Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of ICB Board

Date: Thursday 2nd March 2023
Time:
Location:

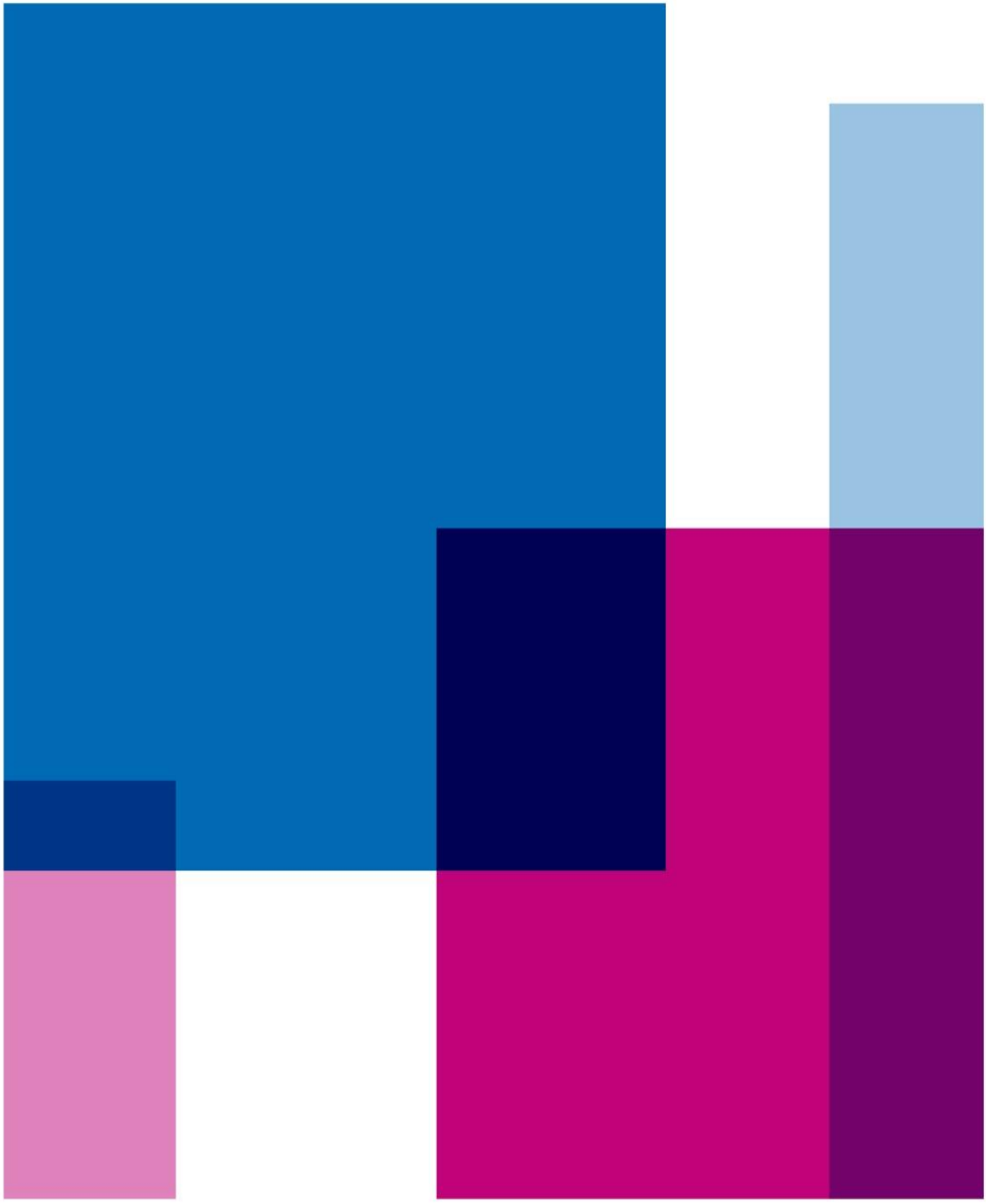
Agenda Number :	5		
Title:	Chief Executive Update – March 2023		
Confidential Papers		**Commercially Sensitive**	No
		Legally Sensitive	No
		Contains Patient Identifiable data	No
		Financially Sensitive	No
		Time Sensitive – not for public release at this time	No
		Other (Please state)	Yes/No
Purpose: For Information			
Key Points for Discussion:			

The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.
The main areas of discussion this month are;

- **ICB Organisational Structures – Focus on Integrated and Primary Care**
- **Winter headlines – Visit from Lesley Watts, NHS National Lead for Discharge**
- **ICS Strategy**

Recommendations:	To note the current position
Previously Considered By and feedback :	No other groups
Management of Declared Interest:	No declared interest

Chief Executive Briefing – March 2023



Shaping better health

Purpose

The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues since the last board meeting, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.

