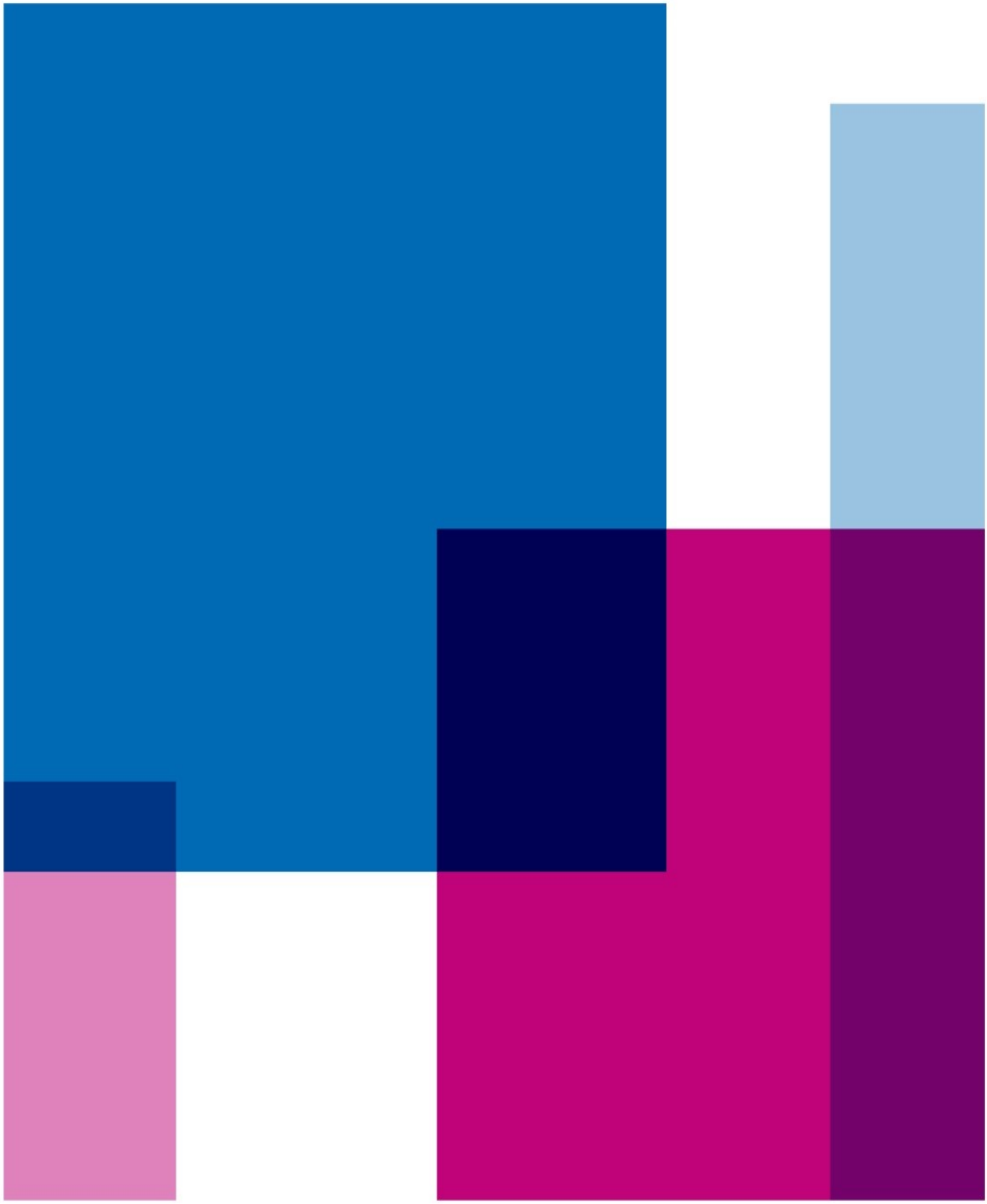
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG ICB Board

Date: Thursday 1st February 2024
Time: 12:30 – 15:45
Location: University of the West of England, Enterprise Park 1, Lecture Theatre, Long Down Avenue, Stoke Gifford, BS34 8QZ

