Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOARD MEETING

Date of Meeting: 27 September 2022	**Agenda item:** 07

Title of Paper: Operational Planning Performance Review, Quarter 1

Paper is for: (Please ✓)	**Discussion**		**Decision**		**Information**	✓

Executive Summary and Implications

This report gives a high-level overview of progress during quarter one of 2022/23 including operational performance metrics for the system, showing current performance and some of the actions in place to maintain/improve performance. The format and content of the performance report will develop as the assurance committees of the integrated care board develop.

The system is challenged, given the operational environmental and post pandemic challenges, and performance is not at the level we want for our population.

The Integrated Care Board (ICB) is not presently achieving its financial plan targets and recruitment to substantive posts has not reached planned levels. In turn, this has led to use of bank and agency over planned levels.

Urgent and Emergency Care (UEC)

- Nationally the NHS has had a challenging period with increased demand for UEC services
- Our system focus is on developing the winter plan and increase capacity and resilience within the system. This is overseen through our BOB (Buckinghamshire, Oxfordshire, Berkshire wide) and Place UEC (Urgent and Emergency Care) Boards.

Planned Care

- All waits of over 104 weeks have been treated except for a small number of complex cases
- Numbers of patients waiting over 78 weeks are reducing

Cancer performance remains a key challenge for the ICB with the highest proportion of patients waiting over 62 days for treatment in the Southeast.

Key performance metrics are included in Annex 1.

Action Required
The Board is asked to note the report and the challenges facing the system and the action in plan to address performance issues.

Date and Name of Committee at which Paper Reviewed: ICB Executive 12/9/22

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Date of Paper: 05/09/2022

Conflicts of Interest
This report contains information including the performance of organisations led by members of the Board. The perspective of these members is an important aspect for enable the Board to focus on where the ICB (Integrated Care Board) and system contribute to improvement.

No conflict identified	
Conflict noted: conflicted party can participate in discussion and decision	✉
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflict noted, supported paper withheld from conflicted party e.g., pecuniary benefit	
Conflicted party is excluded from discussion	

Operational Planning and Performance Quarter 1 review

Context and Overview

1. The paper outlines performance and progress on key aspects of the operational plans submitted by the ICS (Integrated Care System) and inherited by the ICB Board at the initial July meeting. The annex also outlines performance against national standards established through the five-year NHS plan.

2. Good progress has been made in several key areas including reducing long waiting times recovery to pre-pandemic performance, although delivery was impacted by the COVID wave that peaked at the end of June which affected both hospital capacity and staffing availability. At the end of June, the system presently has an £11m adverse financial variance against plan and is slightly below expected workforce levels.

3. The table below summarises our activity, finance, and workforce positions at the end of quarter 1.

Organisation	Finance	Workforce - Whole time equivalents			Elective Activity (against plan)				
	Variance to Plan (Deficit/ Surplus)	Staff in post	Planned staff in post	Variance	Elective + Day case spells	Outpat First	Outpat Follow up	Weighted activity*	Completed pathways
	(£000s)	30/06/2022	30/06/2022						
BHFT	147	4,564	4,675	-2.4%					
BHT	(82)	6,233	6,226	0.1%	76%	95%	85%	102%	86%
OHFT	261	6,395	6,662	-3.8%					
OUHFT	(3,994)	13,839	13,695	1.1%	88%	97%	110%	103%	86%
RBFT	(1,151)	5,711	6,115	-6.6%	96%	80%	108%	102%	89%
CCGs/ICB	(6,400)								
Primary Care		4,186	4,042	3.6%					
Total	**(11,219)**	**40,928**	**41,736**	**-1.9%**	**87%**	**103%**	**108%**	**102%**	**86%**

BHFT (Berkshire Healthcare Foundation Trust)/ BHT (Buckinghamshire Healthcare Trust) / OHFT (Oxford Health NHS Foundation Trust) / OUHFT (Oxford University Hospital Foundation Trust) / RBFT (Royal Berkshire Foundation Trust) / CCGs (Clinical Commissioning groups) become Integrated Care Board/ Primary Care – refers to general medical services only

Finance

4. The ICS's overall financial position shows an excess of expenditure over income of £12.7m for the first three months of 2022/23. Given a phased plan of a £1.6m deficit for the same period there is an overall adverse position of **£11.2m** compared to plan. £6.4m of the adverse variance is reported in the CCGs/ICB. However, £5.5m of this relates to the agreed £21.9m systemwide savings target. There is also a general developing difficulty to deliver the savings targets internal to each organisation. The ICS is £11.5m behind its CIP (Cost Improvement Projects) target – this includes the £5.5m relating to the ICS wide £21.9m.

