NHS DORSET INTEGRATED CARE BOARD (ICB)

ICB BOARD MEETING

PART ONE – PUBLIC

Part One of the meeting of the NHS Dorset ICB Board meeting will be held on **Wednesday 20 July 2022** at **8.30am** in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TG.

If you are unable to attend, please notify the Corporate Office on 01305 368017.

Jenni Douglas-Todd
Integrated Care Board Chair

AGENDA

	Item	Method	Purpose	Lead
1.	**Apologies** Neil Bacon, Chief Strategy and Transformation Officer Dawn Harvey, Chief People Officer Dan Worsley, Non-Executive Member	Verbal		Chair
2.	**Quorum** To confirm that the meeting is quorate before it proceeds further. The Terms of Refence (Constitution) dictates that a quorum, shall be one third of the total number of members and the Chair (7) and must include one executive member, one partner member and one non-executive member.	Verbal		Chair
3.	Declarations of Interest Members to carefully consider and declare any conflicts of interest arising from this agenda. *(A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict).*	Verbal		Chair
4.	**Minutes** To **approve** the Part 1 minutes of the NHS Dorset ICB Board meeting held on 1 July 2022.	Paper		Chair

5.	**Matters Arising** To **note** the Report of the Chair on matters arising from the minutes of Part 1 of the meeting held on 1 July 2022.	Paper		Chair
6. (8.45am 10 mins)	**Chief Executive Officer Report** To note the Chief Executive Officer report.	Paper	Noting	PM
7.	**<u>Items for Decision</u>**			
7.1 (8.55am 15 mins)	**Age Care Technologies** To **approve** the recommendations set out in the Age Care Technologies report.	Paper	Approval	PJ
7.2 (9.10am 15 mins)	**Memorandum of Understanding (MOU) between the Voluntary and Community Sector and the Integrated Care System** To **approve** the 'placeholder' MOU.	Paper	Approval	SC
8.	**<u>Items for Noting</u>**			
8.1 (9.25am 10 mins)	**Dorset's Response to the Next Steps to Integrating Primary Care: Fuller Stocktake Report** To **note** the Fuller Stocktake report.	Paper		DF
8.2 (9.35am 10 mins)	**Messenger Review** To note the report on the Messenger Review.	Paper		EP
8.3 (9.45am 15 mins)	**ICS Transformation Programme Update** To **note** report on the ICS Transformation Programme.	Paper		PR
8.4 (10.00am 10 mins)	**Quality Report** To **note** the report on Quality.	Paper		VR
8.5 (10.10am 10 mins)	**Performance Report** To **note** the report on Performance.	Paper		SB
8.6 (10.20 10 mins)	**Finance Report** To **note** the report on Finance.	Paper		RM
(10.30am 20 mins)	**Comfort Break**			

8.7 (10.50am 10 mins)	**Annual Report on Children in Care and Care Leavers 2021-22** To **note** the Annual Report on Children in Care and Care Leavers.	Paper		VR
8.8 (11.00am 10 mins)	**Annual Review of Data Security and Protection Toolkit** To **note** the Annual Review of Data Security and Protection Toolkit.	Paper		RM
8.9 (11.10am 10 mins)	**Annual Report on Personal Health Commissioning** To **note** the Annual Report on Personal Health Commissioning.	Paper		VR
8.10 (11.20am 10 mins)	**Annual Report on Customer Care** To **note** the Annual Report on Customer Care.	Paper		VR
8.11 (11.30am 10 mins)	**Annual Report on Safeguarding Children and Adults** To **note** the Annual Report on Safeguarding Children and Adults.	Paper		VR
9. (11.40am 5 mins)	**<u>Items for Consent</u>** The following items are to be taken without discussion unless any Board member requests prior to the meeting that any be removed from the consent section for further discussion. **Minutes** To **note** the following minutes:-			
9.1	<u>Approved minutes</u> CCG Primary Care Commissioning Committee (Part 1 – Public) - 13 April 2022			Chair
9.2	<u>Draft Minutes</u> CCG Primary Care Commissioning Committee (Part 1 – Public) – 1 June 2022			
	Urgent decision			
9.3	For the ICB Board to note the following urgent decision:- - Approval of the uplift for providers on the Dorset Council (DC) framework to align with DC rate increases. Approval of an uplift for non framework providers of between 4 – 5.6% to align with the increase given to non framework providers in the Bournemouth, Christchurch, and Poole (BCP) area as some providers provide care for packages located in both Local Authority areas.			RM

10. (11.45am 10 mins)	**Questions from the Public** Questions in writing to be submitted in advance of the meeting.			Chair
11.	**Any Other Business**	Verbal		Chair

12. Date and Time of Next Meeting

The next formal meeting of the NHS Dorset ICB Board will be held on **Thursday 1 September 2022** at **10.00am** in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TG.

13. Exclusion of the Public

To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

12 noon Lunch

4.

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

1 JULY 2022

MINUTES

A meeting of the ICB Board was held at 9.30am on Friday 1 July 2022 in the Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG

Present:

Jenni Douglas-Todd, ICB Chair (JDT)
Neil Bacon, ICB Chief Strategy and Information Officer (NB)
John Beswick, ICB Non-Executive Member (JB)
Cecilia Bufton, ICB Non-Executive Member (CB)
Jonathon Carr- Brown, ICB Non-Executive Member (JCB)
Dawn Dawson, Acting Chief Executive – Dorset Healthcare and ICB Mental Health Partner member (DD)
Siobhan Harrington, Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member (SH)
Spencer Flower, Leader Dorset Council and ICB Local Authority Partner Member (West) (SF)
Paul Johnson, ICB Chief Medical Officer (PJ)
Drew Mellor, Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East)
Patricia Miller, ICB Chief Executive Officer (PM)
Rob Morgan, ICB Chief Finance Officer (RM)
Ben Sharland GP and Primary Care Partner Member (virtual attendance) (BS)
Dean Spencer, ICB Chief Operating Officer (DS)
Kay Taylor, ICB Non-Executive Member (KT)
Forbes Watson, ICB Non-Executive Member (FW)
Dan Worsley, ICB Non-Executive Member (DW)
Simone Yule, GP and ICB Primary Care Partner Member (virtual attendance) (SY)

Invited Participants:

Louise Bate, Manager, Dorset Healthwatch (LB)
Sam Crowe, Director of Public Health (SC)
David Freeman, ICB Chief Commissioning Officer (DF)
Tim Goodson, ICB Programme Director (TG)
Leesa Harwood, Associate ICB Non-Executive Member (LH)
Dawn Harvey, ICB Chief People Officer (DH)
Nick Johnson, Interim CEO Dorset County Hospital NHS Foundation Trust and ICB NHS Provider Trust Partner Member (virtual attendance) (NJ)

Fiona King, Governance and Committee Officer, Dorset CCG (minute taker) (FK)
Pamela O'Shea, Deputy Director Nursing and Quality (PoS)
Matt Prosser, Chief Executive, Dorset Council (MP)
Phil Richardson, ICB Programme Director (PR)
Andrew Rosser, Chief Finance Officer, SWAST (virtual attendance) (AR)
Nikki Rowland, ICB Programme Director (NRo)
Sally Sandcraft, ICB Programme Director (SSa)
Stephen Slough, ICB Chief Digital Information Officer (SS)
Charles Summers, ICB Programme Director (CS)
Natalie Violet, Business Manager to the ICB Chief Executive (NV)

Action

1. Welcome, Introductions and Apologies

Dr Manish Tayal, Associate ICB Non-Executive Member
Vanessa Read, Interim Chief Nursing Officer
Spencer Flower, not available until 10.00am
Forbes Watson, not available until 10.30am

1.1 **ICB Constitution**

1.2 The Chair introduced the Constitution and advised that it had been approved by NHS England and was now available on-line.

1.3 The Chief Executive advised the Board of one correction that had been made since the meeting of the Shadow Board on 20 May 2022. This related to the identification of local authority members as executives and not as elected members. This had now been amended.

1.4 The Board formally accepted the ICB Constitution as their primary governance document.

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of members present.

3. Declarations of Interest, Gifts or Hospitality

3.1 There were no Declarations of Interest made at the meeting.

3.2 Members were reminded of the need to ensure Declarations of Interest were up to date and to notify the Corporate Office of any new declarations.

4. Staff Story

4.1 The Board were advised that the aim was to have a staff/patient story at the start of all Board meetings in the future. The patient story for this meeting related to a member of staff at Dorset County Hospital and her daughter and highlighted what the impact was when families were listened to and the impact on those families when they were not.

4.2 A number of participants in the meeting were aware of the story and offered their reflections.

4.3 The Chief People Officer shared her experience of spending time with the family and highlighted that the workforce across the system was 'our' population and how those with caring responsibilities were supported was fundamental to providing wellbeing for 'our' population.

4.4 The story highlighted the importance of thinking about the holistic person and the need to amplify the voices of not just the child but also those of our communities.

4.5 In terms of lessons learned the Chief Executive advised that she had shared the film with the mental health commissioning team and this and other stories would be put into the wider governance framework to enable clinicians to learn from them. She confirmed that the development of a strategy for children and young people would be a key priority for the ICS and its development delivery would be founded in our agreed approach to co-production with our communities.

4.6 Board members felt this had been a powerful way to start the meeting but considered how it would have been different for someone who was not part of the system and was not familiar with the structures. It was recognised there was a lot of assumed knowledge in public services.

4.7 The Chief Executive University Hospitals Dorset NHS Foundation Trust suggested a mechanism to share the stories from the different organisations within the system could be helpful. Stephen Sough agreed to take this forward. SS

5. Items for Decision

5.1 Establish the Committees, appoint the Chairs/membership of the Committees and approve their Terms of Reference

5.1.1 The Chair introduced the report on the Establishment of Committees – Functions and Decision Map.

5.1.2 The Board was advised that further work was needed on redesigning the system decision making framework to ensure the structure was as flat as possible to enable more agile decision making at the lowest level.

5.1.3 The Board **approved** the functions and decision map, committee structure, committee Chairs and terms of reference.

5.2 ICB Standing Financial Instructions (SFIs) and ICB Scheme of Reservation and Delegation

5.2.1 The Chief Finance Officer introduced the report on the scheme of reservation and delegation and standing financial instructions.

5.2.2 Amendments that had been requested had now been incorporated. The Chief Executive advised that in respect of the SFIs authorisation of bank and agency staff an interim arrangement had been put in place until the Chief People Officer took up her post in September.

5.2.3 The Board **approved** the scheme of reservation and delegation and standing financial instructions.

5.3 Appoint to Specialist/lead roles e.g. Conflicts of Interest Guardian Freedom to Speak up Guardian

5.3.1 The Chair introduced the report on the non-executive champion appointments to specialist and lead roles.

5.3.2 Prior to the circulation of the report there had been discussions with the non-executive members to ensure their understanding and agreement to the roles.

5.3.3 The Chair highlighted the positive engagement that had taken place which reflected the importance of agile working and working at pace.

5.3.4 The Board **approved** the recommendations in the appointment of non-executive champion roles report.

5.4 Governance Handbook and Suite of Core Policies

5.4.1 The Business Manager to the CEO introduced the Governance Handbook along with the suite of core policies which included the Standards of Business Conduct Policy and the Conflicts of Interest policy.

5.4.2 The Handbook described how the ICB would make their decisions and consideration was given that there might need to be a handy guide version of the Handbook for staff as it was a rather substantial document. The Chief Executive's Business Manager undertook to confirm with NHSE the level of detail required to be published in the Handbook. NV

5.4.3 Following a discussion about the Handbook the Board were advised that there was a requirement from NHS England for it to be published on the website from day one of the ICB.

5.4.4 Following a question about committee meetings being held in public, the Chair advised that Part One of the meetings of the Board would be held in public whilst the committee meetings would not.

5.4.5 It was anticipated that minutes from the committee meetings would appear as part of the Board minutes for transparency, although Part 2 minutes from the Board would not be published as they regularly contained commercially sensitive information.

5.4.6 The Board **approved** the ICB Governance Handbook and the suite of Core Policies.

5.5 Appoint the ICB founder member of the Integrated Care Partnership (ICP)

5.5.1 The Board considered the appointment of an ICB founder member for the Integrated Care Partnership.

5.5.2 The Board was advised that ICBs across the south-west were nominating their ICB chairs to this role.

5.5.3 The Chief Executive proposed, and Dr Forbes Watson seconded the proposal to appoint the ICB Chair to the Integrated Care Partnership.

5.5.4 The Board **approved** the appointment of Jenni Douglas-Todd as the founding member with the local authorities in terms of creating the ICP Board.

6. Items for Noting

6.1 There were no items for noting.

7. Items for Consent

7.1 There were no items for consent.

8. Questions from the Public

8.1 There were no written questions from members of the public but the Chair invited those members of the public online if they had any questions.

8.2 It was recognised that some people had encountered difficulties in initially joining the meeting and to try and avoid this for future meetings it was suggested that members of the public joined the meeting a little earlier in order to try and resolve any connectivity issues.

8.3 One person expressed concern about the process for residents being consulted before decisions were made.

9. Any Other Business

9.1 There was no further business discussed.

10. Date and Time of Next Meeting

10.1 The next meeting of the ICB Board would be held on Wednesday 20 July 2022 at 8.30am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

11. Exclusion of the Public

To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

5.

NHS DORSET INTEGRATED CARE BOARD (ICB)

ICB BOARD MEETING

MATTERS ARISING - PART ONE

Report of the Chair on Matters Arising from Part 1 of the Minutes of the NHS Dorset ICB Board meeting held on 1 July 2022.

1. Purpose

To report to the ICB Board on any matters arising from the draft minutes of the last ICB Board meeting.

2. Recommendation

That the ICB Board notes this report and directs any action it sees fit.

3. Background Information

This report covers all outstanding action points contained in the minutes and is required in order that the ICB Board can be satisfied that all action points in the action column have either been done, are being done or will be done in accordance with the timescale contained in the minute, if any.

4. Staff Story

4.7 The Chief Executive University Hospitals Dorset NHS Foundation Trust suggested a mechanism to share the stories from the different organisations within the system could be helpful. Stephen Sough agreed to take this forward.

SS – Work is progressing on this but as yet not resolved.

5.4 **Governance Handbook and Suite of Core Policies**

5.4.2 The Handbook described how the ICB would make their decisions and consideration was given that there might need to be a handy guide version of the Handbook for staff as it was a rather substantial document. The Chief Executive's Business Manager undertook to confirm with NHSE the level of detail required to be published in the Handbook.

NV – The Governance Handbook has been published on the website as per the Day 1 requirements. Recruitment is underway for the Corporate Secretary, once in post, they will be tasked with reviewing the Governance Handbook and liaising with NHSE with regards to a

simplified public version. The Corporate Office currently has some sickness absence, should this return to full establishment ahead of the appointment of the Corporate Secretary, this will be reviewed.

6.

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

CHIEF EXECUTIVE OFFICER REPORT

Date of the meeting	20/07/2022
Author	Natalie Violet, Business Manager to the Chief Executive Officer
Lead Director	Patricia Miller, Chief Executive Officer
Purpose of Report	This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the system is performing and the key areas of focus. The key national developments are as follow: • The NHS moved away from incident level four 'national' to level three 'regional'. This moves the NHS away from national command and control measures, moving away from the COVID response to recovery. • The Next Steps for Integrating Primary Care: Fuller Stocktake Report was published. • The Healthcare Safety Investigation Branch published an interim bulletin looking at the harm caused by delays in transferring patients to the right place of care. • NHS England announced the appointment of a Chief Workforce Officer. Dr Navina Evans has been appointed into the role. • The Messenger Review of NHS Leadership was published. • NHS England publicly set out the plans for the merger of all three arm's length bodies – NHS England, Health Education England, and NHS Digital. • The NHS App will soon be updated with feature supporting more personalised care. • The British Medicine Association (BMA) published the Racism in Medicine report. • The NHS Confederation BME Leadership Network published the Shattered Hopes report. • NHS England published the Allied Health Professionals (AHPs) Strategy for England. • Sajid Javid resigned as Secretary of State for Health and Social Care. Following his resignation, The Rt Hon Steve Barclay MP, was appointed into the role. • The Department of Health and Social Care withdrew the staff and conditions section of the COVID-19 workforce guidance meaning NHS Staff are transitioning back to normal contractual sick pay arrangements.

	Locally the biggest concern lies with system operational pressures. There is an increased trend of patients not meeting the clinical criteria to reside in both acute and community hospitals leading to impact on Emergency Departments resulting in deteriorating waiting times, 12-hour breaches, and ambulance handover delays. In addition, there are pressures within Mental Health and a lack of access to capacity in the community. The increase in COVID cases also has a role to play with increased patients in hospital beds and increased staff absences. Following a system wide review of current and predicted data surrounding COVID along with the increasing numbers of staff and patient illness, mask wearing has been reintroduced across all NHS organisations. From September 2022, this report will also include updates from local authority partners.
Recommendation	The Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	N/A – this report is for information
Involvement and Consultation	N/A – this report is for information
Equality, Diversity, and Inclusion	N/A – this report is for information
Financial and Resource Implications	Failure to address key strategic and operational risks will place the system at risk in terms of its financial sustainability.
Legal/governance	Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable system.
Risk description/rating	Failure to understand the wider strategic and political context, could lead to the Board making decisions that fail to create a sustainable system. The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed.

1. Introduction

1.1 This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the system is performing and the key areas of focus.

2. Strategic Update – National Perspective

2.1 NHS Incident Response Level

On 19 May 2022, NHS England and Improvement wrote to NHS Chief Executives and Accountable Officers moving the NHS from incident level four 'national' to level three 'regional'. This moves the NHS away from national command and control measures, moving away from the COVID response to recovery. There are no further additional expectations or priorities

beyond those set out in the 2022/23 priorities and operational planning guidance. However, systems are expected to immediately focus on delivering timely urgent and emergency care and discharge, provide more routine elective and cancer tests and treatments, and improving patient experience. The letter recognises systems will not be able to return to pre-pandemic approaches.

2.2 **NHS Providers Chief Executive**

Chris Hopson, Chief Executive of NHS Providers left the organisation in June 2022 to become Chief Strategy Officer at NHS England and Improvement. Saffron Cordery, Deputy Chief Executive is Interim Chief Executive while the Board determine the process for a permanent appointment.

2.3 **Healthcare Safety Investigation Branch – Interim Bulletin**

In June 2022, the Healthcare Safety Investigation Branch published an interim bulletin looking at the harm caused by delays in transferring patients to the right place of care. A national investigation, launched in March 2022, seeks to examine the systems in place to manage the flow of patients through and out of hospitals considering the interactions between health and social care systems. The aim is to provide the investigation's initial findings, seeking to highlight harm and existing and emerging risks across the healthcare system and to prompt early action from national bodies.

2.4 **First Women's Health Ambassador**

On 17 June 2022, Dame Lesley Regan was announced as England's first women's health ambassador. Dame Lesley is calling for accessible 'one-stop shops' within the community where women can deal with their health needs. The role aim's to close the gender health gap and will support the development of the women's health strategy.

2.5 **Chief Workforce Officer – NHS England**

In June, NHS England announced the appointment of a Chief Workforce Officer. Dr Navina Evans was appointed into the role following the departure of Prerana Issar earlier this year. Navina has been Chief Executive at Health Education England (HEE) since March 2022. Last year, the Department of Health and Social Care announced major reforms in how the NHS workforce is managed including merging HEE and NHS England. As a result, recruitment, training, and retention of NHS staff will be under the Chief Workforce Officer umbrella.

2.6 **Workforce Reductions – NHS England**

On 07 July 2022, NHS England publicly set out the plans for the merger of all three arm's length bodies – NHS England, Health Education England, and NHS Digital. Estimating a 20 – 30% reduction in whole time equivalent posts as a result. The restructure and reduction in posts will take place by April 2024, although the merger is legally taking place in April 2023. NHS England CEO, Amanda Pritchard advised following the creation of Integrated Care Systems, who need the space to lead at local level, working with NHS England regional colleagues, the leadership must be adapted to effectively deliver the core purpose of high-quality services for all. The aim is to remove duplicate activities and model effective joint working.

2.7 **NHS App Developments**

In June, the Government announced, as part of their plan for a digital revolution to speed up care, improve access, and make efficiency savings, the NHS App will soon be updated with feature supporting more personalised care. From March 2023, App users will be able to book COVID vaccinations, receive messages, reminders, and alerts from their GP, manage planned hospital appointments at participating Trusts, see new GP records, and access and manage their user profile. Virtual consultations are expected to be offered through the App by March 2024.

2.8 **Secretary of State for Health and Social Care**

On 05 July 2022, Sajid Javid resigned as Secretary of State for Health and Social Care. Following his resignation, The Rt Hon Steve Barclay MP, was appointed into the role. A further resignation was received the following day by Health Minister, Edward Argar who was appointed into the role in 2019. Maria Caulfied has now been promoted into this role.

3. Strategic Update – Local Relevance

3.1 **Fuller Stocktake Report**

On 26 May 2022, the Next Steps for Integrating Primary Care: Fuller Stocktake Report was published. The aim is to tackle the real operational challenges driving pressure across systems with recommendations changing care models for two distinct group of patients. The first group of people are those who require urgent access to primary care with the recommendation to introduce a same day urgent care solution including at primary care network level. The ambition is to improve experiences for those seeking urgent appointments outside of core hours and change the early morning phone call queue at practice level. The second group of patients are those who require continuity of care and a more holistic approach. This group are most likely to benefit from an anticipatory care model focused on people with multiple co-morbidities. This will rely on proactive case-finding and system collaboration. It is believed the benefits of managing these patients effectively will benefit all system partners. System leaders and Boards are expected to focus on making improvements for patients in these two groups. The Chief Commissioning Officer will now be leading on this work for Dorset.

3.2 **Messenger Review of NHS Leadership**

On 08 June 2022, the Messenger Review of NHS Leadership was published. The findings centred around two main areas: culture and behaviours and standards and structures. The review highlights two broad themes within culture and behaviour. The culture of collaboration and the culture of respect which impact how people treat each other and service users which consequently affect the quality of care and outcomes. Standards and structures found the perception of management lacks the status experienced by those in established professions within health and social care, and therefore appears an under-valued career. The review recommends seven actions with the aim to drive improvement in leadership and management consequently positively affecting public health outcomes, productivity, and efficiency. The Chief People Officer, due to commence in mid-August, will be considering these recommendations, with system partners, for Dorset as the new organisation develops.

3.3 **BMA Racism in Medicine Report**

On 15 June 2022, The British Medicine Association (BMA) published the Racism in Medicine report. The report presents the findings of the BMA racism in medicine survey which ran for October to December 2021. The aim was to gather evidence of the racism experienced by doctors and medical students working in the NHS, and the impact of these experiences on their working lives and career opportunities. Receiving 2,030 responses, it is one of the largest of its kind. The findings identified widespread racism within the medical workforce with overseas qualified doctors experiencing racism more often than doctors trained in the UK. Sadly, experiences of racism are significantly underreported with those who do report consequently receiving negative backlash such as being seen as a troublemaker, overreacting, being blamed for the incident, and overlooked for progression. The report highlights how racism impacts career progression for many doctors with many considering leaving or have left because of racial discrimination. The report also identifies experience of racism impacting individuals' confidence, and mental and physical wellbeing.

3.6 **BME Leadership Network**

On 17 June 2022, the NHS Confederation BME Leadership Network published the Shattered Hopes report. The report spotlights the findings from a recent survey and engagement on the experience of senior black and minority ethnic leaders in the NHS. The report suggests when

leaders are not representative of the communities they serve, service users suffer. Similarly, when senior staff are unhappy, and turnover is high, organisational stability can be affected. A key part of the NHS People Plan is to achieve equality and create diverse leadership. The report suggests improving working life for senior BME staff should be a critical priority for the health service and highlights three steps the NHS can take urgently.

Within the Dorset system, Dorset County Hospital introduced an Inclusive Leadership Programme. This programme focused on three areas – seeing differently, responding differently, and leading differently. As a result, the 2021 Staff Survey Results provided early indications of the positive impact the inclusion work is having and sharing this experience and programme across the system would benefit both our staff and communities. Staff can not be expected to understand the communities they serve if they do not value and celebrate diversity within organisations.

3.7 **Allied Health Professions Strategy for England**

On 27 June 2022, NHS England published the Allied Health Professionals (AHPs) Strategy for England. This new strategy is for the AHP community: support workers, assistant practitioners, registered professionals, pre-registration apprentices and students. It reflects how AHPs work in multidisciplinary teams and can be used by the AHP community and colleagues to continually improve and redesign services to meet the needs of local communities. Once the Dorset Integrated Care Strategy has been developed, the Chief Nursing Officer will be leading on a Dorset-wide strategy for nursing and allied health professionals.

3.8 **NHS Staff Terms and Conditions – COVID Absences**

Following the Government's announcement, in February, regarding living with COVID, the Department of Health and Social Care has engaged with stakeholders regarding the withdrawal of the DHSC's staff and conditions section of the COVID-19 workforce guidance. Effective from 07 July 2022 this guidance has been withdrawn and staff are transitioning back to normal contractual sick pay arrangements. The NHS Staff Council have produced guidance to support organisations in this transition. This is being worked through across the system within NHS organisations.

4. NHS Dorset Latest News

4.1 **Farewell to the Clinical Commissioning Group**

On 30 June 2022, the Dorset Clinical Commissioning Group (CCG) Annual General Meeting was held. It was heart-warming to see so many people there who were able to share their stories and celebrate the CCG. The CCG has achieved many great things over the years in its role as commissioner and leading the Integrated Care System this far. Without this we would not have the foundations to build the ICB upon.

We also received the final Dorset CCG End of Year Assessment for 2021/22 from NHS England and Improvement. The letter outlined the numerous achievements over the year, despite its challenges. It highlighted the support response to the COVID-19 pandemic, the smooth transfer of services to the ICB ahead of 1st July, the DiiS Team winning the HFMA award for delivering value with digital technologies, outstanding performance in population health and health inequalities, the Dorset Health Villages, and the COVID vaccination programme plus many more. This would not have been possible without the continued hard work, dedication, and contribution of staff and partners.

4.3 **Dorset Health Inequality Webinars**

On Thursday 09 June 2022, the system held the third Dorset Health Inequalities Webinar. Jay Tompt from Reconomy and Schumacher College, and a co-founder of Local Spark in Torbay, joined the session. He was able to share his passion about how local economies can better support self-reliance and resilience in communities and talked about how we can promote both

economic and wider social change through 'community wealth building'. The fourth webinar took place on 07 July 2022, this session was joined by Dr Mike Oliver, a Chartered Psychologist, and registered Health Psychologist. He specialises in workplace health and wellbeing, helping individuals, teams and whole organisations think and behave differently in relation to their health inside and outside of work. He is a Steering Group member of Health Literacy UK as well as a Visiting Fellow at Staffordshire University. He was able to share his views on both sides of the health literacy coin: how people and communities can access and act on health information and how health care organisations support those people to make good health decisions. A further webinar is planned on 21 July 2022, which is being facilitated by colleagues from Wessex AHSN. This will be a rapid insights hour long session exploring what the system would like to do with our newfound Health Inequalities insights. The webinar series is taking a break in August and will return in September for an Autumn programme.

4.4 **Chief Nursing Officer**

On 30 June 2022 we announced the final Board appointment. Debbie Simmons will be joining the ICB as Chief Nursing Officer from Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System. Debbie is expected to commence in post in September. Vanessa Read will continue to cover the role on an interim basis.

4.5 **Visit from The Kingdom of Saudi Arabia**

On 23 May 2022, Dorset welcomed colleagues from the Kingdom of Saudi Arabia. During Autumn 2020, NHS England recommended emerging health leaders from the Kingdom of Saudi Arabia visit Dorset to gather information regarding integrated care and population health management. They were very impressed and would like to work in partnership with the Dorset system in the future. They are about to embark on the same journey we are on so working together will offer benefits to both organisations.

5. System Pressures

On 30 June 2022, the system moved into escalation level 4 (OPEL 4) due to an increasing trend of patients not meeting the clinical criteria to reside in both acute and community hospitals leading to impact on Emergency Departments resulting in deteriorating waiting times, 12-hour breaches, and ambulance handover delays. In addition, there are pressures within Mental Health and a lack of access to capacity in the community. The increase in COVID cases also has a role to play with increased patients in hospital beds and increased staff absences. Executive escalation calls are taking place to oversee the development and delivery of a de-escalation plan and the Strategic Resilience Group are scheduled to manage the de-escalation and provide senior leadership, direction, and support at operational level. A letter was sent to the Regional Director, Elizabeth O'Mahoney on 01 July 2022 to notify her of the situation. Following a system wide review of current and predicted data surrounding COVID along with the increasing numbers of staff and patient illness, mask wearing has been reintroduced across all NHS organisations, including within communal areas of Vespasian House and Canford House.

6. Health Provider Latest News

6.1 **Dorset County Hospital NHS Foundation Trust**

6.1.1 **Your Future Hospital**

On 22 May 2022, as part of Dorset County Hospital's Your Future Hospital Programme, the Trust has submitted plans to Dorset Council to extend its site following feedback from patients, staff, and local communities. The Trust has been earmarked funding to build a new Emergency Department and Critical Care Unit along with aspirations to build a new entrance, hospital support hub, key worker housing, and an Integrated Care Hub. If Dorset Council grants permission, this would be subject to conditions, and the Trust would need to draw up and submit detailed plans for each individual project. On 27 June 2022, Dorset County Hospital selected Tilbury Douglas, a leading UK building, infrastructure, engineering, and fit-out

business, as its main contractor to design and build the brand-new Emergency Department and Critical Care Unit. Subject to planning permission and agreement from the Government, it is hoped that construction will begin in 2024.

6.1.2 **Tackling Care Backlogs**

Dorset County Hospital featured in an NHS Providers Podcast to discuss the creation of the South Walks House outpatient assessment centre in Dorchester and the significant impact on the Orthopaedic waiting list. The success has been through a one-stop shop with multidisciplinary teams and other providers on site. The Orthopaedic service is seeing 31% more patients using the same paid staffing model as before, with volunteers assisting with the smooth running of the centre. There has been a significant reduction in the total waiting and those waiting the longest. From a clinical perspective the service is seeing a reduction in conditions becoming more serious and requiring surgery.

6.2 **Dorset Healthcare University NHS Foundation Trust**

6.2.1 **Vaccination Centres**

At the end of May Dorchester's large COVID-19 vaccination centre at Vespasian House closed after successfully delivering over 25,000 vaccinations over a six-month period. Dorset's vaccination programme is now moving into its next phase with the focus being on reaching more people by offering localised services in key hubs around the county. Including Weymouth, Bridport, Dorchester, and Blandford Forum. A huge thank you to all staff and volunteers involved in the running of the Vespasian House vaccination site.

6.2.2 **Wimborne Victoria Hospital National Accreditation**

On 14 June 2022, it was announced that Wimborne's Victoria Hospital has met national accreditation standards for its gastrointestinal (GI) endoscopy services once again. The Endoscopy Team at the Dorset HealthCare-run community hospital successfully passed its annual review, following an assessment by the UK's Joint Advisory Group (JAG). GI endoscopy allows health staff to examine a person's insides, using a flexible tube with a camera, and diagnose and/or treat a range of conditions in the stomach and elsewhere. It is one of many services offered at the hospital, and JAG accreditation demonstrates that the team delivers high quality, patient-centred care in this area. Accreditation assessments take place every five years, with annual reviews against set criteria in the meantime to ensure standards are maintained.

6.3 **Southern Western Ambulance Service NHS Foundation Trust**

6.3.1 **Trust Plan 2022/23**

In May, Southern Western Ambulance Service NHS Foundation Trust published a special edition of their Stakeholder News to share their 2022/23 Trust Plan with one single aim – improving patient safety by recovering performance.

6.3.2 **Chairman**

Tony Fox stepped down from his role as chairman of Southern Western Ambulance Service NHS Foundation Trust in May after almost 10 years as a non-executive director and five years as chairman. The Council of Governors appointed Gail Bragg as interim Chair whilst a recruitment process for the long-term position takes place over the coming months.

6.4 **University Hospitals NHS Foundation Trust**

6.4.1 **Chair Appointment**

Rob Whiteman, CBE was appointed as the new Chair of University Hospitals Dorset NHS Foundation Trust and commenced on 01 July 2022, replacing David Moss who retired earlier this year. Rob has been Chief Executive of the Chartered Institute of Public Finance and Accountancy for the last eight years and has held many other executive and non-executive roles. Rob brings significant experience of working with the NHS from his time as Chair of North East London Sustainability and Transformation Programme (STP) and as a non-

executive director and Chair of audit at Whittington Health NHS Trust and Barking, Havering, and Redbridge University Hospitals NHS Trust.

6.4.2 **Antenatal Services**

On 22 June 2022, University Hospitals Dorset announced from September 2022, all of its antenatal services will be moved to Poole Hospital as part of its plans to develop a combined maternity service. Currently maternity services run across both the Royal Bournemouth and Poole hospital sites, with women travelling across hospitals for different appointments during their pregnancy. In 2024 a combined maternity service will operate on the Royal Bournemouth site in the new BEACH Building (representing Births, Emergency care, and Critical Care and Child Health), but until that time, all antenatal appointments and in-hospital birthing options will be run from the Poole site.

6.4.3 **Dorset Heart Clinic**

The Care Quality Commission (CQC) has awarded Dorset Heart Clinic the overall rating of "good" in their first report of the independent healthcare provider since its foundation in 2017. The clinic provides private cardiology services to people living in Dorset and the surrounding counties using the facilities provided by University Hospitals Dorset NHS Foundation Trust.

7. Voluntary, Community, and Social Enterprise Sector

7.1 Healthwatch Dorset

7.1.1 **Annual Report**

At the end of June, Healthwatch Dorset published their 2021/22 annual report. The report outlines how the feedback gathered by Healthwatch is helping the NHS and councils to make improvements to services. By sharing valuable insight gained through engagement with children and young people, community outreach work with people experiencing homelessness, and investigations around the lack of access to NHS dentistry and people's experience of using Accident and Emergency services.

7. Conclusion

7.1 The Board is asked to **note** the report.

Patricia Miller
Chief Executive Officer
NHS Dorset Integrated Care Board

Author's name and Title: Natalie Violet, Business Manager to the Chief Executive Officer
Date: 12 July 2022

7.1

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

AGE CARE TECHNOLOGIES – A PREVENTATIVE APPROACH FOR OLDER PEOPLE

Date of the meeting	20/07/2022
Author	S Sandcraft – Programme Director
Lead Director	P Johnson – Chief Medical Officer
Purpose of Report	To seek approval to secure Age Care Technologies (ACT) to work with Dorset ICB, initially for one year, to introduce a large-scale preventative approach for older people.
Recommendation	The ICB Board/Committee is asked to **approve the proposal and the recommendation to secure ACT, initially for one year.**

Monitoring and Assurance Summary

Conflicts of Interest	No conflict of interest identified
Involvement and Consultation	Involvement across the NHS, two Local Authorities with senior managers, voluntary sector leaders and clinicians in the Dorset system have help to shape the proposal and their involvement in agreeing the future governance and implementation, if the proposal is approved, would continue to co-produce the approach. The evaluation would also include older peoples experience of the approach and this will help inform the further roll out.
Equality, Diversity and Inclusion	As part of the implementation planning an equalities impact assessment will be completed.
Financial and Resource Implications	To secure ACT for the initial year one is £150k. Any further commitment would be considered as part of the evaluation and would require subsequent approval. In addition to this the ICB will need to secure additional programme capacity. £202k non recurrent, has been identified as the funding source to deliver year one of the proposal, this is from the ICB national personalisation allocation which is £202k.
Legal/governance	A VEAT notice has been issued to ensure there are no other suitable organisations which could provide the same approach and tools. A contract waiver has also been completed, subject to ICB approval of the proposal.

Risk description/rating	The successful delivery of the outcomes of the proposal will be dependent on system partners commitment and engagement in the implementation and evaluation of the approach. This is a cultural shift to re balance the focus on anticipatory and prevention approaches versus, what is currently a very reactive focused system.

1. Introduction

1.1. The purpose of this report is to present a proposal for approval to engage with Age Care Technologies on a system wide, large-scale programme of work focused on preventative health and wellbeing for older people. The paper builds on the discussions with key stakeholders including the Senior Leadership Team (SLT) during March, April and May 2022 and in particular a system wide workshop on 12th May 2022.

2. Report

2.1 Dorset has the ambition to be one of the U.K.'s leaders in healthy ageing. Behind this challenge are several important demographic characteristics. For example, the number of people aged over 65 is significantly greater than the national average, the underlying economy is poorer than many of the parts of England, with significant differences between relatively wealthy and very deprived communities in Dorset; and the geographically dispersed population in parts of the county presents huge challenges.

2.2 Over the last few years Dorset has made great progress in developing population-based health management plans for older people. There is a well-established needs and risk stratification system. The Dorset Intelligence & Insight Service (DiiS) provides an excellent source of information and actionable insights.

2.3 There is a commitment across Dorset to provide personalised care and support to older people, using well-established multi agency partnerships including community action groups and the voluntary sector. The emergent Dorset ICS acknowledges this good work and wants to build on these solid foundations whilst recognising the significant challenges ahead.

2.4 These challenges include:

- The continued increase in the number of older people in Dorset and the potential deterioration in the quality and productivity of their lives through loss of health and independence;
- The increased pressure on, often distant, family members to become caregivers resulting in a growth in the demand for older people to move out of their own homes into third party care provided by care homes or other institutions;
- The significant increase in the potential cost of care for older people which based on current projections would become unaffordable unless major changes in the pattern of demand and supply are made;
- The increased workforce pressures which mean that even if significantly more money were available, it will be difficult to recruit and retain the necessary staff.

2.5 Both in Dorset, and other parts of the country, services are currently too reactive. They are often crisis and referral driven resulting in negative or suboptimal outcomes. To rise to these challenges, improve the quality of life for older people and reduce the costs of care, Dorset needs to develop a proactive strategic approach to Anticipatory Care including an implementation plan which focuses on “up-stream” preventative assessment and early targeted support.

2.6 The outcome from this Anticipatory Care approach should:

- Identify and meet the real needs of older people which reduces inequalities, extends healthy, independent, active life, and reduces the period people are frail prior to their death;
- Put in place effective ways of supporting caregivers - both paid and voluntary;
- Ensure that the Dorset system leaders can enable effective, efficient and economical services and support to be commissioned and provided in a way which is sustainable.

2.7 Using this highly respected research, Age Care Technologies® (ACT) provides specific strategic and operational frameworks and guidance within which excellent person-centred care can be defined, delivered and analysed.

2.8 ACT use Assess & Connect methods which have been recognised as the only globally validated digitised tools to deliver the World Health Organisation guidance for person-centred, integrated care for older people. They are now being deployed to deliver the guidance in the UK and other countries.

2.9 Through regular reassessment, ACT™ Assess & Connect delivers a person-centred care plan by identifying and addressing the things which matter most to older people and mobilises community assets to meet their needs.

2.10 Assess & Connect methods have been recognised as the only globally validated digitised tools to deliver the World Health Organisation guidance for person-centred, integrated care for older people. They are now being deployed to deliver the guidance in the UK and other countries.

2.11 Through regular reassessment, ACT™ Assess & Connect delivers a person-centred care plan by identifying and addressing the things which matter most to older people and mobilises community assets to meet their needs.

2.12 ACT interventions reduce inequalities by ensuring that people less likely to report their concerns are targeted and encouraged to undertake an assessment. Furthermore, the needs identified by older people can be analysed for socio-economic variables to inform population health management.

2.13 Further detail on the proposal and approach is set out in Appendix 1.

2.14 The cost for securing ACT is £150k for year one, it is anticipated that this would be a 3-year programme with evaluation built into the programme to inform the next steps and future commitment both in terms of resource and contract extension.

2.15 A non-recurrent funding resource has been identified through the national personalisation allocation of £202k to fund the contract for year one with ACT, and if approved, to provide system programme support. In addition to this, it will be essential to have the commitment from system partners to engage and provide time and leadership within the programme.

2.16 In year one, stages one and two of the proposal would be delivered, in summary, we would work with ACT to define and agree the purpose, objectives and most importantly the expected outcomes of the Anticipatory Care Plan (ACP). We propose to build the ACP programme around identifying and meeting the real needs of each of the four main stakeholder groups:

- Older people;
- Family carers;
- Workforce;
- System leaders.

2.17 We anticipate Stage 2 will be a pilot study focussing on the development of the model for first stage preventive assessment in primary care in up to three pilot sites. This pilot work would focus on identifying how we can develop and implement a change management and organisation development plan, which shifts the emphasis to identifying and meeting the real needs of older people and connecting older people and their care givers to the support to meet these needs. It will also include evaluation of acceptability, costs and perceived benefits to older people, family carers, and the workforce (both paid and voluntary). The results of this evaluation would be presented to, and discussed with, system leaders in Dorset.

2.18 The outputs from stage one and two are set out in the proposal along with an outline of the governance which we will co-produce with system partners, initiating this, if approved in early September.

3. Conclusion

3.1 Following initial consideration at SLT and a further system partner workshop, it is recommended that the ICB approve the proposal, which includes contracting, initially for one year with ACT to work with the system to develop and implement a preventative approach to older people's health and well-being.

Author's name and Title: **Sally Sandcraft – ICS Programme Director**
Date: **05/07/22**

APPENDICES	
Appendix 1	**Age Care Technologies Proposal**

Anticipatory Care Plan for Older People in Dorset: Proposal

21 June 2022

ACT Ageing + Health

www.agecaretechnologies.org

1. Introduction

This paper sets out how Age Care Technologies® (ACT) proposes to work with the Dorset ICS to support the development and implementation of an Anticipatory Care Strategy and Plan for older people in Dorset. The paper builds on the discussions with key stakeholders including the SLT during March, April and May 2022 and in particular the workshop on 12th May 2022.

This proposal summarises:

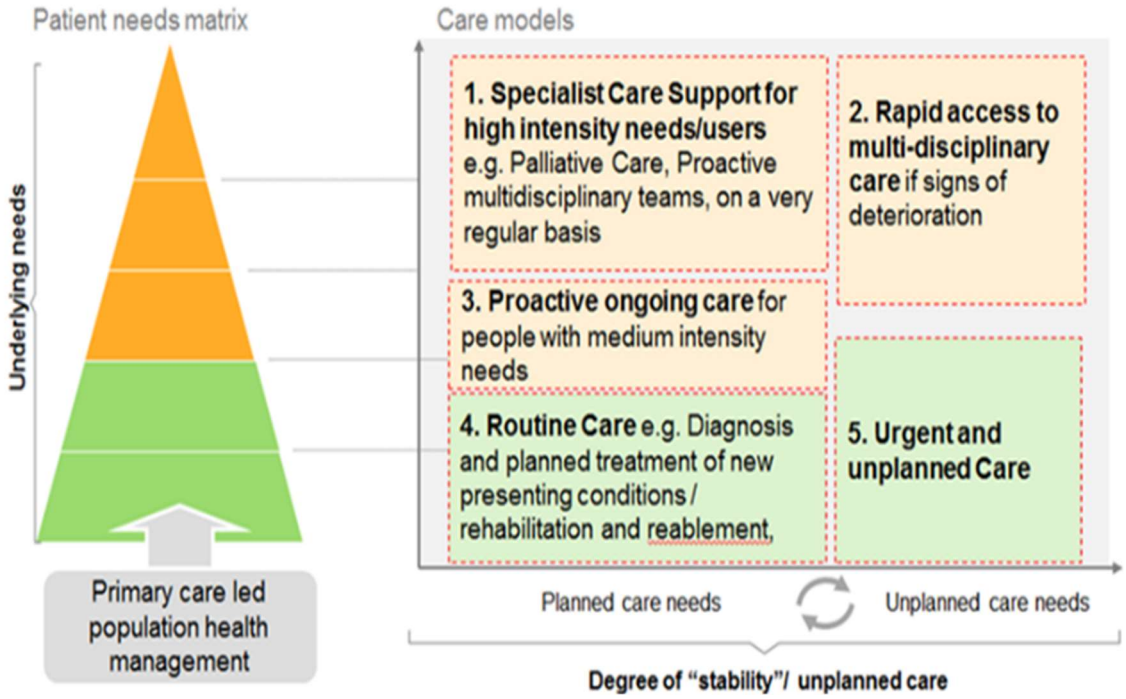
- Our understanding of your requirements including the purpose, objectives and anticipated outcomes from the work.
- Background information about ACT including our experience of undertaking similar work both in the English health and care system and other systems across the world.
- Our proposed approach.
- A summary of the benefits of this approach.
- How we would work with you, including the proposed ACT staffing arrangements and the suggested structure of the project management arrangements and how we would work with staff in Dorset.
- Timescale and cost implications.

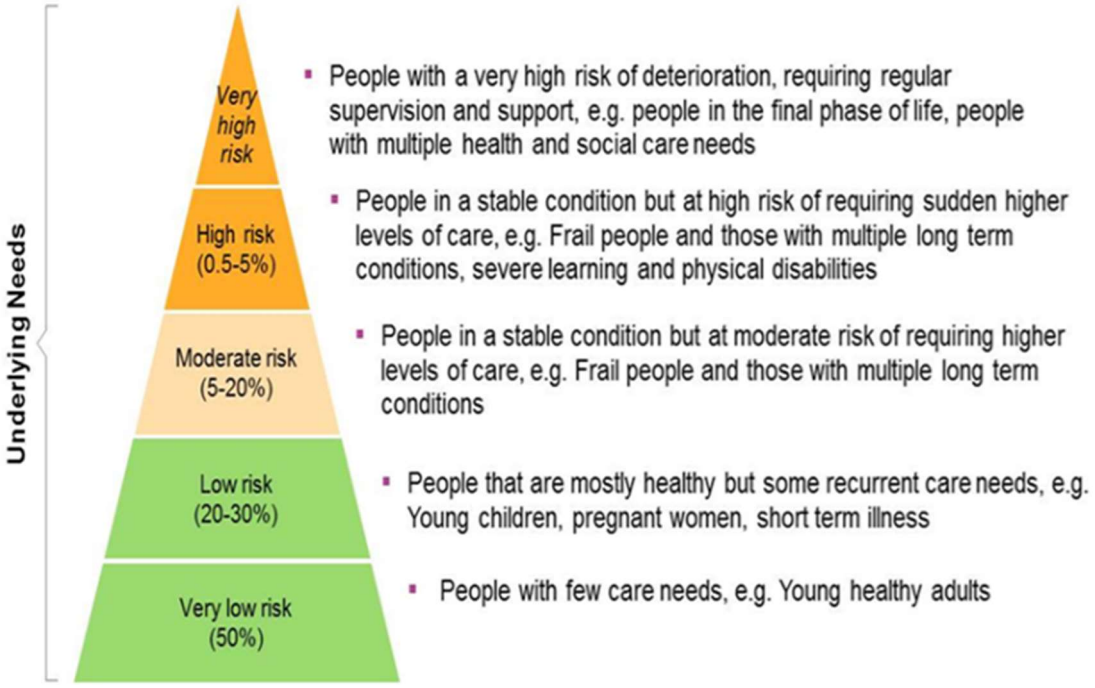
The proposal concludes by suggesting a way forward and next steps.

2. Our understanding of your requirements-purpose, objectives and outcomes

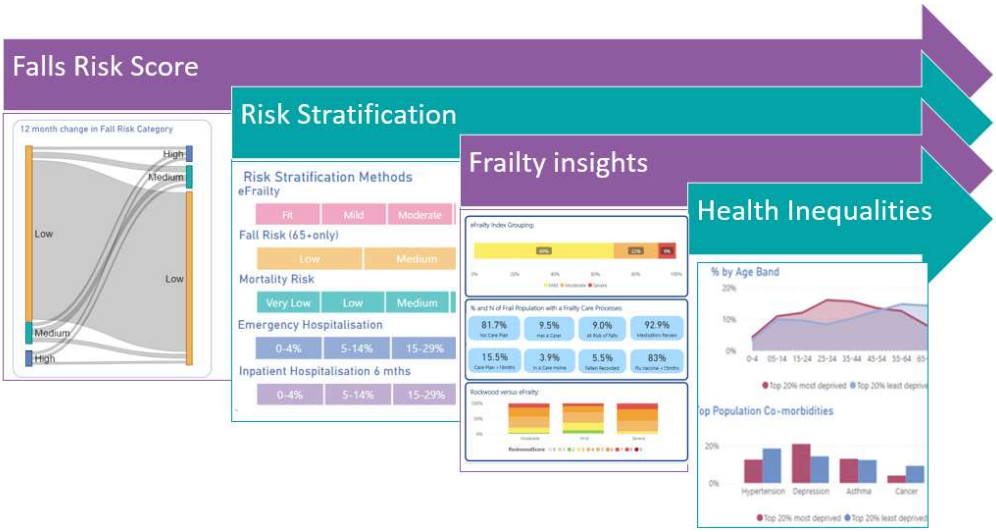
Dorset has the ambition to be one of the U.K.'s leaders in healthy ageing. Behind this challenge are several important demographic characteristics. For example, the number of people aged over 65 is significantly greater than the national average, the underlying economy is poorer than many of the parts of England, with significant differences between relatively wealthy and very deprived communities in Dorset; and the geographically dispersed population in parts of the county presents huge challenges.

Over the last few years Dorset has made great progress in developing population-based health management plans for older people. There is a well-established needs and risk stratification system as summarised below:





The Dorset Intelligence & Insight Service (DiiS) provides an excellent source of information and actionable insights:



There is a commitment across Dorset to provide personalised care and support to older people, using well-established multi agency partnerships including community action groups and the voluntary sector. The emergent Dorset ICS acknowledges this good work and wants to build on these solid foundations whilst recognising the significant challenges ahead.

These challenges include:

- The continued increase in the number of older people in Dorset and the potential deterioration in the quality and productivity of their lives through loss of health and independence.
- The increased pressure on, often distant, family members to become caregivers resulting in a growth in the demand for older people to move out of their own homes into third party care provided by care homes or other institutions.
- The significant increase in the potential cost of care for older people which based on current projections would become unaffordable unless major changes in the pattern of demand and supply are made.
- The increased workforce pressures which mean that even if significantly more money were available, it will be difficult to recruit and retain the necessary staff.

Both in Dorset, and other parts of the country, services are currently too reactive. They are often crisis and referral driven resulting in negative or suboptimal outcomes. To rise to these challenges, improve the quality of life for older people and reduce the costs of care, Dorset needs to develop a proactive strategic approach to Anticipatory Care including an implementation plan which focuses on “up-stream” preventative assessment and early targeted support.

The outcome from this Anticipatory Care approach should:

- Identify and meet the real needs of older people which reduces inequalities, extends healthy, independent, active life, and reduces the period people are frail prior to their death.
- Put in place effective ways of supporting caregivers - both paid and voluntary.
- Ensure that the Dorset system leaders can enable effective, efficient and economical services and support to be commissioned and provided in a way which is sustainable.

3. An introduction to ACT and ACT™ Asses & Connect

About Age Care Technologies®

Age Care Technologies®' purpose is to help improve significantly, the lives of 100 million older people globally by 2030.

The Age Care Technologies® proposition is based on clear, credible and compelling evidence-based research led by our founder, Professor Ian Philp over the last 30+ years.

Using this highly respected research, Age Care Technologies® provides specific strategic and operational frameworks and guidance within which excellent person-centred care can be defined, delivered and analysed.

The Age Care Technologies® proposition is built around three core elements:

THOUGHT LEADERSHIP	GLOBAL NETWORKS	PRODUCTS & SERVICES
Defining excellence in person-centred care for older people and enabling its spread across the world.	Creating, developing and supporting a vibrant global network of experts and specialists interested in the care of older people which encourages a thriving ecosystem of people and organisations who can help to achieve person-centred care locally.	Providing and embedding specific products and services at scale for organisations and individuals across geographies, cultures and communities.

ACT™ ASSESS & CONNECT

United Nations award-winning person-centred assessment and care planning tool, connecting older people to local resources to resolve concerns about their health, independence and well-being which, on average, adds an extra quality life year per older person.

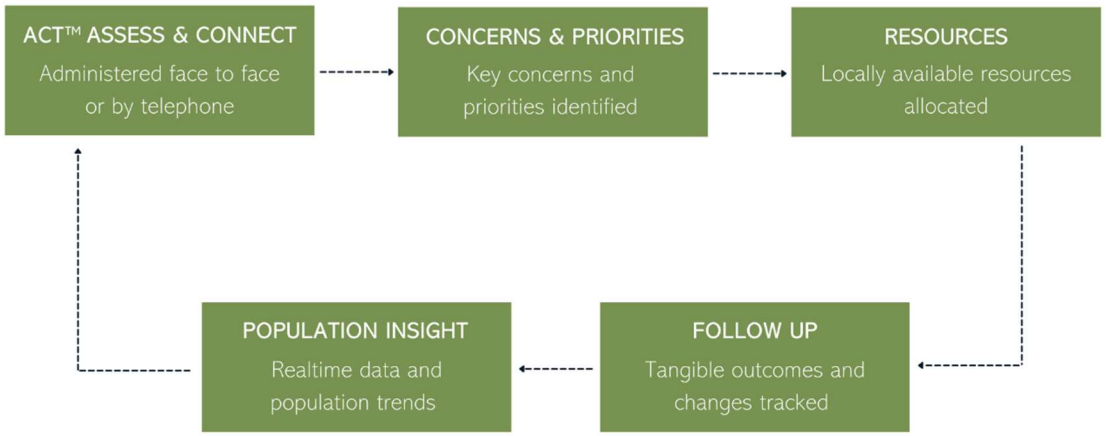
ACT™ ANALYTICS

Person-centred analysis about the concerns, needs and priorities of older people based on historical, real time and predictive data; informing the development of products and services and maximising value for money.

About ACT™ Assess & Connect

ACT™ Assess & Connect methods have been recognised as the only globally validated digitised tools to deliver the World Health Organisation guidance for person-centred, integrated care for older people. They are now being deployed to deliver the guidance in the UK and other countries.

Through regular reassessment, ACT™ Assess & Connect delivers a person-centred care plan by identifying and addressing the things which matter most to older people and mobilises community assets to meet their needs.



ACT has the proven technology to:

- identify the individuals and groups of older people at risk,
- identify their specific risks and assessed priority needs,
- connect them to support and evidence-based pathways of preventative care.

Our evidence-based approach shows that use of this methodology results in an average one-year extension in healthy active life and one year compression in morbidity for each older person. It also reduces long-term care costs by £33,000 per person; meaning that engagement with every10,000 older people within Dorset would result in a saving of £330 million over a 15-year period. Our research shows that the total eligible population is within the region is approximately 40% for those aged 75+ living at home, and 5-10% of those aged 60-75 years old and living at home.

We can also show that ACT interventions reduce inequalities by ensuring that people less likely to report their concerns are targeted and encouraged to undertake an assessment. Furthermore, the needs identified by older people can be analysed for socio-economic variables to inform population health management.

Alongside these long-term and strategic benefits, we also know that within three months of the completed ACT intervention, we will be able to demonstrate:

- decreases in the risk of hospitalisation; for example, reduced incidence of falls and fragility fractures, as shown by randomised control trials
- improvements in health-related quality of life and wellness measures, e.g., reduced loneliness based on one hundred publications and 'before and after' case study reports and;
- generation of data to inform development of policies and practice as shown by the experience in Nova Scotia, Canada since 2019.

4. Our proposed approach

Our proposed approach is based on our experience of working with and advising health and care systems across the world, and our global leadership in older people's care - credentials which are recognised by the World Health Organisation and the United Nations. The proposed Anticipatory Care Programme is tailored to meet the specific needs of Dorset, including the immediate opportunities offered by the introduction and development of the Dorset ICS and the solid foundations which already exist.

The programme will focus on anticipatory preventive care for older people living at home. It will identify unreported threats to their health, independence and wellbeing, and will mobilise community assets to address these concerns which are prioritised by older people. We will also provide a screening assessment with family carers to identify those who may need support in their caring roles. A particular priority will be placed on enhancing the support provided by the community and voluntary sectors.

Older people who are poor, socially isolated and from some minority ethnic groups are less likely to report their concerns. Our proactive approach will benefit all older people and their family carers, but will have a disproportionate benefit for these more vulnerable groups, and will help to level up the experience of healthy ageing in later life.

The Anticipatory Care Programme will provide a foundation for the development of integrated services for older people with dementia, frailty and those at the end of life, by identifying those who would benefit from integrated specialist services, which prioritise care in place, rather than admission to acute hospital care. It will focus (particularly during Stage 2) on the culture, change and management and organisation development processes which need to be put in place to enable a sustainable change in the approach to Anticipatory Care.

Data will be generated and used for population health management and linked into DiiS to measure the concerns and priorities of different groups of older people, use of resources, outcomes of interventions and trajectories in healthy active life.

Academic evaluation will provide evidence of acceptability, costs, and benefits for different stakeholders, with a view to rolling-out the model as a systematic approach to preventive care for older people and their family carers.

We will ensure that the programme aligns with the broader Dorset Integrated Care Strategy as it develops, which will in turn support the UK's contribution to achieving the UN Sustainable Development Goals for Health and Wellbeing and Reducing Inequalities, the WHO ICOPE programme for promoting person-centred, integrated care for older people, the national programme for Ageing Well and the local programme for developing integrated out out-of-hospital care for older people.

In summary, we are proposing that there should be four main stages to the overall programme:

Stage 1: Readiness - Scoping and detailed programme design (3 months)

We would work with you to define and agree the purpose, objectives and most importantly the expected outcomes of the Anticipatory Care Plan (ACP). We propose to build the ACP programme around identifying and meeting the real needs of each of the four main stakeholder groups:

- Older people.
- Family carers.
- Workforce.
- System leaders.

Underpinning all of this will be the need to reduce health inequalities and improve health for all older people in Dorset.

The key outputs from Stage 1 would be:

1. Stakeholder agreement to build a guiding coalition for the ACP programme. This will include the development of an agreed change management and organisation development plan, to help Influence the culture and approach to the development of Anticipatory Care services for older people in Dorset.
2. Identification of, and engagement with, local pilot sites
3. Alignment of methods with the UN Sustainable Development Goals for Health and Wellbeing and Reducing Inequalities.
4. Alignment of methods with the WHO ICOPE international research and development programme.
5. Alignment of the methods with the National Ageing Well programme.

6. Alignment of methods with the local model for older people's integrated out of hospital care.
7. Development of a research/evaluation plan.
8. Development of a dynamic library of services specific to each local place/community.
9. Development of a detailed project plan, including governance, reporting arrangements and deliverables.
10. Confirmation of budgetary requirements and in consultation with key system leaders, identification of potential source of funds.
11. Development of a brief for commissioning support for delivery of the main Anticipatory Care Programme (Stages 2-4).

Stage 2: Pilot studies (Year 1)

We anticipate Stage 2 will be a pilot study focussing on the development of the model for first stage preventive assessment in primary care in up to three pilot sites. This pilot work would focus on identifying how we can develop and implement a change management and organisation development plan, which shifts the emphasis to identifying and meeting the ***real*** needs of older people and connecting older people and their care givers to the support to meet these needs. It will also include evaluation of acceptability, costs and perceived benefits to older people, family carers, and the workforce (both paid and voluntary). The results of this evaluation would be presented to, and discussed with, system leaders in Dorset.

With regards to the specific target population, outcomes and key deliverables in Stage 2, we would propose the following:

Target Population

1. Older People:

- Older people living at home who accept an invitation from their general practitioners for a preventive assessment. People aged 75+ living at home on the GP list will be offered the assessment, together with people aged 60-75 who are identified as being at-risk by their primary care providers.
- Older people with frailty, dementia, some other specific long-term neurological conditions such as Parkinson's Disease, and those at the end of their lives, identified by primary care clinicians and old age specialists.

2. Family carers: The principal family carer will be identified during the older person's assessment. They will be offered a carer screening assessment.

3. System leaders: The work could start with pilot studies in (say) three local communities, representing urban, rural, and coastal communities and also the socio-economic mix across Dorset. This will enable system leaders to decide on the most appropriate way of spreading to the whole population of Dorset, subject to satisfactory evaluation.

Principal Outcomes

1. Older People: An average increase of one year in healthy active life expectancy in this population.
2. Family Carers: Improved wellbeing and satisfaction with support.
3. Workforce: Better outcomes for patients, and best use of workforce (paid and voluntary).
4. System leaders: Reduced use of statutory services including acute hospital and long-term care services - both planned and unplanned.
5. Health Inequalities: Greatest improvements in healthy active life expectancy in deprived populations.

Other Outcomes

1. Older People: Concerns addressed about their wellbeing, independence, social connection and staying healthy.
2. Family Carers: A screening assessment with the offer of support to at-risk carers.
3. Workforce: Optimised use of expertise and increased availability.
4. System leaders: Increased uptake of voluntary and community assets to meet older people's needs and support their family carers. Identification of key markers to identify and measure benefits and outcomes on a systematic basis.
5. Health Inequalities: Targeting and development of community assets to address the unmet needs of deprived groups of older people.
6. Researchers: Can identify what can be researched easily and beneficially, and what cannot (or with great difficulty).

Key Deliverables

- System readiness report to support person-centred integrated care for older people.
- Adaptation of WHO ICOPE guidance and assessment tools for local use.
- Cohort of assessors trained in person-centred care for older people.
- Proof of concept (acceptability, costs, and benefits) of implementation of the approach.
- Generation of unique data about concerns, priorities, and sources of support in preventive care for older people.
- Improved understanding of patterns of need and health status in this population of older people and their family carers and their associations with locality deprivation indices.
- Increased system resilience with greater access to community resources for preventive and out of hospital care
- Extension of healthy active life of older people, with reduced needs for hospital and long-term care services.
- International recognition for work in integrated care for older people.

Scope

The following would be included within the scope of work proposed:

- System readiness questionnaire using the WHO ICOPE system readiness questionnaire.
- First (screening) stage of the ICOPE pathway for preventive care for older people, covering the ICOPE screening questions expanding to cover the top 56 threats to health, independence, and wellbeing of the older person.
- Development of community resources and integrated pathways for older people, including those with frailty, dementia and those at the end of their lives, using ICOPE methods.
- A screening assessment of the family carer, covering positive value, negative impact, and perceived quality of support.
- A social prescription model, to connect older people and their family carers to sources of support to meet their needs.
- Assessors trained in the person-centred assessment principles and practice.
- Data extracted to support population health management.

The following would be out of scope:

- General health promotion for healthy longevity.
- Management of adults with other long-term conditions.

Practicalities and logistics

At each site, 10 assessors (total 30 assessors) will be trained in the assessment methods, which will be administered to 100 older people at each site (total 300 older people), with a carer screening assessment offered to their family carers.

A local resource and community assets checklist will be developed to address concerns identified during the assessment.

We would work with you to develop information systems to integrate the data from the assessments into population health management systems.

Stage 3: Extension and spread (Year 2)

Depending on the results of the pilot and evaluation work in Stage 2, we would expect to extend the model to include the full ICOPE pathway. This would involve:

- Rolling out the agreed methods across more sites in further localities in Dorset.
- Introducing and evaluating additional technologies to enhance the efficiency and effectiveness of the interventions (e.g., communications devices, self-management systems, AI for big data analytics).

Stage 4: Roll-out and scale (Year 3)

Roll-out of agreed methods for uptake in the whole eligible population in Dorset.

These elapsed timelines are indicative at this stage. It is perfectly feasible that Stage 3 (Spread) and Stage 4 (Scale) could be accelerated depending on the ambition, progress and finding in Stage 2 (Pilot). We would wish to review the projected timelines with the Project Board as part of the Stage 2 review and planning process.

5. Benefits of this approach

This proposed programme has significant potential benefits for a wide range of stakeholders. Set out below is a summary of the impact the outcomes of this programme will have on each of the major stakeholder groups:

Older People

- Identifies and addresses the real concerns of older people for their health, wellbeing, independence and social connection
- Reduces inequalities of access and outcome for older people
- Compresses the period people are frail prior to their death
- Extend healthy active life of older people by on average 1 additional year

Family Caregivers

- Identifies their needs and supports family caregivers to be able to provide sustainable appropriate care
- Reduced burden; improved quality of family life

Workforce

- Early identification of key risks to older people, such as cognitive impairment, depression, falls and safeguarding concerns
- Implement best practice guidelines to respond to risks
- Increases job satisfaction

System Leaders

- Embeds a systematic approach to integrating care around the needs of the older person
- Embeds a systematic approach to anticipatory care for older people
- Enhances population health management systems with data about the real needs of older people and trends in healthy active life

- Decreases the risk of hospitalisation and reduces non-elective hospital admissions, e.g. reduced incidence of falls and fragility fractures
- Reduce the costs of long-term care by £33,000 per older person, which means that for every 10,000 people in Dorset, savings would be £330 million over a 15 year period.
- National Policy: Initiative to develop and sustain of health and care systems to improve health outcomes and reduce costs with ageing populations.
- Acceleration of the UN Sustainable Development Goals for Health and Wellbeing, the UN Decade of Healthy Aging and the WHO ICOPE Programme, extending healthy active life, with wider economic benefits to society.

Community Services

- Optimise uptake and development of community assets
- Shift care from acute to community settings
- Increased and improved use of volunteers
- Extend ageing in place

Academics

- Opportunity to study and evaluate leading edge changes to the approach to caring for older people.
- Access to high quality global data and network of leading researchers.
- High quality research publications.
- Greater research Impact on national and global policy goals.

Reputation

- Early adopters of leading edge Anticipatory Care Policy.
- Pioneer site for implementing ICOPE, the WHO foundational programme for health care transformation in the UN Decade of Healthy Ageing
- Member of the ACT™ International Research Network for research and development in person-centred integrated care, contributing to the production of academic publications and Insight Reports for policymakers

6. Working with you

The ACT element of the programme would be led by Professor Ian Philp. Ian would act as Programme Director and would have overall responsibilities and accountability for the delivery of the work. Ian would be supported by Bruce Finnamore and Namrita Sharma, as well as other ACT staff if needed.

