Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

BOB ICB BOARD MEETING

Title	Joint Forward Plan – Progress update		
Paper Date:	06 September 2023	**Board Meeting Date:**	19 September 2023
Purpose:	Update	**Agenda Item:**	09
Author:	Usmaan Rahman, Strategy Development Lead; Robert Bowen, Acting Director of Strategy and Partnerships	**Exec Lead/ Senior Responsible Officer:**	As at publication - Robert Bowen, Acting Director of Strategy and Partnerships

Executive Summary

At the end of June 2023 our first NHS Joint Forward Plan (JFP) for the Buckinghamshire Oxfordshire and Berkshire West (BOB) ICB and partner NHS Trusts was published. This sets out detailed delivery plans to improve services for people who live and work in BOB and how we will move towards delivery of our vision that '*Everyone who lives in BOB to have the best possible start in life, to live happier, healthier lives for longer and to be able to access the right support when they need it*'.

As explained in the JFP, the primary mechanism for reporting progress will be through already established governance groups, most of which have wide system representation to ensure visibility and accountability is maintained.

This paper sets out a summary of progress from the first 4 months of delivery against the ambitions set out in the JFP. The summary has been collated from more detailed service level reporting, coordinated through the ICB directorate teams, using the structure of the JFP documentation.

Our System Challenges

The paper also highlights key transformational work taking place against our 4 identified system challenges:

- Inequalities – We have integrated data from Buckinghamshire and Berkshire West already accessible in our connected care tool. Oxfordshire's data is expected to be included before the end of the calendar year. Using Population Health Management (PHM) this will improve decision making and identify more opportunities for targeted support.
- Model of Care – Work has started on the Primary Care Strategy that will set our plans for a more integrated ways of working. Partner organisations and teams are involved, and we will continue to ensure we have the right input and oversight as plans develop further.
- User Experience – As a system we are aware that some people wait longer than they would like to access the care and support they need. The Acute Provider Collaborative, working with the Elective Care Board have identified initial areas for pathway-based demand and capacity activity, focusing on ENT, Urology and Outpatients.
- Sustainability – We have developed the ICS Efficiency collaboration Group (IECG) to identify areas of productivity and efficiency, supporting the journey to a balanced position and have defined the modelling capabilities to deliver the long-term planning. In July we approved the BOB Interim People Plan 2023. The five-year People plan will build on these ambitions and take full account of national ambitions set out in the NHS long term workforce plan, published on 30 June.

Highlights

JFP delivery highlights from the first 4 months have been summarised using the 3 A's framework.

- Alert – Highlighting challenges to delivery and mitigations (where possible).
- Advise – Minor challenges to delivery, but not significant to delay delivery.
- Assure – Progressing with no concerns.

Early delivery challenges

Several areas have been identified as potential delivery challenges through the JFP reporting process:

- Analytical support – A few service areas have raised concerns on the capability to capture information on metrics and having the data to make informed decisions. Parallel work on analytical capacity and requirements will provide an opportunity to review and prioritise support to relevant service areas.
- Resource – Workforce pressures both within the ICB and our partners may have an impact on the delivery of some workstreams. This has been compounded by the challenges of Industrial Action since April. The acute provider collaborative may mitigate some resource constraints. Others will be subject to ongoing recruitment activities.
- System working – The JFP includes ambition for a system-wide approach to developing and delivering services. In areas where this is new or complex, teams continue to refine ways of maximising partnership working at system and place levels. The ICB continues to share JFP delivery progress with partners and will be including Local authorities in the 2024/25 JFP development work.

Next steps

The strategy and partnerships team will continue to work closely with planning leads to refine the process for monitoring and work closely with financial and operational planning to ensure alignment. The JFP will be shared with local authorities/partners and a plan put in place to develop and share the quantitative part of JFP reporting, working closely with service areas and analytics team.

Development has already started for the 2024/25 JFP refresh; A series of working sessions are being planned for the autumn to agree how system partners can work together to develop a longer-term response to the key challenges the system is facing.

