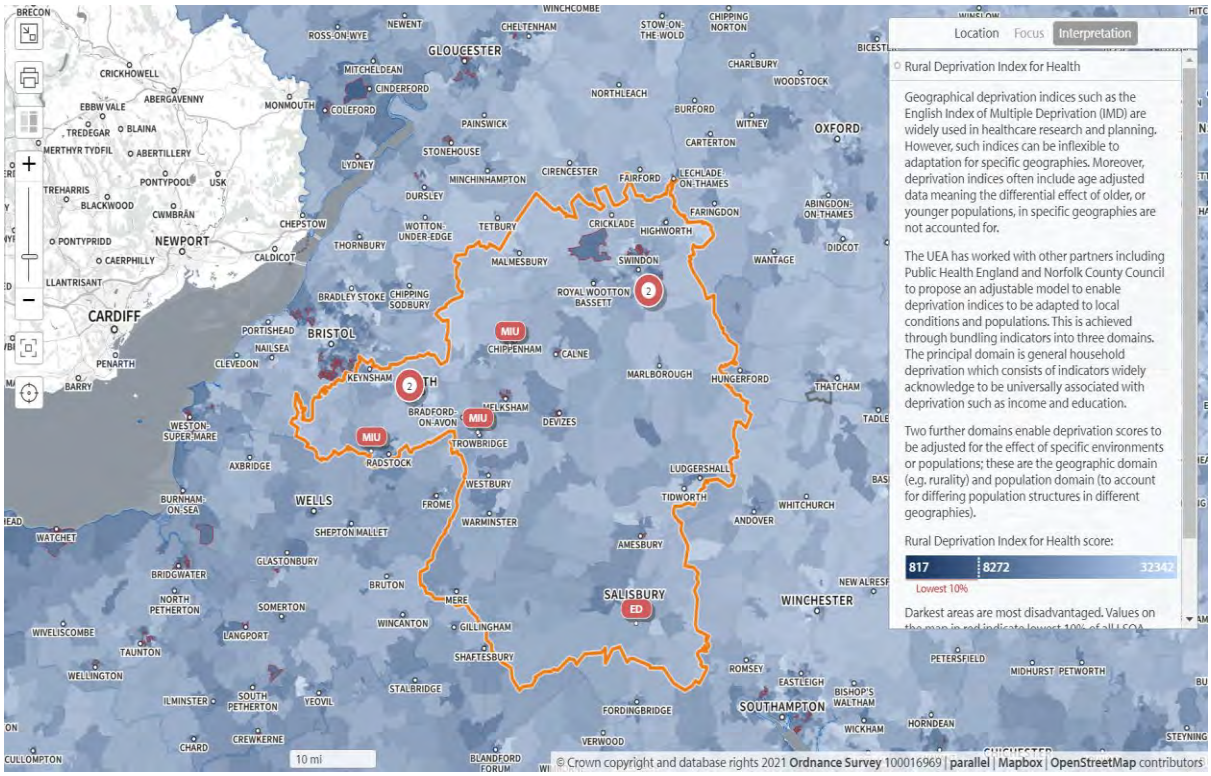
Health Inequalities https://bswccg.nhs.uk/docs-reports/strategies-and-reports/1635-bsw-ccg-interim-equality-diversity-strategy/file

Appendix 2

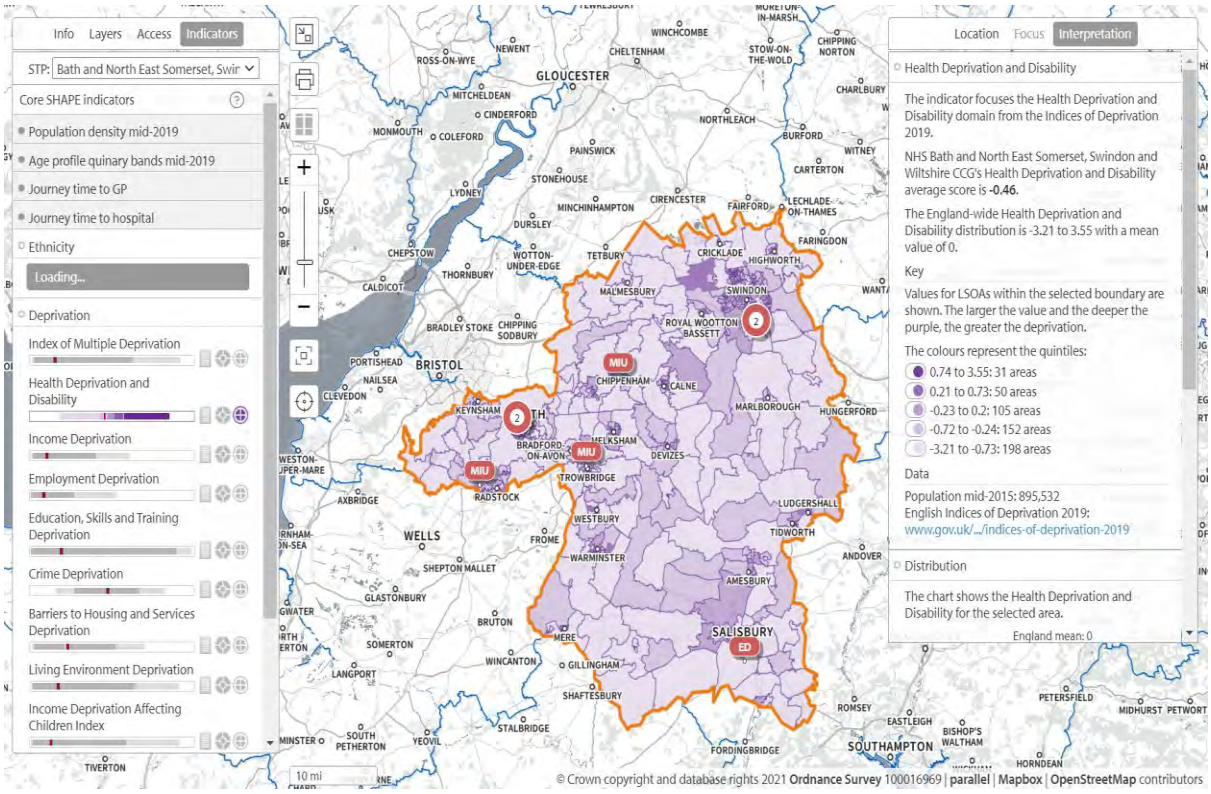
BSW SHAPE maps providing supporting information regarding the health inequalities across the population.

Data Source: [SHAPE • Place (shapeatlas.net)]

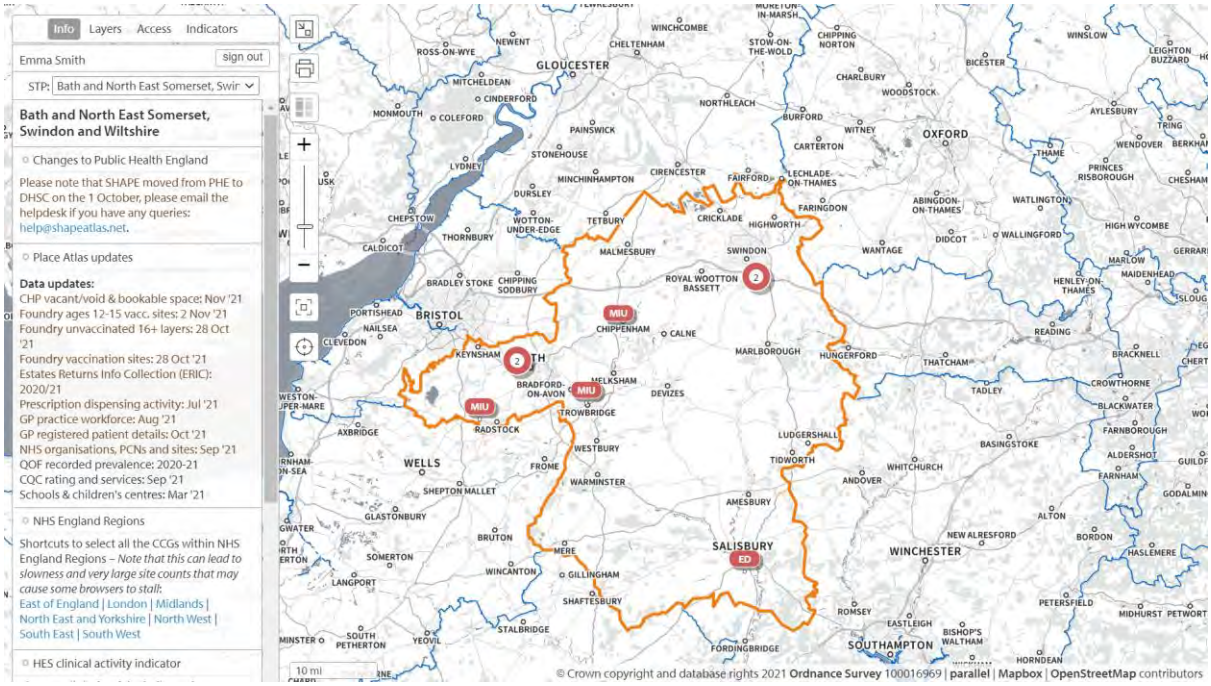
Map 1 - Rural deprivation index



Map 2 - Health Deprivation and disability index

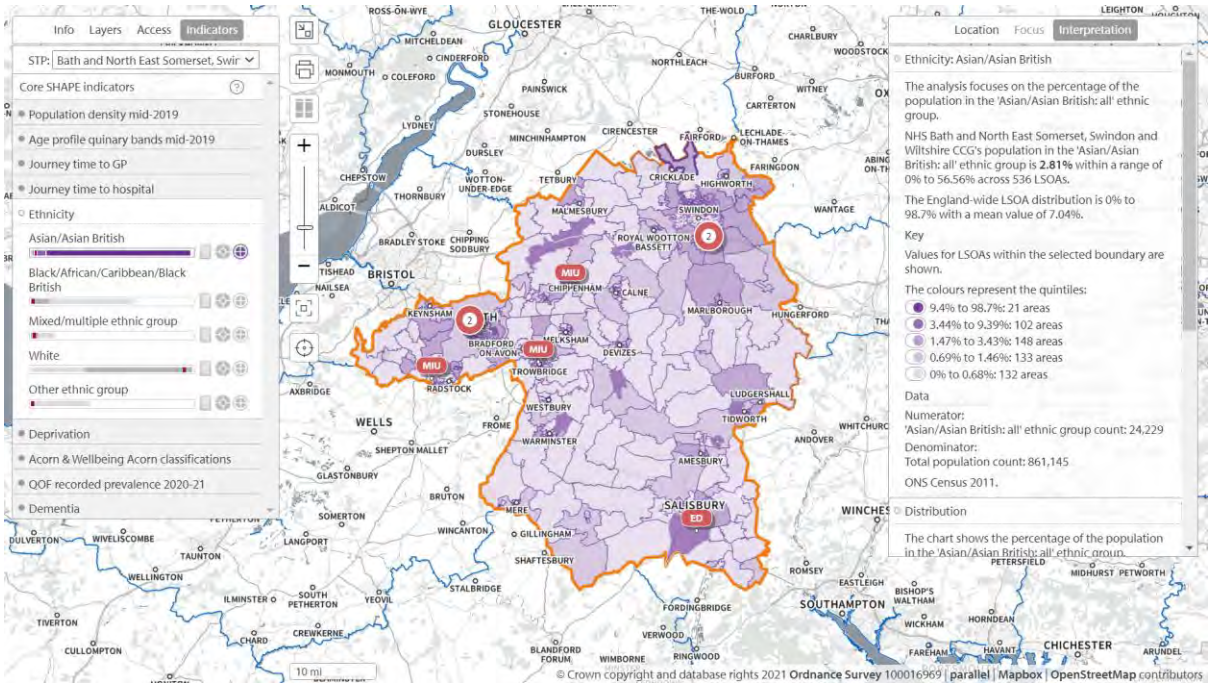


References:



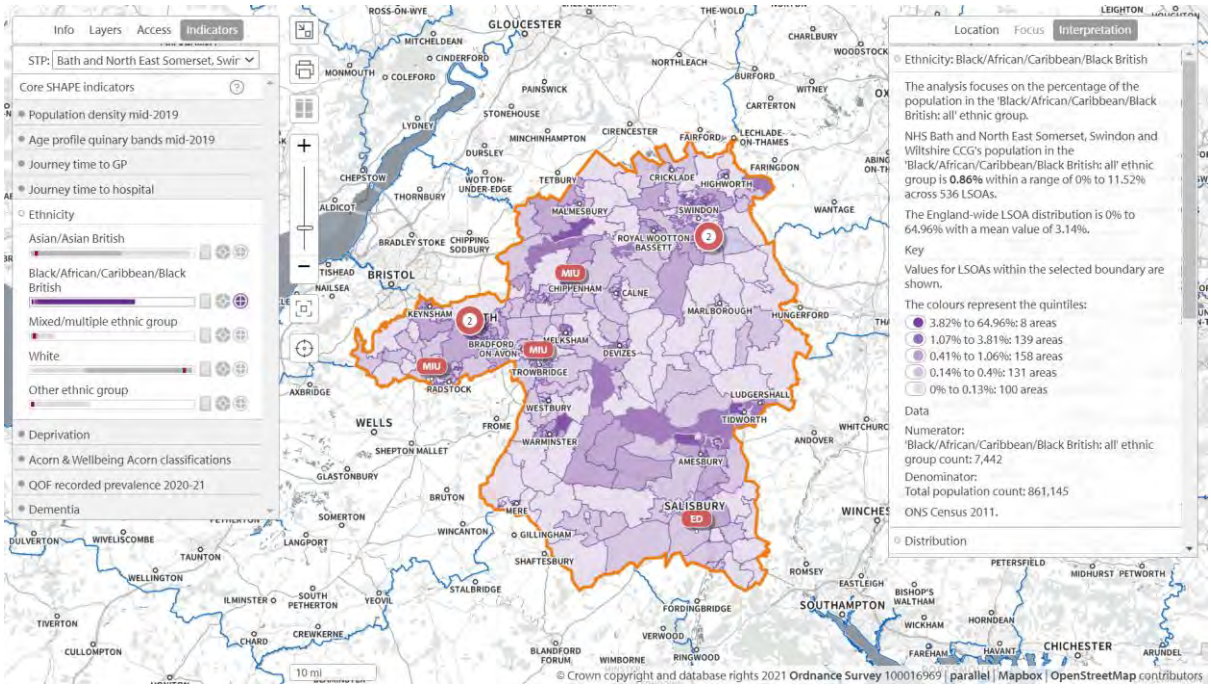
The following map shows the BSW Asian/Asian British population density

Map 4



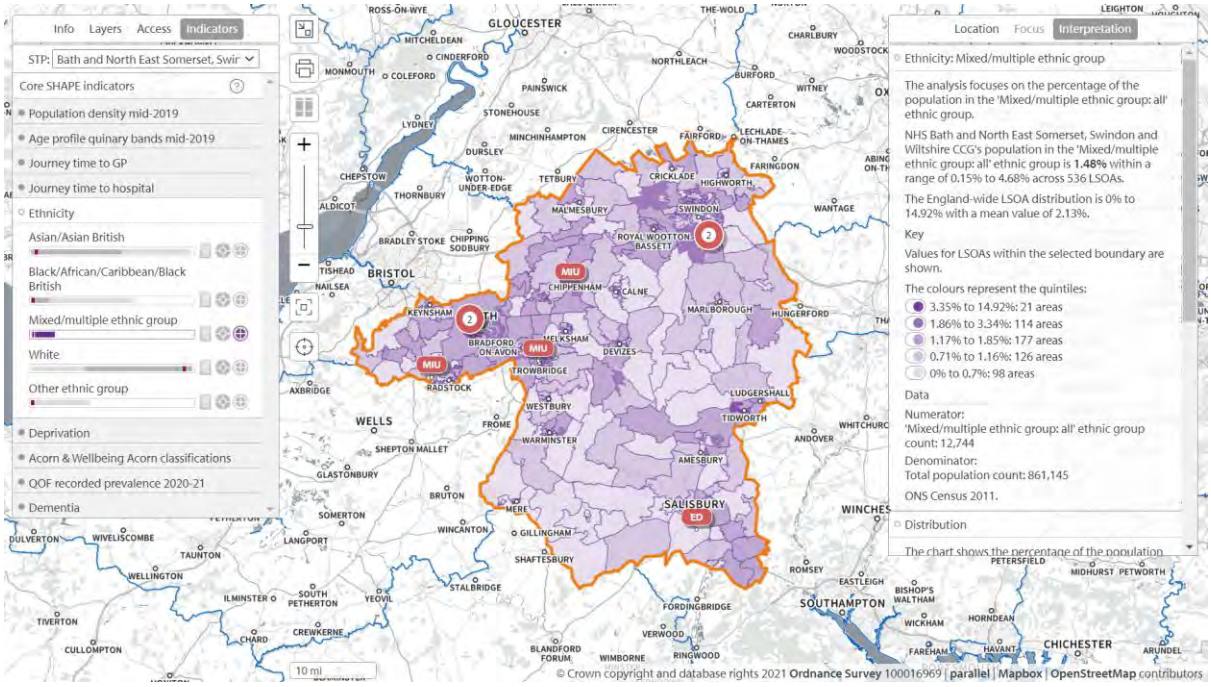
The following map shows the BSW Black/African/Caribbean/Black British population density

Map 5



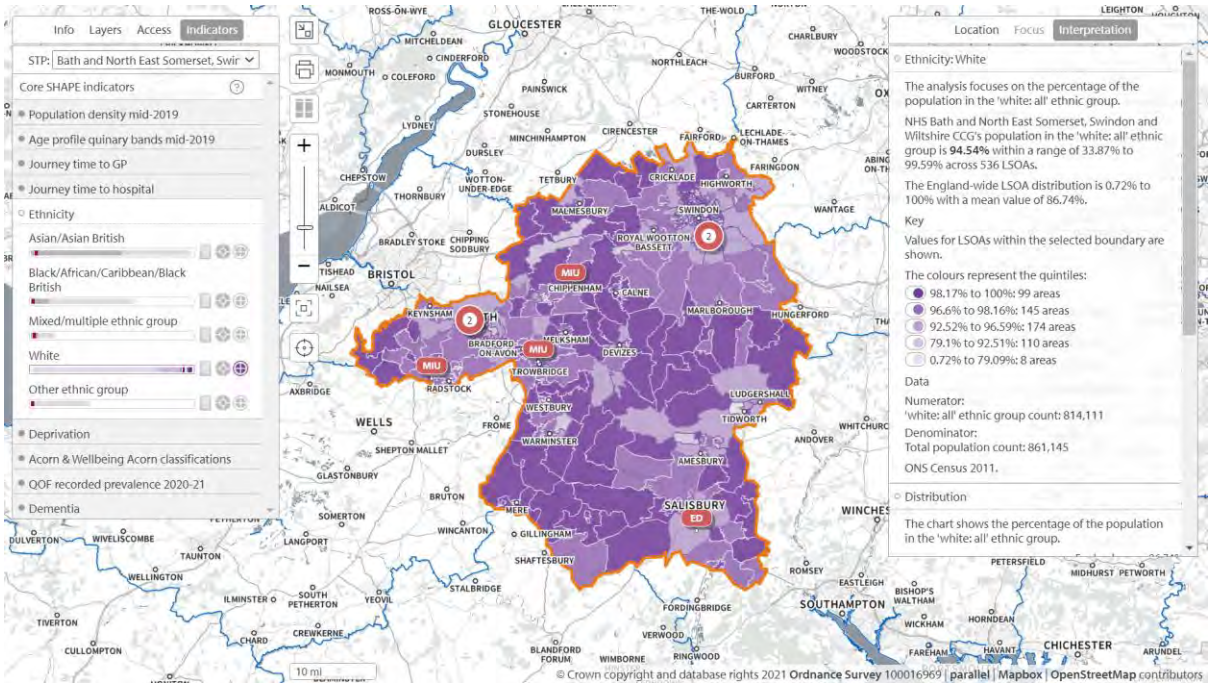
The following map shows the mixed / multiple ethnic population density

Map 6



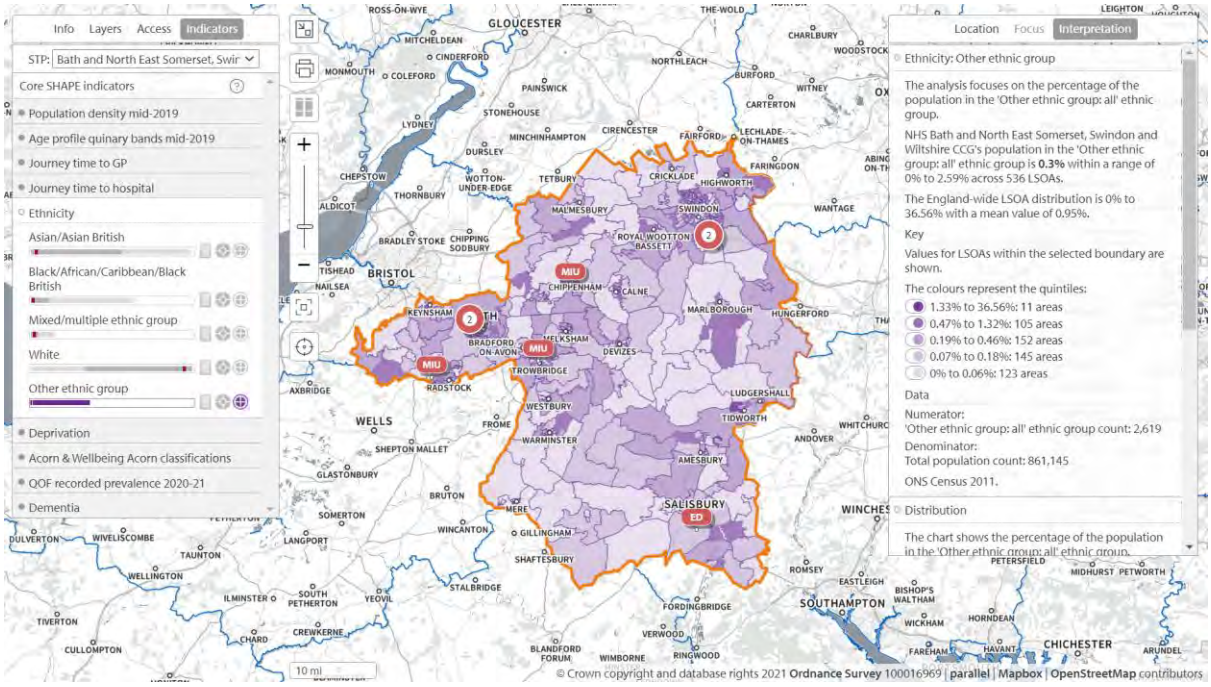
The following map shows the BSW White British population density

Map 7



The following map shows the BSW Other Ethnic Group population density

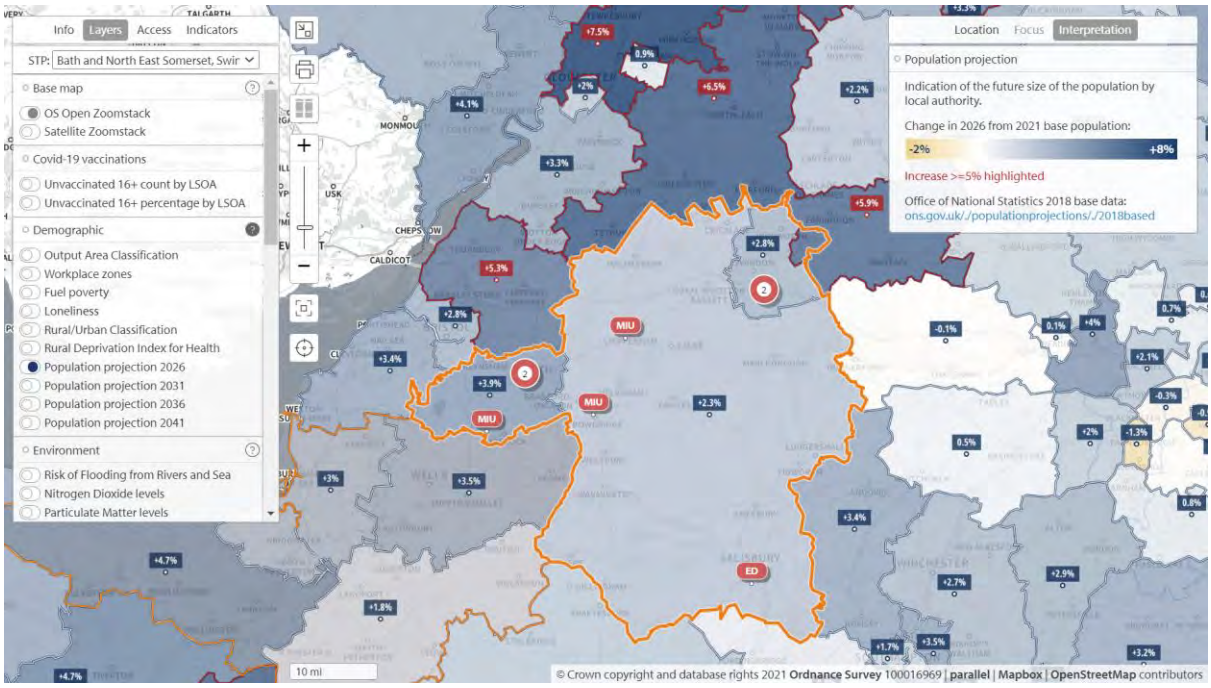
Map 8



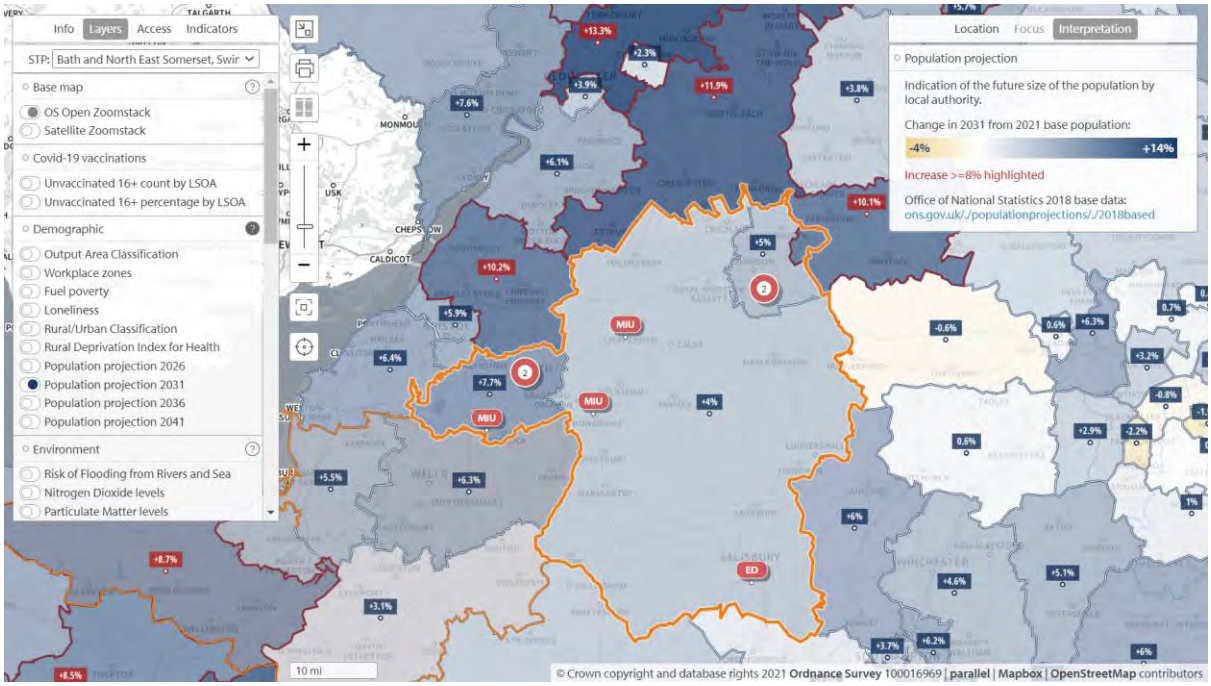
This next series of maps demonstrates the population group that will be seen with BSW in :-