Bruce would have specific responsibilities for the organisation development and change management elements of the work and would act as Quality Assurance Director supporting Ian and the Project Board to achieve the highest quality standards.

Namrita would act as the ACT Project Manager working closely with the Dorset Project Team and in particular, the Dorset Project Manager. Ian, Bruce and Namrita all have significant experience of leading successful projects over many years. We would be pleased to provide their CVs if required.

Integral to the successful delivery of this programme is a strong Project Board and project delivery team. Key roles and responsibilities for proposed project members are listed below.

	Role	**Key Responsibilities**
Project Board	Project Chair	Provide regular project updates to other board members and senior stakeholders. Support the project manager in mitigating risks, resource problems and project delays.
	Local Council representative	Provide key insight about existing infrastructure and pathways which could be utilised to successfully delivery the programme.
	Family Carer Organisation representative	Provide insight about identification and deployment of support for identified carers.
	Locality team leads	Provide locality specific updates to the project board.
	University representative	Oversee approval for academic evaluation.
	Community and Voluntary Sector	Supporting the development (incl. capacity) of voluntary and community-based support.
	Older Person	Ensuring the users' voices are heard.

Project Team	Project Manager	Work with locality team leads to ensure key milestones are met and provide tailored support to ensure successful delivery of the project. Co-ordinate technical ACT™ Assess & Connect changes. Ensure assessors are provided with comprehensive training. Attend project board meetings and report back progress.
	Locality team managers	Working alongside project manager to develop locality specific older people outreach campaigns. Recruitment, and continued support, of assessors. Co-ordination of assessment appointments with assessors. Development of locality specific library of local services for the ACT™ Assess & Connect tool. Attend monthly meetings to provide updates to project team and project manager. Provide locality team leader with regular updates for reporting at board meetings.
	University representative	Engage with the project manager and locality leads to understand locality specific processes for data collection, recruitment etc.
Locality Teams	Assessors	Conduct 10 assessments of older people in the local area (telephone or face-to-face depending on older person's preference). Complete any and all assigned training ahead of project commencement.

7. Timescale and Fees

As set out in the section 'Our Proposed Approach', the initial work would focus on Stage 1 Readiness and Stage 2 Pilot.

The Stage 1 Readiness work would begin as soon as possible after the main summer break. Assuming a 1st September start, we would expect our scoping and detailed programme design work to be completed by end November 2022.

This would enable work to begin on the Stage 2 Pilot Studies in December 2022. These studies would run for up to one year with anticipated completion at the end of November 2023. During mid-2023, a review of the Stage 2 work completed to date would be undertaken. Based on the results, a detailed plan and proposal for Stage 3, to extend and spread the model, would be prepared, intending to include the full ICOPE pathway. Our working assumption is that Stage 3 would begin in December 2023.

Based on our proposed approach and these timescales, fees for completing Stages 1 and 2 of the programme would total £150,000 (excluding out-of-pocket expenses and VAT, which would be recharged at cost). These estimated fees are based on payment of a license fee for the use of the ACT™ Assess & Connect tool, putting in place and supporting the required IT platform(s), the project management infrastructure, and the time of the key ACT staff who will deliver the project.

8. Way forward and next steps

We would suggest that the most appropriate way forward and next steps are to meet with you to:

- Check with members of the May workshop, and if appropriate, confirm that our understanding of your requirements is correct.
- Discuss the overall proposed approach including timescale and agree that this is the most appropriate way to meet the specific needs of Dorset.
- Consult with the July Clinical Reference Group to ensure they support the proposed work.
- Take the proposal to the Integrated Care Board on 20th July for their formal approval.
- Work through the detailed approach set out in Stages 1 and 2; and consider the practical implications of undertaking this work together.
- Prepare a detailed Project Plan for Stage 1 Readiness and an outline for Stage 2 Pilot.
- Put in place the appropriate governance and programme management arrangements to ensure the work is procured and completed to the agreed time, financial and quality standards. This will include reconvening the May workshop group members to co-produce the implementation arrangements.

7.2

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

VCS & ICS MEMORANDUM OF UNDERSTANDING (MOU)

Date of the meeting	20/07/2022
Authors	Emma Lee, Community Action Network (CAN) & Jon Sloper, #HelpAndKindness
Lead Director	Sam Crowe, Director of Public Health
Purpose of Report	Approval of a 'placeholder' MOU between the VCS and ICS as outlined within ICS Design Framework. As an interim document while further codesign work is carried out with all system partners to develop an MOU that all partners have had the opportunity to influence. To ask the ICB to agree nominated links to support the Dorset Voluntary and Community Sector Assembly (Dorset VCSA) within the ICP and ICB both in terms of : • Commissioning/ Resourcing the Dorset VCSA & • Engagement, Partnerships and Communication To confirm ICS/ICP commitment to discussing the provision of resources to support the setup and running of the Dorset VCSA.
Recommendation	The ICB Board is asked to **approve** the 'placeholder' MOU.

Monitoring and Assurance Summary

Conflicts of Interest	N/A
Involvement and Consultation	The ICS Design Framework stated that the Integrated Care Partnerships and the ICS NHS body should develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. Over the last 9 months #HelpAndKindness and CAN have been working with Voluntary and Community Sector (VCS) and system partners to establish an adaptable and flexible framework that enables the VCS to meet this requirement as an equal partner within the ICS – this has led to the formation of the Dorset Voluntary Community Sector Assembly (Dorset VCSA).

	This work has also informed the production of the Memorandum Of Understanding (MOU) which has been co-written by the VCS and a range of stakeholders from within the ICS. The MOU also reflects and has been shaped by feedback gathered at several meetings including ICP Strategy Working Group and Place Based Development Working Group. Sam Crowe, Director of Public Health Dorset has been supporting the production of the MoU.
Equality, Diversity and Inclusion	EIA is in progress
Financial and Resource Implications	TBC
Legal/governance	We can confirm that the MOU is in line with the ICB's governance framework.
Risk description/rating	The risk of not doing this is not meeting the requirements of the ICS Design Framework and recognising the vital role the VCS play in supporting health and wellbeing across Dorset.

1. Introduction

1.1 Partnership working between the VCS and the public sector is now a foundational expectation within the ICS Design Framework

1.2 The ICS Design Framework stated that the Integrated Care Partnerships and the ICS NHS body should develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

1.3 Over the last 9 months, #HelpAndKindness and CAN have developed a new engagement and representation model for the VCS in Dorset, based on the discussion and consultation within the VCSE/ICS Stakeholder Group, the ICS/VCSE Task and Finish Group, and extensive wider consultation with VCS networks, groups and organisations of all kinds and sizes throughout the county. In addition, we have also discussed the ideas with local authority and health colleagues across Dorset.

1.4 Working with the sector, we have established an adaptable and flexible framework (Appendix 2) that enables the VCS to be an equal partner in the ICS. This framework, known as the Dorset VCS Assembly, was agreed by a vote on the 20th June 2022 by VCS organisations in Dorset.

1.5 In the coming months, we will be completing the setup of this agreed framework, the Dorset VCSA, and developing its role and activities. The

Dorset VCSA will seek to strengthen and develop the VCS in Dorset through increasing connections, collaboration and service visibility within the sector, and create the conditions to facilitate and enable improved partnership and integrated working with other partners in other sectors, notably within and through the ICP and ICB.

1.6 In parallel to this, #HelpAndKindness and CAN have been working with the VCS and public sector partners to develop a 'placeholder' Memorandum of Understanding (MOU) between the Dorset VCSA and the ICS. The MOU describes a set of principles for the VCS' involvement in the ICS which will inform and underpin our ways of relating and working together with the ICS and its partners. It strengthens and builds on existing and previously successful approaches, and commits our combined resources, energy and passion to further integrated working in order to develop our collective aims and objectives as equal partners.

2. Report

2.1 Following feedback from a range of stakeholders and partners within the system we are now seeking approval of the 'placeholder' MOU between the VCS (represented by the Dorset VCSA) and the ICS as outlined within ICS Design Framework.

2.2 As you can see from Appendix 1 (Draft MOU VCS ICS), this is an adaptable and flexible framework that nurtures integration through living our values, and promotes a culture that responds to learning and experience. The MOU establishes the framework and foundations for the culture within which we will work, by centring on co-creating our shared vision and values, and putting people in our communities at the heart of everything we do.

2.3 The MOU is intended to be a "living" document. The values and principles that underpin our relationship, that are described in the MOU, will continue to evolve in dialogue and collaboration, with principles of co-creation and co-production being used to enable this. Insights and discussions so far have given us a platform to start that process which is shared within the MOU.

2.4 The MOU details commitments, both jointly and independently, from the VCS and ICS. The MOU commits us for the next 12 months to the undertakings described within it. The expectation is that we will hold each other to account, live our emerging values, and regularly review our working relationship together. The MOU will be able evolve in order to serve and support those changing relationships, values and ways of working.

2.5 The MOU provides a foundation and commitment to the VCS being a valued and integral partner within the ICS. It gives a clear framework for developing strong links and supporting active partnerships between the VCS and other ICS partners within our communities to improve everyone's health and wellbeing.

2.6 In addition to this, the MOU commits to:

2.7 *"Value infrastructure for the VCS and support this; including funding it where relevant and appropriate, subject to approval and prioritisation of the ICB, with agreements that are meaningful to both sectors."*

2.8 With this in mind, and following the approval of the VCS framework and the development of the Dorset VCSA, we ask for clarification of nominated links within the ICP and ICB when we need an agreement on

- commissioning and resourcing of the Dorset VCSA
- engagement and communications

2.9 We also seek a commitment to provide resource for the development and running of the Dorset VCSA and ongoing co-creation of the MOU.

3. Conclusion

3.1 In conclusion, following significant consultation on the creation of the 'placeholder' Memorandum of Understanding between the ICS and VCS, and the development Dorset VCS Assembly framework, we recommend that the MOU should be approved.

3.2 We also ask for clarification on who the Dorset VCSA nominated links will be within the ICP and ICB for:

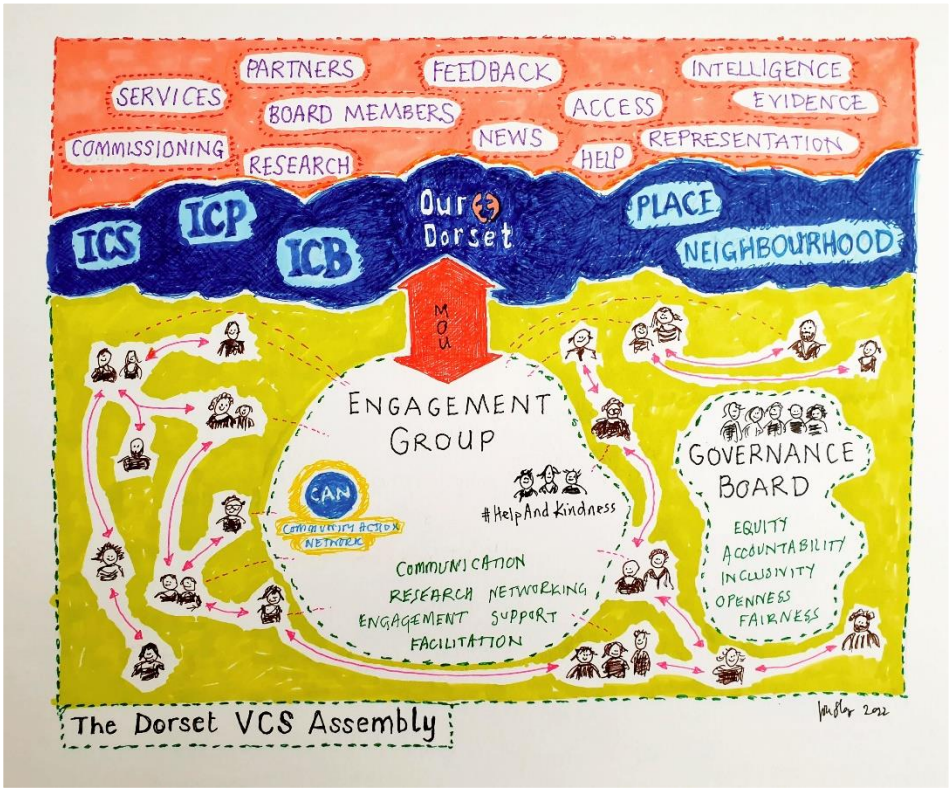
- Commissioning and resourcing of the Dorset VCSA
- Engagement and communications

3.3 We also seek a commitment to provide resource for the development and running of the Dorset VCSA and ongoing co-creation of the MOU.

Author's name and Title : Emma Lee (CAN) and Jon Sloper (#HelpandKindness)

Date : 07.07.2022

APPENDICES	
Appendix 1	Draft MOU VCS ICS
Appendix 2	Drawing of Dorset VCS Assembly Framework



Dorset Voluntary and Community Sector Assembly
The Dorset VCSA will seek to strengthen and develop the VCS in Dorset through increasing connections, collaboration and service visibility within the sector, and create the conditions to facilitate and enable improved partnership and integrated working with other partners in other sectors, notably within and through the ICP.

It will achieve this through:

- Being a focal point
- Communicating, Networking and Engaging with the VCS across Dorset
- Facilitating Joint Working within the VCS and between the VCS and other Sectors
- Representing the VCS
- Championing VCS Expertise
- Promotion, Signposting, Informing

Memorandum of Understanding

Between The Voluntary and Community Sector (VCS) and the Integrated Care System, Our Dorset

Statement of intent

Partnership working between the VCS and the public sector is now a foundational expectation within the ICS Design Framework:

"We expect that Integrated Care Partnership and the Integrated Care Board will develop a formal agreement for engaging and embedding the VCS sector in system level governance and decision-making arrangements, ideally by working through a VCS alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCS partners in relevant forums at place and neighbourhood level."

It is important to recognise that there has been partnership working and vibrant relationships spanning many years.

This Memorandum of Understanding (MoU) commits to new ways of working between the sectors. Strengthening and building on what is already in place, committing resources, energy and passion to integrated working to develop our collective aims and objectives as equal partners.

This is an adaptable and flexible framework that nurtures integration through living our values and promotes a culture that responds to learning and experience. Establishing the framework for the culture within which we will work, by centring on co-creating our shared vision and values and putting people in our communities at the heart of everything we do.

Our Vision

"Working together to deliver the best possible improvements in health and wellbeing"

Everyone deserves to live well. In working together, we will listen to understand how to develop and facilitate seamless methods of working to make Dorset a better and healthier place to live and work for all.

NHS organisations, councils, public services and voluntary, community sector partners are continuing to develop ways of working together as an integrated health, care and wellbeing system.

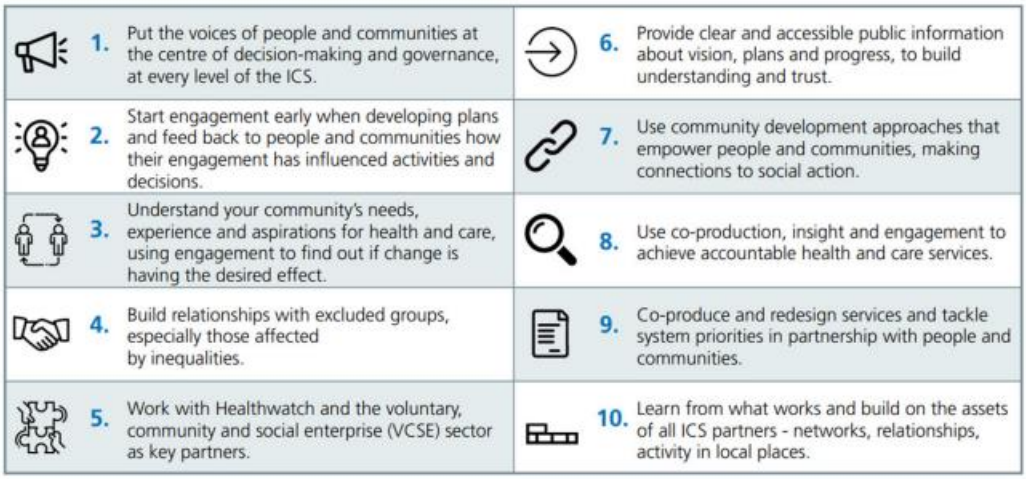
VCS organisations play a valuable role in Dorset. Collectively the sector has hugely rich knowledge and expertise and plays a crucial role in helping prevention and supporting health and wellbeing across the county and helping to improve health outcomes.

Their offer is more vital and relevant than ever, with their ability to mobilise at scale during the recent pandemic evidencing this. Reports such as the Independent Inequalities Commission 'Good Lives for All' and the Marmot Build Back Fairer review regularly references the VCS sector's knowledge and its tested practical solutions to tackling deep-rooted inequalities, addressing environmental problems, and improving mental health and wellbeing of our communities.

Throughout the pandemic the VCS has been welcomed as a strategic partner in the emergency response and recovery efforts, and this MOU seeks to strengthen this relationship and successfully integrate the VCS assembly as an equal partner in the ICS.

Principles for working in partnership with people and communities

The Integrated Care Board (ICB) is committed to working in line with the following principles for working in partnership with people and communities. This includes working with the VCS as key partners. This is referenced in the ICB constitution.



Our Shared Values and Principles

The values and principles that underpin our relationship will be co-designed together once the Integrated Care Partnership (ICP) and integrated Care Board (ICB) are established from 1st July 2022.

Insights and discussions to date are moving us towards the following:

Working together

Our initial values and principles that underpin our work and relationships that will be revisited and built upon together over the next 12 months are:

Collaboration

We will take a whole system approach to addressing the health and care needs of the population of Dorset. This includes building a mutual understanding of our different approaches and ways of working, co-designing services where appropriate, tackling problems together and sharing responsibility, risk and resources.

Equity

We recognise that we approach our shared purpose from different organisational starting points and are committed to developing a new model of shared strategic decision making, planning, and evaluating, in which everyone's expertise is valued. We will work together to remove barriers to inclusion.

Integrity

We will build trust and act with honesty and transparency, and strive to keep the well-being of the person at the heart of our endeavours.

Respect

We will be respectful and solution-focused in our approach to difficult conversations; we will listen to and seek to understand each other's views. We will be fair and respectful in how we share opportunities and recompense organisations, groups and individuals for their contributions

Working with individuals and communities

As partners, we are committed to working with our communities to help everyone live healthy, fulfilling lives with nobody left behind. We acknowledge and respect all residents' voices, their assets and their contributions, and understand we need their perspectives when addressing health inequalities. Providing space for them to share when historically they haven't had the opportunity to. Working together with communities and local people to live healthier, more independent lives.

Impactful
We will work together with our communities to co-create, design and deliver services that make a measurable, lasting, positive difference to individuals and communities.

Community-focused
We will work with local groups and communities of interest to design services that are informed by diverse voices and perspectives, built on the assets of communities, travelling at the speed of trust to meet their needs.

Person-centred
We will take a person-centred approach to service delivery, building on people's strengths, including their diversity, enabling them to exercise choice and control and promotes self-agency, self-care and independence.

Creative
We will encourage innovation across the system and learn from our experiences to inform continuous improvement, recognising that it is OK to get something wrong and the vulnerability in this. Supporting each other to learn from this.

Where we are we now

The VCS and Public Sector in Dorset both have valuable assets and strengths that will help us develop and achieve our shared goals in the county. Importantly, we agree on shared values that underpin our commitments to the way in which we behave and work together.

We have started conversations with colleagues across the ICS to begin to understand our similarities and differences. Building relationships remains key to recognising shared goals, being brave and courageous, having difficult conversations when required and taking opportunities when they arise.

This agreement has been developed through several engagement events held with members of the VCS-and public sector that have suggested a high degree of synergy in our evolving values, principles, and purpose. This dynamic model has been developed to flex and adapt to meet the changing needs of our community, the VCS and the ICS. It gives us the foundation to commit to ensuring the VCS is a valued partner within the ICS, developing strong links and supporting active partnerships with our communities to improve health and wellbeing.

Scope

This MOU will be initially signed by the:

- Chief Executive, Dorset Integrated Care Board
- Chair, Dorset Integrated Care Board

- Dorset VCS Assembly

Our final MOU will be signed by representatives from ICS partner organisations. The lead ICS organisation for this will be the ICB.

When we talk about the VCS in Dorset, we mean voluntary organisations, community groups, the community work of faith groups, individuals acting for the good of their communities, and those social enterprises where profits will be reinvested in their social purpose. This MoU is signed on behalf of the VCS sector by Dorset VCS Assembly.

Joint Commitments

For the next 12 months we commit to the undertakings described in this document. We will hold each other to account, live our emerging values and regularly review our working relationship.

1. We will co-design a shared vision, values and principles for working in partnership.

2. We will collaborate. Embedding the VCS sector as an equal partner in the ICS. Enabling us to maximise on the opportunities and share the risks to achieve the best possible outcomes for individuals, communities and our organisations.

3. We will work together to build and invest in a financially and structurally resilient VCS, empowering our communities to address the challenges they face.

4. We will work together to achieve a permanent reduction in inequalities and inequity within Dorset, addressing the social, environmental and economic determinants of health and wellbeing.

5. We see each other as critical friends. We will invest time in getting to know each other and learning about each other's sector, developing mutual understanding, building learning into our behaviours and practice and work together

6. We will hold spaces to have difficult conversations when required, committed to being open to ideas, debate, challenge, and discussion, through formal and informal channels

7. We will develop an engagement structure that is accountable, representative and a practical model and mechanism for managing the engagement and representation of the VCS as an equal partner of the ICS network. This will be done in a way that is proportionate, impactful, and fair.

VCS Sector Commitments

To work with the ICS to create conditions for community led empowerment:

1. by bringing together the voices of the VCS sector

2. engaging with thousands of voluntary and community groups and community members

3. building on existing community and cross sector networks and developing more where needed

4. providing a voice and influence for the VCS in public sector development at all stages and at all levels – whether strategic, place or neighbourhood

5. strengthen community cohesion and resilience by enabling local people to contribute their skills and time

6. Facilitating and improving the VCS' understanding of the work of ICS Partners and making stronger connections and deeper collaboration at community level

ICS Commitments

To work with the VCS Assembly to:

1. Invite 4 representatives from the Dorset VCS Assembly as members of the ICP forum, with 2 permanent members from the VCS Assembly Engagement Group and 2 that will vary in response to current priorities and the agenda of the ICP

2. Invite representatives of the VCS to attend the Integrated Care Board (ICB)

3. Recognise, respect, and work with existing networks and methods for engaging with the VCS, and co-creating new systems when they are needed

4. Integrate the ideas and experiences of the VCS and the communities they work with into the wider engagement work of the ICS, to inform strategy, service design and delivery

5. Recognise the role that the VCS plays in identifying and delivering creative, innovative and cost-effective solutions to meet the needs of our people and communities

6. Provide named points of contact for the ICP and ICB to support effective and responsive channels of communication

7. Value infrastructure for the VCSE sector and support this including funding it where relevant and appropriate, subject to approval and prioritisation of the ICB, with agreements that are meaningful to both sectors.

8. Commit to appropriate and proportionate commissioning processes for the VCSE sector, whilst also adopting and following appropriate NHS guidance. This includes frameworks and grant funding and consideration for length of contracts/ grants. We understand the need for timely payment of invoices.

7. We recognise that the VCS is an equal partner that sometimes has a different perspective. We respect the sector's right to challenge and campaign without this impacting on the funding relationship with the ICS.

For Place Based Partnerships

8. These commitments will be emulated at Place level, adapting to the identified needs of our people and communities in each Place as appropriate, in order to ensure the VCS Assembly is fully involved.

For Provider Collaboratives

9. The VCS assembly will provide lead representation at the Our Dorset Provider Collaborative (strategic) Group as per the Our Dorset Provider Collaborative Terms of Reference and any another key operational collaboratives as appropriate.

Direction of travel:

It is important we hold a strategic and longer-term direction of travel based on the values and commitments specified throughout and that will evolve through our co-design process. We will review this MoU in 12 months' time, utilising case studies of where things have worked well and where we could collectively improve.

It will then be reviewed on a regular basis to ensure it is still relevant for both sectors and supports partnership working.

Interdependencies (appendix 1):

It is important to note this MoU does not stand alone and has interdependencies with other work being carried out. Over the next 12 months we will map these, consider existing representation and how they link into the VCS Assembly moving forward.

Appendix 1

Interrelated documents include:

- Dorset VCS Assembly Terms of Reference (TOR)
- ICB strategic approach for working with people and communities
- ICP Strategy which is currently under development
- ICB 5 year plan

The numerous statutory boards across the county:

BCP Council

- Community Safety Partnership
- Children and Young People Partnership Board
- Domestic Violence & Sexual Abuse Strategy Group (pan-Dorset)
- Health and Wellbeing Board
- Safeguarding Adults Board
- SEND Improvement Board
- Early Help Partnership Board
- Vibrant Communities Partnership Board

Dorset Council

-

Health

-

8.1

NHS DORSET AND DORSET INTEGRATED CARE BOARD

ICB BOARD
PRIMARY CARE COMMISSIONING COMMITTEE

DORSET'S RESPONSE TO THE NEXT STEPS TO INTEGRATING PRIMARY CARE: FULLER STOCKTAKE REPORT

Date of the meeting	20/07/2022
Author	K. Calvert, Deputy Director Primary & Community Care D. Freeman, Chief Commissioning Officer
Lead Director	D. Freeman, Chief Commissioning Officer
Clinical Lead	Paul Johnson, Chief Medical Officer
Purpose of Report	The purpose of this report is to update the ICB Board and PCC Committee on Dorset's initial response to the nationally commissioned Fuller Report on the *Next steps to integrating Primary Care*, which was released in May 2022.
Recommendation	The ICB Board is asked to note the key recommendations of the Fuller Stocktake report and to note the position of Dorset primary care in relation to these. The ICB Board is also asked to support the Primary & Community Care Team to undertaking further work as a priority to explore how we develop multi-disciplinary neighbourhood teams as set out in the Fuller Stocktake Review.

Monitoring and Assurance Summary

Conflicts of Interest	*Members of the Board linked to providers will have an interest in this paper.*
Involvement and Consultation	*The draft paper was shared with GP members of the Board and reflects some internal team discussion*
Equality, Diversity and Inclusion	*An Equality Impact Assessment has not been considered at this stage.*
Financial and Resource Implications	*N/A*
Legal/governance	*N/A*
Risk description/rating	*Low*

1. Introduction

1.1 The purpose of this paper is to provide the ICB and Primary Care Commissioning Committee with an initial Dorset system view/response to the *Next Steps for integrating primary care: Fuller Stocktake Report*, released in May 2022.

1.2 A copy of the Report is attached as an appendix to this paper.

2. Report

Background

2.1 At the time that the Fuller Stocktake was commissioned by NHSE/I, access to General Practice and wider primary care services was under immense pressure, with increased demand that could not be fully met by the available workforce. Patient dissatisfaction, likely intensified by negative media, resulted in some practice staff subsequently reporting abusive behaviour.

2.1.1 In addition, the Government's plans for health and care reform were moving forward and General Practice had started to raise their concerns about their role and voice within the ICS.

2.1.2 In Dorset, the situation was no different, high levels of demand and limited workforce impacted on all practices, which was evidenced via the *'Health Check'* that was undertaken by the CCG in 2021. Our General Practice and Primary Care Network leaders were also concerned about the future role they would play across the system.

Early Reflections and Future Considerations of the Fuller Stocktake

2.1.3 The stocktake makes some key recommendations for the future of all services based in the community as well as primary care. The key messages include:

- Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

- Streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs.

- Ensuring those who would most benefit from continuity of care in general practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals.

- Taking a more active role in creating healthy communities and reducing incidence of ill health by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector

2.1.4 Some of our primary and community care colleagues have expressed the view that there is 'nothing revolutionary' in Claire Fuller's report. This view is reflective perhaps of where we are in Dorset and therefore not a negative comment in terms of the report's value or intention.

2.1.5 In fact, what the report helpfully provides us with is confirmation that we are still heading in the right direction, especially in relation to our ambition as a system to have fully integrated neighbourhood services that will make a difference for Dorset residents.

2.1.6 Dorset has for some time been developing its neighbourhood model via localities and Primary Care Networks (PCNs), with all key stakeholders. We have included local authorities, especially public health and third/voluntary sectors within our partnerships and therefore have a good base to further build on.

What the Fuller Stocktake means for Dorset

Models of Care & Access

2.1.7 The Fuller Stocktake Review sets out a clear vision for a new, broader model of care that builds on the foundations of General Practice and Primary Care:

> A vision for integrating primary care
>
> At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:
>
> - **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**
> - **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to**,** those with multiple long-term conditions
> - **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

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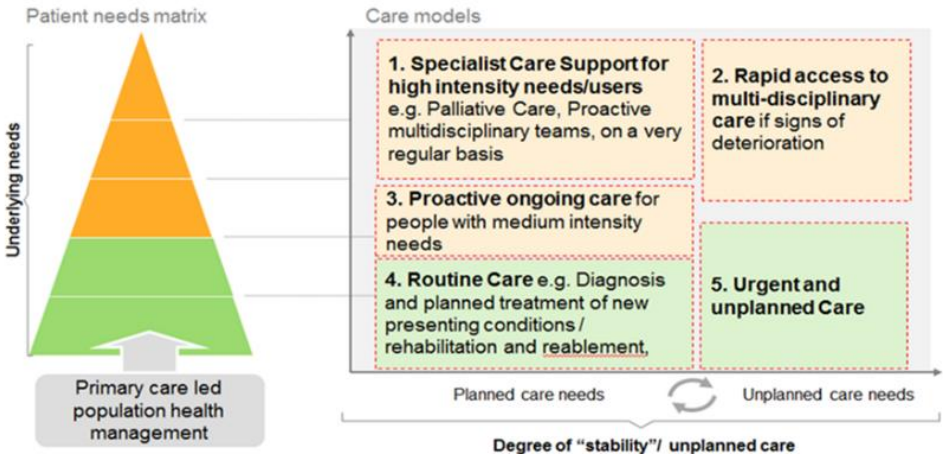
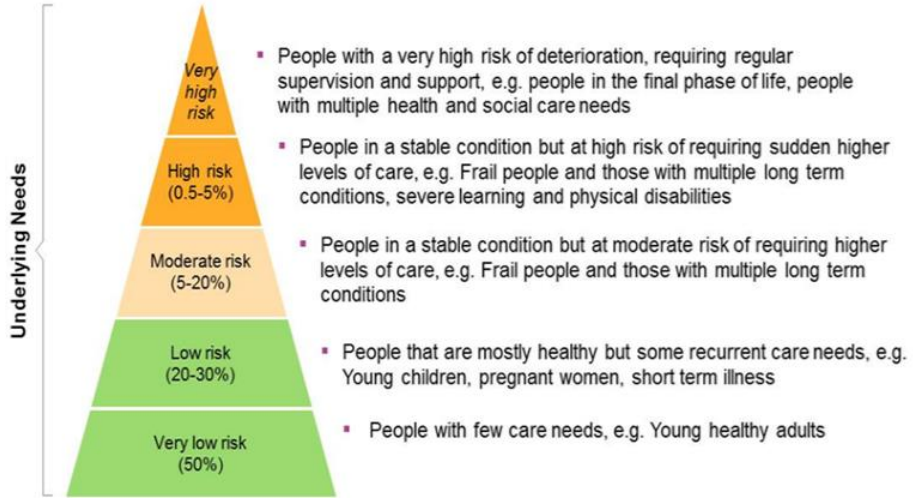
2.1.8 This vision aligns with the Dorset's out of hospital care models as highlighted in the Dorset population care model below:



2.1.9 Understanding our population's health need and risk stratification of this need underpins our approach to delivery.



2.1.10 Taking a personalised care approach and targeting care especially for those with long term conditions and/or multi co-morbidities recognises the importance of continuity of care, as well as maximises the workforce in terms of the skills and capabilities to support delivery.

2.1.11 Our Primary Care Networks collectively work to ensure that they can deliver quality services, at both personal and population health levels. Nevertheless, they are at different stages in terms of their maturity and their relationships with community partners. They will, therefore, all need to be further enabled if they are to evolve into the Neighbourhood teams as described within the Fuller report. Our Community Services Provider also has a key role to play.

2.1.12 Multi-disciplinary Neighbourhood teams that work across the spectrum of health and care being inclusive of specialist services is also important. Whilst we have some element of this in Dorset, it is not universal. Currently, we are developing our strategy for palliative care/End of Life, in which we see our Hospices having a key role to play.

2.1.13 For a child, young person, and their families/carers, we know that trusted local services and support networks need to be accessible. Prevention and targeted care would also strengthen our current health and care offer, especially for vulnerable families. If we can support parents to understand and manage their children's health needs and their own worries, we could no doubt reduce the need for and impact on wider system urgent care services.

2.1.14 Access to services in primary care is complicated, especially in relation to same day access, as there are multiple services, models of delivery, and touchpoints, depending upon what is available in-hours or out-of-hours. In Dorset we have an integrated urgent care service that incorporated the funding for improved access to General Practice services (IAGPS). It has however had its challenges, and with the IAGPS funding moving to PCNs from October this year, there is a risk for the system to the integrated service, from both financial and workforce perspectives.

2.1.15 Whilst we have been involved in some transformation of community pharmacies, there is still a lot more we could do and having delegated commissioning responsibilities should hopefully enable us further to develop integration locally at a neighbourhood level, especially in relation to our services' model for same day access.

2.1.16 Optometry and Dental services and the role they play within our neighbourhoods will also be important. Dentistry in Dorset is a significant challenge, which has been recently highlighted in a local Healthwatch report.

2.1.17 Taken all together, our progress in recent years, the developments currently underway and the opportunities coming, mean Dorset is well positioned to make the most of the recommendations set out in the Fuller report.

Key Enablers

2.1.18 One of the more striking features of the Stocktake report is an emphasis on enablers, seen by the review team as essential for success. In particular, the report makes a clear recommendation to:

> "*Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, Finance, workforce plans and models, and estates*".

2.1.19 We have already made good progress with our estates' developments in Dorset – in fact, our estates work, as you will note, was used as an example of good practice within the Stocktake Report. Building on this and the additional recommendations made, we would welcome the opportunity for locally owned NHS estate, as this could be a catalyst to bring forward some of our capital schemes. A wider system one public estate view would also support development of our integrated neighbourhoods, and this is something we would want to support further.

2.1.20 In relation to the other enabler recommendations:

- Dorset has already established the *Our Dorset Training Hub* that actively supports General Practice and PCNs with their workforce planning, recruitment and retention, and training needs. They have set up communities of practice to support their wider PCN workforce. PCNs have digital champions and all PCNs have been involved in the national Population Health Management programme.

- There is a system Health & well-being support offer for all providers and their staff and we actively promote and encourage the importance of this.

- The Fuller report has a strong focus on leadership and engagement within the ICS at all levels and across all professions across the system. Whilst Dorset has invested in developing the capability of our workforce, there is still more we can do especially in relation to enabling staff to actively participate in the development of our models of care and neighbourhood services, working alongside their communities.

- General Practice will be setting up a Dorset GP Alliance that will represent their collective voice within the ICS. A strong Alliance will enable the ICB and Provider Collaborative to strengthen local leadership and help develop the integrated neighbourhood model.

- In Dorset we have a strong platform to build on, but if we are to maximise our opportunities, in terms of infrastructure and the key enablers for success, this will require further work and support from the system.

<u>Financial Considerations</u>

2.1.21 Following the Clinical Services Review, Dorset CCG/ICS increased its investment in primary and community care services, recognising that this was necessary if we were to have a sustainable impact on avoidable hospital admissions and hospital flow. Unfortunately, due to the Covid-19 pandemic, approximately only one third (£6.5m) of the planned £18m was fully realised.

2.1.22 However, it should be noted that the establishment of Primary Care Networks (PCNs) in 2019 further enhanced Dorset's primary and community care locality model and investment. Although the associated funding is prescribed via the national GP Contract. In addition, NHS investment for community services, via the Ageing Well Programme more recently has also provided us with further opportunity to build on our developed models of care.

2.1.23 Whilst there has been a clear focus and investment for integrated primary and community care services, we do not yet have, what we believe to be, a cohesive model for *out of hospital* services. The investment has also been targeted predominantly at our older population and so the ICB will need to ensure that we also don't lose sight of our children and young people.

2.1.24 We also have a commissioning legacy that is tied to past East and West Dorset PCT decisions, creating challenges for us from both service equity and inequality perspectives. It is still early days in terms of making a differential

investment using population health management and risk stratification, but we are in a strong position to do so.

3. Conclusion

3.1 Whilst acknowledging the Fuller Stocktake report doesn't deliver any significantly ground-breaking insights for Dorset, this is more of a reflection on the nature of our progress in recent years and not a comment on the important or significance of Claire Fuller's recommendations.

3.2 The Stocktake Report comes at the right time for ICSs and the newly constituted ICBs, stating as it does the clear needs, opportunities and essential enablers for integrating primary care into new models of neighbourhood working. In this this shift of emphasis is the real impact of this review – a critical to build new ways of working and supporting our populations up and out from our neighbourhoods and seeking to shift away from the 'top-down' clinical models of care that have led the way for generations.

3.3 It is important to note that this paper only reflects some initial high-level and early discussions and feedback on the Fuller Report. There needs to be a much wider stakeholder conversation as to what it might mean for Dorset and how we take the recommendations forward, acknowledging that some of the changes required would need to be enabled by NHS England.

3.4 However, notwithstanding the further engagement we want to have, it is our view that this report represents a blueprint for further expanding the approach we have been building in Dorset for many years. The Fuller Stocktake Report confirms that we are heading in the right direction, however, we also recognise that there is more to do, especially in relation to *prevention, access,* and *urgent and same day care*. This report gives us the mandate shift more effort and focus into building new types of support with and in our neighbourhoods and communities, and with all partners all the time.

3.5 Dorset has already achieved a lot in relation to integrating primary and community care services and we continue to further develop partner relationships within our neighbourhood/PCN footprints. In addition, there is currently both service and investment variation across Dorset that we need to be better understand from both a good practice and outcomes' perspective. Our Dorset Intelligence and Insights Service (DiiS) holds us in good stead to help us with this, as well as enable us to commission for outcomes. It should be noted, however, that digital interoperability of our information systems and consistent coding will need further consideration.

3.6 As a key enabler, we need to continue the work that we are doing in primary care estates. Any further support from NHSE in relation to this area and removing/minimising current barriers would be welcomed.

3.7 Workforce is undoubtedly a key priority. Our Primary Care workforce needs to grow, especially in relation to General Practitioners, Pharmacy and Dentistry. We also want to ensure that wherever possible Dorset 'grows its own' and can

recruit and retain staff, taking into consideration ICB and ICP priorities for Anchor institutions and affordable housing.

3.8 We want to ensure that our workforce is fully supported, engaged and that our leadership model across all clinical and non-clinical roles continues to be strengthened.

3.9 Finally, we believe that the establishment of the Dorset General Practice Alliance will be a key enabler to the ICB governance, delivery of the ICP Strategy and future development of integrated care neighbourhoods.

4. Recommendations

4.1 The ICB Board is asked to note the key recommendations of the Fuller Stocktake report and to note the position of Dorset primary care in relation to these.

4.2 The ICB Board is also asked to support the Primary & Community Care Team to undertaking further work as a priority to explore how we develop multi-disciplinary neighbourhood teams as set out in the Fuller Stocktake Review.

Authors' name and Title: **Kate Calvert, Deputy Director P&C Care**
David Freeman, Chief Commissioning Officer
Date: **6 July 2022**

APPENDICES	
Appendix 1	*NEXT STEPS TO INTEGRATING PRIMARY CARE: FULLER STOCKTAKE REPORT*

Next steps for integrating primary care: Fuller Stocktake report

Commissioned by NHS England and NHS Improvement from Dr Claire Fuller, CEO (designate) Surrey Heartlands ICS

MAY 2022

Introduction from Dr Claire Fuller

For generations, primary care has been at the heart of our communities. Health visitors, community and district nurses, GPs, dentists, pharmacists, opticians, and social care workers are among the most recognisable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country.

Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS and also providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

Despite this, there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it.

Inadequate access to urgent care is having a direct impact on GPs' ability to provide continuity of care to those patients who need it most. In large part because of this, patient satisfaction with access to general practice is at an all-time low,[i] despite record numbers of appointments: the 8am Monday scramble for appointments has now become synonymous with patient frustration.

At the same time, primary care teams are stretched beyond capacity, with staff morale at a record low.[ii] In short, left as it is, primary care as we know it will become unsustainable in a relatively short period of time. It is against this backdrop that the Chief Executive of the NHS, Amanda Pritchard, asked me to lead this major stocktake of integrated primary care from the ground up.

I want to start by thanking all primary care staff – and staff right across the health and care system – for their magnificent efforts during the pandemic. Since the inception of the NHS, there has not been a generation of leaders and staff who have faced the kind of overwhelming challenges as those working in our system today, and despite the very real toll COVID-19 may have taken on them personally and professionally, they will forever be able to wear their contribution as a badge of honour.

When I agreed to lead this work in November 2021, I don't think I fully appreciated the amount I would personally gain. As a GP for over 25 years, a clinical commissioning group (CCG) chair, a CCG accountable officer and an integrated care system (ICS) CEO designate, I have been involved in numerous system reviews and reforms. However, I do not think I have ever had such an opportunity to share ideas, listen and learn from others, build relationships, and challenge my own understanding, as I have during this process. It's been a pleasure to have met and worked with so many fantastic colleagues during the past six months.

During that time, we have had over 12,000 individual visits to our engagement platform, over 1.5 million Twitter impressions of *#FullerStocktake*, and close to 1,000 people directly involved through workstreams, roundtables and one-to-one meetings. The levels of engagement have been unlike anything I have seen for many years – all driven by a collective desire to create the conditions by which primary care can be supported to thrive in the future.

A moment of real opportunity

Despite the current challenges, there is real optimism that the new reforms to health and social care

– *if properly supported to embed and succeed* – can provide the backdrop for transforming how primary care is delivered in every community in the country.

We are weeks away from the inception of the new ICSs and with it the biggest opportunity in a generation for the most radical overhaul in the way health and social care services are designed and delivered. Primary care must be at the heart of each of our new systems – all of which face different challenges and will require the freedom and support to find different solutions. In an extraordinary and welcome display of common purpose across health and care, each of the CEOs of the 42 new systems has added their signature to this report.

But these new systems alone can't fix all the problems: we need action at every level. This report sets out a limited number of recommendations for NHS England, the Department of Health and Social Care (DHSC), and other national bodies that will enable local systems to drive change in their communities and neighbourhoods. This includes ensuring future national policy is designed to *support and enable* local systems to do what they need to do rather than apply a one-size-fits-all approach.

Support, enablement and respect have been among the most common themes throughout this stocktake. Emerging from the pandemic, it is clear that we all want to build on the best elements of our response to COVID-19 and work together wherever possible: delivering what works locally in step with our communities. As leaders, we have to ensure that we lead in an inclusive, compassionate and respectful way: setting the right tone will accelerate and embed the kind of change we all want to see delivered.

Some – but not all – of the changes needed in this report will require us to grow overall primary care capacity. Additional investment is by no means the main or only answer to the issues we need to solve: we will also need to think differently about how we design integrated primary care services that better anticipate the needs of different groups of people.

It is vital that we retain continuity as one of the core strengths of primary care, but we must also recognise that people's needs and expectations are changing. On the one hand, a growing number of people have complex needs, such as multiple long-term conditions, requiring highly personalised care and support. On the other, many people who are normally in good health would prioritise faster access to advice from a wider group of professionals.

A vision for integrating primary care

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**

- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to**,** those with multiple long-term conditions

- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

It is the collective judgement of the people who have engaged closely in our stocktake that the vision for integrating primary care set out in this report is achievable if we create both the conditions to enable locally led change *and* the supporting infrastructure to implement it: indeed, as demonstrated by many of the case studies contained in this report, systems are already working in this way.

Primary care has always had an entrepreneurial and innovative spirit. We have recently seen the significant, rapid and life-saving adaptations that were made during the pandemic response; including through the COVID-19 vaccination programme delivered together with local authorities, pooling resources to establish COVID-specific 'hot hubs', safeguarding care home and domiciliary visits, ensuring community pharmacy kept its doors open to the public throughout, and shifting to virtual consultations to protect patients, carers and staff.

Locally led, nationally enabled change is a consistent theme in these pandemic success stories. This report offers a vision for transforming primary care led by integrated neighbourhood teams that will be supported to lead change, drawing from the wealth of positive change already underway.

There are no quick fixes, and we have tried through this report to set out pragmatic actions for ICS leadership teams that move us further on the journey, as well as some broader recommendations for national policymakers that will unlock the longer-term changes we need to see.

Improving the experience of accessing primary care is essential to restoring the confidence of the public, who rightly expect us to be there when they need us. Even more important in my view, is the opportunity this new vision for integrating primary care presents in helping people to stay well for longer. This will not only have the greatest impact on the future sustainability of health and care services overall but can genuinely help to transform lives.

All too often, the vast majority of our effort is focused on treating people who have already become sick. We need to create a sense of urgency around providing proactive care and improving outcomes for our population – not only will this help our citizens to lead more active and happier lives, it will help us to reduce the pressure on the NHS and social care in the medium to long term.

This is only achievable if we work in partnership addressing health inequalities through the Core20PLUS5 approach, and taking action to address the wider determinants of health.

Aligned leadership

In my view, ICSs come just at the right time, tasked with achieving four aims: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development.

The ICS CEOs believe that achieving these aims will only be possible if we support and develop a thriving integrated primary care system. This will need to be built as locally as possible, drawing on the insights, resourcefulness and innovations of patients and their carers, local communities, local government and NHS teams, other care providers and wider system partners, as well as, of course, primary care leaders. *This philosophy of partnership is at the heart of my report.*

I am hugely grateful to our workstreams and task and finish groups. By rapidly bringing together a wide range of experience and expertise, they informed our understanding of the current landscape

and what the future should look like. For those who gave us 10 minutes or 10 hours of your time, your input has helped shape this report and I hope you are encouraged by its conclusions. Thank you particularly to all our workstream and task and finish group chairs: Tracey Bleakley, Dr Nick Broughton, Glen Burley, Daniel Elkeles, Professor Kevin Fenton, Professor Simon Gregory, Dr Jaweeda Idoo, Fatima Khan-Shah, Joanna Killian, Dr Neil Modha, Thirza Sawtell, Dr Harpreet Sood, Jan Thomas, and Rob Webster. I'd also like to thank Adam Doyle, who has acted as a critical friend throughout the production of this report.

This report has also been informed by the findings of a King's Fund literature review on levers for change in primary care, commissioned as part of the stocktake, which has provided invaluable insights into what truly drives change: a leadership culture that promotes an enabling and psychologically safe environment, and the capacity, time and skills for people to learn and experiment.

Leading this work has been a privilege, and meeting so many enthusiastic and solution-focused leaders across the health and care system has solidified my optimism for the future.

This report is only the start. To implement these recommendations requires the continued input and effort of my ICS CEO colleagues, the integrated care board (ICB) and integrated care partnership (ICP) chairs and primary care leaders, as well as the support of our system partners. I look forward to being on this journey with you all.

Building integrated teams in every neighbourhood

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

The development of PCNs, established just prior to the pandemic, has already enabled many neighbourhoods to make progress in this direction. However, we've heard consistently that a lack of infrastructure and support has held them back from achieving more ambitious change.

Healthy Hyde PCN employs 34 people across many different disciplines, all of which are working to tackle health inequalities. The PCN covers 77,000 people, over 60% of whom live in the top two deciles of most deprived postcodes in England. It has six health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. Healthy Hyde is working with local voluntary organisations, statutory bodies and community services to provide a full holistic approach to a person's needs. It has set up groups that are run weekly and monthly by professionals ranging from GPs, nurses, social care, citizen's advice bureau, health visitors and mental health professionals. These groups run for people aged 0 to 100. The team has clinical leadership, managerial and admin support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.

Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

This requires two significant cultural shifts: towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams.

The key ingredient to delivering this way of working is leadership – fostering an improvement culture and a safe environment for people to learn and experiment. We heard consistently throughout our engagement that a 'top-down' approach of driving change and improvements risks alienating the workforce and communities and hinders development of trusting relationships: something emphasised in the King's Fund literature review.

Many ICSs are already thinking about how to ensure neighbourhood teams have, for example, sufficient leadership capacity and support to develop a collaborative multiprofessional workforce. Delivering integrated neighbourhood teams will require a step-change in progress, with a systematic cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods. For example:

- full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints', working alongside dedicated, named specialist teams from acute and mental health trusts, particularly their community mental health teams
- making available 'back-office' and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (eg GP federations, supra-PCNs, NHS trusts)
- a shared, system-wide approach to estates, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

This will not only unlock improvements in patient care but will also help individual PCNs and teams better manage demand and capacity, building resilience and sustainability.

Integrated clinical pharmacy service in Wirral

Staff working across PCNs and the hospital trust in Wirral Place deliver a shared clinical pharmacy service, hosted by Wirral University Teaching Hospitals NHS Foundation Trust. The service was co-designed and developed with partners, resulting in an environment where those actually delivering the service are 'system thinkers' focused on the patient, regardless of their organisation. Their ability to link with clinicians and other professionals across the local system through the shared use of IT systems, as well as the trust and relationships which have developed, support the speedier resolution of any issues which might impact on patients and the local population – team members are always cognisant of the impact their actions may have in another part of the system.

As well as supporting members of general practice to resolve medicines issues encountered, the joint pharmacy team are also invaluable assets in the day-to-day running of practices. They have their own clinical caseload, run medicines optimisation clinics and support implementation of medicines safety strategies. While working in hospital, they undertake clinical ward rounds across a range of specialties, with a particular focus on admissions and frailty to support safe transfer of care.

The service grew out of an initial pilot, involving just four members of staff, to a team of 25 within just two years. Some staff rotate across the sectors, while some are permanently working in split roles across both sectors.

The pace at which these teams can be built will depend in part on the pace at which we can deliver the national and system changes set out later in this report. However, with the right support, we heard that systems should aim to have them up and running in neighbourhoods that are in the Core20PLUS5 most deprived areas by April 2023.

This will not only ensure that we can start to better support those communities who need it most, it will create the necessary pace and ambition to move to universal coverage throughout 2023 and by April 2024 at the latest.

Working with people and communities

Throughout the stocktake, we heard that the PCNs that were most effective in improving population health and tackling health inequalities, were those that worked in partnership with their people and communities and local authority colleagues. This partnership focuses on genuine co-production and personalisation of care, bringing local people into the workforce so that it reflects the diversity of local communities, and proactively reaching out to marginalised groups breaking down barriers to accessing healthcare.

Community Health and Wellbeing Workers (CHWWs): Westminster City Council, Pimlico Health at The Marven and Imperial College London have launched a pilot scheme of trained CHWWs to run from May 2021 to June 2023. CHWWs visit local households monthly, irrespective of need, and deliver a broad range of activities including promotion of healthy lifestyles, reminders for vaccinations and screening and management of chronic diseases. In this pilot, CHWWs are available to talk to residents about their health, offer social care support where appropriate and inform them about available services, whether they have existing health issues or not. This proactive, universal and comprehensive role helps to capture health and social care issues as they arise. CHWWs in the pilot have identified undiagnosed serious mental illness and domestic violence and improved cervical screening uptake in Muslim women. Due to the initial success of this pilot scheme, this model is now being adopted by the National Association of Primary Care to promote nationally.

We have a fantastic opportunity to build on the outreach model that characterised the COVID-19 vaccination programme: developing meaningful and sustained relationships within communities, using the expertise, resources and relationships held by the NHS and local government, voluntary, community and social enterprise (VCSE) sector teams and community groups and leaders to understand the local social, demographic and cultural factors.

As a part of this drive, our workforce needs to be given the time and resources to meaningfully undertake this work. Outreach should not be considered a bolt-on to the day job – it's central to people's roles and should be reflected in protected time and job plans, for both current and upcoming roles.

Growing Health Together in east Surrey is a place-based approach to prevention and health creation, which uses ecological design principles to support population health, health equity and the environment. Clinicians in each PCN have regular protected time to work collaboratively with local citizens and partners to co-create evidence-based conditions for health and wellbeing. Solutions differ according to the location, reflecting the unique priorities, needs and strengths of each community. Listening to and building relationships within communities form the foundation of this work. Quality improvement methodology is utilised, and the work is supported by population health data and a community of practice. A comprehensive independent evaluation is underway, exploring quantitative and qualitative impacts on both the health system and wider community.

ICSs have a real opportunity to use their scale and convening power to foster meaningful partnerships between sectors, emphasising the importance of health and care organisations as anchor institutions: for example, with schools and higher and further education (HFE) providers, through outreach, work experience programmes and apprenticeships, to drive the recruitment of a more diverse and representative primary care workforce, including health inclusion groups, people with a learning disability and autistic people.

Working in this truly integrated way with people and communities offers the NHS a real opportunity to deliver more effective and sustainable change and paves the way for a much bigger prize: creating the space and opportunity to do far more on the most pressing challenge for health and social care systems: tackling the determinants of ill health and helping people to live happier and healthier lifestyles.

Ultimately, these integrated teams – rooted in the community and working across the spectrum of health and care – are the central conduit through which we can deliver the new model of integrated care.

Stort Valley and Villages PCN has created a **Young People's Social Prescribing Service** to support young people aged 11 to 25 with their physical and mental health. The PCN developed this model because they recognised that services for young people can be confusing and difficult to navigate. The service aims to signpost young people and their families to appropriate community-based and statutory services after they have been assessed by a GP; support general wellbeing among young people and their families in the local community; highlight how effective community interventions can be within PCNs; offer preventative interventions such as the Family Wellbeing Health Coaching Service provided by Mental Wellbeing in Schools; and work alongside other services with a view to creating activities and groups for those who have been referred. The service has had over 500 referrals since its creation in September 2019 and received positive feedback from young people and their families.

Delivering the change our patients and staff want and need: improving same-day access for urgent care

The two issues that have dominated the debate throughout this stocktake are the need for people to access same-day urgent care *and* the need for GPs to be able to provide continuity of care to those patients who need it most.

In reality, they are two sides of the same coin. Creating a resilient infrastructure and resilience around GP practices that enables same-day access to urgent care to be delivered *creates* space to deliver more continuity of care.

To get there, we are going to need to look beyond a traditional definition of primary care and understand that NHS urgent care is what patients access first in their community – typically from their home or high street and without needing a GP referral. That might be online advice on symptoms and self-care, going to a community pharmacy, a general practice appointment, an urgent treatment centre, or the 111 out-of-hours clinical assessment service. As part of accessing urgent care, a patient may then get immediate referral into emergency care or go online or talk to somebody before walking into a hospital emergency department.

People waiting for an appointment with their GP prioritise different things. Some *need* to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, *but certainly not always*, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly.

Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.[iii]

We saw throughout the stocktake some fantastic case studies of practices and PCNs that are already working as a single urgent care team, including allied health professionals, community nursing teams and others to offer their patients the care appropriate to them when they call the surgery or book an online appointment.

The Foundry Health Centre is a single practice PCN in Sussex with 28,500 patients. Since 2019, it has sought to improve access and keep patients out of hospital. Patients are streamed using systematic triage and clinical judgement and identified as green (generally well – continuity less important), amber (long-term conditions – continuity important; appropriate reactive care delivered), and red (vulnerable or complex – continuity paramount; proactive care given). Combined with creating a dedicated 'green' site for those needing on-the-day access (and 'amber' overflow), capacity across the multi-site practice is easier to plan and manage, drawing on MDTs so patients see the right health professional at the right time.

This approach has improved continuity of care, improved access to a range of services through partnership working, and better utilised additional roles, such as pharmacists, nurses, paramedics, physiotherapists, social workers and those working on behalf of the voluntary sector. Compared with other practices on South, Central and West Commissioning Support Unit programmes, and based on the GP clinical system data, Foundry's top 5% of frequent attenders only use 30% of GP consultations compared with 40% elsewhere, and it has reduced the number of appointments being 'avoidable' from 9% to 6.5% in late 2021, with other primary care services reporting an average of 27% as 'avoidable' appointments.

Managing access for multiple services at a practice level is achievable and scalable if we create the right conditions for this to happen. Working together to make better use of capacity and workforce – as well as creating resilience to deal with demand – can not only help to significantly relieve the burden on practices struggling to cope with finding appointments for their patients, it can also help to reduce demand on other urgent care services across the NHS.[iv]

The truth is, we *can* create a much better offer for all our patients, but it requires effective collaboration across primary care and with the wider health system in a way that we have not managed to date.

Implementing the vision for integrating primary care will enable local systems to plan and organise a coherent urgent and emergency care service by developing an integrated urgent care pathway *in the community*.

Humber Coast and Vale ICS implemented an Operational Pressures Escalation Levels (OPEL) system to understand and manage demand and capacity across primary care. Practices log their on-the-day status online, and if a practice reports capacity issues, the CCG will support and work with it to find a solution.

Though some practices were initially wary of reporting their data, through the relationships of trust between GPs and the CCG and the intelligence that OPEL provides to the system, practices now confidently report their pressures.

This has been particularly successful in Vale of York CCG where all 11 practices report OPEL escalations daily, following three years of relationship development. York CCG's practices have now gone further to improve this system by developing their own anticipated pressures reporting system through the GP Federation, to get ahead of expected demand and capacity issues the day before. Thanks to joint contributions to a shared budget, practices can confirm additional resources are in place before a busy day even begins.

How do we get where we need to be?

We should start by recognising the current system is not fit for purpose – it is fragmented and causing frustration among patients and staff. In the face of rising demand, we need to move to a streamlined and integrated urgent care system – and primary care has an essential role in achieving this.

We need to enable primary care in every neighbourhood to create single urgent care teams and to offer their patients the care appropriate to them when they pop into their practice, contact the team or book an online appointment.

The importance of improvement support, data and leadership is central to making this work and we set out some key recommendations on these later in this document.

Critically, we need to create the conditions by which they can connect up the wider urgent care system, supporting them to take currently separate and siloed services – for example, general practice in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community

response services, home visiting, community pharmacy, 111 call handling, 111 clinical assessment – and organise them as a single integrated urgent care pathway in the community that is reliable, streamlined and easier for patients to navigate.

This will require some shifts to national policy too, specifically the approach to NHS 111, which we heard via the stocktake can often result in duplication of effort for patients, carers and clinicians. At the moment, we do not have a clear and consistent way of counting and measuring same-day urgent access, or unplanned waits for routine appointments. NHS England should consider developing these to support local improvement activity, linked to its wider work with systems in bringing together a set of key primary care standards.

The ultimate arbiters of the success of this approach will be our patients. We should measure patient satisfaction rates throughout this journey, and there should be a move to roll out the new National Patient Reported Experience Metric as quickly as possible. If patients are happier tomorrow than they are today because they are receiving more appropriate care when they need it, then we will be heading in the right direction.

Personalised care for people who need it most

Continuity of care, specifically the relationship between a named GP and their patient, is directly linked to improvements in patient experience and lower mortality, especially for more complex patients.[v,vi] This is a core strength of primary care and we repeatedly heard the fundamental importance of this from staff across primary care and patients alike.

As described earlier, not all patients want or need continuity of care; equally some patients may want continuity of care more generally but be happy to see different professionals as part of their overall care.

By managing urgent care differently and supporting the growth and development of integrated neighbourhood teams, we can create the capacity for team-based continuity, focusing specifically on those people most likely to benefit – aligned to the Ageing Well agenda, for example.

Determining which patients benefit most from more personalised continuity of care can depend on a range of medical, psychological or social reasons and should be determined through conversations with patients and using clinical judgement, as well as supported by risk stratification using the wealth of data increasingly available to primary care teams.

A personalised care approach means *'what matters to me, not what's the matter with me'.* We heard a strong message via the stocktake that we must start with people's abilities and work with them to support self-care and self-management of complex and long-term conditions.

This means shared decision-making with patients and carers and improving availability and usability of patient-held records – for example, ensuring that reasonable adjustments for people with a disability are seen and accessed by all people involved in their care. It also means the further planned expansion of personal budgets and building on the progress made to date in expanding the role of social prescribing in primary care teams.

As integrated neighbourhood teams develop, they will then play a vital role in supporting people with multiple long-term conditions, who we know benefit from a team approach,[vii] drawing in

expertise from primary care, secondary care, social care providers and the VCSE sector to ensure there is comprehensive and co-ordinated care around the patient.

Teams should be collocated and built around the needs of the local population, with a blended mixture of primary and secondary care expertise to provide holistic care for people with more complex and chronic long-term conditions. There should be easy access to a range of diagnostics from phlebotomy, electrocardiogram and spirometry to more complex diagnostics like MRI and endoscopy, without having to bring patients into hospitals, capitalising on the nationwide rollout of community diagnostic centres.

Connecting Care for Children (CC4C) is a partnership between hospital and community health providers, GP federations, PCNs, local authorities, charities, patients and citizens in north west London. Nine child health GP hubs have been set up to provide an integrated child health model of care across multiple agencies and community-based services, with GPs and paediatricians providing specialist clinical input.

MDTs come together to discuss and manage clinical cases, sharing learning on a regular basis. As these teams have matured, they have expanded and now also focus on quality improvement, planning and identifying opportunities for proactive, preventative care: for example, bringing together child health professionals and dental experts to improve children's oral health for the GP practice population. More than 35 CC4C systems have also been established across the UK.

The programme can evidence that it has improved outcomes across patient and family experience of care; staff experience and learning; population health through preventative interventions; and reducing per-capita cost.

At place level (which we recognise will often mean local authority footprints covering populations of around 250-300,000), neighbourhood teams working together and with wider system partners, will provide more intensive support to patients. This should consolidate the multitude of existing models and teams focused on discharge to assess, virtual wards, mental health crisis response, enhanced health in care homes and urgent community response to support people who are unwell to be cared for safely at home, and for those requiring hospital treatment, to ensure safe and effective transfers into and back from hospital. Carers – and the fantastic role they play as well as the additional capacity they provide – will be essential partners to these teams.

This reorientation of our existing workforce to support our most vulnerable and complex patients to stay at home and access care in the community will, over time, contribute significantly to efforts to reduce growth in hospital demand and signal a shift away from a hospital-centric model of care that is no longer suited to the population we serve.

We have seen some excellent examples of good practice from outreach work and joint MDTs for child health, to population-based approaches to management of chronic disease, and partnership working on end-of-life care. All these were characterised by strong relationships, trust and mutual understanding between primary and secondary care clinicians. Capacity and organisational development support for changing clinical models must be identified as part of the implementation of these new teams, supported by practical tools such as job planning and e-rostering across the whole workforce.

In Frimley, an anticipatory care model was introduced to support people with either moderate frailty with eight or more co-morbidities or moderate/severe frailty with no GP encounter in the last six months. The aims are to maximise people's wellbeing, maintain independence and empower people to make their own decisions about care.

People identified as eligible for anticipatory care have a holistic assessment and then comprehensive MDT review, which is led by a geriatrician. Recommendations from the MDT are based on an individual's needs and wishes. The MDT brings together a range of professionals, including older people's mental health services, social care and reablement, pharmacy, community health, occupational therapists, a geriatrician and the GP clinical lead for frailty.

There are a range of interventions provided for people on the pathway, based on what matters to them. Typical interventions include medication reviews, falls prevention, social prescribing referrals, end-of-life planning, nutritional advice and referrals to VCSE services. Anyone in the MDT is able to input into the shared care record, which is then accessible to urgent care services.

The enduring connection to people is what makes primary care so valued by the communities it serves: creating the conditions where we can use integrated neighbourhood teams to support practices by providing personalised care to those people with greatest need, and on-the-day urgent care where appropriate, keeps the connection in place for the future.

Improving urgent care and providing more personalised care to those who need it the most will be central to improving the access issues that have beset the NHS for some time now. Beyond that – and just as importantly – it will create the backdrop and headroom for local systems and teams to work together with communities to tackle the wider determinants of health.

Preventative healthcare

As a nation, life expectancy since 2010 has been stalling, while the amount of time people spend in poor health has been increasing.[viii] This trend is driven in large part by wider socio-economic determinants and a failure to address the health inequalities that result, and it masks significant variability in outcomes, especially between more affluent and more deprived areas where healthy and overall life expectancy are lower.
Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions.

People in the most deprived areas of England develop multiple health conditions 10 years earlier than people in the least deprived areas.[ix] The incidence of multiple conditions is rising; without concerted, targeted responses in our most deprived communities, progress on inequalities in healthy life expectancy will continue to stall.

We have known about the inverse care law,[x] where services are often under-resourced in areas with high deprivation compared to areas with no deprivation, for over 40 years, but efforts to address inequalities in the provision of GP services have not eradicated them.

The Core20PLUS5 approach provides a focus for reducing healthcare inequalities across systems, identifying a target population comprising the most deprived 20% of the population of England (the

Core20) and other groups identified by data (plus groups), alongside five clinical priorities for action to reduce inequalities.

Primary care already plays an essential role preventing ill health and tackling health inequalities. Through the stocktake, we have identified three areas in which primary care is taking a more active role in creating healthy communities and reducing the incidence of ill health: by working with communities, more effective use of data, and through close working relationships with local authorities.

We know that health starts at home, and we need to continue to build on successful national programmes providing lifestyle advice, from stop smoking campaigns to 'Couch to 5k'. Alcohol awareness campaigns, national messaging and campaigns on improving health and wellbeing will also remain important.