Action Required

The board are asked to:

- Note progress on our year 1 ambitions set out in the JFP.
- Note risks to year 1 JFP delivery.
- Support recommendations for JFP monitoring and development.

Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision

The Joint Forward Plan informs the prioritisation of the use of NHS resources. This will have an impact on organisations led by members of the Board. ICB funding contributes to the pooled budgets managed by local Councils and the contracts held by GP practices impacting the primary care and local authority representatives.
The perspective of these members remains an important aspect to development and delivery of our priorities and plans.

Date/Name of Committee/ Meeting, Where Last Reviewed:	N/A

JOINT FORWARD PLAN – DELIVERY UPDATE

Context

1. At the end of June 2023 our first NHS Joint Forward Plan (JFP) for the Buckinghamshire Oxfordshire and Berkshire West (BOB) ICB and partner NHS Trusts was published. This sets out detailed delivery plans to improve services for people who live and work in BOB and how we will move towards delivery of our vision that '*Everyone who lives in BOB to have the best possible start in life, to live happier, healthier lives for* longer *and to be able to access the right support when they need it'*.
2. The final version of the plan is available on the BOB ICB website.
3. As explained in the JFP the primary mechanism for reporting progress will be through already established governance groups, most of which have wide system representation to ensure visibility and accountability is maintained. In most cases the ambitions of the JFP have been built into wider service work plans and are being reported as a part of these activities.
4. Therefore, this paper sets out a summary of progress from the first 4 months of delivery against the ambitions set out in the JFP. The summary has been collated from more detailed service level reporting, coordinated through the ICB directorate teams, using the structure of the JFP documentation.
5. A number of quantifiable metrics have been captured as part of the reporting and they will be refined and shared once they are fully developed across all service areas. A lessons learnt session was recently attended by some planning leads to understand what can be done differently to improve our process for the JFP.
6. This summary report will be produced twice per year.

Our Biggest System Challenges

7. The JFP sets out priority areas for delivery in 2023/24 linked to areas of identified system challenges.
8. Progress of the year 1 JFP has highlighted some key transformational work developing across the system and with our partners.

I. **Inequalities challenge** – In 2023/24 we aim to strengthen our approach to population health management (PHM) through the creation of an Integrated Data Set across our providers to support decision making and identify more opportunities for targeted support. We have integrated data from Buckinghamshire and Berkshire West already accessible in our connected care tool. Oxfordshire's data is expected to be included before the end of the calendar year. PHM will be enabled by the implementation of the shared care record. PHM tools will be available in a similar timeline. To support our Inequalities and Prevention programme, Place Directors have led the production of plans to use the allocated £4m funding.

II. **Model of Care Challenge** – we have collectively recognised the importance of shifting our focus to a more preventative and community-based approach for health and care services. In 2023/24 we are committed to defining a more integrated approach to primary care, through the delivery of a primary care strategy building on recommendations of the 2022 Fuller Stocktake. Worked has commenced on the primary care strategy, with engagement events held through the place infrastructure; This will include plans to deliver the Primary Care Access and Recovery Plan. Joining up primary care and other services closer to patients' homes will be essential to improve the quality of care, reduce the number of hospital attendances, reduce wait times and drive efficiency and productivity.

III. **User experience challenge** – As a system we are aware that some people wait longer than they would like to access the care and support they need. We have committed to reviewing the demand and capacity, on a pathway basis, of some services identified by the Elective Care Board and Acute Provider Collaborative teams. The initial clinical areas are ENT, Urology and outpatients. The development of our acute provider collaborative programme will mitigate some of our resource constraints and deliver system wide productivity and efficiency improvements. Additionally, we are increasing community diagnostic centre (CDC) utilisation and expand our range of services and to develop pathways to support GP direct access to imaging services, cardiology and respiratory testing, and pathology.