5. Providers within the ICS report a variance of £4.8m. Of this figure £4.0m relates to OUH and a smaller sum of £1.2m at RBFT (Royal Berkshire NHS Foundation Trust). Agency spend is significantly above plan - £7.4m at this stage.

6. Whilst rising inflationary pressures have not resulted in significant overspends at this point, more pressures on future prices are becoming evident. This is apparent in many areas of expenditure including energy costs, continuing healthcare (CHC) fees, drug costs, etc. It is clear that energy prices with the continuing war in Ukraine will feature as a major risk in the months to come.

7. Provider capital spend is behind plan at this stage of the year, both in terms of actual spend and capital departmental expenditure limit (CDEL). However, it is expected that the rate of expenditure will increase as the year progresses. Therefore, a year end outcome of plan is anticipated.

Workforce

8. Due to a number of factors, including registered and unregistered nursing staff shortages, recruitment and retention remains difficult and there has been a rise in demand for temporary staffing to fill vacancies and staff rotas. Despite the use of Bank and Agency the system was 1.9% WTEs (Whole Time Equivalent) under plan at end of Q1 with the expenditure on staffing exceeding the planned pay budget by £12.1m driven by spend on agency and bank staff to cover vacancies and undertake extended or additional lists. The demand is driven by numerous factors that include rising sickness and absence, acuity, and a higher-than-expected demand for mental health nursing, and the need to maintain service levels.

9. Primary care WTEs at end of June are 3.6% higher than plan, meaning that general practice has invested in workforce. This is because of the increase in the budget allowing more Additional Roles Reimbursement Scheme (ARRS) roles to be recruited. The data show that the biggest increase is in direct patient care roles providing multidisciplinary care for our patients which supports the PCN (Primary Care Network) investment in ARRS roles.

10. A focus on recruitment and retention initiatives, such as international recruitment for registered staff, will be critical. RBFT held 98 interviews for UK and international radiology and have 247 candidates going through pre-employment checks. At the same time local controls and urgent actions to reduce agency spend including agency nurse approval required from Nursing Directors (RBFT) or ESR (Electronic Staff Record) Committee SCAS (South Central Ambulance Services)) and the Temporary Staffing Programme.

11. NHSE have set agency spend limits for each system and for BOB this is a 30% reduction compared to 2021/22 (i.e., a cap of £78.3m for 2022/23) and reinforced further the importance of this work. Medical agency rates have also risen in the priority because of the publication of the BMA (British Medical Association) Rate Card.

12. ***Non-medical agency***: while summer demand (measured in agency-filled hours) has been 21% higher than the same period last year, making it harder to lower rates with agency suppliers and workers, RBFT have proven the card can drive down hourly costs even when demand is high. Their approach is being adopted by other providers as best practice. Other actions being taken include working with NHSE Southeast regional team for support and to eliminate off-framework rates (end September 2022), "zero tolerance" approach to exception reporting, and reduce the number of agencies in use.

13. ***Medical agency rates:*** our providers agree to maintain their position in relation to BMA rates while making rates visible and accelerating a single Medical Rate Card with appropriate escalations / controls as soon as possible and before winter is an absolute priority.

14. BOB and Frimley CPOs (Chief People Officers) are accelerating their approach across this work to drive unit costs down and help change behaviours. This includes a dedicated bi-weekly session with BOB CPOs (started 2 September 2022).

Elective Recovery Activity Levels

15. The system has recovered activity towards pre pandemic levels although this has varied across trusts and has been impacted by staffing levels and some capacity constraints.