Agenda Number :	5	
Title:	Chief Executive Update – December	
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** • **Winter update** • **ICB / ICP Workshop – Next Steps for the ICS**		
Recommendations:	To note the current position	
Previously Considered By and feedback :	No other groups	
Management of Declared Interest:	No declared interest	

Chief Executive Briefing – February 2024



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**
- **Winter update**
- **ICB / ICP Workshop – Next Steps for the ICS**

ICB Organisation Structures

As agreed at the May 2023 Board Meeting we are taking an engaged approach to the reorganisation of the ICB as is required by NHS England to ensure that running cost reductions are achieved.

In March 2023 NHS England wrote to all ICB's to advise us that we needed to reduce our running costs by 30%; the formal request is for this to be delivered in two stages - 20% to be delivered by the end of 2024/25 and 10% to be delivered by the end of 2025/26.

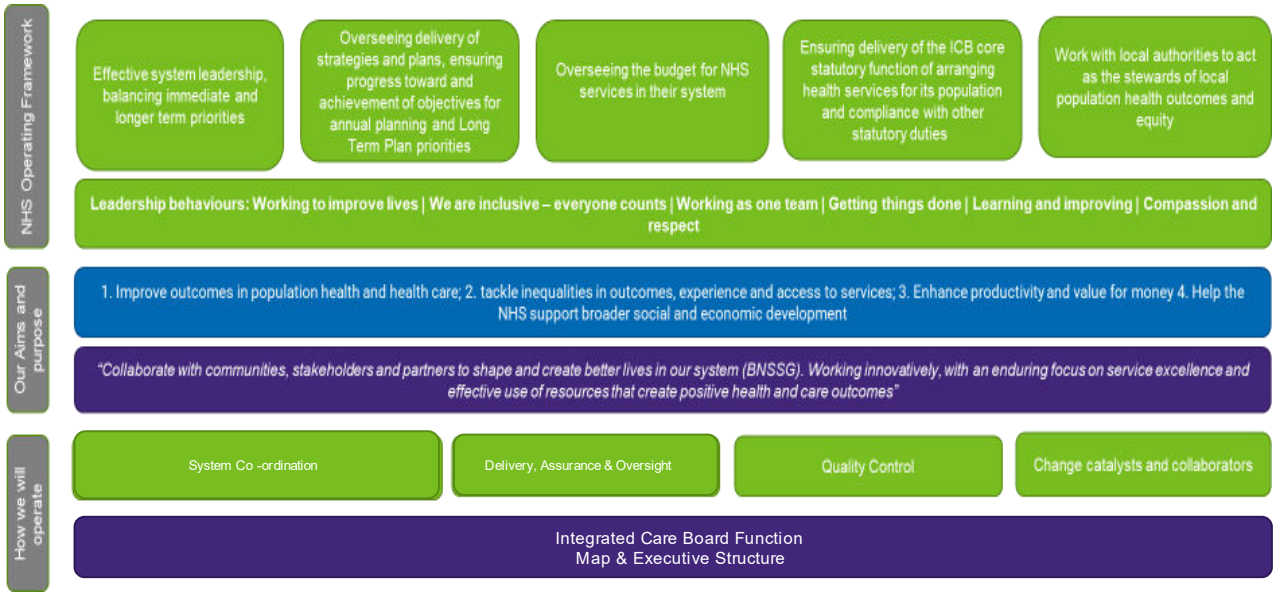
We are approaching this as a single stage process of restructuring the ICB to achieve the required savings – this is to create the headroom to plan and balance the books in the second year. NHSE require us to have an agreed final plan by March 2024 to achieve the whole of the 30% reduction.

NHSE have confirmed, that whilst they will seek assurance from ICBs that plans are on track on a regular reporting basis, the governance and decision making for how the RCA efficiencies are achieved sit within the ICB.

The work undertaken by ICB staff, system partners and supported by NECS has culminated in the development of a collaborative purpose statement and new BNSSG ICB operating model.