This needs to be matched with positive action in local communities; health coaches and social prescribing link workers provide a fantastic opportunity for neighbourhood teams to take a more active role in improving health, and where successfully incorporated into primary care, teams are transforming not just the lives of people and families they work with but also the culture and function of the clinical teams they work alongside. Where used most effectively, these roles can help form an effective bridge into local communities, building trust, connecting up services and galvanising the wealth of expertise in the VCSE sector.

We heard very clearly through the stocktake that the wider primary care team could also be much more effectively harnessed, specifically the potential to increase the role of community pharmacy, dentistry, optometry and audiology in prevention, working together to hardwire the principles of 'making every contact count' into more services. For example:

- on early years and children's services: working with nurseries to tackle dental caries in the under-fives and improve MMR vaccine delivery; working with school immunisation services on HPV vaccination uptake and child and adolescent mental health services; community health service teams improving diagnosis of autism and helping improve the health and life chances of children with special educational needs, as well as safeguarding
- on cancer diagnosis: community pharmacy playing a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate (ACE) programme
- on positive lifestyle choices: eye checks where people are offered brief advice on alcohol and smoking and referred for smoking cessation as appropriate.

Combined with insights drawn from the community, data can empower neighbourhood teams to increase uptake of preventative interventions while also tackling health inequalities by identifying those populations and groups that may currently be underserved.

Reena Barai, a community pharmacist in Sutton, proactively attended a Director of Public Health presentation on local health and social demographics where she learned of the higher than average rates of mental health problems and suicide among young people and males in Sutton when compared to the rest of London.

Having been previously unaware of the severity of the issue locally, her pharmacy team immediately enacted a simple but crucial change in their dispensing behaviour – they endeavoured to check that any young person prescribed anti-depressants was asked how they were feeling and whether they felt the medication was helping. This opportunity to ask for help allowed many people to feel that they could talk to a pharmacist about their mental health and the pharmacy team were able to refer patients back to their GP if they felt they or the patient had concerns.

The trick for ICSs will be to normalise this sort of interaction and subsequent intervention, rather than relying on individuals going the extra mile and stumbling across crucial insights. There is also scope for efficiencies in pharmacies being able to refer onward directly, eg to mental health or other neighbourhood services.

At a place level, we have seen primary care increasingly working in partnership with local authorities (in particular public health and housing teams), local communities and other local system partners, to pool information and population health data. This means sharing expertise to understand what factors lead to poor health and wellbeing in their communities and agreeing how to work together proactively to tackle these. We have seen this type of joint working become commonplace during the pandemic, where a combination of national data tools, collaboration with local authorities and hyper-local engagement were critical success factors. This enabled teams to try different approaches to outreach and communications, get immediate feedback on what is working, and course-correct accordingly. This was essential in minimising the uptake gap by deprivation and ethnicity.

We should build on this, specifically ensuring that we have data made available to integrated neighbourhood teams on uptake of key prevention and population health measures. This will contribute to the effective co-ordination and delivery of vaccination and immunisation, screening and health checks at *place*, in line with national standards, working with NHS ICS partners, local authorities, in particular directors of public health and their teams, over the life course.

Protect Now in Norfolk and Waveney is a proactive care model which focuses on building a detailed data profile of the most deprived populations and offering tailored health interventions to meet their needs. Building on a model called Covid Protect introduced during the pandemic, it is a clinically led collaboration of more than 20 local organisations and partners including local authorities and the VCSE sector. Through the scheme, 100% of those in the top 10% most deprived areas were contacted and information about 1,764 people (49%) was collated. During COVID-19, those who engaged with Covid Protect had statistically better outcomes in terms of COVID-19 infections, mortality and admissions. This methodology has now been successfully expanded to encompass other areas such as vaccination uptake, falls prevention, pain management, diabetes prevention, cervical screening and IAPT uptake.

At a system level, ICSs, particularly through their local authority members, have the opportunity to shape and co-ordinate cross-sector efforts to support people to stay well by working with the voluntary sector, local business and education providers to provide a more consistent offer for socially excluded and most disadvantaged groups, for homeless and inclusion health services. For

example, we heard very clearly the benefit of system-level (and in some instances regional) co-ordination, and co-design of services for **inclusion health groups** will be essential to ensure equity of access and address the needs of people for whom traditional models may work less well.

This principle of equity extends to the life course approach taken through the stocktake. In particular, we heard that there is often insufficient attention and resources directed toward providing effective support for children and young people, and to people with a learning disability and autistic people. Ensuring integrated primary care models are able to effectively adapt their offer will be vital in improving health outcomes and reducing unnecessary future demands on the health service. A real measure of success for this and other ICS strategies will be whether ICSs have meaningfully improved outcomes and experience for these groups which are often not well-served by traditional models.

Creating the national environment to support locally driven change

Making the vison for integrated primary care a reality in every neighbourhood will not happen overnight, and additional workforce and resources – as much as they *are* needed – will not, on their own, get us to where we need to be.

We need a change in how national policy is designed and implemented, which pivots to enabling local teams to be supported to do the job they need to do. We encourage national partners including NHS England and DHSC to continue to consider how to create and support conditions for success and local flexibility, as determined by local leadership and delivery partners in service of local populations.

There are three major areas where we heard very clearly that with the right approach, we can make the biggest impact in creating the environment for local systems to succeed in delivering the new vision for primary care: **workforce, estates and data**.

These three policy areas are crucial to the delivery of the new model because they can enable the flexibilities on workforce that will be central to creating integrated neighbourhood teams, provide the opportunity to co-locate those teams in hubs to ensure greater accessibility for patients and a positive working environment for staff, and equip them with the information to target services where they are most needed.

It is worth noting that most of the recommendations contained in this report are by systems for systems, as well as requiring more national action on workforce, estates and data; and not all the recommendations require additional funding. It is just as important that we create an environment that *supports* local change not *dictates* it: we need to energise local ambition if the new vision for integrating primary care is to succeed.

But there is a simple reality: the pace at which we create the right environment on workforce, estates and data, both at a national and system level, directly impacts on the speed at which the model can be delivered in every neighbourhood.

Confronting workforce gaps

Primary care has never been busier, and capacity gaps lie behind most of the challenges that the NHS faces. These gaps – and the increased demand for services – were growing in the decade before COVID-19 due to workforce pressures and reduced staff satisfaction, the increasing number of people living with multiple long-term conditions, and changes in public expectations.

Layer on the demands of treating COVID-19 patients and vaccinating the nation, and we now have an extremely busy urgent care system, big backlogs of work across elective, community, mental health, social and primary care, and staff unable to offer what they think patients reasonably need. These challenges, while consistent around the country, are more pronounced in areas of greater deprivation, which risks further contributing to health inequalities.[xi]

A new care model will not magic away our workforce challenges: we need to continue to grow the MDTs in primary care and recruit and retain as many extra GPs as we can possibly get. The plain fact is that the aggregate numbers of GP full-time equivalents (FTEs) are simply growing too slowly and we will need more action at every level to address the gap.

In headline terms, the record number of trainees masks the loss of fully trained GPs, particularly experienced partners, who also on average work more hours than salaried GPs, who in turn on average work more hours than those who work solely as locum GPs.[xii] We also face a big potential retirement bulge, and as a nation we should certainly be doing all we can to encourage all our international medical graduates – who make up 40% of all our GP registrars – to settle in England as an NHS GP on a permanent basis. We also heard that looking again at the role of the GP Performers List could enable us to increase capacity if it enables other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.

Addressing the shortfall in GPs is essential and urgent. We have heard through the stocktake that there are also recruitment and retention challenges across the wider primary care workforce, particularly NHS dentistry and community pharmacy, and that there is significant variation across different parts of the country and across employers.

But the workforce picture in primary care is not all bleak. PCNs have been more successful than we all hoped in hiring extra staff in new roles. The latest data as of Q4 2021/22 shows that over 18,000 FTEs were in post by end of March 2022 – significantly ahead of the trajectory towards the 26,000 March 2024 target. This is very welcome, and progress must not stall. We welcome the clarity from NHS England that staff in post will continue to be treated as part of the core PCN cost base beyond 2023/24 when any future updates to the GMS contract are considered.[xiii]

We also heard a strong message through the stocktake that improving the supervision, development and career progression of individuals in Additional Roles Reimbursement Scheme (ARRS) roles is crucial to retain them and make the most of their skills and experience as part of integrated neighbourhood teams. We came across some great examples of practices and PCNs using additional roles to improve patient care, but we know there is variation across the country, something highlighted in the recent King's Fund report. Some local systems have not yet been able to make best use of the scheme due to a lack of local capacity for clinical and managerial supervision, inadequate space in practices, confusion around the purpose of some roles, administrative complexities, and lack of expertise on organisational development and role redesign to embed new roles.

Reforms to education and training to build our workforce pipeline will take time, and we acknowledge that there are no quick fixes when it comes to workforce supply, which is why a long-term workforce strategy is required. The forthcoming national workforce strategy should include a focus on primary care and support ICSs to deliver this report. However, what we also heard loud and clear through the stocktake is that given the right discretion and flexibility, systems can get on with building the right local teams *now*.

Systems working differently to shape their workforce

Creating the environment where we can be flexible and nimble in managing the broader workforce can provide some quick wins. Systems need the flexibility to think creatively about how they maximise the skills and experience across the current primary care workforce and elsewhere in the system. As well as working with system partners to promote education, apprenticeships and new local employment opportunities, ICSs should be supported in the process of appropriately de-medicalising 'care' to help deliver a more personalised offer for patients but also to help with immediate workforce supply issues.

Systems should also support the development and rollout of innovative employment models such as joint appointments and rotational models that promote collaboration rather than competition between employers, particularly where skills are scarce.

To support improved workforce planning, the electronic staff record or a similar integrated workforce solution, should be used throughout primary care to inform demand and capacity planning and enable team-based job planning and rostering to become the norm.

Not only will this support integrated neighbourhood teams to make more effective decisions, the aggregated data would support a greater national understanding of workforce pressures that should guide the development of future national workforce and estates strategies.

Berkshire, Oxfordshire and Buckinghamshire commissioned support to develop an online workforce planning tool for their PCNs. The aim was for general practice recruitment strategies and workforce plans to be better informed by population needs. They used quantitative and qualitative data to provide tailored insights to each PCN on how to meet population and workforce needs one, three and five years into the future. Subject matter experts, including data analysts, supported making sense of the information and identifying pragmatic solutions to current and future workforce challenges. These data packs have been used to inform targeted interventions, including maximising the use of ARRS roles. An insight paper was also provided to the ICS to inform their system-wide workforce strategy. PCNs have already requested to repeat the process next year to capture progress and develop increasingly sophisticated approaches to workforce planning.

ICSs developing system-level workforce data will also enable a better understanding of workforce pressures across primary care: for example, the impact of likely changes in GP numbers in each practice, allowing them to identify what actions they might take to improve recruitment and retention of GPs, such as GP returner and retainer schemes, GP mentors and mentorship schemes, and leadership schemes.

NHS England should work together with systems – recognising they will all have locally driven workforce plans – to identify what measures can be introduced to better *support local recruitment and training* of key community healthcare teams such as community nurses, care support, community psychiatric nurses and district nurses to work alongside primary care in integrated neighbourhood teams.

Extending the agenda beyond headcount

We do not just need to attract new staff into primary care; we need to create the backdrop that allows their roles to be reimagined and made more flexible and attractive – ultimately supporting increased participation and retention in primary care.

This was particularly evident in conversation with the next generation of primary care leaders, who are clear about the need for a sense of parity with specialist careers, a realistic work-life balance, their desire to work in MDTs, and having the ability to pursue a variety of roles to create a diverse working week and, ultimately, career.

There should be a more consistent and comprehensive training, supervision and development offer across primary care – including a focus on medical and non-medical staff and existing staff such as receptionists, practice managers and practice nurses, and retention strategies across early, mid and

late career. Systems will want to work with primary and community care training hubs to ensure 'the offer' they provide is broad enough to help integrated neighbourhood teams flourish.

We need to recognise that PCNs will only be able to meet the challenge set out in this report if they are properly supported. There should be a strong focus on supporting PCNs and GP practices with supervision of the ARRS roles and others, for example, making the most of multiprofessional and remote models of supervision where appropriate.

Birmingham and Solihull (BSoL) has a primary care 4Rs workforce strategy (Recruit, Retain, Returners and Role Allocation). This includes a PCN development plan co-designed with PCNs that complements the training hub, leadership academy and system peoples board. It supports recruitment and retention of ARRS roles across the system – for example, facilitating joint working between PCNs and Birmingham Mental Health Trust on mental health practitioner roles and integrating the community mental health transformation programme. All 29 PCNs have signed up to deliver PCN development plans for three consecutive years.

The strategy has an underpinning framework consisting of a range of joined-up and proactive workforce schemes for early, mid and late-career GPs and nurses. BSoL also has a thriving general practice Equality, Diversity and Inclusion Staff and Allies Network with over 300 members and 29 PCN health inequalities champions. In addition, there is a general practice flexible pools scheme locum bank.

These steps, taken together, will support ICSs to have a fighting chance of improving recruitment and retention in primary care going forward. But this will only get us so far.

Listening to and supporting our frontline staff

We also need to improve the experience of working in primary care for everyone by making the employment culture more compassionate and inclusive, and listening much more effectively to what primary care staff are telling us.

The NHS staff survey is already being piloted in some areas of general practice and now needs to be extended nationwide and considered for NHS-funded primary care. Identifying ways to support and listen to staff who are working as carers would also be very welcome, and primary care staff should have access to Freedom to Speak Up guardians, promoting an open and listening culture. Workforce data, staff surveys and other feedback mechanisms for staff, should be used by ICSs and local leaders across primary care to take action to improve equality, diversity and inclusion across the primary care workforce.

We must tackle racial discrimination and harassment[xiv] because it is the right thing to do, it is crucial to retain our staff, and to further strengthen how the primary care workforce reflects and strengthens its connection with the diverse communities it serves. We must value the important contribution that individuals with protected characteristics, including age, sex, religion or belief, people with disabilities, those from the LGBTQ+ community, black and minority ethnic backgrounds, and with caring responsibilities, make as part of our workforce. Ensuring flexible working and other forms of support are available to these groups and any others that experience discrimination in the workplace should be central to local, system-level and national workforce strategies.

Systems should drive a more standardised and improved employment offer for primary care in line with the NHS People Promise: for example, by ensuring parity of access to system staff health and

wellbeing hubs and occupational health services, and by encouraging employers to adopt NHS terms and conditions by sharing existing good practice and model contracts.

Investing in local leadership to drive change

The role of PCN clinical directors in the future will be essential to the leadership of integrated neighbourhood teams: and when leadership is strong and purpose is clear, retention rates improve.

More focus needs to be given to the development and support of clinical directors beyond the current basic arrangements provided through the national contract, including the local provision of sufficient protected time to be able to meet the leadership challenge in integrated neighbourhood teams.

Some systems will want to go beyond this and use even more innovative ways to support clinical directors to expand and develop their integrated neighbourhood teams, for example:

- some neighbourhood teams may offer an opportunity to develop different areas of focus and specialisation, with senior GPs serving as the 'consultant in general practice' – working across prevention, chronic and urgent care as part of wider teams
- securing the specialist input from secondary care required in neighbourhood teams, as part of job planning for consultants
- supporting community partners to operationally embed relevant teams as an integral part of existing PCN teams, recognising that the integration of community and mental health services with primary care is crucial to delivering more integrated care for patients in the community, as set out in the NHS Long Term Plan.

We also need to consider the leaders of tomorrow. Aspiring leaders already within systems and those coming though the national talent pipeline in the NHS – for example, the NHS Graduate Management Training Scheme – should, in future, be able to access development programmes that promote integrated working across systems. There should be a consistent leadership development offer accessible to primary care staff that is comparable to other NHS family providers and promotes multiprofessional leadership across the breadth of primary care. This should increase diversity across primary care and system leadership. The welcome mindset change we are seeing in the leadership of the emerging ICSs needs to be embedded and tested in what we expect of our future leaders. It is important that primary care leaders can see a career path that extends into system roles in neighbourhoods, provider collaboratives and beyond.

Suffolk and North East Essex One Clinical Community leadership development programmes aim to cross multi-organisational boundaries, support a common purpose across practitioners in the community, develop trust and improve outcomes, and build a network of effective leaders who can together address the key challenges in the wider health and social care system. Since it was commissioned in 2018, the programme has evolved to support leadership development across the eight integrated neighbourhoods teams (INTs) within the Ipswich and East Suffolk Alliance. The core members of INTs on the programme come from community services, social care and mental health, with additional participation from staff working in general practice, secondary care, charity and voluntary sectors, public health and district and borough councils. An evaluation by the University of Suffolk found that the programmes' objectives to enhance leadership skills, support personal development and for the skills and knowledge developed to be applied through the practice of integration impacting teamworking, were met.

Reimagining our approach to primary care estates

In parallel, we need to address and rethink our second capacity constraint: space.

Next steps for integrating primary care sets out a vision of integrated neighbourhood teams, providing joined up accessible care. But much of the general practice and wider primary care estate is frankly not up to scratch.

There are 8,911 premises in England, 22% of which are pre-1948 and 49% of which are owned by GPs, 35% owned by a third party, and 14% owned by NHS Property Services.[xv] Around 2,000 premises have been identified by GPs as not being fit for purpose,[xvi] and there was strong feedback throughout the stocktake that we do not start thinking about estates early enough in our planning and frequently regret it.

Estates are so much more than buildings. We must move to a model that makes estates a catalyst for integration rather than a barrier to it. This new model should focus on patient needs, create a positive working environment for staff and provide adequate space for key activities like training and team development. Creating the right environment has to start with understanding what we have got in terms of estates, something that is best undertaken locally.

In **Dorset**, the primary care estates team has undertaken an 18-month programme to pull together practice profiles for its 120 general practice sites. These profiles include ownership models, square footage, utilisation etc, and are supporting the development of a broader strategic network plan that allows PCNs and practices to take a holistic approach to estates planning.

The focus of capital investment has been weighted towards secondary care – something that now needs to change. Layered onto this is the fact that the GP owner-occupier model includes perverse incentives which can make cross-system collaboration more difficult.
As with workforce, we need to recognise that the current mindset and approach to estates need to change, and that we need to create the permissions and support for local systems to build estates models that better align with delivery of clinical, digital and workforce strategies. Despite investment constraints, there is real opportunity locally to start to deliver improvement now.

We need a detailed review of the space available in each system, service by service, to inform the ICS estates infrastructure strategies. These reviews should help us understand what we have got and what we can fix locally, as well as help us prioritise funding as and when capital becomes available.

ICSs have the reach to take a 'one public estate' approach and think creatively about primary care estates, considering:

- developing primary care estates plans from the perspective of access, population health and health inequalities
- making use of local authority, third sector and community assets, building on the approach to COVID-19 vaccination, including places of worship, community centres, and allotments
- making creative use of void and vacant space in the NHS Property Services and Community Health Partnerships portfolio
- opportunities for co-locating primary care when bringing forward secondary care estates plans

- pragmatic, low-cost opportunities to repurpose existing space, within local funding streams, as well as making use of the potential ability of the local authority to raise capital beyond NHS limits to fund new estates
- opportunities for locating primary care onto the high street as part of local economic regeneration.

In **Waltham Forest, north east London,** a new state-of-the-art health centre following partnership working between the borough council and local NHS has been built. The £1.4 million building, located within the Sutherland Road development in Walthamstow, is due to open in spring 2022 – providing a modern and spacious new home for GPs and other staff at the Lime Tree and Sinnott Healthcare medical practice.

The project formed part of the council's capital plan for regeneration, which included the desire to improve healthcare infrastructure across the borough, in response to demographic changes and increased local demand for primary care services.

The new purpose-built centre will enable the GP practice to relocate from its existing premises and allow it to expand its current registered list from 6,500 to 10,000 patients over the next 15 years. The new-look practice will also benefit from investment in digital technologies to facilitate self-monitoring – allowing patients to take greater control of their own care, alongside convenient access to a wider range of health services in the community.

As systems, we should already be thinking about tackling those issues that create barriers to change. 'Last partner standing' scenarios may require systems to find innovative solutions that maintain service quality and continuity when partnerships propose handing back Primary Medical Services contracts. For example, where the overall benefits to patients and avoided costs of replacing provision would justify it, there may be options such as to transfer ownership to public or commercial system partners. In scenarios such as this, NHS England needs to give permission to systems to make difficult choices, but ones which will ultimately benefit our patients and the taxpayer.

Data, data, data

Integrated neighbourhood teams can only flourish if we ensure information about patient care can be properly shared – for use in providing and improving the co-ordination of care at an individual level, and for wider planning and research. Working across the whole of primary care, PCNs should be given the tools to make routine use of population data to inform how they design care for the people they serve.
PCNs and wider neighbourhood teams need to be able to read and write seamlessly into a shared patient record that provides a single version of events for each patient with appropriate information governance arrangements in place. They also need to be able to access real-time data on demand, activity and capacity so that they are able to improve services, identify gaps and take action to redistribute resources and plan workforce accordingly.

Data sharing is often not the norm in the NHS or other public services, despite the fact that most patients expect relevant information about their care to be shared between different professionals and organisations involved in their care. A number of ICSs are already working through plans for improving data sharing in their area and working with providers collaboratively to co-produce this**,**

looking at how to best invest in the essential IT infrastructure that underpins this – including establishing IT systems that can do the difficult work of linking datasets to enable population health management.

It has always been true that if you give clinicians the data they will respond. Systems can enable this by putting in place a local transformation function which includes joined-up intelligence, improvement and other support functions with a deep understanding of primary care, organised and funded at system or place level, but wholly orientated to provide support for their neighbourhood teams.

System P in Cheshire and Merseyside utilises multiple sources of intelligence to categorise population segments, and then explore the way in which these different groups of people interact with health and care services, and whether their needs are being met in the most effective and person-centric way. The initial focus is on two priority segments: Complex Lives and Frailty & Dementia, both of which have a unique set of needs and risk factors, which must be taken into consideration if outcomes are to improve. Partnership working with the University of Liverpool and utilisation of the CIPHA (Combined Intelligence for Public Health Action) platform is putting both the data and expertise in place.

For much of the country, neither of these things exist and need to be put in place. As part of this, systems will need to consider how they can develop sufficient expertise in data analytics at the right level, including retraining existing staff and planning to increase recruitment in key roles. This means a change of mindset – from a previous focus on using data to inform commissioning and monitoring of contracts, to a two-way process of using data to drive improvement.

Systems have a role to play in articulating a clear plan for data sharing across the system to support the development of population health management approaches at neighbourhood and place level, enabled by a clear information governance framework and work closely with providers and patients to co-produce data sharing agreements where appropriate.

Creating the digital infrastructure needed to underpin integrated primary care

Digital technology has the potential to transform how people access primary care, how services are delivered and how we plan care to better meet the needs of local communities. Often, however, the underlying infrastructure to enable this transformation is lacking – with wide variation in digital maturity, knowledge of digital transformation and procurement across and within systems.

In Brent, London, 20 practices created a centralised 'eHub' for online consultation management. The eHub supports practices to manage increasing levels of patient demand; leverage economies of scale; share existing and additional workforce, resources and flex capacity; optimise additional roles by distributing work to the right person; collaboration and peer support.

The eHub enables clinicians to view patients' 'home' practice records and write to the 'community' record. Notes are shared with the 'home' practice through a 'discharge summary'.

The eHub closes around 90% of online consultations. Face-to-face appointments remain available through patients' 'home' practice and local, face-to-face extended access hub. Many patients reported that they like the improved convenience and speed of the new online access system. The eHub helps reduce pressure on 'home' practices, reduce patient waiting times and enables a faster response. Most requests sent to the eHub are 'closed' by it, increasing time for practices to focus on patients with more complex needs.

During the pandemic, digital technology played an increasingly important role in maintaining services for patients who were happy to use it. We also learned that we can roll out digital technology at pace when circumstances demand. Having created a greater appetite for digital services – both among patients and staff – we should continue to offer a greater diversity of services in this way.

ICSs have a vital role to play in developing a more coherent approach to digital transformation in primary care that focuses on improving patient experience and outcomes. Some are already conducting baseline assessments of the current state of digital infrastructure in their area and understand current needs and gaps and exploring how cloud telephony and online consultation tools, for example, can help to deliver more streamlined systems for accessing general practice.

ICSs can support the development of more interoperable IT systems by following 'what good looks like' principles and the GPIT operating model when making decisions about IT investments and products, and they can leverage their larger scale and purchasing power to improve value for money and quality of service.

Systems will also have a vital role in providing a digital training offer for clinical and non-clinical primary care staff. They will need to consider how digital expertise and leadership inform decision-making at every level. Some have already chosen to appoint a chief information officer (CIO) or chief clinical information officer (CCIO) at executive level, as well as named leads for primary care digital transformation. Digital transformation needs to be embedded as part of a more holistic approach to primary care transformation.

Critically, decisions about digital infrastructure in primary care need to be made in partnership with those who will use them – including engagement with both staff and patients. Ensuring that potential barriers to using digital tools, such as digital exclusion, are understood and addressed will be particularly important. Establishment of digitally enabled primary care hubs on a neighbourhood footprint will be a priority.

Hard-wiring the system to support change

Throughout the course of the stocktake we had a number of themed working groups with expertise from every part of the system coming together to think about the kind of changes we would need to see both to inform the new model but critically how to make it deliverable.

There are a range of near-term and longer-term actions – for systems, national organisations and government – that we can be getting on with now to directly support the delivery of the new model.

Taken together the actions outlined in this section will not just create the conditions for the new vision of integrated primary care to succeed, they will create a common sense of purpose for the ICSs to maximise the impact of new ways of working that the reforms create the opportunity for.

The recommendations in this section are by no means exhaustive and while the majority of this report places the onus on new ICSs to deliver the new model, this can only be done if national policy aligns to enable them to deliver it. To that end, we encourage national partners/DHSC and NHS England to undertake further work to consider the existing legislative, contractual, commissioning, and funding frameworks, which were out of scope for this stocktake. This work should consider what further changes could enable and incentivise this integrated model of care and new models of primary care; and how to improve equity in distribution of resource to ultimately improve health outcomes.

Workforce

The forthcoming national workforce strategy should focus on primary care and identify the wider skills and roles required for successful neighbourhood and place-based teams. This strategy should build on Health Education England's (HEE) Strategic Framework 15 and must inform any future national estates plans to ensure adequate space for training, development and service provision. NHS England should simplify guidance and address common misunderstandings regarding ARRS, as well as consider further flexibilities that could be introduced that support recruitment in the short term. NHS England should work with DHSC and HEE to consider how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it.

The NHS Staff Survey should be rolled out nationally across primary care, building on current pilots in general practice to provide parity across the NHS family – as soon as funding permits.

Estates

DHSC and NHS England should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues, and practical support to work through them, as well as building ICS estates expertise. DHSC and NHS England should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.

The estates reviews, aided by the national plan, are central to creating coherence across services and sectors, and they should drive the transition to a modern, fit-for-purpose primary care estates offering – including future development of hubs within each neighbourhood and place to co-locate

integrated neighbourhood teams, as well as linking into the wider rollout of community diagnostic hubs, for the provision of more integrated services.

Data and digital

National action is needed to help put in place the data and digital infrastructure necessary to transform primary care.

NHS England will need to work with ICSs and IT suppliers to ensure business intelligence tools and timely data are made readily available to practices and neighbourhood teams in an easy-to-use format, supported by the development of real-time data visualisation and standardisation of approaches to data to enable comparability tools.

NHS England can also support ICSs to improve data sharing for direct care, service improvement and research by publishing a revised national template data sharing agreement, making clear that practices will not be liable for General Data Protection Regulation breaches relating to data shared under the agreed terms – an issue that is proving a barrier to setting up such agreements in some areas. It will also need to provide systems with guidance on minimum standards for procurement of analytical software and ensure training, tools and a comprehensive support offer are available.

Both NHS England and systems need to work together to engage both communities and staff in why sharing data is so important and will help improve patient care.

Access

NHS England should consider the implications of a neighbourhood-based approach to urgent same-day access in future national guidance on the wider urgent and emergency care pathway, specifically NHS 111 and integrated urgent care.

NHS England should consider the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.

Pivoting to locally led investment and support

This report marks a strategic pivot to system-led approaches as a key way of driving up access experience and outcomes in primary care.

National contractual arrangements, including for PCNs, have provided essential foundations including for chronic disease management and prevention. But they can only take you so far. As already highlighted in the report, getting to integrated primary care is all about local relationships, leadership, support and system-led investment in transformation.

ICSs putting in place the right support locally will be enabled by maximising what control ICSs have over the direction of discretionary investment. This should be looked at by NHS England as part of the implementation of recommendations.

It is also generally accepted that the distribution of primary care funding to neighbourhoods is not always well aligned to system allocations and underlying population health needs – and we need a concerted local effort to try and fix this. ICS leaders have already started to review discretionary investment in primary care to address this issue, working with clinical colleagues to understand the data and make the case for alternate approaches**.**

ICBs have an opportunity to establish a firm understanding of current spending distribution across primary care weighted by deprivation and other elements of the Core20PLUS5 approach, which can then inform discussions on how discretionary investment can be more purposefully directed to address health inequalities and form the basis of work to secure collective commitment from all system partners to this redistribution.

In Leicester, Leicestershire and Rutland action has been taken to address inequalities in the existing primary care funding model, which is primarily driven by age and gender and not reflective of actual patient need at practice level. They are also tackling disparities in service provision; a population health-based model found that underfunded areas were the most deprived.

The new model calculates practice payments by setting aside the core staff components, based on the current practice core contact income. The remainder of core contract funding and other funding in the model is distributed to practices based on needs and deprivation (90:10). As a result, approximately £3 million was identified to rebalance a fairer level of baseline funding across all practices, based on need and demographics, and the model enables future investments in primary care to be transparently distributed at practice and place, based on population health need.

Beyond national contract entitlements, there are also too many small national pots of programme and system development funding money, ringfenced for particular purposes, which undermines how efficiently resources are allocated. NHS England should consider combining and simplifying central programme and transformation budgets for primary care.

Backing existing practices and new models of provision for primary care

The successful delivery of the new model can only be optimised if systems ensure they bring GP practices of all different shapes and sizes with them. We need to recognise that maintaining stability in general practice will be central to being able to deliver the new model of integrated care.

We need to ensure the right arrangements are in place to support primary care where it wants to work with other providers at scale by establishing or joining provider collaboratives, GP federations, supra-PCNs, or working with or as part of community, mental health and acute providers. Both the contract and funding arrangements were out of scope of this review. But it is clear that changes to these could support this vision. We recommend that DHSC and NHS England rapidly undertake further work to understand how changes to these could support the implementation of integrated and new models of primary care.

Where there are gaps in provision, or individual providers are rated ‘inadequate’ by CQC, ICSs should provide tailored support to practices to improve and, where appropriate, actively commission new providers of integrated list-based primary care, in particular for the least well served communities. ICSs should more generally also provide a primary care support offer for all providers, that includes a focus on quality improvement.

The role of ICSs in supporting the development of integrated primary care as part of a national support and development offer should be explicit with accountability for delivery of integrated primary care reflected in the ICS accountability framework, including the respective roles of ICS and place-based leaders.

Enabling primary care at a system level

System-level expertise on primary care should go beyond contracting to building relationships and developing capabilities within systems as they build their new teams. We heard throughout the stocktake of the importance of a core set of capabilities to support improvement and transformation, with quality improvement; digital, data and analytics; understanding local communities and user experiences; physical infrastructure; workforce planning and transformation; service design; and the development of the primary care provider landscape coming up most frequently.

These key primary care capabilities need to be in place for all systems, but not all need to be provided in-house – some may be brokered or commissioned from other providers at scale: eg GP federations, acute, community or mental health providers, or commissioning support services.

Dudley Integrated Health and Care NHS Trust (DIHC) was created in 2020 by local GPs to provide out-of-hospital care by integrating primary care with community-based services and providing strategic and operational support. Forty-one practices signed an integration agreement with DIHC, committing general practice to deliver a primary care operating model in return for DIHC providing wider workforce and support to enable the model and the Dudley Quality Outcomes Framework to be achieved.

Primary care is at the centre of all DIHC planning and development. Through a management agreement, DIHC supports the running of services and provides a turnaround team to address quality of service or management issues. DIHC produces workforce and estates plans on behalf of the PCNs each year, which PCNs tailor to their population's needs. DIHC employs, trains, supervises and operationally manages all ARRS staff on behalf of PCNs and has established a pharmacy team of 50 to support all practices.

DIHC working with primary care is improving population health outcomes, providing a consistent service offer and supporting delivery of a sustainable model of general practice by providing support though extended access, community services, care home support, and PCN Direct Enhanced Service delivery. Dedicated management capacity and clinical leadership capabilities support primary care planning and development and enable the development and expansion of the range of commissioned services.

All systems should carefully consider the breadth and level of their organisational capacity and capability to turn this framework for integrated primary care into local reality, taking account of responsibilities for commissioning NHS community dentistry, pharmacy and optical services from April 2023.

Embedding primary care leadership throughout systems

ISCs come into being on 1 July this year and have the opportunity to ensure that primary care is deeply embedded in the new governance arrangements they are designing. There are some well-established existing forums for bringing clinical leaders and professions together, in particular for general practice.

ICSs will want to ensure that primary care leadership across all four pillars is embedded across systems – this might be through the creation of a primary care forum or network with credibility and breadth of views to be able to advise the ICS. Building relationships with existing local professional

committees across all four pillars of primary care, such as *local medical, pharmaceutical, dental and optical committees and primary care audiology,* will ensure the support and collaboration of key local leaders in improving access, experience and outcomes for patients and communities.

To ensure that primary care and the views of the communities it works in are heard throughout systems, integrated neighbourhood teams should be well linked to – and represented on – all place-based boards. The connections integrated neighbourhood teams will build both with their respective communities and between them will be invaluable in the planning and decision-making that happens at a place board.

The Black Country and West Birmingham Primary Care Collaborative was established to promote the interests and sustainability of primary care services and ensure a single voice for primary care in decision-making at all levels within the ICS.

It represents grassroot primary care views, and in turn reflects patient and public needs and focuses on tacking inequalities in the planning and delivery of services.

It joins all primary care professionals at a Black Country level, including GP practices, GP federations, primary care providers, local medical committees and PCNs. The collaborative plays a leading role in the design and development of the ICS primary care transformation strategy and acts as an expert reference group to the ICB around primary care issues.

In its next phase, other independent contractors (including pharmacy, optometry and dentistry) will be included as delegation of statutory responsibility shifts to the ICS and is also intended to extend to include community services.

Conclusion

Throughout this stocktake I have been overwhelmed by the energy, hope and appetite for improvement and change that exist today in the NHS. This is all the more remarkable given what everyone has been through for the last two years in supporting patients, families and neighbourhoods through the pandemic.

There is real evidence that the experiences of individuals and teams over the last two years – alongside the enormity of challenge we face in recovery – are forging a new determination to work together to fix the issues that sometimes hold us back from delivering the best services and care.

We arrive at this moment with an opportunity – through the creation of ICSs – to be brave in embracing new ways of working: to reimagine how we might deliver care in the future. To organise ourselves differently and better. To work together, no matter what part of the NHS we're in.

We've learned through the pandemic the true value of bringing people together and working in partnership to come up with local solutions. Communities up and down the country rallied as they never have before to support the COVID-19 vaccination programme and save lives. Harnessing that energy and working with those same communities to rebuild services to be more effective in delivering what they need has to be at the heart of everything we do.

That's why shifting our focus now onto developing integrated neighbourhood teams, places and systems gives us such a great opportunity to build a new, more effective health service designed with our communities to fit their needs.

We also arrive at the point with a growing belief in how we can use digital and technology much better than ever before. The rapid development and rollout of technology-based solutions to support remote care during the pandemic helped all of us to realise the rapid opportunities this presents. More and more people want to use apps and mobile devices to support their healthcare – and this doesn't have to be at the expense of face-to-face care, indeed as this stocktake shows, providing technology-based services for those who want them can free up more time for face-to-face care for those who need it.

Our biggest challenge is creating the conditions by which local change can happen – and that's going to require pivoting away from top-down directives and creating an environment that supports local change, not dictates it from the centre.

Ensuring local systems can access the right data to support the integrated neighbourhood teams to help primary care enhance the services it can provide is a good example. We also need to change step on how investment and financial support flows through the system. More new money is always welcome, but as a minimum every effort should be made to create as much local flexibility around discretionary funding as possible. That won't just support local teams to shape services in a way their communities want them to, it will help them create the right incentives to being GP practices of all shapes and sizes with us on this journey.

The glue that holds all of this together is leadership: investing in leadership at PCN, place and system level will be the difference between success and failure in integrating primary care. The talent pool that exists in primary care is vast: supporting and nurturing that talent to be innovative, brave and collaborative in leading the changes outlined in this stocktake will help to reignite appetite for change and improvement in neighbourhoods right across the NHS.

Very little of what is outlined in this stocktake is easy to deliver: I wouldn't have been asked to undertake this work if it were. But the prize of delivering the ideas outlined in this document is greater than just improving the experience, access and outcomes of primary care: I believe that working this way we can strengthen trust within the NHS and rebuild confidence in the services it provides.

Dr Claire Fuller

26 May 2022

Annex: Framework for shared action

1	**Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.** This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	**Assist systems with integration of primary and urgent care access,** specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	**Enable all PCNs to evolve into integrated neighbourhood teams**, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	**Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams**, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	ICSs

5	**Develop a primary care forum or network at system level**, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards.	ICSs
6	**Embed primary care workforce as an integral part of system thinking, planning and delivery.** Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	**Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England).** Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England and HEE
8	**Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead.** Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decision-making on any future discretionary investment, beyond DDRB and pay uplifts.	NHS England
9	**Improve data flows** including by (i) solving the problem of data-sharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.	NHS England
10	**Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care**, taking a 'one public estate' approach and maximising the use of community assets and spaces.	ICSs
11	**DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues,** and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC	DHSC and NHS England

	should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	
12	**Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.** Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	ICSs
13	**Work alongside local people and communities** in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	ICSs
14	In support of systems, **set out how the actions highlighted for NHS England will be progressed.**	NHS England
15	DHSC and NHS England should rapidly undertake further work on the **legislative, contractual, commissioning, and funding framework** to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes.	DHSC and NHS England

Workstream and task and finish group chairs

This stocktake has been informed by invaluable insights from nine workstreams and four task and finish groups, the Chairs of which endorse its findings

Professor Simon Gregory
Deputy Medical Director, Primary and Integrated Care, Health Education England
Chair, Workforce, people, leadership, education and training workstream

Dr Neil Modha
GP Partner and Chair of Greater Peterborough Network GP Federation
Chair, Data, pop health data, demand & capacity, risk stratification and health inequalities workstream

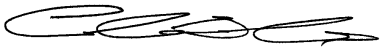
Fatima Khan Shah
Associate Director, Long Term Conditions and Personalisation, West Yorkshire and Harrogate Health and Care Partnership
Chair, Engagement with people and communities workstream

Thirza Sawtell
Managing Director/ Integrated Care, St George's, Epsom and St Helier Hospitals and Health Group
Chair, Governance & decision-making workstream

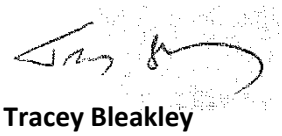
Dr Harpreet Sood
Non-Executive Director, Health Education England, and founding board member, Digital Health London
Chair, Non-physical access and digital workstream

Jan Thomas
Chief Executive Designate, Cambridge and Peterborough ICS
Chair, Physical access and estates workstream

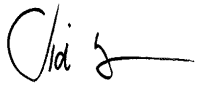
Joanna Killian
Chief Executive, Surrey County Council
Chair, Start well lifecourse workstream



Glen Burley
Chief Executive, South Warwickshire NHS FT, Wye Valley and George Eliot NHS Trusts
Chair, Live & work well lifecourse workstream



Tracey Bleakley
Chief Executive Designate, Norfolk and Waveney Integrated Care System
Chair, Ageing and dying well lifecourse workstream



Dr Nick Broughton
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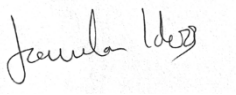
Chair, Mental health task and finish group

Daniel Elkeles
Chief Executive, London Ambulance Service
Chair, Urgent and episodic care task and finish group

Professor Kevin Fenton
Regional Director for the London Office of Health Improvement and Disparities
Co-Chair, prevention task and finish group



Dr Jaweeda Idoo
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Co-Chair, prevention task and finish group

Rob Webster
Chief Executive, West Yorkshire Health and Care Partnership
Chair, Learning disability and autism task and finish group

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[xi] 'Levelling up' general practice in England - The Health Foundation; Build Back Fairer: The COVID-19 Marmot Review - The Health Foundation; and socio-economic inequalities in access to planned hospital care - 210513.pdf (strategyunitwm.nhs.uk)

[xii] General Practice Workforce - NHS Digital: the comparison between contracted hours can be calculated by dividing the FTE figures by headcount for each individual or for each staff role – based on the March 2022 data, GP partners work an average of 85.5% of FTE, salaried GPs an average of 64.0%, and regular GP locums an average of 40.9% in a general practice setting.

[xiii] Update to the GP Contract agreement 2020/21 – 2023/24 (2020)

[xiv] Pan-LondonDiscriminationRacismPrimaryCareSurvey_Final.pdf

[xv] Primary Care Estates Data Gathering Programme

[xvi] NHS Property and Estates (publishing.service.gov.uk)

8.2

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD MEETING

MESSENGER REVIEW

Date of the meeting	20/07/2022
Author	Ellie Parson, Deputy Director Engagement and Development
Lead Director	Dawn Harvey, Chief People Officer
Purpose of Report	To share the Messenger review with members, which considers the leadership and management offer across health and social care organisations. The report shares the summary of the recommendations from the review and suggested next steps for NHS Dorset.
Recommendation	The Committee is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	N/A
Involvement and Consultation	The Messenger review has been reviewed and discussed initially within the working groups of the former People Board.
Equality, Diversity and Inclusion	The Messenger review sets out recommendations to develop an inclusive working culture, with a comprehensive leadership and management offer for all.
Financial and Resource Implications	N/A
Legal/governance	N/A
Risk description/rating	N/A

1. Introduction

1.1 On 8 June, General Sir Gordon Messenger and Dame Linda Pollard published their final report on the review of leadership and management in the health and social care sector, as commissioned by the Secretary of State for Health and Social Care in October 2021.

1.2 The review sought views from staff across health and social care organisations which informed a series of findings and recommendations. The full report is available here or a summary by NHS confederation is here.

1.3 This report provides a brief summary of the recommendations from the review, along with some of the collaborative work already underway within Dorset. The report then makes some suggested next steps for NHS Dorset.

1.4 The review will be presented to the NHS Dorset People and Culture Committee who will lead and have oversight of the People Strategy for Dorset.

2. **Report**

2.1 A summary of the recommendations of the review are below. Also included are a summary of some of the collaborative programmes we have and are delivering across the Dorset Integrated Care system over the last 3 years.

2.2 These recommendations are driven by the NHS but the principles go wider across Integrated Care systems. This is reflected in the local examples for Dorset.

1. Targeted interventions on collaborative leadership and organisational values. • A new, national entry-level induction for all who join health and social care. • A new, national mid-career programme for managers across health and social care.	**Walking in the Same Direction** – 3 day system leadership programme for middle managers working on system programmes (circa 100 attendees) **System Leaders Programme** – 6-12 month programme for senior leaders leading system work (30 attendees) **Management Fundamentals** – across Primary Care initially now integrating with NHS Dorset Leaders (37 attending) **Level 7 Masters in Leading in Health Care** delivered with Bournemouth University for senior leaders (18 attendees) **Level 3 and 5 Leading and Management** Apprenticeship with Paragon (50 people attendees) **Allied Health professionals**- leadership development (60 attended, 50 attending)
2. Positive equality, diversity and inclusion (EDI) action • Embed inclusive leadership practice as the responsibility of all leaders. • Commit to promoting equal opportunity and fairness standards. • More stringently enforce existing measures to improve equal opportunities and fairness. • Enhance CQC role in ensuring improvement in EDI outcomes.	**Beyond Difference** – 3 month programme for middle managers non UK and ethnically diverse employees (50 attendees/ attending)
3. Consistent management standards delivered through accredited training • A single set of unified, core leadership and management standards for managers. • Training and development bundles to meet these standards.	

4. A simplified, standard appraisal system for the NHS • A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.	
5. A new career and talent management function for managers • Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.	**System review of talent management practices**. University Hospitals Dorset are piloting the Scope for Growth tool with the Regional Team.
6. More effective recruitment and development of non-executive directors • Establishment of an expanded, specialist non-executive talent and appointments team.	
7. Encouraging top talent into challenged parts of the system • Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.	

2.3 In addition, a number of webinars linked to Our Leadership Way, action learning sets and a coaching offer have all been available to staff across Dorset's Integrated Care System. Our Leadership Way is being embedded across our training, tools and resources already.

Opportunities for Dorset

2.4 The Messenger review emphasises the opportunity of working across organisations and sectors as a *pre-requisite to better outcomes* and providing staff with the *opportunity to engage beyond their professional environment to appreciate the totality of system, and to value diverse professional approaches.*

2.5 For Dorset, a measure of our success will be an inclusive working culture for everyone which is mature, open and honest about its role and performance.

2.6 Through the leadership of the new NHS Dorset People and Culture Committee, we can co-produce a People Strategy. The strategy for Dorset will be driven by Dorset's Integrated Care strategy and align to the NHS People Plan and Promise. It will be unique to the aspirations and challenges for Dorset.

2.7 The People Strategy will be underpinned by leadership and management development, delivering the recommendations set out in the Messenger review. This will in turn create opportunities for all and a strong, sustainable and consistent career pathway for everyone.

2.8 The opportunity to gather, review and use data to inform our actions will be important. The Messenger review refers to systems exploiting workforce data. In Dorset, we have a leading digital infrastructure which we need to capitalise on to support our People Strategy.

2.9 The opportunity to learn and understand more about what is being delivered by each partner organisation will be crucial in identifying the right opportunities for everyone. It will also help us understand what we can do to create one story and narrative, whilst achieving economies of scale and releasing time, capacity and resource to develop the workforce further.

Next Steps for Dorset

2.10 The NHS Dorset ***People and Culture Committee is established*** with the first meeting on 18 August 2022. It will have a responsibility for the co-production of a People Strategy and setting priorities for the Dorset Integrated Care System.

2.11 To produce the ***People Strategy and supporting implementation plan***, NHS Dorset will lead on the ***engagement and co-design across all partner organisations*** in the Integrated Care System. All partners will have a voice and be represented.

2.12 NHS Dorset People and Culture Committee will oversee a ***comprehensive stocktake*** of what is currently available in Dorset, aligned to the recommendations of the Messenger review. The stocktake will identify what has been successful, what is currently running across individual organisations, what might need to continue or change and what gaps may need to be considered.

2.13 A ***review of workforce data***, what is available and what is needed will be conducted and inform the People Strategy and supporting implementation plan.

3. Conclusion

3.1 The Messenger review is welcomed, providing greater insight and information to inform our work in Dorset. However, it will be used as one part of a wider conversation with our partners in Dorset to ensure our strategy, priorities and implementation plan are reflective of our needs in Dorset.

Author's name and Title : Ellie Parson, Deputy Director Engagement and Development
Date : 06 July 2022

8.3

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

ICS TRANSFORMATION PROGRAMME UPDATE

Date of the meeting	20/07/2022
Author	L Oldham, Head of Design and Transformation
Lead Director	P Richardson, Chief System Integration Officer
Purpose of Report	To provide a summary of progress against phase 1 deliverables and next steps for each workstream within the ICS Development Programme.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	*NA*
Involvement and Consultation	*NA*
Equality, Diversity, and Inclusion	*NA*
Financial and Resource Implications	*NA*
Legal/governance	*NA*
Risk description/rating	*NA*

1. **Introduction**

1.1 The report set out in appendix 1 provides a summary update against programme deliverables and key risks as we begin to bring Phase 1 of the Integrated Care System (ICS) Transformation Programme to a close and transition to the next phase of the programme.

2. **Report**

2.1 The programme has reached the first major milestone of implementing the government's vision set out in the White Paper; Integration and Innovation: working together to improve health and social care for all; and the ICS Design Framework by creating the new legal entity of the Integrated Care Board (ICB) and the transaction of the Clinical Commissioning Group (CCG) to the ICB.

2.2 The completion of the transfer closes 'D1 CCG transfer' as a workstream within the programme and any follow-on actions post transaction including any residual risks have been fully handed over to key leads within the organisation, which are detailed in the project closure report in appendix 2.

2.3 All Phase 1 deliverables set out in the Programme Initiation Document were met with the exception of:

- The oversight and assurance framework due to delays in national guidance
- Financial Framework and Capitalisation plan due to delays in national guidance
- Appointment of Place Based Partnership Leads

2.4 It is important to note that whilst the ICB is now in place there are ICS components still in development. A review against the ICS thriving criteria within the progression tool will also be carried out.

2.5 Therefore, as we move from phase 1 of the ICS programme to phase 2, we are going to be reconsidering the structure of the programme, the role and function of the steering group as well as what still needs to be delivered in the short and longer term.

2.6 Following this a full closure report for phase 1 will be taken to the ICB alongside any closure reports transferring deliverables and risk as appropriate.

3. Conclusion

3.1 The ICS Programme steering group has been postponed to September, however, the ICB are going to agree how to move this forward by the end of July and re-establish a programme management approach in September when all ICB Chiefs are in post.

3.2 The ICB are asked to note the report, appendices, and next steps.

Author's name and Title: **Lianne Oldham, Head of Design and Transformation**
Date: **07.07.22**

APPENDICES	
Appendix 1	Workstream summary update against programme deliverables and key risks
Appendix 2	Closure Report – Workstream D1 ‘CCG Transfer to ICB’

NHS Dorset

ICS Transformation Programme next steps

Phase 1 Programme Summary Report

Lianne Oldham,

Head of Design and Transformation

Version: 01 Date: 08/07/22

Phase 1 National Workstreams

A. ICS Design	
A1: Functions, Governance & Accountability	• Construction of appropriate Governance and Accountability arrangements • Set up the appropriate Regulation and Oversight measures • Agreement and establishment of Provider Collaboratives • Development and agreement of Place-based Partnerships • Develop a framework that enables Strategic and Operational Commissioning • Clinical and Professional Leadership
A2: ICS Financial Framework	• Development of a single ICS Financial Framework
A3: Digital Technology, Data & Intelligence	• Transformation of care, through use of data and digital technology - build smart digital & data foundations, connect Health and Care services, use digital and data to transform care
A4: People and Culture	• Support its people, realise ambitions set out in the NHS people plan & in turn delivery of the LTP • ICS people function and clear accountabilities at system level including planning, transformation, recruitment and retention, staff health and wellbeing, leadership development and talent management, and equality diversity and inclusion • ICS OD delivery being considered with A4 WS- **tba**
B. Implementation	
B1. Change Management, ICS establishment and OD	Change Management, ICS Establishment and Organisational Development (linked to WS A4: People and Culture)
B2: Ongoing System Support and Development	• identify system development needs • influence the ICS implementation plan such that it reflects priorities and development needs.
C. Engagement	
C1: Partnerships and Engagement	Underpinning Workstream
D. CCG Transition	
D1: CCG Transition	CCG Transition

The report provides a summary update against programme deliverables and key risks as we begin to bring phase 1 of the ICS Transformation Programme to a close.

The programme structure and function of the steering group will be reviewed as well as what still needs to be delivered in the short and longer term as the programme transitions to the next phase.

Workstream A1.1: Governance and Accountability Arrangements

NHS Dorset

Update

Integrated Care Board (ICB)

- ICB appointment process complete with all roles appointed.
- First ICB Board meeting held and the following noted and approved: Constitution, governance handbook, appointments, key strategies, policies, and delegation arrangements.
- Appointments Panel held and approved appointments of Chief Executive Officer of the ICB, ICB unitary board members (Non-Executive Members, Chief Officers, and Partner Members) and ICB Committee Chairs.
- Remuneration Committee held and approved salaries of Chief Officers.
- Non-Executive Member pay group held and approved salaries of the Non-Executive Members
- ICB Constitution, governance handbook, standing orders and delegation agreements published on ICB website.
- Delegation Agreements for the new ICB signed by the Chief Executive (CE) of the ICB and returned to the co-commissioning team.
- Establishment Order and Transfer Scheme received from NHSE.

Integrated Care Partnership (ICP)

- ICB approved the founding member for the ICP
- ICP Terms of Refence (ToRs), membership and interim chair agreed.
- ICP Strategy: Review of existing strategies completed, and leadership engagement continues.

System Operating Framework (SOF)

- Have now received the oversight framework metrics and mapped them against the operational plan and contract metrics to inform both contract review meetings and board/committee reporting requirements.

Plan for next 3 months

Integrated Care Board (ICB)

- Recruitment to ICB Corporate Secretary role by Autumn.

Integrated Care Partnership (ICP)

- Corporate Office establishing sequencing of ICP meetings.
- Develop and agree role specification, cost share, and run appointment process for the ICP independent chair.
- Develop first draft of the ICP strategy and socialise with leadership before progressing to partner boards
- The leadership workshop is planned for the 26th of July and is being led by Bruce Finnamore to inform the vision and strategic direction.
- Draft strategy to be developed end of August to then social with partners.

System Operating Framework (SOF)

- Work with the Directors and Deputies to finalise the reporting requirements and implement outcomes and further inform Terms of Reference
- Review of the Terms of reference of existing groups and sub groups to inform full ICB governance and oversight framework.

Current risk areas

- ICP national guidance is due out in July, which may impact plans. **Mitigation**: Review the guidance against plans once published to form a view
- If a Corporate Secretary is not recruited this could impact the capacity within the ICB to robustly manage the duties of the corporate secretary. **Mitigation**: immediate recruitment campaign and reprioritisation of other activities to utilise existing staff to manage the administrative duties in the interim.

Workstream: A1.3 Provider Collaboratives

NHS Dorset

Update

- A single provider collaborative model under a Leadership Board governance model was endorsed as per papers that went to shadow board on the 20.5.22.
- Initial membership is now confirmed as:
    - Dorset County Hospital (CEO) – Nick Johnson
    - University Hospitals Dorset (CEO) – Siobhan Harrington
    - Dorset Healthcare (CEO) – Dawn Dawson
    - Dorset GP Alliance x2 – BCP/Dorset – TBC appointment process close 15.7.22
    - Chief Operating Officer – Anita Thomas (DCH)
    - Chief Medical Officer – Faisil Sethi (DHC)
    - Chief Nursing Officer – Nicky Lucey (DCH)
    - Chief Finance Officer – Matthew Metcalfe (DHC)
    - Chief Transformation Strategy Officer – Richard Renaut (UHD)
    - Chief People Officer – Nicola Plumb (DHC)
    - Chief Information Officer – Peter Gill (UHD)
    - Other Participants:
        - South Western Ambulance Service NHS FT ("SWAST") – Andrew Rosser
        - Integrated Care Board (ICB) Representative – Dean Spencer
- High level phase 2 planning has been carried out to develop further with the Provider Collaborative and a database of all collaboratives across the system is in development.
- The role of chair has been developed alongside an appointment process to be endorsed at the first meeting.

Plan for next 3 months

- Member Onboarding and Inaugural Meeting 8th August 22
- Chair Appointment Process & Formally Appoint Chair and ToRs
- Engage LA and VCSE Sector to broaden membership
- Provider Collaborative Development Session with external facilitator to develop collaboration principles, objectives, value, behaviours and ways of working
- Develop and agree process for developing the case for change, priorities and measuring success
- Develop the maturity matrix and endorse the provider agreement.

Current risk areas

- Limited resource to do the work of the provider collaborative e.g., writing and implementing the strategy. **Mitigation**: Develop a resource plan with collaborative

- The timely development of the ICP strategy and ICB plan will impact provider collaborative progression in the short term as they do not have clear direction until these things are in place. **Mitigation**: Align work of the provider collaborative to the developing work of the ICP strategy and ICB plan.

Workstream: A1.4 Place Based Partnerships

Update

- Place based Partnership footprints and form and function were endorsed.
- Draft ToRs templates were endorsed by the ICB Shadow Board but were not endorsed by place stakeholders. These will be developed further once these groups have been formally established.
- The Working Group continues to showcase examples of local good practice and innovative working as part of the engagement across all sectors within both Place footprints.
- Engagement activity continues across Primary Care regionally with NHSE, with systemic attendance at both working groups.
- The National Place Based Partnership Programme also continues, with an increased attendance from both Dorset Council and BCP Council colleagues.

Plan for next 3 months

- Appoint place Chairs and Leads.
- Pre-engagement with Health and Wellbeing Board (HWB) Chairs through Dorset Public Health Director in order to support a joint HWB development session on 29.7.22
- Identify deliverables beyond July 2022 and agree milestones towards March 2023
- Engagement with Provider Collaboratives and HWBs to develop maturity matrix for Place.

Current risk areas

- Delayed day 1deliverables and focus of national place programme on pilots/showcasing examples will likely delay the implementation of the agreed system governance framework as the infrastructure for Place and place leads is not yet established to focus on its development within the system architecture. **Mitigation**: Agree appointment process and appoint chair/leads with a renewed focus on determining place governance and objectives.

Workstream: A1.5 Strategic and Operational Commissioning

Update

- Strategic Commissioning workstream was stood down at the start of the programme
- Delegation agreement has now been signed with NHS England. ICB PCCC will work with NHS SW Regional Commissioning Hub to oversee Commissioning decisions

Plan for next 3 months

- Consider standing back up and scoping the strategic commissioning workstream
- Establish a cross-directorate Delegation planning group to meet monthly to ensure joint working arrangements can be put in place working with the NHS England Regional Commissioning Hub.

Current risk areas

- Workforce -both ICB to undertake Delegation planning and Regional team -NHSE are working on a People Plan
- Complaints management -currently overseen by NHS South team -People plan being developed for SW and System level resources

Workstream: A1.6 Clinical Care and Professional Leadership (CCPL)

NHS Dorset

Update

- Draft framework and associated development plan endorsement by existing governance groups following system engagement.
- Framework widely socialised across the system and feedback captured via survey
- Planning meeting held to review recommendations and plan for next steps.

Plan for next 3 months

- Agree future programme governance structure and establish new working group
- Capture a collective understanding of Leadership Offers and Opportunities available internally and externally to Dorset ICS (included in CCPL plan)
- Capture a collective understanding of existing and potential funding sources for CCPL leadership roles and programme delivery (included in CCPL plan)
- Develop the initial framework to inform full programme plan to deliver 5 principal outcomes over the next 5 years, mapping dependencies across other programmes of work.
- Baseline current system level maturity against CCPL framework and define process for ongoing maturity assessment.

Current risk areas

- Funding streams to support delivery and CCPL roles are currently unknown, which poses a risk to financial sustainability and delivery of the framework. **Mitigation:** Raise with NHSE (14th July 2022), research / scoping to take place to identify possible internal streams of funding and other systems approaches.

- Risk of potential duplication and lack of connectivity with other areas of work in development of longer-term plan **Mitigation:** Evaluation exercise to identify cross cutting areas.

- Risk of limited clinical capacity / expertise to continue to engage and remain embedded in the co-design and development of future iterations of CCPL framework and longer-term delivery plan. **Mitigation:** Mapping exercise to identify current Clinical Leaders across ICS, continued communication, and engagement activity, work up process to maximise use of clinical engagement input within time constraints.

Workstream: A2 ICS Financial Framework

Update

Capital Prioritisation: Proposals on how the capital prioritisation could work have been shared, final arrangements to be agreed following feedback.
Financial Framework: Has been drafted and included in the SCFMA and shared with OFRG on the 7th July – all partners happy with the draft and will take through their respective organisational governance for final amendments and agreement.

Plan for next 3 months

- The financial strategy will need to be developed alongside the medium to long term plan expectations, which are due in the next quarter, therefore work will commence in the next 3 months.

Current risk areas

- If agreement is not reached on the approach for the capital prioritisation or that organisations do not sign up to the SCFMA and financial framework. **Mitigation:** Maintain engagement to reach agreement.

- For the strategy that we are unable to develop a plan that gets the system back into recurrent balance. **Mitigation**: Will require transformational delivery support to implement the scale of change required that can be incorporated into the financial strategy/plan.

Workstream: A3 Digital Technology, Data, and Intelligence

NHS Dorset

Update

Phase 1 Deliverable: Development and endorsement of the Digital shared service business case

- NHS Digital Shared Service developed and endorsed.
- Outline Business Case was endorsed, and board approval received from all organisations to progress to Phase II of the Design & Implementation of the NHS Dorset Digital Shared Service.
- 5 Year Digital Investment Plan was submitted to NHSE, which will support the requirements and strategic direction of the NHS Digital Shared Service.
- The Data & Analytics Vision was endorsed by the various governance groups.
- Additional support is being provided from SafeHands a specialist consultancy and training service for Digital Clinical Safety.

Plan for next 3 months

- Design and implementation phase of the digital shared service
- Process and resource determined to enable the Digital clinical safety function

Current risk areas

There is a gap in the regulatory process for clinical safety in primary care, with the CSO resource under immense pressure to identify, mitigate and communicate the potential causes of harm in the use of digital platforms with an approved risk management process. If this is not resolved, then it takes significant time to complete clinical safety effectively. So, we could potentially miss potential causes of harm risking patient safety and not be compliant with the ICS Design Framework nor WGLL - Safe Practice.

Workstream: A4 People and Culture

Update

Integrated Workforce Plan: Edition one produced informed by 6 professional workforce faculties and initial action plans agreed.

People Plan: Refresh of ICS People Plan Priorities for 2022/23 have been agreed with Programmes and People Committee and informed by the integrated workforce action plans.

Operating Model: Continuation of existing ICS Workforce delivery team operating model ready for review and alignment to support design and delivery of ICS People and Culture Strategy moving forwards.

Plan for next 3 months

- Work with ICB CPO to support the design and development of the ICS People and Culture strategy and operating model to support the delivery of the ICB/ICP strategic aims
- Further develop the workforce faculties governance and priorities, triangulating the plans with service/operational transformation and financial improvement
- Initial staff engagement work in alignment with the public engagement conversations to help inform the people and culture strategy development

Current risk areas

- Potential lack of connectivity and duplication of work with different workstreams.

Mitigation: Programme alignment and connectivity of existing work

Workstream C1: Communications, Partnerships and Engagement

Update

Working with People & Communities Strategy: Submitted to NHSE&I in line with the national deadline. Full document in plain English and one page infographic.

Public Engagement to inform the ICP Strategy:

- Phase 1 and 2 has commenced with a review of the insight report on what people have told us in the last 4 years and the "Community Voices, 100 conversations".
- The team are working with Point of Care Foundation, which involves building engagement skill/capacity in the ICS and its communities exploring the health and wellbeing needs of people furthest from health and care or difficult to reach.
- Currently recruiting 40 interviewers across health, care and VCS to be trained in semi-structured interview skills in July 2022.
- Supporting materials for 100 conversations including an information pack for interviewers/interviewees, consent form and introduction video in development.

Formal agreement for VCSE: MOU presented to ICS Steering Board on 20 June 2022 with final amendments being made to be endorsed at ICB Board on 20 July 2022.

Current risk areas

- Securing funding to enable the engagement work required to ensure the ICP strategy is informed by health and care staff and our Dorset communities.

Mitigation: Scoping funding options with L Oldham.

Plan for next 3 months

- Recruiting and training the right number of interviewers and interviewees
- Define evaluation process with Traverse and NHSE
- Analysis of the internal conversations as part of the culture work

Workstream D1: CCG Transfer

Update

The completion of the transfer closes 'D1 CCG transfer' as a workstream within the programme and any follow-on actions post transaction including any residual risks have been fully handed over to key leads within the organisation, which are detailed in the project closure report in appendix 2.

Plan for next 3 months

- Lessons Learnt review

Project closure report – D1 CCG Transfer

Project Name:	D1 Workstream - CCG Transfer		
Date:		Version:	0.1
Author:	Julie Mills		
Organisation:	NHS Dorset		
Workstream Exec:	Charles Summers		
Workstream Lead:	Ellie Parson		
Project Manager:	Julie Mills		
Portfolio	ICS Transformation Programme		

Version control

Version ref	Changes made	Changed by	Approved by	Date
0.1	First draft for review	J Mills		
1.0	Final version, incorporating comments from CS and EP	J Mills		

Purpose of this document

A project closure report is used to review how the project performed against the documentation used to authorise it. The project closure report confirms that the objectives have been met, the deliverables have been handed over and that project closure can commence.

It will also describe any abnormal situations or issues that occurred together with their impact. In the report the project manager will review the successes and/or failures of the project against the business case.

The report should review the successes and/or failures of the project against: the project initiation documentation, business case, project implementation plan, benefits plan, risk and issue registers and quality register.

It should also confirm any outstanding actions that need to be taken.

Any available useful documentation or evidence (for example user guides, benefits realisation plans residual risk logs) should accompany the follow-on action recommendation(s)

1.0 Project managers report

Summarising the projects performance, including successes and failures.

The purpose of the D1 Workstream 'CCG Transfer' was to enable the smooth transfer of staff and functions to NHS Dorset ICB by 1 July 2022, within the context of meeting the requirements set out by NHS England and Improvement.
A workstream delivery group was convened, with representation from all directorates as well as from the key stakeholder groups (members wore multiple hats to keep the team to a workable size). The group met on a scheduled monthly basis and by exception when needed, and this proved to be a really valuable meeting, with clear updates and engaged discussions around issues and solutions.

Although there were a number of changes to the delivery requirements from NHSE, this was within the understandable context of 'learning whilst delivering' for the NHSE teams. Some key strengths for the delivery group were: prior experience of change in the NHS, the adaptability of individuals to align to changed requirements, and the development of open and supportive relationships with the NHSE regional team.