IV. **Sustainability challenge –** Recognising the collective challenges of the financial environment and ambition to do more to support our staff and volunteers, we have committed to developing joined up, longer term plans for both areas. We have set up the ICS efficiency collaboration Group (IECG) to identify areas of productivity and efficiency, supporting the journey to a balanced position and have a developed a high-level model to support the scenario planning. In July we approved the BOB Interim People Plan 2023. The five-year People plan will build on these ambitions and take full account of national ambitions set out in the NHS long term workforce plan, published on 30 June. Together these will describe how we will achieve financial balance and a stable, resilient workforce.

Highlights of progress

9. Key highlights of the JFP progress from the first 4 months of delivery can be found below, focussing on the transformational work happening with health and care partners across the system.
10. Highlights grouped using the 3 A's:
    - Alert – highlighting challenges to delivery and mitigations (where possible)
    - Advise – Minor challenges to delivery, but not significant to delay delivery.
    - Assure – progressing with no concerns.

Strategic Theme	ALERT
Promote Health	Inequalities and Prevention • Work yet to commence on mapping our networks and influencing existing physical activity and weight management workstreams. • There is a risk that without accurate data and / or capacity for analytical support, programmes may be poorly targeted, be unable to be adequately evaluated and implemented at Place and/or BOB.
Start Well	• N/A
Live Well	Adults Mental Health • NHS Talking Therapies for Anxiety and Depression some challenges remain around access rates. The complexity and length of time patients require in the service is a significant factor. • There is a risk to the delivery in the elimination of inappropriate Out of Areas Placements. Work is required to baseline bed numbers against patient need and explore opportunities to expand local provision.
	Adults Long Term Conditions • An increasing number of Buckinghamshire general practices do not provide inhouse ECG testing. This is not only affecting equity of access but is impacting on the early detection, diagnosis and treatment.
	Integrated Cardiac Delivery Network • Complexities of Information governance and digital requirements within an evolving ICB/ICS structure has resulted in delays to the overall timeline and roll out.
	Cancer Services • Continued Industrial Action is likely to impact on ability to improve and sustain operational performance. • Access to sufficient clinical data to support improvement work
Age Well	• N/A

Improving Quality and Access	Urgent and Emergency Care (UEC) • Our delivery of reduced General and Acute bed occupancy is interlinked with the need to recover elective care. The extent to which UEC performance can be sustainably delivered is also dependent on capital investment in some instances.
	Planned Care • At the end of June 2023, 27.2% of patients were waiting more than 6 weeks for a diagnostic test in BOB – target is 5%. Overall maintaining position - total waiting list is remaining static and the number waiting over 6 weeks is not increasing significantly. Activity levels are increasing month on month with 59,134 tests delivered in June. • Continued Industrial Action is likely to impact on ability to improve and sustain operational performance. • Diagnostics capacity issues - particularly non-Obstetric ultrasound, MRI, CT, Endoscopy. A refresh of the diagnostics strategy to set out our ambitions and priorities across the system. • Access to funding to support recovery plans i.e., new equipment, outsourcing, insourcing, increasing in-house activity.
	Palliative and End of Life Care (PEoLC) • Workforce issues and boundaries to deliver enhanced transitional services. • Data collection and analyst limitations slowing the co-design for potential PEoLC provider collaborative.
Supporting and Enabling Delivery	Workforce • Cost of Living project underway: research commissioned (close to completion) with working group in progress of being set up to explore and develop further proposals for further work to be considered through People Committee Governance. • Cost of Living Project purely health focused, need to engage and involve wider system partners. • ICS Retention Lead retired from post August 2023, post currently vacant: concern regarding capacity and pace of delivery of objectives.
	Digital and Data • Acute Electronic Patient Records (EPR). The decision has been made not to pursue convergence of EPRs across the 3 x acute providers within BOB. The review of this decision in the medium-term future will sit with the Acute Provider Collaborative.
	Estates • Infrastructure strategy needs to be developed to confirm priorities.
	Safeguarding • Availability of aggregated data to understand demand and capacity. Capacity of ICB Safeguarding Team to deliver an ambitious JFP for Safeguarding Children in Care/Looked After Children whilst maintaining statutory compliance of ICB. Budget constraints. Workforce capacity constraints in child and adult safeguarding across the system impacting safety, performance, oversight, support, and integration. • The following workstreams are delayed due to long term sickness/delayed secondment: o Domestic Abuse o Legal Literacy o Implementation of multi-agency risk management (MARM) frameworks
	Infection prevention and control • Some trusts patient information platforms require updating, transition towards this is being planned for, although there is a risk to a temporary reduction in access. There is some variance in reporting and monitoring of some IPC related aspects e.g., National Standards of Healthcare Cleanliness, Surgical site infections and Healthcare Associated Infections.
	Personalised Care • Significant digital interdependency required to deliver Respects
	Research and Innovation • The ICB has not as yet agreed a robust process to agree the research and innovation priorities of its key workstreams but has reviewed current AHSN programmes and is mapping them with identified JFP clinical priorities. • The ICB still lacks the in-house resource and infrastructure to support this important function.
	Delegated Commissioning • There is a risk that the system will not have sufficient capacity or knowledge to discharge statutory commissioning responsibility for delegated services.