The main areas of discussion this month are;

- **ICB Organisational Structures – Focus on Integrated and Primary Care**
- **Winter headlines – Visit from Lesley Watts, NHS National Lead for Discharge**
- **ICS Strategy**

ICB Organisation Structures

The senior executive appointments are now complete with Jo Hicks started in the role of Chief People Officer on the 27th February.

The Executive Team have been moving forward with the next stages of reorganisation. The team have now developed a proposed new operational structure, below executive level, and the details are in the process of being consulted throughout the organisation. The changes have been designed on the basis of transitioning staff into new directorates and then transforming from within their new teams.

As the board are aware we have a timescale linked to different phases of the transition and transformation. As of the 2nd March we are coming to the close of phase 3 with the formal consultation closing on the 10th March,

Phase 1 This is where we will talk to individuals and teams about transitioning work areas, which need to move into their new directorate.

Phase 2 This is where executives, in discussion with their teams redesign their structures (if necessary). Not all directorates will need to do this. We will also carry out an analysis of the new structures to decide on the best change management approach, which causes the least disruption to teams and individuals.

Phase 3 During this period, we will engage with everyone about the new structures and carryout any formal change management consultation with affected staff.

Phase 4 is when we implement the transformation. We expect this to last from the beginning April to the end of May.

Directorate of Primary and Integrated Care

During the consultation period it has become clear that the proposed changes in the Directorate of Primary and Integrated care have drawn considerable interest from partner organisations. As Chief Executive I have received representation for local authorities, GPs, VCSE and individual staff members questioning the proposals. Although the consultation was not a public one, it was a consultation with staff with regards to their employment, I felt it was important to understand the feedback from partners.