- 2026
- 2031
- 2036
- 2041

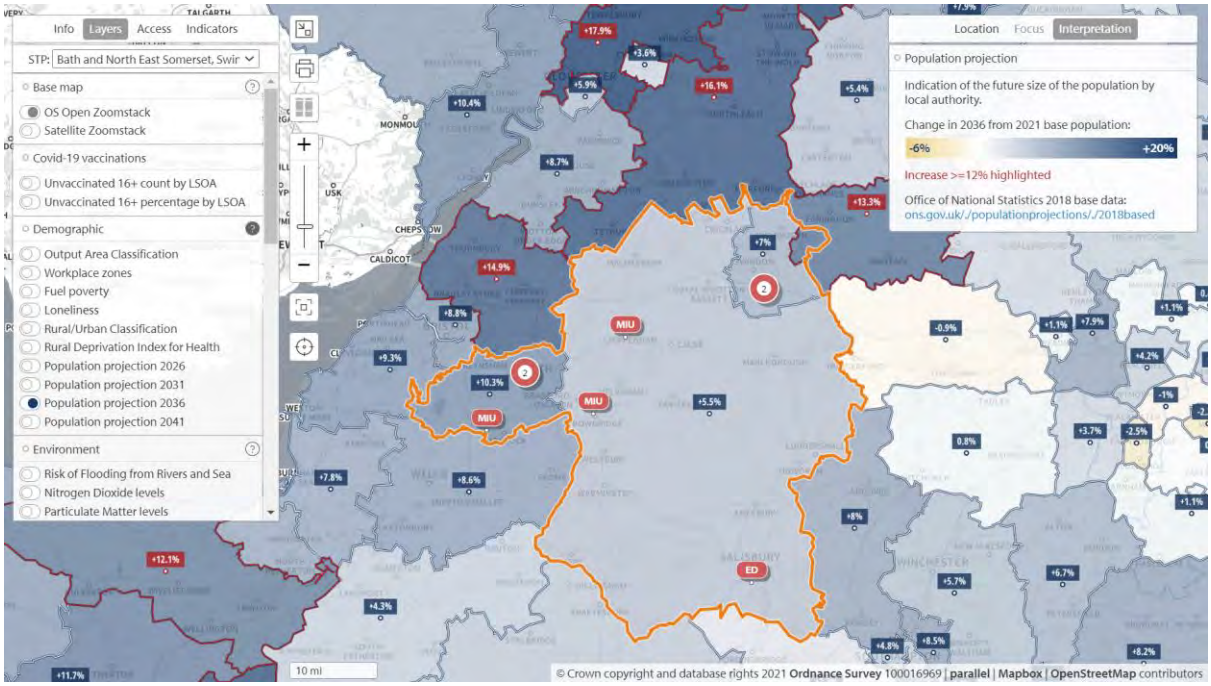
Map 9 – 2026 populations growth predictions



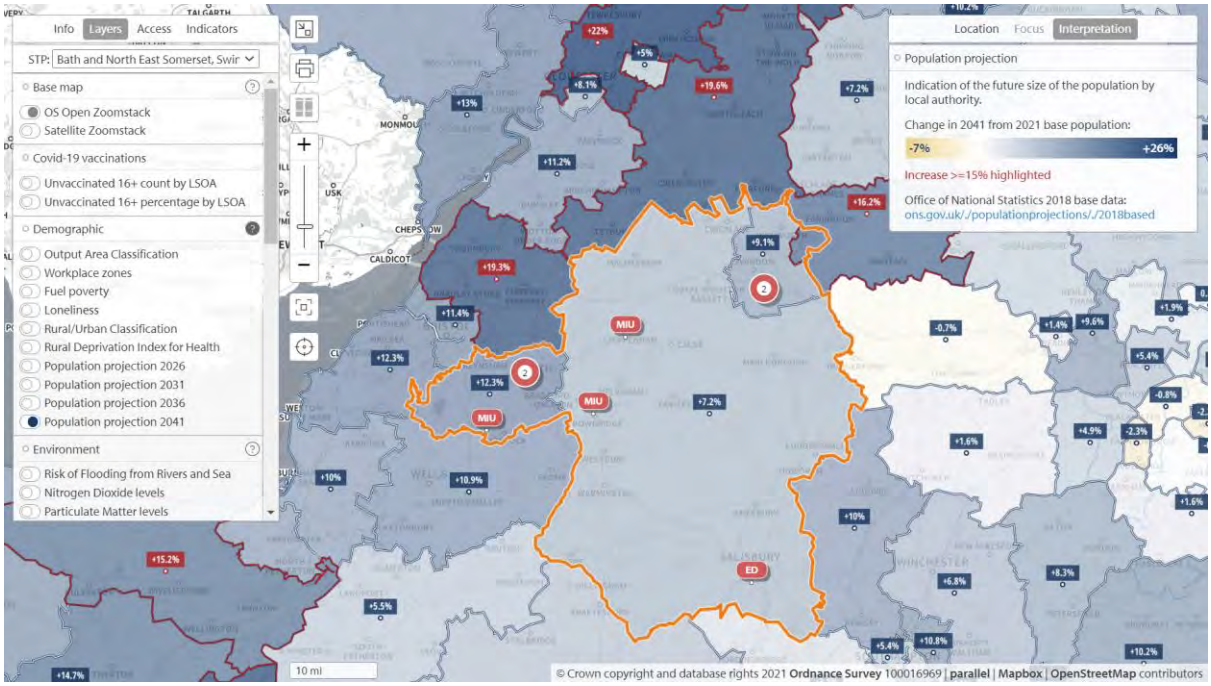
Map 10 – 2031 populations growth predictions



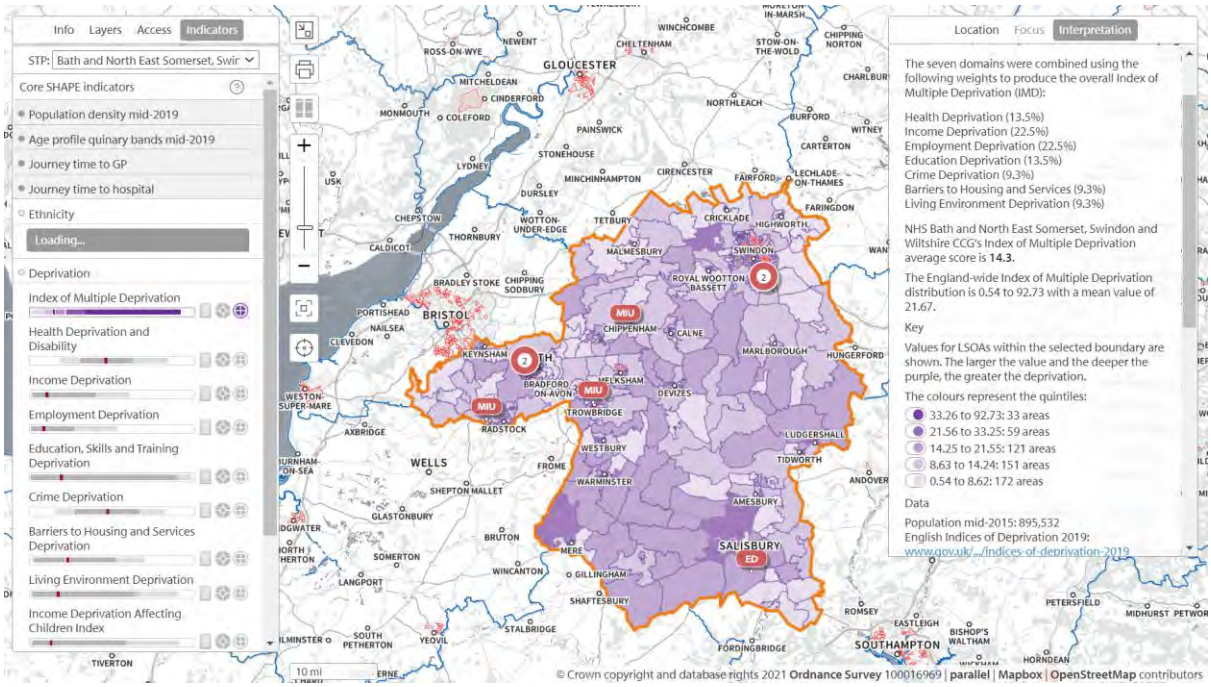
Map 11 – 2036 populations growth predictions



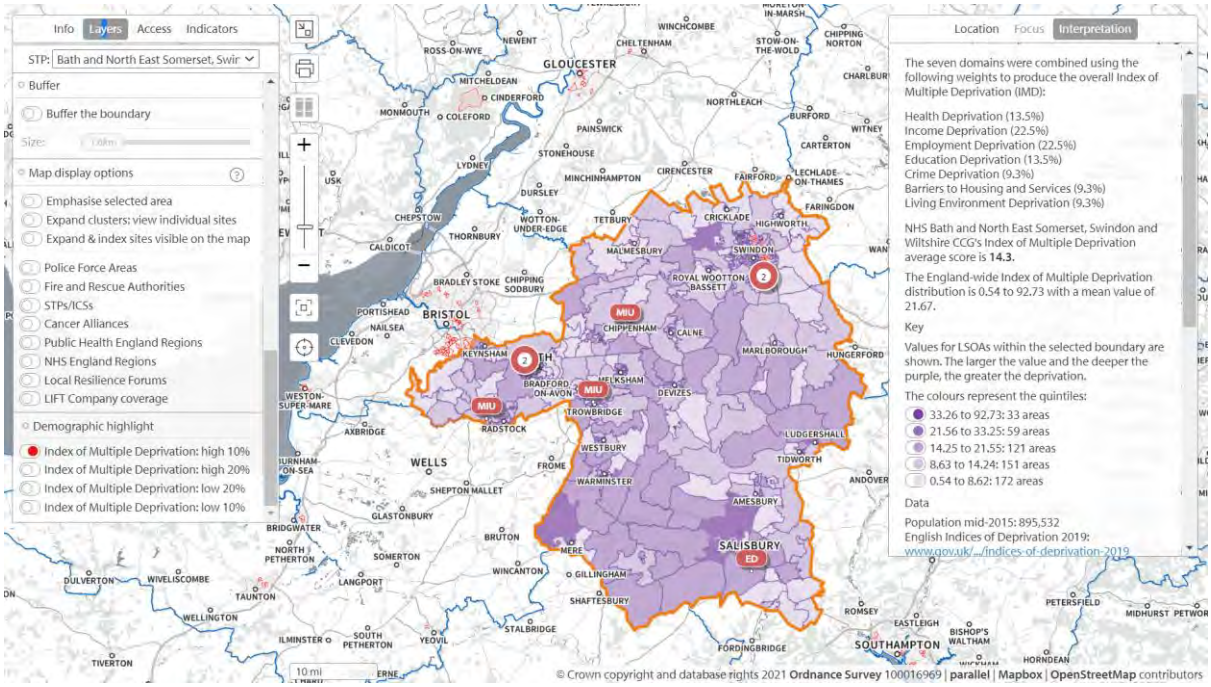
Map 11 – 2041 populations growth predictions



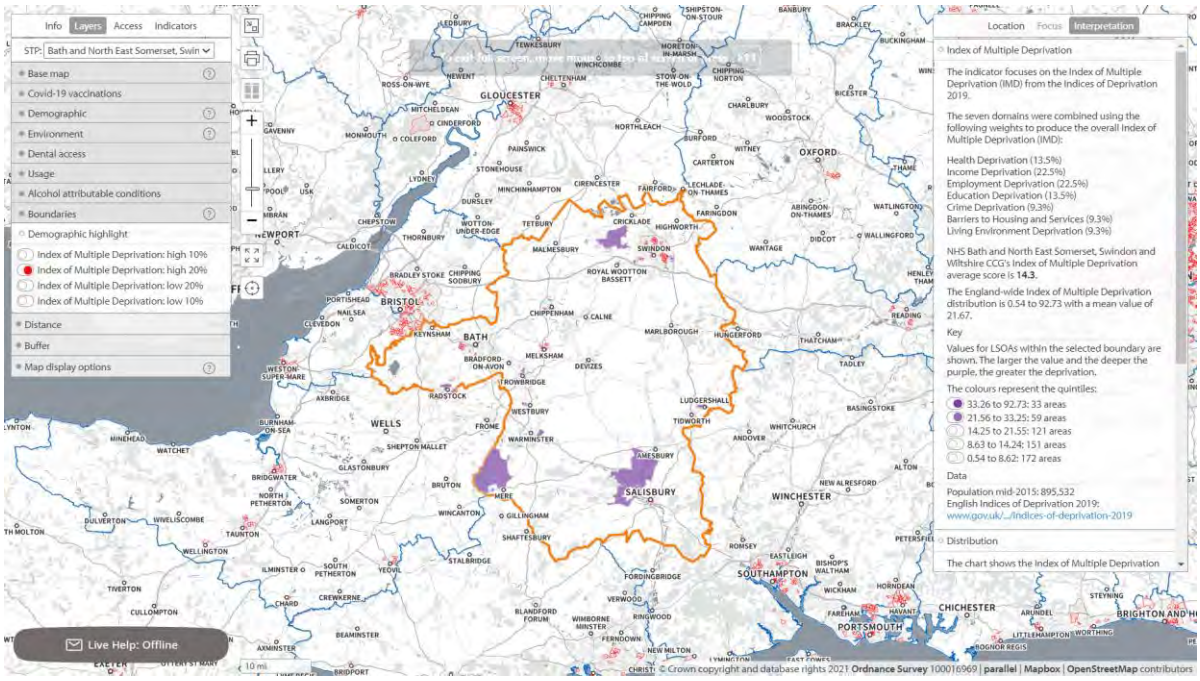
Map 12 – This shows multiple levels of deprivation – with 20% of high deprivation highlighted in red



Map 13 – This map shows multiple levels of deprivation – with 10% of high deprivation highlighted in red



Map 14 - This map shows local areas in BSW that are classified as being in the two highest quartiles with deprivation – with the 20% of high deprivation highlighted in red



Our Health Our Future

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

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Our Health Our Future Panel

Survey 6 results – A survey on **Urgent Care** and **Primary Care**

Survey conducted 26th July to 23rd August 2021

Report structure

Our Health Our Future

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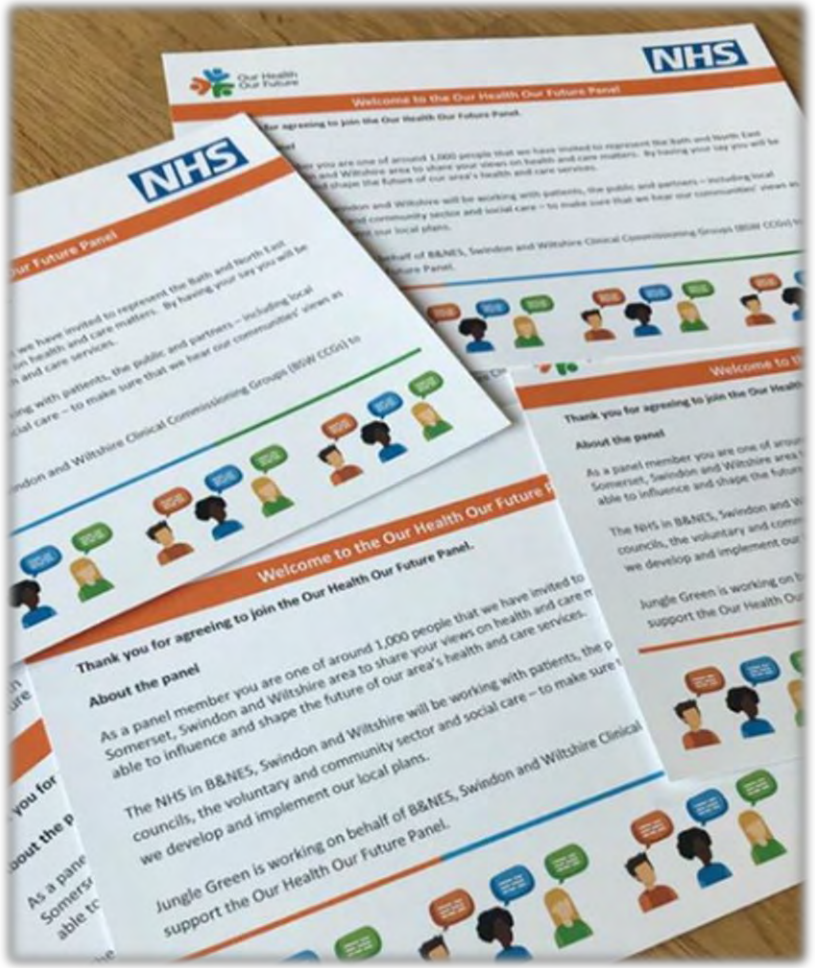
Section 1

Introduction



Vision and mission of the Our Health Our Future Panel

"The Our Health, Our Future (OHOF) Panel is a way for us to engage with those living in Bath and North East Somerset, Swindon and Wiltshire (BSW) to get their views on health and care issues.

In line with our value of "inclusive", the online panel is made up of a representative sample of the population from across our region. Panel members will take part in regular surveys throughout the year.

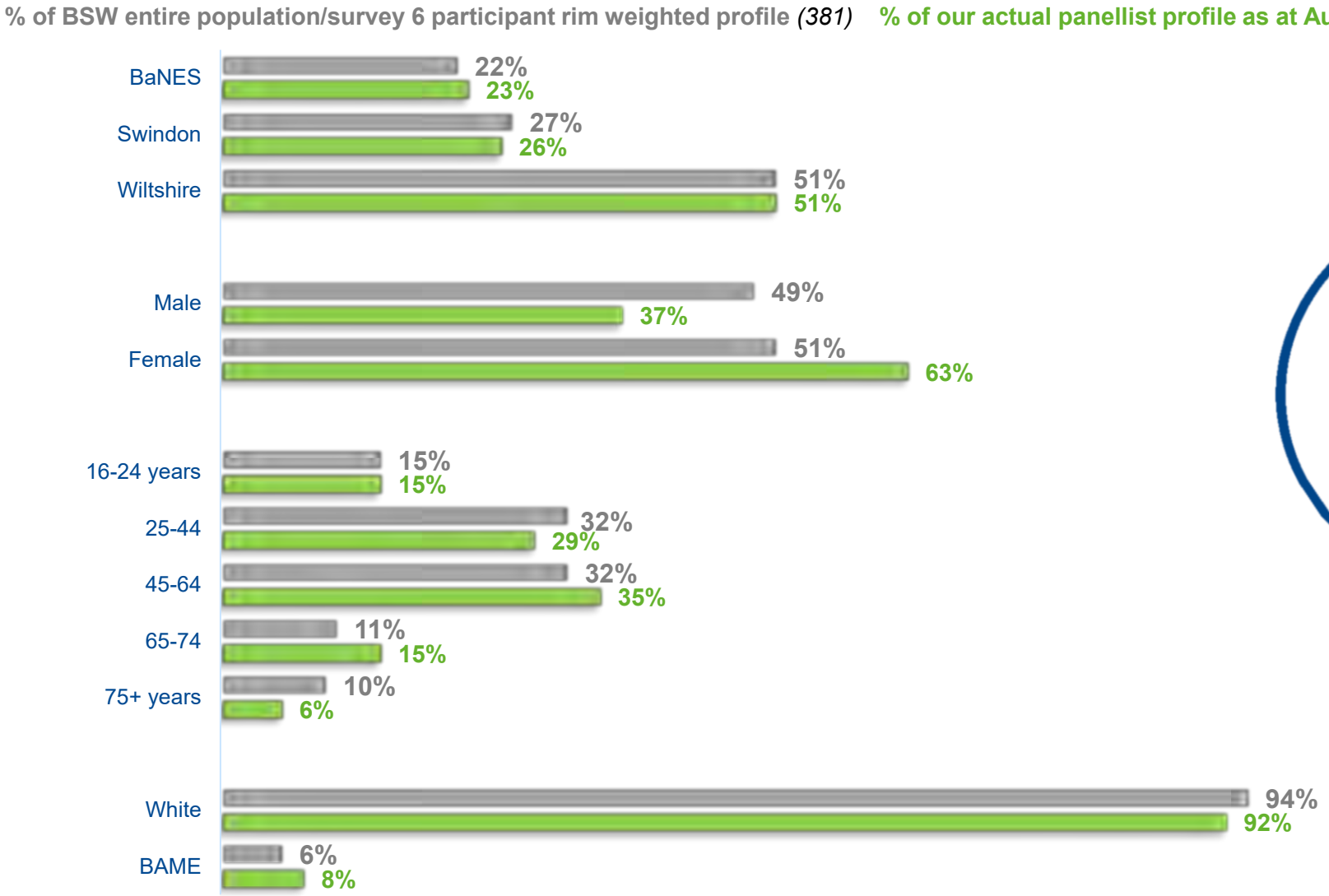
Panel surveys will inform both strategic direction and day-to-day service delivery, particularly around proposed service change or development of new services. Anonymised feedback will be shared with project managers and senior leaders to help shape and influence partnership initiatives and programmes of work. Anonymised feedback will also be made publicly available so panel members and the wider public will have the opportunity to review the results"

Response rates remain strong

- A **40%** response rate is considerably higher than the average response rate for similar panels. Approx 40% remains the target response rate for OHOF

	Survey 1 (Jan to March 2020)	Survey 2 (May 2020)	Survey 3 (Jul/Aug 2020)	Survey 4 (Nov/Dec 2020)	Survey 5 (March/Apr 2021)	Survey 6 (Jul/Aug 2021)
Number of participants	790	381	382	501	395	381
Response rate	100%	48%	45%	50%	40%	38%
Method	*All conducted via via face to face recruitment interviews*	*Conducted online/ postal/ telephone only*	*Conducted online/ postal/ telephone only*	*Including 200 face to face recruitment interviews*	*Conducted online/ postal/ telephone only*	*Conducted online/ postal/ telephone only*

We have a robust and representative panel



NB:
Survey 6 participants' responses have been rim weighted to reflect the exact profile of the BSW population (according to census data and JNSA).

A more detailed panel profile is given in Section 4 of this report.

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Section 2

Overview summary

Keeping well / Urgent care perceptions

- Survey 6 was conducted after restrictions had been lifted and as the vaccination programme was well under way. This potentially explains why the feeling of 'control' in one's life has returned to a higher level this time
- **Scores for feeling 'healthy', however, are at their lowest level since the OHOF panel was formed**

- Overall, panellists consider that a healthcare scenario that can wait for 2 or more days is a **routine** one *(e.g. general aches & pains, cold & flu, routine checks)*. Something needing attention in 4 to 24 hours becomes an **urgent** need *(e.g. persistent/ severe pain or fever)* and if help is needed within 2 to 3 hours it becomes an **emergency** *(e.g. heart attack, severe bleeding, broken bones, breathlessness, stroke)*
- **The 25-44 year old age group are the fastest escalating sub-group**
- If experiencing an URGENT HEALTHCARE NEED:
  - just over **one third** would be happy to use **online** healthcare services first for advice about what to do/where to go. Just under **one half** would prefer **telephone or video** consultation/advice first. The remainder, **one fifth** would prefer to **walk directly in** to the service they feel is best, without any prior contact
  - just under **one half** would want to be able to walk in **without an appointment** following advice. Just over **one half** would want a **booked arrival time** at a service location following advice
  - the most popular locations for being seen/ assessed are **GP practices (81%)** and **MIU/ UTC's (69%)**
  - the most popular HCP to see is a **GP (93%),** followed by a **Nurse (63%)**
- The distribution of **distances that people are prepared to travel** for urgent healthcare needs is evenly spread across 4 options: a minimum distance, 5 miles, 10 miles and 15 miles

- If experiencing an URGENT HEALTHCARE NEED, **having confidence in the advice that is given to you** is the most critically **important factor**, followed by **being in the right/ best place** for the treatment needed
  - Speed of assessment and treatment are the next two most important factors
  - Telling one's story once only is of particular importance to those with LTC's

- **Website/online communication (75%)** and an **NHS APP (67%)** receive the highest levels of interest, in terms of **increasing the public's knowledge** about health services and accessing these services
  - **Information leaflets** are favoured by just over a third of participants, particularly females and those aged 75 and over

- Even though **70%** of panellists know how to do **CPR**, **only 30% are confident** enough to provide it, a further 24% would like to be trained in providing CPR

Our Health Our Future

Primary care appointments

- **One quarter** of BSW residents have NOT made a GP appointment in the last 15 months
  - The majority of these, just under three quarters, **had not needed to** make a GP appointment in that time
  - A further approx. one in ten of these individuals **did not want to put the NHS under further strain** ***(this equates to 1 in 50 of all adults in BSW region)***
  - One in five **tried to make a GP appointment but were unsuccessful,** most of these went on to use an alternative (mainly NHS 111) ***(this equates to 1 in 25 of all adults in BSW region)***
- Among those who have NOT made a GP appointment in the last 15 months, there are **strong awareness levels** (**over 90%** in each case) for most of the factors relating to patient use of a GP practice since the pandemic began
  - The exception is awareness of the possibility to consult with a GP practice via their website/ online consultation, this was **lower at 74%**

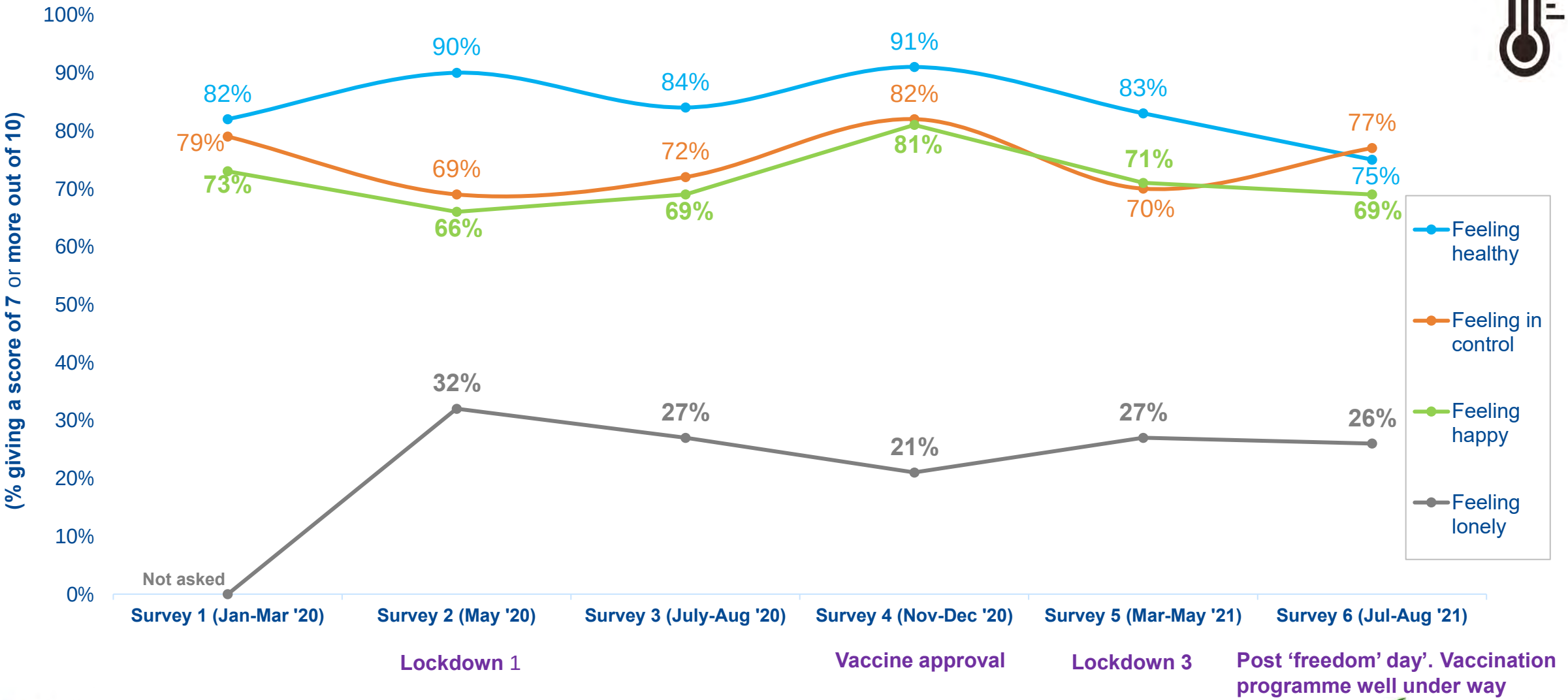
- **45%** of those who had made a GP appointment in the last 15 months had a **face to face** appointment, **53% a telephone** appointment and **2%** a **video/ online** appointment
  - Of those who had a face to face GP appointment, only 1 in 10 *(10%)* had asked for it themselves, rather than it being offered by the GP
  - Of those who had a telephone, video or online appointment, 1 in 6 *(15%)* had asked for a face to face appt but couldn't get one
- Most patients, 95%, saw the type of HCP they wanted to. 3% would have preferred to see a GP rather than a nurse and 2% a physio or nurse rather than a GP
- For **two thirds, 65%,** of all patients, the appointment **fully met their needs** ***(****This rises to **84%** for face to face appts and drops to **50%** for telephone/ video appts)***
  - **30%** said their needs were met partially but they needed **further support** either from another service **(16%)** or their GP **(14%)**
- A **majority** of patients **phoned their GP** practice to book their most recent appointment. One in ten used an online facility
  - **Three quarters** of patients found it very or quite easy to book their appointment and a further 10% found it neither easy nor difficult
  - Those who booked online through the website found it easier on the whole than those who phoned the Practice (the main difficulty being the length of time it takes to get through to the receptionist to book an appointment)

Our Health Our Future

Section 3a

Survey 6 results –
Keeping well

Keeping well trackers – ‘feeling healthy’ scores are the lowest since the panel was formed



Lockdown 1

Vaccine approval

Lockdown 3

Post ‘freedom’ day’. Vaccination programme well under way

Q1. Do you consider yourself to be……Base: n=total participants in each survey

Keeping well trackers – across the sub-groups

❖ Survey 6 was conducted after restrictions had been lifted and as the vaccination programme was well under way. This potentially explains why the overall feeling of **'control' in one's life** has returned to a higher level this time.

