

## BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 29<sup>th</sup> September, 1000-1225, on MS Teams

### Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Denise Moorhouse	Associate Director of Nursing and Quality, BNSSG ICB	DM
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
In attendance		
Sandra Muffett	Head of Patient Safety and Clinical Governance, BNSSG ICB	SM
Jeff Farrar	Chair, BNSSG ICB	JF
Dani Sapsford (Item7)	Head of Performance Improvement (Planned Care), BNSSG ICB	DS
Nick Smith (Item 7)	Deputy Chief Operating Officer, NBT	NS
Sarah Carr	Corporate Secretary, BNSSG ICB	SC
Gary Dawes	BI Manager – Performance, BNSSG ICB	GD
Caroline Dawe	Deputy Director of Commissioning (Performance Improvement), BNSSG ICB	CD
Tina Mostert (notes)	Business Administrator, BNSSG ICB	TM
Apologies		
Michael Richardson	Deputy Director of Nursing & Quality, BNSSG ICB	MR
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS

Item	Action
01	<p style="color: #0056b3;"><b>Welcome and Apologies</b></p> <p>Apologies were recorded as above</p> <p>ED welcomed colleagues to the meeting and confirmed the following members had agreed to join the committee from October: Sue Balcombe (UHBW), Paul May (Sirona), Hugh Evans (Bristol City Council) and Colin Bradbury (BNSSG).</p> <p><b>ACTION: SC to confirm the above have consented to join the committee and can attend the October meeting.</b></p>
	<b>SC</b>

	Item	Action
	<p>ED said the two substantive items on the Agenda, Winter Resilience and the update on Cancer provision, are key to the Committee's continued focus on Quality and Improvement and asked for two or three key areas to be identified by the end of the meeting to take to ICB Board.</p>	
02	<p><b>Declarations of Interest</b></p> <p>None declared</p>	
03	<p><b>Minutes of August 2022 meeting</b></p> <p>Minutes of the previous meeting were agreed as a correct record</p>	
	<p><b>CLOSED SESSION</b></p>	
04	<p><b>System Quality Group (SQG) Update</b></p> <p>Minutes of 13 September 2022 SQG were noted for information.</p> <p>DM updated on discussions at the September SQG.</p>	
	<p><b>OPEN SESSION</b></p>	
05	<p><b>Quality &amp; Performance Report</b></p> <p><b><i>Performance Report</i></b></p> <p>LM highlighted the following:</p> <ul style="list-style-type: none"> <li>• Urgent care performance on 4-hour response has not improved despite the work being done by NBT. Ambulance handover has improved and is above trajectory but remains below the eventual target.</li> <li>• Attendances at urgent care are still below 2020 levels but have increased at UHBW particularly in BRCH.</li> <li>• 52 and 78-week waits are in line with trajectory but there are concerns about the balance of elective performance as winter pressures begin to impact.</li> <li>• The 104-week trajectory is being achieved and is within plan but is still outside national requirements.</li> </ul> <p>ED asked LM to highlight where the actions being taken have had an impact.</p> <p>LM said that due to the work being undertaken, ED teams are able to focus on 4-hour response and should start to show improvement, however this may not automatically translate into the 95% level. NBT's work on sharing risk throughout</p>	

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	<p>the site has had an impact on ambulance handover delays. The new processes are not delivering results every day but, when there are issues, the recovery is much quicker. The BRI have done similar work to share risk across the hospital.</p> <p>There is scrutiny of the Ambulance handover plan every 3 weeks with SWAST and Acute Management and Clinical Staff from both NBT and UHBW. This also looks at SWAST access to Sirona SPA and the 2-hour community response.</p> <p>Same Day Emergency Care (SDEC), which enables patients to be seen, assessed and return home rather than being admitted, has begun on weekdays at the BRI and is extending to weekends. The BRI are investigating how to provide a similar service for the surgical specialities. SDEC is also being implemented at NBT for 16 hours per day over 7 days. There remains a challenge to change culture to ensure this provision is utilised.</p> <p>Meetings are held with the other 7 ICBs to share best practice and also with those ICBs who also have significant ambulance delays.</p> <p>ED asked LM if there was confidence that system improvement will be seen from these actions. LM said it is unlikely that the 95% level will be seen this year. The desire is to reduce volatility to consistently reduce ambulance handover delays and reduce waiting times, as there is evidence that a wait of more than 5 hours is detrimental to a patient's outcome. Improvement will come as the system moves more smoothly.</p> <p>JF noted there is still no clarity on how collective accountability on performance is measured, and where the response to issues flows through committee and board. LM said the current process is to go through the Performance Oversight group, then the Winter Delivery Group and report into this committee. There is collective accountability regarding ambulance trajectories and improvement for the population. There is now a collective relationship with SWAST to make this change which is being driven by Chief Medical Officers (CMOs) and Chief Nursing Officers (CNOs) to change behaviours in hospital and change clinical responsibility at the front door.</p> <p>JF commented on the ABCD of priorities from the new Secretary of State and the need to ensure governance and scrutiny is at the at right level. He said that rather than the ICB holding partner organisations to account, there is now a collective responsibility to be clear about what needs to be done throughout the patient journey, and the impact which partner organisations have on each other, to make improvements. He noted that this process needs to be addressed urgently even though accountability structures may not yet be in place.</p>	

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	<p>ED noted that there is performance data from the acutes but little understanding of the Sirona work with patients before admission and after discharge.</p> <p>JM commented on the work which has been triggered by the 100 day challenge and that discussions are being held senior leadership about the appropriate metrics to use.</p> <p>LM noted that there will be a request from NHSE to include clinicians involved in collection of data and that this committee will then decide upon the data required to give visibility.</p> <p>LM said that SWAST have noted the activity and change processes in the ICS and are confident that improvements will come from working together.</p> <p>LM said the work undertaken within NBT to reduce ambulance handover delays has challenged partner organisations to consider what actions can be taken internally. It has also highlighted that there may not be a direct improvement from actions taken so further initiatives may need to be considered.</p> <p>Referral to Treatment (RTT) mutual aid has been investigated with other providers, to enable balancing of waiting lists across the area. Some elective waits are caused when children need to see specific surgeons, or by parents who elect to wait until school holidays to have treatment for their children. There are contracts in place with all independent sector providers for elective surgery and to provide additional resources for diagnostics. There is weekly scrutiny of the Elective Recovery by national team and actions underway to provide improvement. LM confirmed that, although not meeting national requirements, the system is in line with recovery plans.</p> <p>There have been two issues with 111 services during the summer months. An Adastra outage, likely caused by ransom ware, prevented electronic monitoring of patients and caused delays in call handling. The system moved to business continuity originally using paper and then EMIS. There have been unacceptable response times from PPG, the sub-contractor at Severnside, creating a significant call abandonment rate. A recovery plan is in place for workforce and productivity and is being monitored weekly.</p> <p>LM said that when large national providers such as PPG take on new contracts, it is necessary to ensure the provision under their contract with Severnside is not affected. PPG take on the Devon service this month and will be monitored closely to ensure they stay on track for the recovery plan. Contractual levers are being used to hold PPG to maintain local delivery. There is no data available yet to determine whether there has been an improvement. The practice of 111 providers sub-contracting the call handling operation is common.</p>	

Item	Action
<p>LM expressed confidence that, if there is focus on actions, recruitment and retention of workforce, the situation will improve.</p> <p>LM suggested that a concise version of the Performance Report be presented at future committees with significant issues being considered quarterly. The focus will now be on the Winter Resilience Plan to take to the committee and board. However, there is concern that focussing only on the six required metrics from the Winter Resilience Letter could result in losing sight of other concerns so a balance will be necessary. The Winter Delivery Group would review, assess and escalate where appropriate and the only report for Board will be the Winter Resilience report.</p> <p><b>Quality Report</b></p> <p>DM presented this report, noting that emerging issues had already been covered</p> <p>There are significant numbers of children presenting at ED where there has been a breakdown in support for the family, or the family have struggled to meet the needs of the child at home. This can result in an extended stay in urgent care. A system meeting has taken place to discuss this issue and data is currently being pulled together.</p> <p>An additional 400 Asylum hotels places are expected which will affect demand. This is not simply a numerical increase in Service Users but there are also cultural differences emerging in the footprint.</p> <p>DM noted that there could be a shared commonality between the above two issues with a different cultural approach to managing and accepting the conditions which children have. There is a piece of system work underway to investigate the cultural differences in the populations.</p> <p>NBT had a maternity insight visit following the Ockendon Report which noted good practices and had good feedback from staff about culture and safety.</p> <p>CQC have recently undertaken a planned visit to WGH and given good feedback.</p> <p>ED asked whether improvements are evident in Sirona regarding missed visits and the resulting risks. DM said Sirona are engaging in a reset to check what they are delivering against what they are contracted for as services may have evolved beyond the contract.</p> <p>ED asked if there is visibility of Sirona's performance. SM said that at the next SQG meeting on 13 October, Sirona have been invited to talk about harm</p>	

	Item	Action
	<p>alongside delivery of contract and the risks which they are holding and how they are addressing them. This follows a similar review of harm from Acute providers. Shane Devlin is meeting with the Sirona CEO and the Quality Team are currently pulling together harm data. The ICB Quality team have oversight of the information on missed visits and Serious Incidents.</p> <p>LM noted performance is improving and that there is better visibility of daily operational data and performance reporting for the 2-hour response data.</p> <p>LM said that work is underway on Virtual Wards, and Discharge to Assess (D2A). JM has met with Julie Kell (Head of Performance – Integrated Care) and LM to discuss pathways of care. Pathways 1, 2 and 3 need to be mapped as some of it falls within the Sirona Contract. Additional input has been given to look at Hospital at Home (H@H). There are weekly meetings with the project managers of D2A and H@H which fall under the transformation development arm which is separate from delivery of core services.</p> <p><b>ACTION: JM to bring a report on pathway of care to October Committee meeting</b></p> <p>JM stated that it is too early to comment on level of confidence in this approach.</p> <p>LM said Home First is crucial for winter so there is clinical engagement and scrutiny as well as a push for innovation. It is important to have line of sight going into winter.</p> <p>DM noted that there are new models being discussed for D2A including the use of mutual aid such as moving therapy from acute providers to the community. ED asked for confirmation that all partners are working together on these issues and DM agreed that this is happening.</p> <p>DM said there have been some improvements across some HCAI disease groups but an increase in Klebsiella and that the IPC Cell is meeting regularly.</p> <p>DM noted that progress for delays in treatment is being made by sharing learning at system level.</p> <p>JM noted that CMOs have expressed concern about an increase in Covid and Covid patients in ITU combined with the approach of the expected severe flu season.</p>	JM
06	<p><b>Winter Resilience Plan</b></p> <p>LM introduced the Winter Resilience plan.</p>	

Item	Action
	<p>The information is based on the six metrics from the National Winter letter with the intention of ensuring confidence in mitigations and the escalation framework going into the winter. These metrics can be monitored on a daily basis and are visible to all partners in the system, including Chief Executives and the ICB Board. Actions are in place and trajectories agreed, with further workstreams underpinning them to deliver the required results. The content of the Winter Plan has been mapped to ensure oversight of how each aspect of the plan will impact on service delivery across the system. For example, regarding 111 call abandonment, there is a clear line of sight for improvement on answering times which will impact on ambulance response.</p> <p>There is weekly attention given to delivery of additional D2A community beds. Virtual wards are being implemented and use of these will need to be optimised. Initiatives such as Every Minute Matters and the Flow programme are ongoing and will have an impact.</p> <p>Staffing will be reduced on other wards at NBT to enable the new Level Six ward to be staffed. At both acutes staffing for the SDEC expansion will need to come from other wards.</p> <p>The Mental Health Winter Plan will focus on resilience of community mental health teams and access to psychological support. There are new initiatives for mental health provision to try to prevent patients in crisis being taken to ED unnecessarily. These include a Mental Health Rapid Response Vehicle which can be deployed to support anyone in crisis who dials 999, the piloting of a Mental Health ambulance, and provision of a rapid and dedicated phone line for police to access support and help when responding to a call from the public, which can also be used to request the Mental Health ambulance and Rapid Response Vehicle. Discussions have begun about creation of a Mental Health ED alongside the Acute Hospitals, potentially using the Sanctuary or Gloucester House, to provide same day emergency care. This will need to be tested to see how it performs to support individuals in crisis. A bespoke plan will be needed to look at the increasing presentations at ED of children in need of mental health support.</p> <p>The Winter Resilience plan records the programme director for each piece of work, how concerns are escalated and how the work flows, to ensure that workstreams collaborate. There are responsible officers who will be held accountable by the system for delivery.</p> <p>At a recent Winter planning event there were no new major initiatives proposed and the focus was on ensuring that current processes work smoothly and efficiently. For example, patients remaining in acute settings whilst awaiting prescriptions to be fulfilled. Community Pharmacies are keen to be part of</p>



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	<p>arrangements. This is being progressed by Debbie Campbell (Deputy Director, Medicines Optimisation, BNSSG ICB).</p> <p>A Primary Care Winter Plan is being developed building on the plan created last year which delivered extra appointments, but that additional availability will be needed.</p> <p>An announcement is expected regarding additional allocation for social care but that it is uncertain how this will be deployed. Conversations are taking place with the care market sector to establish any assistance they might require. Early results include: financial assistance; named contacts in Nursing Homes; information on how to access SPA; and continuing to pay for domestic care whilst a service user is in hospital so that they can re-activate a package on discharge.</p> <p>Historically, elective surgery has been stood down to mitigate winter pressures but the recovery plan for elective Surgery does not allow for this so there is a need for balance to be addressed.</p> <p>Management of flu and provision of an anti-retroviral service into Nursing Homes will be by use of Rapid Response when necessary.</p> <p>In theory there are sufficient beds to deliver services through the winter. However, this is dependent on D2A, Virtual wards, the new ward at NBT, productivity gains from EMM matters at UHBW and the Flow programme at NBT. Models have been created for an outbreak of flu and covid together which indicate that the biggest concern will be at UHBW, particularly at the BRI. Mitigation actions will focus on discharges and movement through the site. Additional work is underway to support WGH as it has a disproportional impact on flow. CD is using a process of visiting and revisiting to assess improvements.</p> <p>There will be movement from the current command and control escalation process into a collaboration and control centre approach, bringing in clinical expertise. There will be benchmarking against national standards for a range of sub-metrics which support the headline metrics. The Escalation framework takes the form of a daily 11am call which will evolve from the current sit rep format to one of working through actions across the system, building in intelligence, to provide predictions for the impact of current concerns in particular areas on the rest of the system. Weekly meetings of Chief Operating Officers (COO)s and Deputy Directors of Adult Social Services are being implemented to monitor and provide assurance with the ability to escalate up to directors, with the option of the frequency of meetings being increased. Changes will be made to the routine Gold command by replacing with escalation to Chief Executives.</p>	



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	<p>JM has discussed with CMOs methods for taking a clinical voice into account without pulling clinical staff away from the front line.</p> <p>Discussions have taken place with COOs prior to the Board meeting to establish making arrangements tangible, so that the Board will have confidence in the escalation process.</p> <p>JM noted there is a dynamic risk assessment underpinning the Winter Plan, which takes into account the risk and ethics of potential actions</p> <p>ED asked if the chairs of the individual organisations are confident to escalate when necessary. LM said the organisations involved include: UHBW, NBT, Sirona, AWP, SWAST, Severnside. It is intended to invite a representative from the Care Market to obtain an understanding of the limitations within which they work. For example introducing 7 day discharge is not effective if NHS cannot admit at weekends due to staffing routines.</p> <p>DM offered to provide clinical input to the Winter Delivery Group.</p> <p>LM said plans are being prepared for on-call teams to use, for example, to decide in advance how to mitigate patients with flu and covid sharing wards.</p> <p>There is an alternative decision making framework under the Winter Plan with levels of decision making permissions. Some decisions will be made by Gold, and some reserved to Chief Executives. This potentially involves a rotation of clinical team members briefed on a local basis to make decisions on behalf of the system. This needs to be developed and brought back to the Board meeting next month, and to then be communicated to, and engaged with, all system partner organisations need to ensure that has landed and people are supporting.</p> <p>JM noted that, since NHSE is still at level 3, some actions will be given by national mandate, giving legitimacy for the system to introduce new processes.</p> <p>LM noted the importance of engaging Local Authority (LA) colleagues who are facing significant financial challenges. The system has to understand front door issues as if LAs cannot respond, patients present at Primary Care or ED. If this issue cannot be resolved, Primary Care and EDs will need to be prepared.</p> <p>The daily dashboard against the six national metrics will show hours lost to ambulance handover delay. There has been a significant reduction in this figure during September but the correlation between Cat 2 response and ambulance handovers is not clear, so work is underway to understand how to further support SWAST.</p>	

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	<p>ED asked for clarification about when the innovating, planning and introducing phase ends and moves into a monitoring phase. LM said a process of Test, Adapt and Adjust is due to start in the next week. There is concern about ensuring that the balance of Winter response and improvement is maintained and how issues not part of the Winter Plan can continue to be improved and recovered.</p> <p>JF observed that discussions had focussed on the immediate concerns and risks to the system and the population. However, the population is becoming sicker and not being treated in early life. The role of the ICB is to look at alternative pathways and Winter planning will be business as usual each year going forward.</p> <p>JF challenged the committee to address when it should shift focus to preventative work. JM said COOs and CMOs are considering this. There is a significant proportion of the community who should not ever need to be admitted to an acute setting. There is disquiet about patients on pathway 1 who remain in an acute setting with No Criteria to Reside and decondition before discharge. It is necessary to improve the health of the population as well as improve the system. There will be a wider prevention agenda, considering secondary prevention in addition to primary prevention. For example, the impact of smoking on heart disease and putting preventions into place with are culturally specific. The system has a moral obligation to keep the population safe in the moment and put preventative measures in place for the future health of the population.</p> <p>JF noted that the agenda and content of this committee should reflect mitigations for current concerns and prevention. The committee should consider how the ICB creates most value. This needs assessment at the North &amp; West Bristol local partnership to determine the work being done by partner organisations and may result in more pathways.</p> <p>JF asked the committee to ensure that it is not focussed too tightly on elevating immediate concerns and that it is aware of work being done by partner organisations.</p> <p>ED noted that the October committee meeting should focus on balancing looking ahead and current pressures. ED asked executive members to consider this, and the importance of discussing outcomes rather than performance.</p> <p>ED added that there will be more system partners attending this committee, once up to compliment, who will challenge.</p> <p>ED asked what issues from the Winter Resilience Plan should be amplified at Board. LM replied that the key message is that the Plan can only be delivered by working together across the system.</p>	