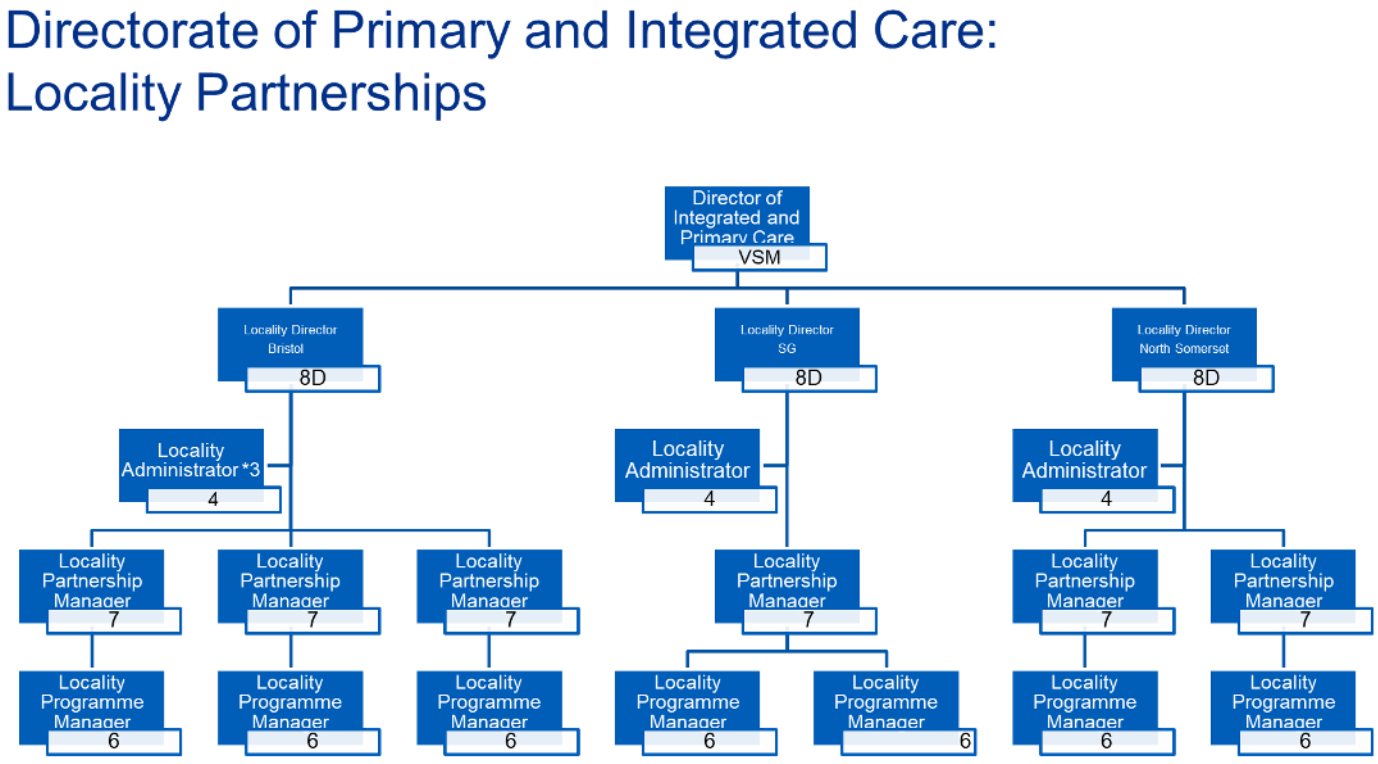
Background to the Proposals

At the heart of the proposal is the intention to put the ICB support to localities on a solid footing. In 22/23 a total of £2.4 million was invested in localities spread across six delivery directors, programme support for the creation of the community mental health service and organisational development. This money was non recurrent and is not available in 23/24.

The executive team were faced with the challenge to create a structure to continue the support for locality development, but from within the recurrent envelope of the newly formed Directorate of Primary and Integrated Care. A number of principles were defined to guide the design of the structure.

- Learn from experience of 22/23 and non-recurrent capacity
- Enable continued development and delivery of Locality Partnerships
- Manage within recurrent funding envelope
- Enable balance of senior strategic leadership and programme/project delivery support for all localities
- Keep the number of staff effected by change to a minimum
- Maintain relationships at System, Local Authority and Locality level.
- Locality Partnerships to draw down further ICB Transformation support through Gateway Prioritisation process and further business support through the ICB business partner model for Business Intelligence, Finance, Contracts and People function
- Locality Partnerships are " Partnerships ", not ICB structures and therefore they will develop a distributed leadership through partners

Proposed Structure



It is proposed that to balance senior leadership, with delivery support and within the financial envelope. The proposal is that the current non recurrent structure of six delivery directors (Band 8d) six heads of locality (Band 8c), one in each locality, should be replaced with three senior leaders each aligned to a Local Authority. Then there should be enhanced delivery support within each locality with a Locality Partnership Manager and a Programme Manager in all six.

Learning from Partners

Initial reaction, from a range of partners, has not been positive. The changes were viewed as a considerable reduction in resources and potentially a signal of a lessoning of support, from the ICB, for localities. A number of stakeholder meetings have been held by the me and the Director of Primary and Integrated care to understand the reasoning. Key leaning from the meetings have included.

- The understanding of the non recurrent nature of the current financing was not fully appreciated. Many were not aware that the existing funds would cease in 2023/24.
- The approach to consultation focussed on our duty as an employer without fully taking account of the impact that would be felt by partners in the system.
- The proposed changes were being viewed in isolation of the complete resource that all partners bring to the localities.
- The uncertainty of continued resources to deliver services, rather than leadership resources, led to a potential mistrust of the process.

- There is a need to clearly articulate the operational model of partnership locality working, not just the ICB funded structures.
- All stakeholders are passionate about locality working and all partners want the model to work.

Next Steps

From a consultation perspective the stakeholder meetings have provided considerable insight into the potential future model of localities. These insights will provide a valuable input into the process and along with staff feedback will enable the final model to be fit for purpose.