❖ **Scores for feeling 'healthy', however, are at their lowest level since the OHOF panel began**

❖ A number of sub-groups gave **consistently lower scores**, especially for feelings of **health** and **happiness**, these were:

- Those in **Swindon**
- Panellists from **BAME** backgrounds
- Those **aged 16-44 years**
- Those with **long term health conditions** *(especially depression and diabetes)*
- Those who are **unpaid carers**

❖ *All the differences mentioned **in purple** above are statistically significant differences*

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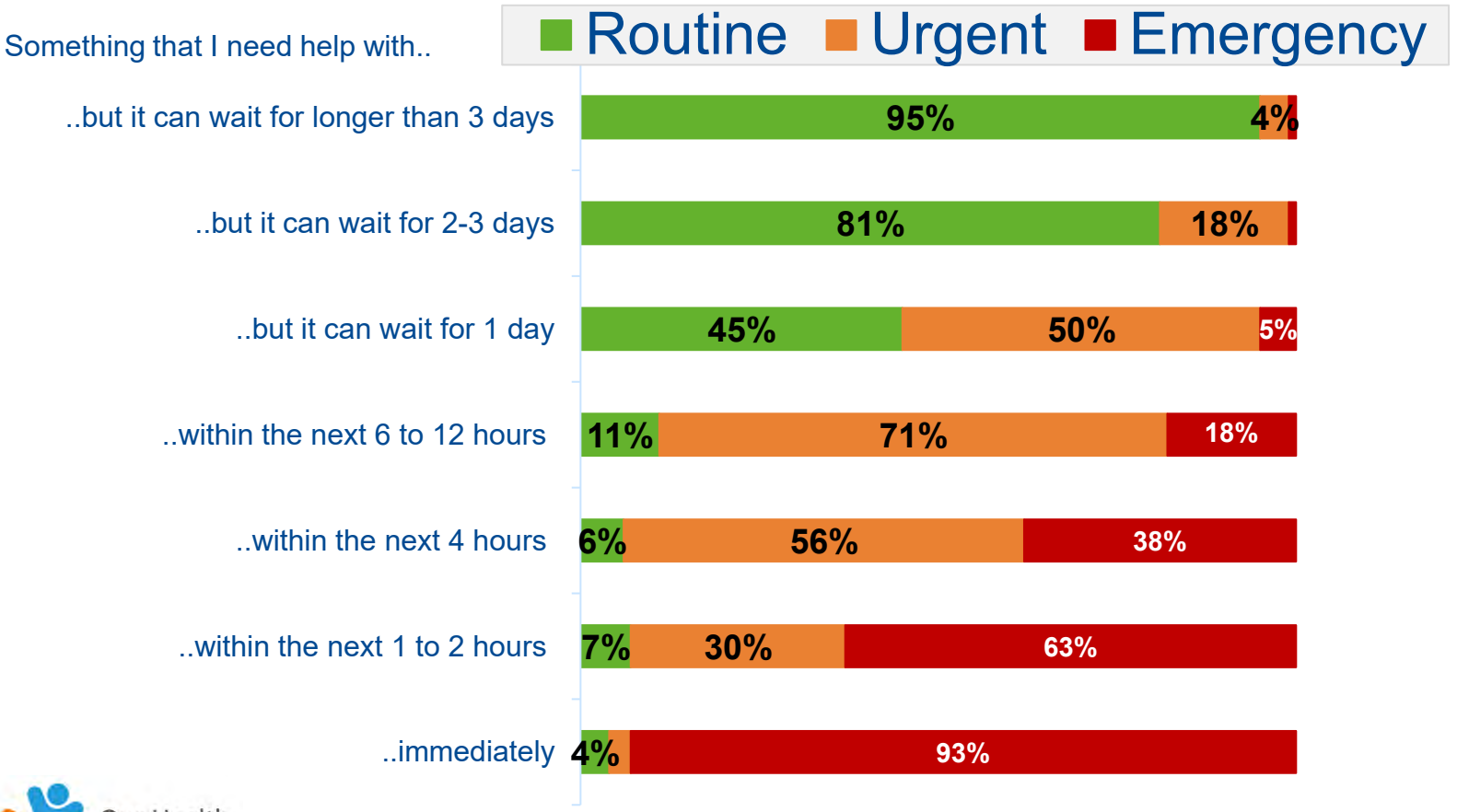
Section 3b

Survey 6 results – Urgent care

Overall, panellists consider that a healthcare scenario that can wait for 2 or more days is a routine one. Something needing attention in 4 to 24 hours becomes an urgent need and if help is needed within 2 to 3 hours it becomes an emergency



However, there are some differences across sub-groups:

- Those **aged 75+ escalate more slowly** than other age groups *(only **24%** say urgent at 1 day and **58%** at 6 to 12 hours)*
- The opposite is true for **those aged 25-44 years, they escalate much more quickly** *(**33%** say urgent at 2-3 days)*
- **Males escalate more quickly** than females *(**51%** of males say emergency at 4 hours)*
- **BAME** participants **escalate to emergency** more quickly *(**73%** say emergency at 4 hours)*
- Those with **LTC's also escalate more quickly** than others *(**24%** say emergency at 1 day)*

Q2. Looking at the list of potential scenarios below, could you say whether you would personally consider each one to be BEST described as a 'routine healthcare need', an 'urgent healthcare need' or an 'emergency healthcare need'. Base: n=366, total participants answering this question

The following are examples of what panellists would consider to be routine, urgent and emergency healthcare needs *(unprompted question)*

ROUTINE

- **General aches and pains** (back pain, migraine, joints, chest pain, sprains) **37%**
- **Cold and flu** symptoms, sore throat **23%**
- **Blood tests,** blood pressure, screening **19%**
- Repeat **prescription**, medication **16%**
- Monitoring **ongoing conditions**, diabetes check **15%**
- **Dermatology,** rash, moles, eczema **14%**
- **General check up,** annual review **12%**
- **Ears,** blocked/wax, infections **9%**
- **Foot problems,** athletes foot, fungal infections **6%**
- **Eye conditions,** glaucoma **5%**

URGENT

- **Persistent, severe pain** (back pain, migraine, swelling, chest pain, sprains) **37%** *(n.b. BAME 70%)*
- **Persistent, severe cough,** coughing blood, fever, high temperature, chest infection **14%** *(n.b. 25-44 yrs 29%)*
- **Sudden deterioration,** dizziness, fainting, change in condition/ symptoms worsening **12%** *(n.b. 25-44's 26%, and LTC's 24%)*
- **Broken limbs**, bones, fractures **10%**
- Injury/ cut with severe/abnormal **bleeding 10%**
- **Dermatology,** rash, moles, eczema **8%**
- **Heart conditions/ attack,** murmurs, problems **6%**
- **Infection requiring antibiotics 6%** *(n.b. 25-44 yrs 15%)*
- **Severe vomiting, diarrhoea 6%**
- **Breathing difficulties 4%** **Unexplained lumps 4%**

EMERGENCY

- **Heart conditions/ attack,** murmurs, problems **48%**
- Injury/ cut with severe/abnormal **bleeding 32%**
- **Broken limbs,** bones, dislocation **22%**
- **Breathing difficulties,** breathless **18%**
- **Stroke,** slurred speech **16%**
- **Loss of consciousness 8%**
- **Persistent, severe pain** (back pain, migraine, swelling, chest pain, sprains) **8%**
- **Sudden deterioration,** floppy, dizziness, fainting, change in condition/ symptoms worsening **6%**
- **Head injury 6%**
- **Life threatening,** need of A&E, ambulance **5%**
- **Mental health crisis,** life threatening **5%**

Our Health Our Future

Q3. Could you now give one or two examples of problems or conditions that you would personally consider to be ROUTINE/ URGENT/ EMERGENCY healthcare needs. Base: n=318, total participants answering this question

If experiencing an URGENT HEALTHCARE NEED, just over one third would be happy to use online healthcare services first for advice. Just under one half would prefer telephone or video advice first. One fifth would prefer to walk directly in to a service without prior contact

I would be happy to use **online healthcare services** who could then advise on the best course of action for me (eg. NHS 111 or DoctorLink or via an NHS APP)

37%

54% of those aged 16-44 years would be happy with this option but only 8% of those aged 75+

I would want to talk to someone first by **telephone or video consultation** who could then advise on the best course of action for me (eg. my GP, NHS 111, 999)

45%

55% of those aged 65+ would want this option. As would 75% of BAME panellists

I would want to go **directly to the service** that I think best suit my needs **without contacting anyone** first

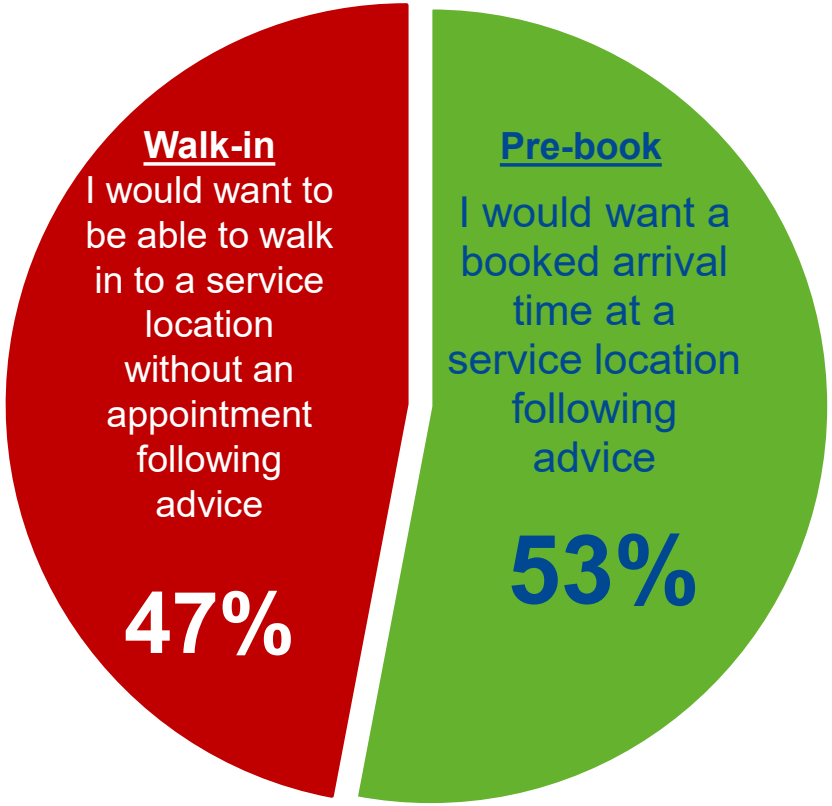
18%

One third of those aged 75+ would want this option. As would one third of those with LTC's

Q4. If you were experiencing an urgent healthcare need (like the ones you may have mentioned earlier, i.e. urgent but not an emergency situation), which of the following actions would you most want to take at first? Base: n=333, total participants answering this question

If experiencing an URGENT HEALTHCARE NEED, just under one half would want to be able to walk in without an appointment following advice. Just over one half would want a booked arrival time at a service location following advice.

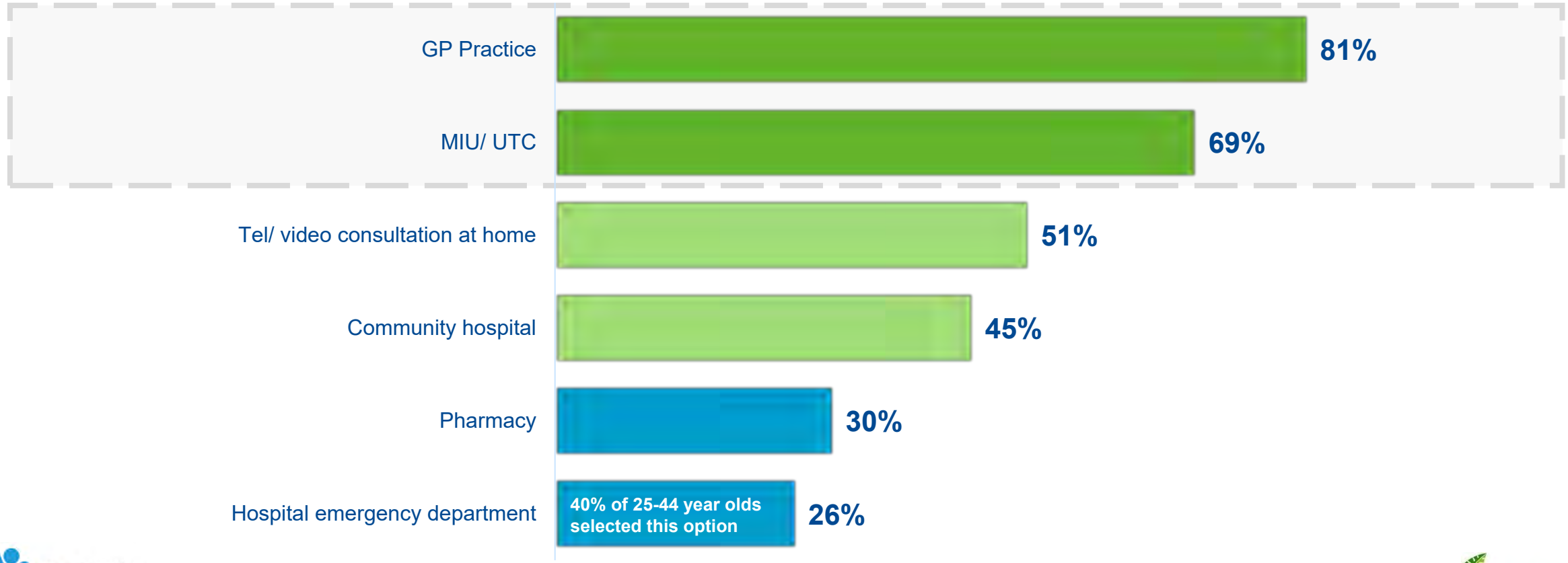
- Most sub-groups followed this same pattern, however those in **Swindon** were slightly more likely to say they would prefer to **walk straight in, 55%.** Those in **BaNES** would be slightly more likely to want a **booked slot, 62%**



Q5. If you were experiencing an urgent healthcare need (like the ones you may have mentioned earlier, i.e. urgent but not an emergency situation), and were advised to go to a service, would you want to be able to walk in at any time or have a booked time slot? Base: n=333, total participants answering this question

If experiencing an URGENT HEALTHCARE NEED the most popular locations for being seen/ assessed are GP practices and MIU/ UTC's

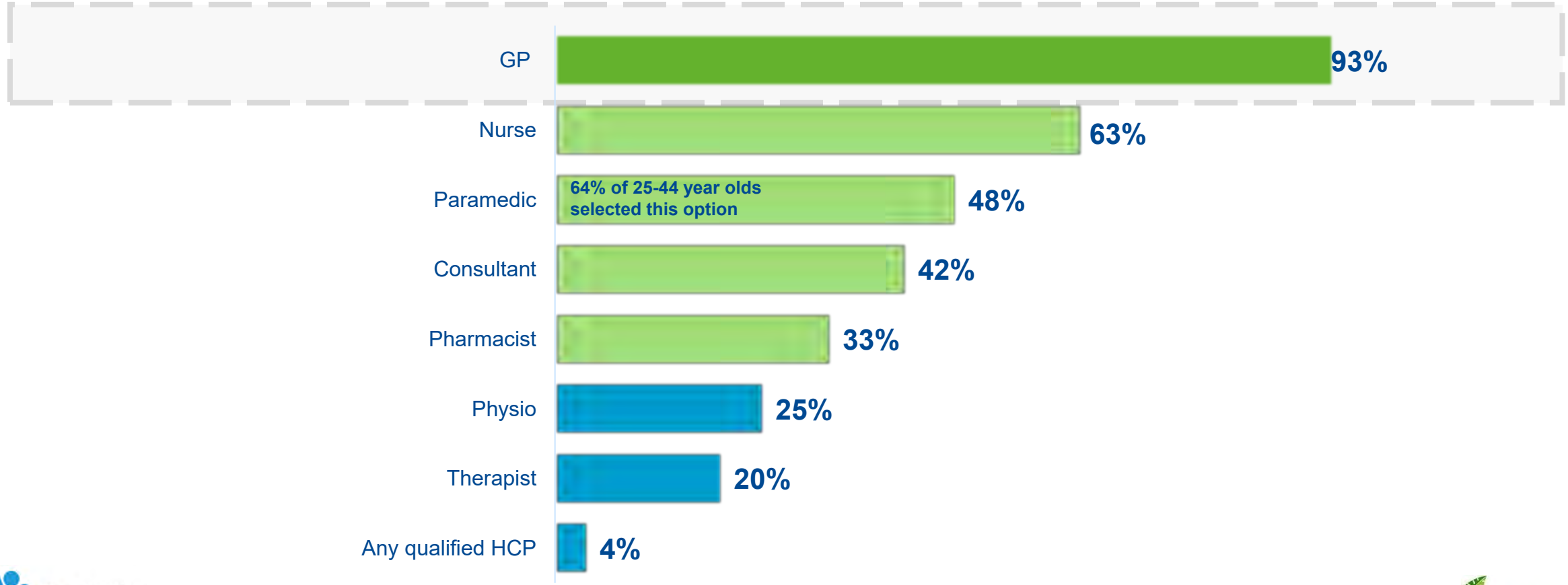
- One half would also be happy with a telephone or video consultation at their own home and slightly fewer a community hospital visit
- A pharmacy and a hospital ED were less frequently selected options. The exception being 25-44 year olds, where 40% selected an ED



Q6. If you were experiencing an urgent healthcare need (like the ones you may have mentioned earlier, i.e. urgent but not an emergency situation), in which of the following locations would you ideally want a healthcare professional to see/assess you? Base: n=316, total participants answering this question

If experiencing an URGENT HEALTHCARE NEED the most popular HCP to see or speak to is a GP, followed by a Nurse

- Paramedics, Pharmacists, Consultants, Physios and Therapists are selected on the basis of differing urgent scenarios

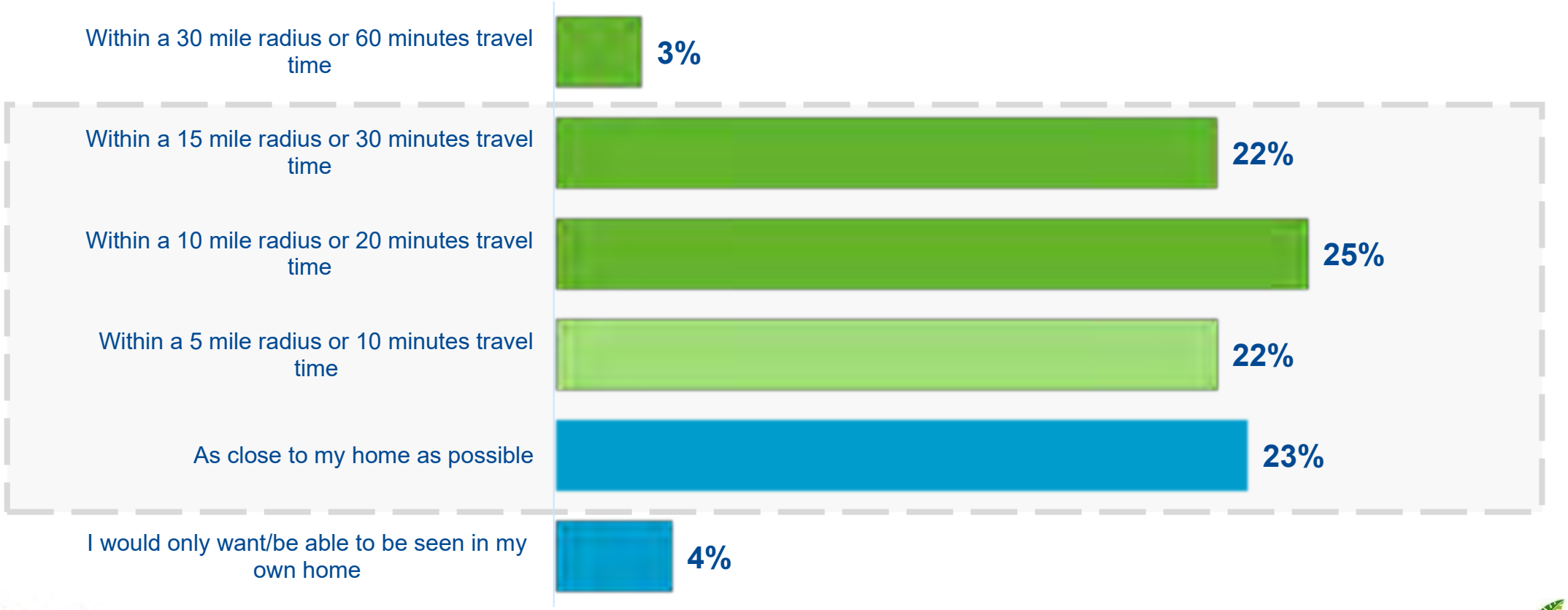


Q7. If you were experiencing an urgent healthcare need (like the ones you may have mentioned earlier, i.e. urgent but not an emergency situation), what sort of healthcare professional would you ideally want to see or speak to? Base: n=316, total participants answering this question

If experiencing an URGENT HEALTHCARE NEED the average time and distance panellists are prepared to travel (if advised to do so) is 8 miles or 16 minutes

This average rises to 10 miles and 20 minutes for the under 45 age group and drops to 7 miles and 14 minutes for those with LTC's

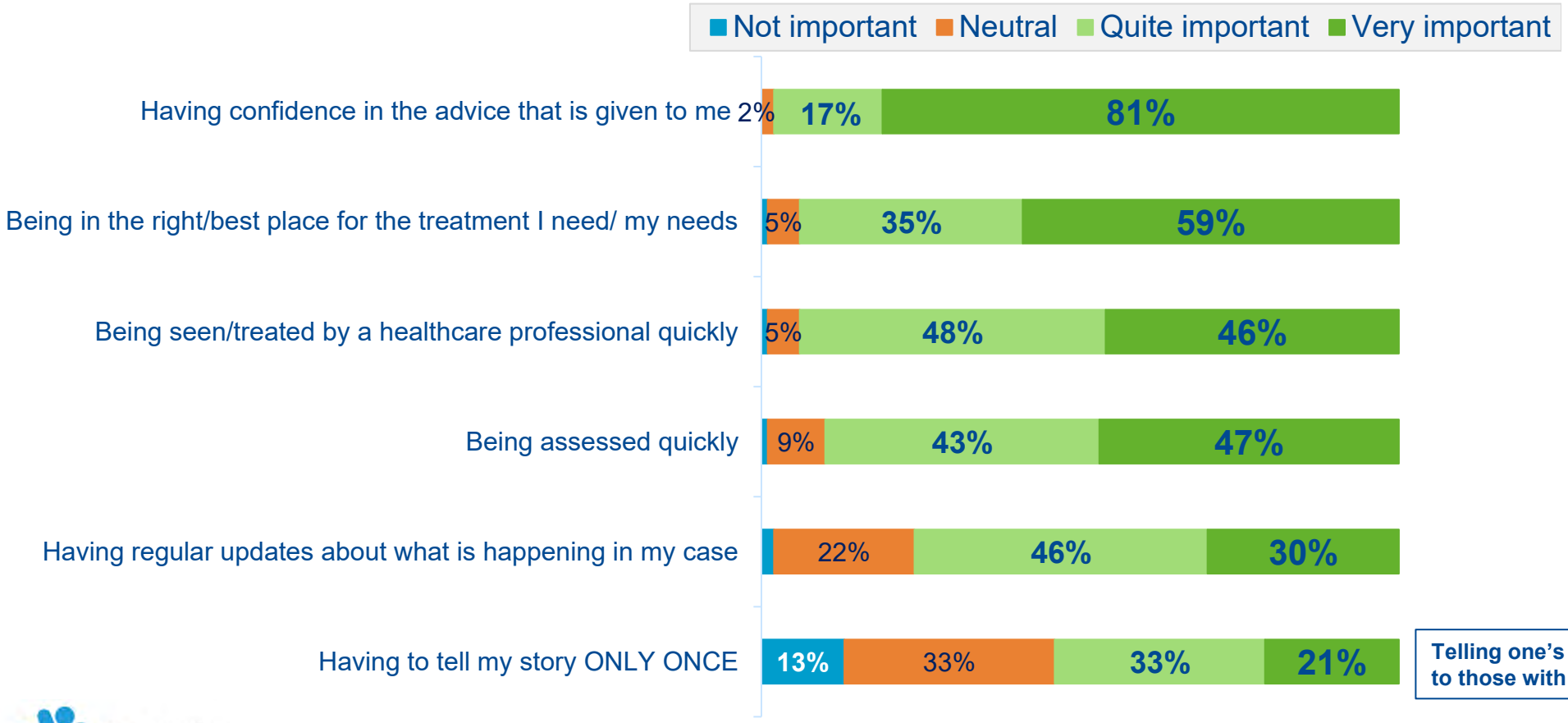
- The actual distribution is fairly evenly dispersed across 4 main options: a minimum distance, 5 miles,10 miles and 15 miles



Q8. Approximately how far would you be prepared to travel to an urgent healthcare service, if you were advised that this was the best course of action for you?
Base: n=316, total participants answering this question

If experiencing an URGENT HEALTHCARE NEED, having confidence in the advice that is given to you is the most critically important factor, followed by being in the right/best place for the treatment needed

- Speed of assessment and treatment are the next two most important factors

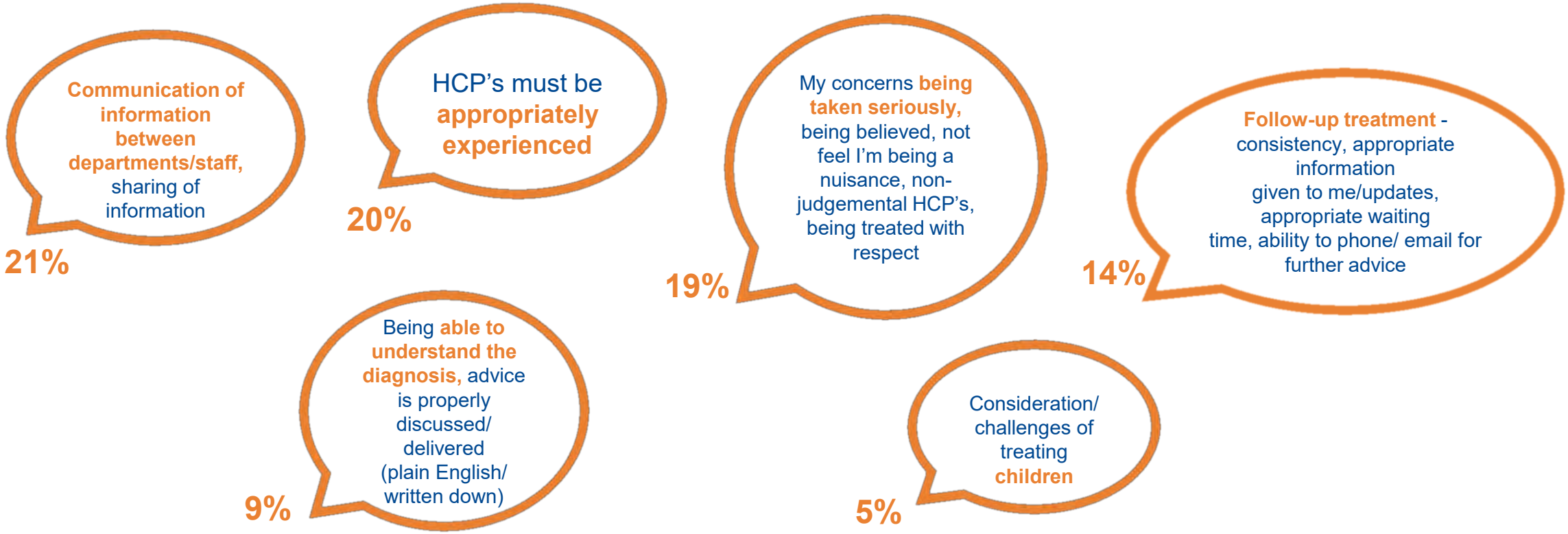


Telling one's story once only is of particular importance to those with LTC's, 40% very and 36% quite

Q9a. If you were experiencing an urgent healthcare need (like the ones you may have mentioned earlier, i.e. urgent but not an emergency situation), how important would each of the following factors be to you in your subsequent treatment? Base: n=313, total participants answering this question

Other factors (not already mentioned) that are important to people in their subsequent treatment of an urgent healthcare need *(unprompted)*