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	<p>ED noted that JF would reinforce the issue of working together</p> <p>ED suggested identifying the work being done by JM which is different to that which has been done before.</p> <p>JF asked for a summary of the challenges which this committee would like to present at Board, rather than simply updates. ED said that JF would cover issues of working together and ED would talk about successes from working together along with the challenges which need system wide working, asking Board members to contribute to the discussion.</p>	
07	<p><b>Cancer Progress Report</b></p> <p>JM introduced DS and NS, and explained that this report identifies key messages as a continuation of the existing position, with BNSSG provision not being adequate and there being concerns about clinical risk. T</p> <p>BNSSG cancer provision is currently being scrutinised by Region, National and the System. This results in significant requirement for reports. With NBT in Tier 1 there is input and visits from national bodies and a danger of there being so much holding to account that the improvement work cannot be done. The SW cancer alliance are not able to deliver so BNSSG has had to cover the provision but governance of this remains unclear.</p> <p>LM explained that NS had been invited to answer specific questions about NBT to assure the committee about the working underway there to address the concerns.</p> <p>DS presented that paper.</p> <p>The situation is moving rapidly and, since the paper was submitted, there has been a notable improvement in the 60 day backlog across both trusts.</p> <p>Within the broader SW context, the two BNSSG trusts are two of only three who are recording improvements, ranking 4<sup>th</sup> out of seven comparing against last year. Most areas were already challenged pre-pandemic.</p> <p>The paper describes what has driven deterioration over the summer and NBT have reworked recovery plans at speciality level, supported by the regional cancer team. Key drivers are skin, colorectal, breast and upper and lower GI. There are high, sustained levels of referrals and there remain workforce challenges from the impact of Covid in early summer.</p> <p>NS reported on actions and activity at NBT.</p>	

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	<p>This is centred on capacity increases including in recruitment and mega-clinics. There is a risk to recovery as plans depend upon recruitment and good will of staff. There is an interim Deputy COO at NBT who has been in post for 3 months and whose remit is partly to address how to improve Cancer.</p> <p>A key target at regional and national level is over 62-day cancer waits. NBT were worst in the country 4 weeks ago and are now 7<sup>th</sup>. Numbers have reduced from approximately 850 to 550 meaning NBT is no longer an outlier. However there are other targets which still need focus. Pre-Covid, NBT relied on additional work to hit Breast Cancer targets, and there is a national shortage of appropriate workforce.</p> <p>With regard to Skin Cancer there are challenges in the system. There needs to be system work to consider how dermatology is approached across BNSSG. Upper and Lower GI Cancers have diagnostic and endoscopy links and there is a recovery plan in place. The Urology Cancer pathway is large and that is how progress can be made to a more compliant position.</p> <p>There is an overarching cancer recovery plan, with significant backlogs to be dealt with by increase in capacity. However this will not return provision to constitutional standards immediately and specific hotspots are expected to remain for Skin and Breast Cancer. NBT are now seeing patients on the Breast pathway at day 40, and the patients receive a one stop experience for assurance, but this is not as good as it should be.</p> <p>ED agreed that the Cancer team being scrutinised by multiple agencies was not good practice and asked what this committee could do support.</p> <p>JM noted significant concerns about the 2-week wait (2WW), with 40 days being unacceptable, and assured the committee that this will have special scrutiny.</p> <p>JM explained that Dermatology pathways intertwine with a regional focus and collaboration. Bristol hospital takes patients from Somerset for some facilities which skews waiting and response times in BNSSG. JM is attending collaborative meetings with colleagues to discuss inflows which impact on delivery of care to the BNSSG population. Regional support can help to drive improvement in this speciality.</p> <p>Breast Cancer issues are more localised and improvements are needed in the pathway so that is an area of focus.</p> <p>DS commented that, ahead of a regional drive on Skin Cancer there will be work undertaken within BNSSG to look at the system and opportunities for improvement. BNSSG are working with Somerset on the inflow within the skin</p>	

	Item	Action
	<p>pathway to address the influx coming in. Immediate permanent improvements will start to improve pathways for patients from Somerset until they can be repatriated.</p> <p>ED asked for a confidence level regarding Breast Cancer, whether links were made with the People Committee, and commented on the effective structure of the paper. NS said the Breast Cancer 2WW is being managed against the national picture and that 80% of breast patients do not go onto have cancer. Focus is on delivery of the 63-day target. Additional capacity will be used to reduce the 2WW backlog, however as demand is greater than capacity, until there is a long-term workforce in place NBT will continue go through peaks and troughs. Confidence on 2WW will be difficult for the next six months. NBT will be aiming to bring the wait down to day 25 but it is unlikely to be reduced to 14 days. Work is being done at regional level and with RUH to create regional pathway on breast pain. There is a national shortage of radiologists who are key to mitigating the 2WW issue and HEE need to be influenced to deliver the necessary work force. There is no definitive request for the ICB to assist. It is difficult to access mutual aid from other providers to clear the backlog as all are in the same situation.</p> <p>JM asked if there was a possibility to subcontract reading mammography. NS said that within NBT the patient sees both the surgeon and radiologist at same time and there is not capacity to see 1000 patients per month in the one-stop clinic. The breast physician and nursing workforce is more stable.</p> <p>ED asked if other systems were implementing any other creative solutions and if there were other opportunities to recruit. LM noted that networks and collaborative working across region could unlock and optimise the clinical resource. DS commented that the diagnostic workforce is challenged and that this is being addressed at regional level. Within endoscopy, there are plans to expedite training of workforce.</p> <p>JM suggested the issue of workforce for wider cancer services should go to the People Committee.</p> <p>JM noted a recent discussion of “Worry lists” with CMOs which raised the issues of Skin and Breast Cancer and the need to keep have oversight until they stabilise.</p> <p><b>ACTION: JM to identify issues which needs a deep dive to the committee</b></p> <p>ED thanked NS and DS for attending and for their presentations.</p>	<p style="text-align: right;"><b>JM</b></p>
08	<p><b>Items for information</b></p> <p><b>8.1 Corporate Risk Register</b></p>	

	Item	Action
	<p><b>8.2 Safeguarding All Age Quarter 1 Report</b>  <b>8.3 LeDeR Governance Group Minutes</b>  <b>8.4 SEND Quarter 1 report</b>  <b>8.5 HCAI</b></p> <p>Items noted for information.</p> <p>LM asked members to note that there are two SEND inspections next week and LM update at the next meeting.</p> <p><b>ACTION: LM to update the committee following the forthcoming SEND inspections.</b></p> <p>ED asked for confirmation that the executive members of the committee would present any pertinent issues. LM confirmed that any escalating issues and risks would be brought back to the committee so they do not need to be on the agenda as separate items.</p>	
09	<p><b>Action log</b></p> <p>The Action log was updated.</p>	
10	<p><b>Items to be taken to Board:</b></p> <p>The committee agreed that the following items will be taken to the Board meeting:</p> <ul style="list-style-type: none"> <li>• Winter resilience will be an overall statement about where BNSSG are for the winter, looking at response and current performance against the operational plan for 22/23.</li> <li>• Key challenges across system: Julie Sharma (Chief Executive, Sirona ) will be asked to describe work under D2A and virtual wards and the tension across the system.</li> <li>• Deep Dive on cancer: actions and challenges</li> </ul> <p>ED asked whether the work which LM is undertaking with Julie Sharma will confirm that Sirona can deliver the beds identified in the plan.</p> <p>ED asked for clarification of the ask of LAs regarding D2A. LM noted that all parts of the system have a responsibility and LAs support people to move into long term placements or support with domestic care. D2A is the part of the system that pulls everyone together and is the first big bit of system work which has been undertaken. Julie Sharma can approach LAs for their input.</p> <p>LM noted that Jo Walker (Chief Executive, North Somerset Council) raised constraints on finance in the last board meeting.</p> <p>JF noted that, if conversations are not possible within committee, then they have to be created in Board. The conversation in the ICB has to be a collective challenge to the LAs.</p>	

	Item	Action
	<p><b>ACTION: JF to inform LAs that there will be Questions around engagement at the ICB Board.</b></p> <p>JF noted that composition of committees needed to be resolved as most are too internal at the moment and partners need to be engaged in the conversations.</p>	
11	<p><b>AOB</b></p> <p>No further business for discussion.</p>	
	<p><b>Date of next meeting:</b></p> <p>Thursday 27 October 0900 - 1130</p>	

**Tina Mostert**  
**Business Administrator**  
**29 September 2022**



# Meeting of BNSSG Integrated Care Board

**Date:** 01/12/2022

**Time:** 11.45 – 15.00

**Location:** Via MST

<b>Agenda Number:</b>		
<b>Title:</b>	Quality and Performance Report – Month 6 (September data)	
<b>Confidential Papers</b>	<b>Commercially Sensitive</b>	No
	<b>Legally Sensitive</b>	No
	<b>Contains Patient Identifiable data</b>	No
	<b>Financially Sensitive</b>	No
	<b>Time Sensitive – not for public release at this time</b>	No
	<b>Other (Please state)</b>	No

**Purpose:** Discussion & Information

**Key Points for Discussion:**

The report provides an overview of September 2022 data to cover Month 6 and Qtr 2 data activity for quality and performance.

The committee are asked to note the following areas.

## **Quality (please see also Appendix 1)**

### **Current updates & emerging concerns**

**Mental Health Provider** – The provider remains in enhanced surveillance and visits focussing on medicines management have been undertaken; No immediate areas of concern were noted and feedback on areas for improvement has been given to the provider. A follow up Quality Improvement Group is scheduled, and a briefing paper is being written and will be presented to the provider and SQG upon completion. Two independent investigations are currently underway for the recent unexpected deaths; the ICB and other partners are assisting with agreeing the terms of reference. The Mental Health Provider Collaborative hosted by Devon Partnership NHS Trust are conducting a separate review visit in late November over 4 days.



### **Dual registered Mental Health facility/Care Home**

The provider remains in enhanced surveillance and following on from the supportive work being undertaken by BNSSG with this provider, an improvement plan has been developed in line with the discussions from the S42 enquiry, CQC recommendations and required actions from the initial visits undertaken by the ICB. The improvement plan is being monitored via the SQG Quality escalation framework. During a visit by ICB senior staff overall improvements were evident, although it was clear that the Registered owner had some educational needs related to Governance, Risk Management and accessing system support.

### **Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services**

Following a BBC Panorama programme raising concerns about the welfare of patients in the care of an NHS Trust, AWP and the ICB have commenced work to obtain assurance that the quality and safety of care delivery is robust. A system position is currently being determined and a paper outlining recommendations will be written upon completion of this project and presented to the committee.

### **Kirkup Report – “Maternity and neonatal services in East Kent – the Report of the Independent Investigation”**

The national report was reviewed by the November BNSSG System Quality Group. System assurance that the recommendations are actioned is being led by the BNSSG LMNS.

### **Continuing Care**

**Adults:** Commissioner Oversight visits have been completed as planned. There has been an increase in Click-through rate (CTR) activity and decrease in Listening and Engagement Active Partnerships (LEAP) activity in September. ICB commissioned placements are now on trajectory however Southwest Property Centre (SWPC) (Secure) placements remain above the trajectory to reach the Long-Term Plan target.

**Children and Young People (CYP):** There has been no new admissions to Tier 4 services. The LEAP requests remain above Community Enhancing Recovery Team (CETR) requests.

### **Healthcare Associated Infections**

- **C.difficile** - BNSSG is below the regional and England average in overall incidence, however numbers are still above pre-pandemic levels. In September 2022, 26 cases were attributed to BNSSG ICB. The CDI working group continues to work with system and regional partners to understand the drivers behind a higher prevalence and incidence of CDI. Work is currently focussing on age standardising the data to determine if there are certain demographics needing particular focus.
- **E.coli** - In September 2022, 47 cases of E.coli bacteraemia cases were assigned to BNSSG ICB. Case activity remains below the thresholds set by NHSE/I, below the Southwest benchmarking and below the all England benchmarking. Activity is also below the 2020/21 and 2021/22 year to date position. Patient hydration remains a key area of focus for improvement in the system.

- **MSSA** - In September 2022, 18 cases of MSSA bacteraemia were assigned to BNSSG ICB. Nine cases were classified as Hospital Onset Hospital Associated and nine cases as Community Onset. Case activity has been below the Southwest average since May 2021.
- **MRSA** - In September 2022, five cases of MRSA bacteraemia were assigned to BNSSG ICB. 4 cases were Community Onset and 1 was Hospital Onset Hospital Associated. The chlorhexidine pilot has been extended in order for a fuller evaluation at the end of the year.

### **Serious Incidents and Learning**

In September 2022, 17 Serious Incidents (SIs) were reported across BNSSG providers, including one Never Event (NE). The NE was relating to the administration of a fascia iliac block under ultrasound guidance on the incorrect side; it was identified in the 72 hour report that there had been failures in the application of the “stop before you block” safety procedure, a full investigation is being undertaken. It was reported that no harm occurred to the patient and duty of candour was undertaken.

Treatment delay and sub optimal care were the leading themes in September with a 40% decrease in the numbers of pressure injury incidents reported from the previous month. Pressure injury incidents remain in the top categories of reported incidents.

At the end of quarter 2 of 2022/23, the Quality team has reviewed 117 SI investigations to identify themes and trends and triangulate the learning. During quarter 2, the top category for reported incidents was Pressure injuries, Obstetric incidents and slips/trips/falls. The themes taken from the investigations for system wide learning are communication/MDT, Policy and risk assessments and care planning.

### **Performance (Appendix 2)**

Three reports are submitted this month to the Board.

These are:

- Summary performance and activity report – now including further information on children’s performance.
- Update on the operational plan performance metrics.
- Waiting list inequalities - an update on metrics and work in progress.

### **Executive Headlines from the summary performance and activity report**

- Overall, BNSSG Trusts’ 4hr A&E performance worsened from 60.1% to 58.9% in October but is better than the national average for Type 1 EDs of 54.8%. NHSEI Support to BNSSG via UEC collaborative with whole system diagnostics, dynamic modelling and NHS111 first and an ambulance handover improvement plan focused on demand management, process improvement, improving flow and reverse queueing capacity.
- For planned admissions, the total waiting list size for the BNSSG population improved from 87,320 in August to 86,771 in September. BNSSG performance of 65.5% was ranked 7<sup>th</sup> out of 42 ICBs nationally (up from 8<sup>th</sup> in August) and ranked 2nd out of 6 ICBs in the South West (same since July).

- The number of BNSSG patients waiting 52 weeks or more for planned treatment decreased from 5,376 in August to 5,302 in September – 6.1% of the total waiting list. The number increased at both NBT and UHBW. The BNSSG position is driven mainly by waits at NBT (2,454 and UHBW (2,083), with the remaining 765 breaches split across 41 other providers. Focused work to facilitate elective recovery ambitions are being implemented.
- The number of BNSSG patients waiting over 78 weeks decreased from 623 in August to 599 in September. The number decreased at both NBT and UHBW. The BNSSG position is driven mainly by waits at NBT (307) and UHBW (187). The remaining 105 breaches are split across 17 other providers, with the majority at Sirona (34), Spire Bristol (17) and Nuffield Health Bristol (15).
- The number of BNSSG patients waiting over 104 weeks decreased from 53 in August to 47 in September. The number decreased at both NBT and UHBW. The BNSSG position continues to be driven mainly by waits at NBT (21) and Sirona (11). The remaining 15 breaches are split across 7 other providers, with the majority at UHBW (9).
- 2 week wait cancer performance worsened in September to 39.21% for the BNSSG population. Performance worsened at both NBT and UHBW. The 93% national standard has not been achieved at population level since June 2020.
- 28 day faster diagnosis standard for BNSSG cancer patients worsened in September to 41.6% for the BNSSG population. Performance worsened at both NBT and UHBW. The 75% national standard has not been achieved at population level since reporting started in April 2021.
- 62 day referral to treatment time for BNSSG cancer patients improved in September to 59.6%. Performance improved at both NBT and UHBW. The 85% national standard has not been achieved at population level since April 2019.
- For the year to date in September, there were there were reductions in activity across all areas compared to the same period in 19/20. From August to September, all activity decreased except non-elective admissions with zero day length of stay, non-admitted and new RTT pathways, GP and total referrals, which increased.

<b>Recommendations:</b>	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
<b>Previously Considered By and feedback:</b>	Previously discussed at the Outcomes, Quality and Performance Committee on 25 <sup>th</sup> November 2022
<b>Management of Declared Interest:</b>	None declared
<b>Risk and Assurance:</b>	The report and appendices provide an update to the Integrated Care Board in relation to key risks to performance and quality within the system and highlight supporting mitigations which are in place.
<b>Financial / Resource Implications:</b>	None referenced

<b>Legal, Policy and Regulatory Requirements:</b>	None referenced
<b>How does this reduce Health Inequalities:</b>	Elements of the report identify activity in place to reduce health inequalities such as the delivery of the LeDeR programme and Mental Health programmes of work
<b>How does this impact on Equality &amp; diversity</b>	As above
<b>Patient and Public Involvement:</b>	Not applicable
<b>Communications and Engagement:</b>	The reports are provided to the Integrated Care Board for information and discussion.
<b>Author(s):</b>	Sandra Muffett – Head of Patient Safety & Quality, BNSSG ICB Caroline Dawes – Deputy Director of Commissioning, BNSSG ICB Gary Dawes -BI Manager, Performance, BNSSG ICB Michael Richardson, Deputy Director of Nursing and Quality, BNSSG ICB
<b>Sponsoring Director / Clinical Lead / Lay Member:</b>	Rosi Shepherd, Chief Nursing Officer, BNSSG ICB Lisa Manson, Director of Performance and Delivery, BNSSG ICB

# BNSSG Performance & Activity Report

November 2022

Created by

Gary Dawes

BI Performance Team

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# 1 Executive Summary – Headlines

- Overall, BNSSG Trusts' 4hr A&E performance worsened from 60.1% to 58.9% in October but is better than the national average for Type 1 EDs of 54.8%. NHSEI Support to BNSSG via UEC collaborative with whole system diagnostics, dynamic modelling and NHS111 first and an ambulance handover improvement plan focused on demand management, process improvement, improving flow and reverse queueing capacity.
- For planned admissions, the total waiting list size for the BNSSG population improved from 87,320 in August to 86,771 in September. BNSSG performance of 65.5% was ranked 7<sup>th</sup> out of 42 ICBs nationally (up from 8<sup>th</sup> in August) and ranked 2nd out of 6 ICBs in the South West (same since July).
- The number of BNSSG patients waiting 52 weeks or more for planned treatment decreased from 5,376 in August to 5,302 in September – 6.1% of the total waiting list. The number increased at both NBT and UHBW. The BNSSG position is driven mainly by waits at NBT (2,454) and UHBW (2,083), with the remaining 765 breaches split across 41 other providers. Focused work to facilitate elective recovery ambitions are being implemented.
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- The number of BNSSG patients waiting over 104 weeks decreased from 53 in August to 47 in September. The number decreased at both NBT and UHBW. The BNSSG position continues to be driven mainly by waits at NBT (21) and Sirona (11). The remaining 15 breaches are split across 7 other providers, with the majority at UHBW (9).
- 2 week wait cancer performance worsened in September to 39.21% for the BNSSG population. Performance worsened at both NBT and UHBW. The 93% national standard has not been achieved at population level since June 2020.
- 28 day faster diagnosis standard for BNSSG cancer patients worsened in September to 41.6% for the BNSSG population. Performance worsened at both NBT and UHBW. The 75% national standard has not been achieved at population level since reporting started in April 2021.
- 62 day referral to treatment time for BNSSG cancer patients improved in September to 59.6%. Performance improved at both NBT and UHBW. The 85% national standard has not been achieved at population level since April 2019.
- For the year to date in September, there were reductions in activity across all areas compared to the same period in 19/20. From August to September, all activity decreased except non-elective admissions with zero day length of stay, non-admitted and new RTT pathways, GP and total referrals, which increased.

