# BNSSG ICB Board Meeting

**Date: Thursday 16th January**

**Time: 9:30 – 12:00**

**Location: Virtual, MS Teams**

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| **Agenda Number:** | 5 | |
| **Title:** | Chief Executive Report | |
| **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;

- Reforming Elective Care for Patients
- Developing a New Model for Community Health Services
- System Planning 2025/26

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|---|---|
| **Recommendations:** | To discuss and note |
| **Author(s):** | Shane Devlin |

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| **Sponsoring Director / Clinical Lead / Lay Member:** | Shane Devlin |

# Agenda item:5

# Report title: Chief Executive Report

## Introduction

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The main areas of discussion this month are;

- Reforming Elective Care for Patients
- Developing a New Model for Community Health Services
- Urgent and Emergency care Pressures

## Reforming Elective Care for Patients

On the 6th January 2025, NHS England issued guidance for the reform of elective care for patients. NHS England » Reforming elective care for patients.

This plan outlines a comprehensive reform of elective care with the goal of ensuring 92% of patients receive treatment within 18 weeks by March 2029. The key focus areas include empowering patients, improving patient experience, addressing health inequalities, and reforming delivery.

**Key Commitments**

1. **Empowering Patients**:
    - Enhanced patient choice and control over their care.
    - Expansion of the NHS App and Manage Your Referral website for better information and appointment management.
2. **Improving Patient Experience**:
    - Clear communication about care and waiting times.
    - Utilization of digital tools to enhance communication and reduce anxiety.
3. **Addressing Health Inequalities**:
    - Targeted interventions to reduce disparities in access to care.
    - Improved data collection to understand and address health inequalities.
4. **Reforming Delivery**:
    - Increased use of community diagnostic centres and surgical hubs.

- Adoption of new technologies and digital tools to improve productivity.

**Implementation**

- **Funding and Oversight**:
  - Financial incentives for providers to improve performance.
  - Regular oversight and support for challenged providers.
- **Digital and Data Use**:
  - Expansion of digital tools like the NHS App and Federated Data Platform.
  - Use of AI and automation to improve efficiency and patient care.

This plan aims to create a more efficient, patient-centred, and equitable elective care system.

Integrated Care Boards (ICBs) will play a crucial role in the reform of elective care. Our responsibilities include:

1. **Patient Awareness and Choice**:
   - Ensuring patients and their carers are aware of the new experience expectations for elective care and their right to choose their care by September 2025.
2. **Health Inequalities**:
   - Setting a clear local vision for reducing health inequalities as part of elective care reform.
   - Implementing interventions to reduce disparities for groups facing additional waiting list challenges by March 2025.
3. **Diagnostic Capacity**:
   - Making optimal use of new diagnostic capacity by implementing new standards for Community Diagnostic Centres (CDCs), including increasing direct referrals and rolling out at least 10 straight-to-test pathways by March 2026.
4. **Independent Sector Contracts**:
   - Ensuring contracts with the independent sector are in place to mitigate waiting list challenges and provide a broader range of diagnostic tests.
5. **Referral Optimization**:
   - Consistently optimizing referrals using Advice and Guidance (A&G) and effective triage to increase the proportion of patients treated in the most appropriate care setting by March 2026.

6. **Remote Monitoring**:
    - Expanding remote monitoring across all long-term conditions where clinically appropriate, helping to remove up to 500,000 lower-value follow-up appointments per year from 2026/27 onwards.

These roles are designed to enhance patient experience, reduce health inequalities, and improve the efficiency and effectiveness of elective care delivery.

The BNSSG operational delivery group (ODG) for Elective Care will carry out a detailed analysis of the guidance and identify the system wide actions to be undertaken.

## Developing a New Model for Community Health Services

At the heart of government's plans to improve the NHS is a commitment to move to a neighbourhood health service, with more care delivered at home or closer to home. The aims are to enable people to live more years of healthy, active and independent life and improve their experience of health and care, whilst connecting together and making optimal use of health and care resource, by enabling the three key shifts:

- From hospital to community: significantly more people to be cared for at home, helping them to maintain their independence for as long as possible, only using hospitals when better for people
- From treatment to prevention: the shift towards preventative and proactive care, including helping to reduce health deterioration or avoidable exacerbations of ill health
- From analogue to digital: greater use of digital infrastructure and solutions.