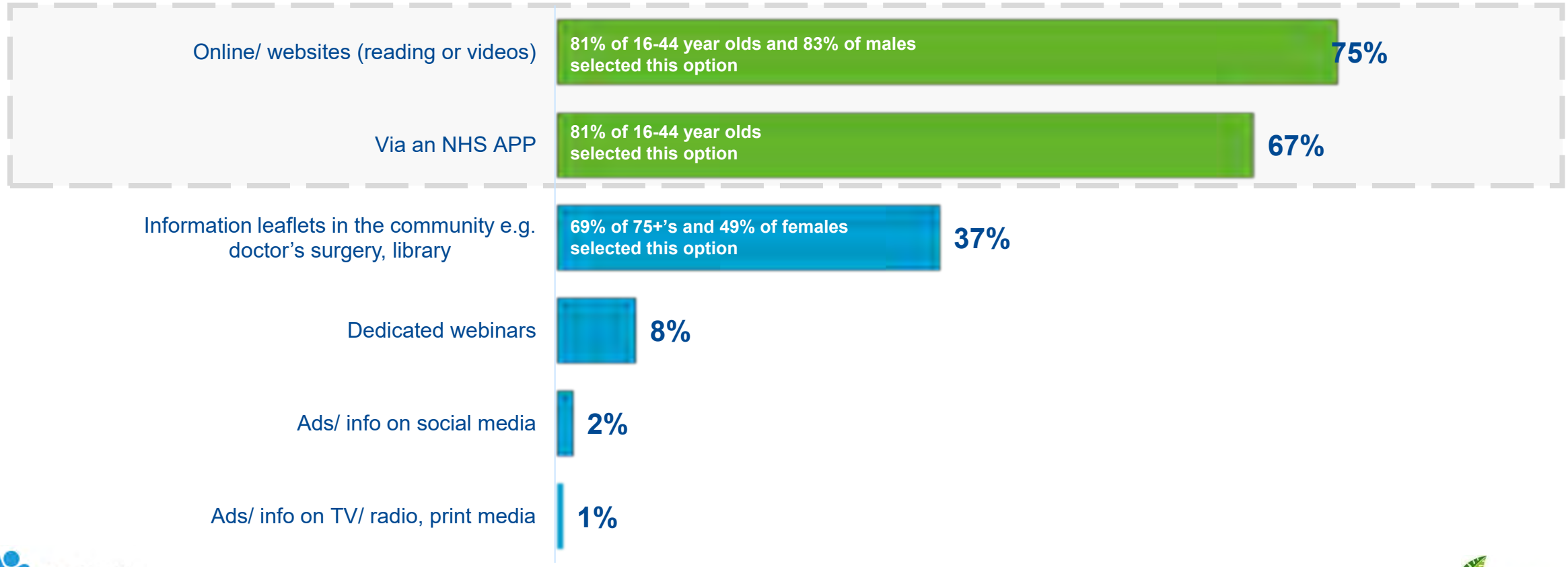
- Those who made additional points here emphasised the need for **joined up and integrated** subsequent care, to be delivered by **appropriately experienced** HCP's.
- The need for ensuring the patient feels **listened to and properly understood** was also significant, along with **ensuring that the case is followed up**



Q9b. Is there anything else that would be important to you in your subsequent treatment, anything that we haven't already mentioned?
Base: n=97, total participants answering this question

Online communication and an NHS APP receive the highest levels of interest, in terms of increasing the public's knowledge about health services and accessing these services

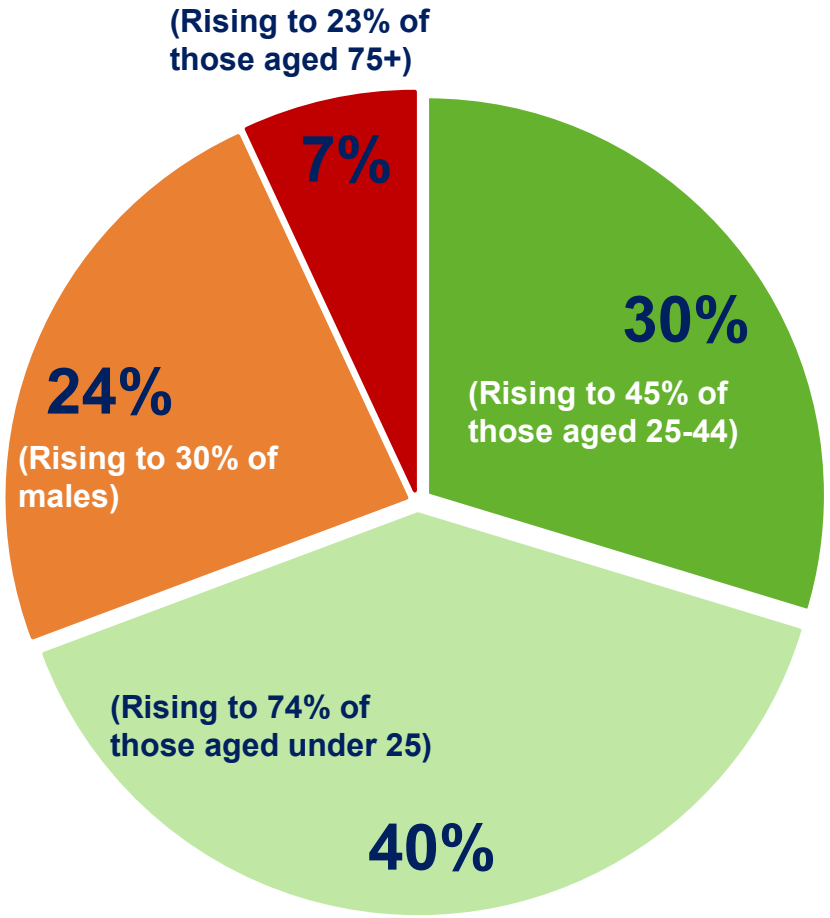
- Information leaflets are favoured by just over a third of participants, particularly females and those aged 75 and over



Q10. What is the best way for us to help increase your knowledge about health services and how you can access them (before you may need to access them)?
Base: n=312, total participants answering this question

CPR – whilst 70% of panellists know how to do CPR, only 30% are confident enough to provide it

- A further **one quarter** would like to be trained in CPR



- I know how to do CPR and I would feel confident to provide it
- I know how to do CPR but I do not feel confident to provide it
- I do not know how to perform CPR but I would like to be trained how to do it
- I do not know how to perform CPR and I do not want to know how to do it

Q11. We would now like you to think about the provision of CPR (Cardiac Pulmonary Resuscitation) in a life- threatening situation for a family member or a stranger. Which of the following statements best applies to you? Base: n=312, total participants answering this question

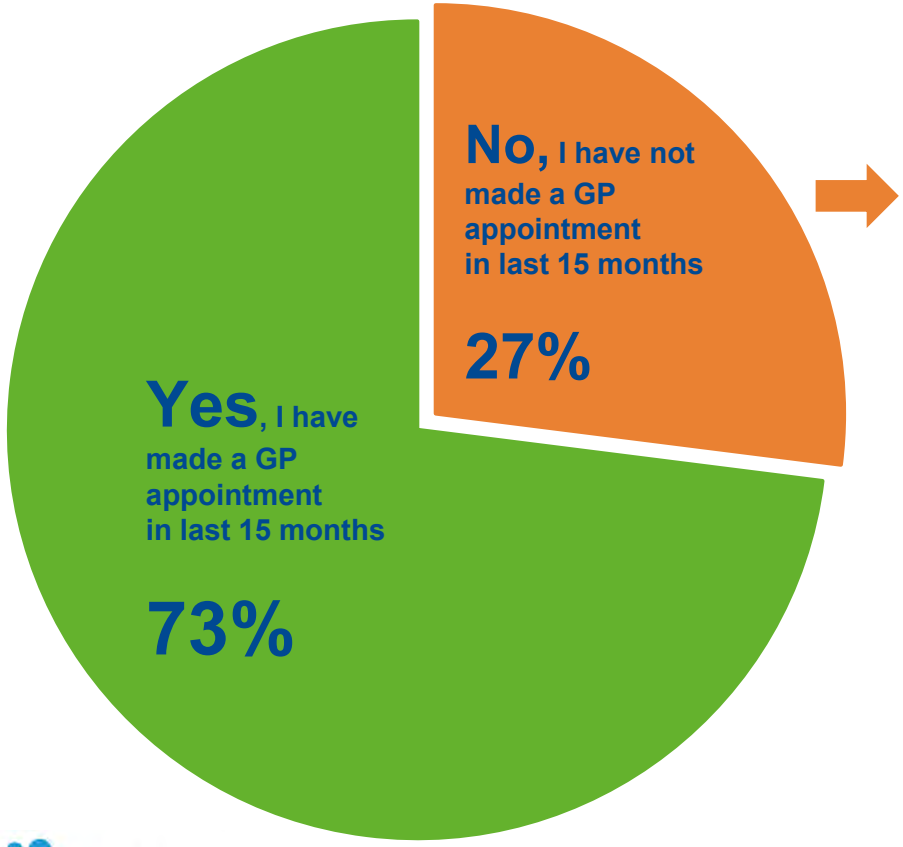
Section 3c

Survey 6 results – Primary care

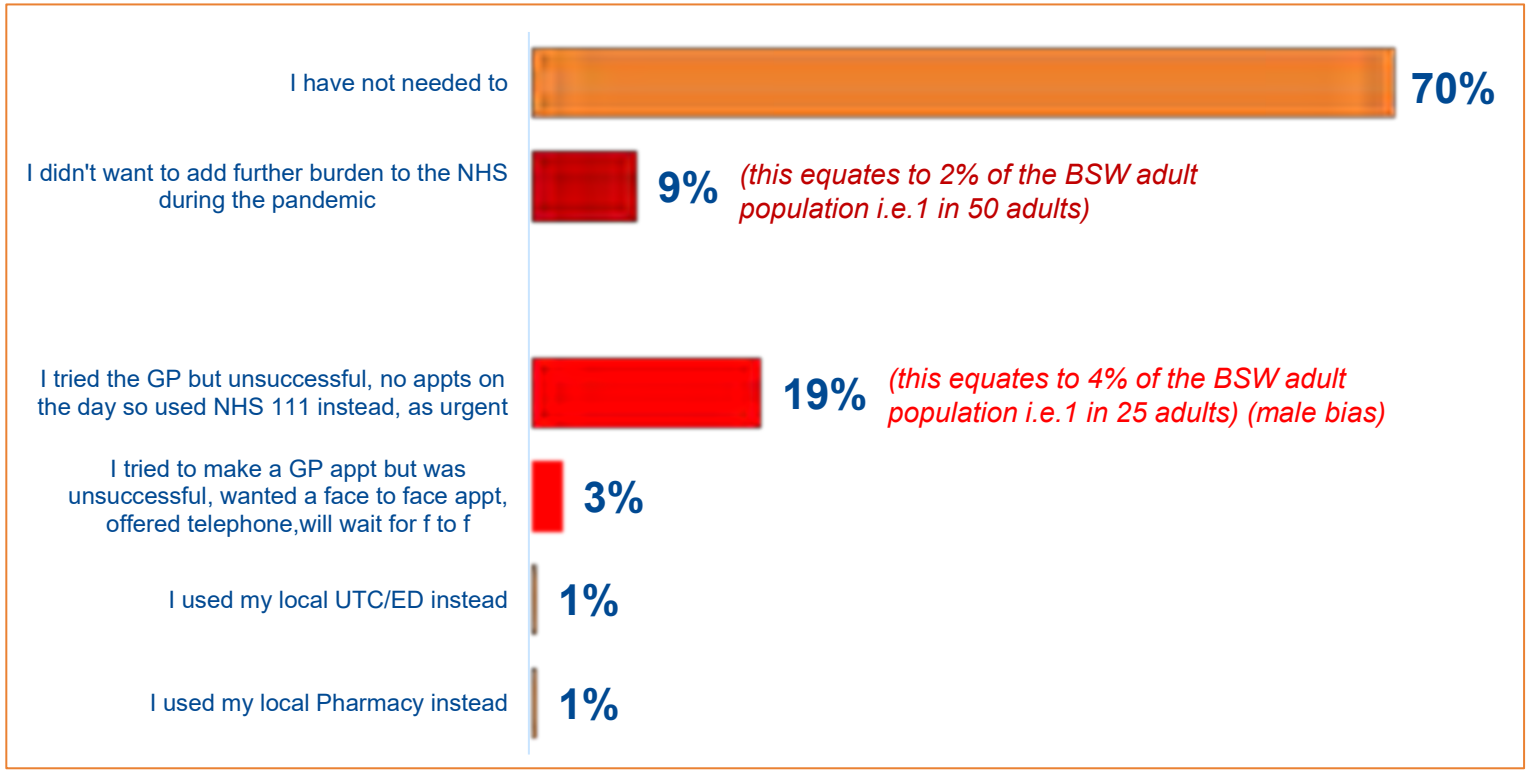
One quarter of BSW residents have not made a GP appointment in the last 15 months, mainly because they haven't needed to

TOTAL SAMPLE OF PANELLISTS

GP appointments



Reasons for not making an appointment… *(Base n = 74)*

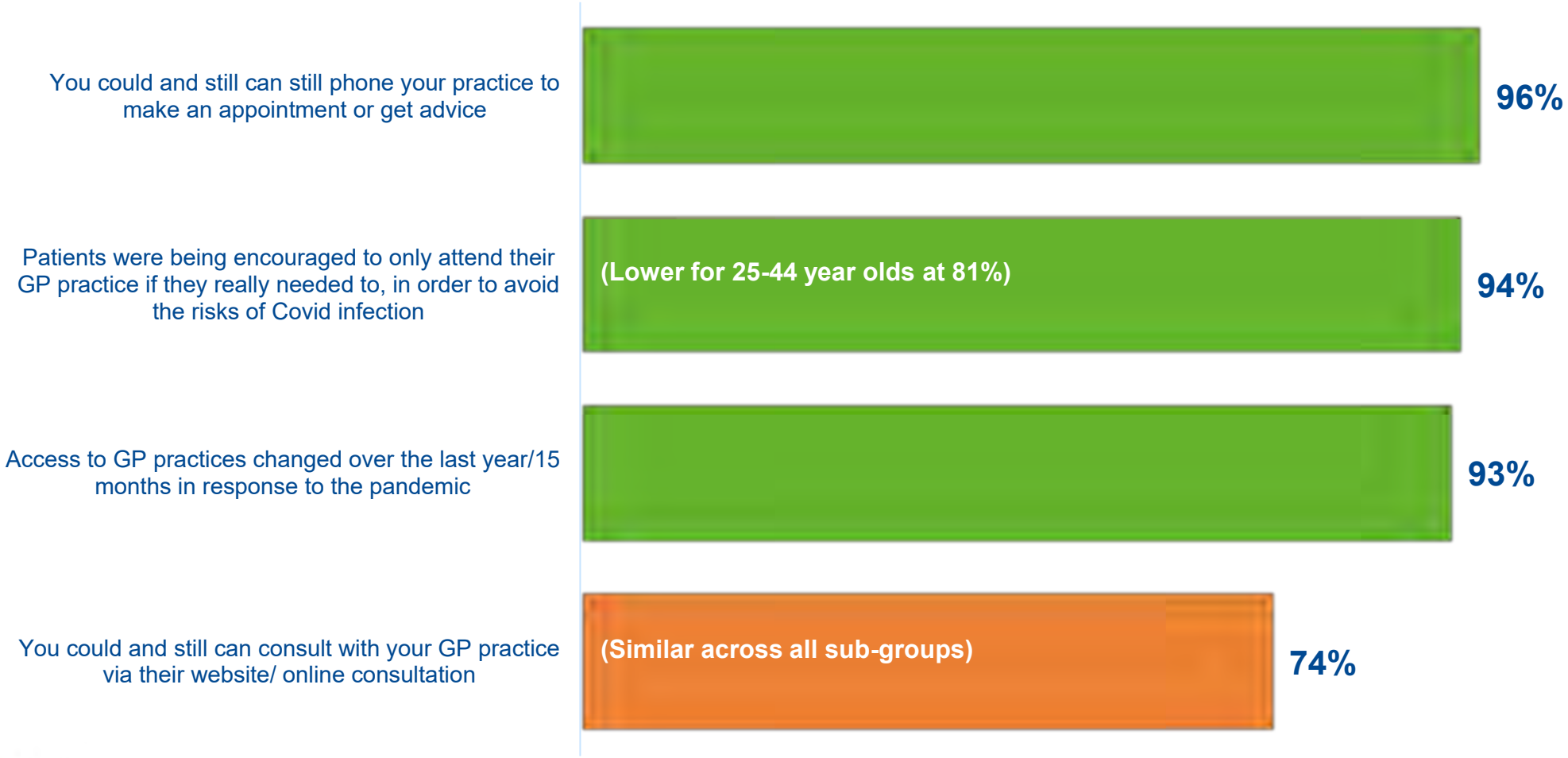


Q's 12,13,14,15,16. Have you made an appointment (either face to face or by telephone or video) with a GP practice in the last 15 months (between April 2020 and July 2021)? If not, why not / what else did you do? Base: n=312, total participants answering this question

Those who have NOT had a GP appointment in last 15 months

Among those who have not made a GP appointment in the last 15 months, there are strong awareness levels (over 90% in each case) on most of the factors relating to patient use of a GP practice since the pandemic began

- The exception was consulting with your GP via their **website/ online consultation**, this was **lower at 74%**



Q17. Still thinking about access to GP practices during the pandemic, can you say whether you are/were aware of any of the following?
Base: n=74, all those who have not made a GP appointment in the last 15 months

Those who have had a GP appointment in last 15 months

Of those who had a face to face appointment, only 1 in 10 *(10%)* had asked for it themselves, rather than being offered it by the GP

Of those who had a telephone, video or online appointment, 1 in 6 *(15%)* had asked for a face to face appt but couldn't get one

Most patients, 95%, saw the type of HCP they wanted to. 3% would have preferred to see a GP rather than a nurse and 2% a physio or nurse rather than a GP

Q18. Thinking about your most recent GP appointment (in the last 15 months), what sort of appointment were you offered?

- Face to face 45%
- Telephone 53%
- Video/online 2%

Base: n=228, those who have made a GP appt in last 15 months

Q19. Did you specifically ask for a face to face appointment or were you offered a face to face appointment by the GP practice?

- I asked for f to f *(mainly aged 65+)* 10%
- I was offered f to f by GP 90%

Base: n=102, those who were offered a f to f appt

Q20. Did you ask for a face to face appt but couldn't get one?

- YES *(all age groups from 25+)* 15%
- No/ can't remember 85%

Base: n=126, those who were offered a telephone / video/ online appt

Q21. Did you get an appointment with a type of healthcare professional that you were happy with?

- Yes 95%
- No 5%

Base: n=228, those who have made a GP appt in last 15 months

Q22. Who did you see and who would you like to have seen?

- 8 of these individuals had seen a practice nurse **but would have preferred to have seen a GP**
- 4 had seen a GP **but would have preferred a physio (x3)** or **nurse (x1)**

Base: n=12, those who were not happy with the type of HCP

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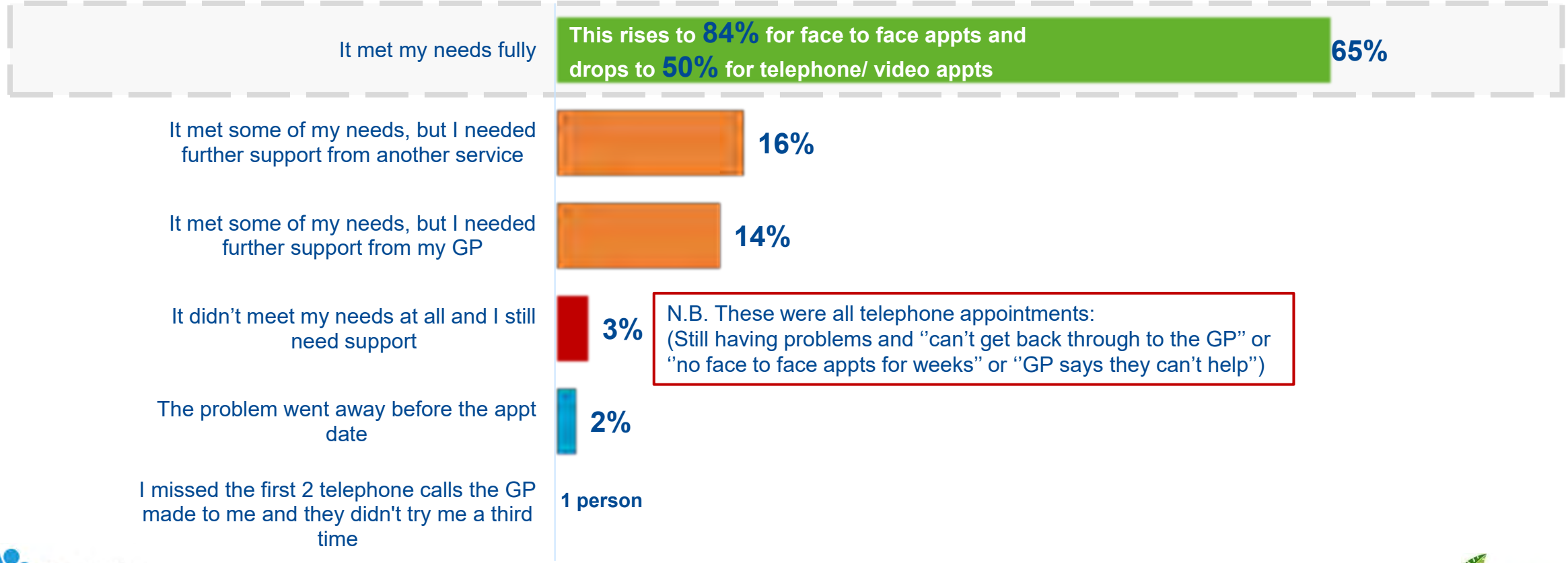
Those who have had a GP appointment in last 15 months

For two thirds of patients, the appointment met their needs fully

- 30% needed further support either from another service (16%) or their GP (14%)

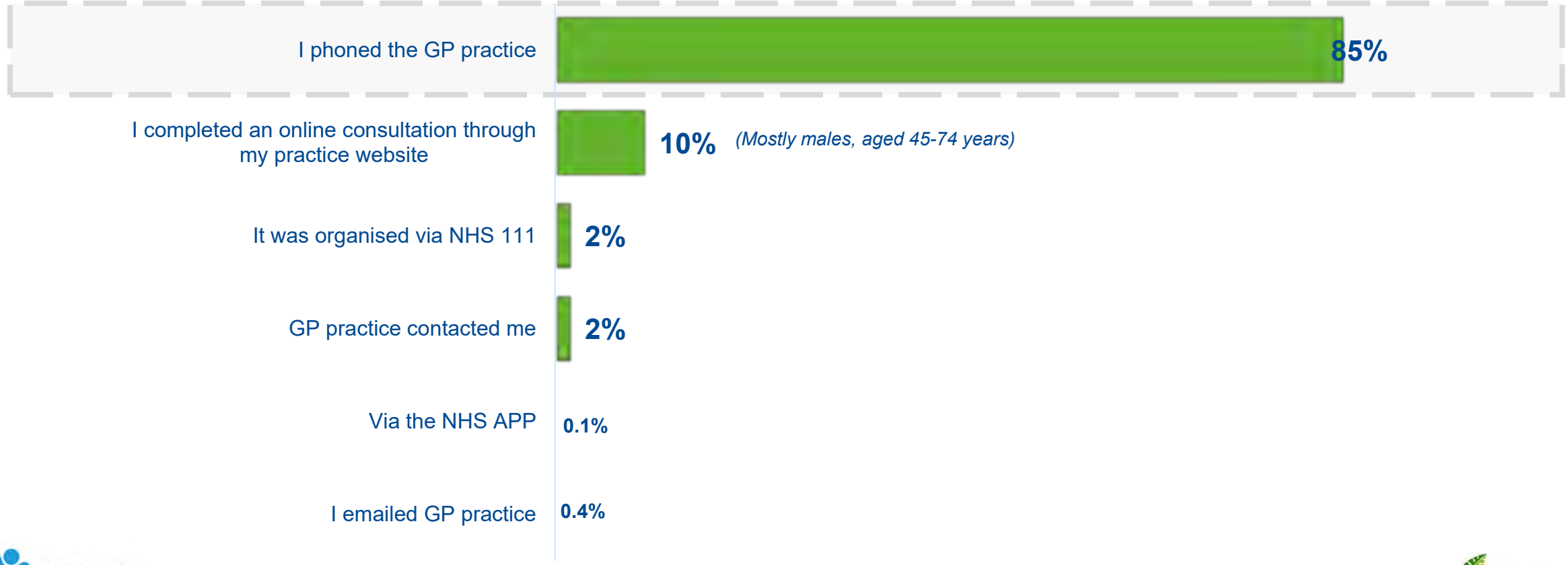


Q23. To what extent did your appointment meet your needs? Base: n=228, those who have made a GP appt in last 15 months

Those who have had a GP appointment in last 15 months

A majority of patients phoned their GP practice to book their most recent appointment. One in ten used an online facility

- 2% had the appointment organised through NHS 111 and the same proportion were approached/requested by the GP practice



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Q24. Thinking back to when you first booked this latest appointment, how did you book it?
Base: n=228, those who have made a GP appt in last 15 months

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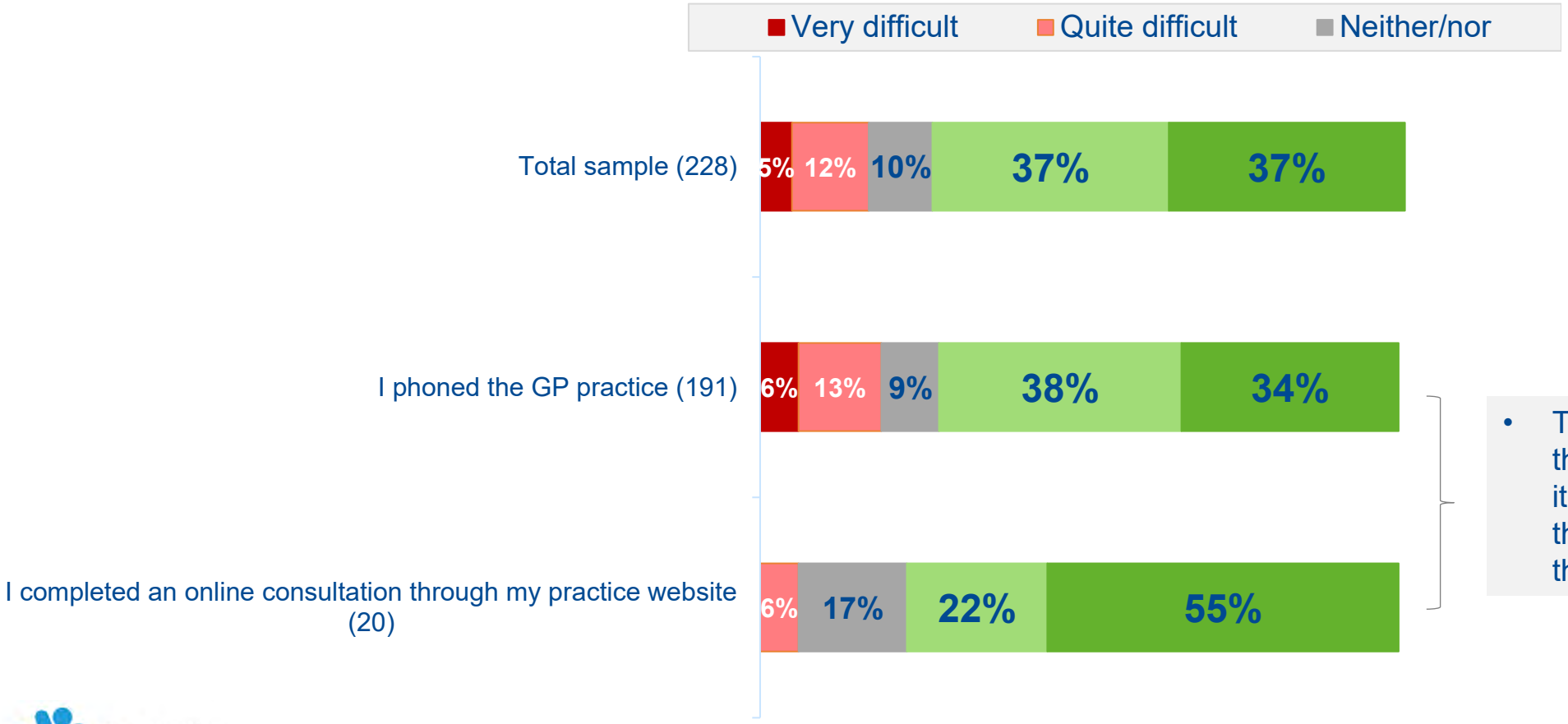
Three quarters of patients found it very or quite easy to book their appointment and a further 10% found it neither easy nor difficult

- Overall, **1 in 6** *(17% in total)* of those who had a GP appointment in the last 15 months found it **very** or **quite** difficult to book. This rises to **25%** of 25-44 year old appointment makers *(notably male 25-44 year olds)*



- Those who booked online through the website found it easier, on the whole, than those who phoned the practice

Q25. How easy or difficult was it to book this appointment? Base: n=228, those who have made a GP appt in last 15 months

Those who found it difficult to book their GP appointment in the last 15 months, mainly mentioned the difficulty in actually getting their telephone call answered in the first place..