Strategic Theme	ADVISE
Promote Health	Inequalities and Prevention • Work ongoing to embed inpatient Tobacco Advisory Services, there is a national expectation that trusts achieve > 60% coverage in inpatients and 100% in maternity. Some recruitment difficulties have been reported in recruiting Tobacco Dependency Advisors (TDAs) so flexible approaches with well-established TDAs in maternity services being explored.
	Immunisations and Vaccinations • Community engagement activities supported across all Places. Trial of multi-vaccination pilot into unaccompanied asylum-seeking children successful with over 70 Vaccines delivered. Significantly lower uptake noted in our Pakistani and Black population in the spring program. Working with Berkshire public health team to review further opportunities for engagement.
Start Well	Women's Maternity and Neonatal • Local Maternity and neonatal system (LMNS) continue to develop their data capabilities and had an analyst starting in the team Sep 2023 and will work solely on data capture monitoring and evaluation to support decision making and quality oversight and measurement of deliverables across the three-year maternity and neonatal plan
	Learning Disabilities • Dashboard in development to monitor Alternating Hemiplegia of Childhood (AHC) and Health Action plans (HAPs). Pilot in development for AHC app for adults. Risk that the pilot does not deliver the expected result.
Live Well	Adults Mental Health • Reducing inappropriate Out of Areas Placements (OAPs): there are data quality issues within reporting for Oxford Health FT (OHFT). Local intelligence is highlighting a decreasing trend in OAPs. Patient Flow Team in place in Oxfordshire and there is a Patient Flow Delivery Group. Award of £2.3m from the Better Care Discharge Fund and work taking place for a BOB-Wide Discharge Group to plan other initiatives. Plan better understanding of the data quality/sources and put in actions to support ambition.
	Adults Long Term Conditions • Our proactive approach requires a few changes to be in place in primary, community and secondary care therefore currently we are working in Places to develop relationships with our partners to set the foundation for this approach.
	Integrated Diabetes Delivery Network • The Diabetes Recovery Locally Commissioned Service came to an end on 30 June 2023. Practices who had not met their targets have been given the opportunity to submit an improvement plan.
	Cancer Services • Ongoing discussions with Trusts via various Trust level fora focussing on Trust Cancer Improvement Action Plans to support oversight and assurances of key actions being taken to deliver both reducing Trust and overall system backlog. Challenges relate to increased referral trends, diagnostic capacity challenges, workforce capacity and pathology.
Age Well	Age Well services • Supporting carers an emerging theme, the ICB have recently employed a member of staff in the Complaints and Patient experience team to co-ordinate knowledge and understanding of work in this area.
Improving Quality and Access	Planned Care • Our aim over the next 12-24 months is to increase community diagnostic centre (CDC) utilisation and expand our range of services and to develop pathways to support GP direct access to imaging services, cardiology and respiratory testing, and pathology. Joining up primary care and diagnostic testing in settings that are closer patients' homes is essential to reduce the number of hospital attendances, reduce wait times, drive efficiency and productivity, and improve the quality of patient care. CDC revenue approvals process for 2024/25 will commence in October 2023. This is an opportunity for providers to bid for additional revenue and central costs to support development and expansion of services.
	Primary Care • Primary care strategy development underway. Plan in place to deliver the Primary Care Access and Recovery Plan including initiatives to provide headspace including direct access referrals and primary / secondary care interface improvements.

