Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 25 August 2022, 1400-1630, on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance	ED
Rosi Shepherd	Chief Nursing Officer	RS
Lisa Manson	Director of Commissioning	LM
Michael Richardson	Deputy Director of Nursing & Quality	MR
Joanne Medhurst	Chief Medical Officer	JM
In attendance		
Sandra Muffett	Head of Patient Safety and Clinical Governance	SM
Jeff Farrar	Chair, BNSSG ICB	JF
Rosanna James (Item 08)	BNSSG D2A Programme Director, Sirona	RJ
Ceridwen Massey (Item 08)	Chief Operating Officer, Sirona	CM
Sarah Carr	Corporate Secretary	SC
Gary Dawes	BI Manager - Performance	GD
Caroline Dawe	Deputy Director of Commissioning (Performance Improvement)	CD
Freda Morgan (notes)	Executive PA	FM

	Item	**Action**
01	**Welcome and Apologies** ED welcomed colleagues to the meeting and welcomed JF to his first meeting.	
02	**Declarations of Interest** None declared	
03	**Minutes of July 2022 meeting** Minutes of the previous meeting were agreed as a correct record, noting items highlighted in yellow are for CLOSED minutes only, with rewording of one sentence on page 4.	

	Item	Action
	ACTION: LM to send FM updated sentence regarding social care risk on page 4.	**LM**
	ED noted that although formal committee meetings were stood down during July and August, it was decided that this committee would continue, to discuss membership inclusion of the patient voice, the Quality and Performance report, and challenges within the system that contribute towards performance issues. It has been evident from discussions that a lot of performance related issues relate to system-wide problems, and JF's view would be welcomed on how these can be covered across committees without duplication. JF said the Risk and Audit Committee will discuss prioritisation and appropriate committees. He would like to see committees inviting colleagues to attend to give evidence. The role of the ICB is to hold partners to account for system decisions. The closed ICB Board next week will cover the rhythm and style of the ICB and its committees. JF noted there were no system partners present at today's meeting. ED said the purpose of the July and August committees was to establish shared understanding and that system partners will have representation from September onwards. JF the ICB Board next week may ask whether all partners are seeing the same data, if there is agreement on priorities and service demand, and whether there is collective management of performance. RS said this committee will be responsible for managing performance as safely and to the best level of quality possible, noting the system is working under constrained circumstances.	
04	**Committee Membership** RS updated. Sue Balcombe of UHBW has been invited as a Non-Executive Director (NED) representative. A community provider nomination is awaited from Sirona. Adrian Childs (Director of Nursing & Quality, AWP) has been asked for a nomination from AWP for Mental Health. Hugh Evans (Executive Director: Adults and Communities, Bristol City Council) has been confirmed as Local Authority Representative. Vicky Marriott from Healthwatch has been asked for advice on the patient voice representative, either through Healthwatch or a voluntary and community sector partner. Primary Care representation is being discussed by RS and LM following this meeting.	

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	LM suggested Sue Balcombe as Vice Chair. ED said she wanted to defer appointing a vice chair until there is understanding of how members work together. JF said that as this is a statutory board, an ICB NED should be vice chair. There needs to be enough non-executive involvement in the committee to apply the right degree of support, challenge and scrutiny. Regular attendance by executive members who are not ICB staff is good, but there will be some challenge around what their particular organisations are doing. JF said he would also like to be able to invite people in for the committee to hold to account, and the committee will need to discuss if that is the same as being a member. RS said acute provider representatives will all be NEDs and will be attending to drive improvement for the system rather than their own organisations. She suggested the Local Authority representative may be rotational. The Primary Care representative is likely to be from the GP Collaborative Board and the patient voice from the voluntary and community sector or Healthwatch. This will provide a good balance of executive and non-executive members, and executives will be invited to talk to specific areas either for subject expertise or to be held to account. SC said Sirona had proposed Mary Lewis (Director of Nursing, Sirona) as provider representative for the community, and Paul May as NED representative. ED said she would like to have at least three or four of these representatives on board for the September meeting. **ACTION: RS and LM to confirm representatives to ED at their weekly update** SC noted there is a NED deep dive meeting on 6 September. She also confirmed that according to the current Terms of Reference, today's meeting is quorate.	**RS/LM**
05	**Quality & Performance Report** MR presented the report, noting that a lot of quality elements will be moved into the performance report in future to avoid duplication. There is a key theme throughout on workforce and capacity and delays in care and deferred visits. The Quality team are working with Sirona who are RAG rating their visits, increasing bank and agency, and have a further action plan. Monkeypox has been stood down from national incident and a pathways group, led by the Nursing & Quality directorate, has been stood up to coordinate monkeypox across the system. Sexual health services have been involved and there are now pathways in place should a national incident be stepped back up.	