*Telephone not answered, engaged, on hold, queueing system, **takes too long to get through to someone***

62%

*Takes **too long to make an appointment**, several attempts needed*

24%

*Appointment **availability is generally poor**, especially if not urgent – 7 days at the soonest*

29%

(online and telephone bookings)

*(This figure rises to **41%** of 25-44 year old appt makers, notably males)*

Receptionist/ triage questions 'put you off', difficult to explain, can potentially end up seeing wrong type of person or told you're not entitled to appointment

9%

(online and telephone bookings)

Q26. Why did you find it difficult to book this appointment? Base: n=34, those who found it difficult

Total sample – Any difficulties/ issues with getting a GP appointment in the last 15 months?

- **21%** of the total sample have experienced difficulties or issues with making a GP appointment in the last 15 months
  - This divides into **13%** who did not go on to seek further advice or use an alternative service instead *(there was a higher incidence of not seeking further help among those aged 65+, at 21%)*
  - And **8%** who did go on to seek further advice or use an alternative service instead. This **8%** figure breaks down as follows *(there is a little overlap where multiple services were used)…*
    - Used a Pharmacy - **3%**
    - Used NHS 111 - **3%**
    - Sought advice from NHS website - **3%**
    - Used local UTC/MIU - **1%**
    - Used a private health care professional (physio/ osteopath) - **1%**

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Q27/28. Did you at any point during the last 15 months (between April 2020 and July 2021) have any difficulties or issues with getting a GP appointment? What alternatives did you use? Base: n=312, total participants answering this question

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Final comments about accessing GP appointments in the BSW region….

It has become increasingly more difficult to see a GP face to face over the past 18 months or so, due to C-19. GP's are paid handsomely to provide a service to the public and I feel that we, the public, have been let down in many areas. My daughter has had, on 2 occasions, great difficulty accessing a GP when her 3 year old daughter was really unwell - the GP surgery didn't even pick up the phone. She ended up in a 5 hour wait at Urgent Care! Other staff within GP surgeries such as senior nurses appear to be picking up most of the work and this, in my view is totally unacceptable, they are not paid to do the GP's work...although it's fair to say that you often get a more 'human' service. As a teacher, I & my colleagues have had to face the public and can't understand how GPs have got away with 'hiding' behind their front line nursing staff. If the country is as safe as the government say it is - GPs should now be visible

My experience took 2 or 3 attempts at phoning GP Surgery to wait up to an hour in a phone queue to make appt. Very frustrating. A routine appt involves a wait of approx 3 weeks. It's no surprise that people are abusing the system and then upgrading their requests for appts to urgent to be seen in a couple of days

Currently awaiting a phone call from my doctor which is 4 weeks away. The choice appears to be between 'urgent' or 'hope you get better before we talk to you'

It's a nightmare trying to call for an appointment. I made 97 calls in the space of an hour and nothing

For those in their 70's and above it is a very insecure feeling about getting immediate help if necessary, especially when one lives on one's own. Also, not every elderly person is IT literate and for those who are IT literate, remembering passwords can be a nightmare! Having to think about getting the correct kind of help when needed, especially when one is emotional, is scary and frightening. The NHS is wonderful, once you are in the system; it's getting into the system which is problematical

My mother in law was very ill. My wife and her two sisters tried every which way they could to get a proper GP appointment and attention to little avail. The result was that we are sure that she died prematurely! If anyone ever reads this I have many details that could be provided

Q29. Any further comments?

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Section 4

Appendices – Panel Profile

Recruitment methodologies – 1,011 panellists recruited

1) Core recruitment – face to face

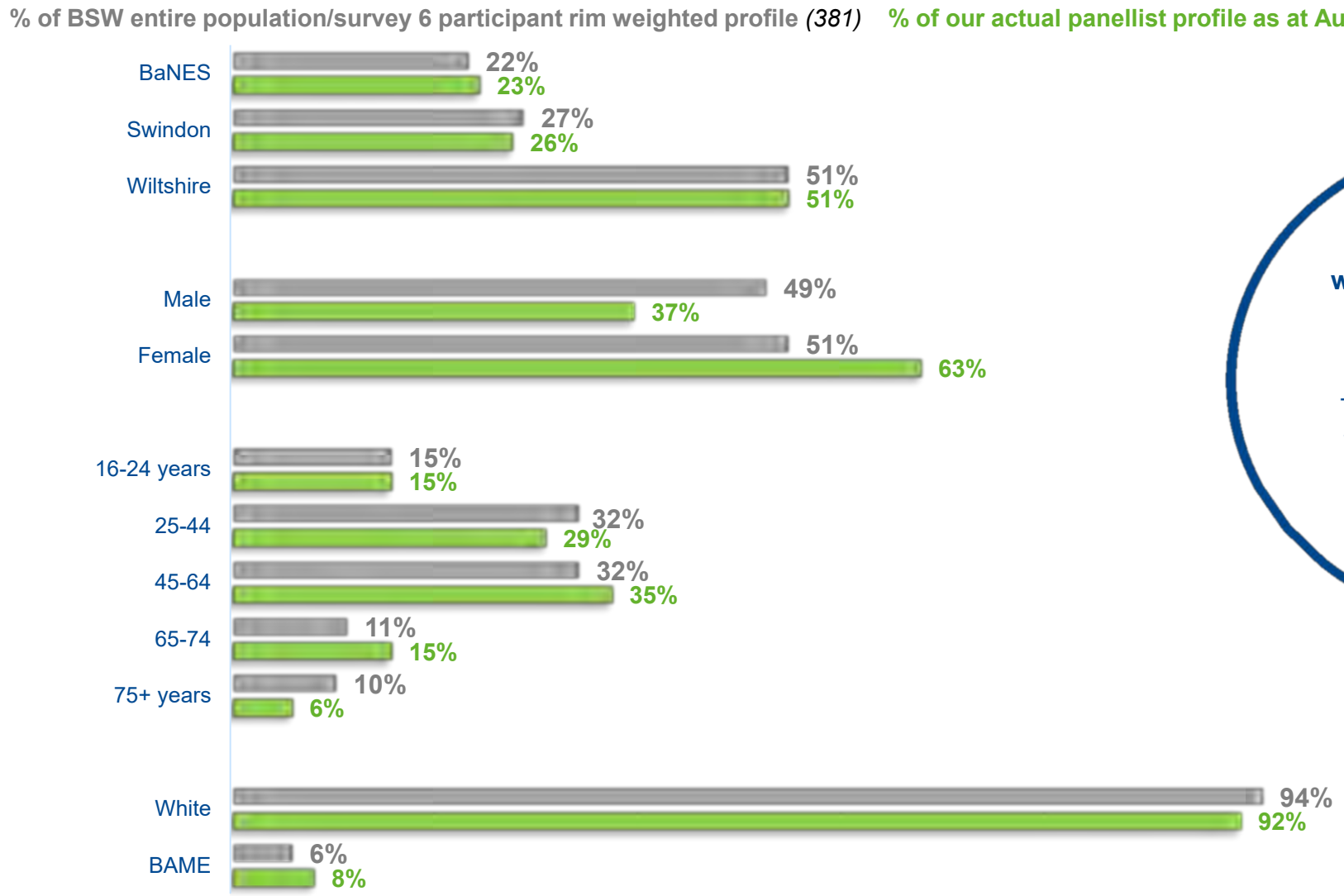
- 33 face to face recruitment days took place in January to March and then November / December 2020 *(always when pandemic regulations allowed)*
  - A mixture of **community days** in town halls, libraries, community & social centres, shopping malls and cafes/inns
  - Along with individual interviewers conducting face to face **on-street shifts and door to door interviews**, among local communities in less busy locations
- These have been **spread right across the BSW region**, including
  - Bath, Batheaston, Midsomer Norton, Keynsham
  - Swindon
  - Devises, Marlborough, Trowbridge, Warminster, Salisbury, Amesbury, Chippenham
- F to F recruitment was the preferred core method: both to avoid self-selection and to enable specific targeting of a representative sample. **914 panellists** have been recruited via this method
- The interaction with the professional recruitment team also provides an opportunity for a clear introduction to and explanation of the purpose of the panel

2) Additional recruitment methods

- These have included **social media** advertising on Facebook and Instagram, **member get member** *(panellists promoting to their contacts)*, engagement with **local organisations** and **promotion by BSW CCG** via it's website, social media and contacts
- An additional **97 panellists** have joined via these methods
- This additional recruitment allowed an element of boosting of certain categories of citizen's, such as younger people and hard to reach audiences

➢ Panellists have completed 6 surveys since the panel started, mainly online. Jungle Green conduct additional interviews by telephone and postal questionnaire where the respondent has chosen these alternative methods

Comparison of the profile of the entire BSW region population *(according to census data/JNSA)*/ our rim weighted panel profile and the actual panel profile recruited as at Aug 2021



NB:
Survey 6 participants' responses have been rim weighted to reflect the exact profile of the BSW population.

The sample profile relating to the findings in section 3 of this report is, therefore, exactly the same as the grey bars in the following charts.

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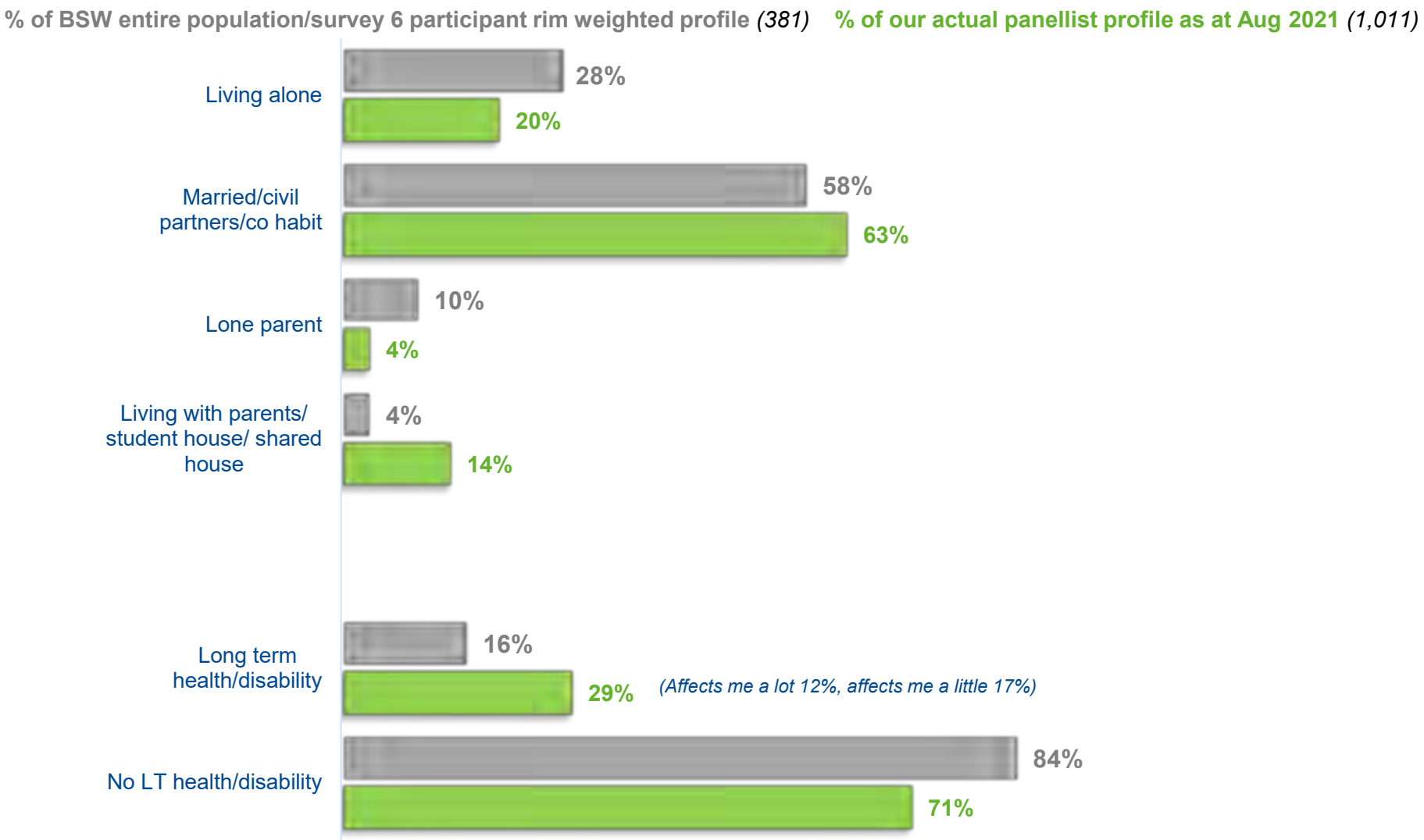
Comparison of the profile of the entire BSW region population *(according to census data/JNSA)*/ our rim weighted panel profile and the actual panel profile recruited as at Aug 2021



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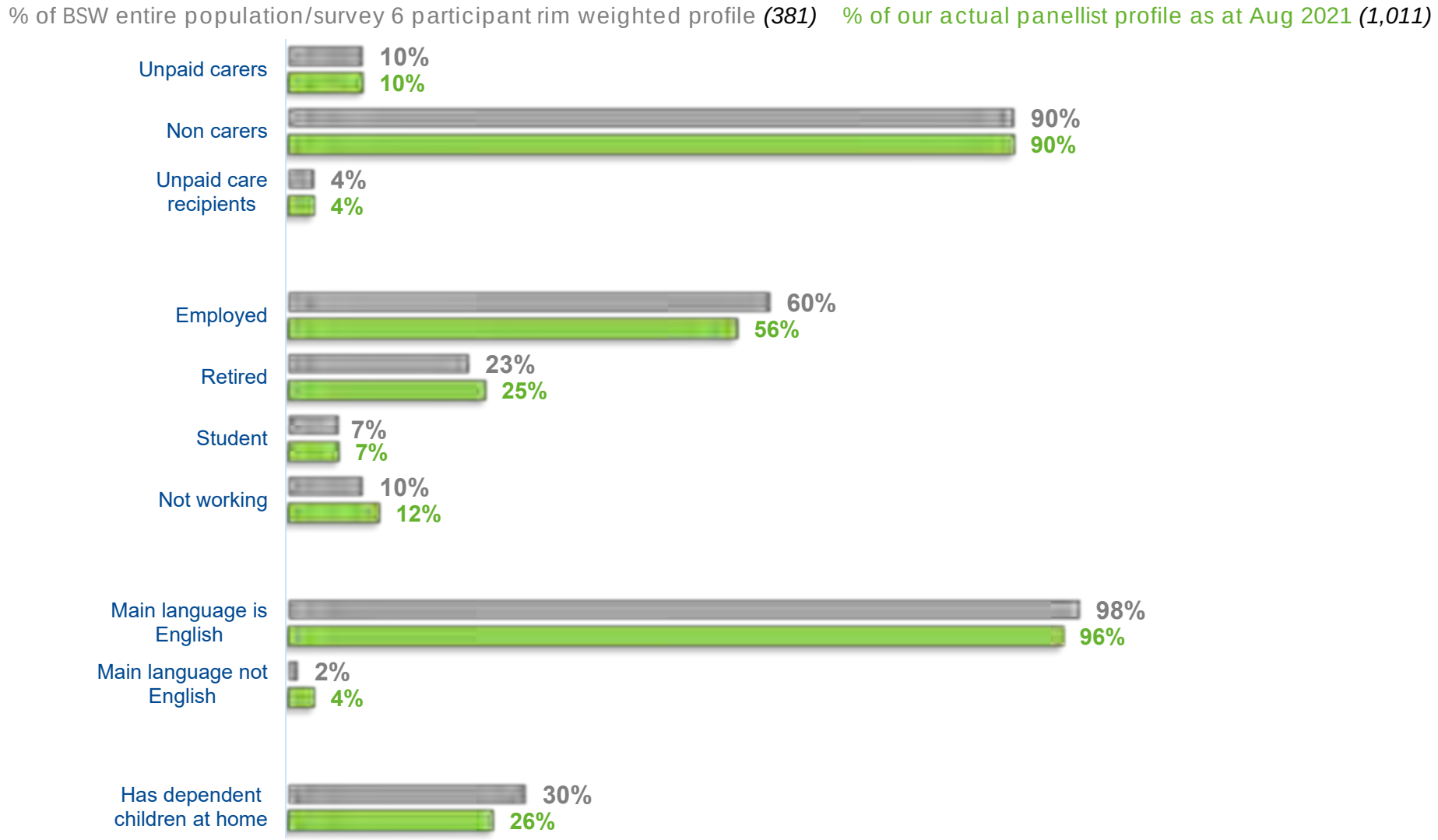
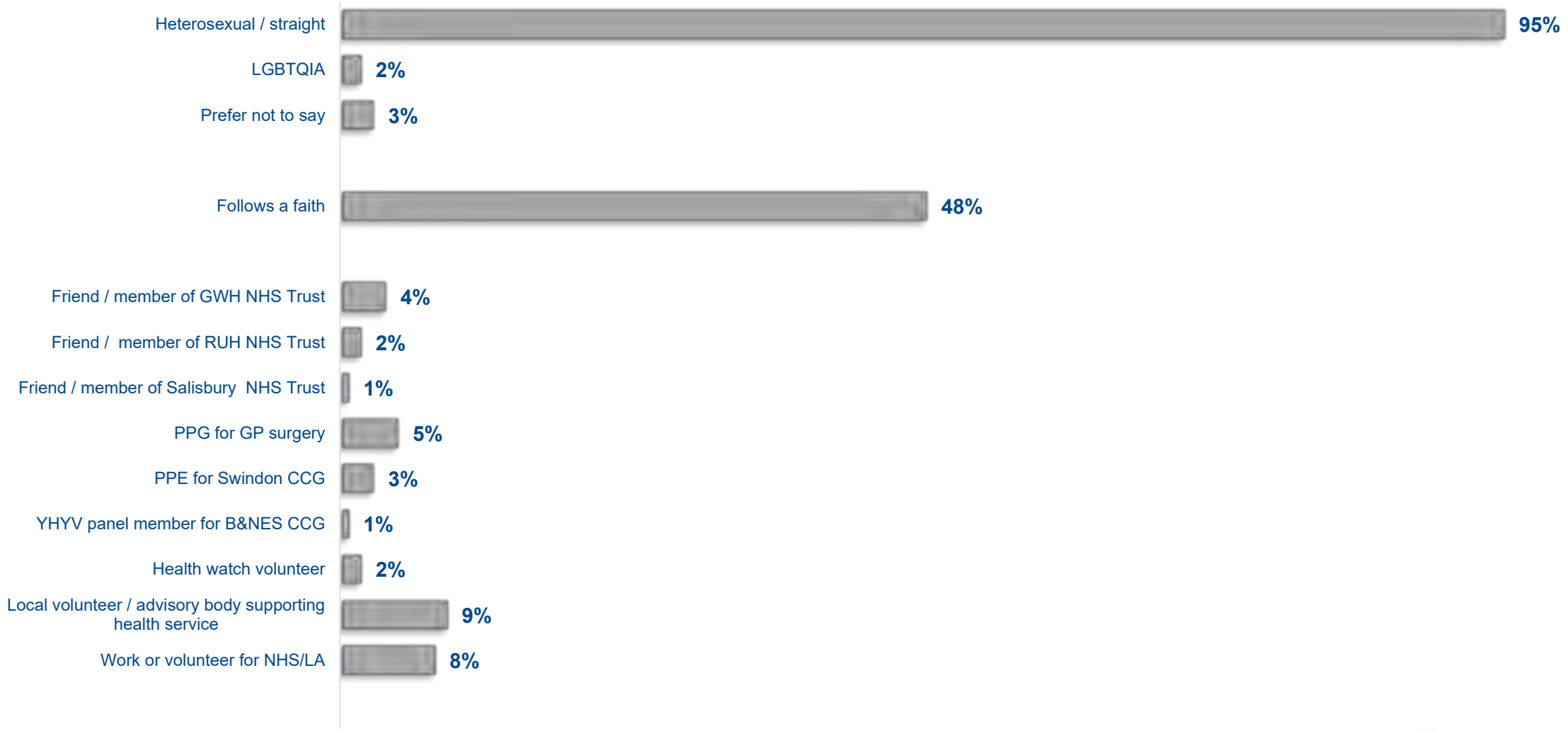


Rim weighted panel profile



Base: n=381

Our Health Our Future

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

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Any questions please contact us:

- Janice Guy, Marketing Research Consultant, Jungle Green mrc – janice@junglegreenmrc.co.uk , 0117 914 4921
- Julie Ford, Recruitment and Data Manager, Jungle Green mrc – julie@junglegreenmrc.co.uk , 01275 818343
- Ruth Atkins, Head of Public Engagement and Insights, NHS BSW CCG – ruthatkins@nhs.net , 07795 355296

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

BSW Partnership Board, 19/11/21, Item no. 12

BSW Performance, Quality and Finance Report – November 2021

Executive Leads:
Richard Smale – Executive Director Strategy and Transformation
Gill May - Executive Director of Nursing and Quality,
Caroline Gregory – Chief Finance Officer
Julie-Anne Wales – Director of Corporate Affairs & Data Protection Officer

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

Report summary

Key points	This is a regular report produced for BSW key meetings to provide a high level review of performance, quality and finance focusing on: • The current key issues and actions in delivering and transforming services • Programme exception reporting against the oversight framework key metrics including performance against the operational plans submitted by BSW partners for 2021/22. Key numerical plans (finance, activity and performance metrics) were submitted for the first half of the year – Half 1 (H1) in May and Half 2 (H2) plans are being submitted in November. • Covid and Vaccination update • BSW Financial System Summary • Appendix 1: includes the BSW Oversight Framework Measures
Recommendation(s)	Action or decision required by the Committee e.g. 1. The Committee is asked to **note** the contents of the report.
Key risks	There are a number of high level risks on the BSW CCG Corporate Risk Register that reflect the challenges and risks to delivering: Quality Care, Performance and Financial Stability: • BSW47 – Ambulance delays in response and handover – impact on patient care and experience & staff welfare • BSW44 – Seasonal Planning – Urgent and Planned Care impacted by COVID-19, Flu and usual Winter challenges. • BSW26 – Covid- 19 Further Waves – particularly in cold weather - impact on all services • BSW22 – Workforce challenges in MH and LD/ASD services – impacting BAU and transformation • BSW11 – Demands on Primary Care / GP Practices - impact on patient care and experience & staff welfare • BSW48 – Delays in hospital discharges primarily for B&NES patients • BSW50 / 06 – Elective Recovery & Performance – delivery risks • BSW23 / 24 – Mental Health Performance Targets and infrastructure gap in all age crisis pathways.
Resource implications	These are included in the report

Executive Summary 1 of 4

Area	Key Issues	Key Actions	Accountability
Elective Care Recovery	• Diagnostic access times are being impacted by high volumes of cancer activity which is being prioritised. • Elective volumes in general have dipped following increased non elective pressure. • 104 week wait risk for March identified in Orthopaedics, Urology, Plastic Surgery and Oral Surgery.	• Analysis of access times beyond the 6 week target to assess gap with intent to focus on patients who have not had an outpatient or diagnostic to mitigate potential harm. • Clinical and operational teams working across system on the high risk specialties to maximise use of combined capacity. • Targeted Investment Fund bids for additional activity to be mobilised.	Elective Recovery Programme of Elective Care Board
Cancer	• H2 planning submission (revised national focus onto number of patients waiting over 62 days for start of cancer treatment; and revised target to achieve by Apr 22) • Insufficient diagnostic capacity (kit and people) continues to be a concern and is one of the key factors inhibiting overall improvement against time-related cancer performance targets • Despite this, progress being made with rapid diagnostic pathways at all three trusts per Cancer Alliance timeframes • Concern that the transition to new advice and guidance provider will lead to a drop in the use of teledermatology advice and guidance and an increase in avoidable 2ww skin referrals	• Submission of next stage Targeted Lung Health Checks bid for Swindon (approval received from NHSE) • Go-live of Minerva and Keynsham PCNs' Non-Site-Specific Tumours rapid diagnostic pathways • Introduction of additional Straight To Test prostate pathway (RUH) • Reintroduction of cancer screening Programme Boards to review progress with backlog and other issues • Delivery of GP cancer education event (100+ attendees) and practice nurse education event	Elective Care Board
Urgent care	• September pressures continued in BSW system in October. Critical incident status confirmed on 20th October; September incident was stood down on 24th September 2021 • Increase in Covid infections and hospital related admissions impacting on workforce, flow and discharges in acutes and community • Further risks identified through the Winter planning process; building on the 5 key risk areas from Risk summit: Communications, Workforce, Data and information, Governance, and Escalation processes	• Progress on System GOLD call actions being monitored through Silver Tactical call and 5 key risk areas. • Local system messaging about: covid risks and personal responsibility, continued rollout vaccination booster programmes, Flu vaccination programme actively under way.	Tracey Cox, Heather Cooper, Integrated Care Alliance (ICA) COOs Julie-Anne Wales Alison Kingscott and Sheridan Flavin Heather Cooper, Urgent Care and Flow Board (UCFB)

Executive Summary 2 of 4

Area	Key Issues	Key Actions	Accountability
All age Mental Health (MH)	• BSW position for adult inpatient beds has improved in month; although flow remains pressured, the out of area position has reduced to four. • Adult Eating Disorder bed pressures are now significant, with a number of people being supported at home with enhanced packages of care and in Acute General Hospitals whilst provider collaboratives undertake national bed searches. • CAMHS (Child and Adolescent Mental Health Services) pressures orientated to workforce vacancies and increased demand (acuity and volume) in the BaNES and Wiltshire - Melksham area have improved through recruitment successes and internal reorganisation of processes and resources. However, pressures in the Swindon locality have increased and business continuity plans may be mobilised in month.	• BSW weekly inpatient flow escalation calls in place. Locality patient flow calls re-established. • BSW MH MADE (Multi Agency Discharge Event) to be held in Dec. • BSW Escalation hub supporting case level management, and system support. • Monthly pressures review and improvement planning meetings in place with OHFT (Oxford Health Foundation Trust) and CCG. • Additional investment in CAMHS approved through Thrive, recruitment to posts now in progress. Additional capacity will enhance access, support and treatment capability. OHFT commenced operating as system lead for CYP access – focused increasing access, as well as the data quality of NHSE MHSDS (Mental Health Services DataSet) submissions.	BSW Thrive Programme Board – next meeting 3/11/2021
All age Learning Disabilities /Autism Spectrum Disorder (LD / ASD)	• Co-production of system response to national recommendations from 'Joanna, John and Ben' Cawston report continuing, with comprehensive direct reviews of all inpatients required by 25/12/21. • Review of reduction to NHSE funding allocation for BSW completed with system stakeholder. BSW now mobilising five as opposed to the 14 intended priority schemes (all informed by LTP targets and local unmet need).	• Management response through BSW Escalation Hub. • Revised Roadmap and mobilisation schemes approved through Extraordinary BSW LDA Programme Board.	BSW LD/ASD Programme Board next meeting 18/11/2021
Maternity	• Continued workforce challenges across providers leading to system pressures including intermittent suspension of homebirths and redeployment of staff from midwifery led birth units to acute units at times; Impacting on all transformation work including Continuity of carer and personalised care plan roll out. • National deliverables due in November (including NHSE response to provider Ockenden Assurance, Local Maternity and Neonatal System Equity Strategy and Provider Continuity of Carer plans. • Increasing numbers of GP practices have given notice for midwifery clinics to cease use of clinical space due to need to accommodate additional staff.	• Maternity workforce strategy support and joint working as a system to identify solutions to support safe staffing for maternity and neonatal services • National requirement for providers to submit Continuity of Carer implementation plans signed off by Trust boards and LMNS by January 2022 (must align to national implementation guidance) • To identity support from Public Health and ICS system to collate LMNS Equity analysis • Provider and ICS to work collaboratively with estates teams to identify appropriate and safe clinical spaces for provision of maternity care in community settings.	BSW Local Maternity and Neonatal System (LMNS)