16. BOB Providers continue to experience larger waiting lists compared to pre-COVID levels with RBFT seeing the largest increase of 48%, OUH at 22% and BHT at 18%. Whilst the waiting list continues to rise, the growth is within patients waiting between 0 – 30 weeks, with the volume of patients waiting 31-51 weeks remaining steady within 2022, and the volume of over 52 week waits slowly reducing.

17. The initial focus has been to treat all patients waiting greater than 104 weeks and apart from a small number of complex patients these have been removed. Substantial progress has been made on reducing 78-week waiters across BOB. As of 14 August, there were 540 BOB patients breaching the 78-week target. BOB is currently ahead of trajectory and is aiming to have no patients waiting longer than 78 weeks by 31 December 2022.

18. Delivering value-weighted activity has been a challenge in Q1 despite that performance in BOB has been strong, delivering 102%[1] (compared to pre-pandemic levels). This compares well to the regional average of just below 100%. As a system we exceeded our Q1 plan.

[1] This includes advice and guidance diversions

19. Unvalidated data for quarter 2 suggest that trusts are struggling to maintain these levels due to staff sickness, funding constraints and workforce challenges. The number of episodes of care starting is also still greater than those stopping which also suggests increasing pressure on waiting lists.

Progress on other key areas of national operational plan delivery

Response to COVID-19

20. Our continued response to COVID centres on embedding our COVID Medicines Delivery Unit (CDMU), providing a comprehensive vaccinations programme and improvement in the long COVID pathway. In the first quarter of the year, we saw a peak of COVID admissions at the end of June and a significant impact on staff sickness which had an impact across all service delivery areas.

CMDU (COVID Medicines Delivery Unit)

21. Our trusts have continued to provide this service and have planned for service delivery through 2022/23 with potential for future surge. We are awaiting the Commissioning Framework due to be published by NHSE and NICE (National Institute for Health and Care Excellence) Guidance on COVID therapies in January 2023 to inform future plans and need to ensure sustainability of this service provision with best value for money in our ICS service model. The impact of delivery of this programme on wider services has been raised and will be kept under review.

Vaccinations

22. The spring booster campaign and evergreen offer have been maintained through Q1. BOB has achieved an 85.8% spring booster vaccination rate compared to the national average of 82.8% and making us 11th in the country as at 22 Aug 2022. Moving forward into phase 5 we will be ready by 5 September to vaccinate under the Autumn Booster campaign and will be prioritising care homes and the housebound. Access routes remain extensive with all patients able to access vaccination within 30 minutes.

23. The focus will remain on the inequalities cohorts with renewed emphasis on the health on the move van with a MECC (Make Every Contact Count) approach. Coadministration of flu and covid remains challenging but there will be an emphasis on this with our most vulnerable including inequalities and care homes. The vaccination team have been secured until March 2023 at which point it is expected that all vaccination will require review and alignment with the National all vaccination strategy.

Outpatients Transformation

24. PIFU (Patient Initiated Follow Up) is being rolled out widely with 45 specialities formally delivering and reporting. A new workflow is being developed to automate data collection and record clinical aspects of PIFU in EPR (Electronic Patient Record) for OUH as it is not currently possible to collect all data. RBFT are also looking at solutions for capture of PIFU numbers in Cerner. BHT have made substantial progress with spinal injuries being highest number of PIFU in BOB.

25. A&G (Advice & Guidance) all Trusts reporting and achieving standard. Increasing specialities in progress across all three Trusts. OUH to move to e-RS (e-referrals) once REGO (referral management system) is implemented between e-RS and the Cerner electronic record system to capture full clinical history. A pilot of REGO is planned to start in mid-October using ENT as the pilot speciality. Pathways are all agreed and ready to be uploaded. GP practices being recruited. Contract to be signed as soon as success criteria agreed by all parties.

Cancer

26. The ICS set out to achieve the target of returning the number of people waiting 62 days or more for cancer treatment to the February 2020 level (plans reduce waiting list to 360 against a target of 366). This position has proved extremely challenging over Q1 with our latest system position of 869 patients waiting over 62 days. This equates to over 11% of the total waiting list. Our most challenged provider is BHT with the particular tumour type challenge of skin, head, and neck, whilst OUH have a challenge with the urological pathway.