Winter headlines – Visit from Lesley Watts, NHS National Lead for Discharge

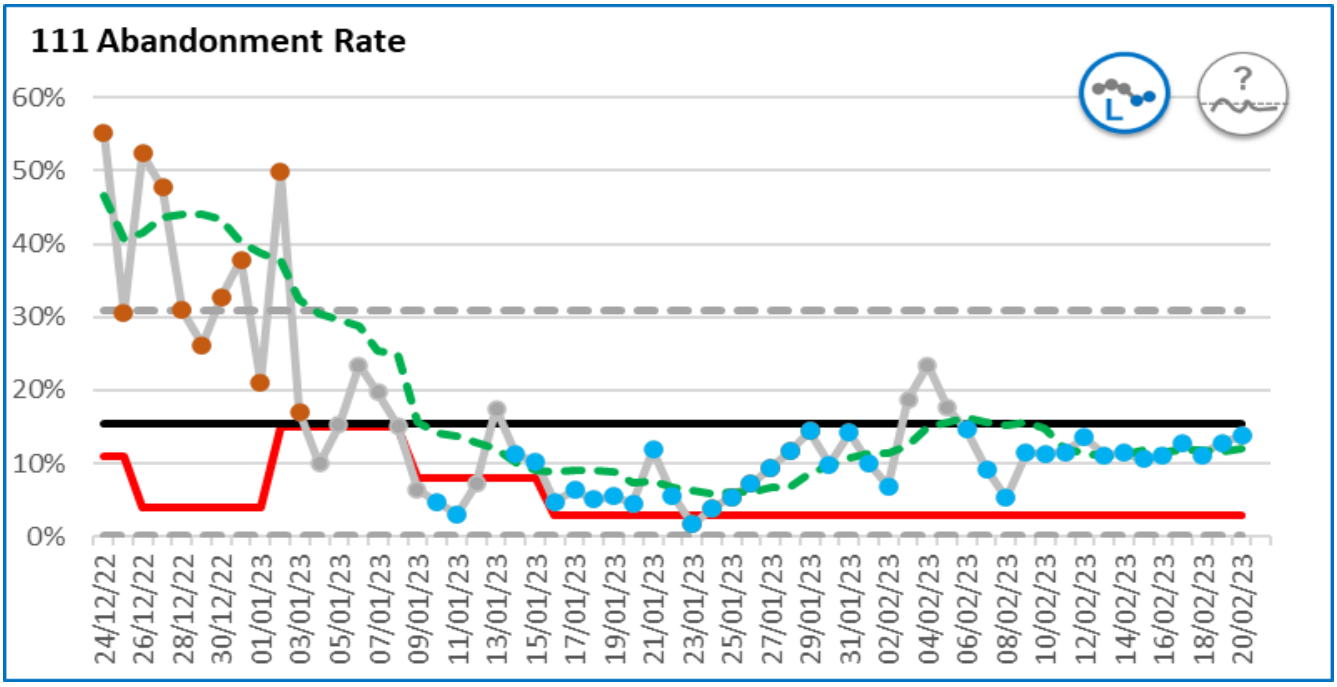
On 23rd to 25th February the system hosted a visit from the Lesley Watts, NHS National Lead for Discharge. The purpose of the visit was to explore how we were managing flow, with a particular focus discharge, and to provide an insight into potential opportunities for further improvement.

We began by describing our system's ambition to deliver a technology enabled home first model of care. This will be delivered by shifting our focus to a preventative and anticipatory system delivered through strong locality partnerships. We also explored how the additional winter discharge resources have had an impact on the challenge of 'No Criteria to Reside' NCTR and how we have performed as a system during winter.