Executive Summary 3 of 4

Area	Key Issues	Key Actions	Accountability
Primary Care	• Continued demand and pressures across General Practices • 23/25 PCN sites opted into delivering Phase 3 Covid Vaccinations Booster • BSW report of appointments in Sept 2021 shows the total appointments booked was 444,8800 compared to 420,250 in Sept 2020. BSW report of mode of appointments in Sept 2021 shows face to face appointments are 58.7% of the total appointments compared to 57.5% in July 2020. • There are currently 5 practices rated as Requires Improvement overall and 1 rated as Inadequate across BSW CCG. • There are limited Primary Care Quality metrics, including Complaints, PALS and Incident information, to inform the CCG, PCNs and practices.	• Working through National Improving Access for patients and supporting GP Services • Implementing Communication plan with message to public focussed on GP Practices • The Quality Team have commenced engagement with Practices and are scoping work to understand shared learning. Points of specialist support have been identified within the CCG to assist and advise on specific topics identified within each action plan. A Primary Care Quality Oversight Assurance Group is being implemented to monitor the completion of improvements plans, mitigations and to ensure the right level of support from the CCG, Draft Terms of Reference have been developed • The Quality Team has commenced internal scoping to develop a work plan and core metrics, with a view to agree focused priorities and timescales for implementation going forwards. These metrics will be monitored through discussions at PCCC and with other key stakeholders. This work will also include developing a process to capture and analyse emerging themes and trends to better inform future improvement work.	Primary Care Commissioning Committee
Workforce	• Development of BSW workforce intelligence infrastructure and dashboard is on going. • The launch of the BSW Education platform has been postponed until November due to low volume of content to share (COVID related). • A targeted Workforce Data Collection has begun to support performance monitoring of the Strategic Workforce Programme. • Annual publication of Adult Social Care Workforce Statistics (12th October)	• The Collaborative International Recruitment Plan has been confirmed, and draft allocation criteria in production. • Funding submission made to National Institute of Health Research to support the deployment of Machine Learning and Artificial Intelligence to support the workforce agenda (Partnered with Dataiku). • Successful HEE bid for £234k for AHP and Nursing placement expansion project, expected to deliver 40-60 extra nurses placed by September 2022.	Operational People Delivery Group (OPDG)

Executive Summary 4 of 4

Area	Key Issues	Key Actions	Accountability
Quality	• Continued pressures in urgent care pathways resulting in request to change 111 DOS (Directory of Services) to remove the dispositions (call outcomes) for low risk /acuity patients where 111 has to arrange a call back within 12 /24 hours and instead ask the patient to contact their GP on the following day. Patients are signposted to alternative services ie pharmacy and are safety netted by being to call again if their condition deteriorates. This allows services to focus on contacting higher acuity patients who are at higher risk with a delayed call back.	• Equality Impact Assessment completed that recognised risk in patient choice, system demand and Infection Prevention & Control. Decision to support trial (commenced w/e of 8th Oct) for the removal of 24-hour disposition only. Audit of patients during the trial period will be undertaken supported by the quality team.	Quality and Performance Committee (QPAC) Quality Surveillance Group (QSG) Elective Care Board Urgent Care Board BSW Thrive Board Primary Care Commissioning Committee (PCCC)
	• .Continued challenges noted across some mental health services: Wiltshire Primary Care Liaison Service (AWP)- workforce resource and backlog management. Daisy Unit (AWP) - leadership and Staffing capacity are the key concerns.	• The team are working closely with AWP colleagues. AWP have identified this as an area of focus, and we await the start of a trust wide plan. • Quality Visit undertaken to the Daisy unit and AWP have put an action plan in place and have senior oversight and monitoring, regular updates on progress provided to the CCG.	
	• Hospital Discharge and Community Support	• Exceptional Action Card: To help clinicians reduce care needs during period of extreme pressure has been developed and reviewed at the BSW Ethical committee. Further action being taken forward to complete EQIA.	
	• Increasing trend in CCG complaints relating to 111 delays . Organisations are also noting an increase in complaints relating to waiting times and treatment delays.	• Close monitoring through Urgent care and Flow board and Elective care board, with updated approach noted in H2 return.	
	• Oversight and scrutiny of GP practices rated as inadequate or Requires Improvement by the CQC	• Primary Care Oversight and Assurance Group will commence in November 2021 to provide oversight and scrutiny	

Workforce

BSW Workforce Position

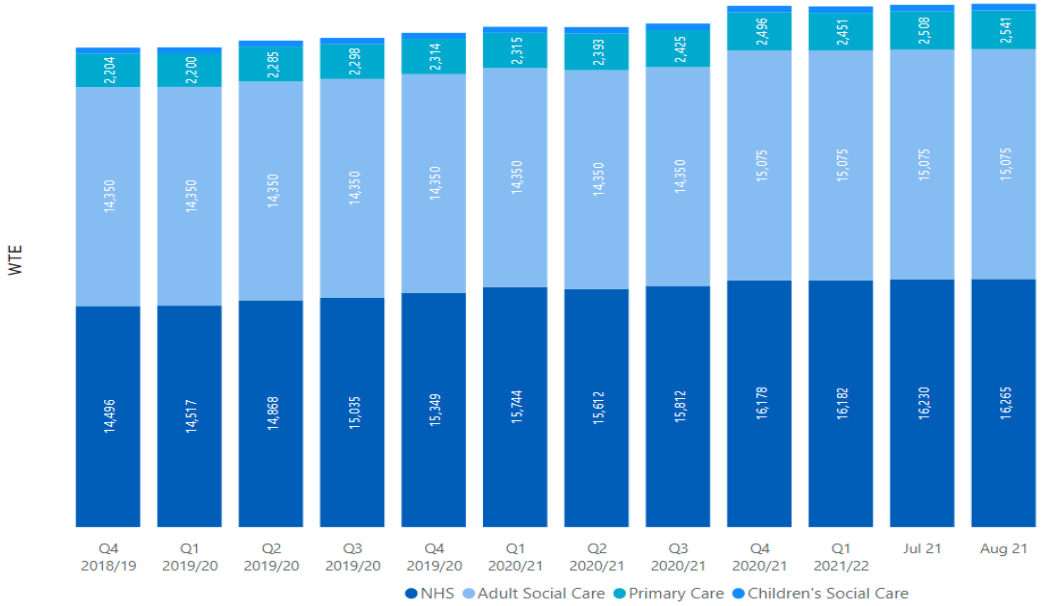
Table 1. BSW Vacancies by Care Setting

Setting	Supply	Demand		Vacancies		
	Staff in Post (WTE)	NHS Long Term Plan (2019 to 2024)	H1 Workforce Plans	WTE	Rate (%)	+/- Change
NHS	16,265	16,286	16,873	607	3.6%	↓
Primary Care	2,541	2,638	2,604	63	2.4%	↓
Adult Social Care	15,075	-	15,930	855	5.4%	↓
Children's Social Care	430	-	535	105	19.6%	→
BSW	34,311	-	35,941	1,630	4.5%	↓

***Data note** – Primary Care Vacancies only consider ARRS roles (Not GPs or GPNs). Total Vacancies are expected to be higher*

Table 1. shows an improving vacancy position across the system. Between March 2020 and March 2021 total vacancies in Adult Social Care have considerably improved, with a positive impact on the system overall. Vacancies for GPs and Primary Care Nurse is yet to be quantified, however vacancies within Direct Patient Care (ARRS) roles in Primary Care are decreasing.

Figure 1. BSW Unified Workforce Supply Position



This is a new, complex dataset with a very high number of data sources. The data contained brings together the most recent publications of these sources, as listed below. To note, Adult Social Care and Children's Services data is only reported annually so will appear static between some reports and change greatly in others

Latest Workforce Intelligence Available			
NHS	Primary Care	Adult Social Care	Children Services
31st August 2021	*31st August 2021*	*31st March 2021*	*30th September 2020*

Table 2 shows vacancies continue to be highest in Additional Clinical Services underpinned by high vacancies for Care Workers in Adult Social Care (~800 wte). Registered Nursing vacancies differ considerably by setting, from ~ 15.6% in Adult Social Care to 5.2% in NHS Providers. Vacancies in the Medical workforce are predominantly at Consultant Grades, while vacancies in *add prof scientific and technic* remain high due to a high level of vacancies for social workers.

Table 2. BSW Vacancies by Staff Group

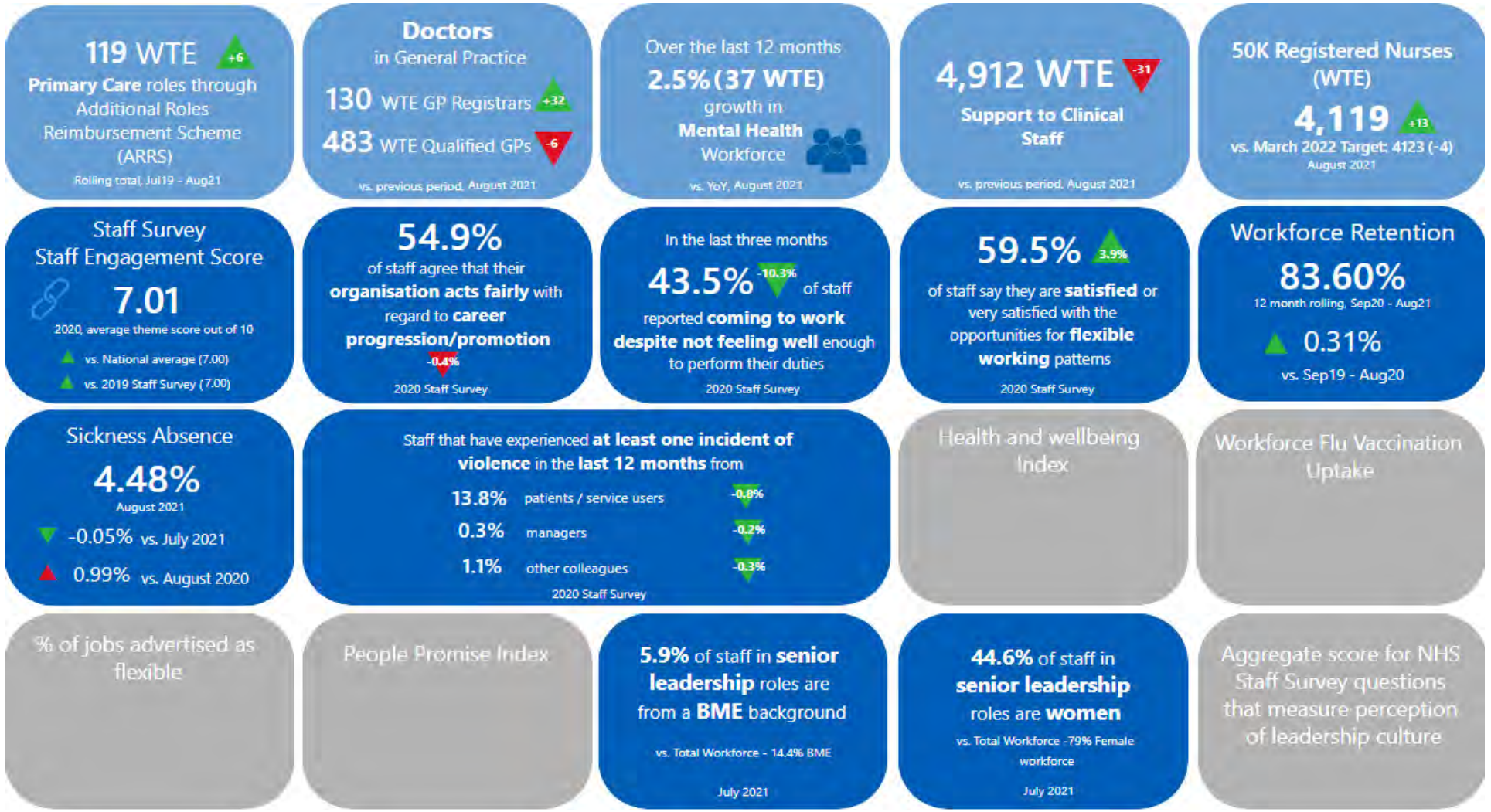
Staff Group	Supply	Demand		Vacancies		
	Staff In Post (WTE)	NHS Long Term Plan (2019 to 2024)	H1 Workforce Plans	WTE	Rate (%)	+/- Change
Add Prof Scientific and Technic	1,348	1,387	1,530	182	11.9%	↓
Additional Clinical Services	13,962	14,629	14,756	794	5.4%	↑
Administrative and Clerical	6,166	6,016	6,265	100	1.6%	↓
Allied Health Professionals	1,224	1,332	1,261	37	2.9%	↓
Estates and Ancillary	789	754	849	61	7.1%	↑
Healthcare Scientists	416	416	426	10	2.3%	↓
Medical and Dental	2,367	2,344	2,421	54	2.2%	↓
Registered Nursing and Midwifery	5,529	5,908	5,847	319	5.4%	↓
*Other	2,510	2,602	2,584	73	2.8%	→
BSW	34,311	35,388	35,941	1,630	4.5%	↓

***Data note** – The workforces from all Care Settings have been mapped to the National Workforce Dataset (NWD) Staff Groups to allow a unified view. The staff group listed as "Other" consists of roles that are incompatible with this mapping, this includes roles such as students on placement or highly specialised roles.*

NHS System Oversight Metrics for 2021/22 - BSW

This is a new, complex dataset with a very high number of data sources. The data contained brings together the most recent publications of these sources, as listed below. To note, Adult Social Care and Children's Services data is only reported annually so will appear static between some reports and change greatly in others.

Latest Workforce Intelligence Available			
NHS	Primary Care	Adult Social Care	Children Services
31st August 2021	*31st August 2021*	*31st March 2021*	*30th September 2020*



The NHS System Oversight Metrics are prescribed by NHS England as part of the Systems Oversight Framework to monitor the performance of Integrated Care Systems in England. Details of these metrics can be found here - NHS System Oversight Framework. This matrix is focused on the workforce related metrics from within this framework.

Where a metric is presented on a grey tile, it is currently under development and can not yet be reported.

The has been movement against a number of metrics in this period:

- Only 4wte growth within the nursing workforce is now required to reach the BSW March 2022 50k Target.
- Sickness absence has remained similar between July and August but remains notably higher than the long term average for Summer/Autumn.
- Qualified GP numbers fell between July and August (-6wte), however 12 month growth remains positive (+21wte).
- Workforce retention (12m rolling) improved but remains an area for further improvement.

BSW Strategic Workforce Programme Performance

BSW Programme Monitoring					
Work Package	**Measure**	**Latest Data Date**	**Previous Position**	**Latest Position**	**Change (+/-)**
Supporting our 55+ workforce	Rate of Leavers over the age of 55+ (NHS)	Aug-21	2.07%	2.13%	0.06%
	Rate of Flexible Retirement (NHS)	Aug-21	3.28%	1.08%	-2.20%
Deployment of a suite of BSW Leadership development training	Number of training places delivered in an ALL BSW collaborative delivery model (commencing November 21)	Sep-21	0	0	0
Development of L&D communities of practice for sharing and collaboration	Number of Communities of practices joined and attended	-	-	-	-
Enhancing EDI awareness in recruitment	Number of recruiting staff trained in unconscious bias recruitment and equality impact assessment training	Oct-21	0	52	52
Increase pipelines into the entry level roles	Number of learners supported on employability programmes (Kickstart, SWAP, Princes Trust)	Oct-21	-	35	35
	Number of T level students supported	Oct-21	-	23	23
	Growth in support worker roles – NHS (WTE)	Aug-21	429	481	52
Increasing Apprenticeships	Total number of apprentices within BSW organisations (Headcount)	Sep-21	163	189	26
	The amount of sunsetting levy / levy transferred in the last quarter (£)	Oct-21	1,570	40,817	39,247
Passporting of mandatory training	Number of organisation signed and adhering to MoU for mandatory training passporting	Oct-21	6	8	2
OD and Leadership	Number of staff completed Structural Dynamics Facilitator Training	Oct-21	0	10	10
	Number of staff completed the BSW System Leadership Development Programme	Oct-21	0	0	0
	Number of staff completed a Structural Dynamics Profile	-	-	-	-
Deploy a BSW L&D sharing platform	Number of course places offered across the system on the BSW digital platform	Sep-21	0	0	0
Passporting of the Care Certificate across BSW employers	Employers signed up to MoU for care certificate passporting	-	-	-	-
Broadening Work Experience Opportunities	Number of students supported with work experience (excluding pre-registration, headcount)	Sep-21	0	0	0
Develop a collaborative approach to international recruitment	Number of international recruits that have been employed using the BSW collaborative approach (headcount) commencing March 22	Sep-21	0	0	0
Developing 'New ways of working'	Monthly leavers citing work-life balance (NHS)	Aug-21	25	19	-5
	Percentage of jobs advertised as flexible	Sep-21	9.55%	9.09%	-0.46%

These metrics are designed to monitor the impact and deliverables of the Strategic Workforce Programme within BSW. The majority of this Intelligence is collected via a provider return, that is intended to be collected quarterly, and currently is in its trial phase.

As is common with provider returns, data coverage will differ from collection to collection, as such the organisations whose data is represented are listed below:

- Wiltshire Health and Care
- Royal United Hospital Bath NHS Foundation Trust

For October , the first month of asking only 2 of our providers have returned data, for the 7 measures from the provider return, so this must be considered when drawing any conclusions. Many of the projects have only recently commenced so we'd expect to show progress over time. Overall it shows general engagement with the project is increasing despite a challenging operational landscape

Workforce Exception reporting

Exceptions Analysis

- Development of BSW workforce intelligence infrastructure and dashboard is on going.
- The launch of the BSW Education platform has been postponed until November due to low volume of content to share (COVID related).
- A targeted Workforce Data Collection has begun to support performance monitoring of the Strategic Workforce Programme.

What did we achieve in the past month?

- Mandatory training 'passporting' has been expanded to include Virgin Care.
- The Collaborative International Recruitment Plan has been confirmed, and draft allocation criteria produced.
- Funding submission made to *National Institute of Health Research* to support the deployment of Machine Learning and Artificial Intelligence to support the workforce agenda (Partnered with Dataiku)
- DWP confirmation of 20 *Kickstart* roles, recruitment has begun.
- Collaborative production of a specification for the workforce element of the Demand and Capacity Programme (Partnered with Whole System Partnership - WSP)
- Successful HEE bid for £234k for AHP (Allied Health Professionals) and Nursing placement expansion project, expected to deliver 40-60 extra placed by September 2022.
- Submission for continuation of HEE Funding of the BSW Advanced Clinical Practitioner project to increase governance, standardisation and roles as linked to service improvement and transformation.
- Evaluation of *Unconscious Bias Training* completed. 100 places are being booked across the system, targeted to Social Care and other colleagues on the waiting list.
- OD support to B&NES and Wilshire Integrated Care Alliance (ICA) away days and workshops.
- Working within HEE South West to produce a toolkit for provider to support scenario planning as a strategic tool for workforce.
- Development of new data sharing agreement to underpin sharing of NHS application with Social care providers and talent pools across BSW.
- Training need analysis collection to capture demand in line with Higher Education Institute (HEI) planning lines and identify possible areas of collaboration.
- Continued delivery of the first cohort of the BSW System Leadership Development Programme.
- Developing Continued Professional Development support package to the Structural Dynamics cohorts to include coaching and masterclasses.

Plans in the coming Month

- Completion and Submission of 2021/22 Half 2 Workforce Plans and narrative
- Values Based Recruitment tool kit of questions and scoring matrices to be finalised
- Work experience platform for BSW identified and commencement of a timetable of events
- Work with Dataiku to develop a proof of concept project to outline use cases of Machine Learning and Artificial Intelligence for Workforce Planning.
- Chief Operating Officer / Director Of Finance and CCG Executive Structural Dynamics workshops.
- BETA sample of the "BSW Workforce Intelligence Dashboard" to be completed and user feedback to be gathered.
- Process mapped and reviewed by partners for application sharing with Social Care
- Process mapped and reviewed by partners for talent pool information sharing
- Flexibility Principles to be finalised
- Flexibility BSW Good practice case studies written up and shared
- Placement expansion project recruitment
- NHSEI Expression of Interest / business case compiled for possible funding for RRS project resource
- Presentation to Operational People Delivery Group of overhauling recruitment plan updates

How will you address any quality and inequalities?

- Equality impact assessments undertaken where relevant,
- Working with the BSW Equality, Diversity and Inclusion Network to include relevant metrics in the "BSW Workforce Intelligence Dashboard" .

Quality

Quality – Patient Experience

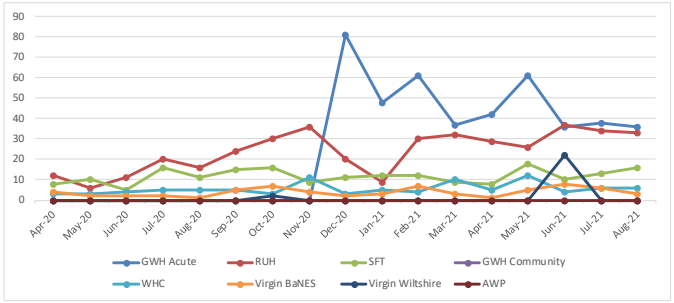
CCG quality team are currently analysing patient experience trends to recognise the key themes throughout the COVID-19 pandemic.

Due to the time lag the data available does not represent the current system pressures and impact on patient experience particularly in urgent care and flow demands- organisations are starting to see, increased complaints relating to waiting times and Cancelled operations and delays in 111- these are monitored through the elective care and urgent care and flow board and updated approach recognised in H2 return

GWH has seen a reduction in its Friends & Family scoring in the Emergency Department, however as a trust they perform well in collating the data.

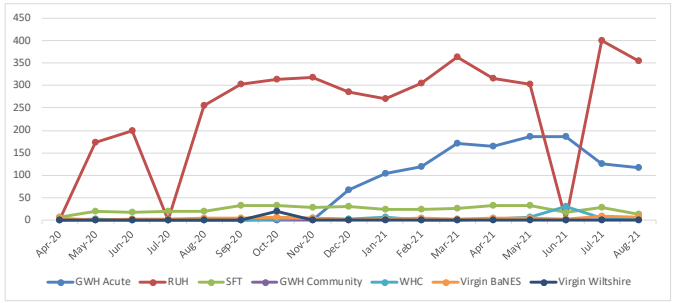
The UTC (Urgent Treatment Centre) at Swindon remains closed overnight due to staffing and at times and for the same reason the UTC at Bath as also had to close early.

Number of Complaints



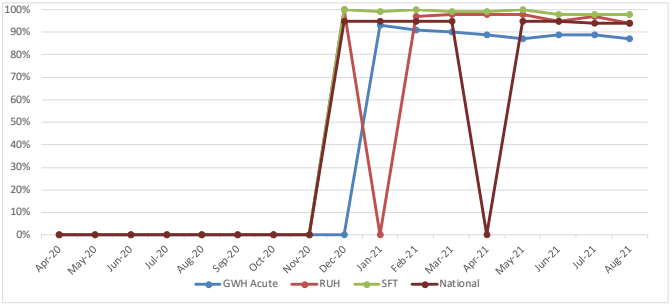
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	61	36	38	36
RUH	26	37	34	33
SFT	18	10	13	16
GWH Community	no data	no data	no data	no data
WHC	12	4	6	6
Virgin BaNES	5	8	6	3
Virgin Wiltshire	no data	22	no data	no data
AWP	0	0	0	no data

Number of PALS



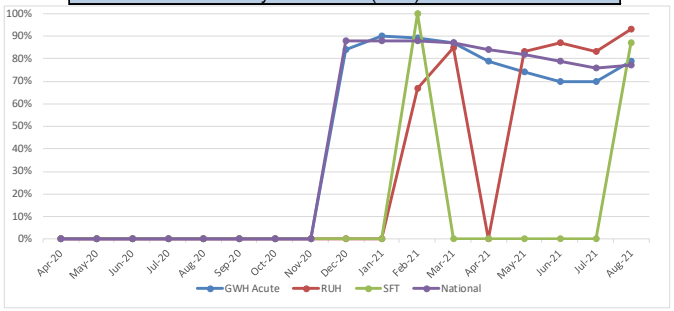
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	186	186	125	116
RUH	303	no data	401	355
SFT	33	17	29	12
GWH Community	no data	no data	no data	no data
WHC	7	30	4	3
Virgin BaNES	4	3	8	6
Virgin Wiltshire	no data	no data	no data	no data
AWP	0	0	0	no data

Friends and Family Test Score (Inpatient) Recommend Rate



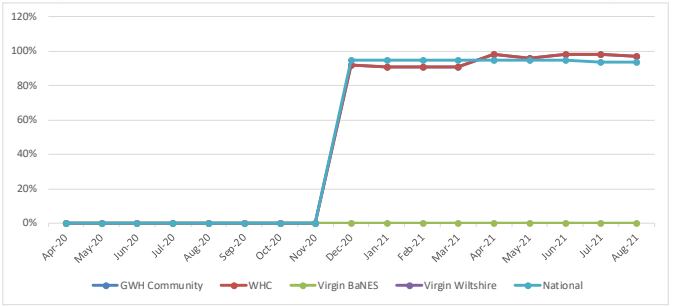
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	87%	89%	89%	87%
RUH	98%	95%	97%	94%
SFT	100%	98%	98%	98%
GWH Community	no data	no data	no data	no data
Virgin BANES	no data	no data	no data	no data
Virgin Wiltshire	no data	no data	no data	no data
WHC	no data	no data	no data	no data
National	95%	95%	94%	94%

Friends and Family Test Score (A&E) Recommend Rate



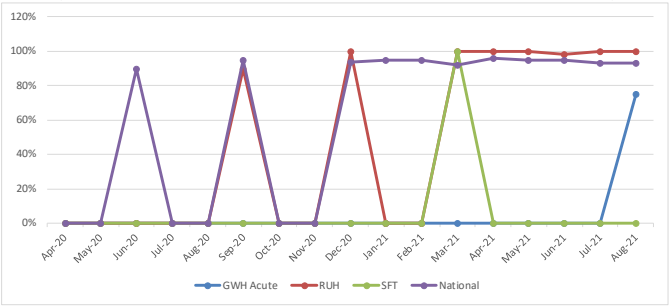
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	74%	70%	70%	79%
RUH	83%	87%	83%	93%
SFT				87%
National	82%	79%	76%	77%

Friends and Family Test Score (Community) Recommend Rate



	May-21	Jun-21	Jul-21	Aug-21
GWH Community	96%	98%	98%	97%
WHC	96%	98%	98%	97%
Virgin BaNES				
Virgin Wiltshire				
National	95%	95%	94%	94%

Friends and Family Test Score (Maternity, Birth) Recommend Rate



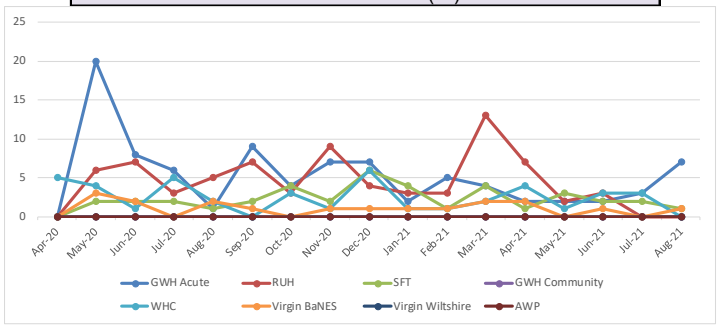
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	*	*	*	75%
RUH	100%	98%	100%	100%
Virgin Wiltshire	NA	NA	*	*
National	95%	95%	93%	93%

Friends and Family Test Score (Ambulance) Recommend Rate

	Dec-20	Jan-21	Feb-21	Mar-21
SWAST				0
National				0

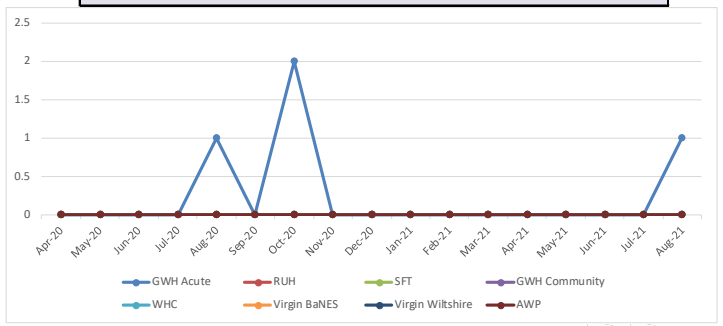
Quality – Patient Safety

Serious Incidents (SI)



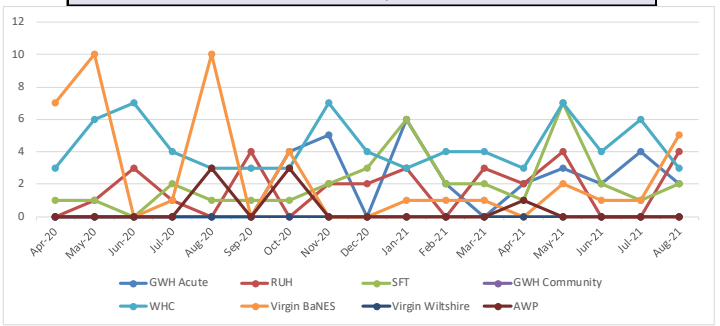
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	2	2	3	7
RUH	2	3	no data	no data
SFT	3	2	2	1
GWH Community	no data	no data	no data	no data
WHC	1	3	3	0
Virgin BaNES	0	1	0	1
Virgin Wiltshire	no data	no data	no data	no data
AWP	no data	no data	no data	no data

Never Events



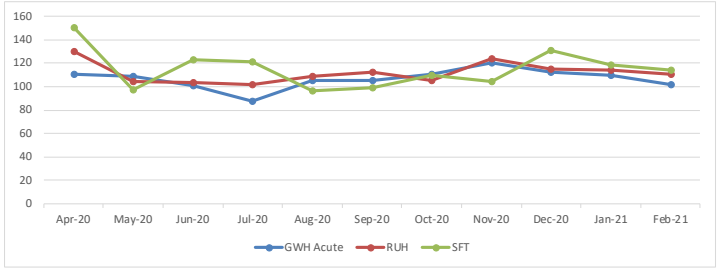
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	0	0	0	1
RUH	0	0	no data	0
SFT	0	0	0	0
GWH Community	no data	no data	no data	no data
WHC	0	0	0	0
Virgin BaNES	0	0	0	0
Virgin Wiltshire	no data	no data	no data	no data
AWP	no data	no data	no data	no data

Falls with Moderate/Severe Harm



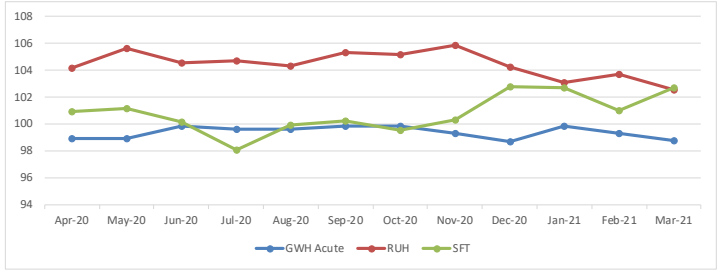
	May-21	Jun-21	Jul-21	Aug-21
GWH Acute	3	2	4	2
RUH	4	no data	no data	4
SFT	7	2	1	2
GWH Community	no data	no data	no data	no data
WHC	7	4	6	3
Virgin BaNES	2	1	1	5
Virgin Wiltshire	no data	no data	no data	no data
AWP	no data	no data	no data	no data

HSMR - Hospital Standardised Mortality Ratio Relative Risk



	Nov-20	Dec-20	Jan-21	Feb-21
GWH Acute	120.4	112.8	109.9	102
RUH	123.6	115.1	114.1	111
SFT	104.8	131.3	118.8	114

SHMI - Summary Hospital-level Mortality Indicator



	Dec-20	Jan-21	Feb-21	Mar-21
GWH Acute	98.7	99.85	99.3	98.78
RUH	104.2	103.1	103.7	102.6
SFT	102.8	102.7	101	102.7

- Some organisations remain challenged with Serious Incident investigations (GWH, AWP and SWAST), the CCG Quality team are working closely to ensure all investigation options are considered to ensure organisations are focused on the importance of learning.
- Serious incident reporting is showing an increase across the months rather than in month, with 3 in month relating to Emergency Department care. Investigation learning should inform wider system learning.
- BSW has received additional information from SWAST relating to their recently published harm paper following the alternative arrangements they instigated to cope with demand and capacity. No Serious Incident's were identified across BSW. the main area of focus from the incidents is the access to GP services
- RUH has seen an improvement in Hospital Standardised Mortality Rates (HSMR) to 106 in month. The rolling 12-month HSMR is now also an improved position of 105.7- RUH have produced a report and implemented actions to continually improve the position. The action plan aligns with recent discussions with NHSEI

Programme Exception Reports

Urgent Care Exception reporting

Related Oversight Framework Metric/Metrics – Acute emergency care and transfers of care

Exceptions Analysis

Percentage of 111 Referred patients that receive a timeslot

- Regional team have shared snapshot of EDDI (Emergency Department direct interface booking solution) data for review, as CCG have been unable to access and triangulate data. Trusts are reporting that patients are still being heralded to emergency departments (ED) but are not being given a booked appointment
- Limited uptake of enhanced Medvivo-Clinical Assessment Service (MCAS) shifts due to workforce appetite to do additional on top of existing roles and requirements to support demand in existing busy ED departments
- In September 86.1% ED dispositions were validated of which 31.9% downgraded, 64.6% remained same and 3.5% upgraded.
- Increased 111 and CAS (Clinical Assessment Service) demand has also seen deterioration of waiting times in the CAS queue for clinical call backs including validation. Request for mitigation to manage 12hr and 24hr primary care dispositions differently over weekends with current 111 provider in place to manage demand.