It is expected that as part of the planning processes for 2025 onwards NHSE will produce guidance to support ICBs to develop and implement new models of care. However in advance of the guidance we are developing our thinking in this space.

Within BNSSG our approach to community health services has been developed around localities. BNSSG has six Locality Partnerships, three in Bristol, two in North Somerset, and one in South Gloucestershire. Each Locality Partnership is diverse in terms of the population it serves and based around geographical boundaries. However, we know communities do not just exist in 'place' but within communities brought together as 'communities of interest' e.g. communities of identity. All six Locality Partnerships have been successful in bringing partners together to build positive relationships and align on key areas such as Community Mental Health and Ageing Well and have focussed on addressing inequalities within their communities. Each Locality Partnership has a Chair and a Locality Partnership Board who make decisions and work together for the needs of their population.

The ICP has recently commissioned a review of localities with a view to developing the potential next steps in this journey.

As Chief Executive of the ICB I am of the view that future model of community health services will be based around neighbourhoods, and we will need to understand how neighbourhood health will connect with our current locality structures.

There is considerable literature being developed on the topic of neighbourhood health and care systems. The NHS Confederation, PPL and Local Trust have produced a literature review of Neighbourhood Working PowerPoint Presentation which provides an excellent overview. It concludes that;

• Geography matters: these models are based around neighbourhoods that are meaningful to the people in them or have some coherent identity. These can be self-defined and may not map onto statutory boundaries.

• Listening to people: understanding the problems and the solutions that are needed through carefully listening to the community, rather than just to professionals, managers or individual representatives, is vital. Data and insights from the statutory sector are helpful, but this is not a substitute for continuing dialogue with community members themselves.

• Bringing together all the stakeholders: some models are not integrated in a formal sense but are made up of organisations and stakeholders with a shared purpose and a shared working model. Coordination and reduced fragmentation can be achieved through this and through developing everyone's understanding of the assets available in the community and roles in working with these.

• Building on neighbourhood Infrastructure: there are clear benefits from having access to a location or facilities to act as a focus for the work, but neighbourhood infrastructure also encompasses the relationships, informal groups and shared passions in a community. Good governance, professional management and coordination makes a difference but there is a very distinct style of facilitative management required to be successful.

• Investing time: developing a partnership way of working between neighbourhoods and other organisations, developing trust, learning to work together and establishing the other factors that result in success take time and patience. This also means that funding arrangements need a component that is stable and longer term.

• Measure impact: this is a consistent challenge, especially when addressing wider determinants or health. Continuous evaluation and learning often using qualitative information is needed to establish the effectiveness of different models of neighbourhood working.

Notwithstanding these lessons, there are significant barriers to be overcome and there is a particular challenge for those communities that have high deprivation and poor social infrastructure, cohesion or social capital.

It is my intention that we will engage with stakeholders over the coming months to further develop our thinking before establishing a major programme of implementation and change management.

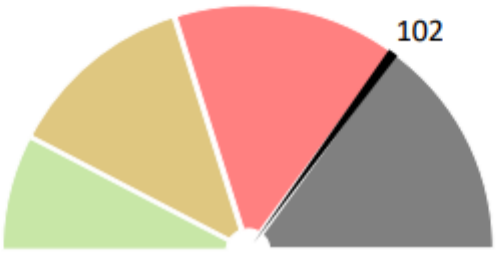
## Urgent and Emergency Care Pressures

BNSSG has developed a winter plan to support safe and effective care over the winter period and that is documented at 7.1.4 of these papers. However, as has been well publicised, the NHS has been under extreme pressure over the Christmas period and BNSSG has been in heightened system escalation. On the 9th January 2025 the system held an system escalation OPEL4 Gold meeting to address the extreme challenges. This agenda item describes the situation that we were in and the actions that were taken.