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	South Bristol Urgent Treatment Centre (UTC) has reported 111 demand exceeding UTC capacity on many occasions, resulting in further system pressure when remote assessments are switched off. AWP are improving their Serious Incident (SI) investigation backlog, and there is more assurance on them implementing learning. There have been less grade 2 pressure injuries reported, but more deep tissue, again related sometimes to delayed visits. C.Diff infections are a little above the England average. The IPC team are working on a hydration project across the system which will help improve E.Coli figures. There was a spike in MRSA in April. The post-infection report has not shown any link, but the team continue to monitor. Adult CHC are keeping to their 28 day performance target. RS noted that healthcare acquired infections will be made worse by extended lengths of stay for older people, as the longer in hospital the more likely they are to acquire infections. JF said there needs to be analysis to pull out which items need a system level focus, and which are already being focussed on by the outcomes committees in partner organisations. RS said areas of harm which are believed to be due to system pressure will be included in the Quality & Performance Report. The goal is for the Quality and Performance teams to work together to target quality elements against system strategic priorities and show impact. There is also information that needs to come to the committee to fulfil statutory duties and reporting arrangements. LM said a decision needs to be made on where to take reports from providers such as Severnside, Vita and Cygnet, who are directly contracted by the ICB but are not partners. JM said she met with SC this morning to discuss the role of the Chief Medical Officer and Clinical Cabinet and asked for agreement on what the Committee needs to see, and what can be delegated to the Chief Medical and Chief Nursing Officers. MR said the new Patient Safety Incident Response Framework (PSIRF) is about focused thematic learning rather than individual incidents and will be able to filter into this.	

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	RS said she will bring minutes from the System Quality Group to this Committee and discuss recent safety issues. JF asked how the ICB's safeguarding responsibility translated into the system. RS said significant safeguarding incidents are dealt with by MR's team, and the annual report is on the agenda for today's meeting. JF said looking at things such as safeguarding from a system perspective can add value, as it will look at the impact on our population from birth to adult in a way that other organisations will not. It was agreed that the partner annual safeguarding reports, which are signed off by their organisations' safeguarding executives, will be brought to the ICB board. LM said the challenge with safeguarding is closing the loop down; the Health and Care Partnership Executive could challenge on changing policies or commissioned services. **Performance Report** LM presented the Performance Reports, including the ambulance handover report and progress against the operational plan. Progress is being made against 104 and 78 week waits for elective care. The system is in Tier 1 scrutiny with the national team, and weekly meetings are being held to monitor progress at individual patient level. A number of options are being explored to eliminate 104 week waits in the acute sector and reduce 78 week waits to under 2,000 by the end of March. This process is being actively monitored. Improvement work is underway in Cancer, particularly in breast and urology which are the most challenged areas in NBT. The cancer team have been invited to attend this committee in September to do a deep dive on testing and embedding in order to deliver the improvement. In urgent care, no providers have delivered the 95% national performance standard. Improvements have been made, and performance is now 60-70%. A range of factors have impacted on this including a significant number of ambulance handover delays and ongoing flow issues within hospitals. NBT have taken actions to improve flow which has had a marked impact on delivery and has led to the system delivering the mean Category 2 ambulance performance. If something similar could be done at the BRI to improve ambulance performance this will free up the ambulance service to meet the needs of the population as well as improving flow in EDs.	