30 minute handover breaches:

- Total hospital handover delays deteriorated in September with 2573 handovers taking over 15 minutes, with 1343 hours lost. This equates to 47% of all handovers in September
- Whilst GWH handovers deteriorated in September, the regional team have formally stood down fortnightly support meetings due to progress made on actions. Trialled and implemented ward in-boarding to reduce handover delays at front door.
- Regional team working with the RUH as one of the six main trusts in the South West with ongoing concerns. Workforce is a challenge within emergency department, RUH to re-submit business case for additional staffing.
- SWAST Hospital Ambulance Liaison Officer (HALO) cover has still been adhoc as required as permanent recruitment for roles is ongoing

What did we achieve in the past month?

Urgent Care

- Collated and submitted Winter Plans and KLOEs to region.

111 to ED referrals

- Implementation of PACCs (Pathway Clinical Consultation Support)
- Minor Injury Units back to walk in mode

Hospital Handovers

- Promotion of Alternative temporary patient transport provision to primary care

Plans in the coming Month

Percentage of 111 Referred patients that receive a timeslot

- Review of BSW EDDI snapshot data to understand access issues triangulated with current demand
- Mobilisation of new 111 provider on 2nd November, and Medvivo clinicians take over prime responsibility for validation on ED and 999 in joint CAS queue. New provider has proven record on top of the DOS ranking selection
- Think 111 programme board continue to meet and review progress against delivery

30 minute handover breaches:

- Evaluation of PTS Short term pilot (20th September until 18th October) to test Alternative healthcare professional referral to secondary care
- SWAST recruitment of permanent HALOs to stop rota shifts being filled with Overtime and adhoc
- Category 2 validation pilot on 15th November - with Medvivo and senior ED clinicians
- GWH Care Home and navigator initiative to access SWAST Computer Aided Dispatch to identify patients in SWAST Call stack that could be managed differently
- Evaluation of WH&C pilot with SWAST w/c 27th Sep to put a ACP (Advanced Clinical Practitioner) in SWAST rapid response vehicle in Salisbury area to identify opportunities to reduce conveyance and alternative response; and SFT plans for ED clinicians

How will you address any quality and inequalities?

- EQIA (equality impact assessment) being completed for Category 2 validation pilot in November to ensure patient safety and quality risks are managed.
- SWAST being supported regionally to transition to Patient Safety Incident Response Framework to address system demand harm incidents. No serious harm identified in the BSW footprint currently but 18 incidents that have occurred in the South West are currently under review
- Staff fatigue / system demand emerging as a contributing theme for patient safety incidents.
- GWH walk through of admission and surge areas carried out 25/10/21 for mixed sex accommodation guidance and potential breach areas. Further discussion required
- Increasing trend in CCG complaints related 111 delays. EQIA undertaken for removal of 12/24 dispositions on weekends to allow the CAS queue to be managed safety and reducing extended call back times

B&NES Discharge & Flow Exception reporting

Related Oversight Framework Metric/Metrics – % Discharges by 5pm, % Non - Criteria to Reside discharged

Exceptions Analysis

- Covid Cases continue to increase. Continued high demand at RUH front door.
- Reablement service remains challenged with more high acuity patients leading to longer contact time.
- Care home closures remain due to Covid and staffing capacity.
- The majority of all nursing beds (which are best suited to Discharge to Assess - D2A where a bed is needed) are now in permanent use and not available to support flow.
- Significant delays in sourcing home care due to lack of availability impacting reablement service and patient flow.
- Daily integrated flow calls continue to support system wide discharges and challenge any issues.

Plans in the coming Month

- Reablement transformation plan, demand and capacity analysis being finalised via Steering Group with Quality Impact Assessments.
- Weekly working group calls to progress 2-hour crisis response for Q4 implementation.
- Local Authority and CCG progressing options for in-housing home care provision.
- Support Pathway 0/1 discharges through review of location and engagement of third sector providers e.g. Age UK in flow calls and physically in RUH and Wellbeing Hub.
- Progressing plans for Pathway 1 wellbeing advisers to support discharges.
- Community hospitals to prepare for re-opening 10 additional beds in November 2021.
- RUH refocus of Hospital@Home to support system.
- Findings from ECIST diagnostic to be progressed with partners to ensure clear system governance and escalation framework.

What did we achieve in the past month?

- Paired down reablement steering group focussing on resolving long standing issues.
- Development of future state reablement process mapping commenced / data sets continue to be collated to support revised metrics for reablement.
- Standard operating procedure for 2-hour crisis response service has been drafted.
- Live in care project has commenced. The success of this project is informing additional live in care commissioning to support the home care market.
- RUH iBeds commenced at Westin Care Home, trajectory of 10 beds on target with discharge enabled using RUH ART+ Team.
- Intermediate Care team have reviewed all D2A beds and are progressing discharges to assist flow.
- The Emergency Care Improvement Support Team (ECIST) diagnostic work continuing to review D2A pathway. Initial findings shared with RUH, VC, Council and CCG.

How will you address any quality and inequalities?

- Completing QIAs for each project.
- Maintaining regular discussion with safeguarding and quality teams to review impact
- Identifying key performance indicators for all emergency schemes to support outcome analysis.
- Obtaining and actioning patient feedback for emergency schemes.
- Monitoring of any serious incidents relating to Discharges and Flow.
- Development of a tracker measuring KPIs/outcomes and reporting these on a monthly basis through the winter.
- Safeguarding issues are identified and addressed during the Patient Flow Calls.
- Monitoring any serious incidents relating to Discharges and Flow.

Swindon Discharge & Flow Exception reporting

Related Oversight Framework Metric/Metrics – % Discharges by 5pm, % Non - Criteria to Reside discharged

Exceptions Analysis

- Format of the integrated discharge calls has changed following a review. Wards now bring escalation cases that require support from Partners to expedite discharge. This will continue to be monitored.
- Significant pressures on Swindon system. GWH continues to remain at OPEL4. Increase in Covid-19 in-patients and ICU patients. Electives being cancelled from 22.10.21.
- Urgent Treatment Centre remains closed overnight (from 10 pm) due to lack of staffing and will continue to be closed until further notice.
- Have identified a lack of Community step-up provision in Swindon – to be considered as part of the Community Transformation Programme.

What did we achieve in the past month?

- Appointment to Trusted Assessor role made – starting 22 Nov 21.
- Wound care task and finish group have completed an analysis of all wound care providers in Swindon – next step is to make recommendations.
- D2A Home First pilot started within GWH w/c 18 October. Identifying patients on Pathway1 who are suitable for same day discharge.
- Implementation of the Weekly Escalation Forum for Reablement and D2A, working with Social Care and Therapy.

Plans in the coming Month

- Develop a Swindon ICA Urgent Care & Flow Tactical Group – this group will monitor winter plans and Hospital Discharge Plan Schemes .
- Identifying options for a Hospital Discharge Safely Home service via Swindon Borough Council (SBC).
- Wound care – identifying recommendations to improve provision across the locality.
- Weekly Covid-19 Infection meetings, jointly with SBC, have been established to link with Care Home Providers to identify and mitigate any risks to care.
- Domiciliary Care staff – identifying the need to commission additional agency staff for the winter period, working with SBC and First City.
- Trajectory modelling for additional capacity within the community.
- Planning and review of contract arrangements for the Urgent Treatment Centre.

How will you address any quality and inequalities?

- Monitoring any serious incidents relating to Discharges and Flow.
- Looking at patient journeys to identify any trends on discharge
- Safeguarding issues are identified and addressed during the daily integrated discharge calls.

Wiltshire Discharge & Flow Exception reporting

Related Oversight Framework Metric/Metrics – % Discharges by 5pm, % Non - Criteria to Reside discharged

Exceptions Analysis

- NC2R (no criteria to reside) discharges - SFT remains above the national and South West average for percentage of NC2R discharged. For RUH performance reporting for Wiltshire only patients has been requested. This will help develop options to improve performance.
- SFT has a longer average length of stay (6.8 days) than RUH (5.6) and GWH (4.6). This is multifactorial however pathway efficiency improvement work will bring consistency to our discharge processes.
- Weekend discharges and referrals to the discharge hub remain at a low level compared to week-day. This will be picked up as part of the Pathway Efficiency improvement work. Regular activity reporting is now in place across 7 days.
- Current readmission rates to hospital are 12% RUH, 11% GWH and 9% SFT. The SFT figure remains low however an increase in Pathway 1 and Pathway 2 discharge readmissions has been identified and is being investigated.
- At the time or writing this report, current average waiting times for discharge on Pathway 1 are approx. 5 days against a target of 2 days. This represents a decrease of 1 day since the previous report. This remains variable and domiciliary care capacity is still a significant challenge.

What did we achieve in the past month?

- Pathway 1 Efficiency Review completed. 4 Priorities identified (see plans)
- Implemented Discharge Flow meetings at GWH – these have been very well received (meetings now take place for all acute and community providers)
- Capacity Modelling live and in place for urgent care and flow reporting.
- Expansion of the Care Home virtual ward offer now supporting 33 care homes (target 50). Expanding the offer to care homes in the South of Wiltshire following agreement on a way forward with SFT and use of consultant geriatrician time.
- Recruited to additional secondment role – Service Redesign Lead (urgent care) to end of May 2022 (this is re-purposed funding). Advert placed for Wilts focused BSW BI Analyst.
- First iteration of Wiltshire Urgent Care and Flow Improvement report published.

Plans in the coming Month

Pathway 1 Efficiency
Implement actions on 4 priority areas – 1) agree standard information and Standard Operating Processes for discharge referrals, 2) Introduce 'webforms' referral mechanism aligned to requirements in Priority1, 3) Ensure clear and up to date capacity information is available to support discharge planning and 4) Review workforce and transport models to extend the time of day that discharges can be facilitated.

Urgent Care and Flow Improvement KPI and metric reporting – continue to develop this further to support decisions and actions.

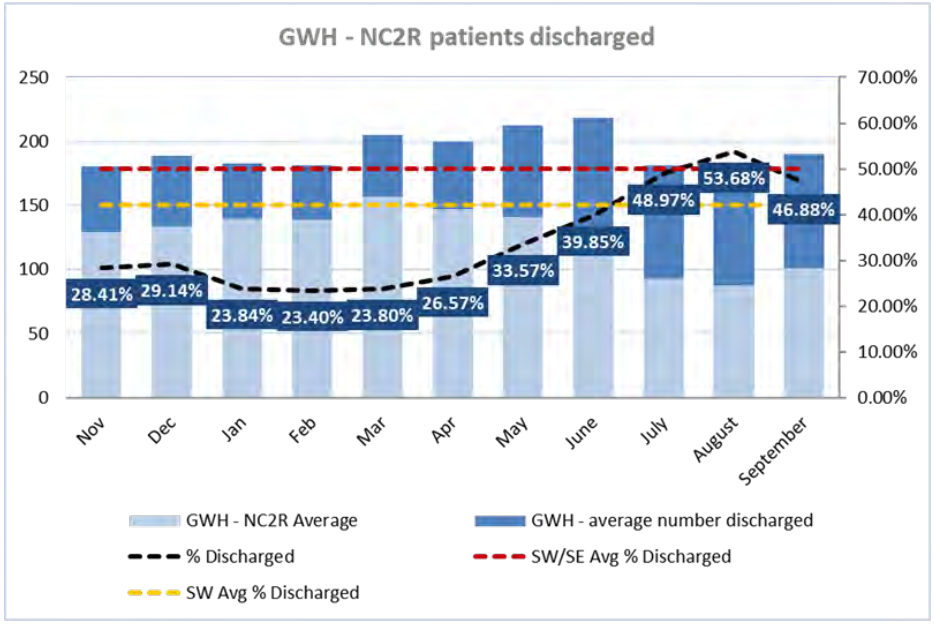
BCF Reviews are continuing, working with Medvivo currently. Aim to complete all reviews by end of January 2022. These reviews are identifying opportunities for service design and improvement.

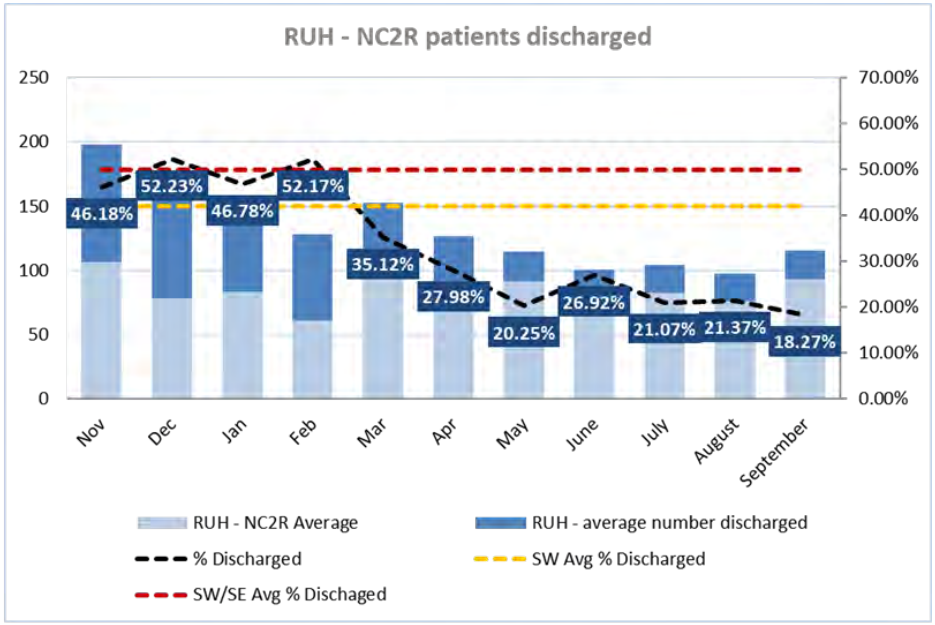
2 Hour Rapid Response and Overnight Nursing service roll-outs continue. Recruitment is ongoing however remains challenging. There is limited capacity to cover the vacancies with existing staff so this remains the most significant risk.

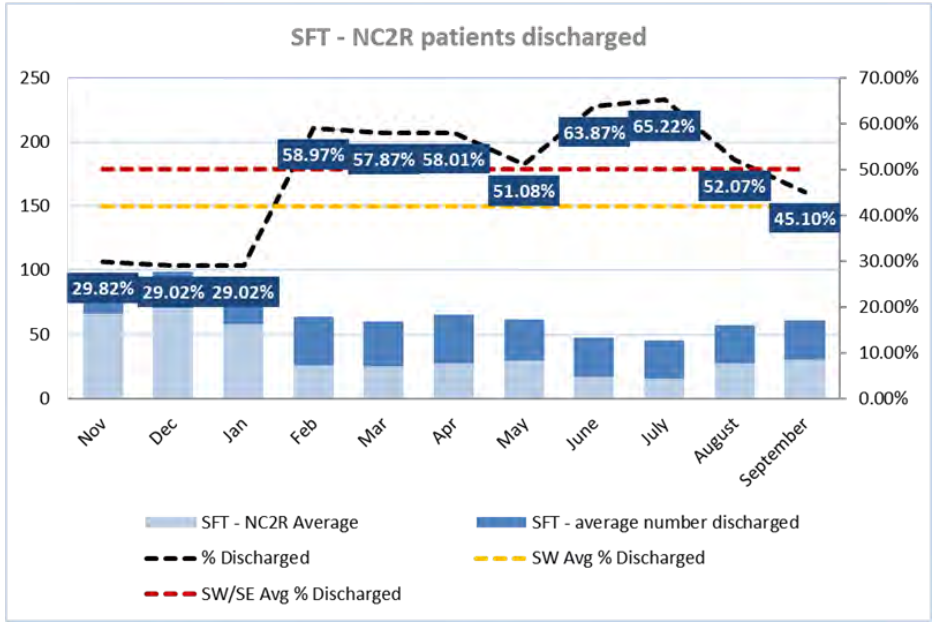
How will you address any quality and inequalities?

- Safeguarding issues are identified and addressed during the Patient Flow Calls.
- Discharge Service Review meetings are the driver for the Pathway 1 and Pathway 2 improvement work. Currently working to develop the Quality and Equality Impact Assessments across all partners.
- People living in rural areas are waiting longer for packages of care – Wiltshire Council inhouse domiciliary care service development has started, and use of assistive technology and alternative placement options are explored for each individual.
- Review and development work on End Of Life pathways for Wiltshire has started, supporting the implementation of the BSW End Of Life strategy.

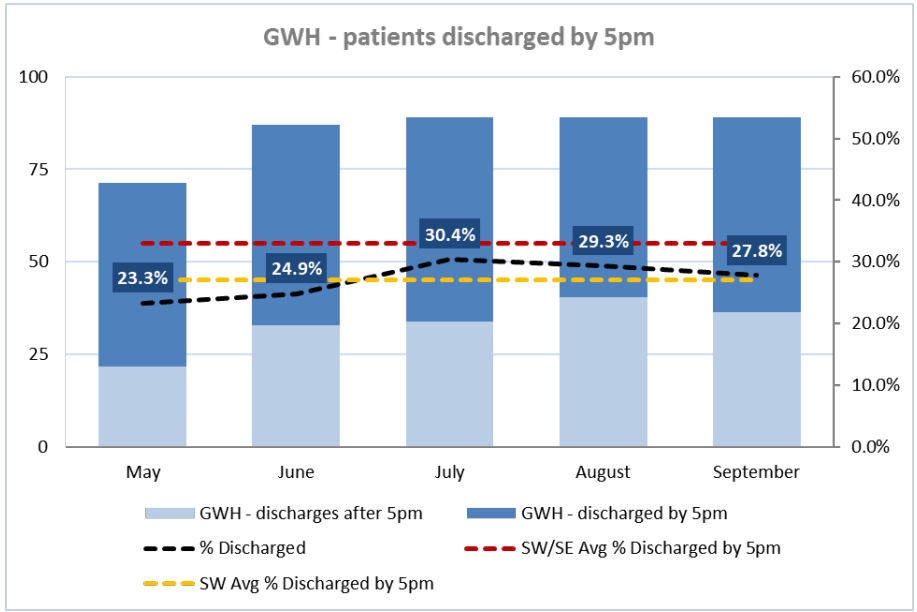
Non-Criteria to Reside - discharges

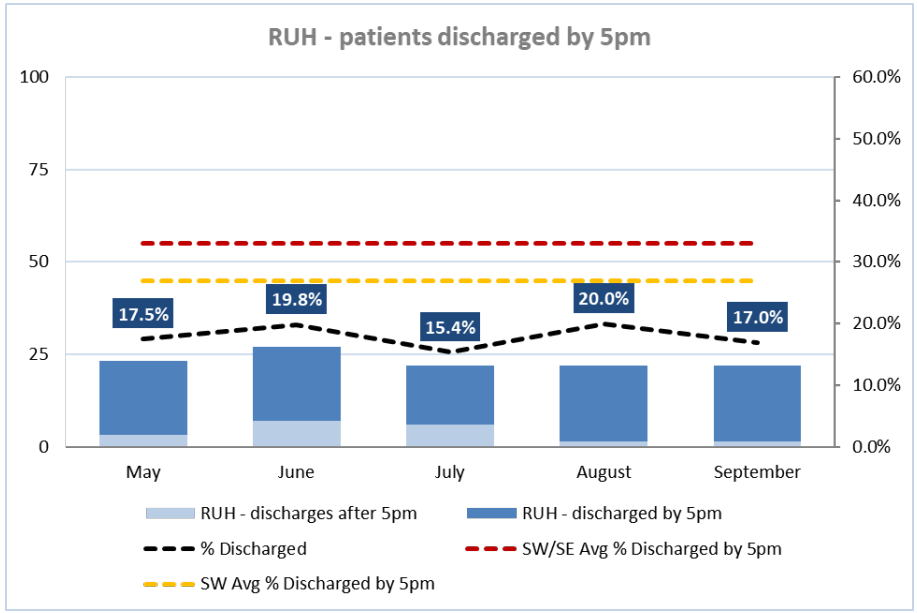


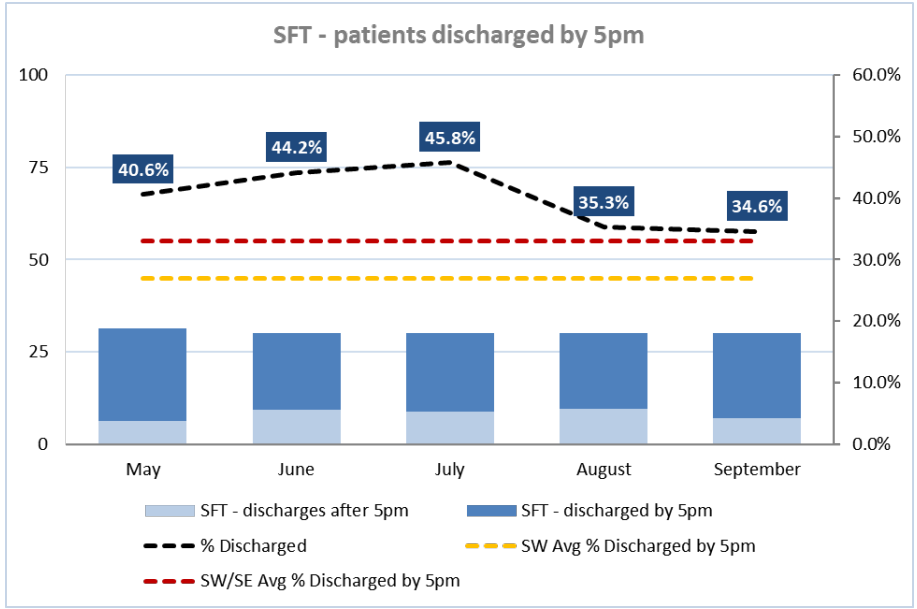




Non-Criteria to Reside – discharges by 5pm







BSW Patient Discharge Pathways – Current position

7 months discharges (March – September 21)

	Pathway 0 – No additional support • Fully independent with no additional post discharge support required	Pathway 1 – Additional support at home/usual place of residence required • Safe to be at home/usual residence • Assessment with additional care/support	Pathway 2 – Additional support required but not able to go home • Unsafe to be at home/usual residence • Temporary bedded rehab/ reablement assessment required	Pathway 3 – Long-term specialist/complex care is require • Complex health/social care needs • Longer term support • Complex support in usual residence
	0	1	2	3
BANES	**85.0%** 65+ patient discharges (53.6%)	**8.3%** 65+ patient discharges (90.9%)	**5.7%** 65+ patient discharges (91.8%)	**1.0%** 65+ patient discharges (83.3%)
SWINDON	**86.7%** 65+ patient discharges (47.2%)	**7.7%** 65+ patient discharges (88.8%)	**4.8%** 65+ patient discharges (83.8%)	**0.7%** 65+ patient discharges (91.4%)
WILTSHIRE	**86.6%** 65+ patient discharges (55.3%)	**7.3%** 65+ patient discharges (92.4%)	**5.4%** 65+ patient discharges (93.3%)	**0.8%** 65+ patient discharges (88.5%)
	65+ proportion is a subset of the pathway 0 discharges only	*65+ proportion is a subset of the pathway 1 discharges only*	*65+ proportion is a subset of the pathway 2 discharges only*	*65+ proportion is a subset of the pathway 3 discharges only*

Planned Care Exception reporting

Related Oversight Framework Metric/Metrics – Cancer 31 day treatments, Cancer Access to Treatment in 62 days, Diagnostic, Outpatient and Elective activity

Exceptions Analysis

- BSW continues to outperform most other SW CCGs/ICS's for volumes of cancer activity – patients seen following 2ww GP referral; and 31d cancer pathways initiated. Thus we have a smaller outstanding proportion of "missing" patients who based on historical trends would have been expected to present with possible cancer symptoms but did not present during the pandemic.
- However this greater volume compared to most other systems has placed additional pressure on cancer teams to be able to see and treat in a timely manner, meaning performance against a number of the cancer performance targets has declined.
- Diagnostic volumes are higher than 19/20 but access times within 6 week standard remain low. Further analysis underway to understand by how much the 6 week standard is being missed to target actions.
- Risk of 104 week breaches and 52 week waiting list stabilisation undertaken which highlights key specialties for collective action.

Plans in the coming Month

- BSW continues to outperform most other SW CCGs/ICS's for volumes of cancer activity – patients seen following 2ww GP referral; and 31d cancer pathways initiated. Thus we have a smaller outstanding proportion of "missing" patients who based on historical trends would have been expected to present with possible cancer symptoms but did not present during the pandemic.
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- Diagnostic volumes are higher than 19/20 but access times within 6 week standard remain low. Further analysis underway to understand by how much the 6 week standard is being missed to target actions.
- Risk of 104 week breaches and 52 week waiting list stabilisation undertaken which highlights key specialties for collective action.

What did we achieve in the past month?