## 2 Activity – BNSSG ICB Position at M6, September 22/23 YTD

The position is outlined for the year to date at month 6 22/23, against the same period in 19/20 to highlight the comparison of the current position with the pre-Covid position.

- For the year to date in September, there were reductions in activity across all areas compared to the same period in 19/20. From August to September, all activity decreased except non-elective admissions with zero day length of stay, non-admitted and new RTT pathways, GP and total referrals, which increased.
- Total referrals are 0.3% lower than the same period in 19/20. GP referrals are 7,17% lower than in 19/20.
- First outpatient appointments are 14.39% lower than in 19/20.
- Follow up appointments are 11.96% lower than in 19/20.
- Total A&E attendances are 15.39% lower than in 19/20, with 25,946 fewer attendances (averaging 142 fewer attendances per day).
- Total non-elective admissions are 12.88% lower than in 19/20. The +1 day lengths of stay (LoS) are 14.88% lower, whilst zero day stays are 9.7% lower.
- Total elective admissions are 8.52% lower than in 19/20. Day Case admissions are 7.88% lower, whilst Ordinary admissions are 13.43% lower.

Activity	Monthly volumes / variance				Year to date volumes / variance			
	Sep-19	Sep-22	Variance	Sep-22 as a % of Sep-19	Sep-19	Sep-22	Variance	Sep-22 as a % of Sep-19
Total Elective Admissions - Day Cases	9,199	9,040	-159	98%	55,250	50,897	-4,353	92%
Total Elective Admissions - Ordinary	1,247	1,191	-56	96%	7,265	6,289	-976	87%
Total Non-Elective Admissions - 0 LoS	3,399	3,512	113	103%	21,011	18,972	-2,039	90%
Total Non-Elective Admissions - +1 LoS	5,424	4,977	-447	92%	33,233	28,287	-4,946	85%
Total A&E Attendances excluding Planned Follow Ups	28,290	23,436	-4,854	83%	168,607	142,661	-25,946	85%
Number of Completed Admitted RTT Pathways	5,506	4,562	-944	83%	34,780	22,921	-11,859	66%
Number of Completed Non-Admitted RTT Pathways	13,266	14,383	1,117	108%	79,020	78,706	-314	100%
Number of New RTT Pathways (Clockstarts)	22,208	23,091	883	104%	139,566	135,289	-4,277	97%
Total Referrals (General and Acute)	23,937	26,743	2,806	112%	145,757	145,316	-441	100%
Total GP Referrals (General and Acute)	13,320	14,451	1,131	108%	82,068	76,182	-5,886	93%
Consultant Led First Outpatient Attendances	19,872	17,398	-2,474	88%	116,446	99,686	-16,760	86%
Consultant Led Follow-Up Outpatient Attendances	39,994	33,853	-6,141	85%	235,958	207,728	-28,230	88%
Total Elective Admissions	10,446	10,231	-215	98%	62,515	57,186	-5,329	91%
Total Non-Elective Admissions	8,823	8,489	-334	96%	54,244	47,259	-6,985	87%

[Latest monthly and year to date comparisons](#)  
This table shows the actual variance for each metric comparing the latest month and year to date positions as a proportion of the same periods in 19/20.

# 3.1 South West Performance Benchmarking 1

Measure	Standard	Performance/Activity								South West Ranking								Change	
		Recent Period	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	National	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	Rank Last Month	
Diagnostics (Waiting 6+ Weeks)	1%	Sep-22	44.58%	27.54%	21.88%	43.93%	27.80%	40.46%	39.22%	29.80%	7	2	1	6	3	5	4	5	→
A&E 4 Hour Performance	95%	Oct-22	68.75%	68.69%	73.09%	76.97%	71.24%	64.95%	59.78%	69.31%	4	5	2	1	3	6	7	6	→
A&E 12 Hour Trolley Waits	0	Oct-22	146	316	653	708	177	1423	1390	43,792	1	3	4	5	2	7	6	6	↓
RTT Incomplete 18 Weeks	92%	Sep-22	61.04%	56.98%	71.70%	58.47%	62.38%	65.54%	52.29%	59.43%	4	6	1	5	3	2	7	2	→
RTT Incomplete Total		Sep-22	92,152	93,165	65,544	64,128	56,513	86,771	158,606	7,071,829	65.5%	69.1%	26.9%	80.2%	56.7%	70.6%	87.5%	72%	↑
RTT Incomplete 52 Week Plus	0	Sep-22	4,022	4,470	1,447	4,558	2,950	5,302	15,597	401,537	3	4	1	5	2	6	7	6	→
RTT 52 weeks + (% of waiting list)		Sep-22	4.36%	4.80%	2.21%	7.11%	5.22%	6.11%	9.83%	5.68%	2	3	1	6	4	5	7	5	→
RTT 78 weeks + (% of waiting list)		Sep-22	0.32%	0.59%	0.16%	1.31%	0.70%	0.69%	2.03%	0.71%	2	3	1	6	5	4	7	4	→
RTT 104 weeks+ (% of waiting list)		Sep-22	0.01%	0.03%	0.01%	0.19%	0.04%	0.05%	0.33%	0.03%	1	3	2	6	4	5	7	5	→
Cancer 2 Week (All)	93%	Sep-22	63.44%	45.58%	88.08%	77.87%	42.28%	39.17%	50.96%	72.56%	3	5	1	2	6	7	4	7	→
Cancer 2 week (Breast)	93%	Sep-22	39.07%	91.27%	91.09%	4.30%	39.13%	14.55%	31.72%	67.70%	4	1	2	7	3	6	5	6	→
Cancer 31 Day Wait First Treatment	96%	Sep-22	90.20%	95.99%	93.35%	94.91%	91.82%	89.69%	92.52%	91.08%	6	1	3	2	5	7	4	5	↓
Cancer 31 Day Wait - Surgery	94%	Sep-22	84.62%	94.17%	80.88%	81.52%	76.39%	64.81%	81.76%	80.67%	2	1	5	4	6	7	3	7	→
Cancer 31 Day Wait - Drug	98%	Sep-22	99.14%	98.80%	100.00%	100.00%	96.72%	100.00%	99.58%	97.98%	5	6	1	1	7	1	4	1	→
Cancer 31 Day Wait - Radiotherapy	94%	Sep-22	94.78%	97.95%	84.15%	98.26%	89.47%	98.61%	97.95%	87.94%	5	4	7	2	6	1	3	1	→
Cancer 62 Wait Consultant	N/A	Sep-22	73.75%	80.31%	67.86%	62.50%	83.17%	80.18%	66.67%	73.81%	4	2	5	7	1	3	6	3	→
Cancer 62 Wait Screening	90%	Sep-22	86.05%	82.50%	93.55%	73.68%	78.57%	54.55%	68.18%	67.60%	2	3	1	5	4	7	6	5	↓
Cancer 62 Day Wait - GP Referral	85%	Sep-22	68.03%	69.23%	64.53%	70.36%	60.71%	59.56%	59.95%	60.49%	3	2	4	1	5	7	6	7	→
Cancer 28 FDS	75%	Sep-22	64.21%	65.37%	76.55%	70.24%	56.59%	41.55%	70.00%	67.22%	5	4	1	2	6	7	3	7	→

# 3.1 South West Performance Benchmarking 2

Measure	Standard	Performance/Activity								South West Ranking								Change	
		Recent Period	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	SWASFT	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	Rank Last Month	
Category 1 - 90th Percentile Duration (hr:min:sec)	00:15:00	Oct-22	00:19:42	00:17:48	00:19:48	00:27:24	00:22:24	00:16:36	00:20:24	00:20:06	3	2	4	7	6	1	5	1	➡
Category 1 - Average Duration (hr:min:sec)	00:07:00	Oct-22	00:11:00	00:09:48	00:11:06	00:14:30	00:12:24	00:09:42	00:11:30	00:11:12	3	2	4	7	6	1	5	1	➡
Category 2 - 90th Percentile Duration (hr:min:sec)	00:40:00	Oct-22	02:41:30	01:46:18	01:33:54	06:23:30	01:58:12	02:35:54	03:09:18	02:41:24	5	2	1	7	3	4	6	3	⬇
Category 2 - Average Duration (hr:min:sec)	00:18:00	Oct-22	01:13:00	00:49:42	00:44:12	02:18:36	00:56:54	01:06:00	01:26:24	01:12:36	5	2	1	7	3	4	6	2	⬇
Category 3 - 90th Percentile Duration (hr:min:sec)	02:00:00	Oct-22	09:23:00	06:48:36	05:21:48	10:09:12	07:37:12	11:01:30	10:26:00	08:52:18	4	2	1	5	3	7	6	4	⬇
Category 3 - Average Duration (hr:min:sec)		Oct-22	03:23:06	02:39:54	02:08:42	03:27:48	02:54:54	04:01:54	03:59:06	03:16:24	4	2	1	5	3	7	6	3	⬇
Category 4 - 90th Percentile Duration (hr:min:sec)	03:00:00	Oct-22	08:41:00	04:27:00	04:53:00	14:14:42	11:44:12	02:40:06	11:39:36	07:22:48	4	2	3	7	6	1	5	4	⬆
Category 4 - Average Duration (hr:min:sec)		Oct-22	04:07:36	02:13:30	02:18:36	03:57:06	04:18:30	01:36:36	03:24:18	02:57:18	6	2	3	5	7	1	4	6	⬆

Measure	Standard	Performance/Activity								South West Ranking								Change	
		Recent Period	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	National	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	Rank Last Month	
Average speed to answer calls (in seconds)	20	Sep-22	51	141	234	29	387	271	**	195	2	3	4	1	6	5		5	➡
% Triaged Calls receiving Clinical	50%	Sep-22	0.0%	34.6%	49.0%	75.8%	68.0%	51.5%	**	46.7%		5	4	1	2	3		5	⬆
% of callers allocated the first service offered by DOS	85%	Sep-22	0.0%	63.9%	66.4%	32.2%	64.6%	70.1%	**	53.7%		4	2	5	3	1		1	➡
% of Cat 3 or 4 ambulance dispositions validated within 30mins	50%	Sep-22	0.0%	62.0%	64.7%	50.6%	60.6%	66.2%	**	34.5%		3	2	5	4	1		3	⬆
% of calls initially given an ED disposition that are validated	50%	Sep-22	0.0%	77.3%	18.6%	92.9%	58.6%	22.5%	**	38.9%		2	5	1	3	4		6	⬆
Abandonment Rate for 111 Calls		Sep-22	3.4%	6.7%	14.7%	1.5%	18.9%	16.0%	**	12.7%	2	3	4	1	6	5		7	⬆

Note: \*\* IUC 111 data for Devon has been omitted as not all calls are included in the published dataset.

Note: IUC 111 data: A cyber-attack on 4th August 2022 caused a major outage on the Adastra system used by many IUC service providers. This had a widespread impact on the IUC service with many providers relying on paper record-keeping from that date onwards during August. Besides impacting service delivery, this has resulted in missing or under-reported data for many contract areas and caution should be taken when interpreting figures.

## 3.2 Urgent Care – Overall Summary

Drivers	Improvement Needs	Improvement actions
<p>Demand from ED ambulance conveyances, major acuity attendances and non-elective admissions remains below 2019/20 levels. The drivers behind performance challenges relate to:</p> <ul style="list-style-type: none"> <li>• Persistence of a very high number of No Criteria to Reside (NC2R) patients in acute beds effectively reduced the overall acute bed base and limits flow. At the end of October NC2R patients accounted for 42% of NBT and 34% of UHBW General &amp; Acute beds.</li> <li>• Numbers of acute Pathway 0 (i.e. non-complex) discharges remain below targets of weekend rates of 80% of weekday rates.</li> <li>• Discharges before noon remain below the agreed standard of 33%.</li> <li>• Residual staffing pressures in the 111 health advisor team (PPG) resulting from the addition of new demand nationally to PPG from new contracts and low numbers of transferring staff. At the end of September the service had a 32% deficit in WTE clinical advisors.</li> </ul>	<ul style="list-style-type: none"> <li>• Discharge to Assess (D2A) Pathways activity remains below required levels (see Integrated Care Performance Report).</li> <li>• Ambulance handover delays worsened in October at all 3 acute sites: <ul style="list-style-type: none"> <li>• NBT total time lost over 15 minutes worsened from 1,792 to 3,207 hours.</li> <li>• BRI total time lost over 15 minutes improved from 2,564 to 2,927 hours.</li> <li>• WGH total time lost over 15 minutes improved from 739 to 948 hours.</li> </ul> </li> <li>• Handover delays continued to impact ambulance response times, including Cat 2 performance which worsened in October to mean 66min (against an 18 minute standard) from 45min, continuing to exceed standards with onward impact on quality / outcomes.</li> <li>• 12hr DTA breaches worsened at both NBT and UHBW in October, from 978 to 1,423 in September, within this delays at UHBW improved but worsened at NBT.</li> <li>• 111 abandonment rate deteriorated in October from 14% to 19.5% due to residual staffing pressures.</li> </ul>	<ul style="list-style-type: none"> <li>• New Winter Escalation Framework introduced in BNSSG in October to manage daily and weekly oversight of the six key winter metrics and their associated plans, and delivery of the additional bed/ bed equivalent capacity funded this winter by NHSE. The major components of this are virtual wards, D2A capacity, SDEC and an additional ward at NBT.</li> <li>• Care Traffic Coordination project - 'Beta' sprint will establish new data flows across Sirona and local authorities to give granularity of delays, demand and capacity in D2A and brokerage services.</li> <li>• D2A business case delivery and LGA peer review report and subsequent development of an action plan (or incorporation into existing plans).</li> <li>• Ambulance handover improvement plan focussed on ED-SWAST interface. Main actions focus on demand management, process improvement and reverse queueing capacity.</li> <li>• Performance notice and remedial action plan in place with Severnside/PPG, forecast to recover Abandonment Rate. Actions include greater overtime rates, recruitment and retention incentives and benefits inc. offering term time contracts, increased training places, throughput and number of trainers, increased targeted advertising of roles and streamlined recruitment process.</li> <li>• Ongoing UEC Collaborative transformation programme. Highlights include remote assessment transformation refocussed onto higher acuity patients and support to SWAST for CAT3_4 demand. Ongoing Community Emergency Medicine Pilot with ED consultant supporting SWAST crew. Piloting of 'warm transfer' of HCP calls to Sirona SPA to support rapid response from UCR teams. Piloting falls traffic light tool to promote UCR for falls and reduce avoidable 999 activity.</li> <li>• UHBW (Every Minute Matters) and NBT initiatives are in place to increase weekend and pre-noon discharges.</li> </ul>

# 3.2 Urgent Care – Summary Performance

## UEC CRS Measures

- This table represents the set of measures from the clinical review of access standards for urgent and emergency care.
- Technical definitions for two of the measures, are still to be published.