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	ED noted the last committee had celebrated the initiative in place at NBT to push beds through towards wards. LM said risk is being managed by discharging patients from ED to be supported in wards instead of waiting for a bed to become available. This spreads risk throughout the hospital, and creates pressure and tension, and encourages use of the discharge lounge and discharge earlier in the day. The intention is to ensure there are always beds to flow into the acute medical units and across the wards. ED asked whether a different kind of innovative solution would be needed at UHBW, given their different architecture. JF said he has spoken to Eugene Yafele (Chief Executive, UHBW) and he said they are looking at changes at UHBW. RS said she is doing a walkabout with Sue Doheny (Regional Chief Nurse, NHSE) at the BRI on Tuesday 6 September. LM said significant actions are being taken within both trusts as part of their hospital improvement programmes, particularly in configuration of services. Some embedded processes were lost due to the redesign of teams during Covid. Sirona are running a programme to ensure people are aligned in consistency of process, and this is starting to bring benefits in sharing learning and ensuring standard operation procedures are in place between wards. AWP had a reset month in July and have reduced out of area placements from over 40 to 26. ED noted a drop in cancer performance, particularly in breast. CD said cancer performance is deteriorating overall in UHBW and NBT due to a range of issues exacerbated with short-term sickness and recruitment challenges. NBT have done an internal check and challenge and have specialty level plans. UHBW struggle in dermatology and colorectal and have been hit by long-term sickness of one consultant in Weston. The trusts are looking to provide mutual aid between them, particularly for colorectal. She believed there will continue to be deterioration at UHBW into October, but with mitigation on staffing this will improve. The system needs to pick up on some of the actions and think about what can be done differently. ED asked whether this committee is the right area for this focus, as the main challenge appears to be related to workforce. JF said that there is a need to be mindful of the individual performance of specific partners. System challenges about workforce should be either picked up in quality or passed to Jaya Chakrabati and the People Committee to look at a system-wide response. Circulation of data is useful, but this committee does not need to get lost in the detail of that data. ED asked GD if he had found discussions on the performance report useful. GD said it is useful to understand the purpose of the report to get the balance.	

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	JM asked if it would be possible to use Statistical Process Control (SPC) on some of the charts to identify common causes, and the balance scorecard for system metrics. GD said there is an aim to move reporting to a "power BI system", and do SPC charts in that vein, and to look at how the oversight framework is reported on as this has themes running throughout and is the framework for the whole system. **ACTION: ED, LM and RS to review the Quality and Performance Reports in advance of the next Committee**	**ED/LM /RS**
06	**System Quality Group Updates** Minutes of July 2022 System Quality Group were noted for information.	
07	**100 Day Challenge and Ambulance Handover Delays** LM presented the report. The 100 day challenge is a national initiative to deliver against the 10 best practice initiatives that have been identified that demonstrably improve flow and should be implemented in every trust and system to improve discharge. Weekly meetings have been set up, and progress is starting to be made. There has been a significant increase in "No Criteria to Reside" driving pressure. Discharge lounges need to be staffed as a priority so patients can be moved into the lounges by midday. NBT have made a difference by moving patients to wards by 10am and continually generating bed space to move people through. There is an aim to progress and issue Single Referral Forms (SRFs) more quickly and reduce the length of stay for patients who then continue to be monitored in the community.	

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	The other area which is challenged in meeting the national standard is weekend discharges as a percentage of weekday discharges. There is a significant drop-off at the weekend. ED asked if there is anything that could be learned from other systems. LM said the main challenge is workforce. There should be a discharge registrar in every trust with a support team, pharmacy and transport. JM said consultants need a strong relationship with pharmacy support so discharge teams can be effective at weekends. ED asked if the weekly meeting has the right attendance to allow progress to be made. LM said this is the overarching system trying to pull discharges in together rather than saying it is any one partner's particular responsibility. This initiative is continuing until the end of September; as a structure it is helpful to pull together higher-level metrics to show delivery across the system. One of the key challenges in view of this being an NHS initiative is recognising the overlap between NHS and local authority ED asked LM to provide a summary for the ICB Board meeting to describe what is required, so partners can be engaged and involved with this work. **ACTION: LM and ED to discuss a summary of 100 Day Challenge for the ICB Board at their 1:1 on Friday 26 August.** ED asked LM if she was confident in the success of the 100 day challenge. LM said she believed it would lead to improvements, but not at the scale desired by the end of September. Further work is needed to identify if this is a helpful methodology or whether key indicators should be pulled from the work providers are already doing, so the right metrics are in place by the end of September.	**LM / ED**
08	**Discharge to Assess** RJ and CM were welcomed to the meeting for this item LM said Discharge to Assess is the first business case to be pulled together across the Integrated Care System. RJ shared the slides which were circulated in advance of the meeting. There is currently a challenged position with the number of No Criteria to Reside in acute trusts on the national radar, and the system has been described as "over-bedded". An audit of P3 patients has shown that at the point the patients are	