27. Key workstreams to support delivery of improvement across all cancer standards include:

- Extending coverage of **non-specific symptom (NSS) pathways**
    - Although we are below plan in this area we are the highest performing system within the Region with more than double the NSS referrals of the nearest ICB.
- **Timely presentation** and effective **primary care pathways**
- Best practice **timed pathways**
- Priority pathway improvement – **FIT (Faecal Immunochemical Test) testing** and **skin pathway redesign**
- **Targeted case finding and surveillance** – Targeted lung health checks, Lynch Syndrome, Liver Surveillance
- **Population Screening**

Diagnostics

28. BOB ICS is finalising the System Diagnostics Strategy which has been developed in partnership with clinical, operational, and managerial leads from the ICB, Providers, Networks and AHSN (Academic Health Science Network). The ICS did not plan to meet the ambitious national target of delivering 120% of pre-pandemic activity levels for diagnostics, we did plan to achieve 110%. Our 110% aim has been reached in

MRI, CT & Colonoscopy with flexi-sigmoidoscopy still proving to be the most challenged modality.

29. The additional capacity secured through the successful bid for continuity of revenue funding (£11.12m) from NHSE to support our three Community Diagnostics Centres (CDC) will contribute to recovery efforts. The ICS is also pursuing additional funding to support additional Endoscopy capital and a further increase in the provision of diagnostics supporting respiratory and cardiology pathways in accordance with the minimum CDC provision requirements set out by NHSE.

Maternity

30. Maternity services are making substantial progress on the 7 IEAs (immediate and essential actions) from the interim Ockenden report. NHSE are undertaking assurance visits at the acute trusts maternity departments across the Southeast. The visits are supportive in nature, whilst seeking assurance on progress towards compliance. Trusts develop action plans following the visits, which will be monitored within their clinical governance structures and through the LMNS (Local Maternity and Neo natal System).

31. To date, Oxford University Hospital and Stoke Mandeville Hospital have received their assurance visits, with Royal Berkshire Hospital scheduled to be visited at the end of September. The LMNS is shortly to receive the first action plan, for OUH, which will be presented at the LMNS Board and subsequently monitored by the Compliance Steering Group (formerly Ockenden Steering Group). The trusts will also be expected to share their action plans at their boards and clinical governance. The LMNS will support the trusts with their action plans and encourage peer collaboration across BOB.

UEC (Urgent and Emergency Care) & Community Care

32. The urgent care pathway continues to be extremely pressured and was impacted in quarter one by increased COVID rates and staff sickness. Trust have been working closely with SCAS to manage the clinical risk around handover delays. The system has struggled to reduce the number of patients who do not met the criteria to reside in acute and community beds and is looking to review delivery against the 10 best practice interventions outlined in the national 100-day discharge challenge.

33. The ICS has successfully secured additional £8m to support demand and capacity initiatives as we approach winter. The system has also submitted plans to develop virtual wards utilising the service development funding available allocated to the system.

34. The overall performance on urgent care standards across BOB is well below national targets but remains comparable with other system across the Southeast.

Primary Care

35. Focus has been on improving access with the roll out of advanced telephony and development of enhanced access schemes by PCNs (Primary Care Networks) in line with their contract for delivery from 1 October 2022. This will provide appointments in the early morning, into the evening and on Saturdays, develop the use of multidisciplinary teams, and support the maturity of Primary care networks.

36. Primary Care Networks continue to optimise the use of their additional role reimbursement scheme posts; there has been an increase of 80.59WTE between end of March and end of June with clinical pharmacists and social prescribing link workers being the most popular roles.

37. On 1 July 2022 NHSE delegated the commissioning of pharmacy, optometry, and dentistry to NHS BOB ICB. The SE (Southeast) region is currently taking an aligned Hub and Host approach to discharge commissioning responsibilities via ICB Committees meeting in common.

BOB Clinical Networks and Inequalities

38. These have developed and are working well to improve outcomes in population health and healthcare as per our 2022/23 Operational Plan.