We re-entered system OPEL 4 on Friday 3rd January and managed our performance through the existing mechanisms. As Chief Executive I chaired a Gold meeting on the 9th January, all of our acute providers, Sirona and SWAST had been in a high level of escalation for the week. The figure below highlights the pressure in the system.

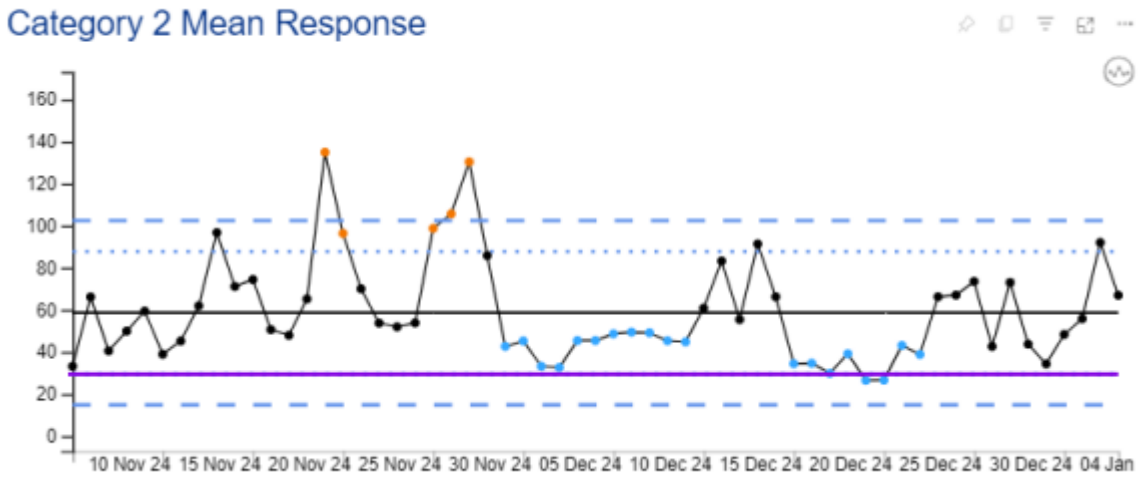
| Provider | Current OPEL Declaration | Weighting | Weighted Score |
|---|---|---|---|
| Sirona Care & Health | OPEL 3 | 3 | 12 |
| NBT | OPEL 4 | 3 | 24 |
| UHBW - BRI | OPEL 3 | 3 | 12 |
| UHBW - WD | OPEL 4 | 3 | 24 |
| UHBW - BRHC | | 1 | |
| AWP | OPEL 4 | 1 | 8 |
| Severnside | OPEL 2 | 1 | 2 |
| General Practice | | 1 | |
| Bristol City Council | OPEL 3 | 1 | 4 |
| South Gloucestershire Council | OPEL 3 | 1 | 4 |
| North Somerset Council | OPEL 3 | 1 | 4 |
| SWASFT | OPEL 4 | 1 | 8 |
| **BNSSG** | **OPEL 4** | 18 | **102** |