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	waiting in acute trusts, 38% could go home on Home First, but due to a shortage of wraparound support this narrows to 10%. For those discharged to the P3 pathway, only 15% return to their usual place of residence, and most end up in long term placements. If changes can be made to the pathway this will affect care resourcing. There has been significant engagement from Directors of Adult Social Services. Sirona improved P1 discharges. An Internal Critical Incident was declared in July but waiting list data will be back to target level by the end of August. P2 rehab beds and P3 length of stay in the community has not changed and more work is needed to make Home First the primary model of care delivery. The P1 impact is evident mainly in North Bristol and Weston but has not affected overall rising numbers due to delays to P2 and P3, largely in the Bristol locality. The Operating Plan 2022/23 is designed to save 132 acute beds by increasing Home First workforce and transforming services to make better use of P3 pathways and quick referrals from acute trusts. Significant work is underway to prepare the mitigation plan for the September ICB Board and bring 2022/23 back into financial balance. A Local Government Association (LGA) free of charge support offer has been secured, which has helped bring full engagement of the three local authorities and has given the programme validity as a combined health and social care led programme, with the aim of understanding how services and workforce can be integrated going forward to give a more recurrent long-term model. There is a 20% turnover of qualified nursing staff and therapists within Sirona. A plan is being developed to push an alternative workforce model. Sharing P3 audit data with clinical teams has led to the setting up of a virtual ward as mitigation for the issues in getting P1 workforce. This needs system support, qualified professionals and Occupational Therapists to move from the acutes, and consultant support into the Virtual Ward, and unqualified support from Sirona and sub-contractors. Other workforce mitigations include an integrated health and care model for P1, pooling of reablement, and a model of rapid turnaround of unqualified band 2 staff to band 3. LM highlighted that No Criteria to Reside is not just an acute issue, and there are equally significant issues in community pathways. One of the core factors of the Discharge to Assess business case was an agreement to achieve agreed lengths of stay by the end of March 2023, and system work is ongoing with the three local authorities to achieve these targets.	

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	JF asked if all partners were fully engaged in the process. RJ said they are. The issues which will drive success are engagement and financial infrastructures being set to deal with the change. JF thanked RJ and CM for an excellent presentation. He said the partnership board needs to recognise the pressures in the system and asked what is being done about vacancies in social care. RJ said local authorities have plan in place based on their individual set-ups. LM said one of the pieces of work in response to the winter resilience letter is engagement with healthcare providers, and a letter of response has been received with different ideas which need to be tested and actioned. JF said all system partners need to be on board with the same sense of urgency. LM said the challenge is keeping the urgency when the pressure is only coming down one route. There has been sustained pressure for some time on having the ability and capacity to make immediate changes whilst doing medium term ones. Investment has been made in all parts of the system to facilitate this and take it through. RS said there is anxiety about the pressure the NHS and the acute trusts will be under, not only for the winter plan but also for cancer and knock-on harm from performance issues. The local authorities will also be anxious, and some of their capacity is being used to maintain people who are vulnerable at home but cannot get into treatment. RS said she was concerned there is significant harm happening, and some partners are starting to worry. JF said the Board will need to agree priorities to focus minds. JM said she has seen full engagement from partners, but complexity increases away from the acutes. A lot of solutions are being suggested from various perspectives, but there needs to be agreement on what can be done in the first month, celebrate achievements, and then move on to the next piece of work, to make the proposed changes less overwhelming. She suggested picking the highest priorities and putting in additional resource to do these, and then move on to the next set. CM said that is the approach this programme is taking. They are focussing on releasing P1 capacity through use of the frailty virtual ward and working through to perform as a system. ED asked whether the expected improvements are being seen yet, and if there is anything further to discuss that can be taken to the Board. CM said programme resource was stepped up in June. A lot of audit focussed work has been carried	