39. BOB Integrated Cardiac Delivery Network: BP@Home (trail blazer pilot site) targeted for at risk groups including deprived areas, SMI (Serious Mental Illness), LD (Learning Disability) - to date 6,753 coded on the BP@Home pathway across BOB. 74% of this group have BP (Blood Pressure) less than or equal to 140/90. Detection and maximising medication for patients with Heart Failure in primary care with 84 practices (trailblazer pilot site)

40. BOB Integrated Stroke Delivery Network: Continue to make substantial progress on access to thrombectomy service and are developing a consistent BOB model for stroke rehabilitation.

41. BOB CVD (cardiovascular disease) prevention Group: Top 3 priorities have been identified as hypertension detection and management, increasing health checks and smoking cessation. Working with Public Health partners to increase health checks (looking at supplementary providers not just through GPs) e.g., health checks for RBH staff. September public hypertension campaign “know your number,” training for healthcare professionals and refocus on management of hypertension in GP practices. Also, community pharmacy detection of hypertension service has been implemented.

42. BOB Respiratory Clinical Network: Launched a supplementary service in primary care to enable early, accurate diagnosis through the re-start and restoration of spirometry to reduce COPD (Chronic Obstructive Pulmonary Disease) exacerbation presentation in A&E. In our plan we aimed to improve Long COVID services for

adults and CYP (Children and Young People) – by increasing referrals and reducing waiting times by expanding Pulmonary Rehabilitation to reduce waiting times and ensure sustainable capacity going forward. This has not happened with 176 accepted referrals in March compared with 95 in July. As of 15th July 317, patients had been waiting over 15 weeks, the highest number since the service commenced.

43. BOB Diabetes Clinical Reference Group: Increasing referrals to NDPP (National Diabetes Prevention programme). Implementation of funding for recovery of diabetes management in primary care targeted at areas with health inequalities and poor control to return to pre pandemic levels for the 8 care processes. Plans in development for levelling up of management of diabetes in primary care across BOB

44. **Tobacco**: Roll out of tobacco dependency support services has started across Physical & Mental health inpatient and Maternity services from NHS Providers in the ICB. These will continue to be rolled out through 2022/23 and into 2023/24 supported by the System Develop Fund.

45. **CYP Immunisations** Work on improving 0-4 pre-school immunisations continues to be progressed ICS wide. SAIS (School Aged Immunisation) teams providing catch up clinics over the summer months where viable. Planning for school flu immunisation programme and COVID-19 vaccination of Clinically Extremely Vulnerable children underway and services secured ready to commence from September onwards

Mental Health services

46. To gain greater oversight of progress across Mental Health services, it has been agreed to construct two governance streams separating transformation from performance and assurance reporting for the ICB, which will be further defined in Q2. TOR (Terms of Reference) and a Governance framework have been established, with clear system responsibilities, accountabilities and reporting arrangements agreed.

47. Progress on key deliverables for Mental Health services across BOB in Quarter 1 include:

- **Autism waits**: Rapid Improvement Events (RIEs) have been held in Q1 with improvement plan and robust timelines for key deliverables agreed. Berkshire West has commissioned pre and post diagnostic support for adults. Progress against improvement trajectory will be presented in Q2
- **Children and young people's mental health services (CYP):** Work has begun to ensure consistent and transparent reporting of referral rates, waiting times and activity in delivery, with a focus on clarifying capacity, demand, and service activity across the system (CReST Pilot). A project lead has been appointed and CYPs dashboard approved to ensure clear ICB oversight of progress being made against improvement trajectory.
- **Eating Disorders:** Progress has been made in Q1 to address recruitment challenges in the workforce teams for eating disorders. Innovative recruitment

approaches, have led to an increase in workforce capacity and we expect to see an improvement in performance in the Q3

- **Improving Access to Psychological Therapies: Develop an IAPT (Improving Access to Psychological Therapies) recovery plan to improve access.** Transformation programme is now in place and a marketing campaign has begun to drive referrals for people from BAME communities and older people. Recovery plan in place, with oversight and trajectories for improvement agreed for the ICB.
- **Dementia Diagnosis Rate:** Clinical lead now in post and a plan has been developed for improving DDR by in reach to care homes.
- **Mental Health Practitioner roles:** Recruitment is taking place across all PCNs to establish Mental Health Practitioner roles, through the Additional Roles Reimbursement Scheme (ARRS) to ensure clinical expertise for Mental Health is developed across our primary care services.