The members of the workstream delivery group were committed to ensuring the delivery of a successful project and did so with positivity and good humour.

I believe this project is a good example of project skills and knowledge providing a secure bedrock, upon which organisational skills and knowledge were able to stand firmly to put in place the necessary changes and actions.

2.0 Review of the business case / project initiation documentation

2.1 Business case viability

Has the final project been able to provide the deliverables that will achieve the objectives as identified in the business case? Will what has been delivered resolve the problem that you were trying to solve?

The objectives, as set out in the Workstream Initiation Document were:

- To lead the legal transfer of staff to the new organisation for 1 July 2022 from all 'sending' organisations, in line with legislation and the national NHS HR Framework.
- To put in place a communications and engagement plan which supports staff involvement, enables open and honest dialogue and signposts staff to associated support and guidance.
- To engage with staff forums, trade unions, wider membership and other stakeholders in an open and transparent way which build trust and enables a smooth and effective transfer.
- To work with colleagues across the CCG and wider system to identify and support the implementation of associated structural changes and transfer of functions and services.

Review
The successful delivery of the 'Due Diligence' (DD) activities and the 'Readiness to Operate Statement' (ROS) activities provided the structure for the legal transfer to occur, which went through successfully on 1 July 2022.

Alongside this, the communications and engagement undertaken ensured that staff were supported and informed, resulting in a positive implementation. The approach of being open and honest in our communications and establishing early communication routes has been a particular strength of the project.

Links to colleagues in areas impacted by changes were established early and well informed, with staff happy to raise any issues for discussion/support, resulting in successful embedding of changes and transfer of functions and services.

2.2 Deviation from the approved business case

What changes (if any) were made to the original approved business case? What impact did this have on the project?

Although as a result ot the deferred legislative timetable, the go-live date was changed from 1st April to 1st July, which necessitated some re-planning, the delivery group surmised that the overall affect for the project deliverables was a positive one and, aside from the change of date, the business case was unaffected.

4.0 Review of project deliverables

Provide details of the deliverables completed below. Please also include the deliverables specifications and sign off documentation (or links to these) in the appendices.

Deliverable	Quality checks (date)		Approved by	Deviation from planned specification	Hand over to BAU date
	Planned	Completed			
Due Diligence complete	27/05	27/05	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
ROS complete	10/06	10/06	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
TUPE/CoSoP transfer complete	04/05	04/05	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
Re-brand ready for Go-Live	30/06	30/06	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
Financial structure in place	30/06	30/06	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
Governance structure in place	27/05	27/05	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
Delegated Commissioning	01/07	Delegation Agreement - NHS Do	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07
IT structure in place	30/06	30/06	Dorset CCG CE, NHS Dorset CE, NHSE	n/a	01/07

5.0 Benefits

4.1 Benefits achieved to date

What benefits have been seen from the project so far? Are these benefits as expected/planned? If not, then what differences from expectations have been noted and what are the reasons for these?

The benefits identified in the workstream initiation document were:

- To align the CCG statutory commissioning role and functions to the newly formed ICB NHS Body.
- To ensure the delivery of the ICS vision and purpose.
- To ensure staff are engaged, motivated and feel part of the change.

To look at each of these in turn:

- The workstream delivery group confirmed that (accepting there will be organisational change in the months following transfer) the identified statutory roles and functions will carry across from CCG to ICB.
- The successful mobilisation of NHS Dorset has been an important statutory step in the journey of Dorset ICS.
- Staff engagement and communication helped staff feel that they were a part of the changes that were happening, positive feedback has been received.

7.0 Lessons learned report

A review of what went well, what went badly, and any recommendations for corporate, project or programme management consideration. If the project was prematurely closed, then the reasons should be explained.

A lessons learned workshop will be convened within six weeks of the project going live for all members of the workstream delivery group, facilitated via the Transformation Team PMO. The learning will be fed back into the work of the Transformation Team to help guide the structure of future projects.

7.0 Follow on actions

Summarise the remaining actions that need to take place to close the project, including how you intend to communicate to stakeholders that the project is completed.

Also include in this section any residual risks that will need to be handed over, along with any user guides or guidance on continuous improvement. Please include residual risk log (or links to the log) in the appendices.

Finance actions – Andrew Gladwell - dates TBC:

- Submission of 'year-end' CCG Annual Report and Accounts for Q1 2022/23
- Inform national finance team when CCG legacy June VAT returns have been submitted

Business Intelligence actions – Andrew Gladwell - dates TBC:

- Confirm that all actions as required by the ODS Reconfiguration Toolkit have been delivered in full or are on target – date TBC:

IT/data actions – Gary Jordan/Paddy Baker via the Information Asset Owners Group:

- Records management review – underway, timescales for completion TBC

Workforce risk – Micki Attridge:

- In the coming months there will continue to be an impact on the workforce team as a result of the transfer e.g. rebranding documentation as it is used. Workforce have been fully involved in the transfer and are well placed to monitor and escalate any impacts.

Finance risks – Andrew Gladwell:

- Signature of contracts with NHS providers will be progressed through BAU routes
- CCG closure financial process will be progressed through BAU routes

8.0 Appendices

8.1 Deliverable sign off documentation

Readiness to Operate:

- Statement from NHSE and Dorset ICB

20220617 Dorset ROS Statement.pdf

- Checklist as of 1st July 2022

Dorset%20Readiness%20to%20Operate%2

Due diligence:

- Checklist:

Appendix D - CCG Close down and ICB E

- Assurance letter from CCG AO to ICB CE:

Due%20diligence%20assurance%20letter%2

- Legal assurance letter:

Appendix B - Legal Assurance on CCG to ICB transition Due Diligence Process.pdf

- BDO audit report:

Appendix A - CCG Closedown audit report BDO.pdf

NHSE letters and orders:

Regional NHSE letter: establishment of NHS Dorset ICB

29062022 SW Regional ICB Establishment Letter_Dorset.pdf

NHSE Transfer Scheme, Establishment Order, and cover letter

Transfer Scheme for CCGs to ICBs Level 1 a

B1770 Integrated Care Boards Establish

2a_Tim Goodson - NHS Dorset CCG Lette

8.2 Residual risks log

Residual%20risks%20passed%20into%20BA

8.4

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

QUALITY REPORT

Date of the meeting	20/07/2022
Author	P O'Shea, Deputy Director of Nursing and Quality J Swarbrick, Patient Safety Specialist K Payne, Head of Nursing & Quality (Quality Governance and Risk) L Plastow, Head of Safeguarding V Melville, Head of Nursing & Quality (Quality Improvement)
Lead Director	Vanessa Read, Interim Chief Nursing Officer
Purpose of Report	To provide a summary of commissioned services during the Covid-19 response.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	*n/a*
Involvement and Consultation	*n/a*
Equality, Diversity and Inclusion	*n/a*
Financial and Resource Implications	*n/a*
Legal/governance	*n/a*
Risk description/rating	Included on the Assurance Framework.

Author's name and Title : **P O'Shea, Deputy Director of Nursing and Quality**
J Swarbrick, Patient Safety Specialist
K Payne Head of Nursing & Quality (Quality Governance and Risk)
L Plastow, Head of Safeguarding
V Melville, Head of Nursing & Quality (Quality Improvement)
Date : **04/07/2022**

APPENDICES	
Appendix 1	**Personal Health Commissioning Annual Report 2021-2022**
Appendix 2	**Dashboard pdf**

Quality Report

July 2022

Quality Contents

Executive Summary

- Ambulance handover delays continue to be seen due to the system pressures.
- A Quality Assurance (QA) visit was also carried out to a St Anns Hospital, and assurance was seen in relation to service delivery and the management of IPC.
- The number of covid outbreaks has increased across providers including care homes in Dorset, system processes of support have recommenced.
- The Initial Health Assessments on Unaccompanied Asylum-Seeking Young people who are challenging their age commenced last month.
- Work continues alongside social care to consider the implications of the draft Liberty Protection Safeguards (LPS) and Mental Capacity overarching Code of Conduct , there are several implications for health including robust training of the whole workforce, minimum data set to be collated and coded within current IT systems, and the appointment of Approved Mental Capacity Practitioner 's to undertake review of complex cases.

Quality monitoring

The Business intelligence Quality Overview Report - v2 - Power BI
represents the most recent available data. Areas are being updated as soon as NHS digital restarts data collection or from direct monthly updates from providers. The dashboard contents and presentation have been updated..

Quality Overview – NHS Acute Provider Trusts

Edited by: Karen Payne

University Hospitals Dorset (UHD):

- Following initial reports that the backlog of discharge summaries had begun to reduce an increase has been seen again. This is likely to be due to data quality issues caused by an upgrade to the data feed system. The issue was noted by clinical teams which indicates the processes implemented are being used by staff effectively. The IT team are working to rectify the issues caused by the upgrade. The meetings to monitor progress will continue until assurance is obtained that progress is sustained.

Dorset County Hospital (DCHFT):

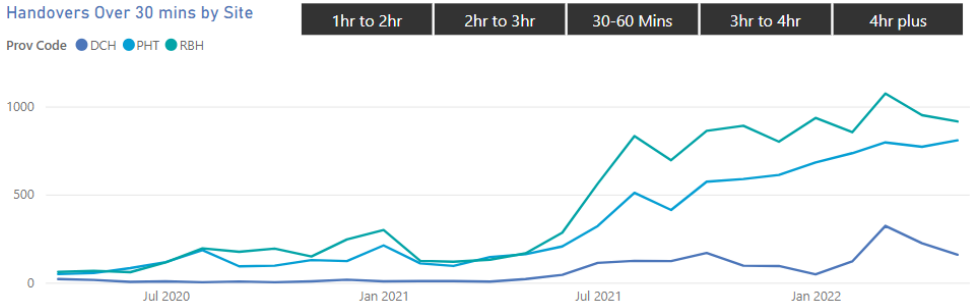
- Issues with discharge summaries have also become apparent. This has been escalated to DCH and closer monitoring will commence.
- A visit to the Hospital at Home team is planned. This will be used to inform ICB work to develop more virtual wards.
- The Medicines and Healthcare products Regulatory Agency (MRHA) visited the trust to review mitigations to risks in the blood science services. Formal feedback from the visit is awaited.

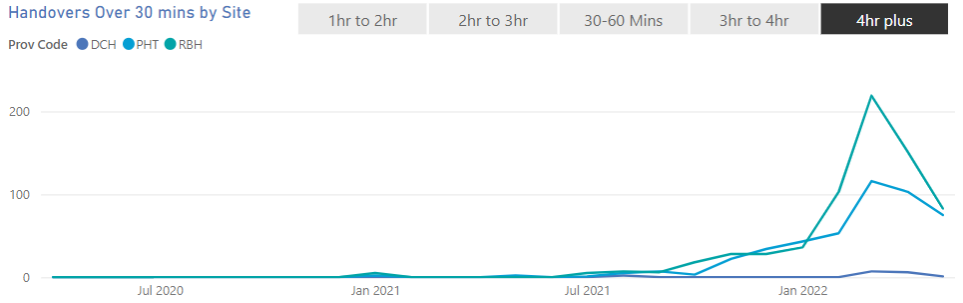
Salisbury NHS Foundation Trust (SFT):

Significant delivery issues identified with the Sleep Service continue to be of concern and the Integrated Care Board CEO has written to the provider. A meeting has been held with the co-ordinating commissioner and actions to address issues have been agreed. Alternate provision continues to be explored.

Ambulance Handover delays:

Significant pressure remains. DCH and RBCH sites have seen a decrease in delays over 30 minutes. PGH site remains an increasing trend. Extreme delays of over 4 hours have declined at all sites. Despite the overall decrease, levels of delays remain significantly high.





Quality Overview - South Western Ambulance Service Trust (SWAST)

Edited by: Pam O'Shea

Ambulance handover delays continue to negatively impact on SWAST performance with a resultant impact on patient safety, outcomes and experience of care. Of particular concern is delays in response times to Category 2 calls. Delayed response time is also impacting on the Home Birth service and all maternity units now have access to a live SWAST activity to support midwives with decision making in relation to a home birth.

Responding to complaints and adverse incidents has now been reviewed and SWAST will return to their pre-COVID approach. This will not come without challenges as the capacity limitations, especially amongst the operational staff continue.

A significant recruitment campaign for call handlers and dispatch staff continues whilst this has yielded some success, retention of staff remains difficult given the highly pressurised operating environment.

Oversight of progress against SWAST's action plan in response to the CQC findings will be through the Quality Assurance Sub Committee (QASC).

The patient safety system wide report has now been completed. It is being considered at an exceptional QASC and will be considered at the regional System Quality Surveillance (SQG) this month.

Quality Overview – Community & Independent Providers

Edited by: Vicky Melville

Dorset Healthcare

- A quality assurance visit was carried out to St Ann's Hospital and a report is being shared with Dorset Healthcare, the visit overall was positive overall, and demonstrated the changes staff have had to make during the pandemic and working in the mental health services.
- Regular quality assurance visits to services across Dorset Healthcare are planned for the next months across both community and mental health services.
- Work around the Leg Ulcer service continues, and a deep dive report has been completed with areas for development identified. Discussions with the CCG team are in place.

Independent Providers (care homes, supported living and domiciliary care)

- The number of COVID-19 outbreaks increased in Dorset Homes, and the support from both the local authority teams continues with support of the Quality Improvement Nurses (QINs) as a key resource for the care homes, who are managing these situations well.
- There continues to be strong evidence that care home providers continue to confidently manage situations and are aware of what processes are required to ensure staff and residents are safe.
- The system piece of work has concluded with a solution for the discontinuation of suspensions which were put in place when an outbreak is identified. A more in depth broker process has been established and is in place to support providers and commissioners with assurance around IPC measure and outbreak control.
- The number of quality assurance visits made to care homes across Dorset from local authority teams and the CCG team continue, with many good areas of practice noted. Some other care homes have required support to focus on areas of improvement and system support is being offered.
- Project being undertaken to gain assurance regarding IPC within care homes. Discussions with partner organisations suggest that care homes are being cautious in areas such as testing, visiting and admissions which may have an impact of flow. A questionnaire has been devised for completion by care homes to understand current practices. The outcome of this will be reported next month.

Quality Overview – Primary Care

Edited by: Vicky Melville

Primary Care

- Primary Care. Quality assurance support visits have commenced with a focus on infection prevention and control, feedback has been positive, and many are planned in the coming months.
- Three practices are awaiting reports following their CQC inspections, Poundbury Doctors Surgery, Lyme Bay Medical Practice and Royal Manor Health Care .
- Two practices are currently in receipt of active support from the CCG:

1. Wyke Regis & Lanehouse – Support required as a result of workforce issues following GP partner retirement. Support meetings have reduced to monthly. The practice engaging well with the CCG
2. Portesham Surgery being supported through the practice merger process. The practice are planning a merger with The Prince of Wales Surgery in April 2023

COVID-19 Outbreaks in Dorset

- Outbreaks of COVID-19 started to increase among the providers within Dorset, in both acute and community hospital settings and the system has been reviewing processes to put in place to reduce impact on the system workforce temporarily.
- Outbreaks in care homes have also increased in number, system support in place but providers managing outbreaks well. Supportive IPC visits and IMTs (incident management team) continue when required.

Infection Prevention Control (IPC) and COVID-19 Outbreaks

Edited by: Vicky Melville

Infection Prevention and Control (IPC) Dorset

- At the recent Dorset system IPC meeting NHSEI colleagues were invited to discuss the future plans for improvement activities within the system associated with the HCAI-CDI improvement collaborative. Highlights of our focus around new data collection processes, development of system C. difficile GP letter to allow better antimicrobial prescribing, and a deep dive into our C. difficile rates were shared, and positive feedback from NHSEI colleagues was given on the progress to date.

- A case of serious incident for C. difficile have been reported by a acute trust in Dorset. This case was identified as hospital onset hospital associated with previous contact with healthcare setting and care home. A full investigation is being undertaken with colleagues and learning will be shared in July Post Infection Review (PIR) meeting.

- A new community associated MRSA bloodstream infection have also been identified, which originally was assessed as an MSSA bacteraemia, however, the antibiotic resistance pattern was felt to be indicative of MRSA. A thorough root cause analysis taken place. No learning has been identified during investigation as patient had no contact with services prior to bacteraemia. There was level of non-compliance with treatment and use of drug substances, that were possibly a high-risk source of the infection.

- Two supportive visits to primary care surgeries at the South Coast Medical Group and The Vale Primary Care Network, have shown excellent leadership and good standards in infection prevention and control. Both IPC Leads within those surgeries were new to their role, however, they were very keen to engage to ensure compliance as per quality assurance CQC Key Lines of Enquiry. One of the themes and area to action identified was that the Roles and Responsibilities for IPC Leads is not provided when role undertaken. This is an action that is taken forward as a system and will be part of quality improvement project for this coming year.

Safeguarding

Edited by: Liz Plastow

Safeguarding

- The bespoke commissioned programme to undertake Initial Health Assessments of the Unaccompanied Asylum-Seeking Young people, in BCP continues to work well and on target to complete all, by the end of July

- The ongoing delays in completing the Initial Health Assessments for Dorset resident children, coming into care has now been escalated to contract leads to performance manage. The current arrangements are not sustainable and UHD remain in breach of their statutory duty

- The LPS Consultation has been extended for a further week and it is anticipated that implementation of the code will be delayed by a further year. NHS Dorset CCG/ICB have responded to the consultation.

- The Safeguarding Team have completed two of the three quality assurance visits to Providers, overall findings will be reported on completion of the third visit. The Section 11 Audit a statutory requirement of the Pan-Dorset Safeguarding Children's Partnership is underway.

- The safeguarding place-based arrangements are increasingly impacting on the capacity to attend all meetings, the CCG are working with Partners to ensure safeguarding standards are maintained as divergent strategies emerge.

- Contributions to the Safeguarding Boards annual reports and NHS Dorset CCG/ICB Annual Reports for safeguarding, Children in Care and Child Death are complete.

Patient Safety and Mortality

Edited by: Jaydee Swarbrick

Local Maternity and Neonatal System (LMNS) Safety

Both Trusts have reported to the respective Boards their position against the 7 Immediate and Essential Actions (IEAs) identified in the initial Ockenden report (see chart below). NHSE insight visits by the regional team to maternity units in Dorset will take place in October to provide further assurance.

Potential delays in provision of ambulance support for homebirths is now discussed as part of risk assessments and choice discussions with women. The risk has been escalated to the regional team who support continuation of homebirth services. Safety huddles in Trusts with SWASFT ensure up to date information is shared with the community midwifery teams.

The seven immediate and essential actions from the Ockenden report	Green Green/Amber Amber Amber/Red Red	1 2 3 4 5	Actions/Mitigations:
	DCH	UHD	
Enhanced Safety	GREEN	GREEN	
Listening to women and families	GREEN	GREEN	
Staff Training and Working Together	GREEN	GREEN/AMBER	Impact of workforce pressures risk and insufficient funding to release staff for training in baseline establishments.
Managing Complex Pregnancy	GREEN	GREEN/AMBER	UHD have a named consultant and have a plan in place with audit lead commencing in April 2022 (this is a new post)
Risk Assessment Throughout Pregnancy	GREEN/AMBER	GREEN/AMBER	DCH have presented full set of audits and are working to achieve compliance in rolling audits. UHD developing plan now audit lead in post.
Monitoring Fetal Wellbeing	GREEN	GREEN	
Informed Consent	GREEN	GREEN	Improvements made to the Maternity Matters website.

Patient Safety in Primary Care

NHS Dorset patient safety team have launched a GP SharePoint site to support engagement in patient safety incident reporting, investigation and sharing learning. The site includes tools to help practices with aspects of the process, case studies and examples to share learning and links to other relevant areas.

Harm Review

The purpose of the review is to identify the opportunities for learning and consider the impact on quality and safety in health and care services for people in Dorset following the challenges faced during the Covid – 19 pandemic response and local operational pressures in services. Requests for information for the harm review are being followed up, work on the chronology for the changes in national guidance has started.

Learning for Patient Safety Events (LFPSE) implementation

NHS EI have set a milestone for all NHS Trusts to be uploading patient safety incidents to the new LFPSE system by March 2023. This process is dependent on the local risk management software providers (e.g. Datix, Ulysses) to upgrade the systems to be compliant. There are concerns raised at national level about the progress being made on this as one software provider will not commence until September 2022 on the older versions (two Dorset acute trusts using this). In addition DHC are in a procurement process for a new system and as yet unable to confirm if the NHS EI milestone will be met.

Mental Health Homicide

An Independent Quality Assurance report has been published by NHSE. The review conducted by NICHE (Health and Care Consulting) looked at the implementation of recommendations resulting from their independent investigation into the care and treatment of a mental health service user, in Dorset and assessed the NHS Dorset was able to evidence that the relevant actions had been completed and tested.

Dorset Quality Surveillance Group (QSG)

Edited by: Vanessa Read

Dorset Quality Surveillance Group - Items for note, May 2022 Meeting

Enhanced Surveillance

SWASFT

- SWASFT remain in a challenged position due to demand and deterioration in several key performance indicators.
- Performance is challenged with loss of hours due to Ambulance handover delays.

Urgent and Emergency Care (UEC)

- There will be a Southwest Ambulance workshop looking at the here and how and future modelling.
- Information is being shared daily on handover delays and Category 1 and 2 calls.
- Stood down from OPEL 4 on Friday 29th April. System Resilience and Tactical groups meeting regularly.
- Working on capturing data as key indicators to feed into balancing the risk across the UEC pathway.
- Have commissioned extra urgent ambulance transport.

111 Element of Dorset Integrated Urgent Care Service (IUCS)

- Remain in enhanced surveillance as linked to high demand and the UEC pathways.

Other concerns

- Concern was raised on the Autism review and how long this will take to complete and therefore reduce waiting times.

Dorset Quality Surveillance Group

Edited by: Vanessa Read

Adult Mental Health

- From the presented report, picked up:
  - How the out of area and named patients are included in data.
  - Management of waiting list for people needing admission.
  - Measurement of impact for MH services to be included in future reports.

Children and young Peoples Mental Health Services (CAMHS)

- From the presented report, picked up:
  - Noted the challenge in increasing the age to 25.
  - Support the approach to develop a seamless service.
  - Interested in reading reports from school services.

Ockenden update

- From the presented report, picked up:
  - Noted stock take beyond maternity; action to progress.

Safeguarding

- From the presentation, picked up:
  - Work going on in the ICS regarding Liberty Protection Safeguards.
  - Challenges in meeting statutory timeframes for health assessments for Children in Care (CiC).
  - COVID recovery.
  - Challenges in place-based provider collaboratives as they start to emerge in relation to mental health.

Patient safety collaboratives

- From the presentation, picked up:
  - Work Ensure right connections, not overlaying work, for those inter relationships.

Dorset Quality Surveillance Group

Edited by: Vanessa Read

Items for noting

- Childrens services and transition report.
- Migrant Health.
- Local Authority representation at QSG remains sporadic.
- Direct commissioning:
  - Challenges in screening rates.
  - Challenges in dental services.
- General Medical Council (GMC) Survey poor response to date.
- Home First report.
- Carers experience survey by HealthWatch underway.

Good Practice

- Positive report from Healthwatch in relation to the Emergency Department (ED) at Dorset County Hospital.
- Reduction in Never Events.
- Medical Examiner roll out to Primary Care.
- Launch of Badgernet at UHD.
- Created improvement patient flow by changing estate in ED at UHD.
- Estate work and the implementation of the AGILE system at DCH.

8.5

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

SYSTEM PERFORMANCE REPORT

Date of the meeting	20/07/2022
Author	S Charles, Head of Service – System Support
Lead Director	D. Spencer, Chief Operating Officer
Purpose of Report	This report informs the ICB Board of the key system performance issues in the system.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	N/A
Involvement and Consultation	Contributions from UHD, DCH and the ICB leads.
Equality, Diversity and Inclusion	N/A
Financial and Resource Implications	N/A
Legal/governance	N/A
Risk description/rating	N/A

Author's name and Title : S Charles, Head of Service – System Support
Date : 11/07/2022

APPENDICES	
Appendix 1	**July 2022 System Performance Report**

NHS Dorset

Dorset System Performance Report

July 2022

Version: 01 Date: 05/07/2022

System Performance Contents

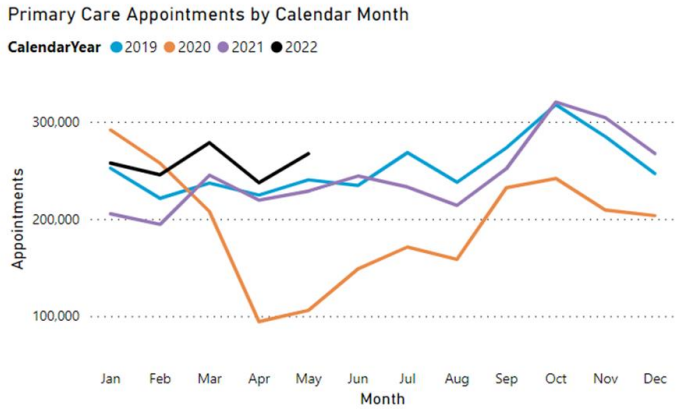
NHS Dorset

Primary Care

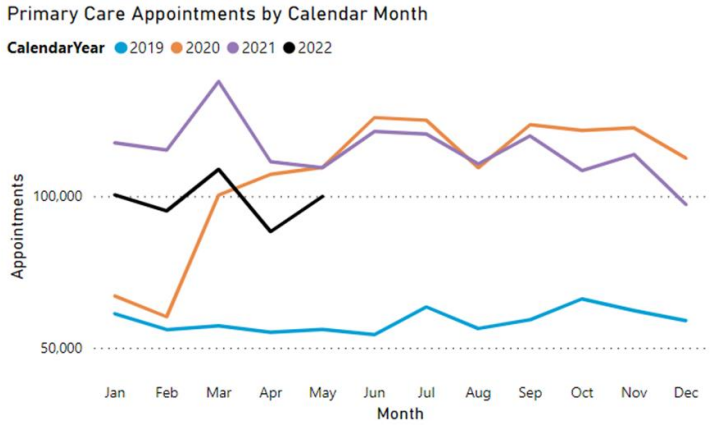
Source: Dorset SPR Dashboard May 2022 & DiiS Flu and COVID Vaccination dashboards

NHS Dorset

Month-end May 2022 – Total Consultations delivered Face-to-Face



Month-end May 2022 – Total Consultations delivered Remotely



- Total consultations for 12 month ending May 2022 increased by **12.5%** (575k) compared to pre pandemic level in 2019/20 (Apr 19 to Mar 20). Face-to-Face activity largely mirrors the profile in 2019 and currently accounts for 74% of activity, remote consultations have increased significantly with the monthly average since Mar 2020 at just under 112,000, double the levels in 2019.

Flu Vaccinations

Vaccinated

69.4% 331206

% vaccinated

Eligible Population

477,181 (59.6%)

(Excl Opted Out Patients)

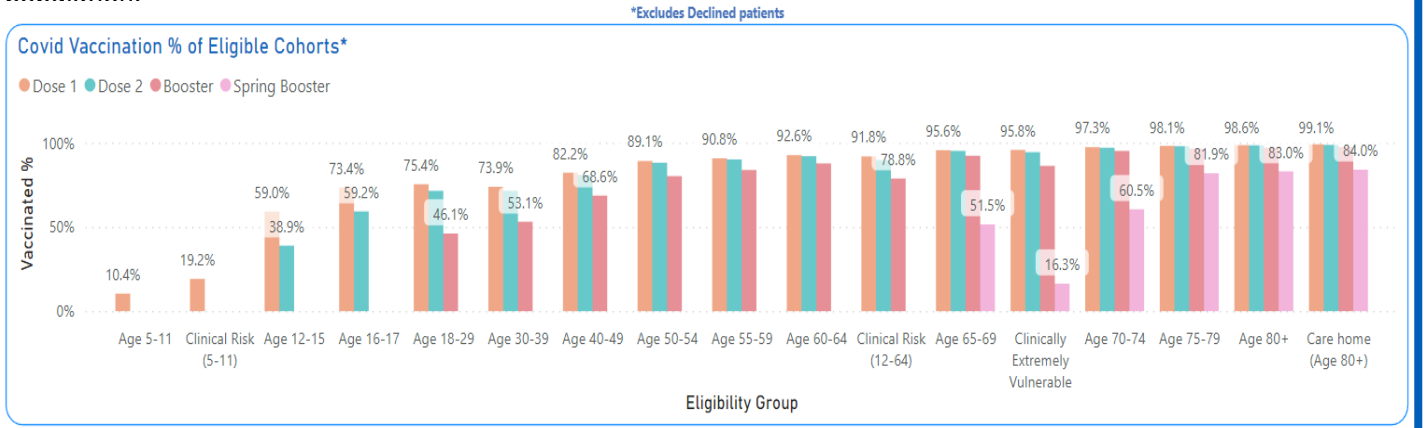
PCN/ Practice

PCN	Eligible	Opt-Out	Vaccinated	%
Sherborne Area	14,576	8	11,864	81.4%
Mid Dorset	32,140	8	24,496	76.2%
Wimborne and Ferndown	27,320	2	20,487	75.0%
Blandford	14,784	5	11,075	74.9%
Purbeck	22,152	6	16,490	74.4%
Christchurch	31,071	11	22,933	73.8%
Poole North	33,118	22	24,204	73.1%
Weymouth and Portland	47,668	5	34,690	72.8%
Crane Valley	21,407	1	15,523	72.5%
Jurassic Coast	26,692	4	19,336	72.4%
The Vale	24,776	2	17,472	70.5%
Poole Central	37,200	27	24,833	66.8%
Poole Bay and Bournemouth	20,787	17	13,666	65.7%
North Bournemouth	24,712	7	15,486	62.7%
Central Bournemouth	23,441	36	14,606	62.3%
South Coast Medical	17,805	15	10,799	60.7%
Shore Medical	32,432	1	19,194	59.2%
Bournemouth East	25,251	4	14,585	57.8%
Total	**477,332**	**181**	**331,739**	**69.5%**

As at 27th June 2022, 331,206 (69.4%) people have received their flu jab out of 477,181 eligible for a free of charge NHS vaccine. Vaccines have been provided in GP, Pharmacy, School and Hospital settings. (National ambition >70% depending on cohort).

Covid Vaccinations

86% (620,095) of the eligible population (721,347) have had at least one dose of a c-19 vaccination (excluding 5-11 cohort). Of those who have had one dose, 96.8% have had a second dose. 87.3% of the eligible population had had a full course including booster (94% for Over 50s). Latest Spring Booster uptake rate is 74.7% of the eligible population.



Primary Care Workforce

Updated on 31/05/2022;
Reporting Period Q4 2021/22

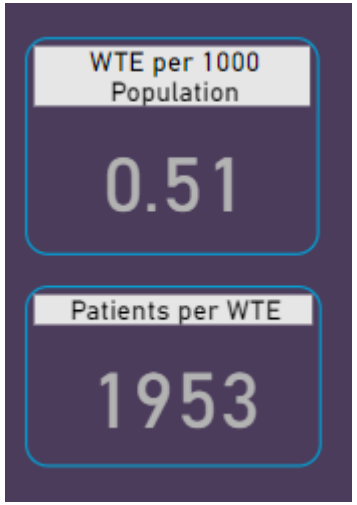
NHS Dorset

StaffGroup	Planned WTE	Current WTE	Vacancies WTE	Vacancy Rate	12 Month Joiners	12 Month Leavers
GP	431.3	419.8	11.4	2.6%	162	69
Nursing	432.0	430.3	1.7	0.4%	193	62
AHP	32.9	32.9	0.0	0.0%	24	4
Pharmacy	16.8	16.8	0.0	0.0%	12	2
Health Coaches / Link Workers	20.2	20.2	0.0	0.0%	31	2
Admin	1,051.5	1,045.1	6.4	0.6%	569	158
Total	**1,984.7**	**1,965.1**	**19.6**	**1.0%**	**991**	**297**

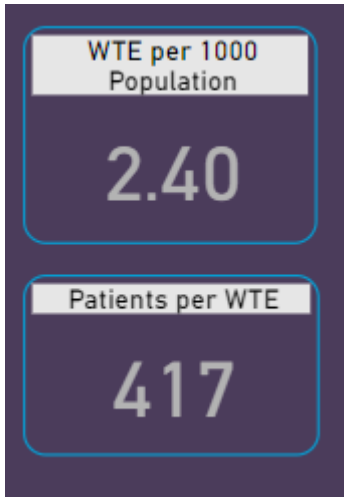
The total primary care workforce currently stands at 1,965.1 WTE.

StaffGroup	Planned WTE	Current WTE	Vacancies WTE	Vacancy Rate	12 Month Joiners	12 Month Leavers
GP	**431.3**	**419.8**	**11.4**	**2.6%**	**162**	**69**
F2	4.1	4.1	0.0	0.0%	7	4
Locum / Sessional	8.0	8.0	0.0	0.0%	14	0
Other	0.7	0.7	0.0	0.0%		
Other GP	4.1	2.4	1.7	41.2%	0	0
Partner	260.2	255.9	4.3	1.7%	29	25
Registrar	21.8	21.8	0.0	0.0%	27	13
Retainer	15.1	15.1	0.0	0.0%	14	3
Salaried	117.4	112.0	5.4	4.6%	71	24

The breakdown of the GP workforce shows the total WTE of 419.8



Breakdown of WTE against the population - For GPs



Breakdown of WTE against the population - For all staff -

Additional Roles (ARRS)

Intentions to March 2023	Actual June 2022
362 wte	226

*Revised PCN intentions for this financial year, and actual wte (June 2022)

Mental Health & Learning Disability

Edited by: Mark Harris

NHS Dorset

Community Mental Health - Adults

Community Services continue to experience high demand and pressure. Specific increase in demand in relation to requests for ADHD diagnosis.

Community Transformation: Phase II of programme commenced to 'cross check' designs for key population cohorts alongside development of operational infrastructure plan. Community Action Network (CAN) working with local community and broader VCSE partners to finalise hub design. Development and mobilisation of a Boscombe community wellbeing hub in progress – led by VCSE partners. Commissioning framework for future provision of hubs also being progressed with engagement with emerging VCSE Assembly and MH Alliance planned

Perinatal Access: Expansion plan agreed and supported with new investment. Recruitment in progress. Current access rate below 21/22 trajectory but expected to recover in coming months

Improved Access to Psychological Therapy (IAPT) – Access rate remains off track. Remedial actions including renewed marketing in situ. Work to understand impact of wider schemes (eg. social prescribing, Dorset MIND Active Monitoring) upon referral rates which remain below expected levels also planned. Recovery rates continue to track close to the 50% threshold with monthly fluctuations.

SMI Physical Health: remains below LTP threshold – model now live in all PCNs. Operational challenges preventing progress beyond current rates. Work with VCSE sector partners continuing with dedicated focus on addressing non-attenders.

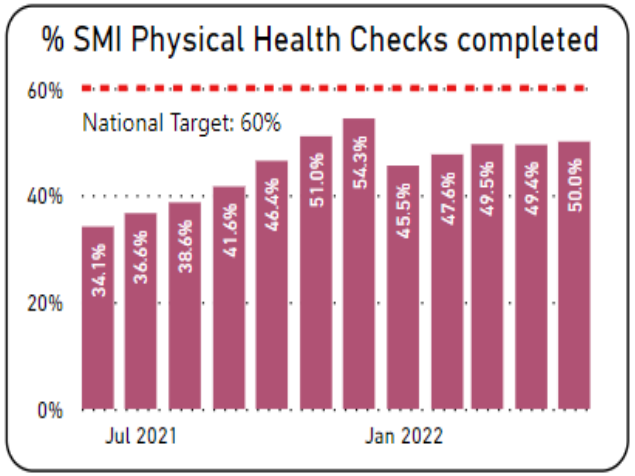
Referrals	Referrals 21/22 YTD	Referrals 22/23 YTD	Growth Ref's Actual	Growth Ref's %
AMH	2,895	2822	-73	-3%
Aspergers Service	118	166	48	41%
CAMHS	1,097	1116	19	2%
Eating Disorders Service	206	128	-78	-38%
Learning Disability Services	171	154	-17	-10%
OPMH	1,641	1408	-233	-14%
Perinatal	121	131	10	8%
Specialist Services	382	534	152	40%
Wellbeing Hub	57	123	66	116%
MH & LD Total	6,688	6525	-163	-2%

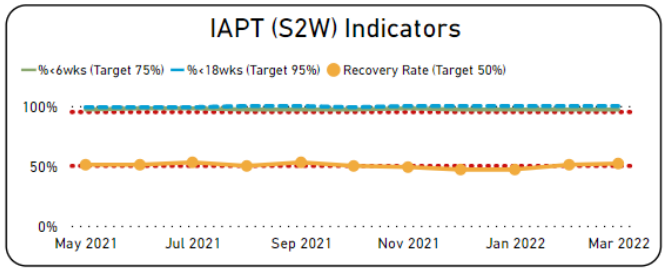
Key: AMH - Adult Mental Health, OPMH - Older People's Mental Health
CAMHS – Children & Adolescent MH Services

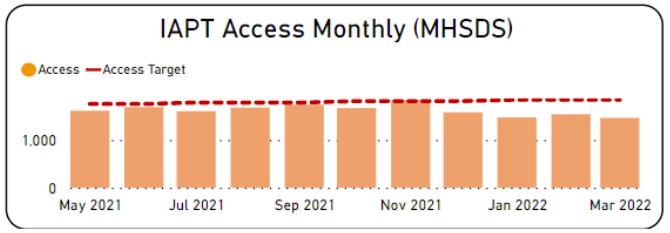
Mental Health Indicators Summary Table

Mental Health Indicator	Period	Target	Dorset	Direction
SMI Health Checks in last 12 months	May 2022	60.00%	50.00%	▲
Perinatal Access*	April 2022	7.10%	6.90%	▲
Dementia Diagnosis Rate (% of prevalence)*	May 2022	67.00%	55.40%	▲
Access Early Intervention in Psychosis within 2 weeks*	March 2022	60.00%	84.00%	▲
Adult CMHT RTA <28 Days	May 2022	95.00%	89.00%	▼
OP CMHT RTA < 28 Days	May 2022	95.00%	96.00%	▼
CAMHS Gateway <4 Weeks (28 days)	May 2022	95.00%	8.50%	▼
Children & Young People Urgent Access to Eating Disorders < 1 week*	March 2022	95.00%	46.51%	▲
Children & Young People Routine Access to Eating Disorders < 4 weeks*	March 2022	95.00%	39.36%	▼
IAPT waiting time within 6 weeks*	March 2022	75.00%	97.00%	→
IAPT waiting time within 18 weeks*	March 2022	95.00%	100.00%	→
IAPT Recovery Rate*	March 2022	50.00%	52.00%	▲
IAPT Access Monthly (MHSDS)*	March 2022	1,836.70	1465	▼
CYP access (1+ contact)*	March 2022	7,768.29	6210	▼
LD Inpatients CYP	May 2022		3	▲
LD Inpatients Adult	May 2022		23	▼
Adult Acute Out of Area Placements*	March 2022		470	▲

* Data from National Reporting







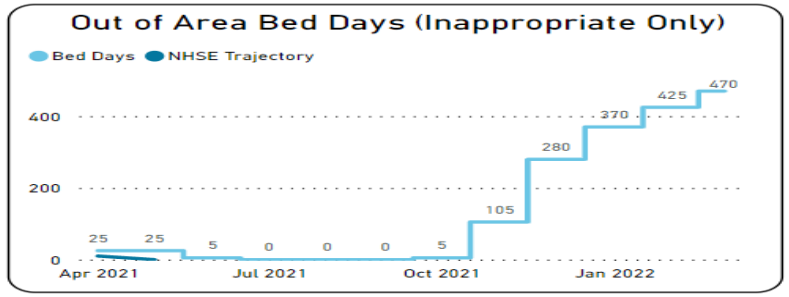
Mental Health & Learning Disability

Edited by: Mark Harris

NHS Dorset

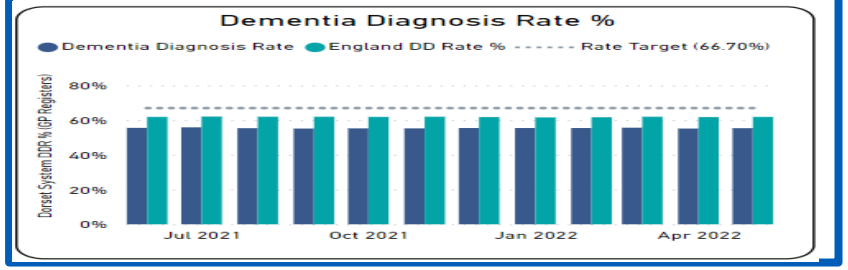
Access Mental Health Services (MH Crisis Care):

Increasing challenge with bed capacity resulting in increased Out of Area placements. As of 1st July, female PICU position improved following discharge and now re-open. No female PICU OOA as a result. Bed occupancy and flow severely hampered by number of DToC with primary reason linked to lack of supported accommodation and/or care home placement. MADE event facilitated 21/6/22 with system partners to address delays. Other work focused on media campaign to re-publicize Crisis alternatives. Delays also experienced in availability of health-based place of Safety – conversation with police planned along with need to look at Sec136 attendance rates which have on average a 23% conversion rate to admission. 999 hub MH practitioner role also ow in place. Ongoing dialogue re the local Joint response Vehicle which has ceased – lack of SWASFT workforce, police decision to cease involvement



Dementia:

Diagnosis rates remain relatively stable and well below national threshold. Memory Assessment Service continues to work through backlog of referrals. Targeted work with PCNs with lower-than-expected rates.

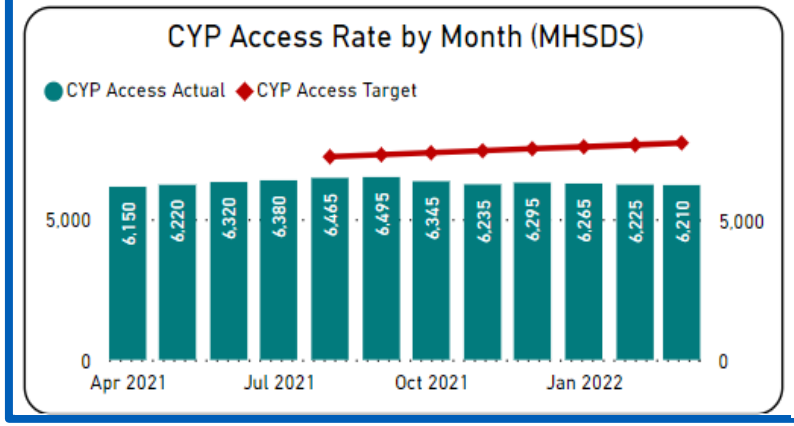


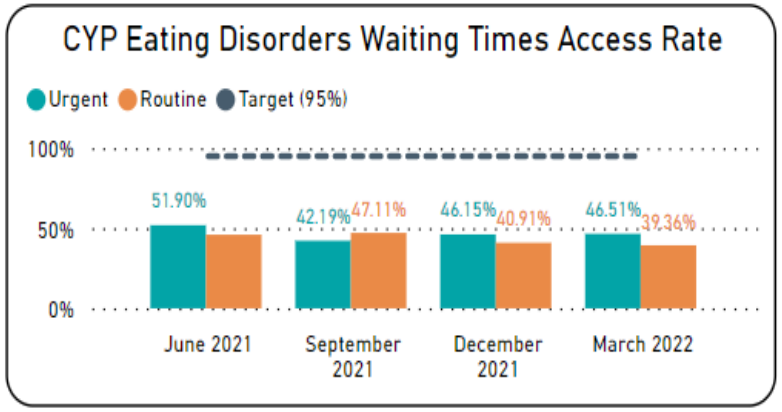
Children & Young People (CYP) Mental Health:

Significant workforce pressures within CAMHS services – Gateway Service struggling to fully recruit. Access rates remain below national ambition – work ongoing to ensure data completeness of submissions.

NHSE are considering means of capturing whole school and year-based activities which are excluded from MHSDS reporting at this time

CYP Eating Disorders – Business case outlining revised model and investment need nearing completion. Once approved trajectories for recovery of access standard will be confirmed.





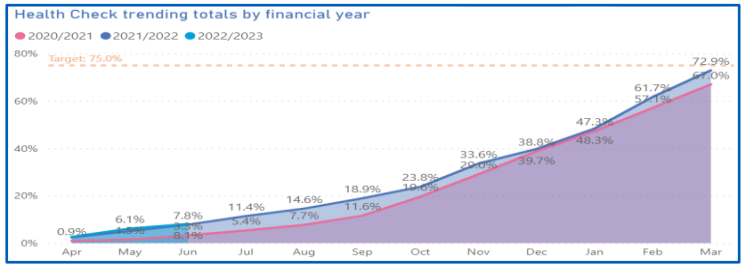
Learning Disabilities (LD) & Autism:

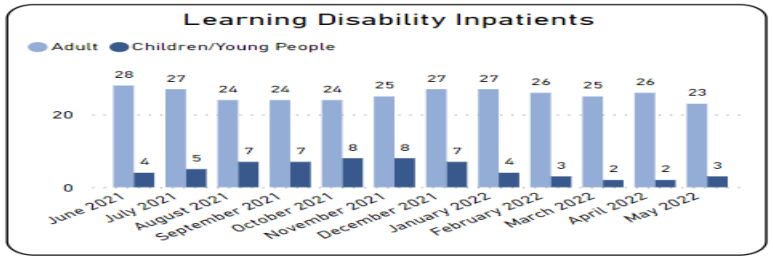
Annual Health Check rates tracking on or near to 21/22 uptake – dialogue in train with local PCNs to identify individuals who not received a healthcheck in recent years

Hospital In-patients – adults and children numbers remain high. Ongoing monthly review meeting focused on discharge planning. Key challenges related to availability within the care market to accept bespoke care packages alongside accommodation shortages. Profile of future housing/accommodation needs being developed to support intelligence and housing conversations

Work ongoing to develop and refine Dynamic Support register which continues to bed in

CYP Keyworker model to be co-produced within the scope of work to review /develop the CYP crisis offer across health and social care



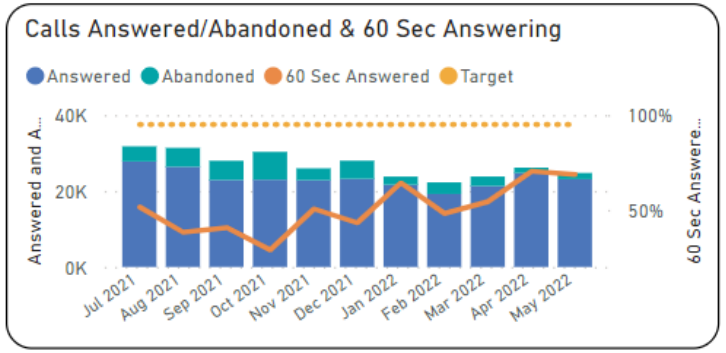


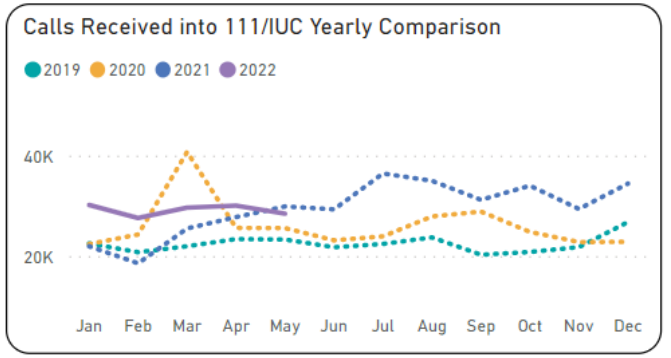
Integrated Urgent Care Service

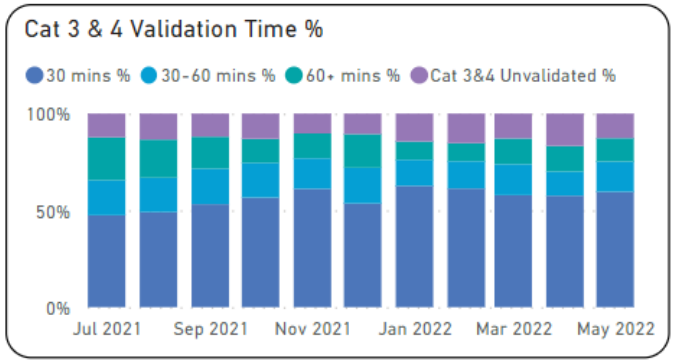
Edited by Emma Wilson

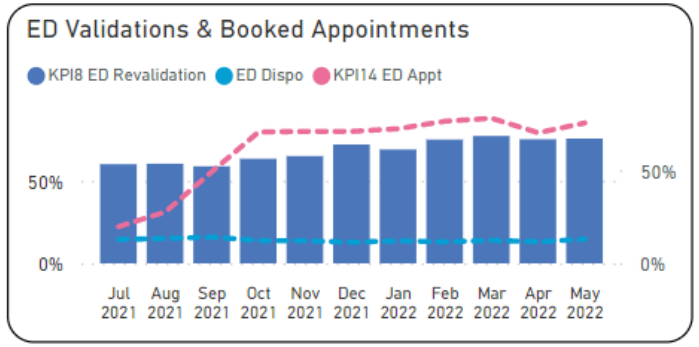
NHS Dorset

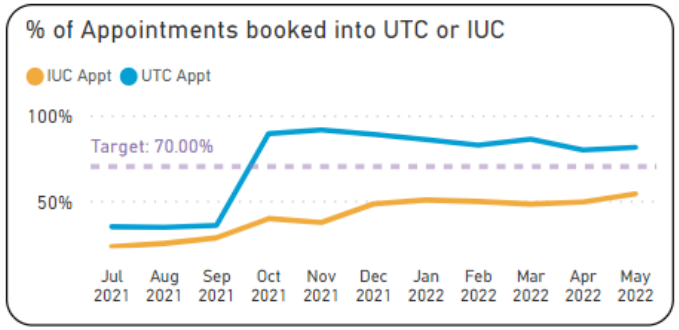
- 111 call answering performance has slightly dipped to 68.68% in May from 70.4% in April. Call abandonment has remained steady at 5.8%.
- Calls received into 111 in Dorset were 28,465 for May which is a 22% increase in demand compared to the same period 2019.
- Staffing remains challenged, especially within the Clinical Assessment Service, recruitment campaign continues.
- ED validations have remained steady at 75%. Cat 3 and 4 validations improved to 87% with 59.6% in 30 minutes – the KPI target is 50%.
- ED Direct Booking percentage has shown an increase to 75.58% against 70.32% in April. KPI target is 70%.
- Urgent Treatment Centre direct booking increased to 81% for May against 79.67% in April.
- The Dorset service has been challenged by increases in activity and with other areas calling upon National Contingency.











Urgent & Emergency Care – In Hospital

Edited by Emma Wilson & Suzanne Lane

NHS Dorset

Handover Data – 1st May to 27th June 2022

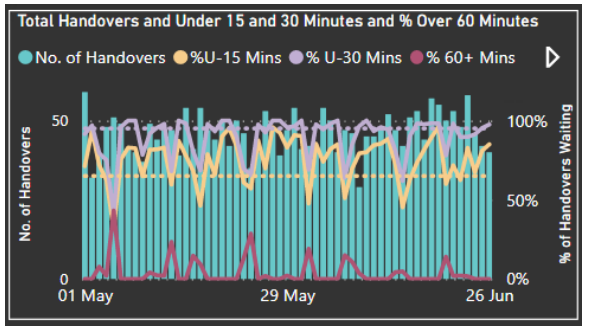
Handover Delays:

- Handover delays continue to be a significant challenge across the system. In June, the total resource hours lost due to handover delays per site were:
  - 133 hours were lost to Dorset County Hospital (156 hours lost in May).
  - 1,759 hours were lost to UHD – Poole (1,221 hours lost in May).
  - 1,357 hours were lost to UHD – Bournemouth (1,468 hours lost in May).
- The Intelligent Conveyancing SOP between the 2 UHD sites continues to be worked upon. Availability and accuracy of data to crews on the road is being reviewed to support their decision making as to where to convey. Final sign off and implementation of this will be monitored via the Ambulance Cell.
- An Ambulance Cell has been set up to focus on addressing the key priority actions across the 3 sites with the overall aim of the cell being to deliver against the improvement trajectory and reduce the level of harm and risk to our patients. The Dorset system lost 3,251 ambulance resource hours in June. This is above the trajectory set for June which was 2,641 hours lost. The trajectory aims to reduce delays to a total of 748 resource hours lost by March 2023 across the system.
- Key priorities to focus on: Increasing the offer of alternative pathways/services such as SDEC for ambulance crews to convey to, review of the front door model and ensuring there is an agreed system escalation plan for handover delays which includes allocated space for cohorting.

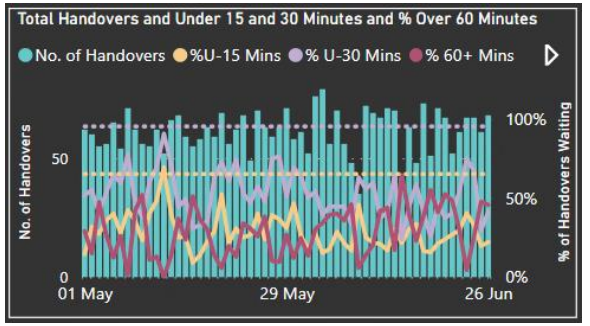
Emergency departments and flow:

- The latest validated data shows ED attendances are close to being in line with June 2021, albeit 2022 levels are higher; however, 2020 data which it had previously been in line with continues to be significantly lower. 999 activity has increased and is now above 2019/20 levels. SWASFT have been at their highest alert level (REAP Black) since June 2021.
- Hospital bed occupancy remains consistently above 95% due to a high proportion of patients who do not meet the clinical criteria to reside. Discharge & Flow Cell has had focus on increasing discharges at weekends, improving flow through mental health beds and community hospital beds.
- NRTR figures continue to hover in the SPA at about 350 delays. COHOS are currently running at 42% delays. This is the highest it has been for a number of months.
- The National Health and Social Care Discharge Taskforce has now launched the 100-day Challenge which will become a key focus for acute flow moving forward.
- The system has escalated to System OPEL level 4 on Thursday 30 June due to ongoing pressure and Covid surge.

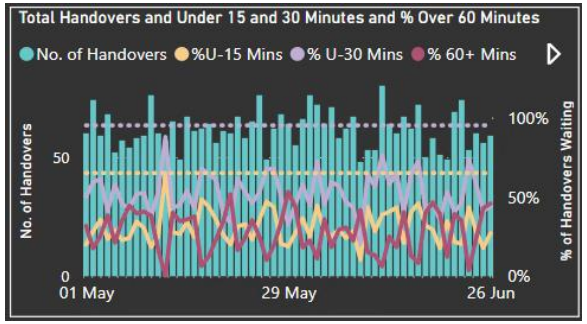
DCH



UHD - Poole

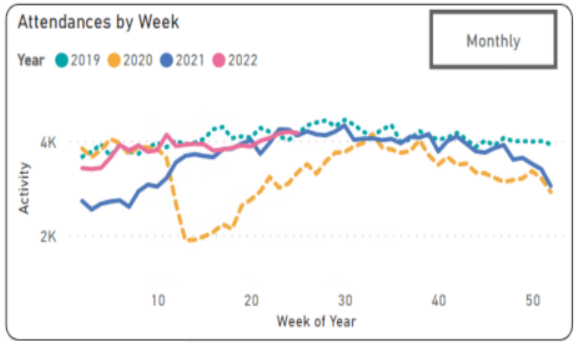


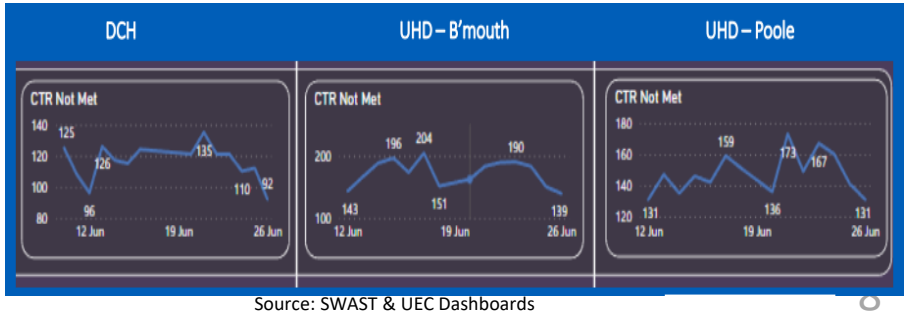
UHD – RBH



999 Activity (data available up to 19th June 2022):

ED attendances (data available up to 19th June 2022):





Source: SWAST & UEC Dashboards

ICS Ambulance Performance

Edited by Emma Wilson & Suzanne Lane

NHS Dorset

Category Response Times:

Cat 1:

- May response times for Dorset saw a slight improvement with Dorset achieving the mean response time for category 1 for the first time in several months, 26 May reported a mean response time of 6.2 minutes for Dorset and 9.2 for SWASFT, against a target of 7 minutes. 90th Percentile times in May were slightly more positive with the target being achieved on several occasions.
- The June month to date (up to 30 June) response times have seen a slight increase overall which saw Dorset achieving a mean response of 10 minutes against the target of 7 minutes and a 90th percentile response time of 18.3 minutes against a target of 15 minutes. This compares to the full Regional SWASFT performance for June which to date ends with a mean response of 11.5 minutes and 21.0 for the 90th percentile.

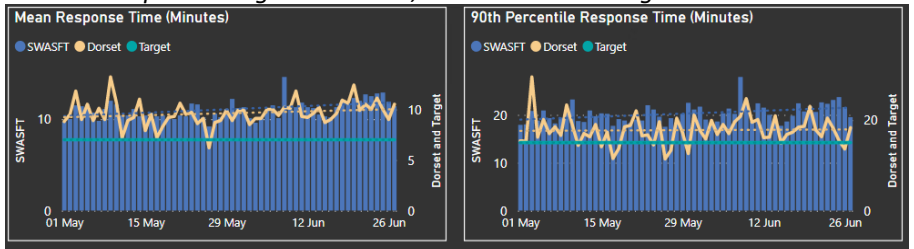
Cat 2:

- May response times for Dorset has not seen a day where Dorset or SWASFT have achieved the mean response time or 90th percentile response time. There were some positive days, 26 May achieved a 28.3 mean response time for Dorset and 46.7 for SWASFT, against a target of 18 mins which is an improvement on the best performance for Dorset last month.
- The June month to date position (up to 30 June) a mean response of 56.3 minutes, against a target of 18 minutes and a 90th percentile response time of 124 minutes against a target of 40 minutes. This compares to the full regional SWASFT performance for June, which ended with a mean response of 69.7 minutes and 156.7 for the 90th Percentile.
- Performance remains a challenge with a number of actions being progressed across the system to mitigate the increased response times (further detailed on slide 8).

All response times for the 90th Percentile for Dorset saw a deterioration on the position of May 2022 into June 2022.

Category 1 Performance

Mean Response Target 7 Minutes, 90th Percentile Target 18 Minutes



Mean Response Time (Minutes) - Latest Two Weeks

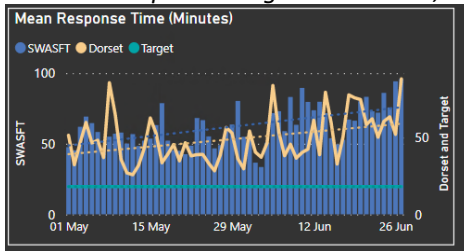
Date	SWASFT	Dorset
14/06/2022	10.50	10.2
15/06/2022	10.30	8.7
16/06/2022	10.20	9.0
17/06/2022	11.30	9.6
18/06/2022	12.10	10.9
19/06/2022	11.70	10.6
20/06/2022	12.30	12.4
21/06/2022	12.00	9.9
22/06/2022	12.70	10.5
23/06/2022	12.50	10.0
24/06/2022	12.80	11.1
25/06/2022	12.90	10.0
26/06/2022	11.90	9.0
27/06/2022	11.40	10.5

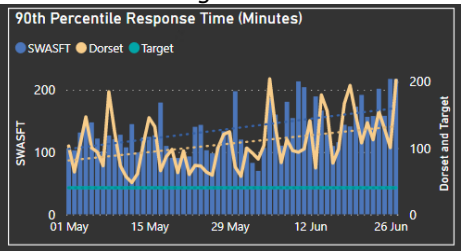
90th Percentile Response Time (Minutes) - Latest Two Weeks

Date	SWASFT	Dorset
14/06/2022	19.20	20.9
15/06/2022	17.70	14.9
16/06/2022	18.60	16.8
17/06/2022	19.80	17.3
18/06/2022	22.40	18.4
19/06/2022	20.70	18.6
20/06/2022	21.80	23.0
21/06/2022	20.60	17.8
22/06/2022	22.60	16.3
23/06/2022	22.30	20.4
24/06/2022	23.10	18.2
25/06/2022	23.70	15.5
26/06/2022	21.60	13.6
27/06/2022	19.50	18.3

Category 2 Performance

Mean Response Target 18 Minutes, 90th Percentile Target 40 Minutes





Mean Response Time (Minutes) - Latest Two Weeks

Date	SWASFT	Dorset
14/06/2022	71.60	79.3
15/06/2022	53.90	58.9
16/06/2022	49.50	32.7
17/06/2022	52.80	50.2
18/06/2022	67.10	77.6
19/06/2022	66.30	75.7
20/06/2022	80.00	74.6
21/06/2022	83.20	58.3
22/06/2022	73.00	62.0
23/06/2022	72.00	50.1
24/06/2022	86.00	60.4
25/06/2022	75.70	63.3
26/06/2022	94.20	52.0
27/06/2022	95.90	88.0

90th Percentile Response Time (Minutes) - Latest Two Weeks

Date	SWASFT	Dorset
14/06/2022	166.60	180.1
15/06/2022	128.10	156.0
16/06/2022	109.70	77.3
17/06/2022	115.80	98.6
18/06/2022	143.80	167.2
19/06/2022	141.10	194.3
20/06/2022	172.90	148.5
21/06/2022	191.70	107.8
22/06/2022	156.50	138.1
23/06/2022	157.80	112.6
24/06/2022	201.60	155.1
25/06/2022	158.10	128.8
26/06/2022	217.40	100.7
27/06/2022	217.30	202.1

Source: Daily SWASFT Demand Dashboard

NHS Acute Hospital KPIs

Edited by: Louise Taylor & Sarah Charles & Alex Geen

NHS Dorset

DORSET SYSTEM POSITION		Apr-22	May-22	Latest Week available *19/06/2022 (WLMDS Acute unvalidated)*
RTT -Total	% 18 Weeks	**56.62%**	**59.38%**	**58.47%**
	Incomplete Pathways	78,813	90,170	92,492
	>52 Weeks	4,607	4,916	6,218
	>78 weeks	1,247	1,002	1,074
	>104 weeks	**423**	**304**	266
RTT - Admitted	% 18 Weeks	**41.36%**	**44.07%**	**45.59%**
	Incomplete Pathways	16,476	18,989	18,054
	>52 Weeks	2,532	2,625	2,380
	>78 weeks	850	729	686
	>104 weeks	323	260	150
RTT - Not-Admitted	% 18 Weeks	**60.66%**	**63.46%**	**61.59%**
	Incomplete Pathways	62,337	71,181	74,438
	>52 Weeks	2,075	2,291	3,838
	>78 weeks	397	273	388
	>104 weeks	100	44	116
DM01	% > 6weeks	**20.70%**	**19.90%**	**22.0%**
	Total >= 13 weeks	**373**	**548**	Not Available
	% >= 13 weeks	**1.90%**	**3.00%**	
Cancer	2 week wait %	**50.70%**	**68.0% (Predicted)**	Not Available
	62 day %	**71.10%**	**67.2% (Predicted)**	
	Faster Diagnosis %	**73.20%**	**73.3% (Predicted)**	
	Backstops	**21**	**25.5 (Predicted)**	

The Single PAS Merger at UHD is ongoing which has artificially inflated the waiting lists numbers and therefore impacted on all measures relating to waiting lists. UHD are working to resolve these issues, likely to continue into August. Validation of >78ww has been prioritised.

RTT Performance has improved in May. The total waiting list increased by 11,357 predominantly on the non-admitted pathways. Clock-starts greatly exceed completed pathways in May.

There has been no reduction of patients with no criteria to reside to impact on activity recovery and performance improvement.

Overall increase of long waiters, 4,916 patients waiting over 52 weeks in May.

- **5.45%** of total waiting list are waiting over a year. The number waiting over 52 weeks has increased significantly into June, due to the duplication of pathways as part of the planned single PAS programme at UHD

Reduction continues of patients waiting >78 weeks to 1,002 in May.

- Re-modelling of 78 week demand & capacity is underway based on new regionally issued methodology.
- Reduction to **1.11% of the total list waiting over 78 weeks,** from 1.58% in April. Increase in total waiting list will skew this reduction.

Reduction to 304 cases waiting over >104 weeks at the end of May.

- Plan for NHSE target of June 2022 has been revised to 145.
- End of June forecast as 30th June shows that **177** will breach 104 weeks (121 for UHD and 56 for DCH). .

DM01 (6-week) performance improvement to 19.9% in May.

- Significant growth in waiting list has stalled in May. Patients waiting over 13 weeks has increased from April, split between Endoscopy and echocardiograms.
- DM01 Performance continues to be high meaning patients are waiting longer in comparison with the SW region performance.

Cancer

- Faster diagnosis standard and 62-day performance stabilised however remains below standard. Increased 2ww referrals (particularly colorectal) impacting on capacity. Implementation of recovery plans commenced with six priority tumour sites. Dorset has third lowest backlog in England by % of PTL.