Theme	Ref	Indicator	Reporting level	Standard	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Pre hospital	1	Response times for ambulances (Category 2 Response time – 90th centile)	BNSSG ICB	0:40:00	3:59:06	3:36:36	3:47:36	2:38:24	4:06:36	5:01:42	3:06:18	1:28:54	2:17:36	2:47:00	1:29:18	1:43:12	2:35:54
	2	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances	BNSSG ICB	TBC	35.6%	39.3%	39.6%	42.0%	37.8%	34.2%	37.7%	42.1%	40.0%	38.2%	42.2%	42.1%	38.1%
	3	Proportion of contacts via NHS 111 that receive clinical input	BNSSG ICB	50%	54.8%	55.1%	56.9%	59.6%	53.6%	50.4%	50.0%	48.5%	48.4%	48.8%	37.3%	51.5%	52.3%
A&E	4	Percentage of Ambulance Handovers within 15 minutes	BNSSG Trusts	65%	22.53%	23.60%	20.66%	19.44%	18.39%	16.95%	18.01%	22.54%	21.66%	15.80%	18.58%	19.03%	15.01%
	5	Time to Initial Assessment – percentage of patients assessed within 15 minutes of arrival at A&E	NBT	TBC	53.3%	62.8%	68.6%	72.4%	58.3%	50.7%	56.9%	68.5%	57.3%	49.5%	57.2%	70.8%	70.8%
			BRI	TBC	56.5%	60.3%	63.3%	68.3%	64.2%	54.1%	61.4%	54.3%	60.9%	61.5%	62.8%	63.3%	57.0%
			Weston	TBC	41.8%	42.4%	46.2%	42.2%	36.5%	34.9%	33.9%	32.3%	29.7%	31.8%	33.7%	35.2%	41.1%
	6	Average (mean) time in Department – non-admitted patients (hh:mm)	NBT	TBC	4:04	4:03	3:54	4:02	4:54	5:06	4:37	3:54	6:19	5:34	4:21	4:34	4:45
			BRI	TBC	5:46	5:06	5:03	5:03	5:28	5:46	5:56	5:37	5:26	5:35	5:41	5:28	5:48
Weston			TBC	4:01	3:19	3:47	4:03	4:01	4:05	4:22	4:03	4:01	4:16	4:23	4:22	4:26	
Hospital	7	Hospital Average (mean) time in Department – admitted patients (hh:mm)	NBT	TBC	8:47	8:09	8:09	10:41	12:31	13:04	11:31	9:08	11:43	11:34	8:27	10:35	12:40
			BRI	TBC	10:02	9:50	9:55	10:22	11:41	12:20	11:28	9:25	8:54	10:10	9:52	9:14	10:11
			Weston	TBC	11:31	14:07	17:11	22:03	16:36	17:35	17:04	11:15	12:29	16:43	17:26	15:38	15:30
8	Clinically Ready to Proceed – time from ‘ready,’ to leaving ED	BNSSG ICB	TBC	Awaiting further details													
Whole System	9	Patients spending more than 12 hours from Arrival in A&E	NBT	2%	6.0%	5.4%	5.9%	10.0%	12.7%	14.4%	11.6%	7.2%	16.0%	12.7%	6.1%	9.3%	12.4%
			BRI		12.8%	12.5%	12.1%	14.0%	14.9%	15.3%	13.9%	10.9%	9.9%	12.9%	12.3%	11.0%	12.9%
			Weston		10.0%	12.0%	13.4%	14.5%	13.9%	13.9%	13.4%	10.8%	12.7%	15.7%	15.7%	14.9%	16.4%
	10	Critical Time Standards (still in development)	TBC	TBC	Awaiting further details - measure still in development												

4h Waits in A&E	Oct-22	Sep-22	Variance	Change	Oct-19	Variance	Change
BNSSG	58.87%	60.07%	-1.2%	▼	80.36%	-21.5%	▼
NBT	57.47%	56.43%	1.0%	▲	80.04%	-22.6%	▼
UHBW	59.59%	62.01%	-2.4%	▼	80.51%	-20.9%	▼

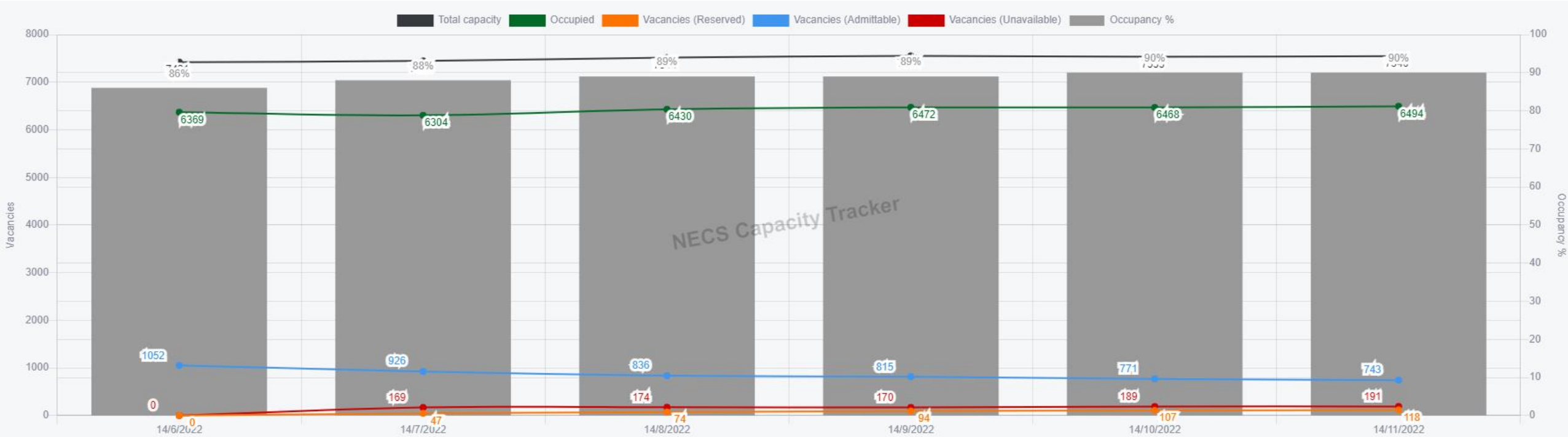
>12hr Waits in A&E from DTA	Oct-22	Sep-22	Variance	Change	Oct-19	Variance	Change
BNSSG Trusts	1423	978	445	▲	25	1398	▲
NBT	482	261	221	▲	4	478	▲
UHBW	941	717	224	▲	21	920	▲

Ambulance Handovers Time Lost >15 mins (Hours)	Oct-22	Sep-22	Variance	Change	Oct-19	Variance	Change
NBT	3,207	1,792	1,415	▲	150	3,057	▲
BRI	2,927	2,564	363	▲	116	2,811	▲
Weston	948	739	209	▲	59	889	▲

- Variance between latest month and previous month or latest month and same period in 19/20
- Change: Is the latest month better (Green Icon) or worse (Red icon) when compare to the previous month or same period in 19/20.
- RAG colours are based on comparison to national standards: **GREEN** = Achieved, **RED** = not achieved



# 3.2 Urgent Care – Care Homes Occupancy Report



Sub ICB	Maximum Capacity	Vacancies (Total)	Vacancies (Admittable)	Vacancies (Unavailable)	Vacancies (Reserved)	Occupied	Admittable %	Unavailable %	Reserved %	Occupied %
<b>NHS Bristol, North Somerset and South Gloucestershire ICB - 15C (274 / 274 / 275)</b>	7546	1052	743	191	118	6494	10%	3%	2%	86%
General Residential	1742	338	290	24	24	1404	17%	1%	1%	81%
General Nursing	1878	258	167	55	36	1620	9%	3%	2%	86%
Dementia Residential	1577	211	139	60	12	1366	9%	4%	1%	87%
Dementia Nursing	1195	143	63	41	39	1052	5%	3%	3%	88%
Learning Disability Residential	594	64	53	7	4	530	9%	1%	1%	89%
Mental Health Residential	278	25	21	4	0	253	8%	1%		91%
Mental Health Nursing	159	7	7	0	0	152	4%			96%
Learning Disability Nursing	74	4	1	0	3	70	1%		4%	95%
YPD - Young Physically Disabled	22	1	1	0	0	21	5%			95%
Transitional	3	1	1	0	0	2	33%		8	67%
Community Care	24	0	0	0	0	24				100%



# 3.3 Planned Care – Drivers and Priority Actions

Top Improvement Drivers: Nov		Priority actions: November - December 2022
RTT	<p><b>1. 104ww clearance</b></p> <p><b>2. Revised &gt;78ww operational plan trajectory achievement</b></p> <p><b>3. Expansion of capacity</b> to support delivery.</p> <p><b>4. Develop opportunities for a collaborative system approach to drive improvement</b> in challenged pathways</p>	<p>(1) Weekly scrutiny and detailed returns to Region/National team on 104/78ww breaches/breach risks.</p> <p>(2&amp;3) Paediatric dental pre-GA WLIs and Locum Endo bids successful vis MA support fund – implementation to commence. Delivery of weekend working, WLI's (commence or continue implementation and/or commence planning) and extended working days to increase capacity/ activity delivery; utilisation of insourcing and outsourcing continues;</p> <p>(4) System group established to drive improvement in Derm pathways – group participated in Region event and now driving a number of improvement actions. Planning for short-stay joint replacement model, similar to Exeter Nightingale commenced.</p>
	<p><b>5. Diagnostic workforce capacity pressures</b> across system.</p> <p><b>6. Progress against regional ambitions</b> - to reduce to zero people waiting &gt;26weeks &amp; no more than 25% of people waiting &gt;6 weeks by 31/03/23. Endoscopy performance (DM01) triggered Regional visit in Sept.</p> <p><b>7. Increase capacity (immediate/backlogs &amp; sustained /future need)</b>- National visit highlighted need to focus on capacity (inc. whole pathways). Demand outstripping capacity, backlogs persist across all high volume modalities, esp Echo, Endoscopy. Demand modelling has identified need for sustained additional capacity.</p>	<p>(5) System 'pool' of clinical endoscopist workforce to work across all sites in development; System engaged with Region drive behind echocardiography workforce capacity; Proof of concept project with local ISP to expedite training lists for endoscopists underway and lists now being delivered – progressing well. Interim evaluation scheduled for early Jan. Collab partnership between ICB, NHSE, InHealth, SWETA/HEE, NBT and UHBW</p> <p>(6) Improve DQ within WLMDs; Preparation for Regional visit – Endoscopy focus – UHBW 17<sup>th</sup> Nov, NBT Dec 13<sup>th</sup> (tbc). Focus on reduction of Sleep diagnostic wait lists to commence – awaiting confirmation of funding approval from NHSE re: 30x Oximeters to support recovery;</p> <p>(6&amp;7) Expanding endoscopy capacity (insourcing and outsourcing) – with current IS providers and at additional sites; Developing EOI for 23/24&amp;24/25 capital allocation for submission at end Nov; WLIs /weekend working / employment of Locums. Increase system echo capacity –Ongoing use of insourcing and agency capacity (aim to increase the latter). NOUS – continue to utilise capacity from insourcing and outsourcing; WLIs. CT – Use of the demountable CT scanner at WGH; weekend WLI's; outsourcing. MRI – IS capacity used; home working stations for radiologists to increase reporting capacity;</p> <p>(7) CDC NHS/IS partnership model in procurement phase; work ongoing across the system to produce a shared PTL and to provide mutual aid to equalise wait times across organisations.</p>
Diagnostics	<p><b>8. Reducing, validating and prioritising</b> patients on outpatient waiting lists</p> <p><b>9. Halting growth / reducing the volume of overdue follow ups</b></p> <p><b>10. Increasing availability and utilisation of advice and guidance.</b></p>	<p>(8) Validation activity continues in both Trusts – engaged with Region pilot (awaiting Region funding arrangements to be confirmed anticipated by w/c 21/11/22 so can commence). Seeking resource for longer-term validation activity proposal and will bring into 23/24 planning round – looking at opportunities with current RS.</p> <p>(9) Planning for follow up reductions; Pathway attention / system approach – e.g ENT pathways, physio services; PIFU roll out to all specialities where clinically appropriate</p> <p>(10.) Standardising processes to ensure consistent provision of A&amp;G across all major specialties via eRS; A&amp;G development - various inc. conversion to referral pilot (paed and rheumatology); progressing towards go-live for endocrinology in Jan. Working through challenges for establishing A&amp;G in some services.</p>
	<p><b>11. Workforce capacity pressures</b></p> <p><b>12. Backlog position recovery</b> (63+day recovery metric)</p> <p><b>13. Pathways of challenge</b> –I (inc. focus on capacity/demand modelling, workforce, access to Diagnostics, referral management, space)</p>	<p>(11) Recovery action plans re-worked across all specialities and include mitigations against workforce capacity challenges in implementation.</p> <p>(12) Increasing capacity through WLI's, Super Saturdays (e.g. Skin) and mega clinics (e.g Breast).; recruitment (substantive &amp; locum)</p> <p>(13) Trusts have re-worked recovery plans at speciality level – inc. pathway reviews/ improvements; efficiencies (clinic/theatre/administration), additional capacity, diagnostics, digital/tech solutions</p>
Outpatients		
Cancer		



## 3.4 Mental Health – Summary Performance

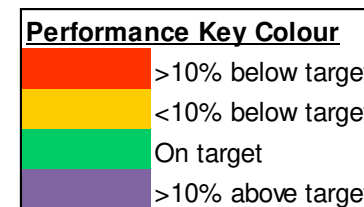
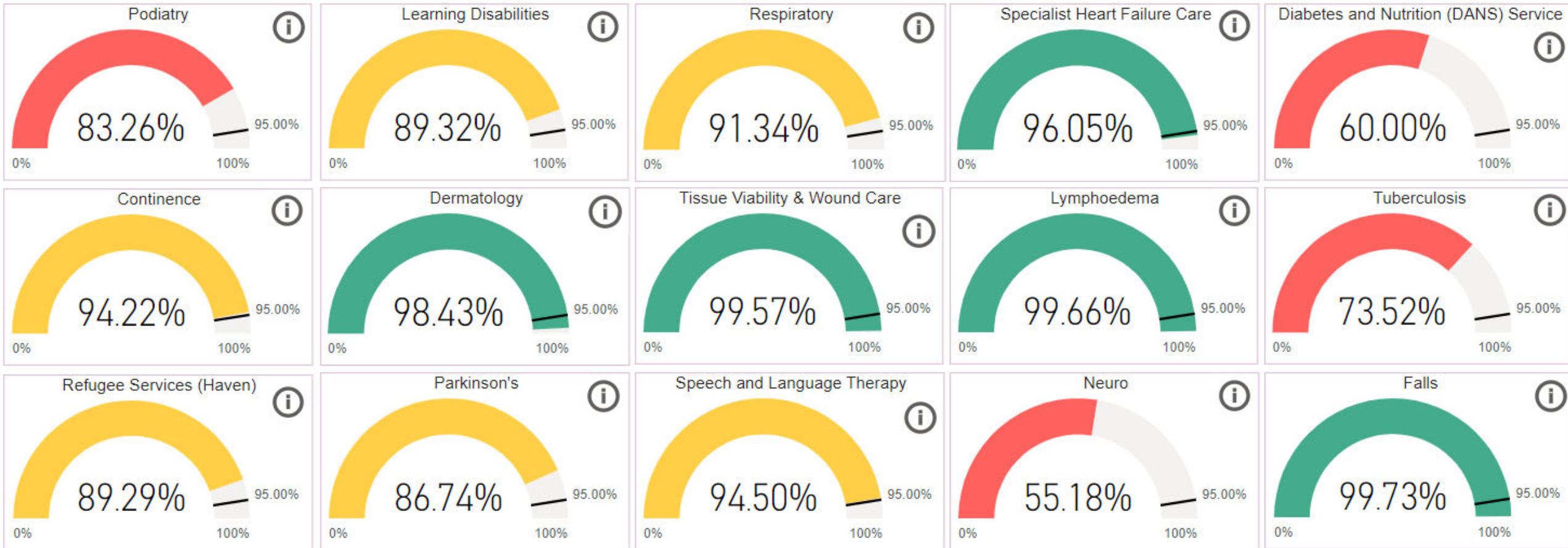
Mental Health, Learning Disabilities & Autism	Period	Standard	Latest	Previous	Variance	Change	19/20	Variance	Change
Dementia Diagnosis Rate	Sep-22	66.7%	65.9%	65.6%	0.3%	▲	70.1%	-4.2%	▼
EIP - 2ww Referral	Jun-22	60%	66.7%	70.0%	-3.3%	▼	85.0%	-18.3%	▼
IAPT Roll out (rolling 3 months)	Jun-22	6.25%	4.4%	4.7%	-0.3%	▼	3.6%	0.8%	▲
IAPT Recovery Rate	Jun-22	50%	52.2%	51.8%	0.3%	▲	N/A	N/A	N/A
IAPT Waiting Times - 6 weeks	Jun-22	75%	95.3%	92.4%	2.8%	▲	N/A	N/A	N/A
IAPT Waiting Times - 18 weeks	Jun-22	95%	100%	99.5%	0.5%	▲	N/A	N/A	N/A
CYPMH Access Rate - 2 contacts (12m Rolling)	Jul-22	34%	31.5%	31.5%	0.1%	▲	11.8%	19.8%	▲
CYP with Eating Disorders - routine cases within 4 weeks	Q2 22-23	95.0%	95.3%	91.4%	4.0%	▲	85.9%	9.4%	▲
CYP with Eating Disorders - urgent cases within 1 week	Q2 22-23	95.0%	95.0%	91.7%	3.3%	▲	62.9%	32.1%	▲
SMI Annual Health Checks (12 month rolling)	Q2 22-23	60.0%	55.4%	56.8%	-1.4%	▼	21.3%	34.1%	▲
Total Inappropriate Out of Area Placements (Bed Days)	Aug-22	N/A	265	330	-65	▼	816	-551	▼
Percentage of Women Accessing Perinatal MH Services	Jun-22	8.6%	6.2%	6.1%	0.1%	▲	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in CCG beds	Oct-22	9	11	13	-2	▼	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in NHSE beds	Oct-22	13	18	19	-1	▼	N/A	N/A	N/A
LD Annual Health Checks delivered by GPs aged 14+	Oct-22	2231	1740	1434	306	▲	N/A	N/A	N/A
AWP Delayed Transfers of Care	Oct-22	3.5%	20.2%	18.3%	1.9%	▲	6.5%	13.7%	▲
AWP Early Intervention	Oct-22	60%	70.0%	73.3%	-3.3%	▼	81.3%	-11.3%	▼
AWP 4 week wait referral to assessment	Oct-22	95%	84.15%	75.00%	9.2%	▲	97.50%	-13.4%	▼

### Key to Table

- Latest = **Latest month / quarter** Previous = **Previous month / quarter** 19/20 = **same month or period in 19/20** (pre-covid comparison), where available
- Standard = National Standard, where available
- Variance: between latest period and previous period or latest period and same period in 19/20
- Change: Is the latest period better (Green Icon) or worse (Red icon) when compare to the previous period or same period in 19/20.
- RAG colours are based on comparison to national standards: **GREEN** = Achieved, **RED** = not achieved

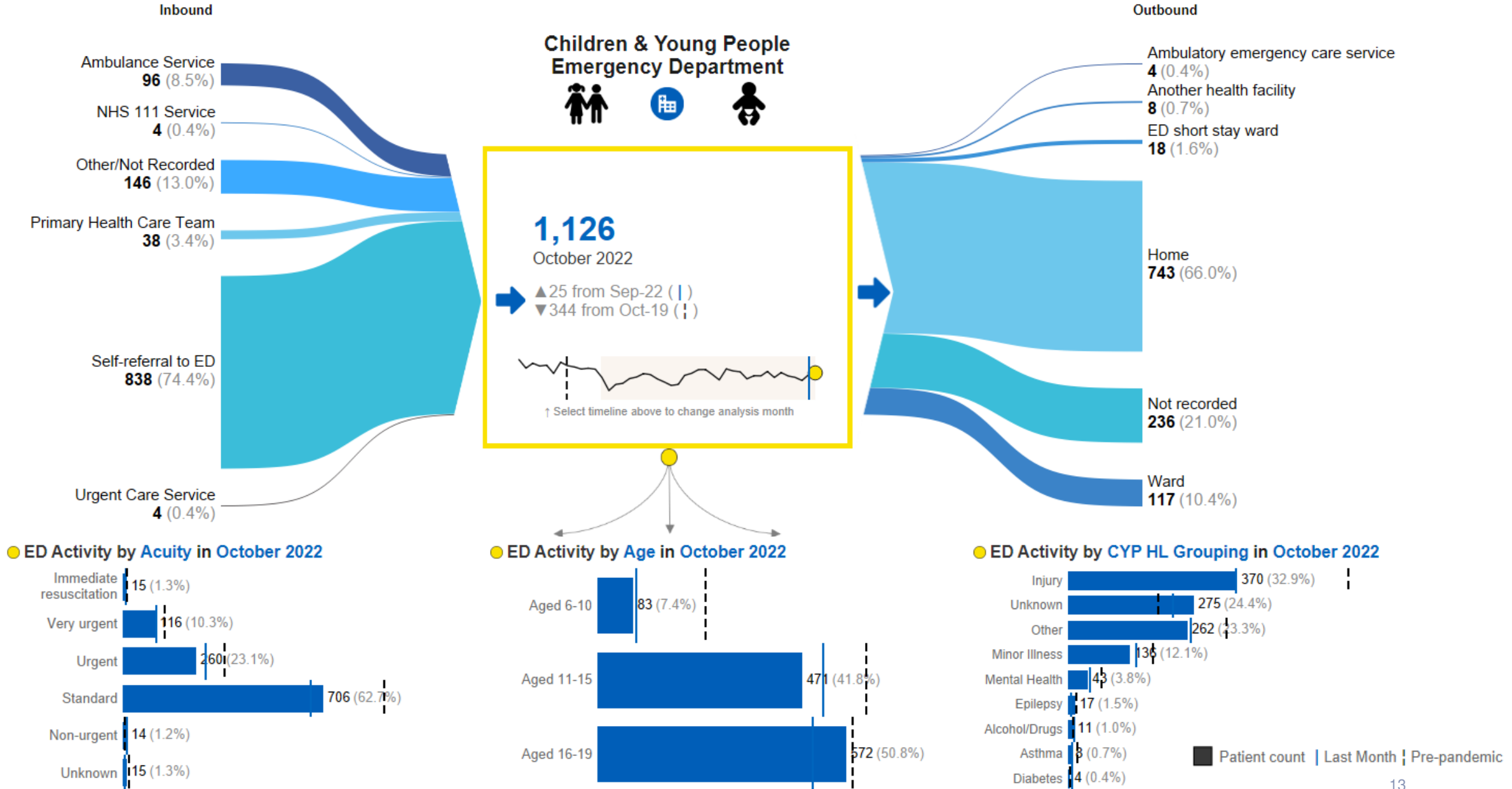
**Please note:** For some metrics, BNSSG ICB performance is only available up to June in the monthly data releases of the IAPT and MHSDS data sets. NHS Digital have not completed the necessary work to align and aggregate provider level data to the new commissioning structures following the transition from CCG to ICB. NHS Digital will include ICB level reporting at the earliest opportunity once the work is complete.