Supporting and Enabling Delivery	Digital and Data • Population health management (PHM) functionality will be enabled by the implementation of the shared care record. PHM tools will be available in a similar timeline to availability of the shared care record. Significant communications and engagement work will be delivered to support clinical and commissioner uptake of these tools when available later this financial year. It is expected (experience from other ICSs) that maturity of in the use of PHM will take time to develop.
	Personalised Care • Interdependency with ICS teams to deliver Personal Health Budgets for Wheelchair users, S117 and Continuing Healthcare
	Net Zero • It has been recognised that the pace and scale of the required cultural change can only be delivered through the leadership and support of our wider System Executive Partners to embed sustainable practices into the heart of our operations and culture at every level. Going forward, BOB ICS must create a compelling case for change across our organisations and align our sustainability ambitions with the delivery priorities of our respective teams. We need to increase the volume of individuals involved and owning the Net Zero agenda.

Strategic Theme	**ASSURE**
Promote Health	Inequalities and Prevention • Place directors have led local production of plans to utilise the £4m inequalities and prevention funding. • £835K allocated across BOB Acute Providers to embed Tobacco Advisor services. First half year funding awarded.
	Immunisation and Vaccinations • The Improving Immunisation Uptake Team (IIUT) have delivered 10 training sessions across BOB which have covered health inequalities and improved uptake. • BOB has provided a Covid Spring Booster campaign for the over 75-year-olds and immunosuppressed. System wide self-assessment of services, in preparation for the future delegation has been undertaken hosted by Buckinghamshire Public Health team.
Start Well	Women's Maternity and Neonatal • Human factors training has been delivered across the BOB LMNS with excellent attendance from a range of different clinical professions.
	Children and Young People (CYP) Mental Health • Berkshire West is transforming the Child and Adolescent Mental Health service, multi-agency workshop held to map against and inform future service specification.
	CYP Neurodiversity • Demand and capacity review completed. Assessment and triage workstream established. ICS and all Local Authorities have agreed to pilot SPENCER tool.
Live Well	Adults Mental Health • Dashboard in development to monitor access to screening services. Individual Placement Support Service (IPS): Berkshire West service scored 99 (national average 93) in the IPS Grow Fidelity Review. Buckingham IPS scored 111 and awarded a Quality Kite Mark and Oxfordshire IPS scored 112. All IPS across BOB are working to raise awareness of the service to promote referral and all have action plans.
	Adults Neurodiversity • Engagement via newly established Patients Engagement Forum. Inpatient units audit completed, and adjustments implemented use of autism packs and recommendations.
	Adults Long Term Conditions • We are making progress on prevention working with our partners to increase health checks, providing targeted smoking cessations and improving the management of hypertension. Earlier diagnosis has been taken forward for heart failure, respiratory conditions, and diabetes. Areas of focus for inequalities continue to be for patients with hypertension, diabetes and respiratory conditions and priorities on CORE20Plus5.
	Integrated Cardiac Delivery Network • CVD Champions agreed, providing local clinical leadership through practice- based initiatives within primary care networks (PCNs) - focusing on Hypertension and cholesterol. Series of Webinars held and ongoing, supporting overall approach.