Latest week data is provisional, monthly values in **RED** are not achieving standard

Source: SWWLMDS & UHD data team/Wessex Cancer Alliance

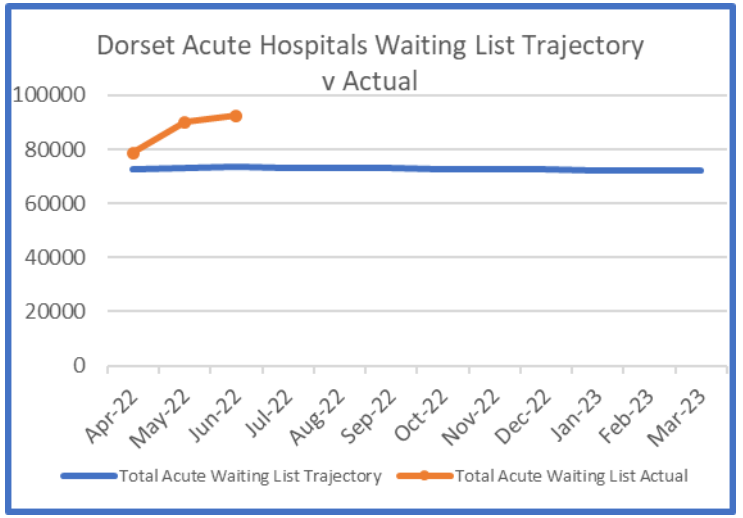
Operational Targets (NHS Acutes only)

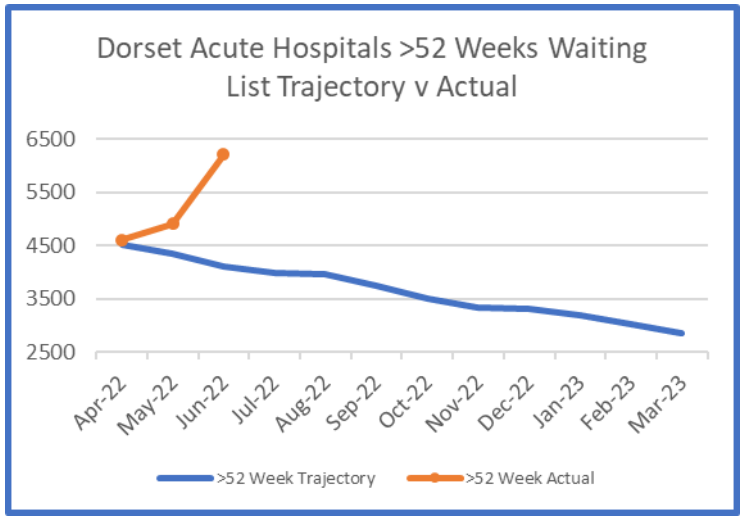
Edited by: Louise Taylor and Sarah Charles

NHS Dorset

End of June 2022 104 wks + unmitigated forecast (as at 29 Jun 2022)						
104 Week Cohort	DCH	UHD	UHD excl Orthodontics	ISP	Dorset	Dorset excl Orthodontics
Admitted	36	65	65		101	101
Non-admitted	11	96	17	1	108	29
Total Cohort	**47**	**161**	**82**	**1**	**209**	**130**
Less: June Target	**25**	**120**	**120**		145	145
Still to Treat	**22**	**41**	**-38**	**1**	**64**	**-15**

Current 104+ wait position against trajectory - 20/06/2022 FINAL PLAN					
Acute Provider	Apr-22	May-22	Jun-22	Current	Variance to June Plan
Dorset County Hospital NHS Foundation Trust	*185*	*110*	*25*	73	-192%
University Hospitals Dorset NHS Foundation Trust	*238*	*194*	*120*	193	-61%
Independent Service Providers				1	
Dorset Total	***423***	***304***	***145***	267	-84%





104+ week unmitigated forecast of **209** at end of June 2022, against plan of **145** and target of **0.**

- **System will not** achieve NHSE target for zero cases by 1st July. 79 Orthodontic cases outstanding across Dorset.
- System position reviewed weekly under Regional Tier 3 Assurance to deliver long wait ambition.
- Total breaches for DCH at end of June is forecast at 25, 19 in oral/max fax and 6 in orthopaedics. Actions are in place to try and mitigate as many breaches as possible.
- Current position is **267 cases breaching 104+ weeks** as at 19/06/2022, including 1 ISP case.
- **Weekly scrutiny** of individual cases continues and **mutual aid** plans to help mitigate further risks being explored.

The total waiting list as at end of May, was 16,887 above the trajectory of 73,283 with further growth into June.

- UHD was 30.1% above total waiting list plan, and DCH was 0.5% above plan at the end of May.
- Validation of duplicate pathways following the move to a single PAS at UHD is ongoing and likely to continue into August.

Over 52 week waits at the end of May were above plan, shows sharp increase into June.

- UHD was **25.6% above plan** and DCH **6.4% better than plan** in May.

Source: Acute Trusts 104ww FORECAST 29/06/2022. SWWLMDS WE 19/06/2022

Operational Targets (NHS Acutes only)

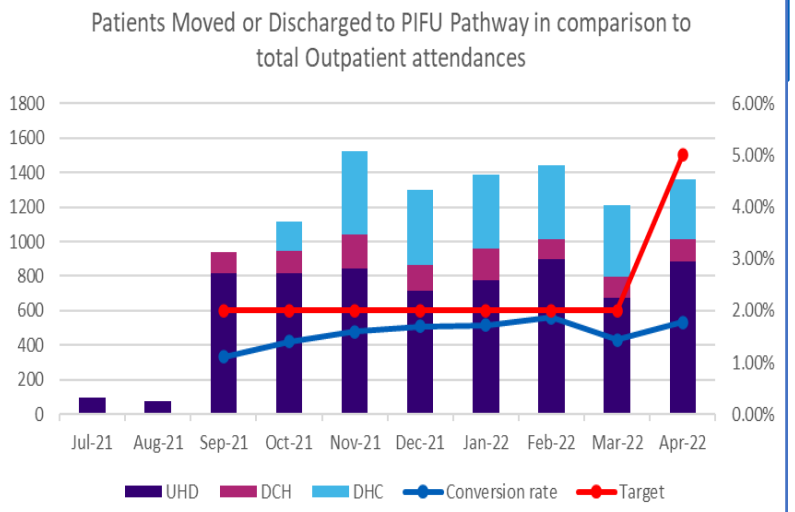
Edited by: Louise Taylor

NHS Dorset

Patient Initiated Follow Up

(target 5% by end of March 2023)

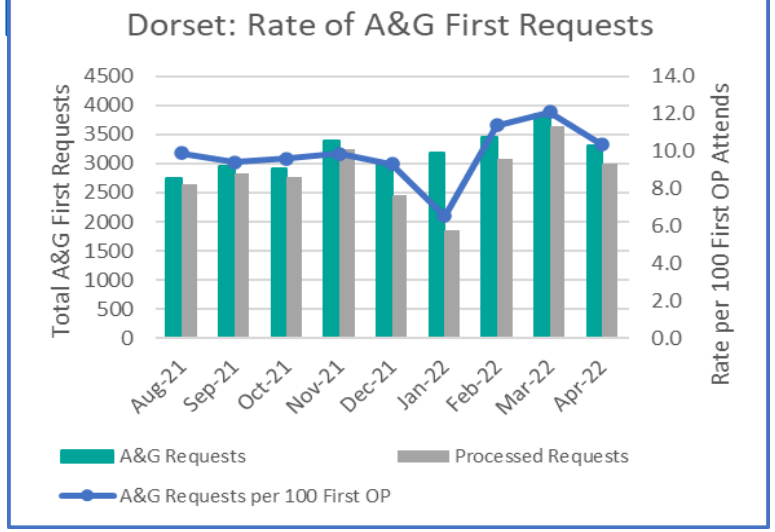
- Improvement to 1.8% of Outpatient Attendances were moved or discharged onto a PIFU pathway at the end of April 2022, below target.
- Target increased to 5% of moving or discharging patients onto a PIFU pathway by March 2023.
- Submissions to the national reporting tool continue by all three Dorset trusts.



Advice & Guidance

(Target 16/100 first outpatient appointments at end of March 2023)

- Revised utilisation rate of advice and guidance has improved for March 2022 to 12.1 and April 2022 currently 10.3 per 100 first outpatient appointments.
- The number of processed requests have risen to 90.8% of total requests.
- The target has increased to 16 per 100 first OPA by March 2023.
- MSK Triage referrals will be added to the EROC submission to improve the post-referral utilisation rate.

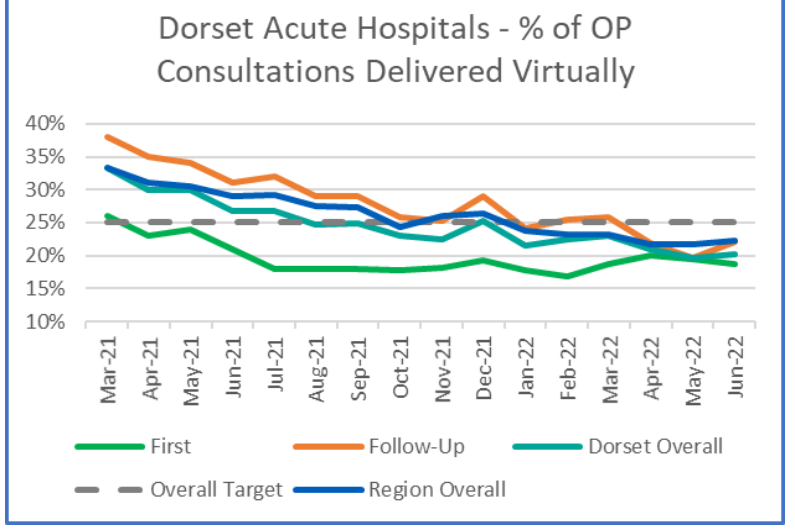


Virtual Consultations

(w/e 19/06/2022 source: Weekly Activity Return, target = 25%)

	19-Jun
Dorset	**20.2%**
UHD	20.7%
DCH	18.8%

- Virtual Outpatient activity remains below the target of 25%.
- Follow Up virtual consultations have remained low since April 2022.
- The system remains below the SW region average 22.3%, also below target.



Source: DiiS Dashboards & NHS Weekly Activity Returns (WAR)

RTT Total Waiting List

May 2022 validated position, June unvalidated to 19/06/2022.

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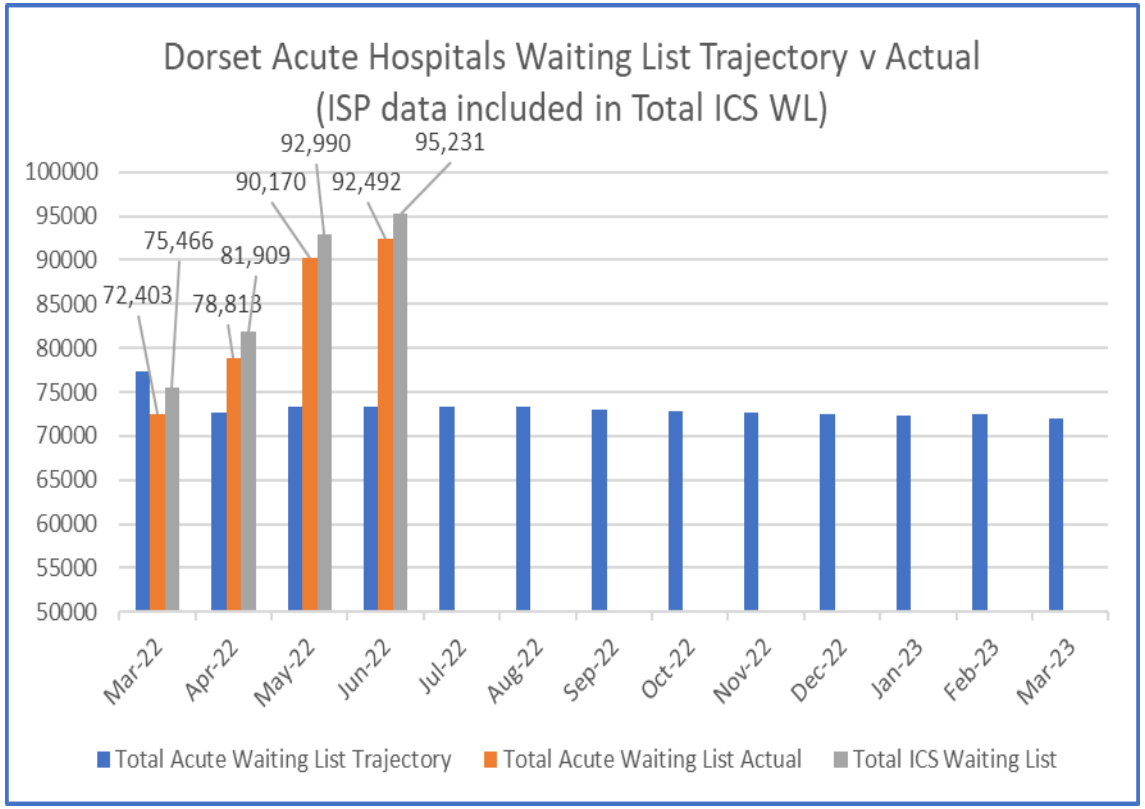


Current Waiting List by Pathway and Provider (we 19/06/22)							
	DCH		DCH Total	UHD		UHD Total	Grand Total
Treatment Function Code	Admitted	Non Admitted		Admitted	Non Admitted		
100: General Surgery Service	356	504	860	886	2930	3816	4676
101: Urology Service	294	587	881	744	2383	3127	4008
110: Trauma and Orthopaedic Service	1434	937	2371	2364	4609	6973	9344
120: Ear Nose and Throat Service	227	2095	2322	518	8283	8801	11123
130: Ophthalmology Service	573	2032	2605	1805	3619	5424	8029
140 & 144: Oral & Maxillofacial Service	898	735	1633	1138	3285	4423	6056
170: Cardiothoracic Surgery Service	0	0	0	0	30	30	30
300: General Internal Medicine Service	1	1	2	7	1236	1243	1245
301: Gastroenterology Service	1	1185	1186	1139	3719	4858	6044
320: Cardiology Service	16	626	642	491	2840	3331	3973
330: Dermatology Service	459	767	1226	698	3353	4051	5277
400: Neurology Service	0	0	0	16	2403	2419	2419
410: Rheumatology Service	0	26	26	72	2320	2392	2418
420: Paediatric Service	0	594	594	5	3237	3242	3836
502: Gynaecology Service	437	651	1088	1010	6325	7335	8423
Other	110	2121	2231	2355	11005	13360	15591
Grand Total	**4806**	**12861**	**17667**	**13248**	**61577**	**74825**	**92492**

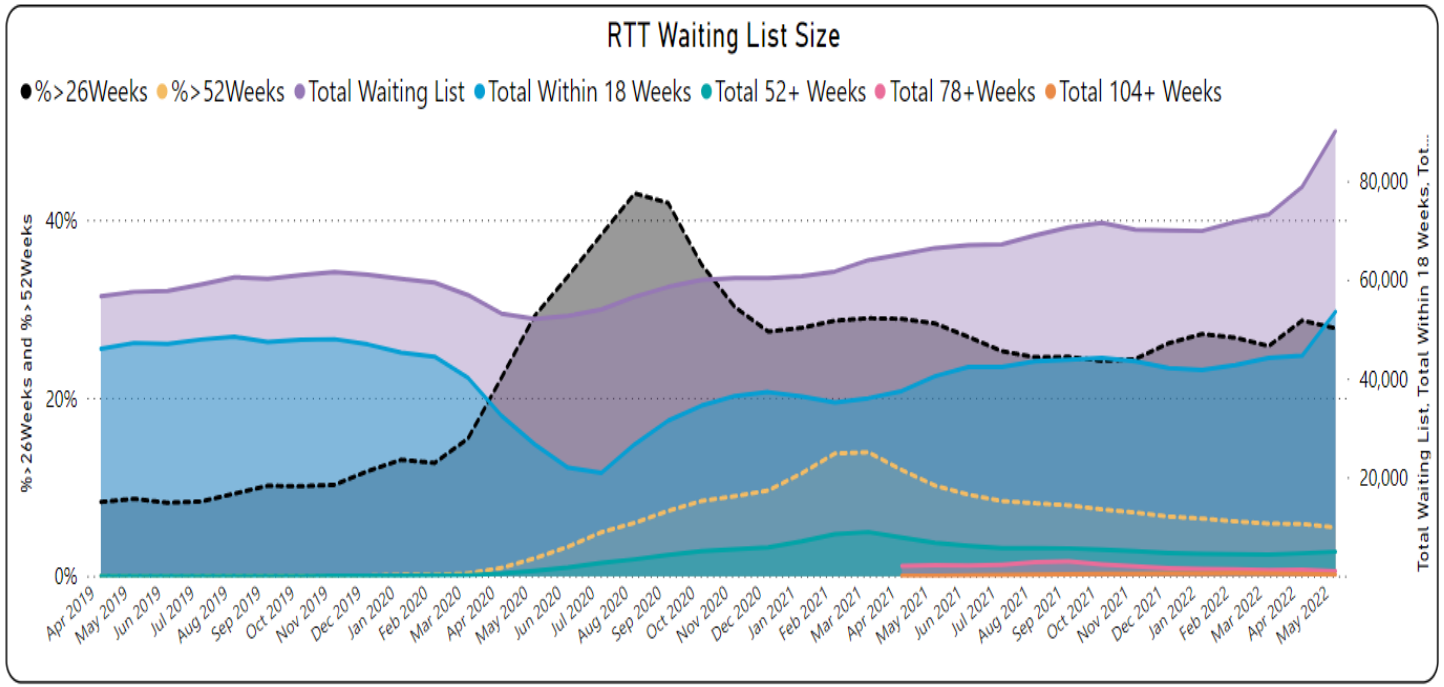
- **Total waiting list across all partners increased by 11,081 cases in May, with further growth into June**. The Single PAS Merger at UHD is ongoing, duplications awaiting validation have artificially inflated the waiting lists numbers and therefore impacted on all measures relating to waiting lists. UHD are working to resolve these issues, likely to continue into August.
- UHD increased by 11,290 cases through May. DCH has shown minimal increase. ISPs have reduced in total waiting list in May.
- Referral to Treatment (RTT) performance reduced in April to 56.6%, returning to 59.4% in May.
- May 2022 has highest peak of clock starts, which far exceed the completed pathways. The impact of the UHD single PAS is apparent across RTT measures, with high number of cases duplicated and validation to original status to continue until August.

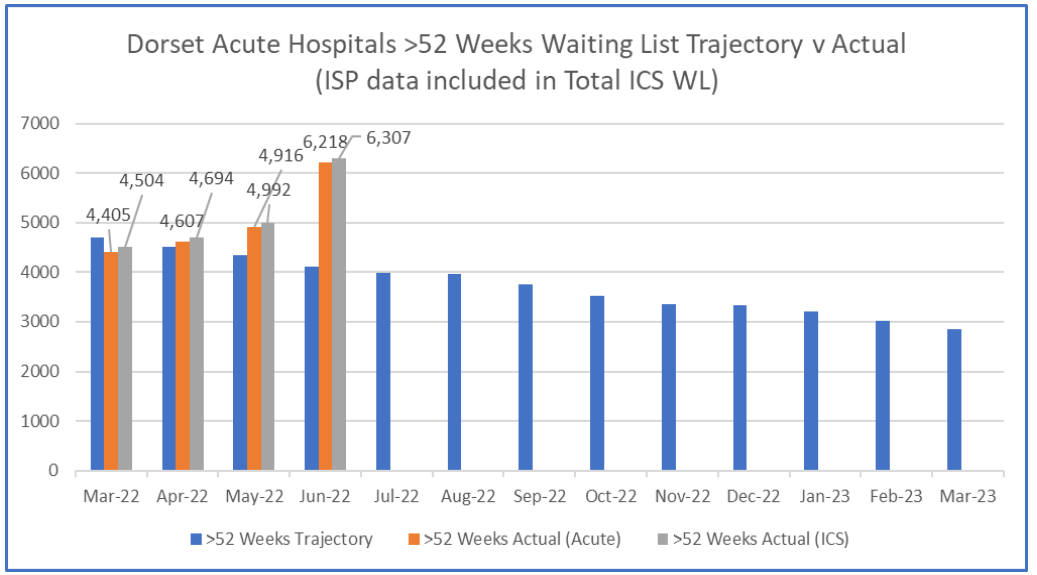
RTT Long Waiters as at 19/06/2022

May 2022 validated position, June unvalidated to 19/06/2022.

Edited by: Louise Taylor

NHS Dorset





- Increase to **4,992 patients waiting >52 weeks** (long-waiters) at the end of May across the system including 76 independent sector (ISP) waiting lists, an increase of 298 cases from end of April. The long-waiters account for 5.5% of the total Acute waiting list. Long waiters are showing a substantial increase into June for those waiting over a year, shifting to 6.7% of the total Acute waiting list .
- In May, the number waiting **over 78 weeks** has reduced by 250 cases to **1,013** waiting, including 11 patients on ISP lists. The total NHS cohort represents 1.1% of the total waiting list.
- At the end of May **306 waiting over 104 weeks** including **2** ISP patients**.** The cohort continues to reduce into June with latest position at 267 including 1 ISP patient.
- System will exceed the **revised plan of 145 waiting at the end of June**, and will not deliver the NHSE target of zero waits over two years by end of June 2022.
- UHD continue under review through Tier 3 weekly assurance meetings to deliver long waiter ambitions.

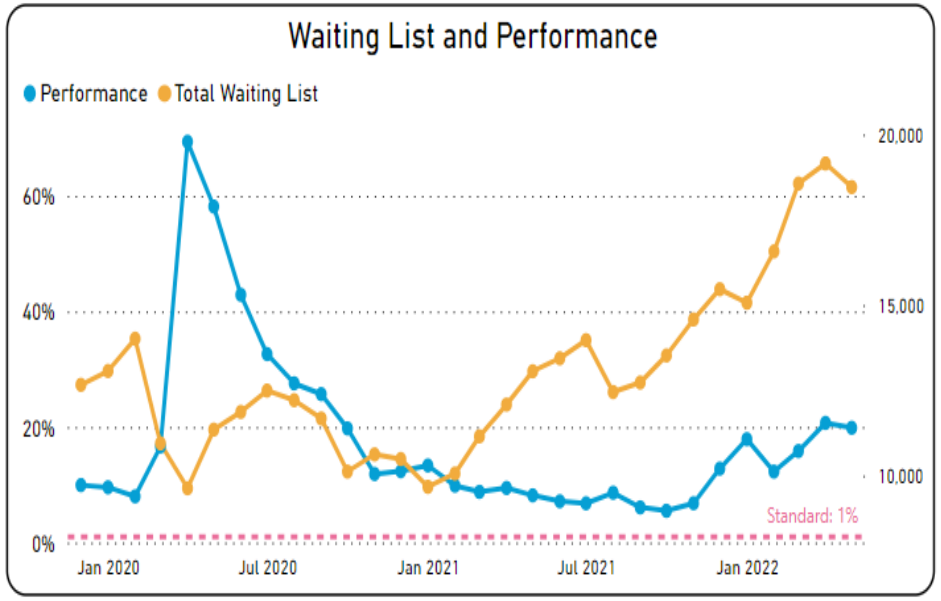
Waiting List by Specialty and weeks waiting (as at 19/06/2022)				
Key Specialty	> 52 Weeks	> 78 Weeks	> 104 Weeks	Total Waiting List
100: General Surgery Service	283	24	5	4676
101: Urology Service	324	74	2	4008
110: Trauma and Orthopaedic Service	557	110	24	9344
120: Ear Nose and Throat Service	1515	98	15	11123
130: Ophthalmology Service	328	65	1	8029
140 / 144: Oral Maxillofacial Surgery	770	253	86	6056
170: Cardiothoracic Surgery Service	14	0	0	30
300: General Internal Medicine Service	87	0	0	1245
301: Gastroenterology Service	575	109	7	6044
320: Cardiology Service	3	0	0	3973
330: Dermatology Service	200	2	0	5277
400: Neurology Service	29	0	0	2419
410: Rheumatology Service	36	1	0	2418
420: Paediatric Service	50	2	0	3836
502: Gynaecology Service	632	103	11	8423
Other	815	233	115	15591
Grand Total	**6218**	**1074**	**266**	**92492**

Source: SW NHS E Region Tableau Tool / National RTT

Diagnostics (DM01) May 2022

Edited by: Louise Taylor & Sarah Charles

NHS Dorset



	Diagnostic Tests by Weeks Waiting	< 6 weeks	6 > 12 Weeks	13 Plus Weeks	Total WL	> 6 Weeks %
Imaging	Magnetic Resonance Imaging	1889	12	5	**1906**	**0.9%**
	Computed Tomography	2273	154	0	**2427**	**6.3%**
	Non-obstetric ultrasound	4850	1101	5	**5956**	**18.6%**
	Barium Enema	0	0	0	**0**	
	DEXA Scan	842	3	0	**845**	**0.4%**
Physiological Measurement	Audiology - Audiology Assessments	430	71	0	**501**	**14.2%**
	Cardiology - echocardiography	1526	947	256	**2729**	**44.1%**
	Cardiology - electrophysiology	0	0	0	**0**	
	Neurophysiology	920	52	4	**976**	**5.7%**
	Respiratory physiology - sleep studies	70	16	3	**89**	**21.3%**
	Urodynamics - pressures & flows	8	3	3	**14**	**42.9%**
Endoscopy	Colonoscopy	677	199	132	**1008**	**32.8%**
	Flexi sigmoidoscopy	343	143	45	**531**	**35.4%**
	Cystoscopy	130	17	7	**154**	**15.6%**
	Gastroscopy	835	404	88	**1327**	**37.1%**
	Total	**14793**	**3122**	**548**	**18463**	**19.9%**

- In May reduction of 692 in Waiting list, from April, with 300 fewer patients waiting over 6 weeks.
- %>6 week performance has minor improvement this month against the 1% target to 19.9% in May.
- Number waiting >13 weeks has increased by 175 to 548 **(1.9% of WL)**. Split predominantly between Endoscopy all modalities and Echocardiograms.
- Dorset improved to 2nd lowest **DM01 performance regionally,** SW regional average at 36.3%.

Provider	TotalWaitingList	Over6wks	13+Weeks	% Over 6 Weeks	% Over 13 Weeks
DCH	5,455	1,252	50	23.0%	0.9%
UHD	13,008	2,418	498	18.6%	3.8%
Total	**18,463**	**3,670**	**548**	**19.9%**	**3.0%**

DiagnosticTestCategory	Endoscopy		Imaging		Physiological Measurement	
Provider	6+ Week Perf	13+ Week Perf	6+ Week Perf	13+ Week Perf	6+ Week Perf	13+ Week Perf
DCH	21.7%	4.8%	23.7%	0.1%	22.1%	0.7%
UHD	38.4%	10.4%	6.9%	0.1%	37.3%	9.6%
Total	**34.3%**	**9.0%**	**11.5%**	**0.1%**	**31.4%**	**6.2%**

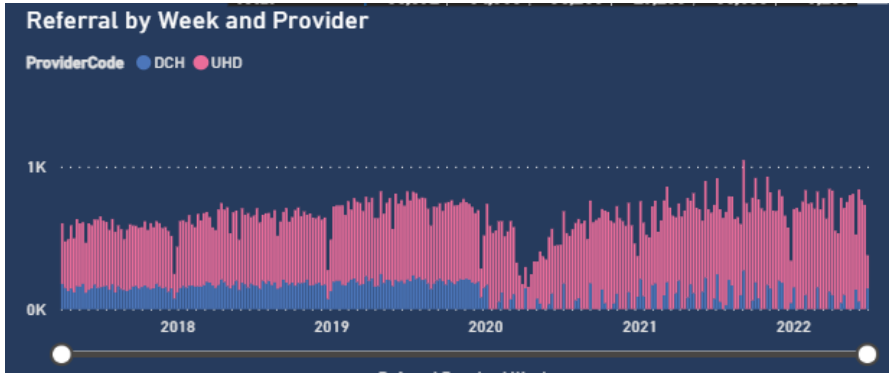
- Endoscopy waiting list size has grown, and performance has deteriorated in May.
- Imaging waiting list slightly reduced in May, with slight improvement in %>6 week performance.
- Physiological measurement waiting list continues to grow and performance has worsened in May, increase to 6.2% >13 week performance.
- Null D Codes : As at 19/06/2022 - 5,254 for DCH and 33 for Nuffield on weekly diagnostics Open Pathways.
- As a 19/06/2022, 27 patients are waiting over 26 week waits (11 DCH, 15 UHD and 1 Winterbourne).

Source: DiiS Dashboards & NHS Weekly Activity Returns (WAR)

Cancer Performance

Chart left: Patient tracking list (number of patients on an open cancer pathway) by trust, March 2020 to June 2022. DCH dark blue, UHD black (highest).

Chart right: 2ww referral activity to 27th June 2022, by trust.



2WW Referrals

Cancer services are currently experiencing significant pressures driven by high levels of 2ww referrals (chart top right) and a high patient tracking list (PTL – patients on an open cancer pathway, top left). This is combined with workforce shortages due to sickness, Covid19 self-isolation, turnover and retirement. This is impacting on the delivery of the cancer performance standards in Dorset. Cancer service teams have worked hard to maintain performance, delivering additional weekend and weekday clinics and managing a higher than usual workload. Whilst this is highly commendable it is not sustainable and impacts on wellbeing and service resilience. In recent weeks there has been a sharp increase in colorectal 2ww referrals likely due to the media reporting on Dame Deborah James who sadly passed away due to colorectal cancer last week. There is a programme of work underway to increase use of FIT testing to support the colorectal pathway including a national GP incentive scheme and a local enhanced service and supporting activity. There are pressures in Upper GI and OMF first outpatient capacity at DCH and gynaecology first outpatient at UHD, trusts are working together to provide mutual aid.

The table below right shows the percentage change in 2ww referral activity over the previous three years for each trust in the Wessex Cancer Alliance region (excluding Portsmouth Hospital due to an incomplete data set). Compared with 2019/20, UHD had the biggest increase in 2ww referral activity in 2021/22 at 26%, followed by DCH at 20%. This is a much bigger increase than the Dorset 2ww referral recovery trajectory of 7% year on year from 2019/20 and the expected increase in activity is being factored into all plans that are being developed to recover cancer performance. The risk is that the Dorset system will not be able to meet the cost or secure workforce for the increased referral and diagnostic activity; to mitigate this risk there is a comprehensive cancer plan within the Community Diagnostic Centre business case, and additional work underway to align cancer pathways to the national timed 28 day pathways and maximise pathway efficiency.

PTL

The top left chart shows the PTL (patient tracking list) by trust from March 2020 to the 6th June 2022. This shows the number of patients on an open cancer pathway and is impacted by the number of new referrals and the number of patients removed from the pathway. UHD has seen the biggest increase in the PTL since shortly after the first Covid restrictions and has the highest PTL in the Wessex region. The increase in the PTL at UHD in April 2020 is aligned to the sharp increase in 2ww referrals at this time.

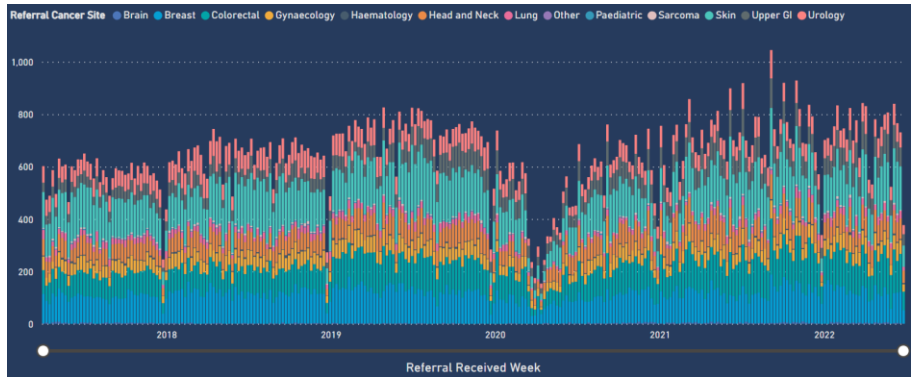


Chart left: 2ww referral activity by tumour site to 27th June 2022.

Chart right: percentage change in 2ww referral activity over the previous three years for each trust in the Wessex Cancer Alliance region (excluding Portsmouth Hospital due to an incomplete data set).

% change on previous year	DCH	HHFT	IOW	UHD	UHS	Total
2021/22	34.1%	20.9%	29.2%	26.2%	22.9%	25.2%
2020/21	-10.2%	-5.2%	-15.9%	-0.2%	-4.9%	-5.0%
% change 2021/22 cf 2019/20	20.4%	14.6%	8.6%	25.9%	16.9%	19.0%

Source: UHD data team/Wessex Cancer Alliance

Cancer Standards & Screening

Edited by: Kim Rickard, Alex Geen and Kate Connolly

NHS Dorset

NHS Cancer Standards

- The Faster Diagnosis Standard improved in April due to additional waiting list initiatives, however this has transferred the demand onto diagnostics in some tumour sites, with particular pressures on CT colonoscopy capacity at both trusts, gynaecology post menopausal bleeding clinic first outpatient capacity at UHD and OMF head and neck and upper GI capacity at DCH. DCH and UHD are meeting to discuss and agree mutual aid from DCH for gynaecology first outpatient appointments, and from UHD for OMF and upper GI. Meetings are taking place with radiology to ensure the demand for Ct colonoscopy is included in capacity planning.
- Performance against the 62 Day Standard for both trusts continues to be challenged. However Dorset continues to have the third lowest backlog in England as a proportion of the patient tracking list which is a very positive achievement. Sites seeing the highest number of 62 day breaches as of 6th July are colorectal, gynae, lung, skin, upper GI and urology. Cancer recovery plans have been developed for these tumour sites (except Upper GI) and DCP and WCA are supporting delivery with reporting and assurance through the DCP Cancer Services Coordinating Group which reports to DCP Steering Board. Upper GI and lower GI tumour sites are the focus of a discussion at the Clinical Advisory Board on 13th July to agree pathway improvement work.
- The 31-day standard for first definitive treatment continues to perform strongly. Performance against this standard is predicted to be achieved in June.

	Measure	Target	Q3 21/22 - FINAL	Q4 21/22 - FINAL	Apr 22 Final	May 22 Predicted	Jun 22 Predicted
Dorset Cancer Partnership	Cancer Two Week Wait (DCH only)	93%	51.2%	58.9%	50.7%	43.8%	53.8%
	Cancer Plan 62 Day Standard (Tumour)	85%	71.2%	69.0%	71.1%	71.2%	72.1%
	62 Day Screening Standard (Tumour)	90%	85.3%	80.3%	81.1%	65.0%	82.9%
	31 Day First Treatment (Tumour)	96%	96.5%	97.3%	97.0%	97.2%	96.4%
	Subsequent Treatment - Surgery	94%	94.6%	90.0%	92.6%	TBC	90.2%
	Subsequent Treatment - Radiotherapy	94%	100.0%	99.3%	97.7%	TBC	96.7%
	Subsequent Treatment - Anti Cancer Drugs	98%	99.2%	99.5%	100.0%	TBC	99.1%
	Faster Diagnosis	75%	66.0%	60.8%	73.2%	65.5%	67.7%
	Reported backstops (confirmed 104 day cancer treatments)	75%	54	58.5	65	57	61

Breast Screening

- The SW backlog has had a continued downward trend but spiked this month from 15,000 to 26,000 women. This is due to increases in backlog in many of the programmes. Dorset is on track to recover their backlog by June 2022.
- It is expected that 90% of ladies in Dorset will be offered screening within 36 months of their last screen by end July 2022, currently the figure is 42.8%.
- The service is reporting capacity pressures and ongoing issues with high symptomatic demand.

Bowel Screening

- All providers have recovered from the impact of Covid-19.
- Delayed 58-year age extension implementation. Southern Bowel Cancer Screening Provider Hub unable to agree/support 58-year age extension rollout whilst funding negotiations continue between Lead Commissioner (NHSE) in South East. Added to SW regional risk register.

Cervical Screening:

- The regional lab is performing well. Due to staff sickness the lab did not meet the 98% 14 day turn around standard (95.2%) for April 2022. The lab is forecasting meeting it in May 2022.
- Dorset has commissioned cervical screening in sexual health clinics. Project to rollout cervical screening offer in colposcopy drop-in clinics has started with aim to increase access.
- Trusts are starting to submit data for 28-day faster diagnosis standard.
- Increase in colposcopy referrals as a result of the introduction of primary HPV has stretched colposcopy capacity at UHD. UHD has not yet successfully recruited additional nurse colposcopist and will go to advert for third attempt. Weekend clinics delivered which has reduced number of patients awaiting low grade colposcopy from 303 beginning of May to 149 last week; these are planned to continue.

Source: UHD data team/Wessex Cancer Alliance

South West Performance Dashboard: Elective

Week Ending : 19 June 2022

		Elective											
		RTT				Diag				Cancellations		Cancer	
		%>52 week	No over 78 weeks	No. of 104 weeks	Total Incomplete	All Diag %>6 week	Endoscopy % >6 weeks	Imaging % >6 weeks	Physiological Measurement % >6 weeks	Cancelled OPs P1-2	Cancelled OPs P3-4	%>62days	No. of 104 days*
BNSSG	N Bristol	6.45%	487	40	42492	44.4%	73.6%	17.9%	73.2%	5	17	20.5%	317
	UHB and Weston	8.42%	1036	279	59012	40.9%	75.1%	27.9%	60.5%	39	71	11.2%	78
	UHB												
	Weston												
BSW	Great Western	3.16%	57	0	32682	57.0%	52.1%	59.9%	38.1%	3	14	10.5%	69
	RUH	4.42%	93	1	35053	32.2%	30.3%	28.4%	70.3%	0	4	5.8%	31
	Salisbury	2.75%	105	1	20509	25.7%	15.1%	21.4%	51.9%	0	1	10.1%	40
Cornwall	Royal Cornwall	4.83%	359	15	41503	47.8%	41.9%	49.0%	45.3%	12	23	7.6%	33
Devon	Royal Devon	9.61%	1780	408	86462	47.8%	40.8%	49.1%	49.1%	21	21	11.4%	146
	Torbay & S Devon	9.82%	807	145	41684	31.2%	55.0%	23.9%	20.6%	29	16	12.1%	66
	Plymouth	7.08%	1205	450	46190	20.6%	8.4%	20.3%	28.8%	25	60	13.4%	68
Dorset	Dorset County	9.12%	410	73	17667	27.6%	26.3%	25.9%	33.0%	6	37	8.4%	35
	UH Dorset	6.16%	664	193	74825	19.9%	26.3%	6.9%	37.6%	32	113	6.7%	38
	Poole												
	Bournemouth												
Glos	GHFT	2.17%	72	0	64005	20.5%	20.7%	1.8%	56.1%	0	6	11.8%	97
Somerset	Somerset	5.79%	427	49	35025	25.8%	13.6%	10.2%	61.3%	10	36	9.5%	57
	Yeovil	6.73%	135	4	12508	19.5%	26.8%	11.2%	61.4%	1	8	9.9%	27

Weekly RTT Via WLMDS	Weekly Activty Return	UEC Daily Sitrep	Weekly Cancer PTL

Where data is reported weekly the actuals for the week ending in C2 are reported.They are then compared with the average of the previous 6 weeks (not including the current reported week).

Weekly Performance is below that of the average of the previous 6 weeks

Weekly Performance is below that of the average of the previous 6 weeks but within 10%

Weekly Performance is above that of the average of the previous 6 weeks

* The formatting of these cells is to show red where values are >5

South West Performance Dashboard: Non Elective

Week Ending : 19 June 2022

		C19			UEC							
					Front Door				Throughput			
		C19 Adult Bed occupied	C19 Adult CC occupied	% of Absence C19 Related	A&E all type attendances	All types - 4 hours performance	Ambulance Handovers over 60 minutes	>12 hour Decision to admit	Bed occupancy	Patients with a LOS +7 days *	Patients with a LOS +21 days *	Patients met the criteria to be discharged
						%						
BNSSG	N Bristol	3.3%	0.5%	21.7%	1976	56.9%	171	7	98.6%	494	225	255
	UHB and Weston	1.8%	0.6%	19.0%	4334	64.6%	261	129	91.5%	415	185	259
	UHB	1.9%	0.6%	21.2%	3421	65.5%	238	72	88.9%	274	125	
	Weston	1.5%	0.0%	9.6%	913	61.1%	23	57	98.9%	141	60	
BSW	Great Western	4.1%	1.2%	15.6%	2411	75.1%	11	16	97.7%	249	76	192
	RUH	4.0%	3.6%	46.7%	2274	65.3%	92	0	92.2%	283	96	198
	Salisbury	2.7%	5.3%	26.0%	1475	72.7%	40	0	95.9%	238	116	119
Cornwall	Royal Cornwall	1.4%	0.0%	17.1%	3913	80.6%	307	145	95.3%	327	147	224
Devon	Royal Devon	2.5%	2.7%	20.0%	3295	61.5%	59	20	92.5%	478	167	247
	Torbay & S Devon	2.7%	4.6%	14.7%	1965	52.5%	218	22	94.4%	163	41	67
	Plymouth	4.6%	0.0%	30.6%	2545	CRS Pilot	227	82	94.2%	459	193	249
Dorset	Dorset County	2.8%	4.9%	14.2%	971	54.9%	4	8	97.2%	166	88	116
	UH Dorset	6.0%	6.8%	23.6%	3201	CRS Pilot	142	32	95.1%	550	251	319
	Poole	5.6%	7.1%	22.9%	1651	CRS Pilot	70	0	93.5%	297	138	
	Bournemouth	6.6%	6.6%	24.5%	1550	CRS Pilot	72	32	96.9%	253	113	
Glos	GHFT	3.8%	0.0%	12.4%	4099	71.0%	300	203	96.1%	472	233	284
Somerset	Somerset	2.9%	0.9%	15.0%	3768	79.6%	13	1	93.6%	276	114	188
	Yeovil	4.6%	1.1%	18.2%	1236	85.8%	6	0	93.6%	164	71	115

Data Source: C19 Acute Daily Sitrep | A&E Daily Sitrep

Where data is reported daily it is totalled up for the current week. This then compared with the previous 42 days (not including the 7 days in the week ending referenced in C2).

Weekly Performance is below that of the average of the previous 6 weeks

Weekly Performance is below that of the average of the previous 6 weeks but within 10%

Weekly Performance is above that of the average of the previous 6 weeks

Areas Requiring Further Assurance

Proposed assurance is sought on: -

- Outpatient SRO is asked to confirm the plans to increase A&G and virtual consultations to meet national targets within planned timescales has been successful specifically at DCH.
- Cancer programme lead is asked to provide update on the progress around implementation of the recovery plans within six priority tumour sites.
- UHD are asked to provide update on the PAS merger and resolution of the impact and issues this has caused.

Glossary

Acronym	Definition	Acronym	Definition
2WW	2 week wait referral	MH	Mental Health
ARRS	Additional Roles Reimbursement Scheme	MIU	Minor Injury Unit
AMH	Adult Mental health	MRI	Magnetic Resonance Imaging
CAMHS	Child and Adolescent Mental Health Service	NHSE / I	NHS England / Improvement
CAS	Clinical Assessment Service	OMF	Oral & Maxillofacial Surgery
CYP	Children & Young People	OPMH	Older Peoples Mental Health
DCH	Dorset County Hospital NHS Trust	PCN	Primary Care Network
DES	Direct Enhanced Service	PHT	UHD - Poole
DHC / DHUFT	Dorset Healthcare NHS Trust	PICU	Psychiatric Intensive Care Unit
DTOC	Delayed Transfer of Care	PTL	Patient Tracking List
ED	Emergency Department	RBCH	UHD - Bournemouth
ENT	Ear, Nose & Throat	RTT	Referral To Treatment
FDS	Faster Diagnostic Service	SDEC	Same-day Emergency Care
GI	Gastro-intestinal	SMI	Severe Mental Illness
IAGPS	Improved Access to General Practice Services	SOP	Standard Operating Procedure
IAPT	Improved Access to Psychological Therapies	SPA	Single Point of Access
ICS	Integrated Care System	SWAS	South West Ambulance Service
IPC	Infection, Prevention & Control	UEC	Urgent & Emergency Care
ISP	Independent Sector Provider	UHD	University Hospitals Dorset NHS Trust
IUCS	Integrated Urgent Care Service	VCSE	Voluntary, Community & Social Enterprise
KPIs	Key Performance Indicators	WL	Waiting List

8.6

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

DORSET ICS FINANCE UPDATE

Date of the meeting	20/07/2022
Author	J Wyatt, Deputy Chief Finance Officer
Lead Director	R Morgan, Chief Finance Officer
Purpose of Report	To present the Dorset ICS and ICB financial position as at month 2 of the 2022/23 financial year including emerging risks.
Recommendation	The ICB Board is asked to **note** the report and financial position.
Reason for inclusion in Part II	The report includes financial information regarding Dorset ICB and its partners which is not publicly available at the time of reporting.

Monitoring and Assurance Summary

Conflicts of Interest	*N/A*
Involvement and Consultation	*N/A*
Equality, Diversity and Inclusion	*N/A*
Financial and Resource Implications	*The report is for information only, to inform future decision making on financial matters*
Legal/governance	*The CCG has a statutory duty to keep expenditure within resource limits.*
Risk description/rating	*In setting a balanced plan for 2022/23, the ICS has identified financial risks totalling £88m which will need to be managed in order to achieve breakeven. If breakeven positions are not reported, the system risks receipt of national funding flows.*

1. Introduction

1.1 Appendix 1 describes the financial position for both the ICS and the ICB as at May 2022.

1.2 The ICC is operating within a fixed financial envelope for 2022/23, with a submitted plan to breakeven across all member organisations.

1.3 However, to note that the report is based on Month 2 reporting, reflecting plans submitted on 28th April. From Month 3 national reporting will reflect final plans submitted on 20th June 2022.

2. Report

2.1 This report has been developed to show the financial position for both the system and the ICB. It will form part of the Integrated Performance Report in future months.

2.2 Reporting will change focus as issues arise, with the dashboard adapting to highlight key areas of focus.

2.3 As at Month 2, providers within Dorset are reporting a deficit of £2.8m against plan. This is driven by unidentified efficiency schemes which are still under development.

2.4 The ICS has a level of efficiency of £118m within the plan for 2022/23. Of this £42.4m is currently unidentified and represents a risk to achieving financial balance.

2.5 The board are asked to note the agency expenditure run rate, which is an area of focus for the system. As noted in the summary, the system is demonstrating a reduction from 2021/22 outturn, however this is not seen across the board and remains a key workstream in the Financial Improvement Plan (FIP).

2.6 Personal Health Commissioning (PHC) remains a key area of focus for the ICB. Early indications shown by Month 2 reporting demonstrates pressure due to increasing rates, led by increases in fuel and the National Living Wage. Funding for this service was increased during planning, and internal planning recognised the pressure, therefore budgets are circa 6% higher than in 2021/22. However, it remains under scrutiny to ensure this does not present a larger financial risk to the ICB.

3. Conclusion

3.1 The ICB Board is asked to note the financial position of both the system and ICB as at May 2022.

3.2 The board is also asked to note that the report reflects plans submitted on 28th April and that future reporting periods will reflect final plans submitted on 20th June.

Author's name and Title : Jennie Wyatt, Deputy Chief Finance Officer
Date : 6th July 2022

APPENDICES	
Appendix 1	**May 2022 Finance Report**

Finance Summary

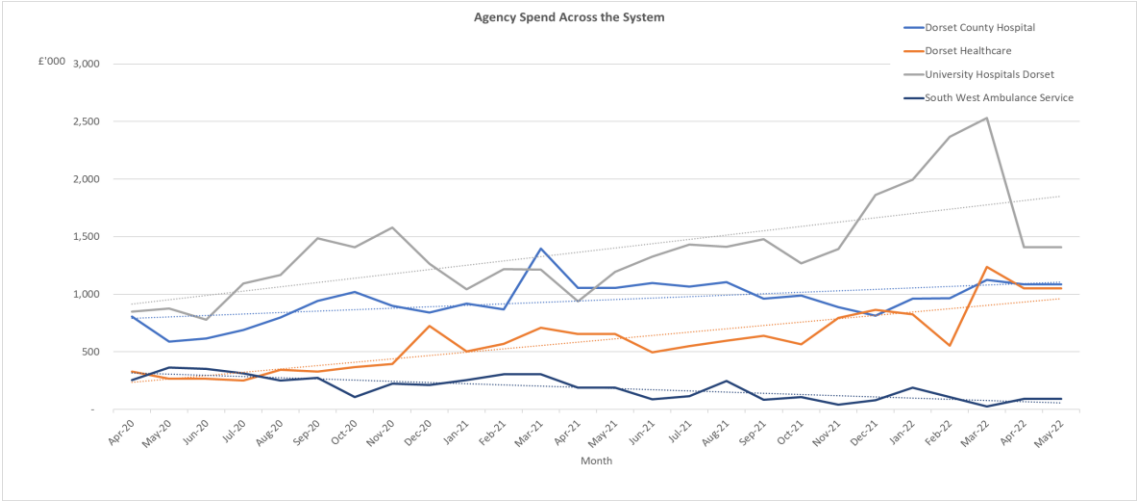
System Financial Position	Finance Improvement Programme (including Productivity and CIP/QUIPP)
As at Month 2, the ICS has reported a variance to plan of £2.8m, against plans submitted on 28th April. The main driver for the adverse movement is unidentified CIP in the two acute providers, with Dorset County reporting a £1.3m adverse variance against plan and University Hospitals Dorset £3.6m off plan. This is partially offset by the South Western Ambulance (SWASFT) reporting a £2.1m favourable variance. From Month 3, reporting will be updated to reflect final plans submitted to NHS England and Improvement. Therefore this position will change to include revised funding, including inflationary pressures, and revised planning assumptions. Agency expenditure in May is lower than both February (26% reduction) and March (9% reduction), mainly driven by reductions within the Ambulance Trust. Both Dorset County and Dorset Healthcare have seen increases from February, however both have reported decreases from March levels. This report focuses on the NHS partner organisations who participate in the overall Dorset shared control total. Future reporting will also include a section on Local Authorities financial positions as they are integral to the delivery of services for "Our Dorset".	The ICS has an ambitious efficiency programme for 2022/23, with planned savings of £118m being required in order to achieve breakeven; of this £42.4m is currently unidentified. This includes a system Financial improvement Plan (FIP) of £20m and a system income/investment slippage CIP of £8.5m. The FIP can be broken down into four main sections, and progress will be reported against these workstreams throughout 2022/23: • Agency Premium • Covid Costs • Elective Recovery/productivity • UEC The ICB has an QIPP programme of £42.3m, including the ICB share of the FIP programme and the £8.5m income CIP. Currently both these elements are unidentified and recurrent sources need to be found to prevent a deterioration in the financial position.
Capital	**ICB Variable Expenditure Prescribing/PHC/ pay/ services outside Dorset NHS**
NHS system CDEL envelope reflects a brokered reduction in the 22/23 envelope of £3m due to a delayed disposal in 2021/22. Plans submitted by the system on 20th June demonstrate a balanced Capital plan, with the exception of the Car Park at Dorset County (£19.4m) which does not currently have a funding source. Discussions with regional Capital colleagues are ongoing.	Pay costs will be an area of focus for the ICB in 2022/23, with early indications suggesting a large vacancy factor will be required in order to live within current budgets. Personal Health Commissioning (PHC) remains an area of concern, with inflationary pressures expected due to the increase in the National Living Wage (NWL) and fuel costs. Known price rises have been factored into financial planning, but volume changes are unknown and therefore run rate will be monitored closely, and reported regularly. The ICB is entering into a pooled budget with Dorset Council for s117 agreements, with final arrangements underway. It is planned that Bournemouth, Christchurch and Poole Council will join in April 2023.

Finance - Dorset ICS

Month 2 system Financial Performance

Surplus / (Deficit)	Year-to-date			
	Plan	Actual	Under/(over) spend	
	£m	£m	£m	%
Total CCG Net Expenditure	255.8	255.8	(0.0)	(0.0%)
In-Year Allocation	256.7	256.7	0.0	0.0%
CCG Total	**0.8**	**0.8**	**(0.0)**	**(0.0%)**
Income excluding COVID Reimbursements	257.4	260.2	2.8	1.1%
COVID-19 Reimbursements	0.1	1.0	0.9	1,161.3%
Total Income	257.5	261.3	3.8	1.5%
Pay	(186.0)	(189.9)	(3.9)	(2.1%)
Non Pay	(81.3)	(84.7)	(3.3)	(4.1%)
Non Operating Items (exc gains on disposal)	(3.6)	(3.0)	0.7	18.1%
Total Expenditure	(271.0)	(277.6)	(6.6)	(2.4%)
NHS Providers	**(13.5)**	**(16.4)**	**(2.8)**	**(1.1%)**
System Financial Performance	**(12.7)**	**(15.5)**	**(2.8)**	**(1.1%)**

Agency



Planned Efficiencies – 2022/23

Efficiencies based on revised plan to breakeven, proposal includes delivery of the following:	CCG £k	DCHFT £k	DHC £k	UHD £k	System Total excl SWASFT £k	SWASFT £k	Dorset System Total £k
CIP - Identified	(23,030)	(2,000)	(10,700)	(19,000)	(54,730)	(25,877)	(80,607)
FIP identified	(4,419)				(4,419)		(4,419)
Identified Efficiencies	**(27,449)**	**(2,000)**	**(10,700)**	**(19,000)**	**(59,149)**	**(25,877)**	**(85,026)**
CIP - Unidentified	-	(4,515)	(5,459)	(8,413)	(18,387)		(18,387)
System income/investment slippage	(8,500)				(8,500)		(8,500)
FIP unidentified (indicative splits)	(6,394)	(1,654)	(2,756)	(4,778)	(15,582)		(15,582)
Unidentified Efficiencies	**(14,894)**	**(6,169)**	**(8,215)**	**(13,191)**	**(42,469)**	**0**	**(42,469)**
CCG efficiencies within provider allocations (1.1% tariff efficiency)	8,712				8,712		8,712
Total system efficiency plan	**(42,342)**	**(8,169)**	**(18,915)**	**(32,191)**	**(92,905)**	**(25,877)**	**(118,782)**

Capital Position

Dorset STP - Provider Capital Overview

Capital	Year-to-date				YTD Spend as % FOT	Forecast Outturn			
	Plan	Actual	(Under)/over delivery			Plan	FOT	(Under)/over delivery	
	£m	£m	£m	%	%	£m	£m	£m	%
Charge against Capital Allocation (Plan) - Excluding IFRS16 impact	**1.9**	**(1.9)**	**3.8**	**200.9%**	**-3.3%**	**58.0**	**58.0**	**(0.0)**	**(0.0%)**
IFRS16 impact on Charge against capital allocation (Plan)	11.1	9.7	1.4	12.7%		19.6	19.4	0.1	0.6%
Charge against Capital Allocation (Plan) - Including IFRS16 impact	**12.9**	**7.7**	**5.2**	**40.1%**	**10.0%**	**77.6**	**77.5**	**0.1**	**0.1%**
National allocations plus other items charged to CDEL	10.7	7.8	2.9	27.3%		102.9	111.0	(8.1)	(7.9%)
Capital DEL	**23.6**	**15.5**	**8.1**	**34.3%**	**8.2%**	**180.5**	**188.5**	**(8.0)**	**(4.4%)**
Performance against Capital Allocation									
- Excluding IFRS16						**58.0**	**58.0**	**(0.0)**	**(0.0%)**
- Including IFRS16						**58.0**	**77.5**	**(19.4)**	**(33.5%)**

Finance - Dorset ICB

ICB Expenditure

Financial Position Overview

Net Expenditure	Year-to-date Plan £m	Year-to-date Actual £m
Acute Services	129.4	129.4
NHS	125.4	125.4
Independent / Commercial Sector	3.6	3.6
Other	0.4	0.4
Mental Health Services	28.0	28.0
Community Health Services	24.2	24.2
Continuing Care Services	16.8	16.8
Primary Care Services	32.5	32.5
Primary Care Co-Commissioning	22.1	22.1
Other Programme Services	0.4	0.4
Running Costs	2.5	2.5
Hosted Services	0.0	0.0
COVID & ERF Unvalidated	0.0	
Total CCG Net Expenditure	**255.8**	**255.8**
In-Year Allocation	256.7	256.7
Total Surplus / (Deficit)	**0.8**	**0.8**

Month 2 reporting is based on plans submitted on 28th April, and will be updated for final plans for Month 3 reporting. Against this backdrop, at month 2 the CCG is on target to deliver it's surplus position of £1.27m (CCG part year effect, full year surplus £5.082m). For month 3, this will be a move towards a breakeven position.

Net month 2 £23k variance (overspend) to the YTD surplus of £847k relates to COVID vaccination costs which are subject to retrospective reimbursement.

Prescribing

Final 2021/22 prescribing position

GP FP10 prescribing	133,077,718
Other FP10 prescribing	4,247
Total (PMD) FP10 prescribing	133,081,965
Other prescribing (note 1)	5,804,094
Total 2021/22 prescribing spend	138,886,059
2021/22 prescribing allocation	139,262,087
2021/22 underspend	**- 376,028**
2021/22 year-end accounts reported positon (note 2)	- 430,281
February & March 2022 position movement	**54,253**

Notes:
Note 1 - Items retained centrally (fairshare allocation), enteral feeds, and dispensing income adjustment
Note 2 - Based on January 22 PMD data as PMD data subject to 2 month time delay

February and March 2022 prescribing data is now available and shows a final prescribing £376k underspend position against the overall 2021/22 prescribing allocation of £139.262m.

This is a £54k deterioration from the reported position at year end (£430k underspend) which is due to total February and March 22 items growth being higher than expected when compared to previous average growth.

Pay (progress against vacancy factor)

Initial calculations suggest that a vacancy factor will be required by the ICB in order to live within our running and programme costs. Further information is being collected and will be reported here in future months, after agreement of proposed actions by the board.

Personal Health Commissioning (PHC)

- The CCG commissions a proportion of CHC packages using the local authority's care purchasing frameworks. They have recently published their 2022/23 rate uplifts as follows;
  - BCP framework increase of 5.6%, non-framework 4%-5.6% with an estimated cost pressure of £1.5m
  - DC have split their framework between an urban and rural rate with uplifts of circa 12.5% and 22.9% respectively, non-framework 4%-5.6% (in line with BCP area) with an estimated cost pressure of between £1.1m and £1.4m
- The 2022/23 Funded Nursing Care (FNC) weekly rate has been uplifted by 11.5%, which looks to be funded nationally on a recurrent basis, however, there is a risk of shortfall in the recurrent funding indicated by the non-recurrent funding given to the CCG for the mandated 2021/22 retrospective, one-off payments. The CCG were allocated £1.243m to make these payments, however, extrapolations from Caretrack reporting indicate these could be higher by circa £130k.

Top 10 High Cost cases

Care Category	Number of Cases	Equivalent Annual Cost
Learning Disability Adult	5	£5,898,312
Physical Disability Adult	2	£1,745,382
Physical Disability Older	2	£1,439,139
Child	1	£754,333
Total	**10**	**£9,837,166**

Packages greater than £5.5k per week:

Weekly Cost	Number of Cases	Equivalent Annual Cost
£5,500 - £7,500	27	£8,537,153
£7,500 - £9,500	15	£6,535,373
£9,500 - £11,500	2	£1,135,888
£11,500 - £13,500	6	£3,947,111
£13,500 - £15,500	4	£3,033,565
£15,500 plus	3	£4,759,802
Total	**57**	**£27,948,892**

8.7

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

ANNUAL REPORT ON CHILDREN IN CARE AND CARE LEAVERS 2021-22

Date of the meeting	20/07/2022
Author	L Harris Smith Designated Nurse for Children in Care and Care Leavers
Lead Director	Vanessa Read Interim Chief Nursing Officer
Purpose of Report	Annual Report
Recommendation	The ICB Board/Committee is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	*There are no known conflicts of interest.*
Involvement and Consultation	*In completing this report, the author has consulted with the Children in Care Services and the Designated and Named Doctors in UHD as well as both Local Authority Children in Care teams.*
Equality, Diversity and Inclusion	Equality, diversity, and inclusion considerations for the unaccompanied asylum-seeking children from Afghanistan have been highlighted in the body of the report.
Financial and Resource Implications	There are potential financial and resource implications highlighted in this report in relation to the increased number of children coming into care.
Legal/governance	*NHS Dorset CCG/ICB have a legal duty to commission services for children who are in care and for those who have experienced care as a young person.*
Risk description/rating	*This paper highlights ongoing concerns with regard to the compliance of the statutory requirement to undertake an initial health assessment within 20 days of a child or young person coming into care.*

1. Introduction

1.1 This report (Appendix 1) provides assurance to the ICB that NHS Dorset CCG/ICB are fulfilling their statutory requirements in commissioning services in identifying and meeting the health needs of their Children in Care (CiC) and the Care Experienced Young People (CEYP) population of Dorset. This report covers the period from 1 April 2021 to 31 March 2022.

1.2 For the purposes of this report, the organisation will be referred to as Dorset CCG and ICB (CCG/ICB) as the report covers the time period prior to transfer to ICB.

2. Report

2.1 Numbers of children into care have increased by 8.2% over the year from April 2021 to March 2022 with a total 31% increase from 2020-21.

2.2 Numbers of care leavers has also increased by 16% over the year from April 2021.

2.3 In Quarters 3 and 4, the numbers of unaccompanied asylum-seeking children increased by 150% from Quarter 1, mainly in the Bournemouth, Christchurch and Poole Council area following hotels being stood up to accommodate asylum seekers. In response to the increased number of UASC requiring statutory initial health assessments, NHS Dorset CCG/ICB have commissioned a bespoke time limited service to meet this need which has involved working with South Coast Medical Practice and the skilling up of a Named GP for Safeguarding.

2.4 A service review was undertaken for the commissioned medical service for CiC. At the time of the review (July/August 2021) the service delivered by University Hospitals Dorset (UHD) was able to evidence sufficient resources to meet the statutory timeframes for children coming into care, complete requested adoption medicals and attend adoption panel. However, due to combination of an increase of children into care, coupled with an increase in adoption medical requests and local authority into care process improvements the service has been unable to meet demand of offering a medical advisor appointment within the statutory timeframe.

2.5 Work continues with both local authorities, Dorset Council (DC) and Bournemouth Christchurch and Poole Council (BCP) Corporate Parenting Boards to improve performance of the Initial Health Assessments (IHA) within the 20-working day statutory time frame. Some improvement has been noted following the changes made within the councils, however this needs to be sustained in 2022-23.

2.6 The Designated Nurse has worked with partners locally and regionally to consider the impact of the new Liberty Protection Safeguards (LPS) as part of the Mental Capacity Act 2005 Code of Conduct and the impact for 16–17-

year-olds. This will continue into 2022-23 in preparation for when the Code will 'go live'.

2.7 Following the learning required from a Multi - Agency Case Audit (MACA) work has begun on a Pregnancy Pathway for CiC to ensure agencies are working together to provide a robust support network around the parents to be.

3. Conclusion

3.1 COVID-19 has continued to impact on all areas of service in 2021-22 and the provider teams have continued to respond rapidly and flexibly to prioritise care and adapt to national changes around seeing children and young people face to face. There have been significant challenges with performance due to workforce capacity and an increase of children into care which has put pressure on the systems to deliver statutory health assessments in a timely way. Other areas impacted have been dentistry and health assessments for children placed out of area, work is ongoing with NHSE and the local authorities to address the gaps for this vulnerable cohort.

3.2 For 2022-23 work will continue to progress with the Dorset Intelligence and Insight Service to consider patterns and themes in ICS data for CiC to inform future service planning and commissioning.

Author's name and Title : Louise Harris Smith Designated Nurse for Children in Care and Care Experienced Young People
Date : 28.06.2022

APPENDICES	
Appendix 1.	CCG/ICB Children in Care and Care Experienced Young People Annual report

NHS Dorset

Children in Care and Care Experienced Young People Annual Health Report 2021-2022 (Appendix One)

Report information

Date of meeting	
Author	Louise Harris Smith
Sponsoring Board member	Vanessa Read
Purpose of report	Annual Update
Recommendation	NHS Dorset CCG/ICB is asked to note the report
Reason for inclusion in Part II	
Stakeholder engagement	
Previous GB/committee dates	
Executive sponsor(s)	

Monitoring and assurance summary	
This report links to the following strategic objectives:	

	Yes Copy and paste tick: ✓	**Action required**	
		Yes (detail in report)	**No**
All three Domains of Quality (safety, quality, patient experience)			
Board Assurance Framework Risk Register			
Budgetary Impact			
Legal/regulatory			
People/staff			
Financial/value for money/sustainability			
Information management and technology			
Equality Impact Assessment			
Freedom of Information			

I confirm that I have considered the implications of this report on each of the matters above, as indicated.	

1. Introduction

1.1 This strategic report is to provide assurance to NHS Dorset CCG/ICB and wider reader that NHS Dorset CCG/ICB are fulfilling their statutory requirements in commissioning services in identifying and meeting the health needs of their Children in Care (CiC) and the Care Experienced Young People (CEYP) population of Dorset. This report covers the period from 1 April 2021 to 31 March 2022.

1.2 For the purposes of this report, the organisation will be referred to as Dorset CCG and ICB (CCG/ICB) as the report covers the time period prior to transfer to ICB.