# 3.5 Sirona – Adults Community Services – % in 18 weeks – October YTD





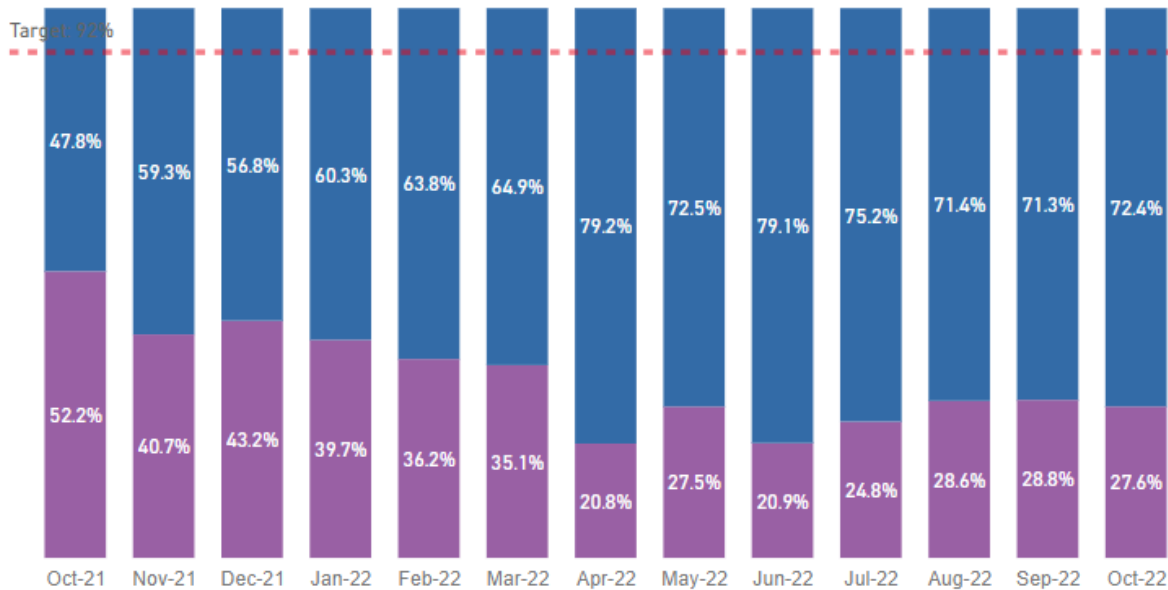
# 3.6 Children – CYP ED Overview BNSSG Trusts



# 3.6 Children – Sirona Community Paediatrics Wait Times

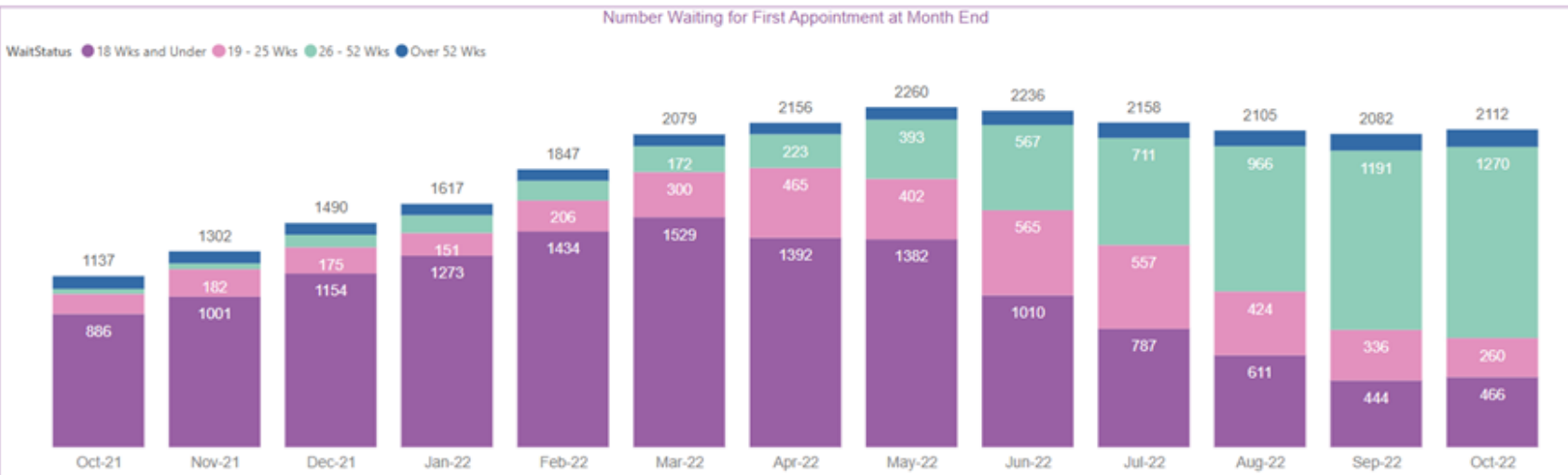
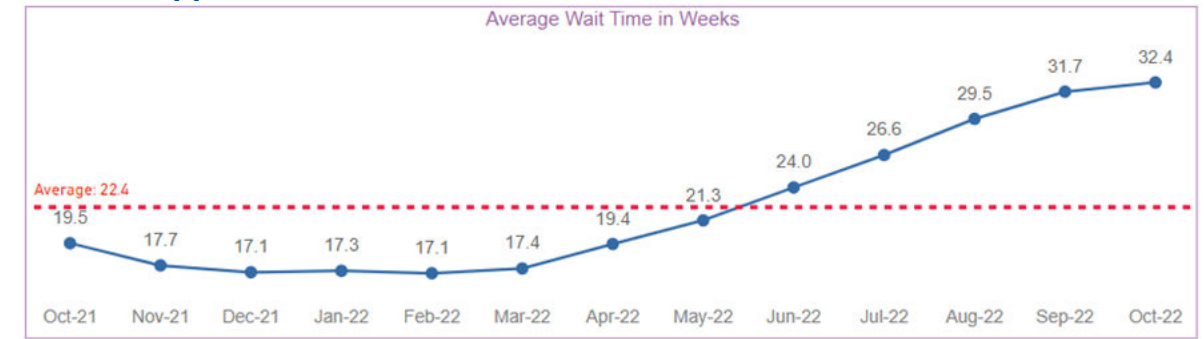
The tables below show Community Paediatric Initial Contact Wait Times for Patients Seen split by time band

● % Under 18 Wks Seen ● % Over 18 Wks Seen



Seen Wait Time Bands	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Total
18 Wks and Under	109	74	63	71	55	47	26	38	19	32	24	23	27	608
19 - 25 Wks	59	61	49	32	37	41	24	32	17	19	7	9	8	395
26 - 52 Wks	13	28	17	57	44	30	59	55	48	62	44	41	49	547
Over 52 Wks	28	19	17	19	16	16	16	13	7	16	9	7	14	197
<b>Total</b>	<b>209</b>	<b>182</b>	<b>146</b>	<b>179</b>	<b>152</b>	<b>134</b>	<b>125</b>	<b>138</b>	<b>91</b>	<b>129</b>	<b>84</b>	<b>80</b>	<b>98</b>	<b>1747</b>

The table below shows Community Paediatric Average Wait Time in Weeks for First Appointment

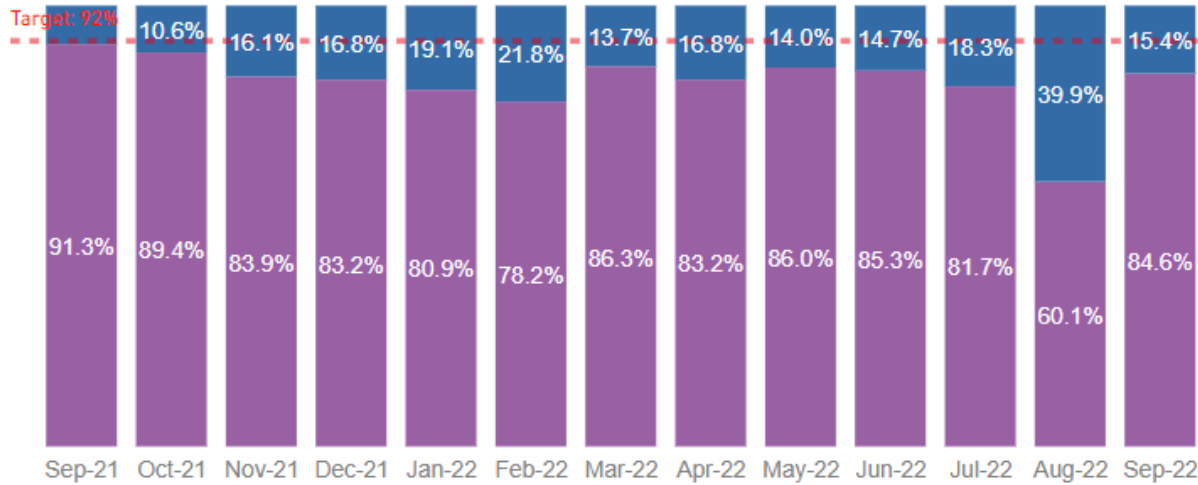


The table to the left shows Community Paediatric Waiting Times for First Appointment at Month End

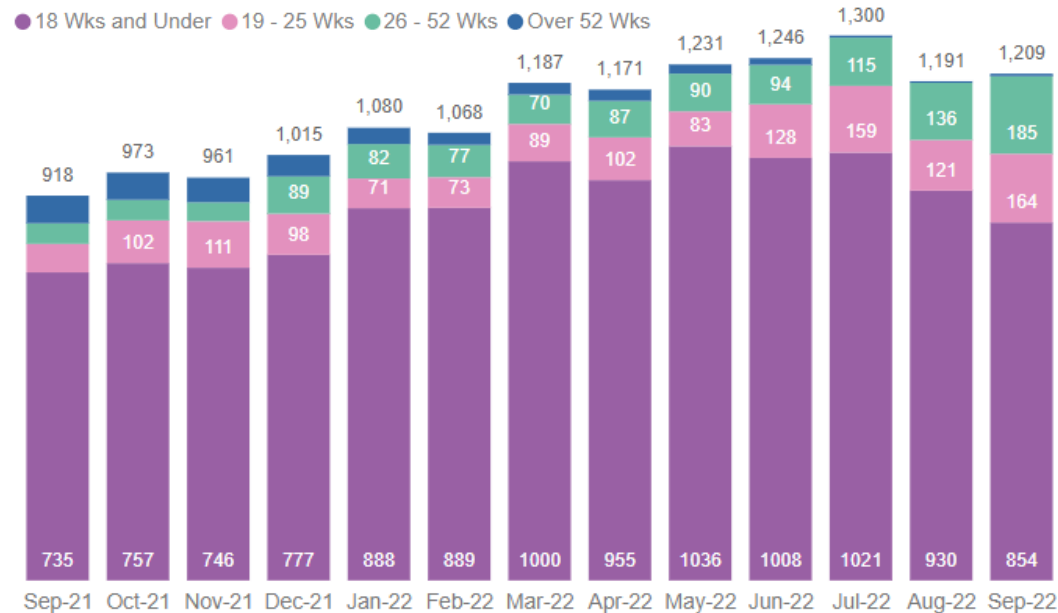
# 3.6 Children – Sirona Therapies Wait Times

The tables below show Therapies Initial Contact Wait Times for Patients Seen split by time band

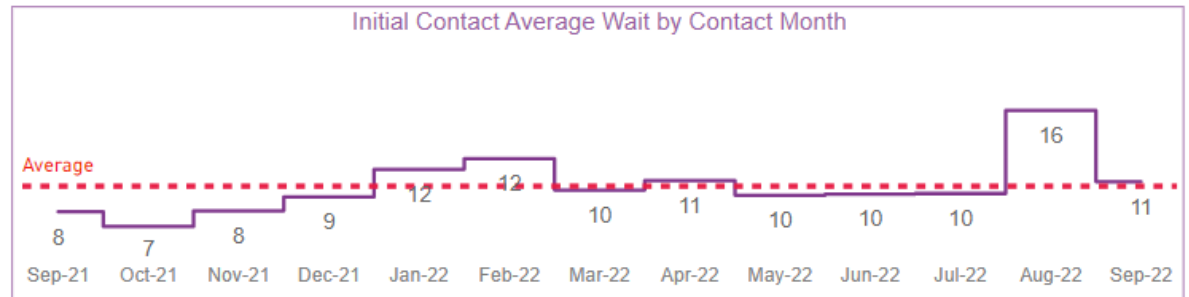
● %% Under 18 Wks Seen ● %% Over 18 Wks Seen



Seen Status	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Total
18 Wks and Under	407	379	490	213	318	259	320	233	361	359	286	167	181	3,973
19 - 25 Wks	24	33	51	23	25	37	29	30	30	25	32	72	16	427
26 - 52 Wks	5	8	30	13	37	24	16	16	21	26	29	37	15	277
Over 52 Wks	10	4	13	7	13	11	6	1	8	11	3	2	2	91
<b>Total</b>	<b>446</b>	<b>424</b>	<b>584</b>	<b>256</b>	<b>393</b>	<b>331</b>	<b>371</b>	<b>280</b>	<b>420</b>	<b>421</b>	<b>350</b>	<b>278</b>	<b>214</b>	<b>4,768</b>



The table below shows the average wait time for initial contact by contact month



The table to the left shows Referrals Waiting at Month End split by week band

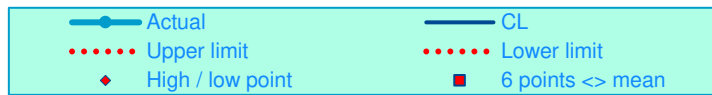
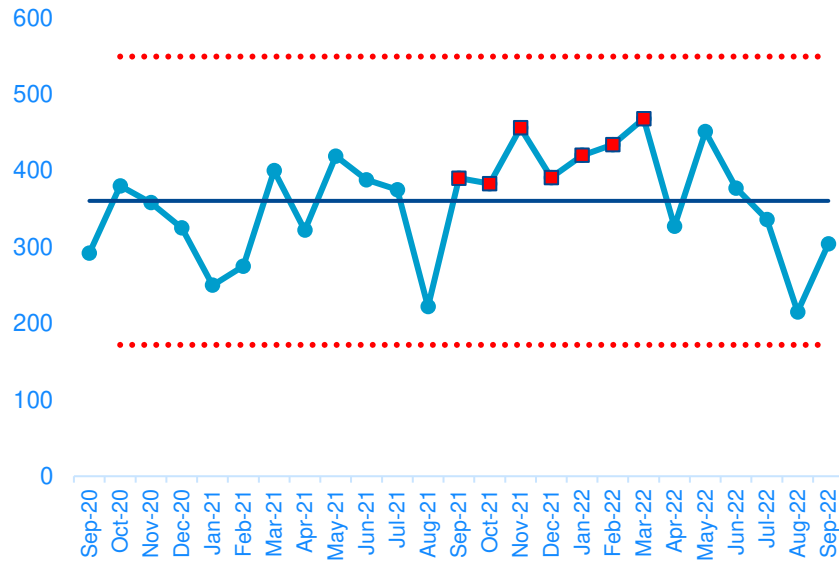


# 3.6 Children – CAMHS Referrals

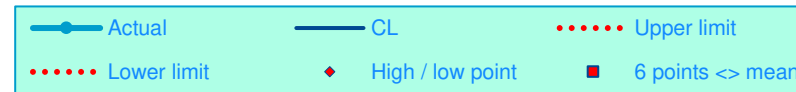
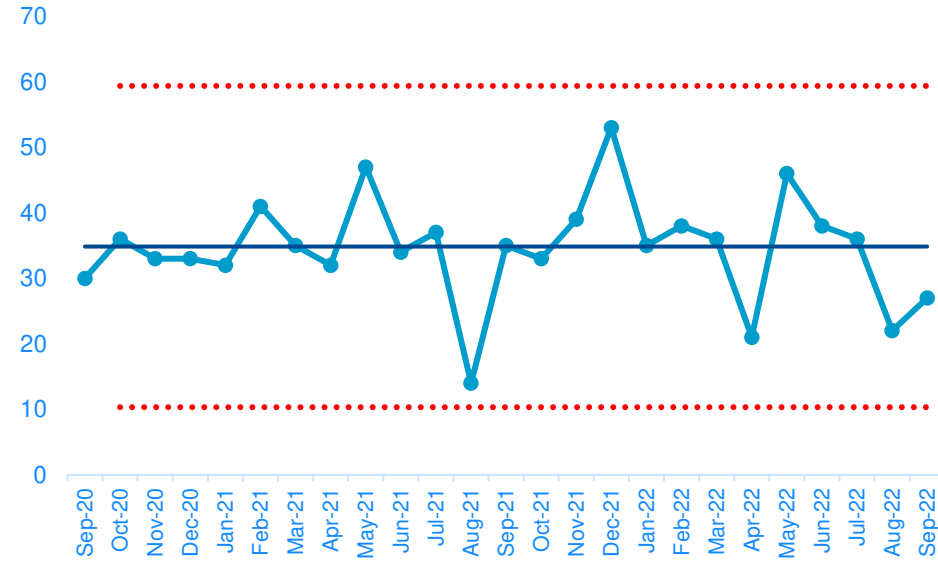
Name of indicator	Latest Month	Type of variation	Trend up / down	Shift up / down
New Referrals	304	Common Cause	No	No