The operating model is set within the wider context of the NHS national and regional requirements, it is built to enable the future delivery of the ICP Strategy through clearly articulating the purpose and aims of the ICB, its role and how it will operate.

BNSSG ICB Operating Model



In support of the operating model a number of high-level function maps and executive structures were consulted on at the Executive layer of the organisation only. Following consultation, the function map and executive Chief led structure were agreed and executive directors confirmed into Chief Officer roles.

The consultation on the full reorganisation was open from 11th December 2023 and ran until 24th January 2024. The consultation responses are now being reviewed and assessed by the Executive Team. It is proposed that we will share the outcome of the consultation in the week beginning 19th February 2024.

In addition to staff responses to the consultation there have also been a small number of responses from partners. These will also be considered by the Executive Team over the same period.

These are very challenging times for all of us and whilst we review and revise our operating model, our staff are continuing to do the day job and deliver on key pieces of work to improve the lives of the population.

Winter Update

As explained in previous reports, winter planning began at the start of the year and we have allocated approx. £40m extra recurrent investment to high-impact urgent/emergency care and discharge/rehab interventions which ramp up during the challenging winter months

Our plans will help to reduce unnecessary hospital admissions by delivering more urgent care outside of hospitals and helping emergency patients return home on the same day (£16.5m extra investment). They will also support faster hospital discharge and reduced length of stay through improved discharge planning and extra community rehab capacity (£20m extra investment)

Other schemes allocated extra investment include ARI hubs, system CAS and SWAST additional crews (£4.1m)

A 24/7 System Co-ordination Centre has been launched to monitor system capacity and performance, and bring partners together to manage winter pressures

- Urgent and emergency care schemes:
    - Expansion of **Urgent Community Response** teams, providing urgent care to people in their own homes to reduce hospital admissions (approx. £1m of additional winter investment)
    - **System Clinical Assessment service**: Expansion of clinical team working with NHS 111 to assess and treat patients who would otherwise be routed to ED/999 (additional planned investment of £1.4m FYE.)
    - Expansion of **Same Day Emergency Care** (SDEC) services at each of our three hospitals, providing senior clinical review, diagnostics and treatment to enable patients to return home the same day and minimise the number for overnight admission (£3.6m FYE)

- Home first/discharge schemes:
    - **Discharge to Assess**: Increased community rehab capacity, with a focus on home-based pathways to support faster discharge and reduce hospital length of stay (£5.6m FYE.)
    - **Transfer of Care hubs** at each ED: increasing multi-agency capacity for discharge planning from hospitals, to support faster discharge from hospital (£5.7m FYE across three hospitals)
    - **NHS@Home/Virtual wards**: Increased virtual ward capacity to support admission avoidance and earlier discharge (£7.2m FYE)

- Other schemes, with non-bed impact
    - **Community Acute Respiratory Infection** (ARI) – dedicated PCN sites to manage patients with acute respiratory infections (£0.6m FYE)

- Additionally, we have invested in comprehensive staff flu and Covid vaccination to protect our workforce over the winter period and continue to deliver vaccinations to our local communities.

Summary at the end of January

- Following system pressures in December, very high levels of escalation capacity have been in use throughout the month. This has made the system fragile to variations in rates of demand or discharge.

- Both acute Trusts reported continuous Operational Pressures throughout January, culminating with North Bristol Trust declaring an internal critical incident on Thursday 25th January. NBT had a sustained high level of attendances and subsequent admissions to the hospital through the Emergency Department. There had not been the required level of discharges to meet the demand and therefore all escalation capacity has been exhausted. The hospital has seen intermittent levels of pressure since December 2023 and has in the main recovered to Opel 3 following short periods of OPEL 4. The hospital had been

declaring OPEL 4 since 20th January and had not recovered the position and on the 25th January declared a critical incident due to patient safety concerns relating to hospital capacity

Performance summary

- Ambulance handover delays have increased significantly since mid-to-late January following a period of relatively low delays over Christmas and in the period following new year, which coincided with the latest doctor industrial action. Category 2 ambulance response times have exceeded the 30 minute interim national standard during this period though these have been reduced to a degree by an expansion of pre-ED queueing at all three acute sites.