2. Outcomes of Key Areas of Development and Achievements 2021-22

2.1 COVID-19 has continued to impact on all areas of service and the provider teams have continued to respond rapidly and flexibly to prioritise care and adapt to national changes around seeing children and young people face to face. The teams continue to deliver a mixed model approach with targeted virtual and face to face contacts, however as lockdown restrictions start to ease there was a move towards returning to pre covid visiting for children, young people, and their carers to improve engagement. Despite the responsive nature of the teams, performance has been impacted on negatively more than the previous year. This has been due to out of area delays, sickness within provider teams and an increase in unaccompanied asylum-seeking children (UASC) during the autumn and winter of 2021. Positively, there is a clear catch-up programme for those review health assessments (RHA) not completed within timeframe and a bespoke service to complete outstanding initial health assessments (IHAs).

2.2 A service review was undertaken for the commissioned medical service for CiC. At the time of the review (July/August 2021) the service delivered by University Hospitals Dorset (UHD) was able to evidence sufficient resources to meet the statutory timeframes for children coming into care, complete requested adoption medicals and attend adoption panel. However, due to combination of an increase of children into care, coupled with an increase in adoption medical requests and local authority into care process improvements the service has been unable to meet demand of offering a medical advisor appointment within the statutory timeframe.

2.3 Work continues with both local authorities, Dorset Council (DC) and Bournemouth Christchurch and Poole Council (BCP) Corporate Parenting Boards to improve performance of the Initial Health Assessments (IHA) within the 20-working day statutory time frame. Some improvement has been noted following the changes made within the councils, however this needs to be sustained in 2022-23.

2.4 The care leaver (also known as Care Experienced Young People CEYP) cohort continues to increase, the CiC health team have altered their delivery model to allow for a Pan Dorset Transition nurse service. However, a combination of the increase in CEYP and the need for a responsive, individualised approach has resulted in demand outweighing capacity and will require further consideration of how we can creatively continue to support this vulnerable group in 2022-23.

2.5 Although the impact of the new front door arrangements for MASH resulted in an increased workload for the CiC health team, they have responded by prioritising their most

vulnerable and complex children. Joint working with police and social care has helped to ensure the process is streamlined and is the most appropriate safeguarding response.

2.6 The monitoring of health provider activity and performance in line with contractual arrangements has been aided by the return of key performance indicators in the scorecards. This has allowed for identification of performance related issues and the request for assurance from the providers that they are able to fulfil service specifications. Data is validated and reported to both local authorities via the Designated Nurse for CiC and CEYP to inform their health data sets.

2.7 The Designated Nurse has continued to act as a positive advocate for NHS Dorset CCG/ICB in promoting good practice identified for CiC and CEYP within Dorset, regionally and nationally during 2021-22. Central to this is the 'voice' of CiC and CEYP, there have been opportunities through Corporate Parenting Board and meeting directly with children and young people to hear some of the issues that are important to them and utilise themes to inform future commissioning and service delivery.

2.8 The Designated Nurse has worked with partners to consider the impact of the new Liberty Protection Safeguards (LPS) as part of the Mental Capacity Act 2005 Code of Conduct and the impact for 16–17-year-olds. This will continue into 2022-23 in preparation for when the Code will 'go live'.

2.9 In response to the increased number of UASC requiring statutory initial health assessments, NHS Dorset CCG/ICB have commissioned a bespoke time limited service to meet this need which has involved working with South Coast Medical Practice and the skilling up of Named GP for Safeguarding.

2.10 Following the learning required from a Multi-Agency Case Audit (MACA) work has begun on a Pregnancy Pathway for CiC to ensure agencies are working together to provide a robust support network around the parents to be.

3. Demographics of Pan Dorset CiC and CEYP population

3.1 The demographic data for Dorset indicates there has been 386 children who have come into care under the age of 18 years in 2021-22, which represents an 8.2% increase since April 2021 and a total 31% increase of the number into care in 2020-21(293).

3.2 Care Experienced Young People (Care leavers) numbers continue to increase, there are now 1038 resulting in a 16% increase since April 2021.

3.3 NHS Dorset CCG/ICB have a responsibility to support the health needs of CiC placed in Dorset by other local authorities. At the end of March 2022, a total of 408 children from other local authorities were recorded on the scorecard, giving a total CiC/CEYP population of 2,398 as of 31st March 2022 in receipt of specialist health support, a rise from 2,138 as of 31st March 2021.

3.4 There was an increase in the number of children coming into care in comparison to the previous year possibly due to enforced lockdown when children did not attend schools and there were significant pressures on families to manage without the support they may have required. It is important to note the increase of unaccompanied asylum-seeking children (UASC), from 3.9% of the CiC caseload in Quarter 1 to 9.5% in Quarter 4. Also of significance is that 53% of the UASC population are placed out of Dorset.

3.5 Children in Care data is now more in line with the Southwest region for both Dorset and BCP, the number per 10,000 population of children remains higher than regional figures for Dorset at 66 per 10,000 and 56 for BCP (March 2021)

County	No of CiC per 10,000 children
Hampshire	56
Dorset	66
Bournemouth Christchurch and Poole	56
Wiltshire	39
Somerset	46
Devon	55
Cornwall	46

However, this is a decrease from the previous year which presented at 70 per 10,000 (March 2020).

4. Performance

4.1 Progress continues to be reported monthly and presented through the Power BI dashboard. Additionally, as agreed with both local authorities (LA), key performance indicators from Dorset Healthcare (DHC) and University Hospitals Dorset (UHD) are validated and submitted by the Designated Nurse to support LA data returns.

4.2 Overall IHA performance of 36.5% for 2021-22 represents a decline against the 2020-21 figure of 45.9% and remains significantly below the required 85% performance indicator for Initial Health Assessments (IHAs) to be completed within the 20-working day statutory time frame. There have been significant impacts on the service delivery which have resulted in a backlog of outstanding IHAs. Delays in consent and notifications have persisted throughout the year, but with a noted improvement in Quarter 4, the LA teams have worked hard to improve processes and now both have dedicated admin staff to support this. The medical service in UHD has suffered a loss in capacity due to sickness and alongside an increase in adoption medicals following the Somerset Ruling[1] have been unable to fulfil their statutory duty to complete Initial Health Assessments within 20 days of a child coming into care. These areas have been escalated to contract performance and remain on the Dorset CCG/NHS Dorset Risk Registers due to a lack of sustained improvement.

4.3 Performance for the CiC Health Team in DHC has taken a dip this year from 84.6% of Review Health Assessments (RHAs) completed in 2020-21, to 75.5% for 2021-22. Exception reports show that out of area delays were the main cause of delay for RHAs to be completed, alongside the capacity of the nursing team due to vacancies and sickness. Assurance has been given by the Named Nurse for the CiC service that there is a catch-up

[1] In November 2021, Somerset LA and the CCG were taken to court with a subsequent ruling about processes and timing for adoption medical reports being completed. This has led to guidance about ensuring an adoption medical report is available before a case is presented to the Agency Decision Making panel. There has been a surge in requests for adoption medical reports as a result (in Jan/Feb 2022 especially). It is likely there will be an overall increase in the number of adoption medicals which will be required.

programme for the RHAs not completed within the specified timeframe. Out of area delays remain a national issue that NHS England and NHS Improvement are aware of.

4.4 Performance for dental is 77.3%, just below the annual target of 80%

4.5 Immunisation rates for CiC are just below the 85% annual target, at 84.7%.

4.6 Regular meetings with the LAs have allowed for discussion around ways to work together to improve into care processes. This has resulted much improved notifications and consent, most noticeable in Quarter 4. This remains on CCG risk registers for both LAs, with the recognition that this improvement needs to be sustained for at least three out of four quarters. Work will be ongoing into 2022-23 to support this progress.

4.7 A key aspect of the Designated Nurse role has been to ascertain the thoughts and wishes of children in care to inform service planning and delivery, this has been achieved through involvement with the New Belongings project in Dorset and participation groups in BCP.

5. Challenges

5.1 As reflected in IHA and RHA exception reporting, out of area health assessment delays have impacted significantly on performance and resulted in children living outside of Dorset not receiving their health assessments within statutory timeframes. This inequity of practice and unwarranted variation has been reported to NHSE&I and is deemed to be a national issue.

5.2 Meeting the needs for the care experienced young people population has been shown to be difficult not only due to the capacity within the nursing team but in recognising the need for services to be dynamic and individualistic in delivery. Working in partnership with young people, and their corporate parents will be an important focus for 2022-23.

5.3 The ability to complete Initial Health Assessments within the 20 days statutory timeframe is an ongoing concern that is being monitored by the contract team.

5.4 Whilst the number of strategy meetings have reduced from the high number at the beginning of 2021-22, the number of risk and safeguarding meetings Pan Dorset have increased for the health team. this has meant reviews in between health assessments remain targeted rather than the universal offer for all children in care.

5.5 There have been challenges to children in care accessing dentistry this has been raised regionally and nationally and persistent cases are escalated to the Southwest Dental Commissioner via the Designated Nurse for Children in Care and Care Experienced Young People.

6. Compliments and Complaints

6.1 No formal complaints have been received during 2020/21. Compliments continue to be received from CiC & CL, foster carers, partner agencies (See appendix 1).

7. Key Areas for Development 2022-23

7.1 To continue to review and escalate IHA performance in order that statutory duty is met.

7.2 To continue to work in partnership with providers, local authorities, and Corporate Parenting Boards to improve performance and sustainability of achieving IHAs within the 20 working days statutory time frame.

7.3 To ensure the voice of care experienced young people, is heard, and facilitate networks across the partnership including the voluntary sector to consider the most appropriate support which caters for their emotional and mental health wellbeing.

7.4 Monitor health provider activity and performance in line with contractual arrangements, in tracking the trajectory of activity and quality indicators to measure impact and outcomes for children in care and care experienced young people. To continue to work towards aligning health and local authority data to ensure the most accurate performance is reported to Corporate Parenting Board.

7.5 Consider how the changes to the Mental Capacity Act and Liberty Protection Safeguards impact for 16–17-year-olds in care and care experienced young people, take an active role in the consultation process locally and regionally to ensure the changes accurately reflect and make clear their care and treatment plans.

7.6 Review the changes to contracting guidelines regarding payments for out of area health timeliness of completing IHAs and RHAs.

7.7 Work in collaboration with the Local Authorities and public health to ensure the health needs of unaccompanied asylum-seeking children are met and where necessary advise and provide specialist advice to commissioners.

7.8 Continue to work in partnership with the Named Nurse and Doctor for CiC and CEYP to hear how we can improve commissioned services including dental, maternity and leaving care/transition.

7.9 Continue to actively participate in the development of the Dorset Intelligence and Insight Service with a specific focus on the Safeguarding Analytics element. This will enable greater knowledge and insight into children on the edge of care and the trajectory through their care journey.

Author's Name and Title: Louise Harris Smith Designated Nurse for Children in Care and Care Experienced Young People

Date: 27.06.2022

APPENDICES	
Appendix 1	**Service User Feedback**

Appendix 1 – Service User Feedback for the CiC Health Team

Feedback from Children and Young People:

understanding, honest, genuine, kind, compassionate

"Thank you for helping me and getting school to listen to how I am feeling".

"u have really helped me talk and work through what is going on in my life-really appreciate the space and time to make sense of things- thank you for all you do for me."

I liked the way it (the RHA) was written and how I'd linked emotional health to the physiological impact it has on the body.

Feedback from the carer:

"Thank you for taking the time to listen and understand. You made the review meaningful; it was by far the best we have received in the 6 years we have been doing this."

Lastly, I would like to express my gratitude to the lady within the health team. She was very supportive, professional, and remained in contact with me until all was resolved. 10 out of 10 service!

I also felt inspired by watching your interactions with YP – it was evident even during that small window over Attend Anywhere that you have been able to build up a really valuable relationship with him which sounds like it

I would like to Thank you for arranging the appointment and your support in this case. It has been a difficult case, but I feel we are now providing this young person with excellent care by having one medical examination, thus reducing any further trauma.

NHS Dorset

8.8

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

ANNUAL REVIEW OF THE DATA SECURITY AND PROTECTION TEAM AND TOOLKIT UPDATE

Date of the meeting	20th July 2022
Author	Paddy Baker, Data Protection Officer
Sponsoring Board member	Stephen Slough, Chief Digital Information Officer
Purpose of Report	To assure the Board that the requirements of the Data Security and Protection Toolkit are being met and that significant improvements continue to be made across the CCG.
Recommendation	The Board is asked to **note** the report.

Monitoring and Assurance Summary

Please consider if this report has implications in any of the following areas and provide the relevant details below in each box, over-writing the current wording which has been provided to assist completion. If any are not applicable, please add a N/A: -

Conflicts of Interest	*N/A*
Involvement and Consultation	*N/A*
Equality, Diversity and Inclusion	*N/A*
Financial and Resource Implications	*N/A*
Legal/governance	*The work undertaken by the Data Security and Protection Team ensures that the CCG/ICB is legally compliant with the Data Protection Act 2018 and associated legislation.*
Risk description/rating	*N/A*

1. Introduction

1.1 The Data Security and Protection Toolkit (DSPT) submission date for 2022 was the 30th of June and Dorset Clinical Commissioning Group published as 'Standards Met.'

1.2 The 10 data security standards making up the DSPT for 2021-22, are broken down into a number of assertions (38 in total), with 88 mandatory evidence items. Please see Appendix 1 for further detail.

2. Data Security and Protection Advisory Team activity - Data Protection Officers for General Practice

2.1 The Data Protection Officers (DPOs) for General Practice commenced their role on 1 October 2019, providing a Dorset-wide service. This continues to be well received by Practices, and use of the service has been growing:

Month	Contact from Practices	
	2020-2021	2021-2022
April	36 contacts: inc. 2 incidents	64 contacts: inc. 3 incidents and 8 training requests
May	41 contacts: inc. 5 incidents	55 contacts: inc. 2 incidents
June	61 contacts: inc. 3 incidents	119 contacts: inc. 3 incidents
July	49 contacts: inc. 3 incidents and 1 training request	86 contacts: inc. 6 incidents and 2 training requests
August	74 contacts: inc. 3 incidents, 2 training requests and 1 remote visit request	64 contacts: inc. 3 incidents
September	77 contacts: inc. 5 incidents	54 contacts: inc. 4 incidents
October	65 contacts: inc. 4 incidents and 1 training request	47 contacts: inc. 2 incidents
November	88 contacts: inc. 12 incidents, 2 training requests and 23 responses to audit offer	49 contacts: inc. 2 incidents and 1 training request
December	53 contacts: inc. 4 incident queries	31 contacts: inc. 1 incident and 2 training requests
January	57 contacts: inc. 5 requests for DPO visits, 1 request for training	79 contracts: inc. 4 incidents, 5 training requests and 1 request for a visit

February	54 contacts: inc. 1 incident query	74 contacts: inc. 4 incidents and 4 training requests
March	67 contacts (as of 18/03/2021): inc. 1 incident	90 contacts: inc. 3 incidents and 3 training requests

2.2 The Data Security and Protection SharePoint site is well established with a variety of guidance, template documents and FAQs available for Practices to use. Newsletters continue to be sent to Practices with updates on national guidance and updates, uses of technology, and the Data Security and Protection Toolkit. There has also been a lot of work updating Privacy Notices in response to COVID19, COPI Notices and various uses of data and applicable opt outs. The GP DPOs continue to chair the Pan Dorset Information Governance Group on a quarterly basis, with a Health specific subgroup meeting monthly. As Chairs of the Pan Dorset IG Group, the GP DPOs also attend the Dorset Working Group, a subgroup of the Dorset Informatics Group to stay up to date with collaborative working and report back to Partners.

2.3 73 GP Practices have published a 'Standards Met' for their Data Security and Protection Toolkit (DSPT) assessment 2021-2022. This meant that, for the second year in a row, 100% of Practices within Dorset complied with their contractual requirement to publish the DSPT. The GP DPOs will continue to support the Practices with their DSPT publications once the Standards for 2022-2023 have been published by NHS Digital.

2.4 Data Protection Audits have been conducted via Teams at 4 Practices, with further audits booked over the coming months. Data Protection and Security training has been delivered via Teams to 8 Practices, and 3 face to face sessions. The GP DPOs have also delivered 6 Data Security and Protection Training Workshops, open to all Practices, and developed a Right of Access Training Module which started being delivered into Practices in March 2022.

2.5 During the third quarter the GP DPOs also undertook a staff Subject Access Request for one of the Practices who had dismissed a member of staff. This involved reviewing 8,945 documents and 140,686 emails, taking over 220 hours.

2.6 Due to ongoing COVID pressures and increasing demands on Practices, a survey of services has not been conducted during the 2021-2022 year, but ad hoc feedback received remains very positive:

- *"Thanks so much for coming yesterday. So many people have told me how informative it was. You guys are brilliant!"*
- *"Brilliant Teams meeting. Thank you both."*
- *"You're a star!"*
- *"Thank you! Brilliant help as ever!"*
- *"Thank you for your excellent and speedy help."*
- *"Thank you, fantastic service as always!"*

3. Data Security and Protection at the CCG

Data Security and Protection Internal Responsibility

3.1 The Information Asset Owners Group (IAOG), consisting of 25 Information Asset Owners and the Senior Information Risk Owner (SIRO), is now embedded in the CCG with meetings every 3 months.

3.2 The Chair of the IAOG passed from the CCG Chief Finance Officer (as CCG Senior Information Risk Owner, SIRO) to the ICB Chief Information Officer (ICB SIRO) after the last meeting in June.

3.3 The IAOG has oversight of all data protection and security issues relating to the CCG/ICB as well as reviewing all Data Protection Impact Assessments and any related CCG/ICB policies.

Data Breaches

3.4 The CCG had two serious data breaches (reportable to the Information Commissioner) for 2021/22.

3.5 The first breach reported on the 24th of August 2021 when a Continuing Health Care (CHC) decision letter relating to a vulnerable patient was sent to the wrong email address (another member of the public).

3.6 A full investigation was carried out and the report was forwarded to the Information Commissioner who accepted the mitigations in the report and took no further action.

3.7 The second incident, which occurred on the 14th of June 2022, involved a member of staff who had copied a template from a previous email and then sent the email with the whole of the previous email string, to a member of the public.

3.8 The erroneous recipient then refused to delete the email and said that she intended to use the information in some sort of an appeal against the CCG.

3.9 The Data Protection Officer then wrote to the recipient explaining that to further process the information, would constitute a criminal offence and confirmation of deletion was then received. The Information Commissioner took no further action.

3.10 The CCG had a significant increase in low level breaches since the first lockdown period, two years ago, and these remained at a high level with 75 breaches registered with the Data Security and Protection Team in 2021/22.

3.11 There were two occasions where staff caused three data breaches during the year and had further one-to-one training with the Data Protection Officer.

3.12 The IAOG have been discussing system control measures which the IT team feel may be employed to cut down on breaches and these measures will be rolled out across the ICB in the coming weeks.

Freedom of Information

3.13 The CCG processed 235 FOI requests in the year 2021/22, an increase of 18% on the previous year.

3.14 The main themes of the requests were consistent with last year with the addition of questions relating to the national pandemic:

- Continuing Healthcare and Personal Health Budgets;
- Primary Care;
- Commissioning of Services, especially Mental Health;
- Covid response.

3.15 99.15% of the requests received were answered within the statutory timescale.

3.16 2 requests were not returned within the statutory timescale. The first was written into the text of a Subject Access Request and was not noticed until the Data Protection Team were reviewing the response. The second required us to seek information from private providers with whom we contract services and one of them was late with the reply.

3.17 The Data Protection Officer apologised to both requesters, and they were satisfied with the reasons given.

3.18 An exemption was applied to one Freedom of Information Request after a Public Interest Panel was convened. The requester had asked for detail of the Corporate Risk Register and minutes regarding discussions that take place during Part 2 meetings.

Requests for Internal Reviews

3.19 If an applicant is dissatisfied with the response the CCG has provided, they can request an internal review. During 2021/22 no requests were received for review.

Subject Access Requests

3.20 There were15 Subject Access Requests (SAR), and eight requests from patients to delete all of their medical records, under their ‘Right to be Forgotten’. All SARs were appropriately responded to within the statutory timescale.

Staff Mandatory Training

3.21 Throughout the year there were 626 staff working for the CCG (inc. agency, Bank staff, starters and leavers). Of those, 526 attended their mandatory training, with 5 new starters scheduled for further sessions whilst 95 members of staff were either leavers, long term sick or on maternity leave. This means

the CCG attained 99% compliance with staff mandatory training.

4. Conclusion

4.1 NHS Dorset CCG had robust processes for managing Data Security and Protection and the associated responsibilities that come with the commitment to adopt best practice policy and procedures in order to protect patient and service users' information. These processes will be adopted for the ICB.

4.2 The CCG met the standards required for the DSPT submission for 2021/22. The Data Security and Protection Team, with the assistance of representatives from IT and the IAOG, will continue to work to ensure the ICB achieves the same high level going forward.

4.3 The Board is asked to receive and note this report.

Author Name and Title: Paddy Baker, Data Protection Officer
Date: 7th July 2022

APPENDICES	
Appendix 1	**Data Security and Protection Toolkit Interim Assessment Summary 2021-22**

Appendix 1

Data Security and Protection Toolkit
Final Assessment 2021-22

N.B. The numbering systems relates directly to the evidence items in the DSP Toolkit which are relevant to CCGs.

1 Personal Confidential Data

All staff ensure that personal confidential data is handled, stored, and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

1.1	The organisation has a framework in place to support Lawfulness, Fairness and Transparency		
1.1.1	What is your organisation's Information Commissioner's Office (ICO) registration number.	Mandatory	COMPLETED
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Mandatory	COMPLETED
1.1.3	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Mandatory	COMPLETED
1.1.4	When did your organisation last review both the list of all systems/information assets holding or sharing personal information and data flows?	Mandatory	COMPLETED
1.1.5	List the names and job titles of your key staff with responsibility for data protection and/or security.	Mandatory	COMPLETED
1.1.6	Your organisation has reviewed how you ask for and record consent. And has systems to record and manage ongoing consent.		
1.1.7	Was the scope of the last data quality audit in line with guidelines.	Mandatory	COMPLETED
1.1.8	A data quality forum monitors the effectiveness of data quality assurance processes.		

1.2	Individuals' rights are respected and supported		
1.2.1	How is transparency information (e.g., your privacy notice) published and available to the public?	Mandatory	COMPLETED
1.2.2	Your organisation has a process to recognise and respond to individuals' requests to access their personal data.	Mandatory	COMPLETED
1.2.4	Is your organisation compliant with the national data opt-out policy?		COMPLETED

1.3	Accountability and Governance in place for data protection and data security		
1.3.1	Are there board-approved data security and protection policies in place that follow relevant guidance?	Mandatory	COMPLETED
1.3.2	Your organisation monitors your own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	Mandatory	COMPLETED
1.3.3	Has SIRO responsibility for data security been assigned?	Mandatory	COMPLETED
1.3.4	Are there clear lines of responsibility and accountability to named individuals for data security and data protection?	Mandatory	COMPLETED
1.3.5	Does your organisation operate and maintain a data security risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility?	Mandatory	COMPLETED
1.3.6	What are your top three data security and protection risks?	Mandatory	COMPLETED
1.3.7	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	Mandatory	COMPLETED
1.3.8	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to	Mandatory	COMPLETED

	your existing risk management and project management, to action this.		
1.3.9	Is data security direction set at board level and translated into effective organisational practices?	Mandatory	COMPLETED
1.3.10	How are data security and protection policies and Data Protection Impact Assessments made available to the public?		COMPLETED

1.4	Records are maintained appropriately		
1.4.1	The organisation has a records management policy including a records retention schedule.	Mandatory	COMPLETED

2 Staff Responsibilities

All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards.		
2.1.1	Is there a data protection and security induction in place for all new entrants to the organisation?	Mandatory	COMPLETED
2.1.2	Do all employment contracts contain data security requirements?	Mandatory	COMPLETED
2.1.3	The results of staff awareness surveys on staff understanding of data security are reviewed to improve data security.		COMPLETED

3 Training

All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

3.1	There has been an assessment of data security and protection training needs across the organisation.		
3.1.1	Has an approved organisation wide data security and protection training needs analysis been completed after 1 July 2021?	Mandatory	COMPLETED

3.2	Staff pass the data security and protection mandatory test.		
3.2.1	Have at least 95% of all staff, completed their annual Data Security awareness training?	Mandatory	COMPLETED

3.3	Staff with specialist roles receive data security and protection training suitable to their role.		
3.3.1	Provide details of any specialist data security and protection training undertaken.	Mandatory	COMPLETED
3.3.2	The organisation has appropriately qualified technical cyber security specialist staff and/or service.	Mandatory	COMPLETED
3.3.3	The organisation has nominated a member of the Cyber Associates Network.	Mandatory	COMPLETED

3.4	Leaders and board members receive suitable data protection and security training.		
3.4.1	Have your SIRO and Caldicott Guardian received appropriate data security and protection training?	Mandatory	COMPLETED
3.4.2	All Board Members have completed appropriate data security and protection Training?	Mandatory	COMPLETED

4 Managing Data Access

Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.

4.1	The organisation maintains a current record of staff and their roles.		
4.1.1	Your organisation maintains a record of staff and their roles.	Mandatory	COMPLETED
4.1.2	Does the organisation understand who has access to personal and confidential data through your systems, including any systems which do not support individual logins?	Mandatory	COMPLETED
4.1.3	Are users in your organisation only given the minimum access to sensitive information or systems necessary for their role?		

4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems.		
4.2.1	When was the last audit of user accounts held?	Mandatory	COMPLETED
4.2.2	Provide a summary of data security incidents in the last 12 months caused by a mismatch between user role and system accesses granted.		COMPLETED
4.2.3	Logs are retained for a sufficient period, managed securely, reviewed regularly and can be searched to identify malicious activity.		COMPLETED
4.2.5	Are unnecessary user accounts removed or disabled?	Mandatory	COMPLETED

4.3	All staff understand that their activities on IT systems will be monitored and recorded for security purposes.		
4.3.1	All system administrators have signed an agreement which holds them accountable to the highest standards of use.	Mandatory	COMPLETED
4.3.2	Are users, systems and (where appropriate) devices, always identified and authenticated prior to being permitted access to information or system?	Mandatory	COMPLETED
4.3.5	Have all staff been notified that their system use could be monitored?		COMPLETED

4.4	You closely manage privileged user access to networks and information systems supporting the essential service.		
4.4.1	The organisation ensures that logs, including privileged account use, are kept securely and only accessible to appropriate personnel. They are stored in a read only format, tamper proof and managed according to the organisation information life cycle policy with disposal as appropriate.		COMPLETED
4.4.2	The organisation does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-	Mandatory	COMPLETED

	risk functions, in particular reading email and web browsing.		
4.4.3	The organisation only allows privileged access to be initiated from devices owned and managed by your organisation.		COMPLETED

4.5	You ensure your passwords are suitable for the information you are protecting		
4.5.1	Do you have a password policy giving staff advice on managing their password?	Mandatory	COMPLETED
4.5.2	Technical controls enforce password policy and mitigate against password-guessing attacks.	Mandatory	COMPLETED
4.5.3	Multifactor authentication is used [wherever technically feasible].		COMPLETED
4.5.4	Passwords for highly privileged system accounts, social media accounts and infrastructure components shall be changed from default values and should have high strength.	Mandatory	COMPLETED
4.5.5	Does your organisation, or your supply chain with access to your systems, grant limited privileged access and third-party access only for a limited time period, or is it planning to do so?		COMPLETED

5 Process Reviews

Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents.		
5.1.1	Root cause analysis is conducted routinely as a key part of your lessons learned activities following a data security incident, with findings acted upon.	Mandatory	COMPLETED
5.1.3	List of actions arising from each process review, with names of actionees.		

5.2	Participation in reviews is comprehensive, and clinicians are actively involved.		
5.2.1	Provide a scanned copy of the process review meeting registration sheet with attendee signatures and roles held.		COMPLETED

5.3	Action is taken to address problem processes as a result of feedback at meetings or in year.		
5.3.1	Are the actions to address problem processes, being monitored and assurance given to the board or equivalent senior team?		COMPLETED

6 Responding to Incidents

Cyber-attacks against services are identified and resisted and security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.

6.1	A confidential system for reporting data security and protection breaches and near misses is in place and actively used.		
6.1.1	A policy/procedure is in place to ensure data security and protection incidents are managed/reported appropriately.	Mandatory	COMPLETED
6.1.3	Is the Board or equivalent notified of the action plan for all data security and protection breaches?	Mandatory	COMPLETED
6.1.4	Individuals affected by a breach are appropriately informed.	Mandatory	COMPLETED

6.2	All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway.		
6.2.1	Has anti-virus/anti-malware software been installed on all computers that are connected to or capable of connecting to the Internet?	Mandatory	COMPLETED
6.2.3	Anti-malware and Anti-Virus are kept continually up to date.	Mandatory	COMPLETED
6.2.4	Anti-malware/Anti-Virus software scans files automatically upon access.		COMPLETED

6.2.5	Connections to malicious websites on the Internet are prevented.		COMPLETED
6.2.6	Number of phishing emails reported by staff per month.		COMPLETED
6.2.8	You have implemented on your email, Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) for your organisation's domains to make email spoofing difficult.	Mandatory	COMPLETED
6.2.9	You have implemented spam and malware filtering and enforce DMARC on inbound email.	Mandatory	COMPLETED

6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses.		
6.3.1	If you have had a data security incident, was it caused by a known vulnerability?	Mandatory	COMPLETED
6.3.2	The organisation acknowledges all 'high severity' cyber alerts within 48 hours using the respond to an NHS cyber alert service.	Mandatory	COMPLETED
6.3.3	The organisation has a proportionate monitoring solution to detect cyber events on systems and services.	Mandatory	COMPLETED
6.3.4	Are all new digital services that are attractive to cyber criminals (such as for fraud) implementing transactional monitoring techniques from the outset?	Mandatory	COMPLETED
6.3.5	Have you had any repeat data security incidents during the past twelve months?		COMPLETED

7 Continuity Planning

A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

7.1	Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services.

7.1.1	Your organisation understands the health and care services it provides.	Mandatory	COMPLETED
7.1.2	Do you have well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise?	Mandatory	COMPLETED
7.1.3	You understand the resources and information that will likely be needed to carry out any required response activities, and arrangements are in place to make these resources available.		
7.1.4	You use your security awareness, e.g. threat intelligence sources, to make temporary security changes in response to new threats, e.g. a widespread outbreak of very damaging malware.		COMPLETED

7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents.		
7.2.1	Explain how your data security incident response and management plan has been tested to ensure all parties understand their roles and responsibilities as part of the plan.	Mandatory	COMPLETED
7.2.2	From the business continuity exercise, explain which issues and actions were documented, with names of actionees listed against each item.	Mandatory	COMPLETED

7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions.		
7.3.1	On discovery of an incident, mitigating measures shall be assessed and applied at the earliest opportunity, drawing on expert advice where necessary.	Mandatory	COMPLETED
7.3.2	All emergency contacts are kept securely, in hardcopy and are up-to-date.	Mandatory	COMPLETED
7.3.3	Are draft press materials for data security incidents ready?		COMPLETED

7.3.4	Suitable backups of all important data and information needed to recover the essential service are made, tested, documented and routinely reviewed.	Mandatory	COMPLETED
7.3.5	Do you test your backups regularly to ensure you can restore the service from backup?	Mandatory	COMPLETED
7.3.6	Are your backups kept separate from your network ('offline'), or in a cloud service designed for this purpose.	Mandatory	COMPLETED

8 Unsupported Systems

No unsupported operating systems, software or internet browsers are used within the IT estate.

8.1	All software and hardware have been surveyed to understand if it is supported and up to date.		
8.1.1	Provide evidence of how the organisation tracks and records all software assets and their configuration?	Mandatory	COMPLETED
8.1.2	Does the organisation track and record all end user devices and removeable media assets?	Mandatory	COMPLETED
8.1.3	Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the SIRO.	Mandatory	COMPLETED

8.2	Unsupported software and hardware are categorised and documented, and data security risks are identified and managed.		
8.2.1	List any unsupported software prioritised according to business risk, with remediation plan against each item.	Mandatory	COMPLETED
8.2.2	The SIRO confirms that the risks of using unsupported systems are being managed and the scale of unsupported software is reported to your board along with the plans to address.	Mandatory	COMPLETED

8.3	Supported systems are kept up-to-date with the latest security patches.

8.3.1	How do your systems receive updates and how often?	Mandatory	COMPLETED
8.3.2	How often, in days, is automatic patching typically being pushed out to remote endpoints?	Mandatory	COMPLETED
8.3.3	There is a documented approach to applying security updates (patches) agreed by the SIRO.	Mandatory	COMPLETED
8.3.4	Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied.	Mandatory	COMPLETED
8.3.6	Is your organisation is actively using and managing Active Threat Prevention (ATP)?		COMPLETED
8.3.7	Are 95% of your server estate and 98% of your desktop estate on supported versions of operating systems?		COMPLETED

8.4	You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service.		
8.4.1	Is all your infrastructure protected from common cyber-attacks through secure configuration and patching?	Mandatory	COMPLETED
8.4.2	All infrastructure is running operating systems and software packages which are patched regularly, and as a minimum in vendor support.	Mandatory	COMPLETED
8.4.3	You maintain a current understanding of the exposure of your hardware and software to publicly known vulnerabilities.		COMPLETED

9 IT Protection

A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.

9.1	All networking components have had their default passwords changed.

9.1.1	The Head of IT, or equivalent role confirms all networking components have had their default passwords changed to a high strength password.	Mandatory	COMPLETED
9.1.2	The Head of IT, or equivalent role, confirms all organisational devices have had their default passwords changed.	Mandatory	COMPLETED

9.2	A penetration test has been scoped and undertaken		
9.2.1	Annual IT penetration testing is scoped through negotiation between the SIRO, business and testing team and includes a vulnerability scan and check that all networking components have had their default passwords changed.	Mandatory	COMPLETED
9.2.2	The date the penetration test was undertaken.	Mandatory	COMPLETED

9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities.		
9.3.1	All web applications are protected and not susceptible to common security vulnerabilities, such as described in the top ten Open Web Application Security Project (OWASP) vulnerabilities.	Mandatory	COMPLETED
9.3.2	The SIRO or equivalent senior role has reviewed the results of latest penetration testing, with an action plan for its findings.		COMPLETED
9.3.3	The organisation uses the UK Public Sector DNS Service or equivalent protective DNS service, to resolve internet DNS queries.	Mandatory	COMPLETED
9.3.4	The organisation ensures that changes to its authoritative DNS entries can only be made by strongly authenticated and authorised administrators.	Mandatory	COMPLETED
9.3.5	The organisation understands and records all IP ranges in use across the organisation.	Mandatory	COMPLETED
9.3.6	The organisation is protecting its data in transit (including email) using well-configured TLS v1.2 or better.	Mandatory	COMPLETED

9.3.7	The organisation has registered and uses the National Cyber Security Centre (NCSC) Web Check service, or equivalent web check service, for your publicly visible applications.	Mandatory	COMPLETED
9.3.8	The organisation maintains a register of medical devices connected to its network.		

9.4	You have demonstrable confidence in the effectiveness of the security of your technology, people, and processes relevant to essential services.		
9.4.1	You validate that the security measures in place to protect the networks and information systems are effective and remain effective for the lifetime over which they are needed.		COMPLETED
9.4.2	You understand the assurance methods available to you and choose appropriate methods to gain confidence in the security of essential services.		COMPLETED
9.4.3	Your confidence in your security as it relates to your technology, people, and processes has been demonstrated to, and verified by, a third-party onsite assessment.		COMPLETED
9.4.4	Security deficiencies uncovered by assurance activities are assessed, prioritised and remedied, when necessary, in a timely and effective way.	Mandatory	COMPLETED
9.4.5	What level of assurance (overall risk rating & confidence level rating) did the independent audit of your Data Security and Protection Toolkit provide to your organisation?	Mandatory	EXEMPT

9.5	You securely configure the network and information systems that support the delivery of essential services.		
9.5.1	All devices in your organisation have technical controls which manage the installation of software on the device.	Mandatory	COMPLETED
9.5.2	Confirm all data are encrypted at rest on all mobile devices and removeable media and you have the ability to remotely wipe and/or revoke access from an end user device.	Mandatory	COMPLETED
9.5.3	You closely and effectively manage changes in your environment, ensuring that network		COMPLETED

	and system configurations are secure and documented.		
9.5.4	Only approved software can be installed and run, and unnecessary software is removed.		COMPLETED
9.5.5	End user devices are built from a consistent and approved base image.		COMPLETED
9.5.6	End user device security settings are managed and deployed centrally.		COMPLETED
9.5.7	Autorun is disabled.		COMPLETED
9.5.8	All remote access is authenticated.		COMPLETED
9.6.9	You have a plan for protecting devices that are natively unable to connect to the Internet, and the risk has been assessed, documented, accepted and signed off by the SIRO.	Mandatory	COMPLETED
9.6.10	Does your organisation meet the secure email standard?		COMPLETED

9.6	The organisation is protected by a well-managed firewall .		
9.6.1	Have one or more firewalls (or similar network device) been installed on all the boundaries of the organisation's internal network(s)?	Mandatory	COMPLETED
9.6.2	Has the administrative interface used to manage the boundary firewall been configured such that; it is not accessible from the Internet, it requires second factor authentication or is access limited to a specific address?		COMPLETED
9.6.3	The organisation has checked and verified that firewall rules ensure that all unauthenticated inbound connections are blocked by default.		COMPLETED
9.6.4	All inbound firewall rules (other than default deny) are documented with business justification and approval by an authorised individual.		COMPLETED
9.6.5	Have firewall rules that are no longer required been removed or disabled?		COMPLETED

9.6.6	Do all of your desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to block unapproved connections by default?		COMPLETED

10 Accountable Suppliers

IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

10.1	The organisation can name its suppliers, the products and services they deliver and the contract durations.		
10.1.1	The organisation has a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration.	Mandatory	COMPLETED
10.1.2	Contracts with all third parties that handle personal information are compliant with ICO guidance.		COMPLETED

10.2	Basic due diligence has been undertaken against each supplier that handles personal information in accordance with ICO and NHS Digital guidance.		
10.2.1	Your organisation ensures that any supplier of IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification.	Mandatory	COMPLETED
10.2.3	Percentage of suppliers with data security contract clauses in place.		COMPLETED
10.2.4	Where services are outsourced (for example by use of cloud infrastructure or services), the organisation understands and accurately records which security related responsibilities remain with the organisation and which are the supplier's responsibility.	Mandatory	COMPLETED
10.2.5	All Suppliers that process or have access to health or care personal confidential information have completed a Data Security and Protection Toolkit, or equivalent.		COMPLETED

10.3	All disputes between the organisation and its suppliers have been recorded and any risks posed to data security have been documented.

10.3.1	List of data security incidents – past or present – with current suppliers who handle personal information.		COMPLETED
10.4	All instances where organisations cannot comply with the NDG Standards because of supplier-related issues are recorded and discussed at board		
10.4.1	List of instances of suppliers who handle health and care data not complying with National Data Guardian standards, with date discussed at board or equivalent level.		COMPLETED

10.5	The organisation understands and manages security risks to networks and information systems from your supply chain.		
10.5.2	Where appropriate, you offer support to suppliers to resolve incidents.		COMPLETED

8.9

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

PERSONAL HEALTH COMMISSIONING ANNUAL REPORT

Date of the meeting	20/07/2022
Author	C Pascoe, Deputy Director Personal Health Commissioning
Lead Director	V Read, Interim Chief Nursing Officer
Purpose of Report	To provide an overview on the performance in Personal Health Commissioning.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	*There are no conflicts of interest to note*
Involvement and Consultation	*There is no requirement to involve or consult to produce this report.*
Equality, Diversity and Inclusion	*There is no need for an equality impact assessment*
Financial and Resource Implications	*The report notes that the PHC service is £7.2m overspent with full rationale given for spend and actions taken*
Legal/governance	*No legal advice is required an no decisions required. The report is for noting.*
Risk description/rating	*This report does not seek to address an existing risk*

1. Introduction

The Personal Health Commissioning Team produces an annual report providing an overview on the performance of the service.

2. Report

2.1 The report is attached as Appendix 1.

3. Conclusion

3.1 The Board is asked to note the report.

Author's name and Title : C Pascoe, Deputy Director – Personal Health Commissioning
Date : 04/07/2022

APPENDICES	
Appendix 1	**Personal Health Commissioning Annual Report 2021-2022**

NHS Dorset

Personal Health Commissioning (PHC)

Annual Report 2021/22

Report information

Date of meeting	**20 July 2022**
Author	C Pascoe, Deputy Director, Personal Health Commissioning
Sponsoring Board member	V Read, Interim Chief Nursing Officer
Purpose of report	The annual report providing an overview of Personal Health Commissioning performance 2021/2022
Recommendation	The ICB is asked to note the report
Reason for inclusion in Part II	Confidential
Stakeholder engagement	n/a
Previous GB/committee dates	n/a
Executive sponsor(s)	

Monitoring and assurance summary	
This report links to the following strategic objectives:	System Leadership response to COVID19 Enabling a recovery response from COVID19 ICS Development and Transformation

	Yes Copy and paste tick: ✓	**Action required**	
		Yes (detail in report)	**No**
All three Domains of Quality (safety, quality, patient experience)	✓		✓
Board Assurance Framework Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal/regulatory	✓		✓
People/staff	✓		✓
Financial/value for money/sustainability	✓		✓
Information management and technology	✓		✓
Equality Impact Assessment			
Freedom of Information			

I confirm that I have considered the implications of this report on each of the matters above, as indicated.	**C Pascoe**

1. Introduction

1.1 This report provides an overview on the performance for Personal Health Commissioning (PHC) during 2021/22. The service incorporates the funding streams for Adult Continuing Healthcare (CHC), Children and Young People's Continuing Care (CYPCC), Funded Nursing Care (FNC), S117 / named patients, Complex Rehab and Joint Funding.

1.2 The service has reset post suspension of CHC during COVID19 with the small number of remaining deferred assessments completed early in the year. The service has continued to operate in a virtual by default capacity and has focused on performance improvement in a challenging care market environment. This report highlights some of the key achievements and challenges over the last year as well as some areas of focus for the year ahead.

2. Key Programmes of Work

2.1 One area of focus was joint funding applications. The service had a historical backlog of these which were dealt with through the year and a policy developed and agreed through Joint Commissioning Board for adults with an additional policy for Children and Young People being finalised. This ensures all partners are clear on the expectations and information required to consider joint funding requests.

2.2 A programme has been undertaken in partnership with local authorities and Dorset Healthcare to review all individuals who are currently within the Moving On From Hospital Living (MOFHL) cohort. This has resulted in greater clarity with regard to responsible commissioner for Liberty Protection Safeguards (LPS), ensured that there is legal compliance with the NHS Continuing Healthcare Framework and places all organisations in a sound position for discussion regarding the future of the pooled arrangement in readiness for budget setting for 2022/2023. Estimated annual savings at end of year were c. £400k.

2.3 The Children and Young People's Continuing Care team has struggled to recruit substantive resource but has still made good progress regarding the review of the caseload both in terms of eligibility and in terms of ensuring equity in provision across the cohort. Estimated annual savings at end of year were c. £1m.

2.4 The end of the year saw the decommissioning of IEG4 and the replacement of a new front end portal for referrals that is integrated with the back end Caretrack (patient database) system. Both local authorities are utilising this system for CHC referrals and there is a plan for onboarding of DHC staff by September 2022. Additionally, an electronic referral platform has been developed for Children and Young People's referrals which is scheduled to go live in Q2 2022/23.

2.5 A significant level of work has been undertaken with partners over the year to create a pooled budget, hub model and work plan to improve services for the S117 cohort. The pooled budget arrangement will initially launch between Dorset Council and Dorset CCG (Apr 2022) with a view to Bournemouth Christchurch and Poole Council joining in April 2023. The hub is due to be hosted by Dorset Council and all partners are contributing towards the costs for this.

2.6 PHC are engaged in the system wide discharge to assess model in line with the Hospital Discharge and Community Guidance. There has been significant work throughout the year with regard to the changing eligibility for national funding and the now local model. PHC will continue to engage in this work to support the development of a robust intermediate care model for Dorset.

2.7 Some of the retrospective cases for CHC have been outsourced to Mid and Lancs Commissioning Support Unit for completion. This alleviates the pressure on the system with what had been a longstanding cohort of outstanding assessments. This work will continue into 2022/2023.

2.8 NHSE required the submission of patient level data sets for the first time this year. The team has worked closely with our software provider and the national team to ensure our submission was as accurate as possible.

2.9 The service implemented a 28-day programme due to being an outlier in terms of performance against this standard. This has required the reallocation of staff, the changing of processes and increased management reporting to keep abreast of cases against timescales. The work has proved to be beneficial with the team performing at 58% at the end of Q4 against an original position of 28% at the end of Q4 in 2020/21. It is anticipated that the service is on the right trajectory and will continue to improve against the NHSE standard of 80%.

3. Financial Position

3.1 The final financial position for PHC is shown below:

Funder name	Full year OT 2021/22 £	Budget 2021/22 £m	Over/Under spend £m
Adult CHC	69.015	60.195	8.82
Funded Nursing Care (FNC)	12.982	14.462	-1.48
Children & Young People Continuing Care (CYPCC)	6.811	6.719	0.092
Interim Funding (formerly FOH Funded Out of Hospital)	0.001	-	0.001
Section 117	12.775	12.447	0.328
Named Patients	8.735	8.73	0.005
Complex Rehab	1.236	1.718	-0.482
Total	**111.555**	**104.271**	**7.284**

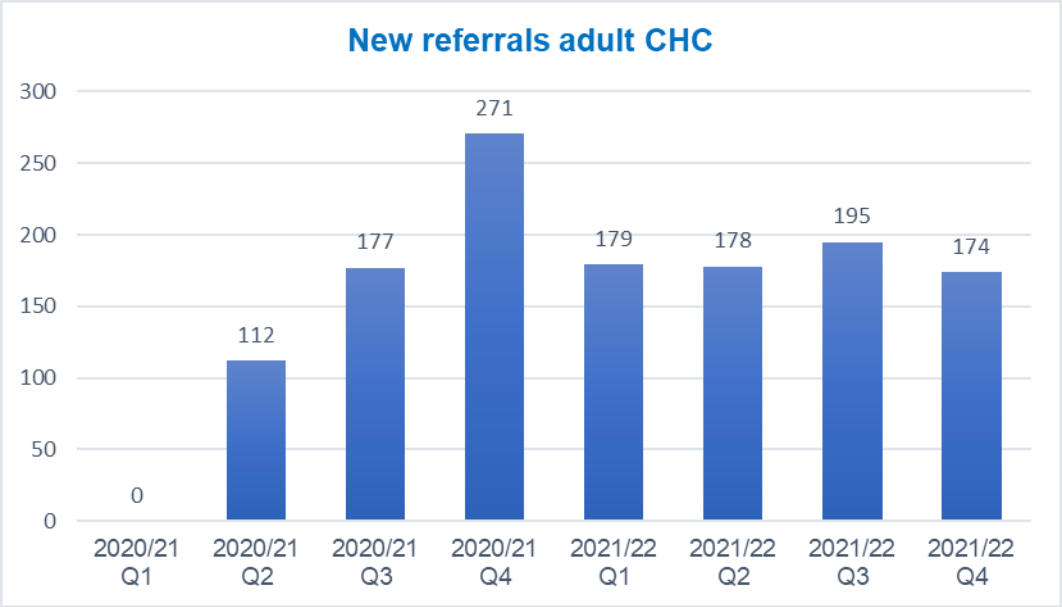
3.2 The overarching month 12 financial position was £7.284m overspent.

3.3 The significant overspend in Adult CHC is attributable to the fragility of the care market, increasing costs of care and the national allocation did not represent the uplift given to providers in alignment with the local authority frameworks.

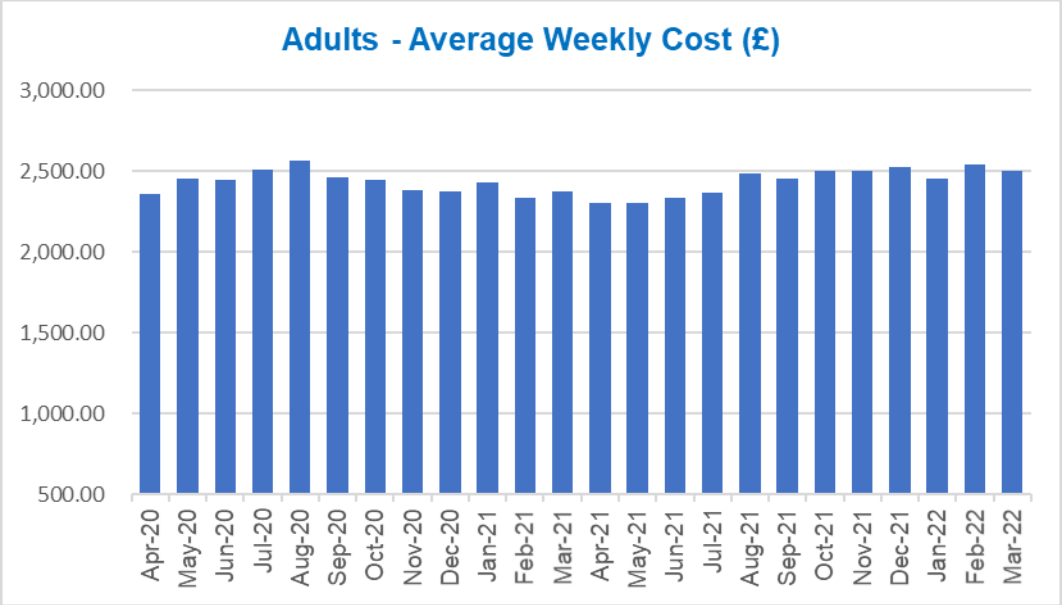
4. Adult Continuing Healthcare

4.1 New referrals for adult continuing healthcare in 2021/22 have increased by 30% compared to 2020/21 although it is difficult to do a direct comparison as some of the referrals undertaken in 2020/21 were in relation to deferred assessments due to the suspension of CHC during COVID19.

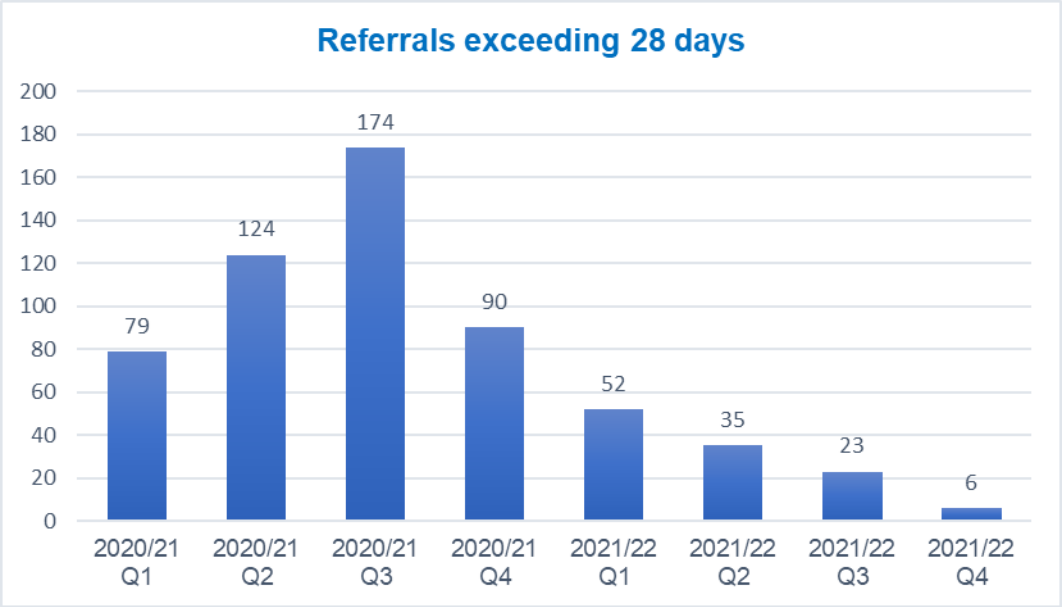
4.2 Figures as shown in the graph below.



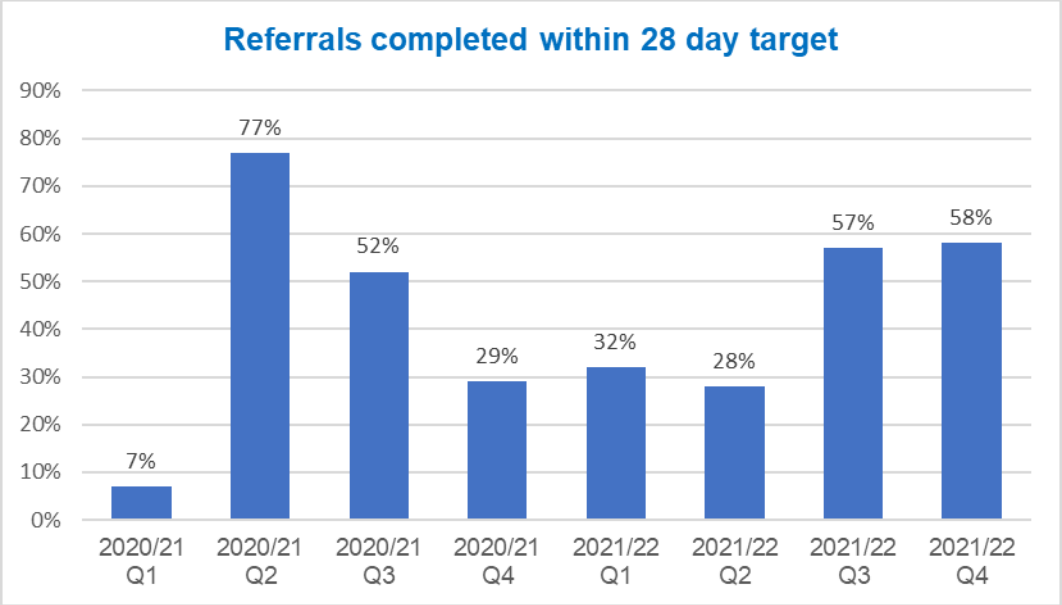
4.3 Average weekly costs of care have continued to rise over the last 12 months. There has been increased pressure on the service due to a lack of available provision. A number of nursing homes have closed or de-registered their nursing status resulting in the re-brokering of care packages. The changes in the national living wage and NI contributions have also played a part in increasing costs from providers. At the end of 2021/22 the average package cost for adult CHC was £2,370 per week and for fast-track application it was £565 per week.



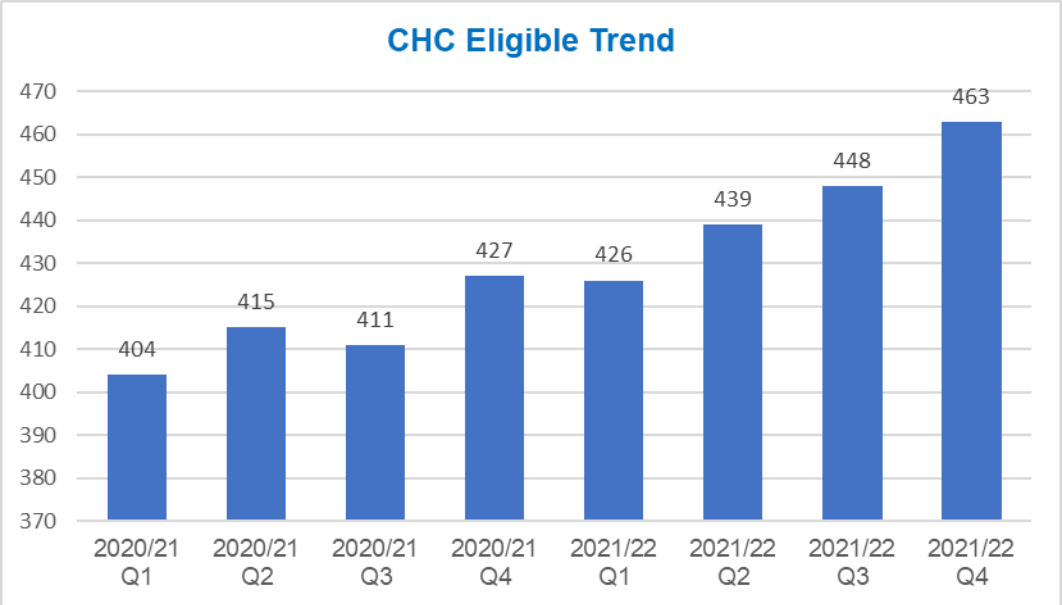
4.4 The service has historically not met the national 28-day target for referrals and carried a significant backlog. A targeted 28-day programme was undertaken through the year which has seen a significant decrease in backlog levels and a reduction in complaints in relation to delayed assessment outcomes.



4.5 Our latest report to NHSE (Q4) showed that referrals were being completed within 28 days for 58% of cases. While still below the required NHSE standard of 80%, this shows a significant improvement on Q4 of the previous year and is, in part, due to the clearance of the long-standing backlog of assessments. Please note in the below graph that the figures for Q1-Q3 2020/21 are impacted by the COVID19 suspension and deferred assessment programme so are not a realistic representation of business as usual. Over the coming year, the service will continue to improve on achievement against the NHSE standard, early indications show 74% for Q1 2022/2023.

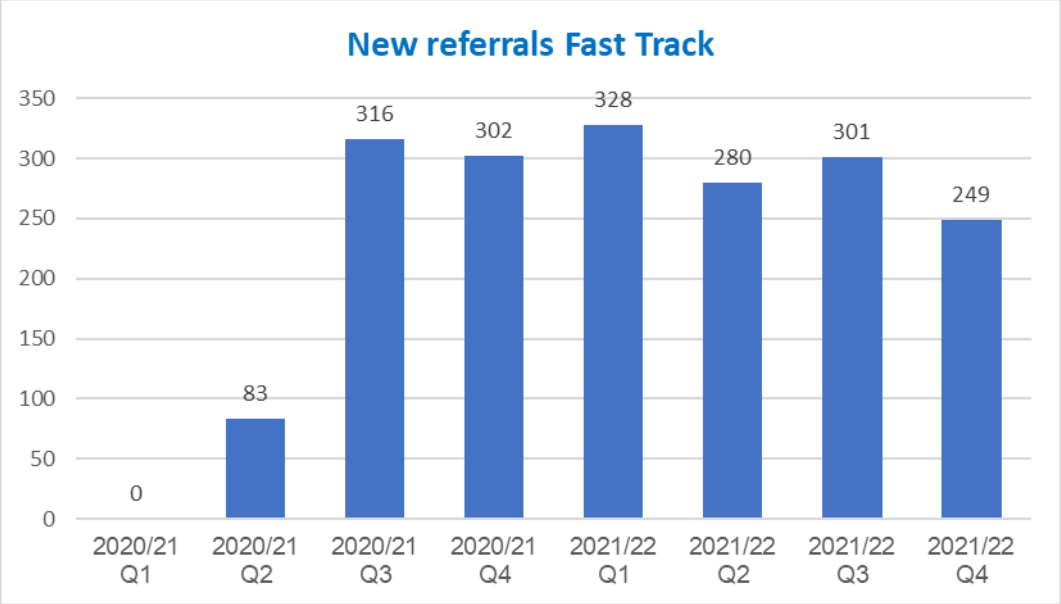


4.6 The number of patients eligible for CHC has steadily risen throughout the year, with an additional 36 patients now on the caseload. Assessments and reviews have continued to be undertaken in a 'virtual by default' approach. This has proved beneficial in enabling professionals to meet swiftly to assess and review individuals although it is recognised that there is a need for face to face assessment for some – there is a process in place to enable this to happen where required. Due to the market pressures, there remains delays in gathering evidence for assessments. A minimum data set has been agreed and staff allocated with the specific task of ensuring evidence is received in a timely fashion.



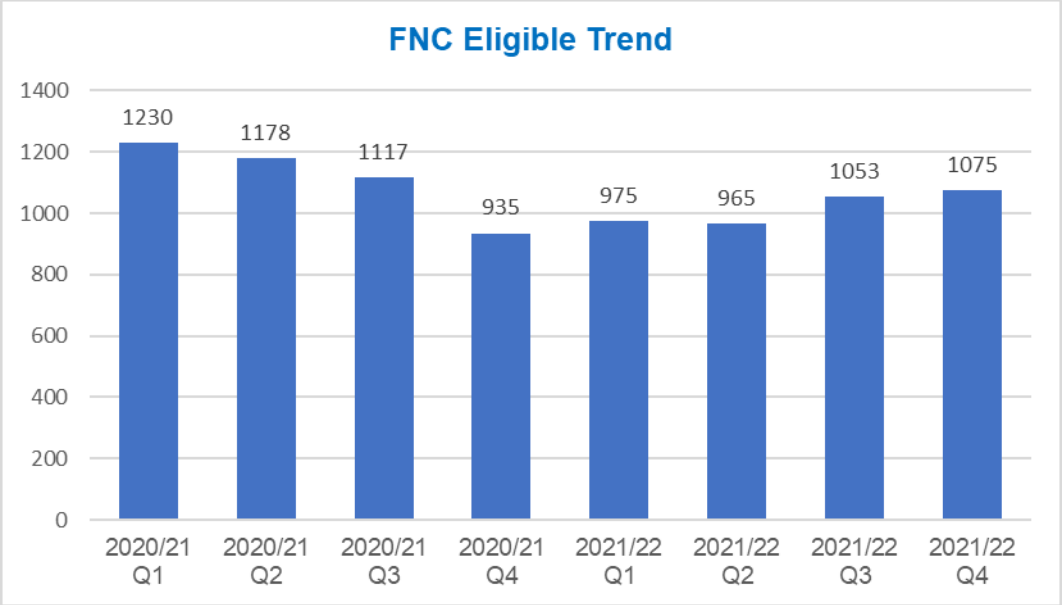
5. Fast Track

5.1 New referrals for fast track in 2021/22 increased by 39% over the year as shown in the graph below. This is in part due to the non-completion of fast-track referrals during the COVID19 period. The service is working with Primary and Community Care to pilot a model in which no referral is required, and discharges accelerated for those opting to die outside of the hospital setting. There is further work required to ensure for all patients at end of life that they are easy and equal access to the specialist care they need regardless of whether they start their journey from a hospital or community setting. To grow the specialist support across the Dorset footprint, work is being undertaken with several specialist providers to look at new commissioning options. It is intended that the case management of this cohort will be brought inhouse effective July 2022 to ensure those not requiring specialist services are removed from the pathway at the earliest opportunity.



6. Funded Nursing Care (FNC)

6.1 Funded nursing care has seen a slight decrease in the cumulative number of eligible patients from 1,888 at the end of 2020/21 to 1,881 in 2021/22. This is a temporary position due to the regrettably high levels of RIPs (794) over the year of FNC patients and the provision of national funding supporting those newly admitted to nursing home environments. The eligible trend graph below clearly shows the increasing number of FNC patients, and it is expected that this trend will continue over the coming year.



7. Children's and Young People Continuing Care (CYPCC)

7.1 There are currently 94 children on the CYPCC pathway, this is a reduction of 10 cases in comparison to the number of cases at the end of last year. This is, in part, attributable to the significant levels of work that have been undertaken as part of the CYPCC review programme which has also significantly reduced the levels of outstanding reviews for both 3 and 12 months. The programme has also delivered estimated annual savings of £1,054,032.

7.2 The most significant risk in this area remains the ability to recruit substantive staff with the required skill set resulting in an over reliance on agency staffing. This will be reviewed over the coming year.

8. Personal Health Budgets (PHBs)

8.1 Across Adult CHC and CYPCC there are 158 PHBs. Adults who are eligible for CHC funding have a legal right to have a personal health budget, including those in receipt of Fast Track funding.

8.2 The service has undertaken a targeted programme of work to ensure that there is greater assurance surrounding PHBs and that staff are fully trained and enabled to talk prospective PHB holders through it. Rates for personal assistants have been reviewed and a tiered rate introduced which reflects the varying complexity of individual needs.

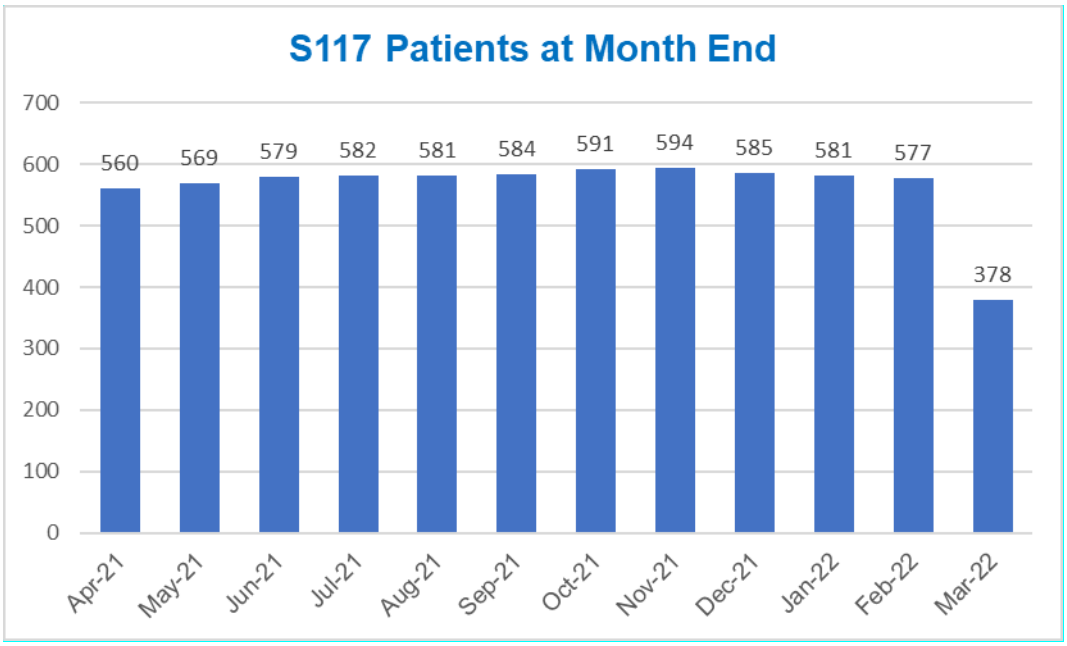
9. S117, Named Patients and Complex Rehab

9.1 There are currently 570 jointly funded Section 117 (Mental Health Act 1983) packages which is an increase of approximately 3% on the previous year. The S117 programme

has been undertaken in conjunction with local authorities and Dorset Healthcare to agree a programme of work to review these packages as well as looking at the longer-term commissioning strategies surrounding this cohort. The programme will also link with the wider system with the aim of preventing needs for detainment. The system has worked collectively to agree a pooled arrangement for S117 (effective from April 2022 for Dorset Council and NHS Dorset with Bournemouth, Christchurch and Poole Council projected to join in April 2023). Partners have agreed a hub model for oversight of S117 cases with the hub being hosted through Dorset Council. Apportionment of costs between NHS Dorset and the local authorities remains consistent.