**Todays Date:**
**09-Jan-25**

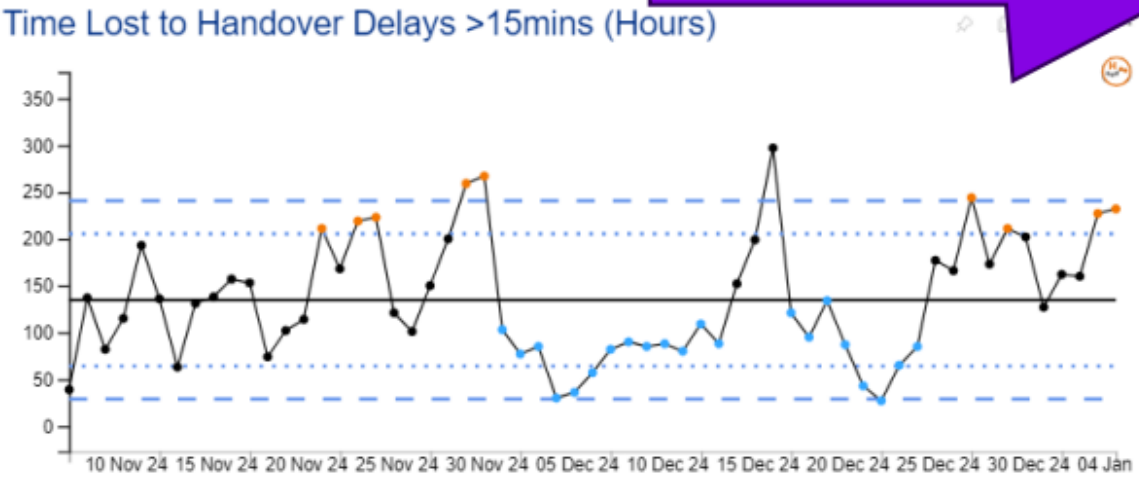


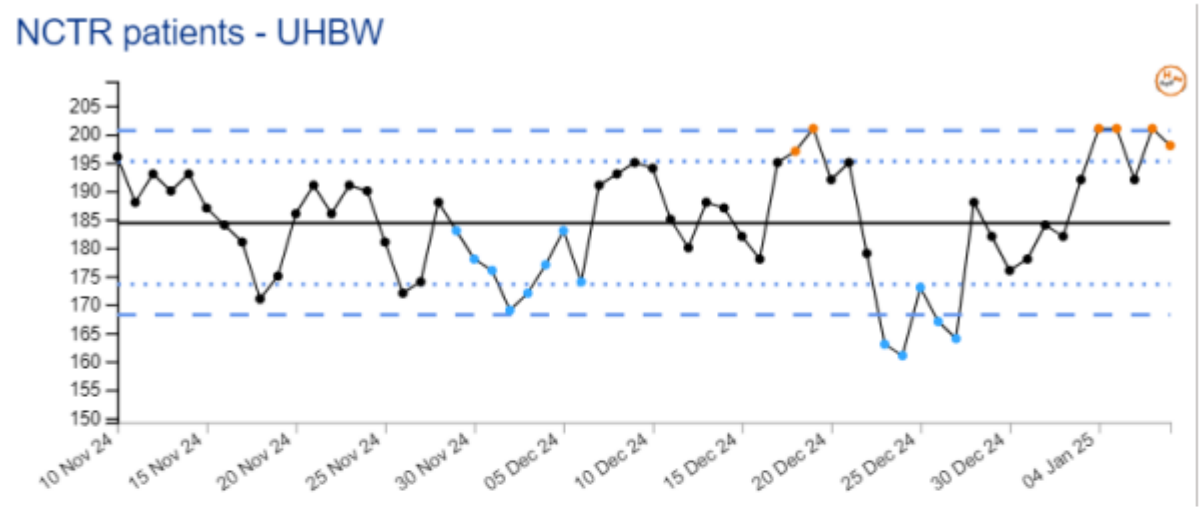

It was also clear that all systems in the South West were In a heightened escalation.

Other key winter metrics were under extreme pressure with Category 2 Ambulance Response Times, Time lost to handover, No Criteria to Reside and Escalation Beds at an extremely high level.




Handover time lost increased over the past week, corresponding above target performance for category 2 response