	• Work in Berkshire West to develop an integrated approach to Heart Failure, with ability for transferability of learning to areas. Successful bid for national funding to support earlier case finding and optimising of treatment.
	Integrated Diabetes Delivery Network • Following an application for funding to NHSE, a locally commissioned service is underdevelopment to improve outcomes in those with early onset Type 2 Diabetes (aged 18-29). The funding of £168k per year for two years will be used to help improve glycaemic control, weight management, and improve care and outcomes during pre-pregnancy and pregnancy.
	Integrated Respiratory Delivery Network • First Respiratory Innovation and Insight Panel was held on 28 March. Four innovations reviewed and assessed. Potential pilot for Helicon Health Hailie Smart Inhaler working with the AHSN.
	Integrated Stroke Delivery Network • Utilisation of NHSE Catalyst to fund two projects to increase psychological support for patients in Buckinghamshire and deliver 6-month reviews for patients in Oxfordshire to reduce variation in rehabilitation services to ensure equity across BOB.
	Cancer Services • There has been a steady reduction in the over 62-day cancer backlog across the 3 Acute Providers so far this year. TVCA have continued to ensure oversight of the reduction of the 62-day backlog. • TVCA have commenced engagement with Place Inequalities Leads within BOB to broaden the reach of the Allies Programme and ensure alignment with the overall BOB health inequalities strategy. • TVCA work with our Clinical Advisory Groups (CAGs) which are in place for all tumour types to review and monitor treatment variation across the ICB. As part of the National Cancer Programme requirements and Getting It Right First Time, we have been supporting work with Lung Cancer.
Age Well	Age Well services • Exceeding Social Prescribing referral trajectories for referrals to social prescribers for patients across BOB. ICB Social prescribing team supporting PCNs to realise the impact and value of NHS Social prescribers, care coordinators and Health Coaches and to retain the services in to 2024/25. • ICB Personalised Care training team offering training to health staff to build confidence, knowledge and skills around personalised care and support planning and motivational interviewing.
Improving Quality and Access	Urgent and Emergency Care (UEC) • All three acute providers have ED recovery plans in place to support improved patient experience and performance against key UEC indicators. We continue to share best practice from across and beyond the system to ensure adaption and adoption of proven initiatives from elsewhere. • As a system we continue to perform well in the delivery of Urgent Community Response, consistently exceeding the 70% standard for a 2hr response by more than 15%. • All three places have robust plans in place to expand virtual ward capacity by the end of March 2024 and the system continues to deliver good occupancy rates which are consistently more than 70%. In Q1 virtual ward capacity expanded by 78 beds (from 270 to 348 beds).
	Planned Care • We have a refreshed Diagnostics Strategy which sets out our ambitions for the next 5 years. The priorities set out have been developed with colleagues through a range of methods and will be key to focussing our collective efforts on the work required to support elective and cancer recovery, ensuring we continue to address health inequalities and improve access. The Strategy also sets out the actions required to secure sustainable services and the transformation required to expand our capacity and capability over the coming years to meet our growing population needs through the implementation of digital enablers and workforce development. • Moving to new models of care such as: Discuss and refer, asynchronous appointments, diagnostics before referral, one stop shops with diagnostics on the day etc. • Work commenced with lead provider to refine and cleanse source EPR dataset in preparation for scaling across the ICS.
	Primary Care • 90% of practices have advanced telephony in place. • Proof of concept for 6 practices / PCNs in robotic process automation
	Palliative and End of Life Care (PEoLC) • Working with our Virtual Wards teams to move forward with having Virtual Wards for PEoLC. In Berkshire West, there has been a virtual wards workshop in July to discuss what this will look like and next steps. Task and Finish Groups will commence from September 2023 working towards a go live for a Berkshire West PEoLC Virtual Ward.