Name of indicator	Latest Month	Type of variation	Trend up / down	Shift up / down
New Referrals - Eating Disorder	27	Common Cause	No	No

**New Referrals - Routine - All localities**



**New Referrals - Eating Disorder - Routine - All localities**



## 3.6 Children – CAMHS Performance & Waiting Times

		Total			Bristol			South Glos			North Somerset		
Access to services	Target	Most recent month	Average for last 3 months	Average for last 6 months	Most recent month	Average for last 3 months	Average for last 6 months	Most recent month	Average for last 3 months	Average for last 6 months	Most recent month	Average for last 3 months	Average for last 6 months
Referral to Treatment													
% with treatment start within 18 weeks	83%	<b>73%</b>	<b>73%</b>	<b>75%</b>	77%	79%	81%	30%	31%	46%	100%	91%	84%
-- Ave wait (days) - i.e. where treatment has started		<b>95.7</b>	<b>95.1</b>	<b>93.5</b>	92.9	81.6	75.3	159.5	152.1	137.2	48.3	78.5	98.4
No. awaiting treatment		<b>142</b>	<b>149</b>	<b>162</b>	85	94	94	21	26	32	36	29	36
-- Ave wait (days) - i.e. still waiting		<b>168.6</b>	<b>170.7</b>	<b>150.2</b>	214.9	200.6	169.4	143.1	154.6	148.5	74.1	88.7	102.2

# 4.1 BNSSG ICB Scorecard

Theme	Indicator	Standard	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	22/23
Urgent Care	A&E 4hr Waits - BNSSG Footprint	95%	73.03%	73.50%	70.83%	70.71%	70.55%	71.55%	67.04%	67.44%	65.76%	72.74%	69.21%	66.32%	61.78%	66.15%	64.95%	66.98%
	A&E 4hr Waits - BNSSG Trusts	95%	64.98%	64.22%	61.86%	62.65%	63.04%	64.19%	60.27%	59.73%	59.46%	65.46%	61.80%	57.10%	61.78%	60.07%	58.87%	60.66%
	>12hr DTA breaches in A&E - BNSSG Trusts	0	7139	494	623	765	696	1071	1211	1401	1169	755	873	1182	815	978	1423	7195
Planned Care	RTT Incomplete - 18 Weeks Waits	92%	65.39%	69.74%	68.09%	67.98%	66.04%	65.53%	65.93%	65.39%	65.75%	65.76%	66.17%	65.71%	65.75%	65.54%		65.54%
	RTT Incomplete - Total Waiting List Size		74,505	70,914	71,292	71,134	70,653	70,869	71,772	74,505	75,720	76,803	80,749	85,720	87,320	86,771		86,771
	RTT Incomplete - 52 Week Waits		3779	3353	3664	3791	3902	4020	3864	3779	4052	4164	4764	5134	5376	5302		5,302
	RTT Incomplete - % of WL > 52 Weeks		5.07%	4.73%	5.14%	5.33%	5.52%	5.67%	5.38%	5.07%	5.35%	5.42%	5.90%	5.99%	6.16%	6.11%		6.11%
	Diagnostic - 6 Week Waits	1%	37.90%	38.73%	38.09%	36.09%	40.13%	40.79%	36.86%	37.90%	41.09%	38.14%	38.46%	38.36%	41.30%	40.46%		40.46%
	Diagnostic - Total Waiting List Size		32,024	27,673	27,987	28,809	29,304	30,640	30,517	32,024	32,109	31,592	31,976	31,991	31,480	33,279		33,279
	Diagnostic - Number waiting > 6 Weeks		12,136	10,719	10,659	10,398	11,760	12,498	11,250	12,136	13,193	12,049	12,298	12,273	13,000	13,464		13,464
	Diagnostic - Number waiting > 13 Weeks		6,623	4,997	5,394	5,118	5,875	6,345	6,465	6,623	7,543	7,539	7,597	7,099	7,067	7,503		7,503
Cancer	Cancer 2 Week Wait - All	93%	64.91%	64.64%	60.99%	64.50%	67.27%	54.62%	70.34%	70.70%	61.38%	57.06%	48.91%	44.15%	44.78%	39.17%		48.97%
	Cancer 2 Week Wait - Breast symptoms	93%	28.22%	75.37%	26.23%	6.25%	11.84%	8.82%	16.87%	17.86%	21.35%	52.86%	22.83%	35.56%	4.88%	14.55%		26.28%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	66.40%	64.38%	67.40%	69.69%	65.99%	55.43%	73.56%	73.09%	67.96%	72.62%	69.30%	61.04%	53.13%	41.55%		60.64%
	Cancer 31 Day first treatment	96%	92.45%	95.31%	92.04%	88.51%	84.56%	87.44%	91.57%	88.79%	86.60%	89.02%	91.31%	93.53%	92.83%	89.69%		90.56%
	Cancer 31 day subsequent treatments - surgery	94%	81.11%	82.35%	79.57%	79.66%	70.83%	69.42%	81.37%	75.21%	71.00%	70.91%	68.48%	70.11%	67.02%	64.81%		68.70%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	98.97%	99.36%	99.38%	98.68%	100.00%	95.89%	99.32%	97.99%	97.66%	100.00%	95.83%	97.76%	100.00%	100.00%		98.54%
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.68%	100.00%	100.00%	99.42%	100.00%	99.37%	99.44%	100.00%	100.00%	100.00%	98.87%	100.00%	100.00%	98.61%		99.55%
	Cancer 62 day referral to first treatment - GP referral	85%	68.74%	60.16%	65.90%	74.47%	69.33%	61.43%	58.30%	65.99%	61.21%	57.96%	53.53%	56.90%	56.00%	59.56%		57.37%
	Cancer 62 day referral to first treatment - NHS Screening	90%	59.57%	68.42%	46.43%	61.36%	47.22%	39.47%	68.00%	63.89%	55.56%	82.14%	43.48%	62.16%	69.70%	54.55%		62.01%
Quality	Total Number of C.diff Cases	308	303	25	26	10	24	26	22	17	23	20	27	27	26	26		149
	Total Number of MRSA Cases Reported	0	38	2	1	3	6	7	0	3	4	2	1	1	2	5		15
	Total number of Never Events	0	4	1	0	0	0	0	0	0	0	0	0	0	0			0
	Eliminating Mixed Sex Accommodation (BNSSG CCG)	0	2	N/A	1	0	0	0	0	1	1	0	2	1	1	1		6
	Eliminating Mixed Sex Accommodation (BNSSG Trusts)	0	0	N/A	0	0	0	0	0	0	0	0	0	0	0	0		0
Mental Health	Dementia Diagnosis Rate - People 65+	66.7%	65.39%	64.27%	63.94%	64.35%	64.16%	64.33%	64.79%	65.39%	65.34%	65.41%	65.31%	65.65%	65.62%			65.62%
	EIP - 2ww Referral	60%	54.55%	33.33%	37.50%	50.00%	60.00%	50.00%	54.55%	61.54%	76.92%	70.00%	66.67%					66.67%
	IAPT Roll out (rolling 3 months)	6.25%	4.33%	4.23%	4.24%	4.88%	4.50%	4.80%	4.33%	4.73%	4.44%	4.66%	4.35%					4.35%
	IAPT Recovery Rate	50%	53.22%	48.82%	52.83%	52.27%	45.06%	53.07%	53.22%	54.73%	50.60%	51.81%	52.15%					52.15%
	IAPT Waiting Times - 6 weeks	75%	91.53%	87.43%	90.18%	87.36%	88.62%	89.67%	91.53%	90.34%	93.60%	92.42%	95.26%					95.26%
	IAPT Waiting Times - 18 weeks	95%	99.44%	98.86%	99.39%	98.90%	98.80%	99.46%	99.44%	99.52%	100.00%	99.49%	100.00%					100.00%
	CYPMH Access Rate 2+ contacts (rolling 12m)	34%	26.41%	24.95%	24.83%	25.04%	25.24%	25.94%	26.41%	26.73%	28.08%	30.54%	31.47%	31.53%				31.53%
	CYP with ED - routine cases within 4 weeks (quarterly)	95%	88.52%	83.88%		86.09%			88.52%			91.35%			95.31%			95.31%
	CYP with ED - urgent cases within 1 week (quarterly)	95%	83.33%	79.66%		79.17%			83.33%			91.67%			95.00%			95.00%
	SMI Annual Health Checks (quarterly)	60%	45.67%	15.94%		31.44%			45.67%			56.81%			55.40%			55.40%
	Out of Area Placements (Bed Days)		420	595	475	450	465	465	420	465	450	470	455	330	265			265

# 4.2 Provider Scorecard – NBT

Theme	Indicator	Standard	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	22/23	
Urgent Care	A&E 4hr Waits - Trust	95%	61.48%	61.75%	60.82%	60.17%	61.80%	60.78%	51.53%	52.74%	55.54%	72.71%	59.32%	50.99%	60.83%	56.43%	57.47%	59.14%	
	A&E 4hr Waits - Footprint	95%	69.58%	70.96%	69.31%	68.10%	68.82%	68.03%	59.36%	61.25%	61.71%	77.70%	66.62%	60.85%	60.83%	62.29%	63.12%	65.05%	
	>12hr DTA breaches in A&E	0	1378	38	29	59	20	295	367	449	360	176	297	304	57	261	482	1937	
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	64.71%	71.87%	70.37%	69.68%	66.67%	65.61%	65.17%	64.71%	64.23%	62.62%	64.80%	65.78%	65.82%	66.30%		66.30%	
	RTT Incomplete - Total Waiting List Size	Op Plan	39,101	36,787	37,268	37,297	37,264	37,210	38,498	39,101	39,819	40,634	42,326	46,991	48,766	49,025		49,025	
	RTT Incomplete - 52 Week Waits	Op Plan	2242	1933	2068	2128	2182	2284	2296	2242	2,454	2,424	2,675	2,914	3,131	3,087		3,087	
	RTT Incomplete - % of WL > 52 Weeks		5.73%	5.25%	5.55%	5.71%	5.86%	6.14%	5.96%	5.73%	6.16%	5.97%	6.32%	6.20%	6.42%	6.30%		6.30%	
	Diagnostic - 6 Week Waits	1%	40.25%	42.83%	41.80%	40.32%	44.30%	45.45%	40.00%	40.25%	43.61%	40.13%	41.00%	42.75%	48.09%	48.27%		48.27%	
	Diagnostic - Total Waiting List Size		17,111	14,818	15,176	15,768	15,872	16,790	16,469	17,111	17,114	17,114	17,166	17,504	17,124	16,928	16,690		16,690
	Diagnostic - Number waiting > 6 Weeks		6,888	6,346	6,343	6,357	7,031	7,631	6,588	6,888	7,464	6,889	7,177	7,321	8,141	8,057		8,057	
	Diagnostic - Number waiting > 13 Weeks		4,097	2,724	3,029	2,913	3,501	3,948	3,951	4,097	4,664	4,780	4,897	4,718	4,844	4,971		4,971	
Cancer	Cancer 2 Week Wait - All	93%	51.63%	51.22%	42.70%	53.75%	58.38%	41.42%	66.47%	69.78%	57.66%	46.16%	39.21%	40.99%	40.18%	35.85%		42.99%	
	Cancer 2 Week Wait - Breast symptoms	93%	27.21%	74.64%	28.13%	6.15%	11.54%	6.90%	14.55%	16.78%	14.94%	46.03%	18.95%	21.05%	2.50%	6.12%		19.35%	
	Cancer 28 day faster diagnosis standard (All Routes)	75%	60.77%	56.07%	59.95%	66.29%	57.52%	47.10%	72.01%	72.93%	66.82%	72.83%	70.87%	58.29%	48.83%	35.18%		58.28%	
	Cancer 31 Day first treatment	96%	89.09%	91.89%	88.51%	86.94%	79.59%	79.18%	89.91%	80.99%	81.82%	83.77%	85.53%	91.20%	87.36%	87.76%		86.23%	
	Cancer 31 day subsequent treatments - surgery	94%	74.28%	80.90%	69.62%	65.77%	65.59%	55.66%	80.68%	65.49%	62.77%	57.29%	51.85%	58.11%	43.84%	50.00%		54.33%	
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	97.90%	95.45%	96.30%	100.00%	100.00%	92.31%	100.00%	83.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	
	Cancer 62 day referral to first treatment - GP referral	85%	64.36%	56.98%	57.14%	74.07%	67.52%	56.88%	51.17%	58.66%	56.48%	50.15%	48.40%	45.10%	55.59%	58.90%		52.45%	
	Cancer 62 day referral to first treatment - NHS Screening	90%	64.40%	75.00%	41.67%	68.75%	53.25%	50.00%	72.22%	70.59%	63.64%	82.14%	51.02%	57.53%	74.24%	62.50%		65.36%	
Quality	Total Number of C.diff Cases		62	5	4	1	6	6	1	6	7	4	5	3	3	4		26	
	Total Number of MRSA Cases Reported	0	0	0	0	0	0	0	0	0	4	1	1	0	0	0		6	
	Total Number of E.Coli Cases		48	3	6	3	2	6	3	5	5	4	3	3	3	2		20	
	Number of Klebsiella cases		24	3	2	4	3	2	2	3	1	3	3	1	1	3		12	
	Number of Pseudomonas Aeruginosa cases		10	2	0	0	0	2	1	0	2	0	0	1	1	1		5	
	Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
	Number of Never Events	0	1	0	0	0	0	0	0	0	0	0	0	0	0			0	
	VTE assessment on admission to hospital	95%		94.90%	94.53%	93.84%	94.55%	93.80%	93.99%	92.63%	93.36%	93.29%	92.40%	89.24%					

# 4.3 Provider Scorecard – UHBW

Theme	Indicator	Standard	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	22/23
Urgent Care	A&E 4hr Waits - Trust	95%	66.79%	65.47%	62.38%	63.90%	63.69%	66.01%	64.83%	63.26%	61.51%	61.69%	63.04%	60.15%	62.31%	62.01%	59.59%	61.45%
	A&E 4hr Waits - Footprint	95%	74.75%	74.73%	71.57%	71.98%	71.41%	73.34%	70.88%	70.46%	67.81%	70.28%	70.47%	68.96%	62.31%	68.14%	65.86%	67.96%
	>12hr DTA breaches in A&E	0	5761	456	594	706	676	776	844	952	809	579	576	878	758	717	941	5258
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	59.17%	61.76%	60.20%	60.25%	58.60%	58.73%	59.50%	59.17%	58.65%	58.32%	58.76%	56.37%	55.56%	54.35%		54.35%
	RTT Incomplete - Total Waiting List Size	Op Plan	55,021	53,697	53,743	53,328	53,253	53,909	54,305	55,021	57,019	57,940	60,404	60,738	62,010	61,870		61,870
	RTT Incomplete - 52 Week Waits	Op Plan	3,920	3,110	3,248	3,318	3,558	3,599	3,604	3,920	4,362	4,654	5,298	5,591	5,970	6,141		6,141
	RTT Incomplete - % of WL > 52 Weeks		7.12%	5.79%	6.04%	6.22%	6.68%	6.68%	6.64%	7.12%	7.65%	8.03%	8.77%	9.21%	9.63%	9.93%		9.93%
	Diagnostic - 6 Week Waits	1%	39.05%	35.53%	36.73%	34.60%	38.86%	39.45%	37.48%	39.05%	42.11%	39.90%	38.78%	36.50%	37.79%	35.54%		35.54%
	Diagnostic - Total Waiting List Size		16,610	14,049	14,125	14,307	14,525	15,154	15,576	16,610	16,521	15,819	16,042	16,426	15,387	17,577		17,577
	Diagnostic - Number waiting > 6 Weeks		6,486	4,992	5,188	4,950	5,644	5,979	5,838	6,486	6,957	6,311	6,221	5,996	5,815	6,246		6,246
	Diagnostic - Number waiting > 13 Weeks		3,372	2,930	3,169	2,949	3,180	3,240	3,349	3,372	3,799	3,697	3,616	3,245	2,968	3,294		3,294
Cancer	Cancer 2 Week Wait - All	93%	82.37%	82.33%	86.39%	80.30%	78.30%	71.03%	75.41%	66.51%	63.02%	67.99%	57.22%	44.62%	45.18%	41.14%		53.06%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	76.33%	76.16%	77.64%	75.68%	78.65%	70.03%	77.86%	73.83%	72.02%	73.19%	67.40%	64.56%	57.28%	50.54%		64.15%
	Cancer 31 Day first treatment	96%	92.90%	97.73%	93.04%	84.18%	89.51%	91.11%	89.62%	93.50%	89.58%	90.61%	92.88%	93.92%	93.92%	91.01%		92.06%
	Cancer 31 day subsequent treatments - surgery	94%	85.07%	85.96%	88.00%	84.21%	86.00%	73.53%	80.00%	82.09%	83.33%	76.27%	80.00%	88.89%	85.94%	87.69%		83.76%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	99.28%	100.00%	100.00%	98.72%	100.00%	97.28%	99.33%	99.35%	97.67%	100.00%	94.77%	98.53%	100.00%	100.00%		98.48%
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.53%	100.00%	100.00%	99.47%	98.65%	97.89%	100.00%	100.00%	99.38%	100.00%	99.48%	99.38%	100.00%	99.37%		99.61%
	Cancer 62 day referral to first treatment - GP referral	85%	76.05%	69.75%	75.80%	80.00%	73.12%	68.09%	70.18%	78.05%	67.81%	70.95%	61.83%	69.42%	52.16%	64.85%		64.16%
	Cancer 62 day referral to first treatment - NHS Screening	90%	50.28%	33.33%	66.67%	23.08%	55.56%	39.13%	60.00%	55.56%	0.00%	33.33%	25.00%	50.00%	50.00%	50.00%		34.21%
Quality	Total Number of C.diff Cases (HOHA)	89	82	6	7	3	6	6	8	2	6	4	10	12	6	7		45
	Total Number of MRSA Cases Reported	0	7	0	0	0	2	3	0	1	0	0	0	0	0	1		1
	Total Number of E.Coli Cases	119	75	8	8	8	2	7	5	9	13	10	5	7	4	6		45
	Number of Klebsiella cases		48	9	9	4	2	3	1	1	3	4	3	5	7	3		25
	Number of Pseudomonas Aeruginosa cases		15	4	0	2	2	1	0	0	1	1	1	1	4	4		12
	Eliminating Mixed Sex Accommodation	0	0	N/A due to C-19	0	0	0	0	0	0	0	0	0	0	0	0		0
	Number of Never Events	0	3	1	0	0	0	0	0	0	0	0	0	0	1			1
	Rate of slips, trips and falls per 1,000 bed days	4.8	4.83	4.87	4.80	4.57	5.20	5.54	4.85	5.50	5.54	4.78	4.09	3.27	6.63			4.87
	No. of Pressure Ulcers grade 2, 3 & 4 per 1,000 bed days	0.4	0.174	0.132	0.187	0.159	0.255	0.256	0.1	0.3	0.248	0.089	0.093	0.089	0.118			0.127
	VTE assessment on admission to hospital (Bristol)	95%	83.3%	85.7%	83.7%	84.3%	83.2%	83.8%	82.60%	82.20%	81.3%	81.9%	82.4%	82.1%	83.7%			82.3%