NCTR patients - UHBW
205
200
195
190
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150
10 Nov 24
15 Nov 24
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25 Nov 24
30 Nov 24
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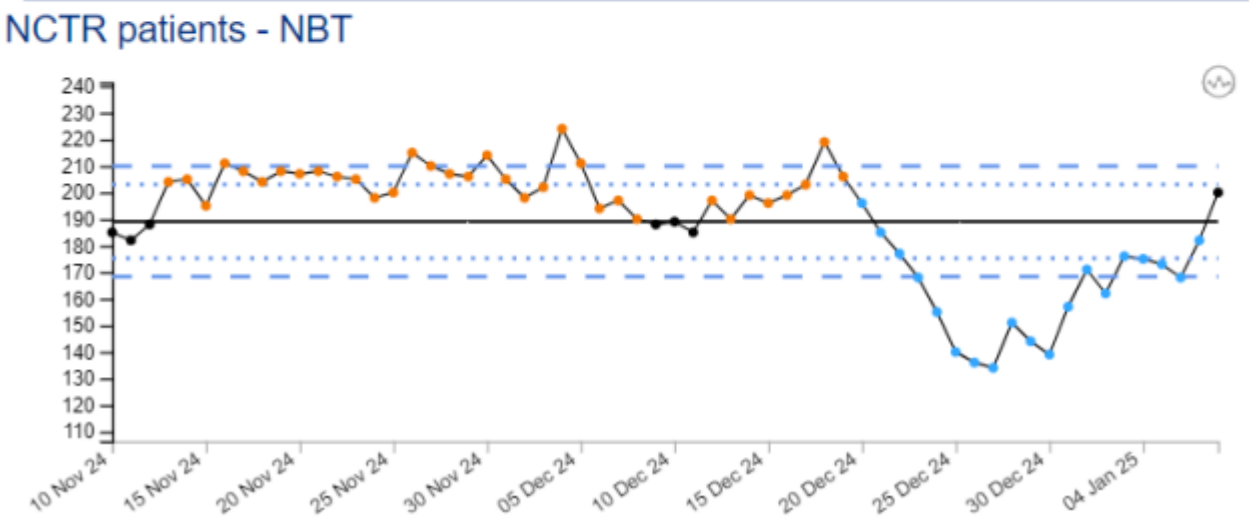
25 Dec 24
30 Dec 24
04 Jan 25