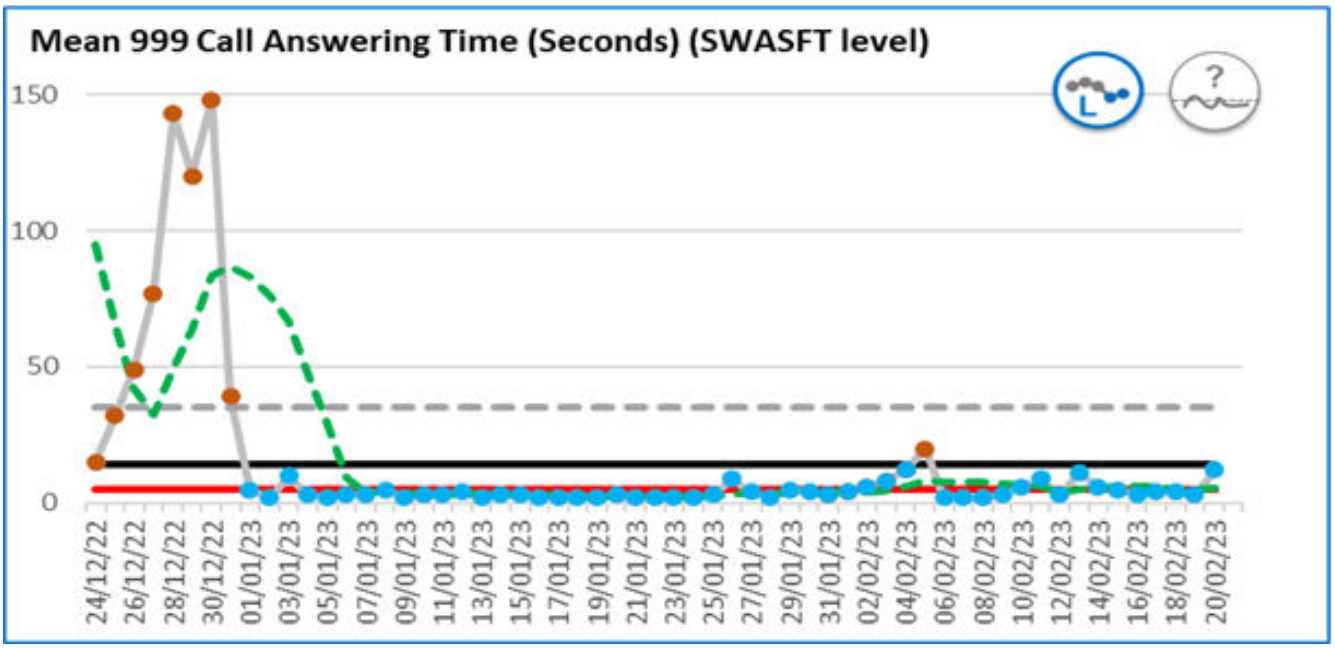
In advance of winter, NHS England outlined six key measures that systems would be held account for delivering over the winter period.

1. 111 Abandonment Rate
2. Ambulance Category 2 Mean Response Rate
3. % of G&A Beds Occupied
4. Mean 999 Call Answering Time
5. Operational Time lost to Ambulance Handover Delays
6. % Beds Occupied by NCTR Patients

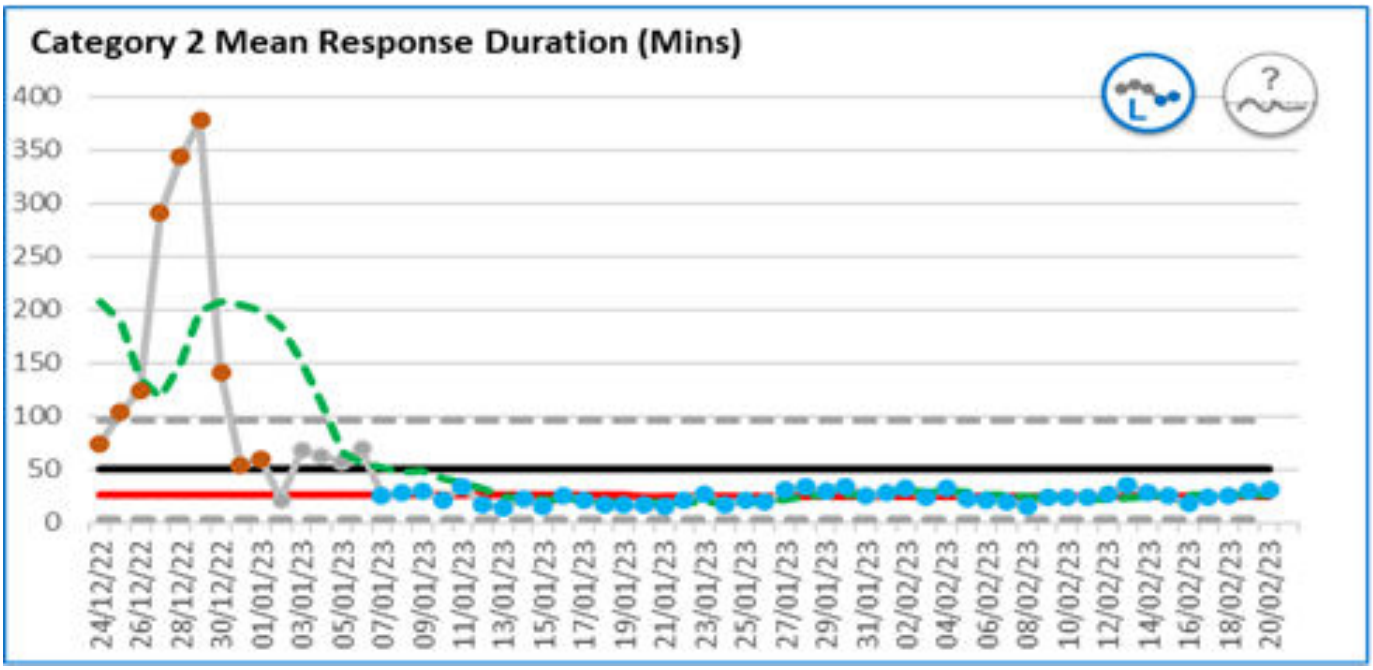
The graphs overleaf indicate the system performance since the end of December. As can be see there is a considerable improvement in overall performance reflecting the significant partnership activity to grip the winter flow challenge.