Supporting and Enabling Delivery	Digital and Data • Implementation of the Thames Valley & Surrey Shared Care Record across BOB is expected to go-live for direct care applications in October 2023 (Buckinghamshire and Berkshire West) and December 2023 (Oxfordshire). • **Virtual Wards (VW).** The programme is on track to meet the NHSE targets of 460 VW beds by Apr 2024 across BOB; however, most of these beds will not be using remote monitoring technology. A digital working group has been established to scope digital & data requirements.
	Finance • Operating plan process for 2023/24 finalised and submitted in accordance with national timeframes; planned deficit agreed with national team. • Long term financial model in progress, now populating with information across system partners.
	Quality • National Patient Safety Strategy being implemented across the system. All providers managing transition to patient safety incident response framework (PSIRF) supported by the ICB. • Quality assurance framework co- designed with system partners, consulted on and approved. Implementation plan for its use being developed. restructure to support use implemented. Common dataset on place.
	Safeguarding • Second meeting of BOB ICS Partners Safeguarding Committee, 19 July 2023 brought together senior system partners and highlighted our collective passion to safeguard our most vulnerable citizens and the pressure points in the system. These will be addressed at both place and system level and within individual agencies where indicated.
	Infection prevention and control (IPC) • IPC Leads across ICS are meeting regularly to develop relationships, discuss IPC issues and identify shared learning.
	Personalised Care • Over 300 members of health staff trained in personalised care approaches in Q1 (Shared Decision Making, Motivational Interviewing, Making Every Contact Count, Understanding Personalised Care) • LMNS Personalised Care and Support Plan finalised and coproduced with patient peer leaders.
	Research and Innovation • The ICB has met with the AHSN to agree and share our joint research and innovation priorities for 2023/24. These will then be discussed and shared with member and partner organisations to identify areas of commonality and to begin discussions around future planning beyond 2023/24.
	All Age Continuing Care • Transformation programme developed which identifies opportunities for strengthening capability and capacity at ICB level e.g., commissioning specialist placements and provision of CYP CHC. Two OHFT teams transferred in to the ICB.
	Delegated Commissioning • The **Specialised Commissioning (SC)** Partnership Board has been established since April 2023 with ICB executive representation to discharge our joint decision-making authority for the 59 (Green) SC services and deliver the requirements for the transfer of Specialised Commissioning responsibility

Early delivery challenges

11. A few risks are highlighted in the JFP updates, and they have been grouped into the following themes; Where applicable, the risk has been recorded on the BOB ICB 4risk system.

- Analytical support – A few service areas have raised concerns regarding capacity to access and analyse data to understand progress and make informed decisions. In discussion with our analytical team, the ICB are mapping all the metrics/data sources currently available. There will then be an opportunity to review and prioritise support to teams which will better enable them to develop metrics in their service areas and avoid duplication.

- Resource – Workforce pressures both within the ICB and our partners may have an impact on the delivery of some workstreams. This has been compounded by the challenges of Industrial Action since April. The acute provider collaborative may mitigate some resource constraints. Others will be subject to ongoing recruitment activities.

- System working – The JFP includes ambition for a system-wide approach to developing and delivering services. In areas where this is new or complex, teams continue to refine ways of maximising partnership working at system and place levels. The ICB continues to share JFP delivery progress with partners and will be including Local authorities in the 2024/25 JFP development work.

Asks of the Board

12. The Board is asked to:
    - Note the delivery progress made against our year 1 ambitions as set out in the JFP.
    - Note challenges for year 1 JFP delivery.
    - Support next steps for JFP monitoring and development.

Next steps

13. The strategy and partnerships team will continue to work closely with planning leads to refine the process for monitoring and work closely with financial and operational planning to ensure alignment. We continue to engage with local authorities/partners on our JFP process, outlining their involvement/membership in the sub committees which oversee delivery. We will also develop and share the quantitative part of JFP reporting, working closely with service areas and analytics team.
14. We have an outline timetable for the development of the next iteration of the JFP update facilitated by the strategy and partnerships team. This will focus on identifying and agreeing priorities for system delivery, in line with the Integrated Care Strategy with system partners, before January 2024 and then developing the more detailed plans in parallel with system operational planning, in advance of April 2024.
15. Development has already started for the JFP refresh from 2024/25; A series of working sessions are being planned for the autumn to agree how system partners can work together to develop a longer-term response to the key challenges the system is facing; plans will form part of the JFP refresh for 2024/25. A timetable will be developed and refined over the next 6 months and will be presented to the appropriate committees/Board in March 2024.