9.2 The numbers of named patients and complex rehab patients have remained relatively consistent throughout the year. However, bed closures nationally are making it more difficult to source appropriate care for these cohorts in a timely fashion.

9.3 The graph below does not include the patients that are part of the pooled arrangement between Dorset Council and NHS Dorset which explains the significant down step in numbers at the end of March 2022.



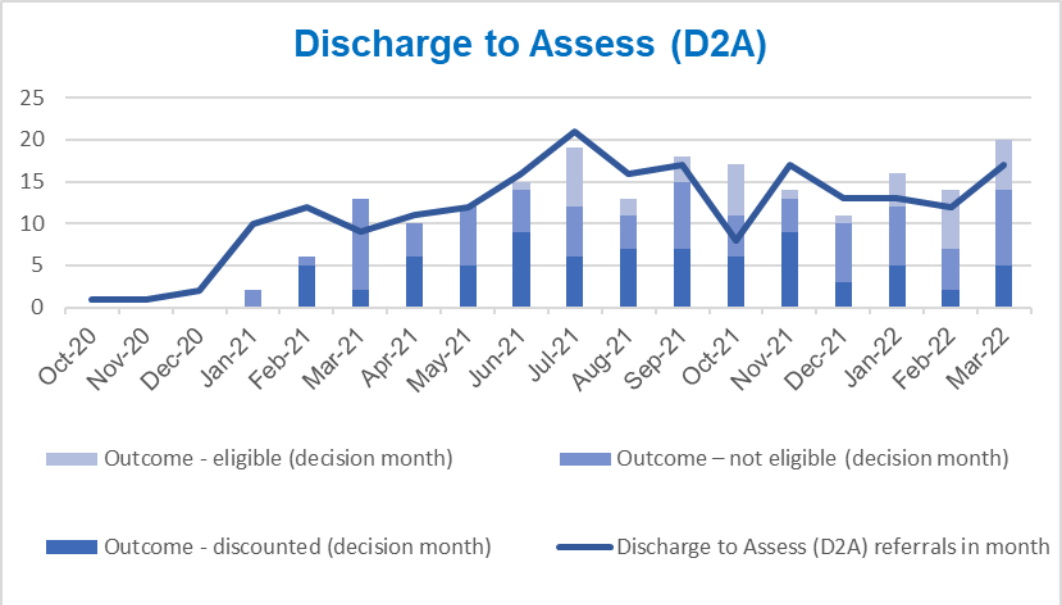
10. Joint Funding

10.1 Over the last year, the service has worked with partners to reduce the backlog of joint funding requests and to develop and agree a Joint Funding Policy for adults. This has been approved through the Joint Commissioning Board and provides the basis for ensuring a consistent approach across all applications. There are currently 82

patients across Dorset in receipt of joint funding. The coming year will see the development of an aligned policy for Children and Young People.

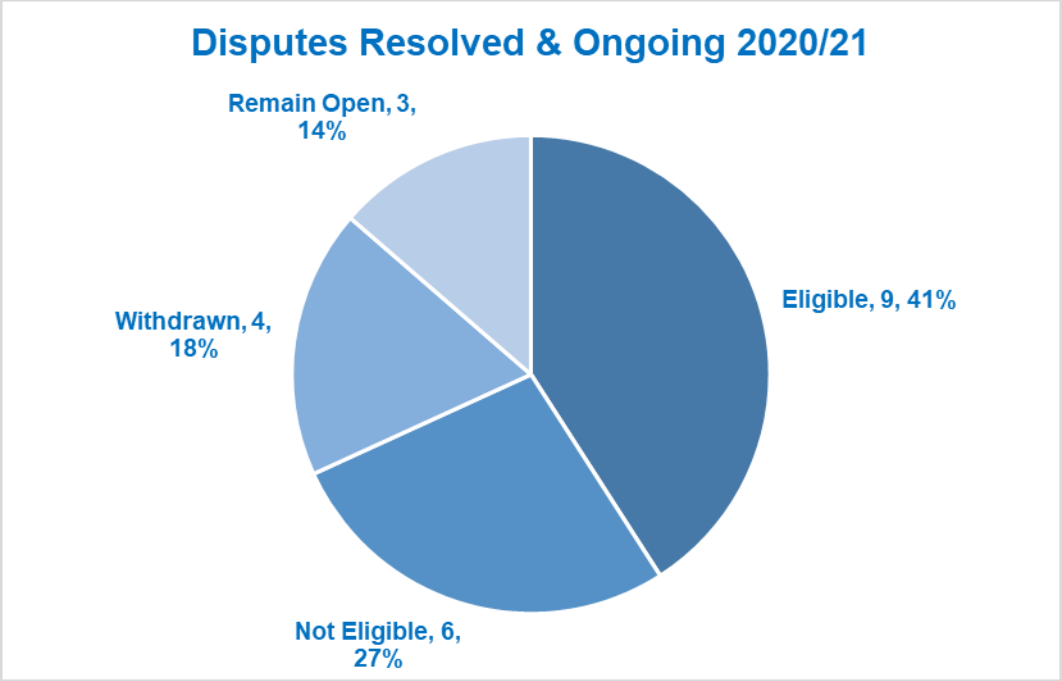
11. Discharge to Assess (D2A)

11.1 The following graph highlights the number of referrals to PHC for patients on the D2A pathway since 01 September 2020 (when it was introduced). The D2A model is still partially funded through local channels allowing up to a maximum of 4 weeks post discharge for assessments to take place outside the hospital setting where the responsible commissioner is unclear and needs cannot be met through existing services. PHC is working with partners across the system to ensure that there is a sustainable model for D2A when this funding ceases.



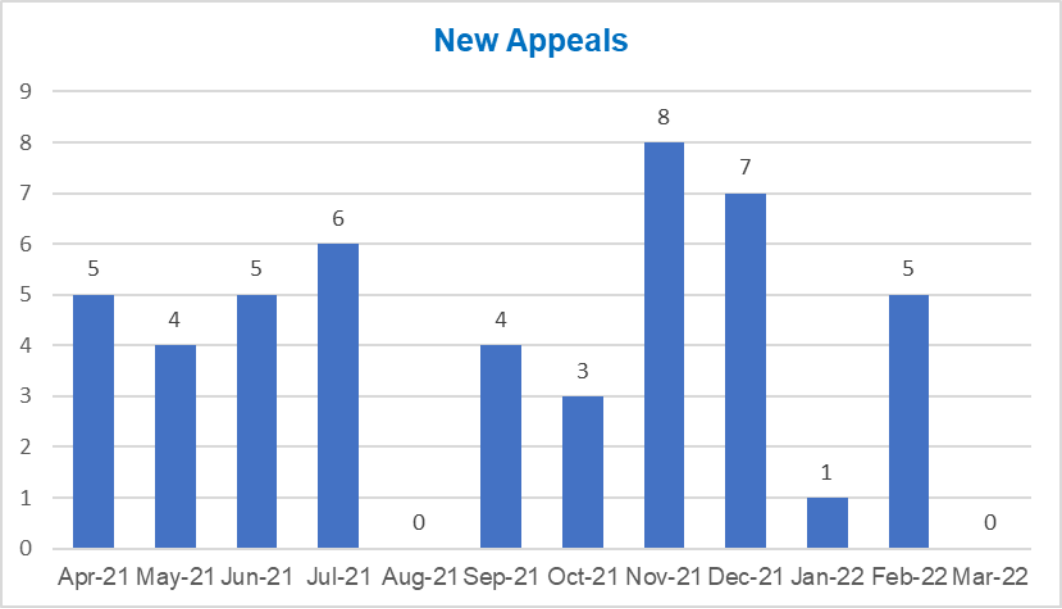
12. Disputes

12.1 The numbers of disputes outstanding at the end of the financial year was 73% lower than that of the previous year. The revised disputes protocol has assisted in ensuring that outcomes are reached swiftly and do not disadvantage the patient. There is further work to be undertaken to train staff across the system on the common reasons for dispute to reach a shared understanding of these. These are often complex areas and it is intended that independent specialists will be engaged to provide the required training. A new Joint Disputes Protocol was introduced on 01 January 2021 to better align disputes with the 28-day target. 3 disputes remained open at the end of the financial year (all stage 3). The below graph highlights the outcomes for disputes from the NHS Dorset perspective.



13. Appeals

13.1 The number of appeals received has risen slightly through the year as shown in the graph below:



13.2 The number of outstanding appeals reduced from 57 to 22 over the period with a significant proportion of these remaining as outstanding independent review panel (IRP) cases (41% of all outstanding appeals). 9 cases are currently awaiting IRP dates.

13.3 IRPs are undertaken by NHS England. There is now a significant reduction in outstanding IRPs. PHC provides resource to these panels to present Dorset CCG cases and to provide independent panel members to the IRP to hear cases from other areas.

14. Continuous Improvement, Performance and Support

14.1 The Continuous Improvement, Performance and Support has continued to lead on a number of the work programmes across the service as well as being the service lead for the transition from CCG to ICB.

14.2 The team has decommissioned IEG4 and has led on the implementation and training of staff against DRAR which is the new system for CHC referrals. Additionally, they have been working closely with operational colleagues within CYPCC to develop an electronic referral for this cohort.

14.3 The team is responsible for the logging and scheduling of process change and ensuring that staff across the service are adequately trained. There have been 19 in-house training courses available to staff over the year with full attendance at each. The ICB Learning and Development Team have arranged 41 courses which were attended by 88% of the PHC workforce attending training.

14.4 Wellbeing support has continued for staff with the comprehensive wellbeing programme to support the change in working practices and help staff manage their wellbeing both professionally and personally.

15. Priorities for 2022/23

15.1 Priorities for 2022/23 are:

- Continuing to support staff with their wellbeing and the move to a hybrid model of working.
- Continuing to work towards the NHSE 28-day standard of 80%
- Developing channels for service user feedback and incorporating this within performance monitoring
- To support the implementation of the Liberty Protection Safeguards (LPS). LPS provides protection for people aged 16 and above who are or who need to be deprived of their liberty to enable their care or treatment and lack the mental capacity to consent to their arrangements. They will introduce a new role for ICBs whereby they become the responsible body for patients in receipt

of CHC, where LPS applies. LPS replaces the Deprivation of Liberty Safeguards (DOLs). The implementation was delayed nationally as a result of COVID19 with a new date yet to be confirmed. At the point of writing this report, consultation on the new guidelines is in progress following which the full LPS guidance and implementation date will be confirmed.

- To utilise the outcomes of the Moving on from Hospital (MOFHL) programme to undertake discussions with system partners about future funding models.

- To review and design the Joint Funding arrangements for children and young people. Where an individual has clearly identified health needs that are above the lawful limits of the local authorities and cannot be met through universally commissioned services, there is a legal requirement to consider funding for these unmet health needs.

- Conclude the review programme for CYPCC and relook at roles and structures within this area to mitigate resourcing issues.

- Continue to jointly work collectively with partners for the S117 cohort to identify opportunities to reduce the costs of existing packages of support, address unit costs, and to review the scope for discharge from S117 of individuals where appropriate and safe to do so. The service will support the embedding of the hub roles and the development of performance reporting that provides assurance across partners. Further work will be required to incorporate Bournemouth Christchurch and Poole Council into the pooled arrangement effective from April 2023.

- The service will be required to align itself with the new governance structures and priorities in relation to NHS Dorset. It is particularly keen to look at areas in which the patient experience may be improved through provision via universal services. It is anticipated that this work will be scoped over the coming year.

- To continually review the digital offer in place and to continually improve processes to bring out further efficiencies via automation to free up practitioners to manage the individuals referred to PHC.

- The Commissioning priorities will be to ensure that PHC is part of system wide commissioning decisions to maximise the opportunity for commissioning to be undertaken at a system level. This area of the service has a key point of focus over the coming year on the provision of an equitable offer for specialist care for fast-track individuals and the potential of blending this with the wider end of life offer. Additionally, the service will be looking at the remaining PHC cohorts

and working with partners across the system to look at commissioning options and delivery models for these with a view to increasing stability within the marketplace.

Author's name and Title: **C Pascoe**

Date: **02/07/2022**

Telephone Number: **07919 060703**

NHS Dorset

8.10

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

ANNUAL REPORT ON CUSTOMER CARE

Date of the meeting	20/07/2022
Author	K Payne - Head of Nursing and Quality A James - Business Support Manager
Lead Director	V Read – Interim Chief Nursing Officer
Purpose of Report	To provide assurance in relation to CCG Customer Care for the year 2021/22.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	N/A
Involvement and Consultation	N/A
Equality, Diversity and Inclusion	N/A
Financial and Resource Implications	N/A
Legal/governance	N/A
Risk description/rating	N/A

1. Introduction

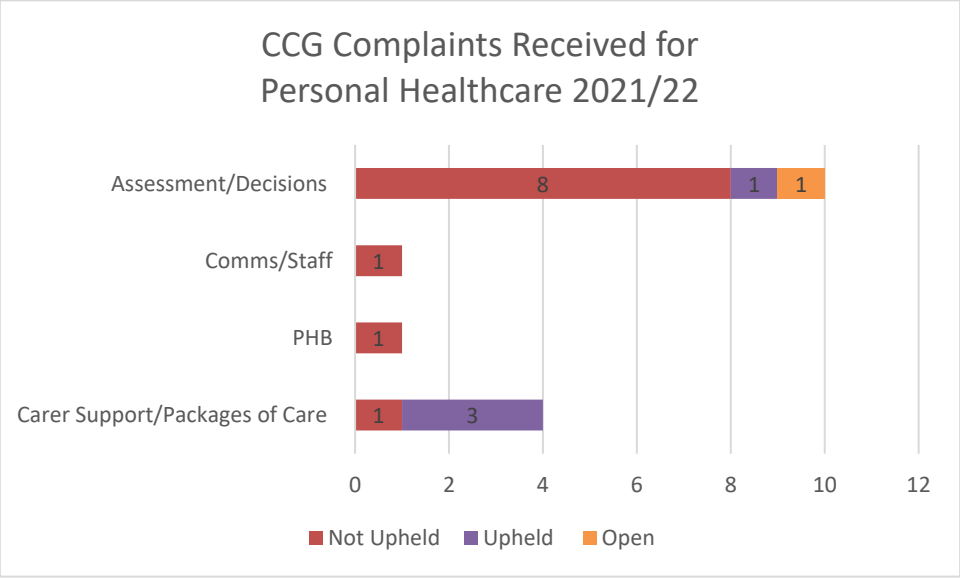
1.1 This report provides an outline of the complaints, comments and concerns received by NHS Dorset Clinical Commissioning Group (CCG) along with themes and trends noted from providers 2021/22.

2. Complaints Reported to Dorset Clinical Commissioning Group (includes those relating to the CCG plus Providers)

2.1 **Table 1** gives the number of complaints received each financial year for the last three years broken down into CCG and Provider responsibility. The significant decline in the number of complaints received is attributable mostly to the effects of the Covid-19 pandemic since 2020 and slow resumption of a lot of services over the last year.

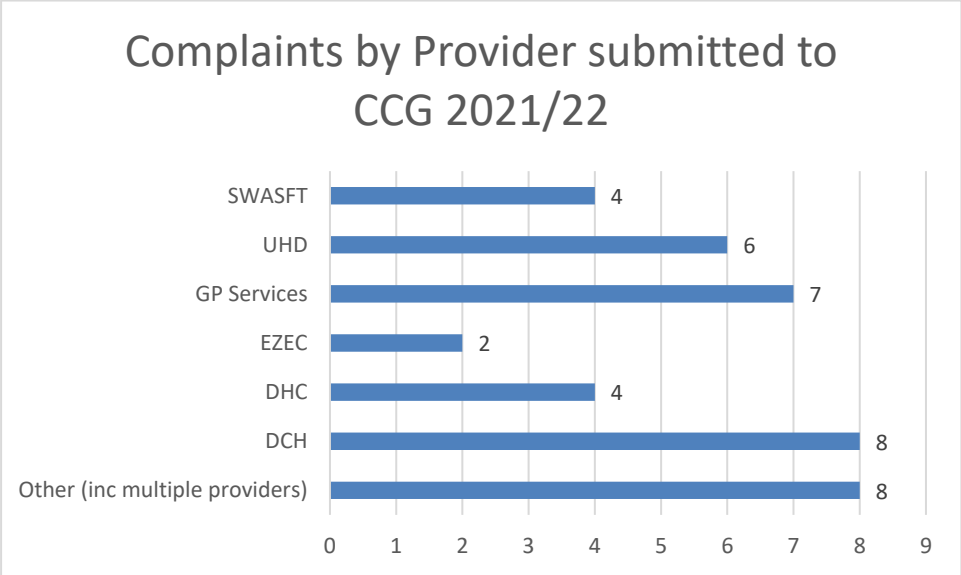
Complaints Received by the CCG Year on Year	**2019/20**	**2020/21**	**2021/22**
Total no. of complaints received	**198**	**62**	**74**
No. of complaints responded to by CCG	**92**	**33**	**35**
No. of complaints forwarded to providers for direct response	**106**	**29**	**39**

2.2 Of the 35 complaints received for the CCG to respond, six related to the vaccination programme and 17 were around Personal Health Commissioning (PHC). **Table 2** provides an overview of the themes arising from the PHC complaints with the majority being in relation to assessments and decisions made.



2.3 **Provider Complaints**

Table 4 shows the split of complaints across the main providers that the CCG were asked to forward on:



3. Compliments

3.1 Dorset CCG received five compliments from across the system, which included three specifically regarding service received from the Vaccination Centre set up at Bournemouth International Centre. All were giving praise for the standard of customer care received.

4. CCG Enquiries, Feedback and Miscellaneous Contacts

4.1 **Table 5** details the number of enquiry and feedback contacts handled in the last three years. This number has sharply risen year on year with matters relating to Covid-19 accounting for the 71% increase since 2019/20.

Enquiries, Feedback and Misc Contacts	**2019/20**	**2020/21**	**2021/22**
Total no. of logged contacts received	**496**	**632**	**848**

5. MP Letters

Table 6 shows 73 MP letters were received during 2021/22. This number includes 24 letters around Covid-19 vaccination programme and 10 regarding GP services with five of those relating to lack of face-to-face appointments. A further 10 were around access to services in general.

MP Letters Received Year on Year	2019/20	2020/21	2021/22
Total no. of letters received	**77**	**57**	**73**

6. Parliamentary and Health Service Ombudsman (PHSO)

6.1 The PHSO has requested information for a total of 9 cases with the following outcomes:

4 cases - PHSO will not be taking any further to full investigation.

3 cases - PHSO have been sent all files but have not yet let CCG know if they will proceed to full investigation.

2 cases – PHSO have been sent all files, but the CCG have also advised that it is not considered a CCG complaint. Awaiting acknowledgement from PHSO.

7. Learning From Complaints

7.1 The CCG remains committed to learning from all complaints and feedback received. Training continues to be delivered to all staff across the organisation in complaint handling legislation and best practices. There has also been a roll out of training in some processes which span the system i.e., Continuing Healthcare checklists, to improve customer experience.

7.2 With the implementation of MS Teams Telephony in April 2022 which enables call recordings, it is anticipated that this will also assist in identifying training needs.

8. Themes and Trends from Providers

8.1 All providers have seen an increase in the levels of complaints this year although they remain lower than pre-pandemic levels.

8.2 Without the usual contracting processes in place information on complaints and patient experience remains limited this year.

8.3 University Hospitals Dorset

The trust has received a total of 492 complaints this year which is an increase from last year (447) No cases were opened by the PHSO. There has however, been an increase in PALS concerns which try to resolve complaints informally. This year PALS have dealt with 5200 concerns compared to 4423 last year.

The Trust has implemented an early resolution of complaints process. This is part of the formal complaint process but is intended to provide a quicker response within 10 working days. Over the past year the Trust has also investigated 120 complaints under this process.

14% of complaints were upheld and 34% were partially upheld and 52% were not upheld. The main themes of complaints were

- clinical treatment
- consent
- privacy, dignity, and wellbeing

The key themes are consistent with PALS concerns.

The trust has consistently met the 3-day statutory acknowledgment timeline. There has been inconsistent performance with complaints being completed within agreed timescales, with different performance between sites. The average working days taken to respond has also experienced significant variance across sites with responses ranging from 35-55 days. The teams were merged, and processes aligned which has begun to reduce the variance. However, operational pressures also impact upon the ability to respond to complaints in a timely manner.

8.4 Dorset County Hospital

The Trust received 345 complaints, an increase from 298 last year. During the year 1 complaint was referred to the PHSO.

The main themes of complaints were

- consent, communication, and confidentiality
- access, admission, transfer, and discharge
- Care and welfare of patients

PALS received 727 enquires with the same key themes as complaints.

Although some complaints were not responded to within the 40 working day timescale, the complainants were contacted to renegotiate the response date and a new agreed timescale has been met where possible. As other providers the hospital has experienced extreme pressures with divisions and clinical teams prioritising clinical care which has meant that some complaint responses have taken longer.

8.5 Dorset Healthcare

The Trust received 526 complaints; an increase compared to the previous year (400). During the year, 4 complaints were referred to the PHSO. 1 case was not investigated, and 3 cases are ongoing.

PALS received 3,141 enquiries, an increase from the previous year (1959).

17% of complaints were upheld, 23% partially upheld, 31% not upheld with the remainder ongoing or on hold. The main themes are consistent with previous years. The recurring complaint themes were

- patient care
- communication
- access to treatment and drugs
- values and behaviours.

These are similar to the themes for PALS; access to treatment or drugs, appointments, communications, and patient care.

Mental Health services receive the most complaints followed by the Integrated Urgent care service and CAMHS (Child and Adolescent Mental Health Services). Analysis of the data indicates that the service areas and teams identified as receiving the most complaints is consistent with previous years.

The Trust acknowledged 98% of complaints within the statutory 3 working days. The internal response timeframe remained challenging for services during 2021/22 due to the impact of the COVID-19 pandemic, staffing challenges and increased clinical pressures. 73% of complaints were closed within the timescale agreed with the complainant

8.6 SWAST

The trust received 1405 complaints this year from a total of 1,474,717 patient contacts equating to 0.1% of patient contacts. PALS received 858 enquiries.

Of the complaints received during the reporting period, the Patient Experience team were able to close 395 on receipt. These were closed with assurances given to, and agreement from, complainants that the necessary information would be passed to the relevant operational sectors/regional service lines. The most common concern was related to access and waiting. Due to demand and hospital handover delays this is not unexpected.

Due to operational pressures, complaints relating to operational colleague's clinical care and attitude receive only a high-level review. During the pandemic, complaints relating solely to attitude were sent a standard response letter offering an apology, with recognition that the reported events did not meet the standards expected by the Trust.

With regards to clinical care complaints, the Patient Experience team has a Paramedic on light duties undertaking clinical reviews. The team then provide a written response all complainants where there is clinical care element to the complaint.

SWAST have struggled, as other providers have, to meet their statutory response timescales during the pandemic. Efforts are being made to ensure a process is in place to support the identification of learning in the most efficient

way. This includes high level clinical reviews and the targeted request for information in line with the primary concern.

Provider learning from complaints

8.7 Although providers share individual complaint learning within reports it appears the thematic analysis of complaints and other patient feedback requires further attention.

8.8 SWAST are the only provider who appear to have a forum where they which brings together learning from complaints, adverse incidents, review, learn and Improve incidents, moderate incidents, claims and inquests. Identified themes and learning are discussed and these discussions inform a number of Trust projects. In addition, key learning is reflected in statutory, mandatory and essential training programmes.

8.9 UHD have shared their aim is to present all sources of patient insight in one place to care group teams, so that all patient experience intelligence is used to learn and inform improvement plans.

8.10 As a system there does not appear to be a forum where learning from complaints and patient experience is shared between providers. This is an area that the Integrated Care System may wish to pursue in the future.

9. Priorities for 2022/23

9.1 The CCG continue to work with the Parliamentary Health Service Ombudsman in developing their Complaints Standards framework, anticipated roll out at end of 2022 (delayed due to COVID).

9.2 A renewed focus on the collection of data around equality, diversity and inclusion impact on the complaints function.

9.3 Consider developing a system level forum to share learning from complaints to improve patient experience.

Author's name and Title : **Abigail James - Business Support Manager**
Karen Payne - Head of Nursing and Quality
Date : **10.06.2022**

8.11

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT

Date of the meeting	20/07/2022
Author	L Plastow – Head of Safeguarding J West - Deputy Head of Safeguarding
Lead Director	Vanessa Read - Interim Chief Nursing Officer
Purpose of Report	This annual safeguarding report aims to inform the Integrated Care Board of the safeguarding activity for Dorset Adults and Children and to assure it that the CCG/ICB continues to meet its safeguarding statutory duties. The report is provided for NHS Dorset which comes into being on 01.07.2022 however refers to activities which took place during the time of the CCG.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	None known. The Corporate Office will also identify any individual potential conflicts of interest from the Register.
Involvement and Consultation	• The ICB Executive Lead for safeguarding (Interim Chief Nursing Officer is a statutory member of both the Adult Safeguarding Board and Children Safeguarding Partnership. • The CCG/ICB Safeguarding Team engage with NHS Providers, General Practice and Primary Care. • The CCG/ICB safeguarding Team engage with Dorset (DCC) and Bournemouth, Christchurch, and Poole (BCP) Local Authorities and the Police. Elements of public engagement are undertaken through the Adult Safeguarding Board and Children Safeguarding Partnership.
Equality, Diversity and Inclusion	Equality, diversity, and inclusion considerations for the unaccompanied asylum-seeking children from Afghanistan have been highlighted in the body of the report.
Financial and Resource Implications	There are potential financial and resource implications highlighted in this report in relation to the increased number of children coming into care.

Legal/governance	The Report reflects the legislative and statutory duties of the CCG/ICB to safeguard children, young people, and adults.
Risk description/rating	This report intends to assure the Board of any safeguarding risks and what is in place to mitigate those risks.

1 Introduction

1.1 This annual Children and Adult Safeguarding report provides an overview of safeguarding activity across NHS provided and funded services.

1.2 The purpose of this report is to assure the Board that the CCG/ICB is meeting its statutory functions under the Children Act (1989, 2004) and the Care Act (2014).

2 Statutory Duties/ Assurance

2.1 The CCG/ICB has a statutory duty under the Children's Act (1989, 2004) and the Care Act (2014) to provide assurance that all health care services commissioned, contracted, and provided have robust processes in place to identify, refer and protect both adults and children from abuse, harm, and neglect. The CCG/ICB also has a statutory duty to be involved in Safeguarding Adult Reviews (SAR) Child Safeguarding Practice Reviews (CSPR) and Domestic Homicide Reviews (DHR).

2.2 NHS Dorset CCG/ICB is compliant with its statutory requirement for children and adult safeguarding.

The CCG/ICB also monitors the effectiveness of safeguarding partnership arrangements through Bournemouth, Christchurch, and Poole (BCP) and Dorset Council (DC) QA groups which report to the PDSCP Board.

3 Safeguarding Integrated Care System

3.1 The CCG/ICB and provider safeguarding leads are working collaboratively to develop structures and procedures to support an Integrated Care System. The Dorset Health System Safeguarding Group (DHSSG) is the mechanism for delivery, current work includes developing mechanisms to share information, linking workstreams and embedding learning.

4 Safeguarding Activity

4.1 The number of adult safeguarding concerns overall continues to rise, more than 20% compared to this time last year approximately 50% of cases relate to 'neglect and acts of omission', 12% physical abuse and 9% psychological.

4.2 BCP area data (see Appendix 1- Annual Report) shows an overall increase in the number of children subject to a child protection plan, the largest increase being in the emotional abuse category of approximately 44%.

4.3 The increase in emotional abuse correlates with mental health services reporting an increase in the numbers of children being referred for their services. This position triangulates with DHC and UHD data that shows increased safeguarding activity related to emotional health in addition to the misuse of alcohol and drugs which is being seen in much younger children (10-13 yr. olds). It is commonly understood that this has been because of the effects of the pandemic on young people, the extent of which may yet to be realised.

4.4 The CCG/ICB have responded to the consultation on the 'Draft changes to the MCA Code of Practice and implementation of the LPS' no date has yet been confirmed for implementation, it is not anticipated before October 2023. The responsible body project group is planning for implementation and a health hub is under consideration, although this work is ongoing.

5. Achievements in 2021-2022 to improve safeguarding practice

5.1 Throughout 2021-22, the safeguarding team have been involved in several initiatives:

- The 'reachable moments' pathway was launched in April 2022 in University Hospitals Dorset (UHD) emergency departments (ED) to assess children attending ED, who may be being exploited.
- Operation Encompass – a system of police informing schools early with regard to domestic abuse incidents, will be extended to midwifery and health visiting in June 2022.
- A bespoke migrant health service to offer initial health assessments to unaccompanied asylum-seeking children in BCP.
- A workstream to consider and address the challenges of safeguarding in a digital world and to adapt safeguarding quality assurance to meet these new ways of working.
- Membership of the suicide prevention strategic group to facilitate and strengthen links between safeguarding, domestic abuse and suicide prevention.

- The voice of our Children in Care and Care Leavers has been achieved via consultation through both BCP and DC Children in Care Councils, Corporate Parenting Boards and providers feedback questionnaires.
- A bespoke 'prevent' training package specifically tailored around the vulnerabilities of unaccompanied asylum seekers is being developed between CCG/ICB staff and the police.
- GP Safeguarding report response rate has increased from 25% to 70% following the introduction of the safeguarding CCLIP.
- The Dorset Insight and Intelligence Service (DiiS) has worked with safeguarding to develop a population-based safeguarding and inequalities dashboard. Work to develop this into a multi-agency dashboard continues.
- All safeguarding information is now captured on Ulysses Safeguarding module and data is now available to provide better analysis and provide a monthly activity report.
- Dorset have led on the regional NHSE implementation of 360 Skills for Life virtual platform to support children and young people to make safe decisions and is particularly relevant to child and criminal exploitation.
- The CCG/ICB safeguarding Team have developed a General Practice Domestic Abuse Toolkit.
- The CCG/ICB Adult Lead has resurrected the Dorset wide Prevent Network for health to raise the profile and improve referral rates.

Further information on these achievements can be found in the Annual Report (Appendix 1)

6. Challenges

6.1 Along with achievements there have been challenges, some of which are linked to the ongoing pandemic throughout this reporting period:

- Compliance rates for safeguarding mandatory training dropped during covid, action plans are in place and compliance is improving across all providers.
- There continues to be a significant pressure on acute trusts from the number of young people presenting with complex needs. Often there is delay finding suitable placements once the young person is fit for discharge. The Children with Complex Needs task and finish group has been established to address this issue.
- There is an identified need for trauma informed specialist support for children in care and care experienced young people.
- The areas of most concern during recovery from the pandemic are the impact of 'Hidden Harm' and the effect on emotional wellbeing and mental health. A covid action plan has been developed.

- The Violence and vulnerability unit: Locality Review Bournemouth (March 22) report describes an established local issue around criminal exploitation, drug dealing, county lines, cuckooing, wounding, knife crime.

7. Safeguarding Adult Reviews (SAR)/Children's Safeguarding Practice Reviews (CSPR's) /Whole Service Reviews/ Domestic Homicide Reviews

7.1 Due to the confidential nature of these statutory reviews a separate report is presented in part two of the Board.

8. Conclusion

8.1 The CCG/ICB continues to maintain its statutory obligations and focus on safeguarding across Dorset's healthcare system.

8.2 Inevitably COVID -19 has continued to impact on safeguarding throughout this year, with the impact of hidden harm and on emotional / mental health being realised.

8.3 The priority focus for the next year will be to align with the PDSCP and SAB priorities. In addition, delivering on and further strengthening, quality assurance of safeguarding across health services at the same time as creating safeguarding metrics in the Dorset Intelligence & Insight system to better inform commissioning and identify safeguarding themes and trends.

Author's name and Title : **Liz Plastow, Head of Safeguarding**
Janice West, Deputy Head of Safeguarding
Date : **29.06.2022**

APPENDICES	
Appendix 1	**|Annual Report Safeguarding Children and Adults**

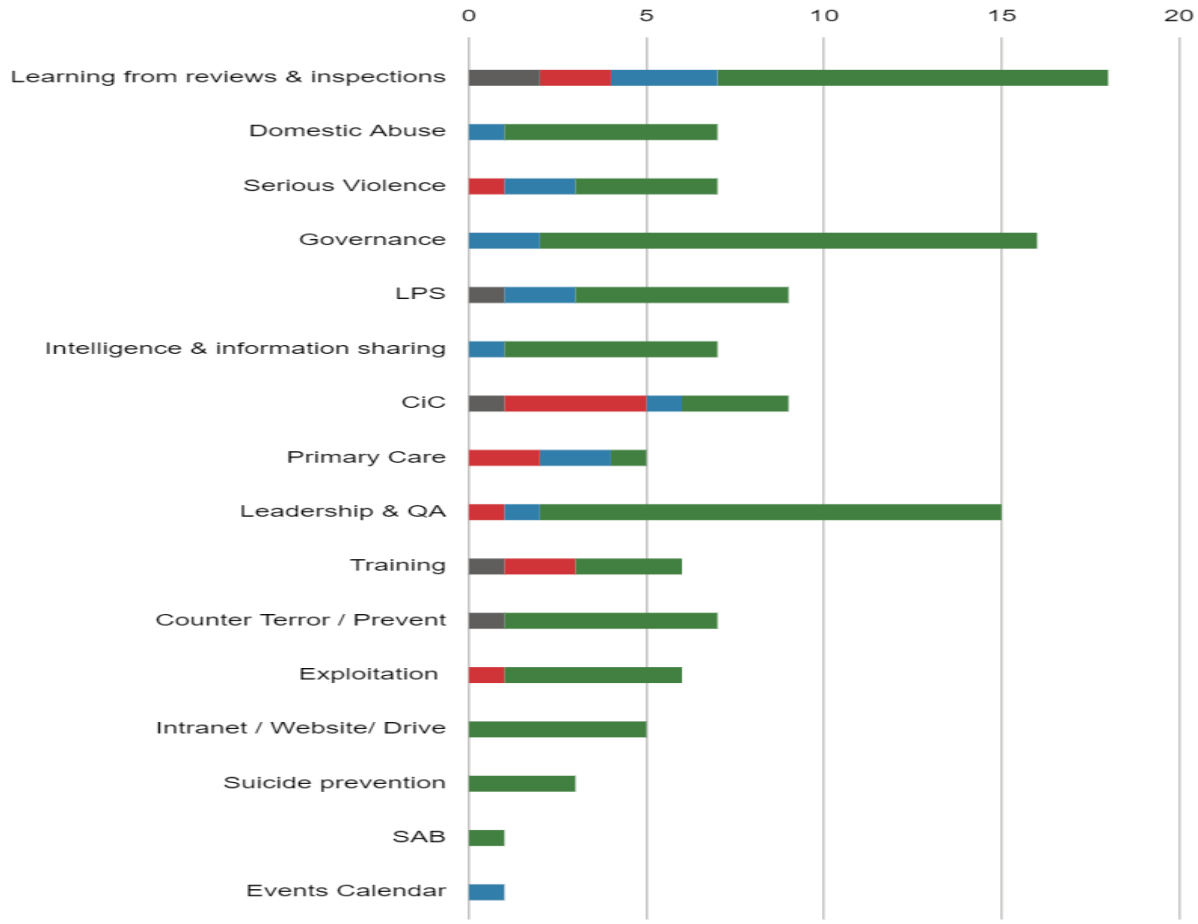
NHS Dorset

SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT 2021/22

1. Introduction

This bi-annual Children and Adult Safeguarding report provides an overview of safeguarding activity across NHS provided and funded services.

The purpose of this report is to assure the Governing Body that the CCG/ICB is meeting its statutory functions under the Children Act (1989, 2004) and the Care Act (2014).



Graph: snapshot of safeguarding workstreams

The diagram above shows the headings under which the CCG/ICB safeguarding team workstreams are set. The majority of the work relates to learning from reviews and inspections, governance and leadership / quality assurance work.

2. Statutory Duties

The CCG/ICB has a statutory duty under the Children's Act (1989, 2004) and the Care Act (2014) to provide assurance that all health care services commissioned, contracted and provided have robust processes in place to identify, refer and protect both adults and children from abuse, harm and neglect. The CCG/ICB also has a statutory duty to be involved in Safeguarding Adult Reviews (SAR) Child Safeguarding Practice Reviews (CSPR) and Domestic Homicide Reviews (DHR).

The CCG/ICB safeguarding team has developed and implemented an annual quality assurance (QA) cycle through which assurance is sought that safeguarding is integral to service delivery and development across provider services. This includes having assurance that provider governance and reporting mechanisms are in place in line with the NHSE Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019). The Section 11 audit has commenced and will be summarised in the next report. The CCG/ICB also monitors the effectiveness of safeguarding partnership arrangements through Bournemouth, Christchurch and Poole (BCP) and Dorset Council (DC) QA groups which report to the PDSCP Board.

The Serious Violence Duty places a statutory duty on a range of authorities including local health boards to collaborate to prevent and reduce serious violence in the area. CCG/ICB safeguarding and information governance have been engaged in the development of a SW regional information sharing agreement in relation to this duty. Partnership work has commenced to formulate an evidence-based analysis of the problems associated with serious violence in the area, in order to produce and implement a strategy. The CCG/ICB safeguarding team are a core member of each area violence reduction strategic group through which this work is being progressed. This duty brings an obligation to conduct serious violence reviews, commencement date and guidance are awaited.

The Domestic Abuse Act 2021 provides for a statutory domestic abuse perpetrator strategy. The DRIVE programme was implemented in 2021 with health representation and outcome data will be reported via the Police when available. The CCG/ICB is a core member of both Local Authority area domestic abuse strategic groups and providers are engaged across the local DA frameworks, feeding back through the Dorset Health System Safeguarding Group (DHSSG). The QA of domestic abuse activity is distinct in the CCG/ICB QA cycle, which includes the quality of training.

The Section 11 (Children Act, 2004) audit will be conducted over Q4 21/22 and Q1 22/23. This audit seeks assurance that providers are meeting their statutory responsibilities. Outcome of this audit will be included in the next annual report.

3. Safeguarding Integrated Care System

The CCG/ICB and provider safeguarding leads are working collaboratively to develop structures and procedures to support an Integrated Care System. The Dorset Health System Safeguarding Group (DHSSG) is the mechanism for delivery, current work includes; developing mechanisms to share information, linking workstreams and embedding learning.

The current Safeguarding policy has been jointly rewritten by provider services as an overarching document, facilitated by the CCG/ICB. The intention is that, each provider has their own variation that sits alongside it.

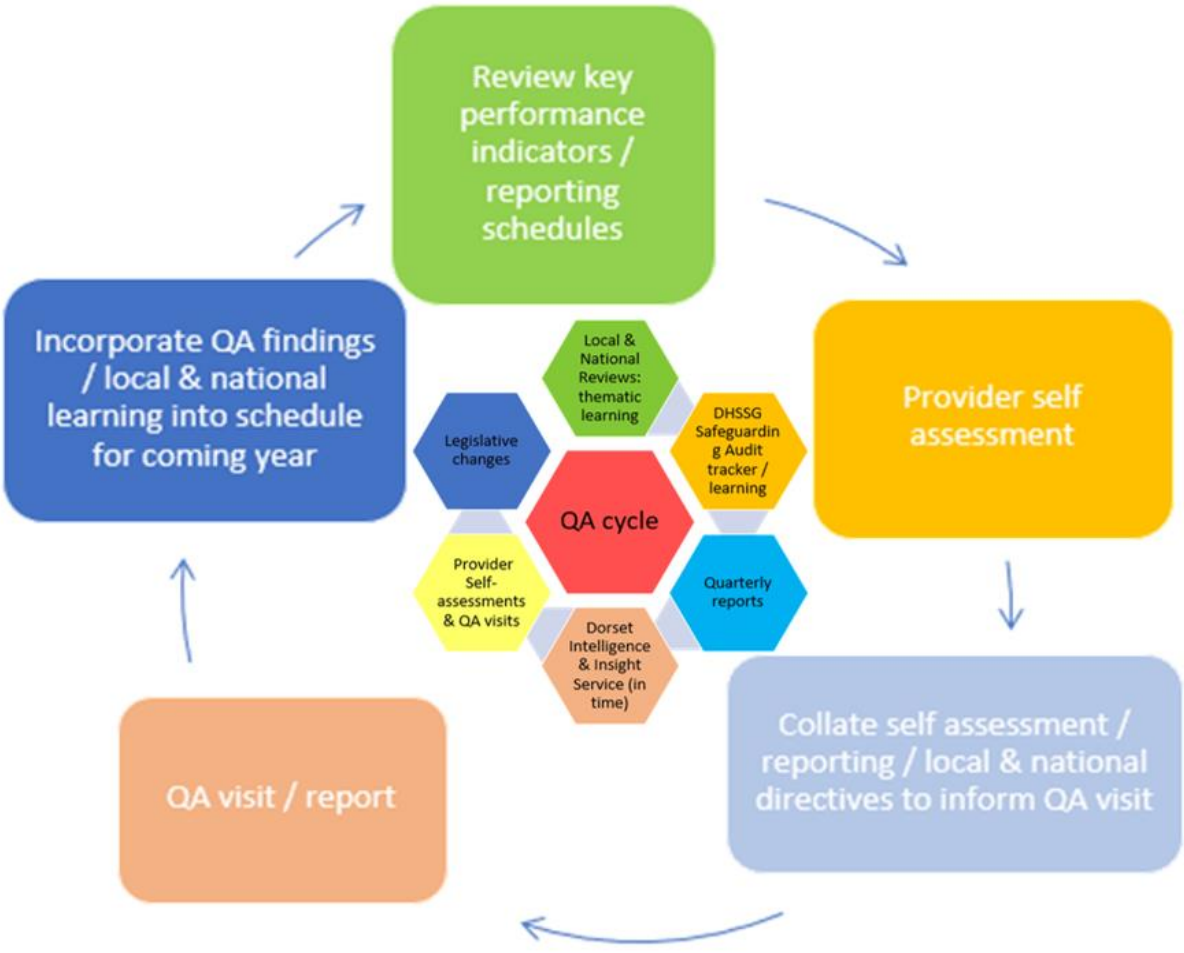
The transition to place-based models is currently having a resource impact on safeguarding as there are now two Quality Assurance groups, two Child Safeguarding Practice Review Panels, and Learning Hub Arrangements in both council areas in place of single Pan-Dorset meetings. A safeguarding ICS matrix approach to managing this is in development in tandem with strategic discussion regarding alignment opportunities.

4. CCG/ICB Safeguarding Assurance

Dorset CCG/ICB is compliant with its statutory requirement for children and adult safeguarding.

The CCG/ICB safeguarding team have reviewed all NHS and Independent provider performance indicator (KPI) dashboards and refreshed with updated standards compliant with the 22/23 NHS contract, NHSE Safeguarding Commissioning Assurance Toolkit and the Intercollegiate documents, and is compiled under CQC quality headings (see appendix 3).

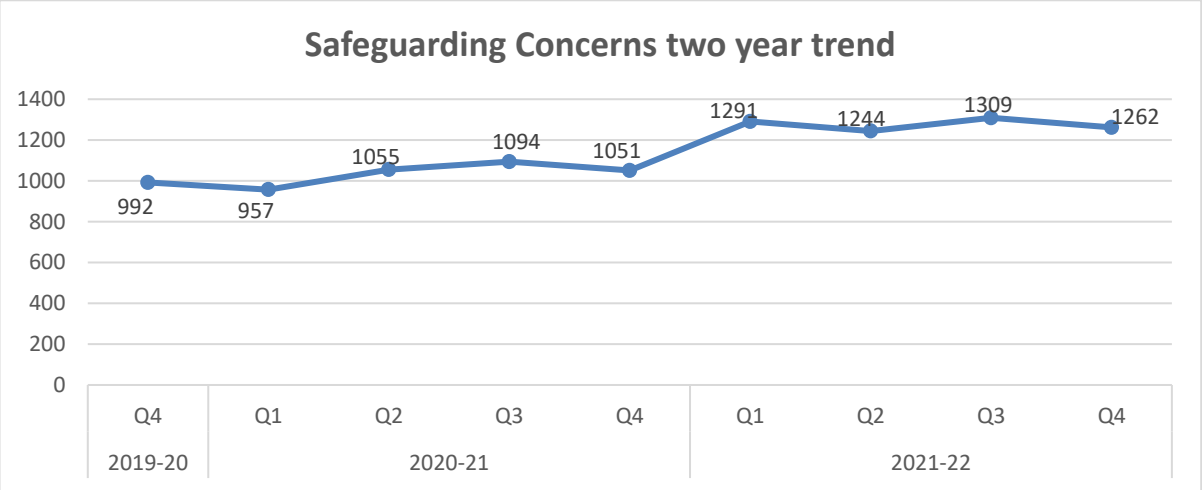
The KPIs, thematic learning from reviews, audit findings and any legislative changes will feed into the newly developed annual safeguarding QA cycle, shown below.



A guidance document and guide to quality assurance visits has been developed (see appendix 4).

5. Adult Safeguarding

DORSET Adult Safeguarding activity



There has been a significant increase in the number of Safeguarding concerns progressed to Sec 42.1 enquiry in Dorset since September 2021 which is, in part, as a result of a new process to progress all safeguarding concerns related to medication errors & falls, to enquiry, during Q4 these accounted for 22% of concerns received.

However, the number of adult safeguarding concerns overall continues to rise, an increase of more than 20% compared to this time last year.

Data on section 42 enquiries in 2021/22, reveals that the type of abuse in approximately 50% of cases is 'neglect and acts of omission', 12% physical abuse and 9% psychological. 52% of abuse occurred in the client/ patient's own home, 38% in a care home (residential and nursing).

Provider data is analysed and shared with the Safeguarding Adults Board (SAB) Quality Assurance group to monitor safeguarding activity across the whole landscape. Data reporting to the SAB is currently under review to ensure that the data health services provide is purposeful.

DHC dashboard shows a continued increase in the number of calls from staff requiring adult safeguarding advice, although these calls do not necessarily result in a safeguarding referral it is a consistent trend at all levels of the work.

The CCG/ICB Adult Safeguarding Lead works with the patient safety team and quality improvement team to cross reference concerns and strengthen a shared understanding of the safeguarding / quality improvement interface.

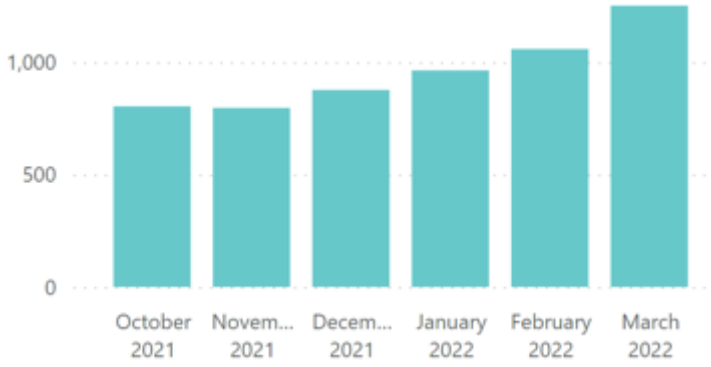
Police inform all Partners of incidents where a police public protection notice is issued in order to pro-actively safeguard individuals, work has commenced to improve the communication of these notices to Primary Care.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

The CCG/ICB have responded to the consultation on the 'Draft changes to the MCA Code of Practice and implementation of the LPS' no date has yet been confirmed for implementation, however it is not anticipated before October 2023. The responsible body project group is planning for implementation and a health hub is under consideration, although this work is ongoing.

An E-learning module will be provided by NHSE with six competency levels across health and social care and it is understood the IT requirements for implementation of the national minimum dataset is also being led by the National safeguarding team.

6. Children Safeguarding



Graph: Number of cases on SystmOne showing a Safeguarding children flag (from DiiS)

BCP area data (see appendix 1) shows an overall increase in the number of children subject to a child protection plan, the largest increase being in the emotional abuse category of approximately 44%. Neglect has consistently remained highest although monthly variation is seen, there is no significant increase or decrease in neglect. Physical & sexual abuse figures have also stayed relatively the same across the year although we know there are age disparities in these two categories in particular, the data available does not describe this.

The increase in emotional abuse correlates with mental health services reporting an increase in the numbers of children being referred for their services. It is commonly

understood that this has been because of the effects of the pandemic on young people, the extent of which may yet to be realised.

This position triangulates with DHC and UHD data that shows increased safeguarding activity related to emotional health in addition to the misuse of alcohol and drugs which is being seen in much younger children (10-13 yr. olds).

DHC also saw a significant 54% increase in safeguarding advice requests from the health visiting service in Q4 and suggest this may be due to workforce issues across both CYP services and CAMHS.

Both acute hospitals and primary care report, after an initial dip in the first lockdown, increasing numbers of referrals into their services for children and young people. They have developed new pathways for the most at risk under ones and non-mobile baby group, to ensure that correct safeguarding procedures are followed for every child attending emergency departments and improvements to communication pathways is made between acute, community and primary care.

There continues to be a significant pressure on acute trusts from the number of young people presenting with complex needs. Often there is delay finding suitable placements once the young person is fit for discharge. The Children with Complex Needs task and finish group has been established to address this issue.

7. Child Exploitation (CE)

Both Local Authority areas have strategic / operational arrangements to tackle child exploitation in the local area. It is of note that the 'Violence and Vulnerability Unit: Locality Review Bournemouth (March 22)' report calls for greater alignment of these models.

In BCP, Children's Services have published a Multi-Agency Child Exploitation Improvement Plan (CEIP) 2020-2023, which focuses on four priority programmes of Prepare; Prevent; Protect and Pursue. The CCG/ICB and health are working with BCP to support this. The CCG/ICB is a core member of BCP CE strategic group.

Dorset Council have implemented the Harbour Project which provides multi-agency intensive support in response to the complex needs of young people at risk of exploitation. Health services 'reach in' to this project.

The 'reachable moments' pathway launched in April 2022 in University Hospitals Dorset (UHD) emergency departments to assess children attending ED who may be being exploited and enables a referral for a 'reachable moment' whilst in the department. This is in response to national findings that there are missed

opportunities in healthcare settings to engage with young people, especially those that are hard to reach. The findings from this project will be reviewed and further roll out considered.

NHSE have contributed to the funding for a '360 Skills for Life' Digital Programme which is hosted by Dorset CCG/ICB. This programme supports children and young people to understand the consequence of decisions they make related to exploitation, county lines and serious violence.

8. Multi-Agency Safeguarding Hub (MASH)

The refreshed service specification for health MASH has been incorporated into provider contracts for 2022/23.

DC and BCP Councils have redesigned their MASH / front doors, moving towards place-based models. Whereas Police and Health continue to work to Pan-Dorset models. A programme of work is underway to review how all partners can effectively work in a place-based model across the partnership.

After an initial decrease in MASH activity during covid lockdown there has been a significant increase in MASH work since restrictions were lifted with some quarters data revealing increases of 30 – 35%. However, although the increase is seen across both Local Authority areas the workload is more heavily weighted towards BCP.

9. Children in Care (CiC) / Care Leavers (CL)

There has been significant progress in building effective partnership working with providers, local authorities, other agencies and the voluntary sector in order to inform the focus of health provision, work is ongoing in tracking trends and impact.

The voice of our CiC and CL population informing future commissioning arrangements has been achieved via consultation through both BCP and DC Children in Care Councils, Corporate Parenting Boards and providers feedback questionnaires shared with the Designated Nurse.

Over 60 adult (home office assessed) Afghan immigrants were placed in Bournemouth hotels who were subsequently declared as children and therefore taken into care by BCP Council. 50% have been placed out of area, for which Dorset CCG/ICB remain accountable for meeting their health needs.

To date fourteen unaccompanied asylum-seeking children have been placed under the care of Dorset County Council, a 120% increase from April 2021. This has put significant pressure on both the Children in Care team (DHC) and the medical IHA service.

A bespoke migrant health service has been implemented to offer initial health assessments to 60 unaccompanied asylum-seeking children in BCP, this is planned to be completed by end July 22.

In addition, there has been an increase (8%) in the number of resident children coming into care, and alongside the refugees this is impacting on the Children in Care team who are responsible for ongoing health assessments and meeting all identified health needs. Inequality remains when children are placed out of area, for although the CCG/ICB remain accountable for them having their health needs assessed and met, it is the area where they are placed who are responsible for carrying out the actions, whereas children placed in Dorset by other local authorities are offered a health assessment as requested in a timely way.

Emotional health and wellbeing remains high on the agenda for children in care and care experienced young people, nationally there is a lack of provision for children requiring therapeutic placements and a lack of scrutiny in what these placements offer from a mental health perspective. This often leads to inappropriate hospital admissions and long stays in acute settings until a suitable placement can be found. Their behaviour if often in response to emotional dysregulation as a result of the adverse childhood experiences they have suffered but are wrongly considered to be mentally ill and requiring CAMHS support.

10. The Impact of Covid

Covid-19 has had a significant impact on health partners with increased staff sickness, ongoing impact on service delivery and outbreaks seen in nursing and care homes.

Whilst safeguarding staff have not been re-deployed the CCG/ICB safeguarding team have supported the vaccination programme where able and offered support to providers.

The areas of most concern during recovery from the pandemic are the impact of ‘Hidden Harm’ and the effect on emotional wellbeing and mental health.

A covid action plan has been developed, in response to national ministerial directives, for health services and shared with statutory partners (see appendix 2).

During the pandemic health services found innovative ways of engaging with families and vulnerable adults through digital means. Some of these digital solutions are likely to become embedded in service delivery and more services are being developed using digital platforms. The CCG/ICB safeguarding team has developed a workstream to consider and address the challenges of safeguarding in a digital world and to adapt safeguarding quality assurance to meet these new ways of working.

11. **Domestic Abuse (DA)**

The CCG/ICB and provider partners continue to work to the BCP Community Safety Partnership Domestic Abuse Strategy 2020 – 2023.

The police have recorded a 5% increase in DA offences from last year (National Crime Survey 2021). Data from victim services suggests that experiences of domestic abuse intensified during periods of national lockdown and that victims faced difficulties in safely seeking support under these conditions.

In BCP, Multi-Agency Risk Assessment Conferences are held every week and Dorset HealthCare NHS Trust provide a health representative. Although there has been a slight overall drop in cases by 6% there was a significant rise in the months of January, February, and March 2022 as a likely impact of lockdown; 56% of all cases were linked to children which gives an indication of the impact of DA on child safeguarding / children services.

In Dorset the High-Risk Domestic Abuse (HRDA) model is used for managing high risk domestic abuse cases, this meets daily to address the most high-risk cases. The CCG/ICB provide a HRDA chair monthly. The CCG/ICB has fulfilled its statutory duty to be involved in all Domestic Homicide Reviews locally, the learning from which is embedded in the QA cycle as described.

There are a number of initiatives nationally and locally to strengthen our response to DA:

- The Department of Health and Social Care, NHS England and NHS Improvement and the Ministry of Justice are working collaboratively to ensure alignment between Integrated Care Systems (ICSs) in health and social care in England, and victim support services for victims and survivors of domestic abuse and sexual violence, the Government will be investing up to £7.5 million in healthcare settings over the next three years.

- Locally several of the Domestic Homicide Reviews have been related to suicide, a CCG/ICB safeguarding professional now sits on the suicide

prevention strategic group to facilitate and strengthen links between safeguarding, domestic abuse and suicide prevention.

- UHD & DCH have recruited a Domestic Abuse advocate with the aim of ensuring that victims get the right support at the time of attendance.

- Public Protection notices for domestic abuse incidents in which there are linked children have increased by approximately 15% in the quarters following the easing of restrictions. There are ongoing discussions with GPs and the police on how the RAG rating system can be used to prioritise their response.

- Operation encompass has commenced to expand the dissemination of PPNs to Dorset Schools (BCP area this is already in place). The project was launched in April 2021, phase two is a proposed expansion to early years settings in June 2022, there is no formal evaluation of this project to date.

- The DRIVE perpetrator programme was implemented in Dorset during March 2021. This programme is aimed at helping perpetrators of domestic abuse rehabilitate their behaviours. Dorset police have secured funding for this programme to continue, evaluation data is awaited, DHC Criminal Justice Liaison and Diversion Service have a representative on the programme.

12. PREVENT

'PREVENT' is a national government initiative to safeguard individuals from being drawn into terrorism and ensuring those vulnerable to extremist and terrorist narratives are given appropriate advice and support at an early stage. In the Southwest, the most prevalent category is risk from online radicalisation and far-right extremism and data shows this involves an increasing number of young people.

All NHS providers submit quarterly PREVENT data to the Home Office. Training compliance for basic awareness training across Dorset fell during covid and is being closely monitored with Providers. Level 1 & 2 compliance has recovered to target levels across all Providers as has Level 3 excepting DHC which dropped to 59.7% in Q4, DHC have made this a priority (see training section). Although referrals are low, for health they are mostly from DHC mental health practitioners.

The Pan-Dorset Prevent Partnership co-ordinates work with our partners to deliver on the PREVENT agenda and feeds into the Regional Prevent Network. The number of referrals from health remain low, as are referral numbers overall. In the absence of a formula to work out how many referrals should be expected it is difficult to measure but more likely than not it should be higher. Work is ongoing with partners to update and review training offers and raise the profile with all staff groups. The

CCG/ICB Safeguarding Team have set up a quarterly health prevent leads meeting to progress this agenda.

Channel Panels are now held in each Local Authority area. Referrals are managed in line with national protocol and multi-agency action plans formulated. Case numbers are low but assurance has been gained through partnership working under the Contest Board that conversion thresholds from Prevent to Channel Panel are appropriate. Most cases reaching Panel involve right-wing extremism and predominantly are young people under 18 years which reflects the Southwest picture.

Operation Spotlight, Dorset Police counter terrorism group has been re-established following Covid and CCG/ICB Safeguarding team have a standing representative on this group. There is a growing recognition of the important role that health can play in 'prevent', 'pursue', 'protect' and 'prepare' aspects of the work.

13. Serious Violence, Modern Day Slavery and Human Trafficking

The Violence and vulnerability unit: Locality Review Bournemouth (March 22) report describes an established local issue around criminal exploitation, drug dealing, county lines, cuckooing, wounding, knife crime. The problem is said to have increased during and after lockdown, with a younger cohort of local young people involved and actively recruited by local and external groups.

There has been an increase of over 50% of young people from out of area presenting at hospital emergency departments with wounds. In addition, there has been an increase of younger people, aged 13 years upwards presenting in ED with drugs, alcohol and trauma issues.

Modern Day Slavery and Human Trafficking remains a priority for the wider community although there have been a small number of reported cases of trafficking across Dorset.

A Modern-Day Slavery and Human Trafficking Network has been re-established in the SW region; our Designated Nurse for Children in Care represents the CCG/ICB.

Work to address and reduce criminal exploitation and violent crime takes place across several partnerships in Dorset, (CSP, Safeguarding Boards, Serious Organised Crime Boards, CCG/ICB etc), the CCG/ICB are working with partners to ensure cohesiveness and single strategic direction is in place to avoid the potential duplication of resource and activity.

14. Sexual Violence / Violence against women and girls

The National Crime Survey shows that the number of sexual offences recorded by the police increased by 12% in the year ending September 2021 compared with the same period in the previous year. This is the highest number of sexual offences recorded within a 12-month period.

Violence against women and girls is a PDSCP priority and a priority of the CSP violence reduction strategy. The CCG/ICB and provider safeguarding leads will be working to this priority over the coming year, an update will be provided in the next report.

15. Female Genital Mutilation (FGM)

There has been no reported cases of a child being subject to FGM during last twelve-month period. Data continues to be reported to NHSE.

16. Safeguarding Training

Safeguarding training was delivered virtually during the pandemic and implemented at pace. This is now returning to face-to-face classroom teaching or a blended approach. Compliance rates for safeguarding mandatory training dropped during covid because of a combination of the suspension of face-to-face sessions and workload pressures on health staff. The CCG/ICB are closely monitoring this situation, action plans are in place and compliance is improving across all providers and have largely returned to pre-pandemic level, except for Prevent training in DHC. The Prevent Health Leads group will closely monitor compliance of Prevent training and action plans for improvement.

The CCG/ICB is working with police to develop a bespoke prevent training package specifically tailored around the vulnerabilities of unaccompanied asylum seekers. It is anticipated that this will be delivered initially to health staff conducting IHAs but can then adapted and shared with Children Social Care staff.

Mandatory safeguarding training for CCG/ICB staff is compliant with 90% target and all staff roles have been mapped against the Intercollegiate Document.

The CCG/ICB Head of Safeguarding provided the annual training update to the Governing Body in February 2022. A rolling programme of training for primary care is in place and updated in response to trends in safeguarding and learning from

statutory reviews. A Review of the CCG/ICB commissioned L3 training for GP's is a current workstream for the safeguarding team.

17. Named Safeguarding Lead GPs

The Commissioning Care Local Improvement in Practice (C-CLIP) finishes in April 2022. All practices have been offered quality assurance visits with all but a small number of practices that require visits rearranging, and one practice that has failed to respond. All practices who have been reviewed have adapted their reports to meet the advised style and contact which has been extremely positive. Response rates can only be calculated using Dorset data due to the unfortunate ceasing of accurate information being shared by BCP. This has now been resolved and will resume this financial year. Based on Dorset Council Figures, when removing surgeries which are out of county or where no GP has been listed on the council data, the response rate has increased to 70%. This is a big improvement from the 25-35% prior to the introduction of the safeguarding aspect of the CCLIP

For 2022/2023 collaborative fees arrangements are taking place to continue funding and quality assurance to maintain the quality and response rates of child protection conference reports. This process has been agreed with both BCP and Dorset Council.

The Safeguarding Dashboard development is moving forwards with good 'buy in' from multi-agency partners now to the task and finish group. This dashboard should allow us to work as an ICS to track themes, trends and highlight areas with increased safeguarding demand, to help guide service provision and future commissioning decisions.

Bi-annual GP peer supervision sessions continue to allow local GPs to update their safeguarding skills to level 3 for both adults and children safeguarding. Sessions have been tailored based on feedback.

The Named GPs have authored the primary care reports for all DHRs, CSPR's and Rapid Reviews providing knowledge and expertise to the panels. Key learning is then fed back and shared accordingly.

The 2022, Primary Care Section 11 audit including adult standards has been prepared. This is a 3 yearly audit and will follow the same structure as 2019 and created with NHS England Southwest. It allows the safeguarding team to quality assure practices that they are maintaining safeguarding practises and are aware of recent changes to local safeguarding practice. The results will be analysed to guide future training and identify areas of discussion within the annual safeguarding practice visits.

Dorset Named GPs continue to be involved with the Southwest Named GP Network in order to share good practice as well as raise any identified areas of improvement/concerns within Dorset or feedback and act on those identified elsewhere to reduce any potential risks. We are also strengthening links with NHS-E initiatives to ensure Safeguarding is an active partner and any risks from a Primary Care perspective are mitigated. Current work streams are: Online GP Registrations and access to online patient records.

18. Safeguarding Adult Reviews (SAR)/Children's Safeguarding Practice Reviews (CSPR's) /Whole Service Reviews/ Domestic Homicide Reviews

Due to the confidential nature of these statutory reviews a separate report is presented in part two of the Governing Body Report.

There are currently eight ongoing Domestic Homicide Reviews (DHR), with one pending coroners' decision.

Themes from reviews are collated bi-annually and feed into the Quality Assurance cycle.

Learning from DHRS:

- Domestic Abuse training to be embedded.
- Routine enquiry and professional curiosity to become daily practice.
- Awareness of domestic abuse in the primary care setting.
- Evidenced based approach to identification and management of domestic abuse.
- Commission a perpetrator programme.
- Health information for MARAC to be provided.
- Domestic abuse policies to incorporate a whole family approach.
- Ensure records are contemporaneous.
- Trigger questions added to case recording systems to ensure domestic abuse is captured in the records.
- Improve how services work together across the whole ICS.

Domestic abuse appears to be a causative factor in all statutory reviews (CSPR, SAR and DHR) in addition application and understanding of the mental capacity act, abuse by minors with adverse childhood events on members of extended family and sharing information across agencies feature in SAR's. There was specific learning in relation to intra-familial abuse of children, contextual safeguarding, vulnerabilities of under ones and the importance of connecting adverse childhood events throughout the young person's life, in CSPR's.