NCTR patients - NBT
240
230
220
210
200
190
180
170
160
150
140
130
120
110
10 Nov 24
15 Nov 24
20 Nov 24
25 Nov 24
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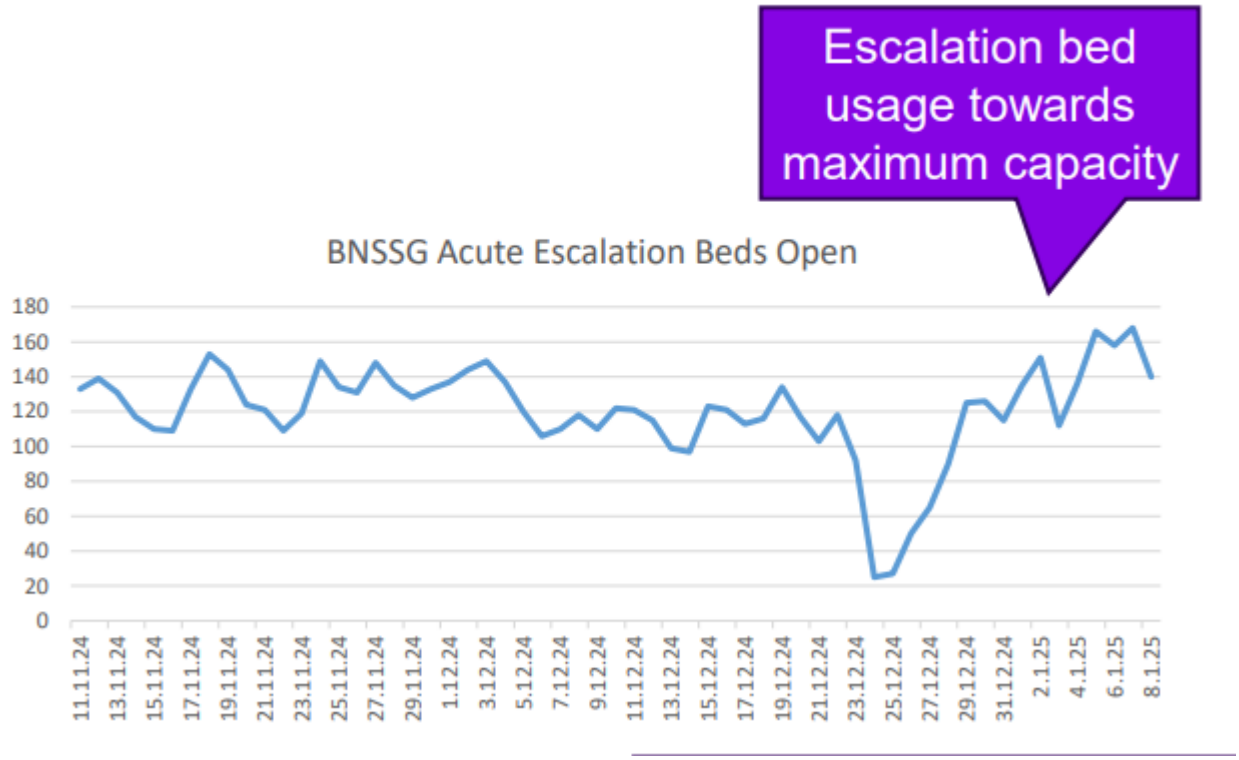
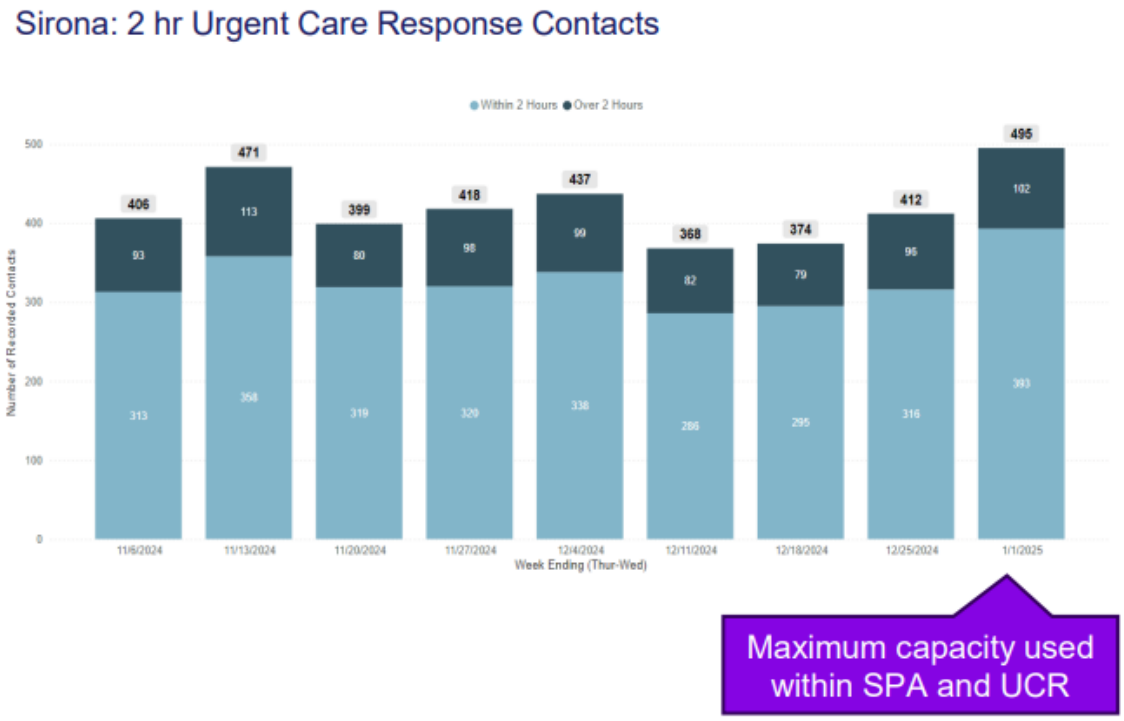
04 Jan 25




In addition the community demand was at maximum level



The members discussed the causes of the challenges including increased demand and complexity and the impact of Influenza. The members also reviewed the exceptional actions that had already been taken to increase capacity and flow, in addition to those documented in the winter plan (agenda item 7.1.4).

Five further potential actions, and costs, were presented and following robust discussions these were approved. The actions included

1. North Somerset – Bridging of patients from Sirona to the Local Authority
2. Individual spot purchasing of P3 beds for patients in UHBW
3. Individual spot purchasing of p3 beds for patients in NBT
4. Further investments in respiratory hubs (ARI Hubs)
5. Catch up and expansion of Flu Clinics.

The system remains under pressure but has reduced to Opel 3.