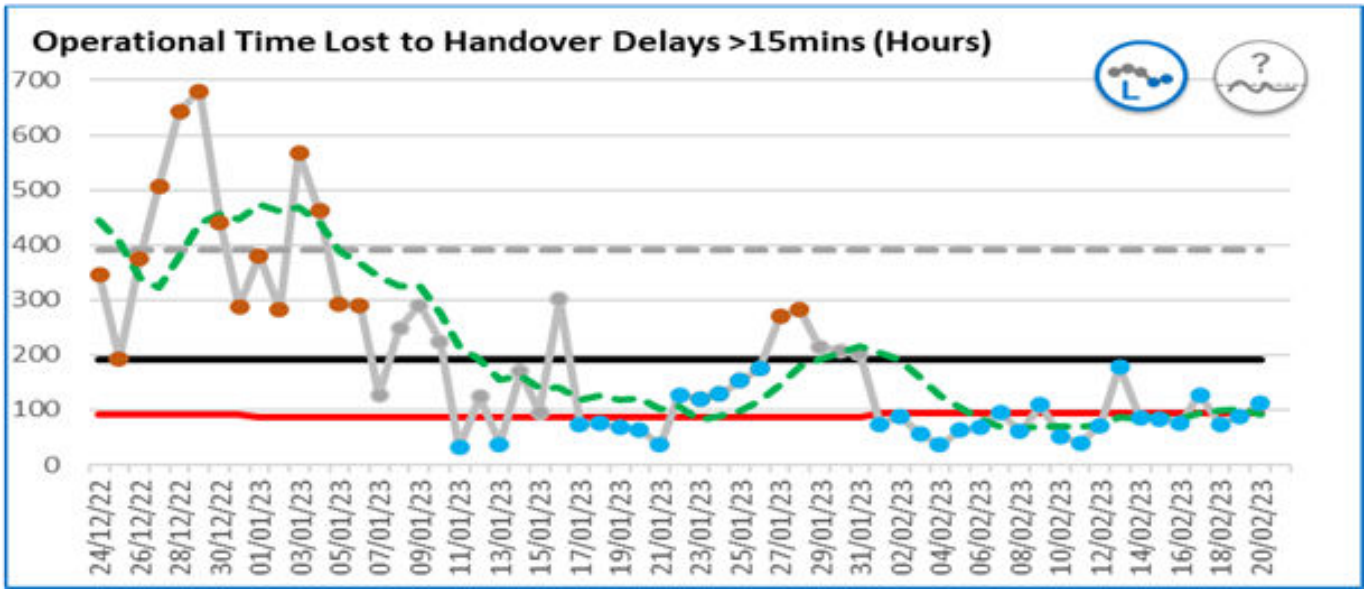
As can be seen above, the 111 call abandonment rate over the Christmas period was at times over 50%. It is now averaging circa 10-12%. Although there is still room for improvement this level of service provides a strong start to the patient journey and will help to get patients key information to ensure that they get on the right pathway.