Learning Disabilities and Autism

48. The ICS has invested into Green Light Toolkits across BOB at various stages. The ICB is extending the reasonable adjustments service (RAS) team model across the ICB, and training developed for anticipatory adjustments, which has been added to universal mental health training guide and focussed training delivered in inpatient wards across the system.

Digital

49. The final costed digital roadmap is yet to be published. However, to ensure that a system-wide approach to Population Health Analytics is developed in such a way to allow rich data and analytics functionality at all levels of our system, a review into overcoming the technical and organisational barriers to this vision has now been completed by an external specialist team. The provider Chief Executives and Chief Information Officers met with senior leadership representation from the ICB and have agreed a plan to deliver this functionality within an estimated 12 months. This data strategy will also result in a BOB-wide Shared Care record and provide patient-level analytics for clinicians on-the-ground.

50. The BOB Virtual Ward programme is providing technology enabled acute bed equivalent care for two specific patient groups, acute respiratory and frailty (as defined) and is expanding capability into Heart Failure/Function and Palliative Care. All providers at place are looking to increase their use of digital monitoring tools to improve diagnosis and to ensure that local people can get the care they need in their homes without having to be admitted to hospital unnecessarily.'

Summary and Conclusion

51. Delivery of our 2022/23 Operational Plan is extremely challenged given the operational pressures and financial constraints. The ICB will continue to work with system partners to address elective backlogs, pressures on the emergency care system and the development of further cost improvement targets.

Annex 1. Q1 Actuals vs Plan

Planned Care					
Metric		Plan	Actual	Variance	RAG
EM7	Total Referrals	172,635	154,528	-10.5%	
	GP referrals only	96,666	89,507	-7.4%	
EM8	1OP	156,912	128,751	-17.9%	
	1op with proc	25,285	16,591	-34.4%	
EM9	FUOP	253,065	190,602	-24.7%	
	FUOP with proc	41,382	26,998	-34.8%	
EM32	Total OP	567,732	586,869	3.4%	
EM32e	1st OP non F2F	43,457	51,720	19.0%	
EM32f	FUOP non F2F	61,848	79,104	27.9%	
EM33	Specialist A&G	33,388	57,119	71.1%	
EM34	PIFU*	14,059	9,293	-33.9%	
EM10	Elective Spells	48,965	42,615	-13.0%	
EM18	RTT admitted	22,445	19,685	-12.3%	
EM19	RTT non-adm	73,905	62,219	-15.8%	
EM20	New pathways	115,866	103,325	-10.8%	
EB3a	Waiting List	129,149	148,423	14.9%	
EB18	52+ ww	6,804	6,849	0.7%	
EB21	78+ ww	652	994	52.5%	
EB19	104+ ww	0	16**	-	

*PIFU data capture issue – confidence is high that we are achieving plan
**Allowable due to complexity

Cancer					
Metric		Plan	Actual		RAG
EB27	28FDS	75.1%	73.6%	-1.5%	
EB31	31d Treat	2,438	2,370	-2.8%	
EB32	63+ wait	539	783	45.3%	
EB33	NSS Referrals***	352	110	-68.8%	

***Data quality issues due to it being still a relatively new data item

Diagnostics					
Metric		Plan	Actual		RAG
EB26	Total Diagnostic activity	182,416	176,568	-3.2%	
EB26a	MRI	26,929	27,567	2.4%	
EB26b	CT	48,459	56,081	15.7%	
EB26c	NOU	46,762	39,933	-14.6%	
EB26d	Colon	3,141	3,508	11.7%	
EB26e	Flexi Sig	2,065	1,471	-28.8%	
EB26f	Gastro	3,411	3,445	1.0%	
EB26g	ECG	51,649	44,563	-13.7%	

Exceeding Trajectory
Inside 5% of Trajectory
Outside 5% of trajectory