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	out to enable the team to identify what is needed to make changes. LM said the operational plan is based around a delivery start date of 1 October. There has been a dip below the baseline at times, particularly on P1, which has caused challenges. The balance to strike is maintaining the bed base in P2 and P3 above business case levels, to give stability, recognising that winter will be challenging. Progress will be included in the performance report to give this committee oversight. ED asked if RJ and CM could give an understanding of what plans are in place to get the Sirona workforce into a stronger position going forward. CM said the vacancies currently being carried in Sirona are down to two elements. One is service growth, for example in Discharge to Assess coupled with the Stroke and Virtual Ward programmes, which are three big demands for extra recruitment. There are also a significant number of agency and bank workers in post. A focussed piece of work is underway on recruitment and retention, and the 20% gap in nursing and therapy. There has been a reset in the integrated network teams that deliver community nursing, therapy and response, particularly looking at safer staffing and harm aligned to the national safer staffing rules which are coming in. ED asked if RJ and CM were confident Sirona will be in a position to be ready to support the Discharge to Assess initiative. CM said there is confidence around some elements, particularly the mitigations for P1, but recognising the national situation on recruitment, there needs to be a way of thinking differently about the skill mix, and there is a plan to trial some work with health navigators in the Single Point of Access (SPA) to support delivery. RS said some of the trusts are focusing on international recruitment for nursing and therapy roles, and significant funding is available to trusts for this. Because Sirona is a CIC and not an NHS Trust, they are not eligible for some of the same funding resources as trusts. Mary Lewis has done an amazing job to lobby on this, and has managed to get some money, but this is less than a third of what the acute trusts receive. JM asked what actions are being taken to mitigate staffing shortages, and if the committee required assurance there are robust plans to manage this. **ACTION: JM to meet with CM to discuss Sirona's plans to mitigate staff shortages.**	**JM**
09	**Safeguarding Annual Report**	

	Item	Action
	MR presented the report, which demonstrates delivery of the CCG/ICB's statutory duties for safeguarding children and vulnerable adults. A key piece of work undertaken was a thematic knife crime review which had input from all three local authorities. Webinars were held across the system with statutory and voluntary agencies. The ICB has taken responsibility for the recommendation to improve access to therapeutic support for those at risk from serious violence and the safeguarding team are working with colleagues across the ICB to understand commissioning arrangements for these services. Following engagement with children and young people in care, there has been a clear message to use the term "Children in Care" rather than Looked After Children or LAC. A lot of work has been done to support delivery of services in this area. A designated doctor and an additional nurse have been recruited. A system workshop is to be held next month looking at improvement in a range of areas and working to set up a system dashboard to see where there are improvements in the lives of children in care and health services. There is currently one month of data on the dashboard. The team were grateful to CD for her work leading the implementation of a Care Hotel earlier this year. The Safeguarding team were involved in undertaking quality and safeguarding visits during the planning and operation of the hotel. The focus for the coming year will be on realigning and improving the capacity of the team to develop a system and place based safeguarding model Work will be undertaken with system partners to guide learning and assurance. CD said there had been a lot of tried and tested models for care hotels across different systems. The Care Hotel in Bristol was set up as a system resource providing 30 beds. There was good support from acute partners, and a positive impact particularly on BRI and Weston. ED asked if there was anything that could be learned from the Care Hotel which may be applicable to other programmes. RS said that whilst the hotel provided additional beds, if there are beds available, they will be filled, so there still needs to be a focus on discharging people home, and some of the work LM is undertaking will be a better model. It is easy to see queues and delays at the hospital back door from waiting lists, but it is much harder to see the delays in the community and the impact of these. A System Quality Group session has been planned where Sirona and the local authorities are invited to articulate the potential harm they see in their systems, which can be included in performance reporting going forward.	

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	LM said the care traffic control data will provide insight into partner data which will assist in understanding the challenges. JM said that she and RM are encouraging Sirona to be more overt with their metrics, so we can work with them on that. ED thanked MR and the Safeguarding Team for the annual report and commended the visuals in the report.	
10	**Items for Information** 10.1 Corporate Risk Register Item noted	
11	**Committee Action log** The action log was updated as attached.	
08	**AOB** No further business for discussion.	
	Date of next meeting: Thursday 29 September, 1000-1230	

Freda Morgan
Executive PA
25 August 2022