# 4.4 Non-Acute Provider Scorecard

Provider	Indicator (BNSSG level - except ambulance handovers)	Standard	21/22	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	22/23
SWASFT	Category 1 - Average Duration (hr:min:sec)	0:07:00	0:08:48	0:10:12	0:09:30	0:10:18	0:09:00	0:09:48	0:11:06	0:09:54	0:08:48	0:09:24	0:10:12	0:09:30	0:09:06	0:09:42	0:09:30
	Category 1 - 90th Percentile Duration (hr:min:sec)	0:14:00	0:15:54	0:18:06	0:16:18	0:18:06	0:16:06	0:16:54	0:18:48	0:17:24	0:15:24	0:15:54	0:17:42	0:16:36	0:15:42	0:16:36	0:16:36
	Category 2 - Average Duration (hr:min:sec)	0:18:00	1:10:00	1:48:30	1:28:48	1:33:48	1:06:48	1:40:18	2:02:24	1:16:30	0:40:42	0:57:12	1:09:54	0:42:00	0:45:12	1:06:00	0:56:42
	Category 2 - 90th Percentile Duration (hr:min:sec)	0:40:00	2:54:24	3:59:06	3:36:36	3:47:36	2:38:24	4:06:36	5:01:42	3:06:18	1:28:54	2:17:36	2:47:00	1:29:18	1:43:12	2:35:54	2:14:12
	Category 3 - 90th Percentile Duration (hr:min:sec)	2:00:00	9:11:06	12:44:48	10:47:36	11:49:12	9:08:36	14:37:18	20:50:42	10:55:12	6:28:06	8:49:30	9:14:18	5:32:06	7:54:54	11:01:30	8:34:42
	Category 4 - 90th Percentile Duration (hr:min:sec)	3:00:00	8:00:06	12:16:18	12:06:48	5:58:30	4:39:30	14:06:36	30:34:36	13:58:36	6:02:18	5:44:00	10:35:54	7:20:18	8:39:54	2:40:06	7:39:54
	Ambulance Handovers - % within 15 minutes at NBT	65%	25.0%	19.6%	21.0%	18.7%	16.4%	15.1%	14.7%	16.8%	21.0%	16.8%	13.5%	18.2%	17.6%	11.9%	16.6%
	Ambulance Handovers - % within 30 minutes at NBT	95%	56.8%	45.9%	53.0%	51.3%	44.7%	38.6%	38.3%	44.4%	53.9%	45.5%	42.8%	56.2%	51.5%	38.7%	47.7%
	Ambulance Handovers - % within 60 minutes at NBT	100%	75.3%	68.8%	73.2%	75.2%	65.0%	58.3%	57.2%	66.2%	77.2%	68.0%	67.5%	80.9%	75.9%	62.2%	71.3%
	Ambulance Handovers - % within 15 minutes at BRI	65%	22.2%	16.8%	14.4%	14.2%	14.1%	10.9%	11.7%	11.6%	13.9%	17.5%	9.7%	12.0%	13.3%	10.3%	12.6%
	Ambulance Handovers - % within 30 minutes at BRI	95%	41.6%	32.7%	32.1%	33.4%	29.2%	22.5%	23.3%	25.3%	34.7%	42.9%	26.2%	30.7%	36.1%	27.6%	32.0%
	Ambulance Handovers - % within 60 minutes at BRI	100%	60.0%	54.2%	54.5%	57.4%	47.6%	37.8%	39.3%	44.2%	56.0%	65.2%	48.1%	51.2%	58.4%	49.7%	53.3%
	Ambulance Handovers - % within 15 minutes at WGH	65%	32.6%	26.9%	22.7%	17.5%	19.5%	21.3%	17.6%	16.9%	25.0%	23.5%	15.0%	19.0%	16.3%	14.2%	18.6%
	Ambulance Handovers - % within 30 minutes at WGH	95%	60.0%	47.4%	46.5%	40.6%	48.4%	53.7%	40.9%	40.5%	52.4%	55.9%	36.3%	47.5%	46.6%	44.0%	46.3%
Ambulance Handovers - % within 60 minutes at WGH	100%	75.2%	62.8%	63.9%	63.8%	70.9%	74.5%	60.2%	58.1%	71.2%	72.7%	56.0%	65.0%	66.2%	65.2%	65.0%	
SevernSide IUC	Average speed to answer calls (in seconds)	20 Sec	227	304	205	327	228	166	325	318	274	756	713	723	271	413	483
	% of calls abandoned	3%	12.8%	13.9%	10.9%	15.1%	11.4%	9.3%	16.0%	16.1%	13.5%	30.0%	28.4%	29.2%	14.0%	19.5%	21.7%
	% Triaged Calls receiving Clinical Contact	50%	55.9%	54.8%	55.1%	56.9%	59.6%	53.6%	50.4%	50.0%	48.5%	48.4%	48.8%	37.3%	51.5%	52.3%	48.5%
	% of callers allocated the first service offered by DOS	85%	67.5%	69.0%	70.8%	72.2%	70.0%	69.9%	70.5%	70.0%	68.7%	69.3%	70.2%	68.8%	70.1%		69.5%
	% of Cat 3 or 4 ambulance dispositions validated within 30mins	50%	59.5%	58.2%	57.1%	64.8%	69.4%	51.3%	47.8%	53.1%	45.8%	38.0%	45.0%	58.5%	66.2%		51.0%
	% of calls initially given an ED disposition that are validated	50%	61.7%	60.0%	70.5%	73.3%	78.3%	49.3%	30.6%	24.2%	13.2%	13.8%	13.4%	17.9%	22.5%		17.6%
AWP	Delayed Transfers of Care	3.5%	10.7%	8.8%	8.5%	10.4%	11.4%	13.4%	11.1%	10.3%	13.4%	10.6%	12.7%	15.8%	18.3%	20.2%	
	Early Intervention	60%	49.1%	35.7%	57.8%	38.4%	33.3%	72.7%	61.9%	76.9%	55.0%	63.1%	81.8%	76.1%	73.3%	70.0%	
	4 week wait Referral to Assessment	95%	80.7%	83.5%	84.4%	81.1%	70.0%	80.6%	80.7%	78.9%	76.9%	76.9%	84.3%	82.9%	75.0%	84.2%	

**Please note regarding SevernSide IUC data:** A cyber-attack on 4th August 2022 caused a major outage on the Adastra system used by many IUC service providers. This had a widespread impact on the IUC service with many providers relying on paper record-keeping from that date onwards during August. Besides impacting service delivery in August, ongoing reporting issues have resulted in missing or under-reported data for some contract areas and caution should be taken when interpreting figures from August to September.

# **BNSSG Quality Report**

**November Report**

**for**

**Month 6 and Quarter 2**

**(September data) 2022/23**



# Contents

- **Current updates/emerging issues** **Slide 3**
- **Health Care Acquired Infections (HCAI) and IPC Cell Overview** **Slides 4 – 11**
- **Serious Incidents (SI) and Never Events (NE)** **Slides 12 – 13**
- **Datix and Datix project** **Slide 14**
- **Funded Care** **Slides 15 - 17**

*Please note: All information, data and graphs represent the latest information available at the time of the report.*

**Cygnets Kewstoke Hospital** – 2 further visits have been undertaken to Kewstoke Hospital to review medicines management processes and policies. No immediate concerns were noted and feedback was provided to the senior management team. A report is being produced and will be shared in December with the provider and SQG. A further Quality Improvement Group is scheduled with the Provider. The Mental Health Provider Collaborative is currently planning a separate 4 day review of services in late November 2022.

**Sherwood Lodge** – Following on from the supportive work being undertaken by BNSSG with this provider, an improvement plan has been developed in line with the discussions from the S42 enquiry, CQC recommendations and required actions from the initial visits undertaken by the ICB. The improvement plan is being monitored via the SQG Quality escalation framework. During a visit by ICB senior staff overall improvements were evident, although it was clear that the Registered owner had some educational needs related to Governance, Risk Management and accessing system support.

**Workforce and Recruitment** – Workforce risks and challenges continue to impact on the system although work continues to support partners in their efforts to recruit staff and manage workforce related risks.

### **Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services**

Work has started to establish the proposed governance framework which will be used to establish a robust system position for the quality and safety of MH, LD and autism inpatient services and visits are being planned to inpatient sites to support this process.

**Never Events** – At the beginning of November two new Never Events were reported in the system affecting the same patient, resulting from the same procedure. The first event involved a nerve block performed on the incorrect limb on admission to ED and the second event involved performing a left hemiarthroplasty which should have been a right hemiarthroplasty. Both Never Events were as a result of incorrect labelling of admission Xray's which led to the wrong site procedures being undertaken.

**Kirkup Report – “Maternity and neonatal services in East Kent – the Report of the Independent Investigation”** The national report was reviewed by the November BNSSG System Quality Group. System assurance that the recommendations are actioned is being led by the BNSSG LMNS.

# Quality Report – Health Care Acquired Infections (HCAI) ICB Overview

## Reporting Period – Month 6 2022/23 – September & Q2 data

Information Source and date of information – UK Health Security Agency (UKHSA), ICS HCAI Lead as of 13/10/2022

### BNSSG Annual Standard

- Integrated Care Boards (ICB's) and secondary care provider threshold levels for 2022/23 were released in April 2022 by NHS England and NHS Improvement.
- Both ICB and secondary care threshold levels are specified below:

- **Clostridiodes difficile (CDI)** = 308
- **Escherichia coli (E. coli)** = 534
- **Methicillin Resistant Staphylococcus Aureus (MRSA)** = 0
- **Methicillin Susceptible Staphylococcus Aureus (MSSA)** – No threshold
- **Klebsiella** = 160
- **Pseudomonas aeruginosa** = 63

### Performance for September 2022

- **CDI** = 26 HOHA=10 (NBT-4, UHBW-6), COHA=4, COCA=9, COIA=3
- **E. coli** = 47 HOHA=7 (NBT-2, UHBW-5), COHA=8 COCA=32, COIA=0
- **MRSA** = 5, HOHA=1 (NBT-0, UHBW-1), COHA=2, COCA=2, COIA=0
- **MSSA** = 18, HOHA=9 (NBT-6, UHBW-2, Papworth=1) COHA=2 COCA=7 COIA= 0
- **Klebsiella** =12 HOHA=4 (NBT-2, UHBW-2) COHA=3, COCA=5, COIA= 0
- **Pseudomonas aeruginosa** = 9, HOHA=4 (NBT-0, UHBW-4), COHA=1, COCA=4, COIA=0

**HOHA** – Hospital Onset, Hospital Associated  
**COHA** – Community Onset, Hospital Associated  
**COCA** – Community Onset, Community Associated  
**COIA** – Community onset, Indeterminate Association

### Risks/Assurance Gaps

BNSSG CDI Case Review Group have met to share learning from case reviews. Future meetings have been scheduled bimonthly. End to end CDI methodology is being discussed. Community Onset, Hospital Associated (COHA) focus for review may be prioritised. MSSA increases continue. The September data (UKHSA FES report) reports an unusual increase in MSSA bacteraemia cases at NBT that are apportioned as HOHA.

Pseudomonas and Klebsiella cases exceeded threshold this month. The September data (UKHSA FES report ) reports an unusual and sustained increase in Pseudomonas aeruginosa bacteraemia cases at UHBW that are apportioned as HOHA.

### **Commentary**

- MRSA- Zero tolerance has not achieved. There were five cases in September- 4 in the Community.
- CDI- The 26 cases are currently categorised as follows: New infection (22), Continuing Infection (3), Repeat/Relapse (1).
- EColi- the majority of the 47 cases continue to be Community Onset (40).

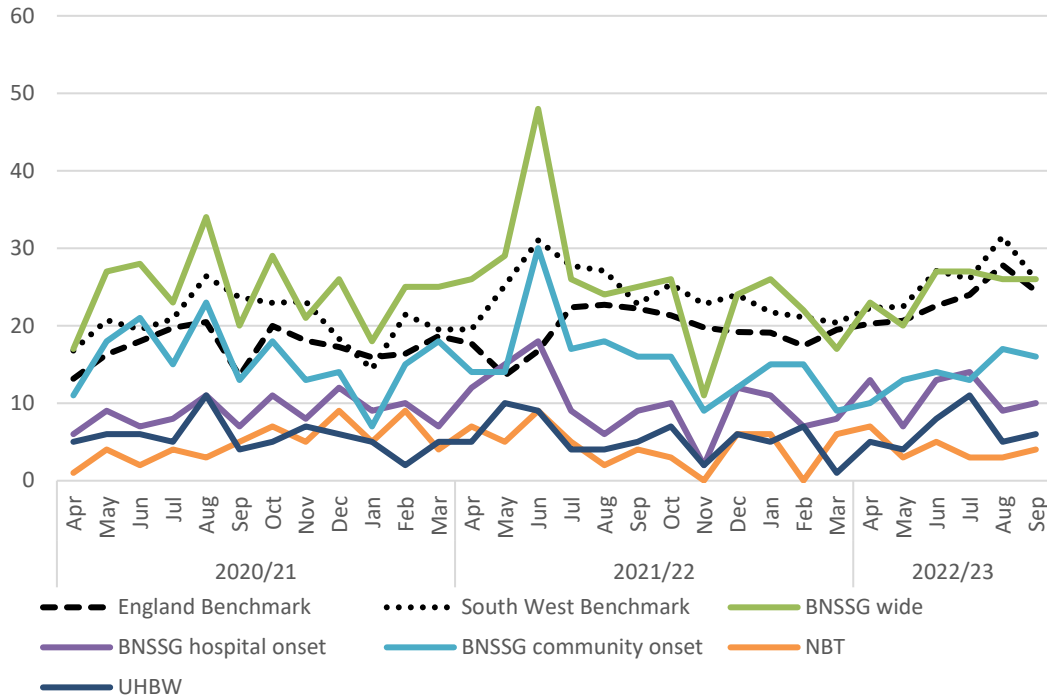
### **Assurance**

- Comparison with all England and Southwest 2022/23 benchmarks is provided.

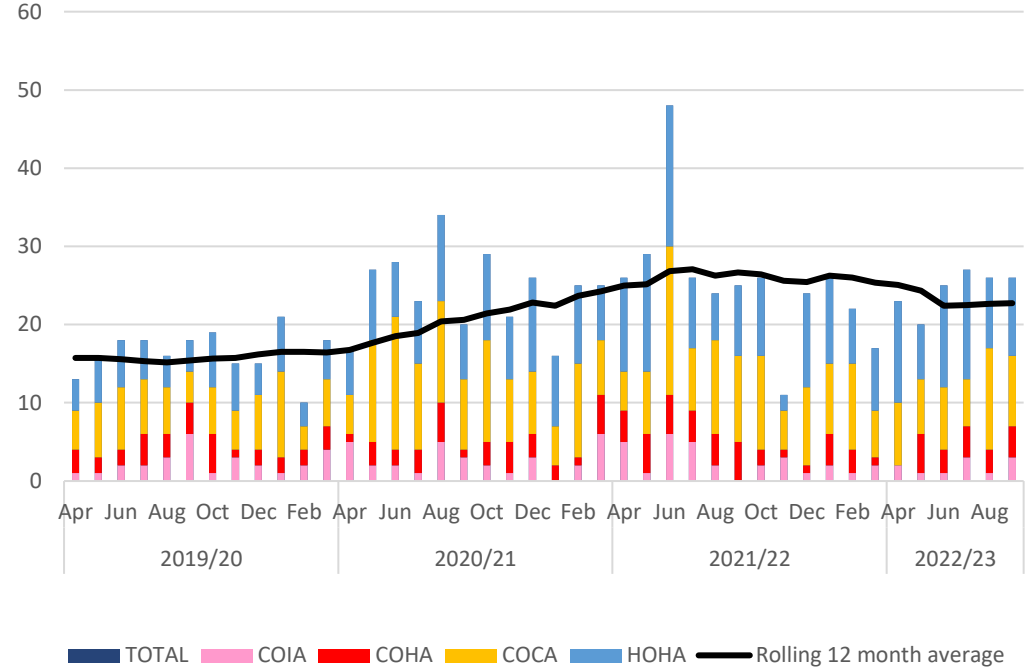
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Threshold to date	Assigned Cases 2022/23	Position against threshold	Month 6 position 21/22	Month 6 position 20/21
C. difficile	23	20	27	27	26	26							154	149	↓	178	149
E. coli	42	39	49	43	40	47							267	260	↓	289	306
MRSA	4	2	1	1	2	5							0	15		18	15
MSSA	16	12	10	17	13	18										86	86
Klebsiella spp	11	13	16	17	17	12							80	86	↑	86	74
Pseud A	3	5	7	6	7	9							32	37	↑	43	36

\*The above table provides the monthly ICB assigned cases as well as the year to date total. The final columns are our benchmark against the 2020/21 and 2021/22 position.