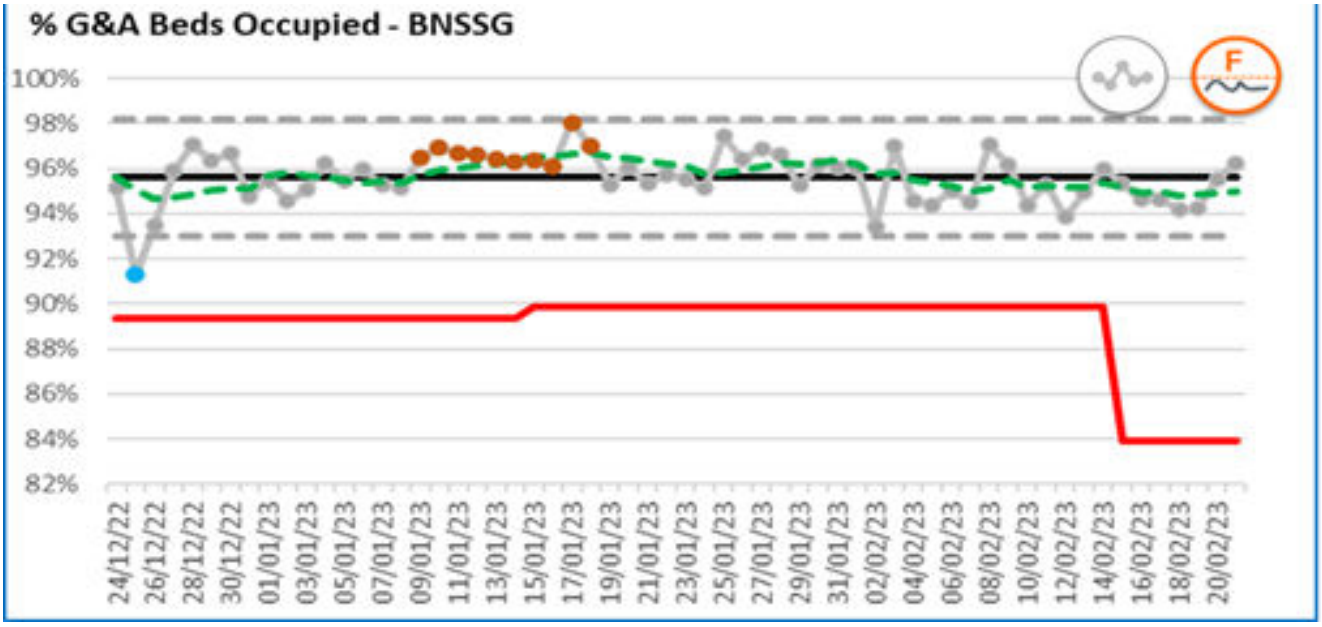
The mean 999 call answering time has fallen from a high of two and a half minutes to averaging 5 seconds in the last 7 days.