- Agreement for RUH cancer services to join existing Colon Capsule Endoscopy pilot
- Approval of Swindon as location for Thames Valley Cancer Alliance targeted lung health checks pilot
- Issues around reporting responsibility for bowel cancer screening patients identified and discussed; solutions identified
- GP and Practice Nurse cancer education events held
- Workshop held to focus on 104 week wait risk and 52 week waiting list stabilisation.
- Targeted Investment Fund bids produced and supported by region to mitigate impacts of urgent care on electives and increase capacity.

How will you address any quality and inequalities?

- Results of Community First research into digital exclusion and rural inequality impacting B&NES and Wilts cancer patients being reviewed to identify actions for CCG and key partners
- Continue to work with partner organisations to enable inreach into relevant communities and groups to reiterate key messages about the importance of cancer screening; and seeing a GP if worrying symptoms, including continued education events for non-clinical (NHS and non-NHS) staff
- The acute hospitals are reporting an increase in complaints in relation to delays in elective care and cancellations of elective care. The CCG Quality Team are working with the providers to establish the key themes and extent of these complaints

Mental Health Exception reporting

Related Oversight Framework Metric/Metrics – CYPMH Access, SMI Annual Health Checks, Out Of Area Admissions

Exceptions Analysis

- Out of area placements have reduced from 19 to four but remain high. Themes in bed pressures include flow to specialist placements (lack of specialist provision nationally for individuals with EUPD (Emotionally unstable personality disorder) , Eating disorder comorbid to EUPD and/or requiring nasogastric refeeding), and care home placements.
- Continued challenge of access to tier four CAMHS (Child and Adolescent Mental Health Services) beds – across all forms of beds; general adolescent unit, psychiatric intensive care units and eating disorders.
- Serious Mental Illness (SMI) annual health checks rates continue to increase but more work required to improve engagement and attendance.
- CYP (Children and Young People) access has improved, although the alteration in the national KPI has brought some complexity to monitoring. Additional investment to CAMHS approved through Thrive to enhance access, support and treatment capability is now mobilising.
- Adult ADHD [BSW] and ASD [Swindon locality] remain of significant concern. Dedicated system working groups are supporting and implementing mitigation and improvement plans.

Plans in the coming Month

- Co-development and submission of the NHSE Bereavement liaison bid 15/11/21; system task and finish group mobilised.
- Dedicated RUH Adult Eating Disorder pressures meeting to support risk management and actions 26/10. Urgent review of refeeding pathway for Eating Disorder patients to commence through BSW Crisis Steering group.
- Co-design of transitional model for annual health checks to merge into Community Mental Health Framework to be presented to Nov Thrive. Proposal will ensure continuity of support through Q3/4, whilst enabling the Community Services Frameworks (CSF) to mobilise their enhanced pathway offer.
- BSW escalation hub to commence development of strategic proposals to enable the transition of appropriate high cost placements, and diversion of future placement need [where possible].
- BSW/ BNSSG working group to review HBPOS (Health Based Place of Safety) pathway, section 140 system policy and plan for super system demand and capacity workshop (Nov 2021).
- BSW CSF year 1 stocktake and year 2 planning workshop (Nov 2021).

What did we achieve in the past month?

- BSW escalation and complex needs oversight hub has mobilised. System live testing of draft tiered escalation process.
- Multi-agency BSW Places of Calm workshop held, co-creating a system improvement plan to evolve the access and operational specification. Next phase to develop resources as alternatives to A&E, and to accept direct referrals from emergency services and 111.
- Dedicated workstream for data, outcomes and digital mobilised

How will you address any quality and inequalities?

- Additional investment in CAMHs approved through Thrive, recruitment to posts now in progress. Additional capacity will enhance access, support and treatment capability. OHFT commenced operating as system lead for CYP access – focused increasing access, as well as the data quality of NHS E MH SDS submissions.
- AWP mobilising inpatient flow team.

Primary Care Exception reporting

Exceptions Analysis

- Continued Operating Model in line with national IP&C guidance for primary care (29.09.21) so practices are Covid secure with social distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate
- National release of Improving access for patients and supporting GP Services (14.10.21) intending to increase the ability for patients to access primary care services: local focus is on working across the GP Practices, PCNs and local systems to use this fund to best support primary care in the difficult months ahead in response to the unprecedented levels of demand being experienced. Our local priority is to develop a set of plans that will support and help all 85 GP Practices across BSW.
- The monthly appointment data for September 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.

What did we achieve in the past month?

- 23/25 PCN sites delivering Phase 3 Covid Booster programme
- Commenced seasonal flu programme
- BSW Communication Plan rolled out with focus on primary care including BSW GP leaders issued an open letter to local people detailing the pressure currently affecting primary care services offering an insight into the increasing demand being seen by frontline GPs and their teams and explains how staff absences, rising coronavirus cases and an increase in demand for urgent and emergency care has created the kind of pressure not usually seen outside of winter.
- Continued close working with CQC regarding performance concerns

Plans in the coming Month

- Managing continued demand across General Practices and across whole system.
- Development and submission of plan for Improving Access on behalf of BSW (28.10.21)
- 23/25 PCN sites continuing to deliver Covid Vaccinations booster programme

How will you address any quality and inequalities?

- The Quality Team have commenced engagement with Practices and are scoping work to understand shared learning. Points of specialist support have been identified within the CCG to assist and advise on specific topics identified within each action plan. A Primary Care Quality Oversight Assurance Group is being implemented to monitor the completion of improvements plans, mitigations and to ensure the right level of support from the CCG, Draft Terms of Reference have been developed
- The Quality Team has commenced internal scoping to develop a work plan and core metrics, with a view to agree focused priorities and timescales for implementation going forwards. These metrics will be monitored through discussions at Primary Care Commissioning Committee and with other key stakeholders. This work will also include developing a process to capture and analyse emerging themes and trends to better inform future improvement work.

COVID-19

As reported 3/11/2021

COVID-19 1 of 3

COVID-19 Capacity Thresholds and Triggers - Acute Providers

System/Locality
BSW

OPEL Status

	30 Oct	31 Oct	01 Nov	02 Nov	03 Nov	04 Nov	05 Nov	06 Nov	07 Nov	08 Nov	09 Nov
GWH	4	4	4	4	3	4	3	3	4	3	4
RUH	4	4	4	4	3	4	4	4	4	4	4
SFT	3	3	3	3	3	4	3	3	3	4	4

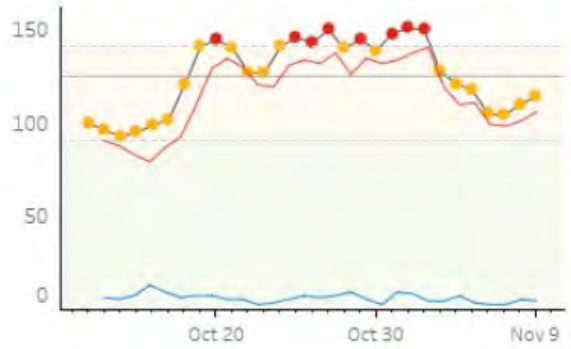
Confirmed & Suspected COVID Cases (Acute)

09 Nov **114**

Total No of confirmed COVID cases (Acute) **110**

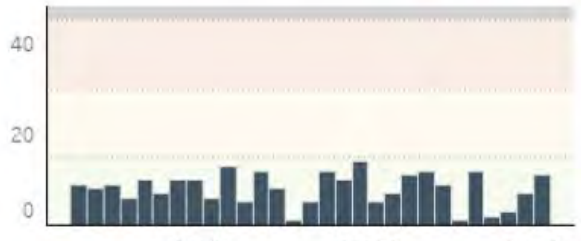
Total No of suspected COVID cases (Acute) **4**

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



Inpatients diagnosed with COVID

09 Nov **11**



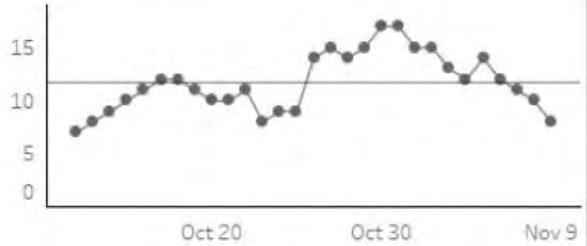
Total No of patients in ITU

09 Nov **44**

Total No of confirmed COVID patients in ITU **15**

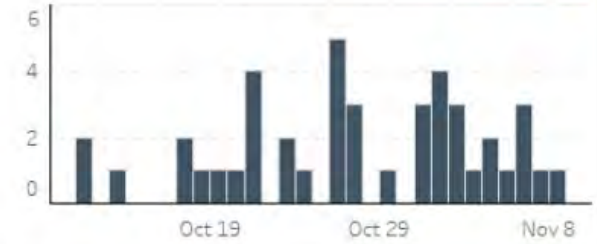
Number of COVID-19 patients on non-invasive ventilation

09 Nov **8**



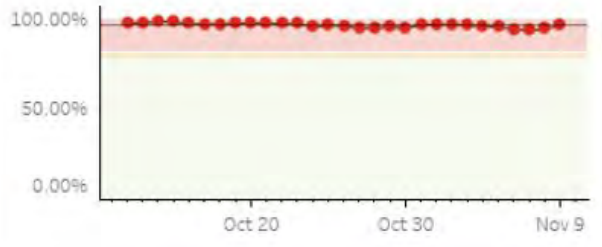
No of Deaths from COVID

08 Nov **1**



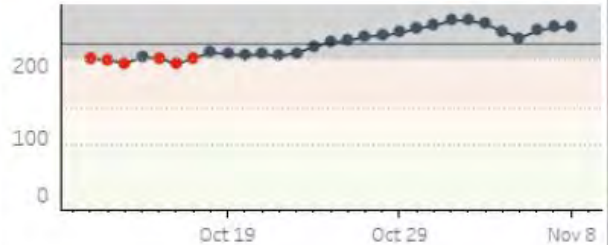
Acute Bed Occupancy

09 Nov **95.81%**



Super-Stranded (Acute)

08 Nov **255**



COVID-19 2 of 3

COVID-19 Capacity Thresholds and Triggers - Community Providers

System/Locality
BSW

OPEL Status (Community)

	30 Oct	31 Oct	01 Nov	02 Nov	03 Nov	04 Nov	05 Nov	06 Nov	07 Nov	08 Nov	09 Nov
SCHS	4	4	4	4	3	4	3	3	4	3	4
VC	4	4	4	4	4	4	4	4	4	4	3
WHC	4	4	4	4	4	4	4	4	4	4	4

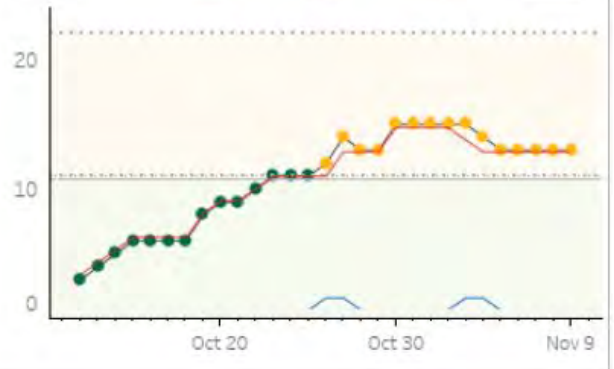
Confirmed & Suspected COVID Cases (Community)

09 Nov: **13**

Total No of confirmed COVID cases (Community): **13**

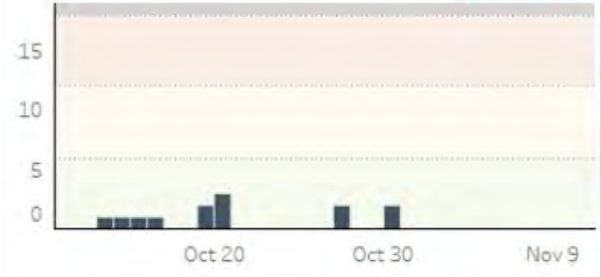
Total No of suspected COVID cases (Community): **0**

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

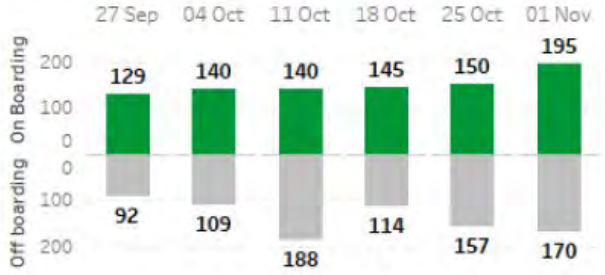


Community Inpatients diagnosed with COVID

09 Nov: **0**



Oximetry (BSW)



Number of COVID-19 patients on non-invasive ventilation

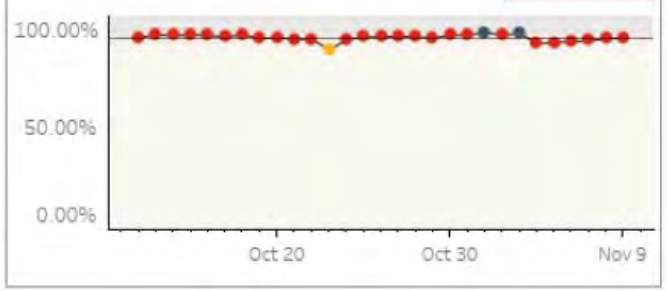
09 Nov: **0**

No of Deaths from COVID

08 Nov: **0**

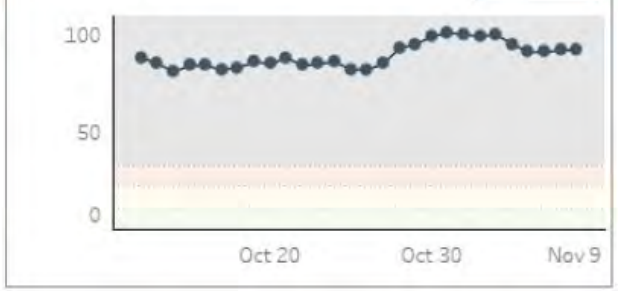
Bed Occupancy (Community)

09 Nov: **93.27%**



Super Stranded (Community)

08 Nov: **92**



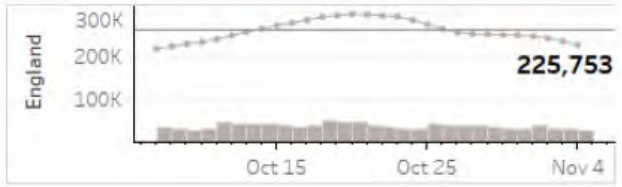
COVID-19 3 of 3

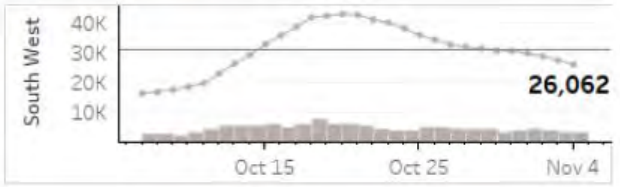
Cases and Prevalence

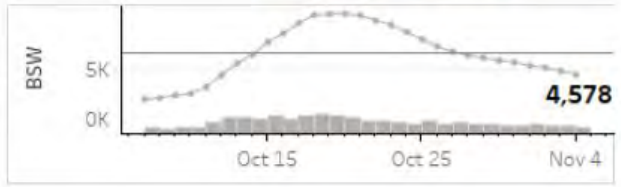
Data shown are cases by specimen date and because these are incomplete for the most recent dates, the period represented is the seven days ending 5 days before todays date. Inline with how its reported on the Gov.UK website.

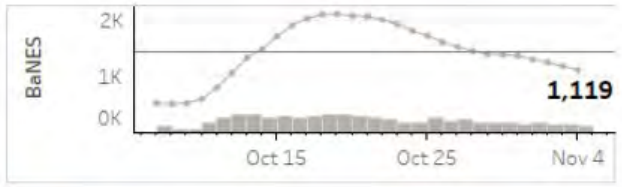
Number of cases in the last 7 days (Line Graph) & Daily cases (Bar Graph)

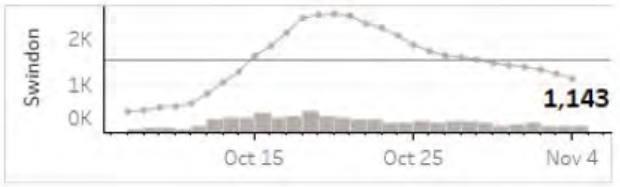
November 4, 2021

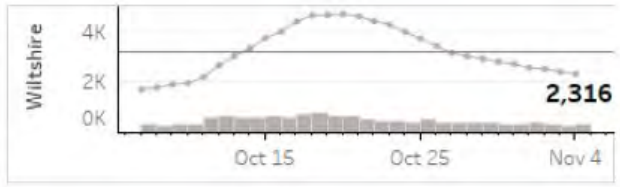












Rate of cases in the last 7 days per 100,000

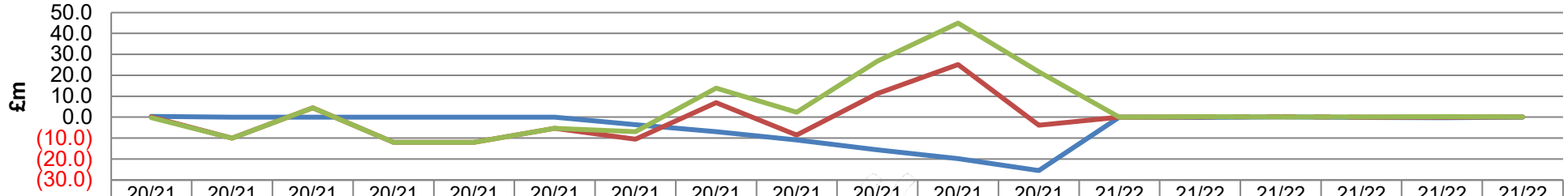
	21 Oct	22 Oct	23 Oct	24 Oct	25 Oct	26 Oct	27 Oct	28 Oct	29 Oct	30 Oct	31 Oct	01 Nov	02 Nov	03 Nov	04 Nov
England	570.23	561.41	548.34	544.36	548.43	523.10	507.92	491.78	483.74	472.91	472.33	485.38	469.72	458.74	441.42
South West	860.67	844.43	806.66	786.15	773.86	724.72	694.89	664.28	644.68	622.59	615.94	623.98	596.77	572.15	545.40
Bath and North East Somerset	1,075.11	1,046.14	1,004.23	943.18	898.17	835.57	796.76	754.86	726.92	722.78	712.43	677.77	652.41	614.65	578.95
Swindon	1,117.05	1,040.99	999.13	929.37	836.66	777.70	735.85	720.09	698.49	663.39	645.83	628.28	601.73	563.02	514.42
Wiltshire	919.36	880.16	852.96	795.56	740.56	684.17	631.37	602.77	584.17	559.57	542.57	512.38	501.78	480.58	463.18
Bournemouth, Christchurch and Poole	524.62	529.18	527.66	528.17	519.56	505.91	490.98	493.26	500.85	510.71	521.34	526.65	521.59	518.55	494.27
Bristol, City of	755.54	724.90	697.06	652.38	605.55	572.10	537.58	509.30	495.28	484.49	476.07	471.54	453.19	428.38	407.23
Cornwall and Isles of Scilly	514.59	501.77	501.25	481.06	460.52	437.87	425.75	418.38	416.45	411.53	415.04	418.73	411.71	403.63	389.76
Dorset	613.20	606.86	607.91	593.12	567.49	575.15	553.49	565.11	574.36	576.21	564.85	559.57	540.54	522.05	483.48
Devon	526.69	530.80	529.18	513.97	498.40	499.14	489.92	490.17	493.66	487.68	487.93	486.06	476.34	466.49	446.55
Gloucestershire	1,047.77	986.55	943.85	879.02	820.16	780.76	734.93	705.89	681.40	659.74	647.18	621.60	593.18	554.73	522.71
North Somerset	1,003.01	925.36	894.20	853.28	741.22	698.44	636.59	606.36	602.18	578.93	560.79	534.29	506.39	479.42	450.12
Plymouth	523.85	522.70	529.95	522.70	506.68	503.62	487.60	490.27	495.23	483.02	491.80	484.55	462.04	437.24	417.40
Somerset	884.88	845.57	812.13	769.80	717.86	674.11	626.26	616.48	593.00	575.93	572.72	535.37	506.20	486.28	451.95
South Gloucestershire	961.44	913.39	873.05	830.61	759.75	743.62	688.55	668.55	652.77	644.35	639.09	621.20	579.81	545.79	510.36
Torbay	469.68	480.68	489.49	491.69	507.84	499.77	526.92	544.53	551.14	550.40	551.87	537.19	524.72	499.77	456.47

Finance

2021/22 Month 6 Financial Overview

Finance Executive Summary

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)	(0.2)	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	0.1
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	0.3	0.1

Financial Summary

The NHS system has ended H1 with a small surplus against a planned breakeven position. We have now received the H2 guidance and at the time of writing we are preparing our H2 financial plan which is due to be submitted on the 16th November, with a draft submission going to NHSEI on the 21st October. We are anticipating that H2 is going to be more challenged than H1 with less funding available and an expectation that we will deliver efficiency savings. Our focus in the next two months will be production of our H2 plans. The Finance Directors have agreed the distribution of the Elective Recovery Funding for H1 and we are working through the Elective Recovery Fund (ERF) forecasts based on the new criteria for H2 planning.

In total Adult Social Care is forecasting an underspend against their budgets of £1.6m with Wiltshire underspending and Swindon overspending. It is not possible to compare performance based on budgets as the Councils have different budgeting methods.

Risks and Mitigations

As previously reported 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 Elective Recovery Fund thresholds, costs could be greater than income potential in H2.
- We are expecting to overspend against notified capped funding for the Hospital Discharge Programme. CCG submissions assume this will be funded
- We are currently working through the financial regime for H2 and there is an expectation that efficiency savings will be made.
- We are required by NHSEI to have a 5 year capital plan that does not exceed our 2021/22 capital envelope. Our future plans are currently exceeding this envelope and we are working with NHSEI about how to manage this.

BSW Income & Expenditure Report

2021/22						
Organisation	**Planned YTD Outturn at Month 6**	**Actual YTD Outturn at Month 6**	**Variance from YTD Plan at Month 6**	**H1 Planned Outturn**	**H1 Actual Outturn**	**Outturn 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	32	32	0	32	32
Royal United Hospitals FT	0	0	0	0	0	0
Salisbury NHS FT	0	44	44	0	44	44
Total Acute Providers	**0**	**76**	**76**	**0**	**76**	**76**
Total BSW NHS Position	**0**	**76**	**76**	**0**	**76**	**76**
Avon and Wiltshire MH Partnership @ 45%	0	0	0	0	0	0
Total NHS	**0**	**76**	**76**	**0**	**76**	**76**
B&NES Adult Social Care			0	0	0	0
Swindon Adult Social Care			0	0	(899)	(899)
Wiltshire Adult Social Care			0	0	2,546	2,546
Total Adult Social Care	**0**	**0**	**0**	**0**	**1,647**	**1,647**
Total Health & Adult Social Care	**0**	**76**	**76**	**0**	**1,723**	**1,723**

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 & B&NES Adult Social Care figures are @ Month 5 due to reporting timescales

Appendix 1: Oversight Framework

BSW Oversight Framework 1 of 4

Phase 1- Initial 23 Indicators agreed for August 21 Report. Phase 2 – to include Social Work Indicators

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?
	% of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend	BSW CCG	Monthly 2021 09	34.30%	36.40%	↑	75%	✗
Implementation of Agreed Waiting Times	30-Minute Ambulance Handover Breaches	BSW CCG	Monthly 2021 09	1083	1,278	↑	0	✗
Transforming Community Services and Improving Discharge	% of Discharges by 5pm	GWH	Monthly 2021 09	61.51%	60.34%	↓		N/A
		RUH	Monthly 2021 09	75.61%	76.07%	↑		N/A
		SFT	Monthly 2021 09	67.29%	66.51%	↓		N/A
	% of Patients Meeting the Criteria to be Discharged that are Discharged	GWH	Monthly 2021 09	47.29%	46.73%	↓		N/A
		RUH	Monthly 2021 09	26.29%	22.42%	↓		N/A
		SFT	Monthly 2021 09	52.38%	53.97%	↑		N/A

Deterioration
Improvement
No Change

Below Standard ✗
Meets Standard ✓

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	84.69%	86.66%	↑	85%	✓
Quality	Clostridium difficile infection rate	BSW CCG	Monthly 2021 09	23	16	↓		N/A
	E. coli bloodstream infections	BSW CCG	Monthly 2021 09	55	36	↓		N/A
	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	BSW CCG	Monthly 2021 09	0	1	↑	0	✗
	Serious Incidents	BSW CCG	Monthly 2021 09	24	20	N/A		N/A

BSW Oversight Framework Scorecard 2 of 4

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 09	(+)£263,000	(+)£76,000	↓	0	✓

Primary Care & Community Services

	Indicator	Organisation	Frequency / Latest Period	Previous value	Current value	Change from Previous	Target or Standard	Meets Target / Standard?
Improvements for people with conditions such as diabetes, CVD and obesity	Number of Referrals to the NHS Diabetes Prevention Programme	BSW CCG	Monthly 2021 09	463	309	↓	337	✗
Primary and community services including new community services response times	2-Hour Urgent Response Activity	Wiltshire Locality	Monthly 2021 09			→		N/A
	Access to general practice – number of available appointments	BSW CCG	Monthly 2021 08	448,001	413,742	↓	420,971	✗

Screening and vaccination programmes

	Indicator	Organisation	Frequency / Latest Period	Previous value	Current value	Change from Previous	Target or Standard	Meets Target / Standard?
Screening and vaccination programmes meet base levels in the public health agreement or national goals	COVID Vaccination: % of adults vaccinated	BSW CCG	Monthly 2021 09	87.00%	88.10%	↑	90%	✗

BSW Oversight Framework Scorecard 3 of 4

Mental Health

Deterioration
Improvement
No Change

Below Standard ✗
Meets Standard ✓

	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 08	6,660	6,655	↓	6,038	✓
	IAPT Access - Patients entering treatment	BSW CCG	Monthly 2021 07	3,135	3,100	↓	5,697	✗
	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 07	400	580	↑	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%	21.21%	↑	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%	7.58%	↓	12%	✗

BSW Oversight Framework Scorecard 4 of 4

Restoration of elective and cancer services*

Deterioration
Improvement
No Change

Below Standard ✗
Meets Standard ✓

	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 08	466	443	↓	498	✗
	RTT Incomplete 52+ wks	BSW CCG	Monthly 2021 08	2,008	2,022	↑	0	✗
	Numbers of patients seen in a first outpatient appointment following urgent referrals	BSW CCG	Monthly 2021 08	3,345	3,283	↓	3,387	✗
	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 09	108	102	↓	52	✗
		RUH	Monthly 2021 09	173	206	↑	110	✗
		SFT	Monthly 2021 09	137	160	↑	90	✗
Diagnostic Activity Levels	Diagnostic Activity Against Plan	BSW CCG	Monthly 2021 09	5,734	5,883	↑	5,937	✗
Elective Activity Levels	Daycase Activity Against Plan	BSW CCG	Monthly 2021 09	1657	1686	↑	1820	✗
	Elective Activity Against Plan	BSW CCG	Monthly 2021 09	226	235	↑	311	✗
	Outpatient Activity Against Plan	BSW CCG	Monthly 2021 09	16,596	18,312	↑	18,270	✓

date		BOARD 19 November 2021	BOARD 28 January 2022	BOARD 1 April 2022
venue		virtual, in public	virtual, in public	in person, in public
time		9:00-12:00	9:00-12:00	9:00-12:00
paper deadline		10/11/21	19/01/22	23/03/22
send / publish				
Standing items	Declarations of interest - note		Declarations of interest - note	Declarations of interest - note
	Minutes of the Previous Meeting - approve		Minutes of the Previous Meeting - approve	Minutes of the Previous Meeting - approve
	Actions from the Previous Meeting - note		Actions from the Previous Meeting - note	Actions from the Previous Meeting - note
	Qestions from the public - note		Qestions from the public - note	Qestions from the public - note
Performance / monitoring	Chair's Report - note		Chair's Report - note	Chair's Report - note
	SRO's Report - note		SRO's Report - note	SRO's Report - note
	BSW Performance quality and finance report - note		BSW Performance quality and finance report - note	BSW Performance quality and finance report - note
			Transformation work streams, update report	Transformation work streams, update report
Assurance, Governance	ICS development programme update - note; R Smale, B Irvine •ōutcomes of engagement with first draft ICB constitution •ūpdate from ICS development programme work streams		ICS development programme update - note; R Smale, B Irvine	
				formal approval / endorsement of ICB governance docs (ToRs, SoRD, SFI, Governance handbook) - approve
				MoU for 2022/23 incl. operating plans (cf. planning guidance 21/22, 2.3) - agree
			System approach to risk - note	start-up' of ICB, report re close-down of CCG / transition of CCG functions - note
Operations				
	Deep dive: Digital - note, J Young		Deep dive: Mental health	
Strategy, policies	BSW Urgent Care Strategy - approval; E Smith			formal approval of ICB policies - approve
				BSW Green plan - approve