The CCG/ICB led on a multi-agency Pan Dorset response to the national publication Myth of Invisible Men (2021) , which focused on safeguarding children under 1 from non-accidental injury caused by male carers. It identified in Dorset there is good work being delivered by health providers, but resources such as the Dads Pad are not well utilised.

The National panel report in response to the tragic deaths of Arthur Labingjo-Hughes and Star Hobson was published late May 2022. The CCG/ICB safeguarding team is working to identify the learning form these cases for health and any required actions / national recommendations with partners.

19. Serious Incident Investigations/ Managing Allegations

All serious incident investigations are triangulated with any safeguarding requirements via Ulysses. All health providers continue to take their own responsibility for managing allegations of staff, whilst the CCG/ICB report any allegations from Primary Care into NHS England for review in line with the Performers List requirements.

20. External Inspections and Reports

In DC the recommendations and requirements from previous Ofsted and SEND inspections were incorporated into the Strengthening Services Plan. Any outstanding actions from this Plan have been incorporated into the Children and Young Peoples Strategic Alliance. A further SEND inspection has been conducted by OFSTED end April 22 and the outcome is awaited.

DC received outstanding for Leadership and an overall grade of ‘Good’ at their recent Inspecting Local Authority Children’s Services inspection, (ILACS). BCP Local Authority had an ILAC’s inspection in December 2021, the outcome was ‘inadequate’ and the CCG/ICB are working with BCP Local Authority on their improvement plan.

21. NHS England Southwest South Safeguarding

The CCG/ICB are represented on several workstreams led by NHSE SW. These include:

- Southwest Safeguarding Steering Group.
- Southwest Regional NHS Prevent Leads Network.

- Southwest Regional Serious Violence and Contextualised Safeguarding Data Set & Information Governance Reference Group.
- Southwest Safeguarding Workforce and Learning and Development Reference Group.
- NHSE Adult Equity Group to raise profile of adult safeguarding to bring it on a par with children.

22. Achievements in 2021-2022 to improve safeguarding practice in single and multi-agency working around safeguarding children

Work is continuing on the transformation of safeguarding into the ICS.

The Head of Safeguarding chairs the Children's Safeguarding Practice Review Group and is working with partners to ensure recommendations from statutory reviews are outcome focused and the Group receives feedback once actions are implemented, and outcomes achieved.

Work is progressing in aligning the work across Safeguarding Partnerships, Adult Boards and Community Safety Partnerships.

Quality assurance groups have been re-established, from a Pan-Dorset QA group to place-based arrangements. The CCG/ICB safeguarding service are core members of each & co-chair.

The Dorset Insight and Intelligence Service (DiiS) has worked with safeguarding to develop a population-based safeguarding and inequalities dashboard. Work to develop this into a multi-agency dashboard continues.

The Dorset Health System Safeguarding Group continues to develop, work includes a shared audit plan, meetings matrix and improved sharing of information and learning.

All safeguarding information is now captured on Ulysses Safeguarding module and data is now available to provide better analysis. In addition, the safeguarding service is now able to provide a monthly activity report.

Refreshed the 'SharePoint' site for safeguarding to make it current and relevant to CCG/ICB staff.

Work has commenced to manage a change of delivery model in the MASH.

The safeguarding schedules have been mapped against the NHSE Safeguarding Commissioning Assurance Toolkit and health's statutory safeguarding

responsibilities and arranged in themes that reflect the CQC framework. A guidance document and guide to quality assurance visits has been developed. All QA work has been described in an annual cycle.

Dorset have led on the regional NHSE implementation of 360 Skills for Life virtual platform to support children and young people to make safe decisions and is particularly relevant to child and criminal exploitation. The platform has now gone live.

The CCG/ICB safeguarding Team have developed a Domestic Abuse Toolkit to be used in General Practice. The evaluation of this will form part of the annual QA visits to practices.

The CCG/ICB Adult Lead has resurrected the Dorset wide Prevent Network for health to raise the profile and improve referral rates.

Several bespoke reviews and reports related to specific areas of safeguarding have been produced to inform the safeguarding ICS and wider partners.

23. Objectives for 2022 / 23

Key strands of work in addition to core business will include:

- To implement the new safeguarding schedules across core and independent commissioned Providers to strengthen assurance of safeguarding practice. Re-establish QA visits and complete the first full cycle of QA activity using findings to support priority setting for the service.

- Complete Children Act Section 11 audit, monitor any action plans arising and using findings to inform 22/23 QA cycle.

- Complete a scoping exercise around the PDSCP priorities and produce a safeguarding ICS workplan to progress the priorities.

- Building on the work already in place with Partners to strengthen safeguarding within the ICS.

- To work across the Children's Safeguarding Partnership, the Safeguarding Adult Boards and the Community Safety Partnerships to align workstreams and address priority areas.

- Ensuring all learning from Inspections and Statutory Reviews are acted on and evaluated.

- Prepare for implementation and quality assurance of the Liberty Protection Safeguards in partnership with PHC and Providers.

- Serious Violence Duty - to understand the extent of the issues locally and to be assured relevant multi-agency systems and process are in place to address the risk.

- Review the delivery of statutory processes for Children in Care.

- Review the processes for Unaccompanied Asylum-Seeking Children alongside local authority colleagues to ensure health needs are met

- Work with NHSE commissioners, Sexual Assault Referral Centres, local authorities and acute hospitals to refresh the child sexual abuse pathways.

- A review of MASH to be explored to ensure partners are working effectively under a shared vision and model.

- Working with both Community Safety Partnerships to address the increasing demand on the system of the consequences of complex domestic abuse, shifting from a reactive to a more pro-active model in managing the changing nature of abuse.

- Identify the impact of domestic abuse and how, as partners, a co-ordinated approach will prevent duplication and how agencies can intervene much earlier to break the cycle of abuse.

- Embed the learning from audits including the HRDA audit on elder domestic abuse, and the DCC audit on childhood exploitation.

24. Conclusion

The CCG/ICB continues to maintain its statutory obligations and focus on safeguarding across Dorset's healthcare system.

Inevitably COVID -19 has continued to impact on safeguarding throughout this year, with the impact of hidden harm and on emotional / mental health being realised.

The priority focus for the next year will be to align with the PDSCP and SAB priorities. In addition, delivering on and further strengthening, quality assurance of safeguarding across health services at the same time as creating safeguarding

metrics in the Dorset Intelligence & Insight system to better inform commissioning and identify safeguarding themes and trends.

APPENDICES	
Appendix 1	BCP Child Protection Plan Data
Appendix 2	Covid Action plan
Appendix 3	Safeguarding Provider Performance Indicator Dashboard
Appendix 4	Quality Assurance visit guidance document

Appendix 1: BCP CP Data

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	#####	Apr-21	#####	Jun-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
CP@snapshot	271	271	313	296	301	295	327	318	326	305	308	346	346	350	348	349	345	367	389
Male	130	127	153	146	157	152	172	169	174	158	152	177	171	176	181	177	176	190	202
Female	136	139	156	148	142	142	152	142	142	136	146	161	169	168	165	169	163	171	177
Unknown	5	5	3	2	2	1	3	7	9	10	9	8	6	5	2	3	5	6	10
Other	0	0	1	0	0	0	0	0	1	1	1	0	0	1	0	0	0	0	0
Unborn	5	5	5	5	1	1	2	4	6	7	7	4	5	5	3	3	4	6	10
0-5	117	114	128	112	116	110	117	104	108	101	107	122	112	114	119	112	118	121	123
6+	149	152	180	179	184	184	208	210	212	197	194	220	229	249	226	234	223	240	256
duration 2y+	4	6	7	10	7	2	0	0	0	0	4	4	7	5	4	4	6	6	5
Emotional Abus	71	63	77	75	80	70	81	77	77	77	67	71	90	113	119	113	103	114	109
Neglect	162	158	179	177	182	186	206	207	217	202	211	239	220	195	182	192	200	213	236
Physical Abuse	28	41	49	35	28	28	30	25	25	15	20	23	22	32	39	35	32	32	37
Sexual Abuse	10	9	8	9	11	11	10	9	7	11	10	13	14	10	8	9	10	8	7

Appendix 2: Covid Plan

This document has been written in response to a letter from the Department of Education dated 03.01.2022 (Appendix 1) which tasks Safeguarding partners to have assurance in a number of areas related to the safeguarding of children and young people during the ongoing pandemic.
The areas of focus and CCG/ICB action / progress on actions are detailed in the table below:

	Covid-19 arrangement	Action	RAG	Current position
1	There is a process for developing and collectively agreeing a list of children and young people at risk of harm, or in need of support in your area.	Work with both LAs & CYP service DHC to establish a process to maintain a contemporaneous shared list (also see 8)		See 8 Digital Unborn tracker implemented in BCP BCP: 02.02.22 no shared list in place DCC: 02.02.22 no shared list in place
2	Partners are regularly establishing whether these children are attending nurseries, schools, and colleges and assure yourselves that these children have reengaged in education following the Christmas holiday	Work with both LAs & CYP service DHC to establish a process. CCG/ICB to consider information sharing in health and agree expected response from health providers if children are not re-engaged		BCP: DHC CYP service have made requests to share information re home educated children or children missing from education with School Nursing but as yet this information has not been made available DCC: Share information re home educated children and children missing from education on an annual basis with School Nursing / need to consider if this is sufficient?
3	There is a process for ensuring that partners and agencies have 'eyes on' these children, particularly when absent from school – this could include conducting visits to check on their wellbeing and safety	See 2 above CCG/ICB to gain assurance that relevant services maintain face to face service offer at pre-covid levels		CAMHS NHS England directive cases may be prioritised but service continues NHSE directive health visiting & school nursing continue / services not to cease or be redeployed. Face to face contact in health visiting is re-established

				for all NBV, 6–8-week check and at all contacts for children at UP or above.
4	Information sharing processes are adequate and effective between partners and agencies	Weekly senior safeguarding leadership meetings to review covid plans CCG/ICB to ensure oversight of MASH activity including audit CCG/ICB to ensure core safeguarding business is continuing at pre-covid levels across the SG system		Workstream on MASH pathways reaching conclusion / pathways clear & agreed – will be monitored by MASH operational group Meeting to review & agree process for requesting paediatric medical & attendance at strategy discussions with BCP held 24.01.22. Problem cases identified & being reviewed to understand where things went wrong. Pathway reviewed & updated CSE pathway review / CCG/ICB leading working alongside CYP Principle Lead, this work will form part the CCG/ICB HSB pathway workstream Safeguarding in Health Visiting and School Nursing is continuing at pre-covid levels
5	Partners are working with Virtual School Heads to support the attendance of looked after children and the extended group of children with a social worker that they support	CCG/ICB to work with Virtual School in both LA to ensure CiC school attendance is prioritised & plans are in place where required		Designated Nurse CiC has linked with BCP and Dorset Virtual Head leads to ascertain awareness and plan for this cohort (5.1.22)
6	Partner agencies and a breadth of professionals, including health	CCG/ICB to ensure that safeguarding children remains high priority		Health Visitors and School Nurses are able to identify children with safeguarding concerns

	visitors, GPs and midwives are utilised to identify children, make appropriate referrals, and provide suitable support.	CCG/ICB SG team should meet to consider comms and other avenues to achieve this / workstream Ongoing monitoring of safeguarding training compliance		and make appropriate referrals through their mandated contacts. All children at UPP or UPP (statutory) receive face to face contact for assessment. Necessary to consider how vulnerability is identified between mandated contacts as relationships are limited Safeguarding training compliance levels are recovering post-covid and have now reached or just below target for all providers
7	Partners are using their own communication channels and relationships with local communities to signpost to support and routes to report concerns.	Communication channels & support was reviewed as part of multi-agency response to covid		Parentline text messaging service in place in Health Visiting pan Dorset, to enable parents of 0–5-year-olds to receive swift support, advice and signposting. ChatHealth text messaging service in place in School Nursing to enable young people to receive swift support, advice and signposting Community appointment clinics established in Health Visiting pan Dorset Do we need to consider Drop-In clinics for most vulnerable will find it difficult to plan ahead and have an appointment
8	In addition, we would ask safeguarding partners to have processes that are adequate for	Ensure maternity case tracker is in use and contemporaneous		BCP maternity tracker reviewed & relaunched Jan 22

	identifying pregnant women, babies, and young people who may be at risk of harm should any additional COVID-19 restrictions come into force	See 1 & 2 Work in partnership with LA, maternity services and partners to ensure plans are in place to support pregnant CiC and Care leavers		DCC no tracker in place / conversations have been commenced by CCG/ICB Designated Nurse SG children Multi agency pregnancy pathway in development for CiC Transfer of information process in place between midwifery and health visiting which identifies pregnant women/babies who may be at risk
9	The Department will also be moving to a fortnightly collection of the Vulnerable Children and Young People Survey from 4 January. Regional Improvement Support Leads will work with local authorities and safeguarding partners to gather intelligence on workforce absences, changes to referral numbers, and the number of children becoming looked after.	Contribute to data collation CCG/ICB to ensure that data on workforce absences is available CCG/ICB to monitor referrals from health CCG/ICB to monitor children coming into care		Awaiting Survey request Monthly meetings continue with both LA to track numbers into care

Appendix 3: Safeguarding Performance Indicators

Safeguarding Children & Adult Performance Indicator (PI) Dashboard

For 2022/23 contracts

Reporting Period		
Safeguarding Adult /Children Annual Report	April - March	1st week of August
Looked After Children Annual Report	April – March	1st week of August

Reporting Period		Report received by CCG/ICB by	Report to be presented at Contract monitoring meeting in
Quarter 1	April - June	1st week of August	August
Quarter 2	July - September	1st week of November	November
Quarter 3	October - December	1st week of February	February
Quarter 4	January - March	1st week of May	May

Quarterly Reporting	**Reporting requirement & method**		
	CQC Standard (2021) • **Smarter regulation**: Smarter, more dynamic, and flexible regulation that provides up-to-date and high-quality information and ratings and a more proportionate response • System wide thinking • Partnership working • Corporate parenting • Governance		
	Written report to the commissioner which will include:		**Reporting measure**
	Trust Board Objectives for Safeguarding Children and Adults *Safeguarding Commissioning Assurance Toolkit (SCAT) Leadership & Organisational accountability / A4.1 multi-agency working*	A document mapping the meetings for the LSCPs and LSABs and the provider's attendance rate at these meetings as agreed in the Safeguarding ICS meetings matrix. (To include attendance at Board meetings)	Quarterly report/ DHSSG ICS meeting matrix
	Effective supervision and reflective practice **Children**: Standard 4	Safeguarding Supervision sessions received by Named Doctors Acute	Quarterly compliance Number & Percentage

	SCAT A7 patient engagement and supervision	Safeguarding Supervision sessions received by Named Doctors Community Safeguarding Supervision sessions received by Named Doctors Children in Care	
		Safeguarding Supervision sessions received by Named Doctors Primary Care & other relevant Primary care staff	Reportable via GP QA visits
		Safeguarding Supervision sessions received by Designated Nurse Children Safeguarding Supervision sessions received by Designated Nurse Children in Care Safeguarding Supervision sessions received by Adult Safeguarding Lead Safeguarding Supervision sessions received by Head of Safeguarding / Professional Lead Safeguarding Supervision sessions received by Named GPs	Quarterly compliance Number & Percentage
		Safeguarding Supervision sessions received by Named Nurses Acute Safeguarding Supervision sessions received by Named Nurses Community Safeguarding Supervision sessions received by Named Midwives Safeguarding Supervision sessions received by Named Nurse Children in Care	Quarterly compliance Number & Percentage

		Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Acute Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Community Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Midwifery Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Primary Care	Quarterly compliance Number and Percentage
		Safeguarding supervision sessions received by eligible Midwifery practitioners	Quarterly compliance Number and Percentage
		Safeguarding supervision sessions received by eligible Community Children & Young People Practitioners – health visitors Safeguarding supervision sessions received by eligible Community Children & Young People Practitioners – School Nurses Safeguarding supervision sessions received by eligible paediatric staff (including ED & paediatric safeguarding leads)	Quarterly compliance Number and Percentage
	Effective supervision and reflective practice: **Adults** *SCAT A7 patient engagement and supervision*	Safeguarding Supervision sessions received by Named Doctors Acute Safeguarding Supervision sessions received by Named Doctors Primary Care Safeguarding Supervision sessions received by Named Doctors Community	Quarterly compliance Number and Percentage

		Safeguarding Supervision sessions received by Named Nurses Acute Safeguarding Supervision sessions received by Named Nurses Community	Quarterly compliance Number and Percentage
		Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Acute Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Community Safeguarding Supervision sessions received by Safeguarding Specialist Practitioner Primary Care	Quarterly compliance Number and Percentage
		Safeguarding reflective sessions / supervision sessions received by eligible Adult Practitioners Acute Safeguarding reflective sessions / supervision sessions received by eligible Adult Practitioners Community Safeguarding reflective sessions / supervision sessions received by eligible Adult Practitioners Primary Care (e.g., LD, MCA lead, DA lead)	Quarterly compliance Number and Percentage
	Best Practice	Provider narrative highlighting areas of good / best / innovative practice	Provider quarterly report narrative
	CQC Standard (2021) • **<u>Safety through learning</u>**: Regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives • Statutory learning reviews • Reducing inequalities		
	Written report to the commissioner which will include:		
		The provider will provide oversight and assurance	Narrative

	Reporting safeguarding serious incidents: Standard 6 (child) & 10 (adult) *SCAT Leadership & Organisational accountability / implementation*	of the thematic analysis & learning in relation to safeguarding issues in SIs	
		The Provider will inform the CCG/ICB of any incident which identifies a child/ CiC or adult safeguarding SI via the CCG/ICB safeguarding notification form.	Number and Narrative
	Engaging in Safeguarding Practice Reviews: Standard 7 (Child) Standard 8 & 9 (Adult) *SCAT A5 implementation (sharing and learning good practice), training, interagency working, leadership & organisational accountability.*	Rapid Reviews Child (new this quarter)	Number
		Safeguarding Adult Review Scoping (new this quarter)	Number
		Domestic Homicide Review Scoping (new this quarter)	Number
		Child Safeguarding Practice Reviews in progress	Number
		Domestic Homicide Reviews in progress	Number
		Safeguarding Adult Reviews in progress	Number
	Workforce Safeguarding Training: Standard (child) Standard 8 (adult) *SCAT Training A2*	Safeguarding adults & children training Level 1 (including DA)	Number & Compliance Percentage
		Safeguarding adults & children training Level 2 (including DA, FGM & MCA)	Number & Compliance Percentage
		Safeguarding children training Level 3 (including MCA)	Number & Compliance Percentage
		Safeguarding children training Level 4/5 (including MCA)	Number & Compliance Percentage
		Safeguarding adults training Level 3 (including MCA)	Number & Compliance Percentage
		Safeguarding adults training Level 4/5 (including MCA)	Number & Compliance Percentage
		Safeguarding Board level training (CCG/ICB)	Number & Compliance Percentage
		Domestic Abuse training (mandatory) for all eligible staff	Number & Compliance Percentage
		MCA DoLS / (LPS) training for all eligible staff	Number & Compliance Percentage
		Prevent Level 2 training	Number & Compliance Percentage

		WRAP Level 3 training for all eligible staff	Number & Compliance Percentage
		Details of any bespoke training, showcasing any new, innovative training	Narrative in provider quarterly reports
	Best Practice	Provider narrative highlighting areas of good / best / innovative practice	Narrative in provider quarterly reports
	CQC Standard (2021) • **Accelerating improvement**: Enabling health and care services and local systems to access support to help improve the quality of care where it's needed most • Engaging wider partners / transparency / cultures / understanding / relationships • Placed based safeguarding arrangements • QA agenda		
	Written report to the commissioner which will include:		
	Adherence to child protection process: Standard 5 Adherence to Adult Protection Process: Standard 8 & 9 **(see MASH below) (see Midwifery below)** *SCAT interagency working, leadership & organisational accountability SCAT A4.1*	Number of referrals to Children's Social Care	Number
		Number of concerns raised for consideration under Section 42 (42.1 42.2)	Number
		Number of referrals to Adults Social Care for Section 42 (42.1 42.2)	Number
		Child Protection strategy meeting invites received (open cases)	Number
		Child Protection strategy meetings attended (open cases)	Percentage
		Initial Child Protection Conference invites /reports requested	Number
		Initial Child Protection Conference reports completed & provided	Percentage
		Review Child Protection Conference invites /reports requested	Number
		Review Child Protection Conference reports completed & provided	Percentage
		Initial Child Protection Conferences attended	Percentage
		Review Child Protection Conferences attended	Number
		Number of Child Safeguarding Medicals performed: physical	Number
		Number of Child Safeguarding Medicals performed: CSA in hospital	Number

		Number of Child Safeguarding Medicals performed: CSA in SARC	Number
		Number of CDOP rapid response meetings initiated	Number
		Number of child cases escalated using PDSCP escalation policy	Number
		Initial Adult Enquiry Planning meeting invites received	Number
		Initial Adult Enquiry Planning meetings attended	Percentage
		Number of Nominated Enquiry Forms requested & completed	Number & Percentage
		Number of DoLs applied for	Number
		Number of DoLs authorised	Number
		Number of DoLs not proceeded	Number
		Number of Court of Protection applications made related to Safeguarding	Number
		Number of best interest meetings held related to Safeguarding	Number
		Number of adult cases escalated using LSAB escalation policy	Collated via partnership
		Number of Child Exploitation meetings attended (MACE / ETAC)	Number & Percentage
		Number of CiC review meetings invites received	Number
		Number of CiC review meetings attended	Percentage
		Number of MAPPA meetings attended	Number
		Number of MARAC / HRDA meetings attended	Number
		Number of Channel panels attended	Number
		Health plan provided for CiC review	Number & percentage
	Multi-Agency Safeguarding Hub (MASH) only	Child Protection strategy meeting invites received	Number
		Child Protection strategy meetings attended	Percentage

		Child Protection strategy meetings held within 4-hour timeframe (of those allocated for urgent response)	Percentage
		Child Protection strategy meetings held within 24-hour timeframe (of those allocated for 24-hour response)	Percentage
		MASH information sharing requests received (per record)	Number
		MASH information sharing requests processed (per record)	Percentage
		Public Protection Notices processed (please exception report backlog issues)	Number
		Number of strategy discussions where paediatrician was invited	Number
		Number of strategy discussions where paediatrician attended	Number & percentage
	Managing Allegations including Safer Recruitment Standard 8 & 9 (child) Standard 7 (Adult) *SCAT safer recruitment / HR A3*	Number of Local Authority Designated Officer (LADO) cases (new this quarter)	Number
		Number of LADO cases involving provider staff (new this quarter)	Number
		Number of LADO involving primary care / community commissioned services	Number
		Number of Persons in Position of Trust (PIPOT) cases (new this quarter)	Number
		Number of PIPOT involving provider staff (new this quarter)	Number
		Number PIPOT involving primary care / community commissioned services	Number
	Specific Midwifery Safeguarding metrics – core standard 5 & 10	Unborn infants subject to a child protection plan	Number
		Unborn infants / mothers subject to Child in Need Plan	Number
		Number of babies subject to ICO/ EPO	Numbers
		Pregnant women under 18 years subject to a child protection plan	Number

		Number of pregnant Children in Care	Number
		Number of referrals to Midwifery specialist teams (e.g. Oasis, where applicable)	Number & narrative
		Number of pregnant women referred to PMHT	Number
		Number of pregnant women referred to young parents / teenage pregnancy service (DCH only)	Number
		Number of pregnant women referred to children's social care	Number
		Number of pregnant women referred to children's social care & referral accepted	Number
		Child Protection Strategy meetings attended	Number
		Initial Child Protection Conference invites/ reports requested	Number
		Initial Child Protection Conference reports completed & provided	Number
		Review Child Protection Conference invites/ reports requested	Number
		Review Child Protection Conference reports completed & provided	Number
		Initial Child Protection Conferences attended	Number
		Review Child Protection Conferences attended	Number
	Looked After Children	CiC domains collated separately	CiC power BI
	Best Practice	Provider narrative highlighting areas of good / best / innovative practice	Provider quarterly report narrative
	Integrated Care System (Safeguarding)	Provider narrative providing a summary of progress towards ICS working in Safeguarding	
	CQC Standard (2021) • **People and communities**: Regulation that is driven by people's needs and experiences, when they access, use and move between services • Transitional safeguarding • Voice of user • Contextual safeguarding / think family • Placed out of area / placement location		

	• Reducing inequalities • Dashboard / population health management		
	Written report to the commissioner which will include:		
	Clinical Safeguarding: Activity Standard 5 & 10 Child, Activity Standard 2 & 7 (Adult) *SCAT implementation, patient engagement*	Attendance at ED / MIU checked against CP-IS - age under 18 years	Percentage
		Attendance at hospital departments / MIU for sexual assault or related concerns age under 18 years	Number
		Children referred due to risk of FGM age under 18 years	Number
		Hospital / MIU attendance due to deliberate injury / self-harm age under 18 years	Number
		Hospital / MIU attendance due to suspected Non-Accidental Injury age under 18 years	Number
		Hospital / MIU attendance due to substance / alcohol misuse age under 18 years	Number
		Children / Young people brought to acute trust as place of safety (ED)	Number
		Children / Young people brought to acute trust as place of safety (admitted)	Number
		Children / Young people admitted under section 136	Number
		Adults / children seen who are suspected of being trafficked / exploited (safeguarding notification to CCG/ICB)	Number
	Best Practice	Provider narrative highlighting areas of good / best / innovative practice	Provider quarterly report narrative
	Exception reporting:		
		Any changes in the Provider's organisational structure	Narrative
		The Provider will escalate any relevant safeguarding children and/or adult risks, scoring 12 or above to the lead commissioners	PDSCP / SAB risk register report / provider quarterly report

		and provide a copy of their risk register entry (including mitigations) (NHSE 22/23 contract schedule 2, section K)	
		Details of any gaps in providers ability to meet safeguarding legislative framework and policies.	Narrative
		CCG/ICB will require narrative as to progress of action plans from any safeguarding related inspections. CCG/ ICB to be notified of any delay / inability to deliver on safeguarding actions.	Narrative
		The Provider will share progress against CSPRs/Adult Reviews, Domestic Homicide Reviews and Learning Reviews. This will include evidence that action plans are progressing and how learning is cascaded to frontline staff	Narrative
		Any safeguarding related freedom of information requests received	Narrative
	Provider actions:		
	MASH	The provider will undertake quarterly multi – agency MASH audits, the findings will be reported to commissioners in the following quarter	Narrative
	CiC	CiC team quarterly themed audit	Narrative
	SAB	Providers will undertake SAB audit and peer reviews & respond to findings with an agreed action plan (any audit to be agreed annually / timetabled)	Narrative
	SAB	Providers to evidence the implementation of 'Making safeguarding personal' at a local level and its impact on engagement and outcomes.	Narrative

Annual	**Written report to the commissioner which will include:**	
	Narrative summarising the impact of the following on patient outcomes, organisational practice and describe plans for further development; Safeguarding children and adult standards Looked After Children, Safeguarding Children and Safeguarding Adult Annual Reports Mental Capacity Act (MCA) Policy and Deprivation of Liberty Safeguards	
	Narrative summarising quarterly achievements to contain as a minimum. Summary of progress throughout all levels of the organisation over the four quarters of the year Summary of improvements to practice and increased positive outcomes to children and adults The mechanisms by which the organisation is assured that improvements are sustained Evidence that Board level representative (or senior deputy) attends 75% of the Local Safeguarding Adult/Children Board meetings/Corporate Parenting Board Training compliance at all levels in line with 'Safeguarding Children and Young People: roles and competencies for health care staff' (RCPCH, 2020), Looked after children: knowledge, skills and competencies of health care staff' (RCN and RCPCH, 2019) and Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document (RCN 2018) Domestic Abuse / FGM / CE / Modern Slavery and Trafficking training is included in all Level 2 and above training Forward plan/objectives for the following year	
	A copy of the Provider's organisational structure Details of the Provider's Named Leads with assurance of sufficient capacity (if applicable) for: Children Midwifery CiC Adults	SCAT A1.2 / A1.5
	Details of Named leads for: Prevent (children and adults) Missing, Exploited and Trafficking (MET) Children in Care (CiC) Female Genital Mutilation (FGM) PIPOT Modern Slavery Domestic Abuse Adverse Childhood Experiences (ACEs) & Trauma informed Practice	SCAT A1.2 / A1.5/ A3.6
	Details of key safeguarding policies. E.g., Safeguarding (adult & child), prevent, DA, whistleblowing, DBS, MCA, supervision. *See Appendix 2 for NHSE list*	NHSE Schedule 2 / SCAT
	Details of the Provider's Executive Leads for Safeguarding Children, Adults and Prevent	SCAT A1.1
	Evidence that the organisation ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding	SCAT A6.1
	The Safeguarding Audit Programme and if applicable CiC Audit programme for the year	
	Providers should produce an annual cross reference of CiC who also have special educational needs or complex health needs and evidence that these children have had a holistic assessment covering the requirements of both the SEN and CiC registration with their medical review	NHSE Schedule 2 section K

	Inspections: Providers will inform commissioners of inspections of their services by CQC/Ofsted or other bodies on the day of inspection. Commissioners will require sight of the action plans developed from the recommendations of inspections to ensure that they are evidenced and progressed effectively. Providers will comply with the Section 11 (Children Act, 2004) self-assessment audit and will share the audit actions with the commissioners. The quality/safeguarding assurance report will include an update with regards as to how they are progressing self-identified actions.	NHSE Schedule 2 22/23 section K
	All commissioned providers will be required to work to the most recent legislative framework and adhere to any changes to statutory guidance during this reporting period. For Safeguarding Children and Adults, this includes (please note this is not an exhaustive list): • The Children Act 1989, 2004 • Statutory guidance 'Working Together to Safeguard Children' (HM Government, • 2018) • UN Convention on the Rights of the Child 1989 – adopted by the UK in 1990 • Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13: Safeguarding service users from abuse and improper treatment • Local Safeguarding Children Partnership Procedures • Local Safeguarding Adult Board Procedures • NICE guidance: When to suspect child maltreatment (2009 updated 2014) • NICE guidance: Domestic violence and abuse: multi-agency working (2014) • The Care Act, 2014 • NHS England Prevent Training and Competencies Framework (2015): https://www.england.nhs.uk/ourwork/safeguarding/our-work/prevent/ • Promoting the health and well-being of looked-after children (2015) • Children and Social Work Act 2017 • The Crime and Disorder Act 1998 • Female Genital Mutilation Act 2003 • The Domestic Abuse Act 2021 • Mental Capacity Act 2005, 2019 • Human Rights Act 1998 • Convention on the Rights of Persons with Disabilities 2006 • Mental Health Act 2007 • Children and Families Act 2014 • Modern Slavery Act 2015 • Serious Crime Act 2015	NHSE Schedule 2 22/23 section K
Annual Quality Visit	Evidence and access to the Provider's safeguarding policies & protocols including updates on any action plans on areas identified for improvement	Safeguarding Standards
	The Provider will give evidence that they promote a 'Think Family' approach to safeguarding.	Best Practice
	The provider will demonstrate awareness of Contextual Safeguarding and consider the potential risks that are present outside of a family/home context, including criminal exploitation, trafficking, and county lines	Safeguarding Standards / best practice
	The Provider's strategic objectives regarding safeguarding	SCAT leadership
	The Provider will share relevant safeguarding children and/or adult risks with the commissioners and provide access to a copy of their risk register entry, including the actions taken to mitigate the risk	Safeguarding Standards / SCP & SAB standards
	Evidence will be provided to the commissioner regarding the type of incidents the Provider has identified and will demonstrates that learning has been applied across the whole system to prevent/mitigate future recurrences. This includes Duty of Candour as well as assurance of learning from reviews and audits	Safeguarding Standards / SCAT
	Evidence from internal and external audits and walk arounds to be provided	Safeguarding Standards

	Confirmation that safeguarding training is part of staff annual performance review or appraisals & that Domestic Abuse / FGM / CE / Modern Slavery & trafficking training has been provided for relevant staff groups	Safeguarding Standards / SCAT
	Evidence that safe recruitment procedures are followed. This includes: Every employee's job description containing a statement specific to each individual post which reflects the role and responsibility of the individual in relation to safeguarding adults/children. NHS Employers DBS checks for all employed staff, volunteers etc	SCAT A3
	Can the organisation provide evidence that safer recruitment standards are monitored by the Executive Director and action taken where they fall short of expectations? (i.e. charity visitors, volunteers, celebrities and agencies are monitored by the executive director and are consistent with their own HR internal policies)	SCAT A3.3
	Can the organisation demonstrate how they manage requests for access from volunteers, paid / unpaid charity fundraisers, celebrities and 'friends' of the organisation?	SCAT A3.4
	Can the organisation evidence that it is managing allegations against staff in line with LSAB and SCPs? This must include reference to risk assessments and a clear process when protection thresholds in the local authority are not met. Should include referrals to LADO for concerns around children's safeguarding and referrals relating to PIPOT in relation to adults, must include review of prevent concerns around staff.	SCAT A3.6
	Can the organisation demonstrate that there are systems in place to report unsafe practice to external professional bodies, i.e. Police, DBS, NMC, GMS etc?	SCAT A3.5
	Evidence that children/young people and adults have participated in service redesign or review which includes user feedback	Best practice
	Evidence that the Provider is compliant with the Care Quality Commission (CQC) guidelines regarding consent	CQC
	Evidence to demonstrate that the Making Safeguarding Personal programme is embedded into practice: This includes routine enquiry and professional curiosity becoming daily practice (theme from local DHR D5 & D7)	Best practice
	Evidence that Multi Agency working is actively promoted. This will include strategy meetings attended, child protection conferences (where appropriate) attended and meetings such as MARAC, MAPPA, MARM and Channel Panel when required	Safeguarding Standards / SCAT
	Evidence that the Provider has contributed and participated in multi-agency audits as requested by the LSCP/LSAB	SCAT / SCP & SAB standards
	Evidence that MCA is included in the Job Descriptions of staff making responsibilities explicit to the requirements of each post holder	Safeguarding Standards / SCAT
	Evidence that the Provider has planning in place to adopt LPS arrangements	Legislation
	Evidence that the organisation has a policy regarding internet and social media use which addresses safeguarding	SCAT A1.3
	Can the organisation demonstrate it engages with eh strategic data collection service to discharge it's prevent data reporting obligations?	SCAT A4.2
	Safeguarding investigations: can the organisation consistently evidence that learning has been embedded into practice?	SCAT A5.2
	The provider must be able to demonstrate compliance with the MCA, that the principles are embedded in all care delivery and that records demonstrate consideration of capacity and use of	Standard 5

	best interest decision making have been applied where appropriate	
	Provider must be able to demonstrate that all eligible practitioners receive regular safeguarding supervision	Intercollegiate Document
	The provider must be able to demonstrate that training packages meet Intercollegiate standards for levels of training.	Intercollegiate Standards
	Evidence of compliance to record keeping standards (to be observed during the QA visit)	Record keeping standards
	The commissioner will report outcomes of the visit to the provider within three months of the visit	

Appendix 4: Safeguarding Quality Assurance Visit Guidance Document

Dorset Clinical Commissioning Group (Safeguarding Team) March 2022

Introduction

In health care, quality assurance in safeguarding has become an established component of the Governance Framework; effective quality assurance ensures that risks are mitigated, safeguarding trends are rapidly detected, good practice is shared, and lessons are learned. Safeguarding quality assurance visits are an integral part of the overall assurance process.

Within the NHS contract every provider has an obligation to meet their statutory safeguarding requirements, the quality assurance visit is one tool to enable the commissioner to be assured these duties are met.

Definition:

A Quality Assurance visit is the evaluation of work by colleagues in the same field in order to maintain or enhance the quality of the work or performance. It is a process to ensure that safeguarding practice is as robust and evidence-based as possible.

Purpose of the QA visit

· To provide a proactive culture of learning, professional development and support, education and training, service improvement and improvement of multiagency processes.

· To provide support in a non-hierarchical environment, decrease professional isolation, promote the sharing of best practice and understanding of the complexities of safeguarding situations.

· Participation in QA visits provides service-level assurance that cases are managed safely & effectively, safeguarding policies & procedures are in place & staff are supported in their safeguarding practice.

· Early identification of safeguarding issues that may require further monitoring or support to mitigate risk.

Good Practice Recommendations

1. The CCG/ICB should formally establish an annual QA visit process for safeguarding, in line with the standards of this document, and ensure the availability of appropriate training, support, documentation and time within job plans to allow for this.

2. All providers should participate in the annual QA cycle, complete self-assessments and allow time within job plans to allow for this and the QA visit as per their contract.

3. The length of the QA visit should be enough to meet the operational demands of the provider and at the same time provide sufficient time to explore safeguarding in a supportive context. This will be agreed between the CCG/ICB & the provider prior to the visit, being up to a full day ‘on site’.

4. All aspects of safeguarding should be reviewed including case management, safeguarding processes within the organisation and contribution / participation in safeguarding activity with partners.

5. Access to records does not require specific patient consent as QA activity is part of the provider contract & is conducted by designated / lead safeguarding professionals.

6. QA visit templates should be kept, documenting evidence, learning points and actions. Patient-identifiable information should NOT be included.

7. QA visits must be a collaborative activity between the CCG/ICB & the provider.

8. All participants must ensure a challenging yet supportive environment. Challenge should be documented and audited to ensure robust review.

9. The CCG/ICB will review their QA visit findings to ensure their practice is fair and equal across all services.

10. Colleagues' names should not be used in reports.

11. All participants must endeavour to avoid all forms of bias.

12. Providers must produce all the evidence detailed on their self-assessment document.

13. CCG/ICB must produce a final report detailing the findings of the QA visit & share with the provider within 6 weeks.

14. It is expected that the report would contain 'no surprises' as the assurance activity is collaborative with open & honest dialogue, any concerns / areas requiring improvement should have been discussed during the visit & actions agreed.

15. An opportunity to discuss the QA visit and final draft report will be provided and any inaccuracies rectified.

16. Feedback on the QA visit will be sought by the CCG/ICB and inform future QA visits and safeguarding schedules.

17. With agreement of the provider, good practice should be shared across the safeguarding ICS and equally any learning that may apply to the ICS.

18. Evidence of participation in QA visits should form part of annual reporting.

Principles & Scope

The aim of the QA visit is NOT to generate either a second opinion or an expert opinion on safeguarding cases, and the provider retains responsibility for their case management and opinion.

Safeguarding work is emotionally demanding. It is acknowledged that the opportunity to discuss cases with peers undertaking similar work, and to receive assurance around case management, has a significant role in maintaining the wellbeing and perspective of professionals involved. QA visits should provide a supportive atmosphere; however, the primary purpose is not to provide emotional support; QA visits should not be considered a

substitute for supervision or individual debrief following particularly challenging cases, nor should the need to support colleagues prevent robust discussion where necessary. Similarly, although not its primary purpose, the QA visit provides excellent learning opportunities.

Aims and Objectives

The aim of the QA visit is to provide system oversight and assurance of safeguarding practice

Objectives of a QA visit:

· To retrospectively review safeguarding practice, the evidence-base and multiagency processes/working/communication.

· To provide a proactive culture of learning, promote quality improvement, maintain high evidence-based safeguarding practice standards.

· To provide a supportive environment to discuss safeguarding practice in order to help prevent professional isolation and aid sharing of best practice.

· To support organisations to identify development opportunities.

· To recognise good practice in safeguarding &, where appropriate, share this across the safeguarding ICS.

· To provide time for discussion of practice in a relaxed, non-threatening atmosphere

· To review practice to ensure appropriate evidence-based management and opinion.

· To provide support through the sharing of professional experiences of others.

· To help identify areas of development for the service to support service planning.

· To stimulate ideas for audit and/or research.

· To identify any process issues that may require a review

· To ensure all policies and pathways are up to date, in place and regularly reviewed

· To identify any issues with wider safeguarding partners that may require escalation

· To recognise multi-agency collaborative working.

· To assure the CCG/ICB that there is an understanding of both statutory & legislative requirements.

Conducting the QA visit

· The QA visit should be arranged with the provider in advance.

· Arrangements should be confirmed in writing (email).

· Two CCG/ICB Safeguarding professionals are required for the QA visit.

· Providers must ensure there is a room available for uninterrupted, private discussion.

· Providers must ensure that staff have protected time to participate in the QA visit.

· Providers must facilitate access to all documents detailed as evidence on their self-assessment form. Access to other records may also be required to triangulate findings.

Disagreement and Escalation

It is rare that a fundamental disagreement arises with safeguarding significance, that cannot be resolved through discussion at the QA visit. In such an event, the matter should be escalated through senior management using the safeguarding escalation process.

Where performance, professionalism, competency, or training issues arise, these should be dealt with according to local escalation policies with patient/client safety as the foremost concern.

Confidentiality and Consent

Quality assurance is essential to the care of all individuals residing in Dorset and therefore does not require specific consent.

Patient identifiable information must never be recorded in any QA visit documentation.

Details of cases discussed at the QA visit will be given due confidentiality in accordance with NMC Professional Standards of Practice (2020)

NHS DORSET CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE

13 APRIL 2022

PART ONE PUBLIC - MINUTES

Part 1 of the Primary Care Commissioning Committee of NHS Dorset Clinical Commissioning Group was held virtually at 2pm on 13 April 2022.

Present:
Maurice Dunster, Governing Body Lay Member and Chair of the Primary Care Commissioning Committee (MD)
Tim Goodson, Chief Officer (TG)
Blair Millar, Governing Body GP Representative (BM) (part)
Ravin Ramtohal, Governing Body GP Representative (RR) (part)
Vanessa Read, Director of Nursing and Quality (VR)
Sally Sandcraft, Director of Primary and Community Care (SSa)
Kay Taylor, Governing Body Lay Member and Deputy Chair, Primary Care Commissioning Committee (KT)

In attendance:
Gareth Bryant, Acting Chief Executive, Wessex LMC (GB)
Margaret Guy, Healthwatch Dorset Representative (MG)
Steph Lower, Corporate Office Manager (SL)
Edd Rendell, Medical Director, Wessex LMC (ER)
Louise Trent, Personal Assistant (LT) (minute taker)
1 member of the public

Action

1. Apologies

1.1 Sam Crowe, Director of Public Health, Public Health Dorset.
Nikki Rowland, Chief Finance Officer.

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of Committee members present.

3. Declarations of Interest

3.1 Declarations were made as follows:

Agenda item 7.1 - Clinical Commissioning Local Improvement Plan

All GP members/attendees would be conflicted in relation to the decision. GP members would be able to take part in the

discussion but required to withdraw from the meeting for the decision as it relates to primary care funding.

SL

Agenda item 15 – Historical Primary Care Estate Service Charge Payments

All GP members/attendees would be conflicted in relation to the decision. They would be required to withdraw from the meeting for this item. The report had been redacted from their pack of papers accordingly.

3.2 Members were reminded of the need to ensure Declarations of Interest were up to date and to notify the Corporate Office of any new declarations.

4. Minutes

4.1 The draft minutes of Part 1 of the meeting held on 2 February 2022 were **approved** as a true record.

5. Matters Arising

5.1 7.4.5 Gluten Free prescribing – The Committee noted the reference to a further cost implication in relation to dietician services which would be considered at the Dorset Medicines Advisory Group (DMAG) meeting in March and directed that an update be provided.

RR

5.2 The Committee **noted** the Report of the Chair on matters arising from the Part 1 minutes of the previous meeting.

6. Chair's Update

6.1 The Chair had no matters to update.

7. Reports

7.1 Clinical Commissioning Local Improvement Plan

7.1.1 The Director of Primary and Community Care introduced the Clinical Commissioning Local Improvement Plan report.

7.1.2 The Clinical Commissioning Local Improvement Plan (CCLIP) outcomes for 2021/22 would be reported in October on the annual cycle however intelligence from the current in-year activity had informed the forthcoming CCLIP intentions.

7.1.3 The 2022/23 priorities included a continued focus on areas from 2021/22 which included Population Health Management (PHM), with particular emphasis on Long Term Conditions (LTC) with

expansion for Cardiovascular Disease (CVD) and diabetes. Further focus included the ambition for improved data quality through the standardisation of application of clinical templates and coding of GP appointments. The local and national workforce challenges were recognised with the intention to improve resilience with incentives for Primary Care Networks (PCNs) to work collaboratively for business continuity.

7.1.4 Safeguarding monitoring arrangements had changed and would not be featured in the CCLIP. There was an enhanced focus on access, demand and capacity which would build on the work undertaken through the Winter Access Fund arrangements.

7.1.5 The funding allocation had been set out to reflect the combination of both practice and PCN contribution to the achievement of the CCLIP. A set of deliverables had been determined to measure the impact with minimal pressure on PCNs and practices for data reporting. Work was underway to review the Ardens template within SystmOne to assist with data extraction for any required reporting.

7.1.6 The Primary Care Reference Group (PCRG) had recommended the CCLIP intentions for approval.

RR and BM left the meeting.

7.1.7 The Committee **approved** the recommendations in the Clinical Commissioning Local Improvement Plan report.

RR and BM re-joined the meeting.

7.2 Primary Care Commissioning Update

7.2.1 The Director of Primary and Community Care introduced the Primary Care Commissioning Update report.

7.2.2 Two practices were currently undertaking discussions in relation to a potential merger with support provided from the Primary Care Team for the due diligence work. The Local Enhanced Services (LES) income protection would return to the pre-Covid-19 arrangements. This would be subject to a period of transition between April and September with work underway with practices to validate the data and provide a refreshed baseline.

7.2.3 The Child Protection Conference Reports had been subject to ongoing dialogue with the Local Authorities. This had now concluded with an agreed contribution of £40 per report. This had been assisted through engagement with Wessex Local Medical Committees (LMC) and would be subject to monitoring.

7.2.4 The Winter Access Funds programme had been adapted from the NHS England (NHSE) framework and it was anticipated that work would continue as part of the CCLIP. This had been managed to be responsive for Dorset and had positive results further to the initial NHSE directive being received negatively. Demand continued for GP services with an increase in appointments seen with both face to face and delivery through other media.

7.2.5 There had been sustainable improvement in the provision of Learning Disability (LD) and Serious Mental Illness (SMI) Healthchecks. In response to a query it was noted that the region had recognised the positive Dorset position.

7.2.6 Work on virtual wards continued which built on the Clinical Services Review (CSR) for out of hospital models. This included early indications for patients who required anticipatory care with the provision of support and a joined up rapid response offer. NHSE had commenced a resourced work programme though the Operations Plan with an expectation for match funding in year two with recurrent arrangements thereafter. Work was underway in Dorset to determine if this would be a priority area to proceed with the NHSE defined programme.

7.2.7 The Committee was concerned in relation to the potential viability risks for practices with two or fewer partners. The Director of Primary and Community Care said that work was underway with practices to understand workforce models and issues and to work through different scenarios for resilience and risk mitigation. The CCG had undertaken Practice Health Checks which had provided information and early indications on partners forthcoming retirement plans. The comprehensive multi-skilled workforce model assisted with the provision of patient care.

7.2.8 In response to a query, it was clarified that the appointments data did not include vaccination provision. It was not known whether there was duplication in the appointment data with triage resulting in further face to face provision and this would be checked. SSa

7.2.9 Healthwatch Dorset continued to receive complaints in relation to appointment access difficulties. It was noted that practices were transitioning from the traditional model to ensure that patients were seen by the appropriate professional to assist with their condition, for instance musculoskeletal (MSK) or podiatrist with patients occasionally dissatisfied with not seeing their GP. Difficulties remained in practices with provision of appointments. The GB GP Representative (BM) confirmed that his Bridport

practice utilised triage for all patients to determine the appropriate care and ensure timely face to face provision as required however this impacted phone access with initial answering delays.

7.2.10 The Committee **noted** the Primary Care Commissioning Update report.

7.3 Medicines Optimisation Group Update

7.3.1 The Director of Primary and Community Care introduced the Medicines Optimisation Group Update report.

7.3.2 The forecast for the decrease in Category M values would be a £1-2M underspend which would diminish the significant cost pressures from previous years. The Medicines Optimisation Quality, Innovation, Productivity and Prevention (QIPP) Plan had been approved by the Medicines Optimisation Group (MOG) in March.

7.3.3 Work had been underway with practices and pharmacists as part of the National Rebate Scheme for Direct Acting Oral Anticoagulants (DOACs) in PCNs to maximise the benefit of the scheme for patients and to facilitate effective prescribing. This included the review of alternative DOACs.

7.3.4 The reduction seen in antibiotic prescribing during Covid-19 was now increasing across all age groups. Dorset remained slightly below the national average which was now approaching pre-pandemic levels. This remained under review with practices to address unwarranted variation.

7.3.5 Transformational pharmacy work continued which included Electronic Repeat Dispensing (eRD) and variation remained with application of the programme. The GP Community Pharmacy Consultation Service had featured in the Winter Access Fund to maximise the potential of the service. Software tools had been engaged to assist and to support General Practice with the application with work underway to demonstrate the benefit of the service to practices.

7.3.6 The Committee was concerned with the reported practices that did not submit results for the opioid and DOAC audits and queried how this was being monitored. The GB GP Representative (RR) said that although some practices had not engaged in the audit further work had been undertaken alongside with assurance provided. One practice that had not engaged with both had workforce issues. Prescribing Leads had been working directly with the practices to gain assurance that the work was ongoing. The DOAC audit was part of the PCN

impact investment fund which would be mandated going forward. Further information from the Prescribing Leads would be circulated when available. RR

7.3.7 The Committee noted the Category M savings included a reduction in antidepressant costs however noted that a previous update had reported the requirement to be reinvested into the Mental Health Investment Standard (MHIS) and whether this would represent a saving that could be used to offset other costs. The Director of Primary and Community Care said that as part of the MHIS the increased cost pressures for antidepressant drugs had to be taken into account which linked to the Category M drugs. An additional £700,000 had been invested back into the MHIS Transformation Programme which maintained compliance with the MHIS value.

7.3.8 The Committee **noted** the Medicines Optimisation Group Update report.

7.4 Primary Care Contract Update

7.4.1 The Director of Primary and Community Care introduced the Primary Care Contract Update Report.

7.4.2 Correspondence had been received from NHSE setting out General Practice contract arrangements for 2022/23. Further guidance had now been received with work underway to address the review and implications of the contract changes in collaboration with LMC. The overview of changes and the consideration of key impacts and risks had been set out with the work undertaken to mitigate wider implications. Locally a significant amount of the Improving Access to General Practice Services (IAGPS) resource had been allocated to the Urgent Care Service. It had been confirmed that the resource would go through the network Directed Enhanced Service (DES) with a 'go live' date for October with work underway with practices to support.

7.4.3 The LMC Representative said that there had been difficulties with the imposition of the contract by NHSE with the failure of negotiations with the British Medical Association (BMA). Concerns had been communicated to the LMC from practices.

7.4.4 The Committee was concerned with the reference to online appointment booking. The GB GP Representative (BM) said that triage was currently undertaken within his practice to provide appropriate appointment provision. A return to online booking would result in difficulties with access and potential extended waiting times.

7.4.5 The Committee **noted** the Primary Care Contract Update report.

7.5 Primary Care Provision for Asylum Seekers and Refugees

7.5.1 The Director of Primary and Community Care introduced the Primary Care Provision for Asylum Seekers and Refugees report.

7.5.2 The LES had been developed to respond to the support required for the provision of medical services. South Coast Medical Group had been providing the service to asylum seekers and refugees placed in hotels in the Bournemouth, Christchurch and Poole Council (BCP) area. The service was funded nationally through a framework to recompense associated activity.

7.5.3 It was anticipated that a hotel situated in Weymouth had been potentially identified for provision. Concern remained with the lack of timely engagement with the Local Authority and NHS and with the utilisation of deprived areas. The concern had been fed back nationally for appropriate consideration of the deployment process for placements.

7.5.4 The Committee commended the work undertaken by South Coast Medical Group who had provided a rapid and agile response. It was noted that this would further affect Dorset particularly in relation to the situation in Ukraine. This had put pressure on services for South Coast Medical Group and could create a similar situation in the event of placements in Weymouth.

7.5.5 The Committee **noted** the Primary Care Provision for Asylum Seekers and Refugees report.

8. Public Health Dorset

8.1 The Chief Officer said that the number of Covid-19 positive hospital inpatients was currently between 250 to 270. There was a high number of NHS staff absences which further impacted the position and system challenges during Easter.

8.2 The Director of Primary and Community Care said that the Governing Body had raised concern in relation to the performance of the Health Visitor service and an update would be provided for the next meeting. SSa

9. Any Other Business

9.1 There was no further business discussed.

10. Date and Time of the Next Meeting

10.1 The next meeting of the Primary Care Commissioning Committee would be held at 2pm on Wednesday 1 June 2022, venue to be confirmed.

11. Exclusion of the Public

11.1 It was resolved that representatives of the Press and other members of the public were excluded from the remainder of this meeting having regard to the confidential nature of the business transacted, publicity of which would be prejudicial to the public interest.

NHS DORSET CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE

1 JUNE 2022

PART ONE PUBLIC - MINUTES

Part 1 of the Primary Care Commissioning Committee of NHS Dorset Clinical Commissioning Group was held virtually at 2pm on 1 June 2022.

Present: Maurice Dunster, Governing Body Lay Member and Chair of the Primary Care Commissioning Committee (MD)
Tim Goodson, Chief Officer (TG)
Blair Millar, Governing Body GP Representative (BM)
Ravin Ramtohal, Governing Body GP Representative (RR)
Vanessa Read, Director of Nursing and Quality (VR)
Nikki Rowland, Chief Finance Officer (NRo)
Kay Taylor, Governing Body Lay Member and Deputy Chair, Primary Care Commissioning Committee (KT)

In attendance: Kate Calvert, Deputy Director of Primary and Community Care (KC)
Katherine Gough, Chief Pharmacist (KG)
Margaret Guy, Healthwatch Dorset Representative (MG)
Andy Purbrick, Joint Chief Executive, Wessex LMC (AP) (part)
Edd Rendell, Medical Director, Wessex LMC (ER)
Louise Trent, Personal Assistant (LT) (minute taker)
Joanne Wilson, Head of Programmes, Public Health Dorset

Action

1. Apologies

1.1 Sam Crowe, Director of Public Health.
Sally Sandcraft, Director of Primary and Community Care.

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of Committee members present.

3. Declarations of Interest

3.1 Declarations were made as follows:

- Agenda item 16 – Portesham Surgery and Prince of Wales Road Surgery Merger Application – The Governing Body Lay Member and Deputy Chair, Primary Care Commissioning Committee Kay Taylor was a patient at the Portesham

practice. She would be able to remain for the discussion and decision as her role would not be conflicted.

- Agenda item 17 - General Practice / Primary Care Network Support Programme and Discretionary Funding Protocol – Dr Blair Miller, Dr Ravin Ramtohal and Dr Andy Purbrick would be conflicted. All had received the report and would be able to remain for the discussion but would be required to withdraw for the decision. Edd Rendell was not a Dorset GP however recognising the conflicted position of the LMC Representative he would withdraw from the meeting too. LT

3.2 Members were reminded of the need to ensure Declarations of Interest were up to date and to notify the Corporate Office of any new declarations.

4. Minutes

4.1 The draft minutes of Part 1 of the meeting held on 13 April 2022 were **approved** as a true record.

5. Matters Arising

5.1 The Committee **noted** the Report of the Chair on matters arising from the Part 1 minutes of the previous meeting.

AP joined the meeting.

6. Chair's Update

6.1 The Chair had no matters to update.

7. Reports

7.1 Primary Care Update

7.1.1 The Deputy Director of Primary and Community Care introduced the Primary Care update report.

7.1.2 Primary Care had progressed towards a 'business as usual' position for payments and reporting from April 2022 with an end to Income Protection and with the reintroduction of Local Enhanced Service (LES) activity reporting. The previously reported practice list closure had been reopened early during May due to successful recruitment.

7.1.3 The work undertaken by the Primary Care Team in relation to the Winter Access Fund had received recognition from the NHS England and Improvement (NHSE&I) South West Team,

particularly in relation to Mental Health and the training hub administration scheme.

7.1.4 GP appointment provision remained high due to increased demand in the system. Work in relation to Learning Disability (LD) and Serious Mental Illness (SMI) Health Checks continued. It had been anticipated that the SMI Health Check target would be achieved however this had not been met within the planned timescale.

7.1.5 Work had progressed towards the establishment of a GP Alliance with positive sign up to the Memorandum of Understanding (MOU) by 67 out of 73 practices at this stage.

7.1.6 The LMC Representative noted the increased GP appointment demand and delivery against the backdrop of a reduction in GPs and an increase in practice list sizes. Difficulty remained with patient perception for appointment availability due to media reporting.

7.1.7 The Committee noted that undertaking remote triage for appointments provided efficient access to patients within an appropriate timescale and a return to the previous booking systems would have the potential to generate increased waiting times. Consideration would be required for links with the Primary Care Networks (PCNs) and the Patient Participation Groups (PPG) for the approach to communication with the public for access to appropriate appointments.

7.1.8 The Committee noted the reference within the report to 70% response rate for safeguarding however the reporting did not indicate what the percentage response rate was in relation to and directed that this be clarified. KC

7.1.9 The Committee noted that the reported complaints information did not provide a benchmark to interpret the data. The Director of Nursing and Quality said that the focus within the CCG for complaints was on the analysis to determine themes, trends and learning and for triangulation of the data with any adverse incidents rather than on the quantity received. It was anticipated that complaints would increase due to the rise in demand.

7.1.10 The Committee **noted** the Primary Care update report.

7.2 Medicines Optimisation Group Update

7.2.1 The Deputy Director of Primary and Community Care introduced the Medicines Optimisation Group Update report.

7.2.2 Prescribing had demonstrated a year-end £370K underspend. The Quality, Safety and Cost Effectiveness (QCSE) plan for 2022/23 had been approved at the Medicine Optimisation Group (MOG).

7.2.3 Implementation of the National Rebate Scheme on Direct Oral Anticoagulant (DOAC) prescribing would provide the potential for a significant savings margin of up to £4M achievement over a period of years. Combined with the national PCN Directed Enhanced Service (DES) and the Investment and Impact Fund (IIF) this provided incentives to practices. Structured Medication Reviews (SMR) provided the opportunity to identify suitable patients with DOACs being a criteria for these to be undertaken.

7.2.4 In response to a query in relation to altering DOAC prescribing for patients who remained stable on their current medication to deliver a cost saving it was clarified that this was not a recommendation. This would be for prescribing in the first instance and for any appropriate patients identified through SMR which would provide the opportunity for change. Patient safety remained the priority with the work being undertaken.

7.2.5 The gluten free restricted formulary had been developed with implementation underway and a reduction in the use of a variety of gluten free products anticipated.

7.2.6 Discharge from hospital care remained an evidenced area of potential medication related harm. The Discharge Medicines Service (DMS) encouraged medication review within two weeks of discharge to ensure that medication changes had been communicated appropriately. This had worked demonstrably well in the West with implementation planned for the East.

7.2.7 Work was underway to expand usage of the Community Pharmacist Referral Service (CPRS) with implementation for referral through GP practices.

7.2.8 The Quality, Innovation, Productivity and Prevention (QIPP) plan for the preceding year had not been achieved. The team had been subject to redeployment during the Covid-19 pandemic and therefore had limited resource to support. However, there had been reductions across some areas, such as cost effective formulations and drugs of low clinical value.

7.2.9 The Committee queried whether pharmacist roles had been effective as part of the Additional Roles Reimbursement Scheme (ARRS). The Chief Pharmacist clarified that variation remained across practices. Difficulties had been encountered with individuals utilised to support the vaccination programme and with leavers, due to job dissatisfaction through under-utilisation.

Engagement was underway to ensure that the roles were being utilised to maximum potential.

7.2.10 The Committee **noted** the Medicines Optimisation Group Update report.

7.3 CCG Primary and Community Care Directorate Legacy

7.3.1 The Deputy Director of Primary and Community Care introduced the CCG Primary and Community Care Directorate Legacy report.

7.3.2 The legacy report presented a summary of the positive work undertaken within primary care. This provided the opportunity to acknowledge the support from the Committee on behalf of the Primary Care Team.

7.3.3 The Committee **noted** the CCG Primary and Community Care Directorate Legacy report.

8. Public Health Dorset

8.1 **Children and Young People's Health Service**

8.1.1 The Head of Programmes, Public Health Dorset provided the Committee with a presentation on the Children and Young People's Health Service.

8.1.2 Key points included:

- The Children and Young People's (CYP) Health service was provided though Dorset HealthCare University Foundation NHS Trust (DHC).
- The service model provision consisted of assessment and partnership working, health and wellbeing improvement, system leadership and delivering transformation.
- The Healthy Child Programme was provided through skill mix across a range of settings with remote delivery introduced during Covid-19.
- Both the antenatal and new birth visits had been prioritised to be undertaken through face to face Health Visitor approaches.
- The Key Performance Indicators (KPIs) for the mandated contacts undertaken across the two Local Authority (LA) areas were comparable to the England and South West figures for the quarters.
- Delivery challenges had been experienced in the Bournemouth, Christchurch and Poole Council (BCP) area due to high vacancy rates and rising demand which

had led to the requirement for prioritisation of higher need families.

- A confidential text message service had been implemented which provided families with access for prompt contact to the Health Visiting Service for information and advice. This had received positive uptake and feedback.
- Work underway to improve outcomes for CYP and families included a focus on breastfeeding rates with support provision from the Breastfeeding Network.
- The mandatory checks undertaken through the early identification and ready to thrive programme assisted with informing areas of support required for families. Work was underway with multiagency partners to build packages for further development.
- Video Interaction Guidance provided an intervention service to enhance communication within relationships with focus areas set out for review.
- A confidential text message service had been provided for CYP aged 11+ to obtain advice from the School Nurse Service.
- Future priorities included development of a robust healthy child offer for 0–19-year-olds to promote wellbeing and to tackle health inequalities and wider health determinants.

8.1.3 The Committee noted the reported challenges for the Health Visitor service in the BCP area which had moved to a central hub to bolster service resilience. GP feedback in relation to service centralisation had included a loss of personal contact with the removal from practices and with continuity of care for families who reported being seen by a different Health Visitor for each appointment. The difficulties in the hub had been recognised with the challenges to build local relationships alongside recruitment difficulties.

8.1.4 The Committee was concerned that the reported figures indicated the achievement percentages within timescales rather than the total number of children who had received checks. The reported prioritisation of families with the greatest need or vulnerability to receive the assessments was queried as it would only be when the visits had been undertaken that this could be determined and it was important to receive assurance that the data reflected that the same child or family was not being missed. There remained the requirement to ensure that Public Health colleagues worked with the provider to determine any gaps to ensure that opportunities for intervention would not be missed. JW

8.1.5 The Committee noted the early identification and ready to thrive figures for communication skills with 94% meeting the threshold

for quarter one but with all other skill areas showing higher rates of achievement. It was noted that this was in relation to the approach to capture the data during each period and work was currently underway to drill down and review all areas.

8.1.6 The Committee was concerned with the reported KPI figures with whether these indicated that checks were not being received within the given timeframe or were not being undertaken at all. It was noted that for some areas this would be due to the data submission timeframe with the example that new birth visit figures were captured for those undertaken within 14 days however these were also undertaken out with that timeframe but within 30 days. Families with the greatest need and vulnerability had been prioritised for the 14 day contact. Additional checks were being determined for timescales where developmental milestones had not been met with these further follow ups not captured within the mandated data.

8.1.7 The Committee **noted** the Children and Young People's Health Service Presentation.

9. Any Other Business

9.1 There was no further business discussed.

10. Date and Time of the Next Meeting

10.1 The arrangements for the next meeting of the Primary Care Commissioning Committee would be confirmed shortly.

11. Exclusion of the Public

11.1 It was resolved that representatives of the Press and other members of the public were excluded from the remainder of this meeting having regard to the confidential nature of the business transacted, publicity of which would be prejudicial to the public interest.

9.3

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

URGENT DECISIONS REPORT

Date of the meeting	20/07/2022
Author	F King – Governance and Committee Officer
Lead Director	T Goodson – ICB Programme Director
Purpose of Report	To inform the ICB Board of urgent decisions taken by the Chair and Accountable Officer of the CCG.
Recommendation	The ICB Board is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	There are no conflicts of interest identified in relation to this report.
Involvement and Consultation	N/A
Equality, Diversity and Inclusion	N/A
Financial and Resource Implications	The cost of the proposal for the set rate uplift of framework provision to align with DC has financial impact of £406,952 and the costs of a % uplift for non framework providers has a financial impact of £697,256 to £1,003,156 This is additional and needs to be recurrent monies.
Legal/governance	Urgent decisions are undertaken in accordance with the powers reserved to the ICB Board as set out in the Dorset NHS Integrated Care Board Constitution.
Risk description/rating	N/A

1. Introduction

1.1 The purpose of this report is to inform the ICB Board of Urgent Decisions made by the Chair and Accountable Officer of the CCG in consultation with the Chair and Chief Executive of the Dorset ICB under Standing Orders.

2. Report

2.1 Standing Orders permit decisions reserved for the ICB Board, to be exercised by the Chair and the Accountable Officer, having consulted at least two members. Exercise of such powers should be reported to the next formal meeting of the ICB Board in public session for noting.

3. Conclusion

3.1 That the ICB Board **notes** the decisions taken by the Chair and the Accountable Officer of the CCG (or those acting in their stead) under Standing Orders.

Date	Details of Decision
16/06/22	Approval of the uplift for providers on the Dorset Council (DC) framework to align with DC rate increases. Approval of an uplift for non framework providers of between 4 – 5.6% to align with the increase given to non framework providers in the Bournemouth, Christchurch, and Poole (BCP) area as some providers provide care for packages located in both Local Authority areas.

Author's name and Title: **F King – Governance and Committee Officer**
Date: **06/07/22**