- Type 1 ED attendances and admissions have surged over the previous week.

- Over the last week norovirus, flu and covid infections has impacted acute flow through the restriction of a significant portion of the G&A bed base in line with infection prevention and control processes, particularly at Weston General which peaked with near 60 restricted beds. These bed restrictions are on a downward trend but remain high.

- Escalation capacity usage remains very high at circa 130 beds across the system, similar to the ceiling capacity of circa 140 beds in use in early-to-mid December. This lack of headroom creates challenges in the system's ability to deal with natural variation in demand for beds and therefore increases ED and ambulance queueing.

- Acute NCTR numbers have increased at both acute trusts from 'pre-winter' levels in September, growing circa 6% at UHBW and circa 20% at NBT. Both sites have improved in late January from historically high levels seen in mid-December and early January . The delays are driven largely by waits for D2A P2 and P3 capacity.

- There has been a recent increase in utilisation of Section 140 of the Mental Health Act; a joint ICB-AWP review of policies and root causes is underway and will report to the Performance Oversight Meeting and Mental Health ODG. This includes system actions to unlock delayed discharges to the community from acute MH settings.

Actions

In addition to the underlying winter plan, system actions taken ahead of the Christmas period included:

- Cancellation of community planned therapy, plus introduction of 'overbooking', to support Pathway 1 and aim for 30+ discharges per day. This has reduced the P1 waiting list to levels seen at the start of December.
- Additional temporary purchase of additional community beds:

  Pathway 2 = 20 beds
  Pathway 3 = 29 beds
  Additional beds since last report = 9
  Total 58 beds.

More recently actions include:

- Both acute trusts have reviewed and increased inpatient escalation capacity as well as waiting area/ corridor capacity for cohorting patients awaiting handover from SWAST. Much of this capacity is in sub-optimal settings, such as doubling capacity of side rooms and using of non-clinical areas, following clinical risk assessments.

- On 1st February we will be discussing plans for clinical visits between acute and community sites to share learning around creation of bedded escalation capacity to support flow.
- Revisiting operational oversight and performance oversight of D2A pathways, especially P2 and P3, with recommendations being made to the Performance Oversight Meeting (POM) on 8th February.
- As of 29th January a second daily 1630 system flow call has been escalated to executive level and taking place across all system partners.
- Ongoing work between acute trusts and Sirona to explore use of bank staff to support D2A capacity.
- A joint review of MH inpatient flow and escalation procedures, including use of S140.
- Demand and capacity modelling is in train to advise on internal system standards for length of stay and daily flow across all discharge pathways (including P0) to support day-to-day operational system management.

ICB / ICP Workshop – Next Steps for the ICS

On the 11th of January 2024 the Integrated Care Partnership (ICP) and the Integrated Care (ICB) came together to begin to define who best the two structures can work closer together to ensure that the integrated care system delivers value for the population.

The purpose of this first facilitated session, was to set out the respective roles and responsibilities of the ICP and ICB boards, based on the high-level distinction of the ICP setting the "what" in terms of ICS strategy, and the ICB Board attending to the "how" in terms of its delivery. The workshop aimed to agree how formal processes could be set up to ensure that the 2 groups keep each other informed and coordinate their respective work which will complement each other's objectives of meeting the ICS 4 aims and the objectives of the ICP Strategy.

The workshop focused on two key areas;

1. Defining the roles and responsibilities of the ICP going forward – what are the differences between the ICP and ICB?
2. How the ICB and ICP interface, to support the delivery of the 4 key ICS Aims and the ICP strategy

The outcome of the workshop will be made available to all board members in due course, however as Chief Executive it highlighted to me some areas that require further consideration.

With regards to the roles and responsibilities of the two bodies there was a clear consensus about the strategy setting role of the ICP whist the ICB had the clear statutory responsibility for coordinating the delivery of strategy. However, when it came to the second area the clarity of understanding was not as obvious. Issues such as how the ICP continues to be involved in shaping and guiding the system, the role of the Health and Care Improvement Groups (HCIG) in delivering in line with the strategic direction and the regular feedback and learning between the two bodies require further actions.