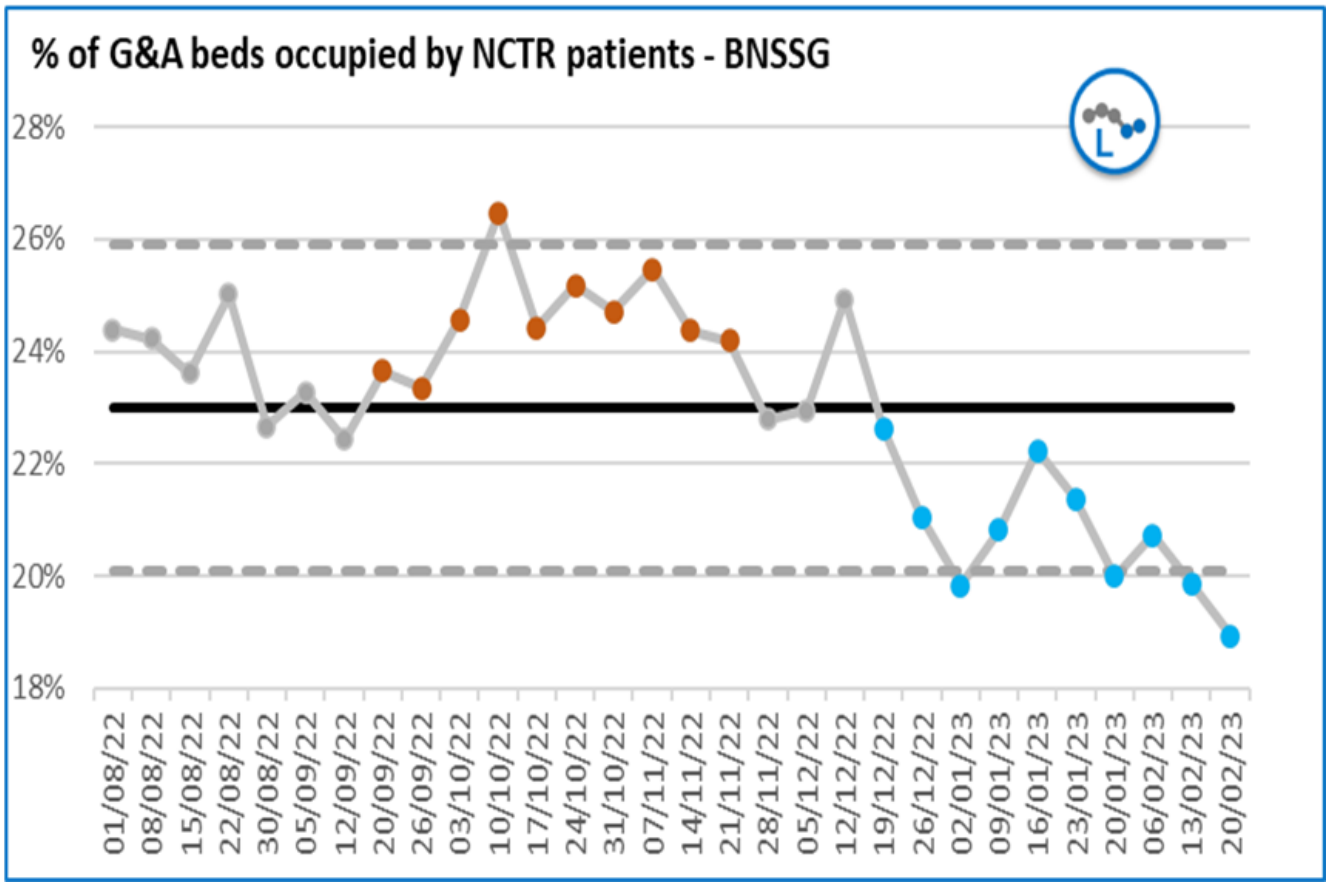
Category 2 Ambulance Mean Response Time is viewed as a major patient safety indicator and is driven by many factors including availability of crew resource and ambulances delayed at the handover of patients at hospital emergency departments. The performance in this area has shown a major improvement.



Operational time lost to ambulance handover delays has followed a similar pattern to the other indicators however the improvement is not as marked and continues to have considerable variability.



The graph above shows the percentage of beds occupied remains high and has shown a small reduction and is averaging between 96-97%. This will be is a key target in the 2023/24 operating plan and considerable further improvements are required with BNSSG.



As can be seen in the graph above there has been a consistent improvement in the % of G&A beds occupied by patients with no criteria to reside. Although this a welcome reduction it should be noted that considerable bedded community capacity was increased over the period as a short term solution.

ICS Strategy

In December of last year, the BNSSG Integrated Care Partnership published a Strategic Framework. This document set out key principles and an overall approach as to how we should go about developing an integrated care strategy for the system..

Building on the work that is already in train within BNSSG, the ICP is clear on the importance of focussing initially on a small number of key strategic priorities. This will support our collective aims to improve outcomes, reduce inequality, derive good value for money and promote local social development

The ICP met again in late February to hear progress on the prioritisation framework that is being developed. It also agreed ways of collaboratively working together as a system – particularly in terms of ensuring a strong and equal role for the voluntary and community sector within our partnership. The ICB Board will take on responsibility for strategic delivery of the system priorities, supported by new recurrent investment in both anticipatory care and children's services. This will be coordinated through a joint planning process that will produce a draft strategy at the end of March and then a first full iteration at the end of June.