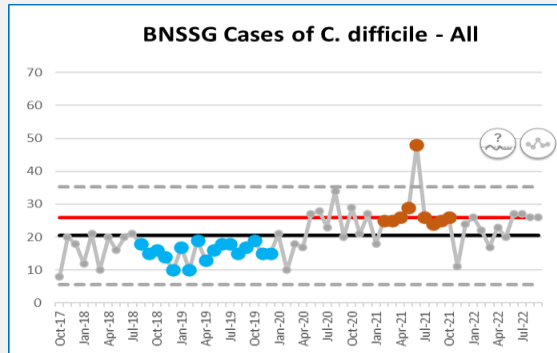
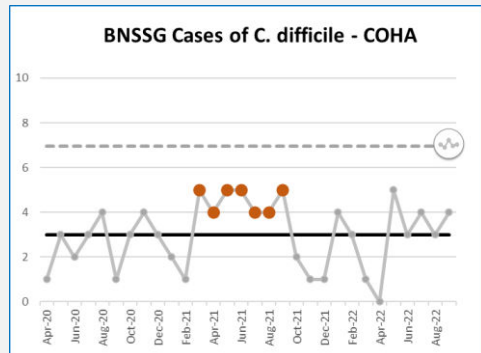
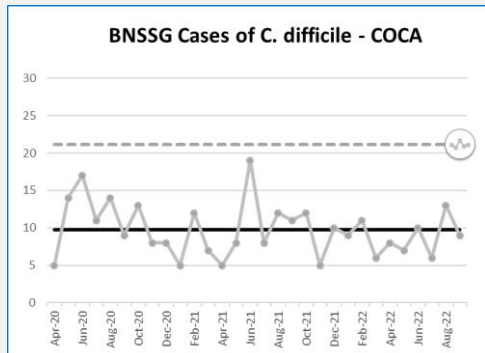
## BNSSG ICB Assigned C. difficile Cases since Apr 2020/21



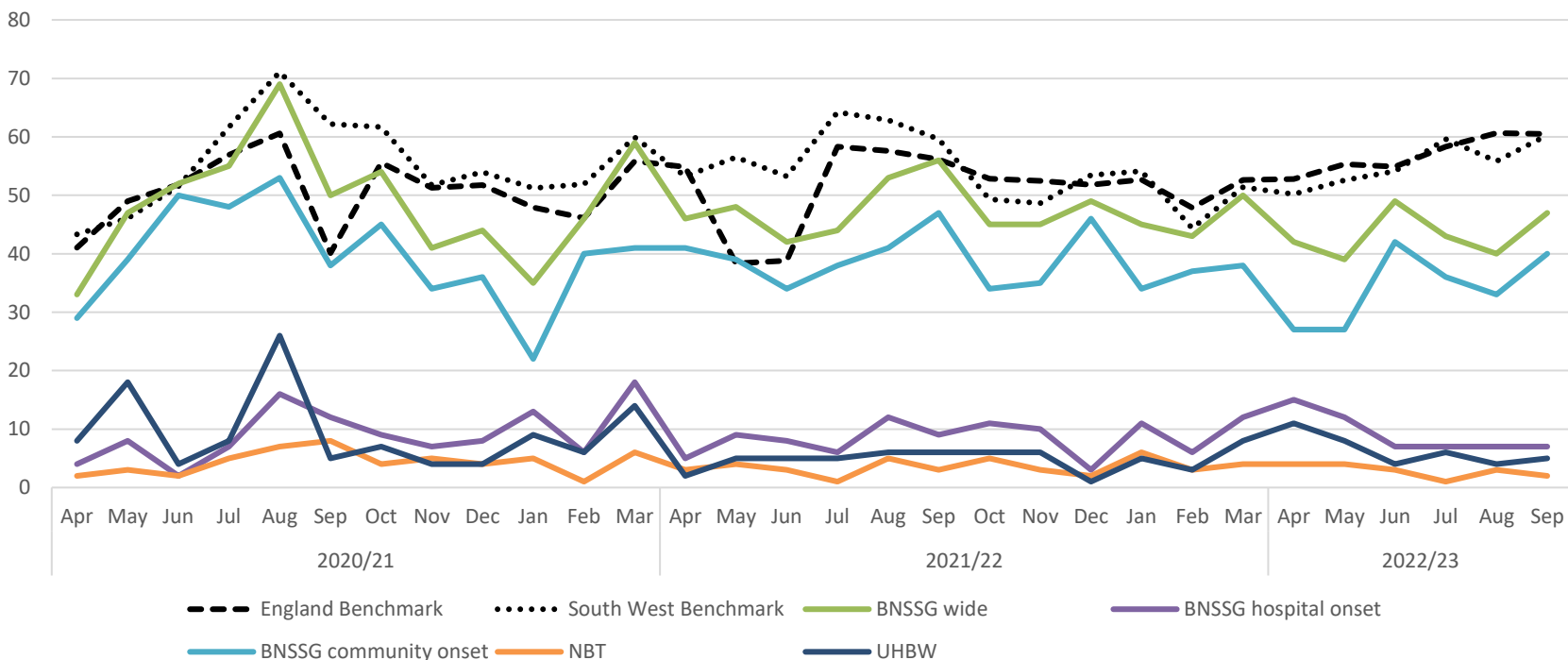
## C Diff Cases in BNSSG Since April 2019



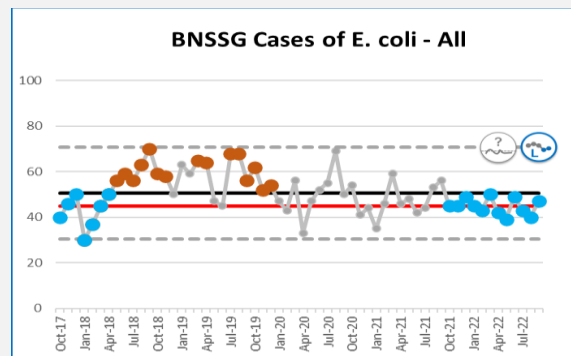
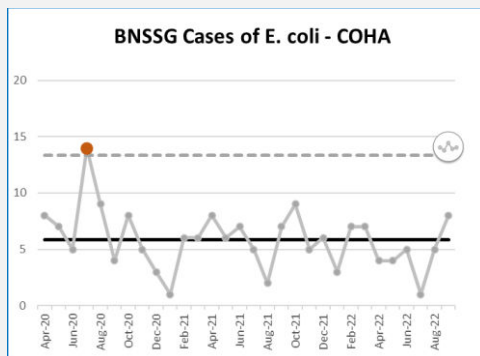
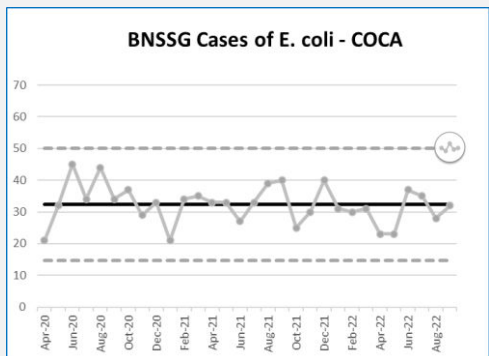
**Clostridioides difficile (CDI) : 26 cases in September** HOHA 10 (NBT-4, UHBW-6), Community 16: COCA 9, COHA 4, COIA 3 Community Onset, Hospital Associated (COHA) appears to be above the average rather than Community Onset, Community Associated (COCA) - see SPC charts



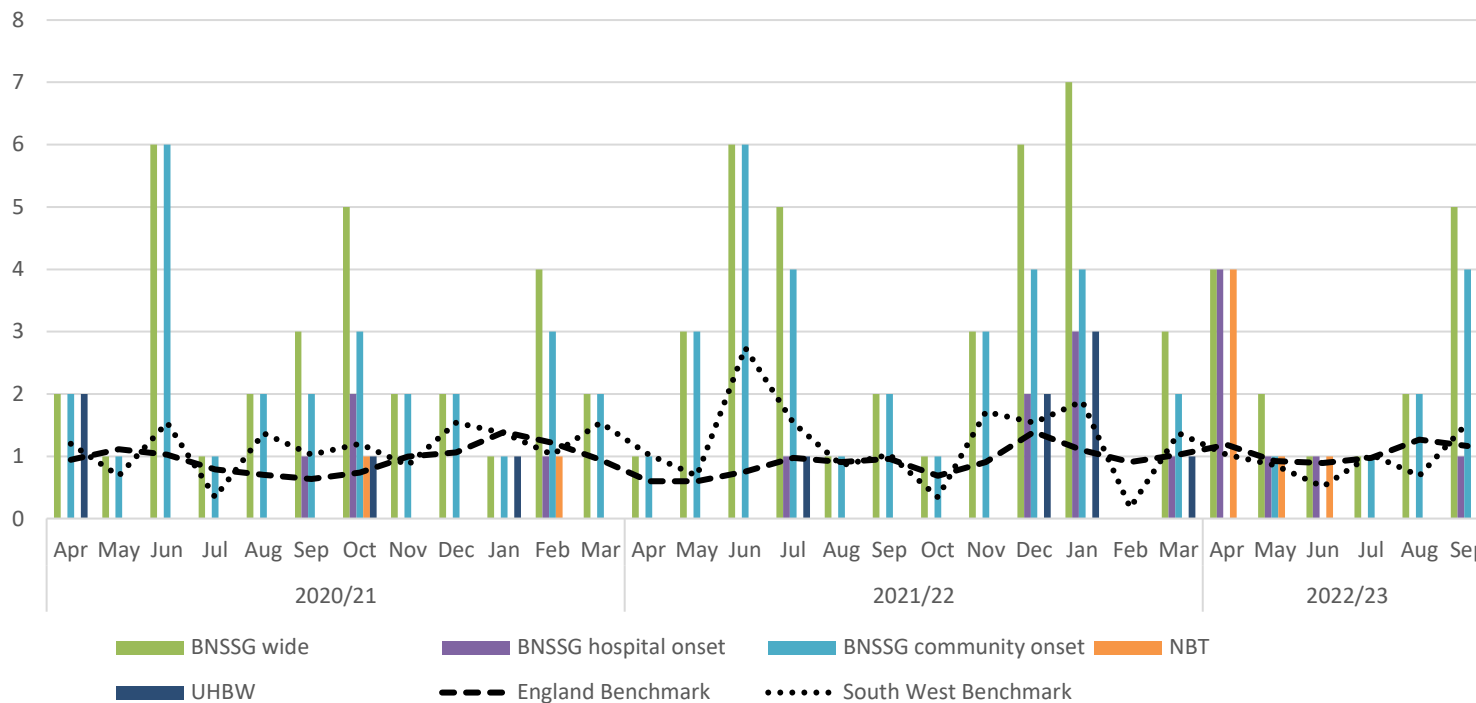
## BNSSG ICB Assigned E. coli Bacteraemia Cases since Apr 2020/21



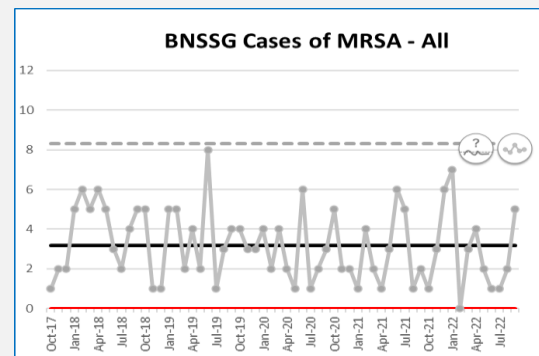
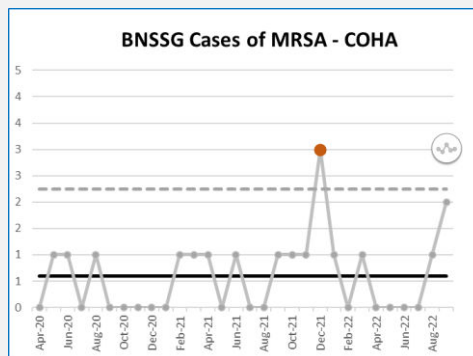
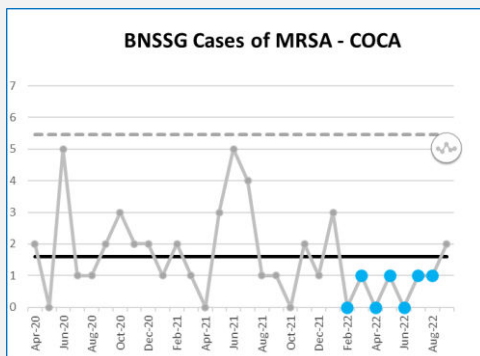
**Escherichia coli (E. coli) : 47 cases in September** HOHA=7 (NBT=2, UHBW = 5), Community 40, Community Onset, Hospital Associated (COHA) appears to be increasing rather than Community Onset, Community Associated (COCA) - see SPC charts



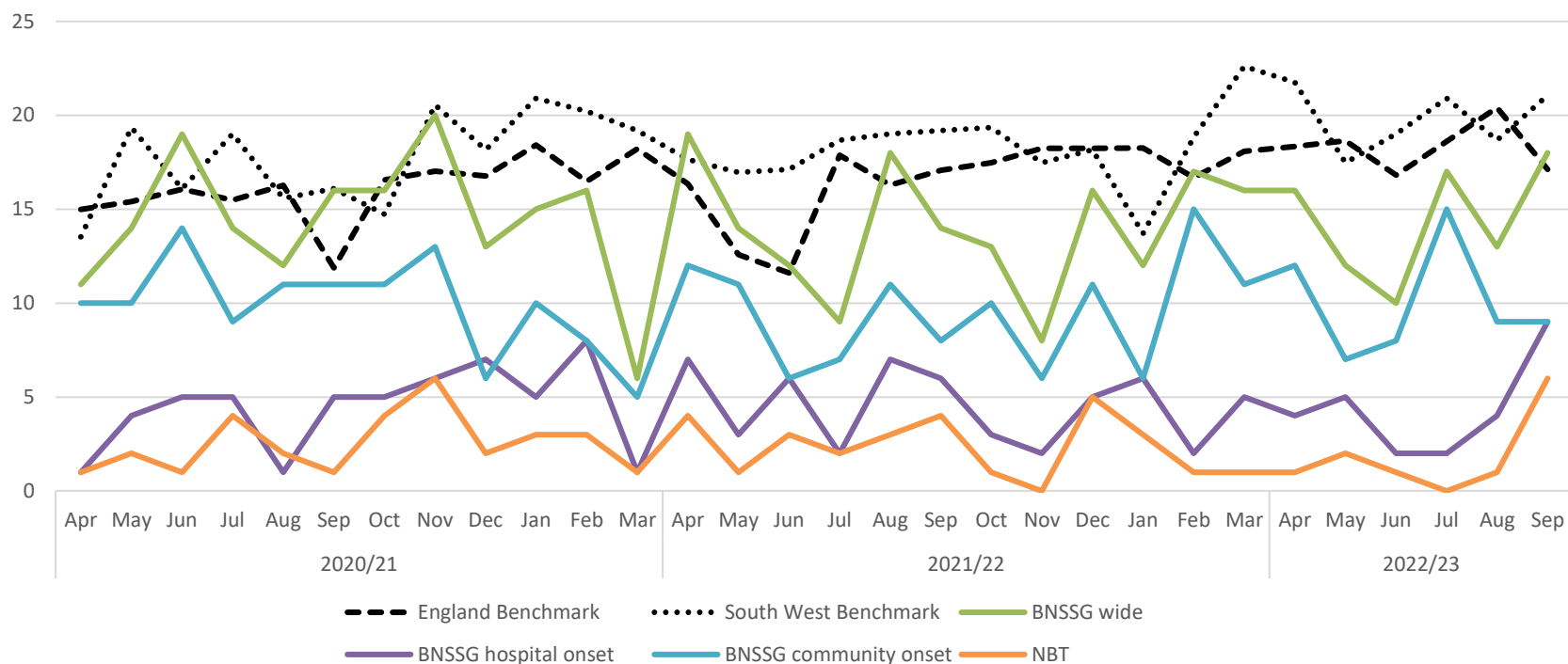
BNSSG ICB Assigned MRSA Bacteraemia Cases since Apr 2020/21



**Methicillin Resistant Staphylococcus Aureus (MRSA): 5 cases in September HOHA=1 (NBT-0, UHBW-1), Community 4, Community Onset, Hospital Associated (COHA) appears to be increasing rather than Community Onset, Community Associated (COCA) - see SPC charts**

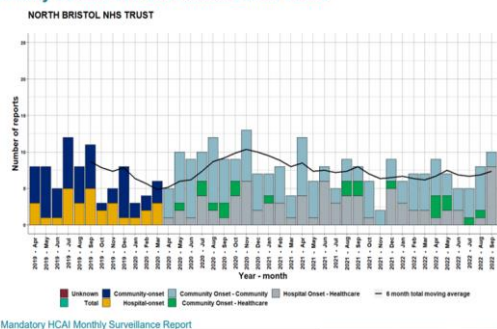


## BNSSG ICB Assigned MSSA Bacteraemia Cases since Apr 2020/21



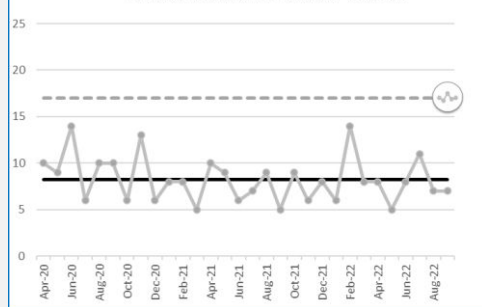
**Methicillin Susceptible Staphylococcus Aureus (MSSA) : 18 cases in September HOHA=9 (NBT-6, UHBW-3) Community 9 Community Onset, Hospital Associated (COHA)** appears to be above the average rather than Community Onset, Community Associated (COCA) - see SPC charts. The September data (UKHSA FES report) reports an unusual increase in MSSA bacteraemia cases at NBT that are apportioned as HOHA.

Monthly counts of MSSA bacteraemia cases

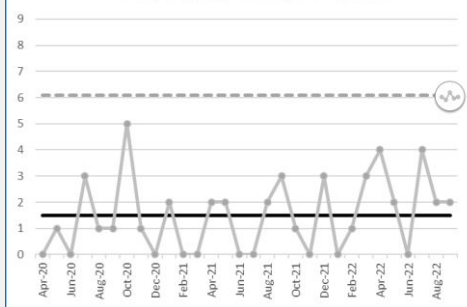


25 Mandatory HCAI Monthly Surveillance Report

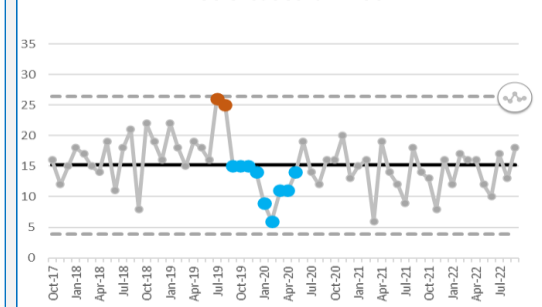
BNSSG Cases of MSSA - COCA



BNSSG Cases of MSSA - COHA

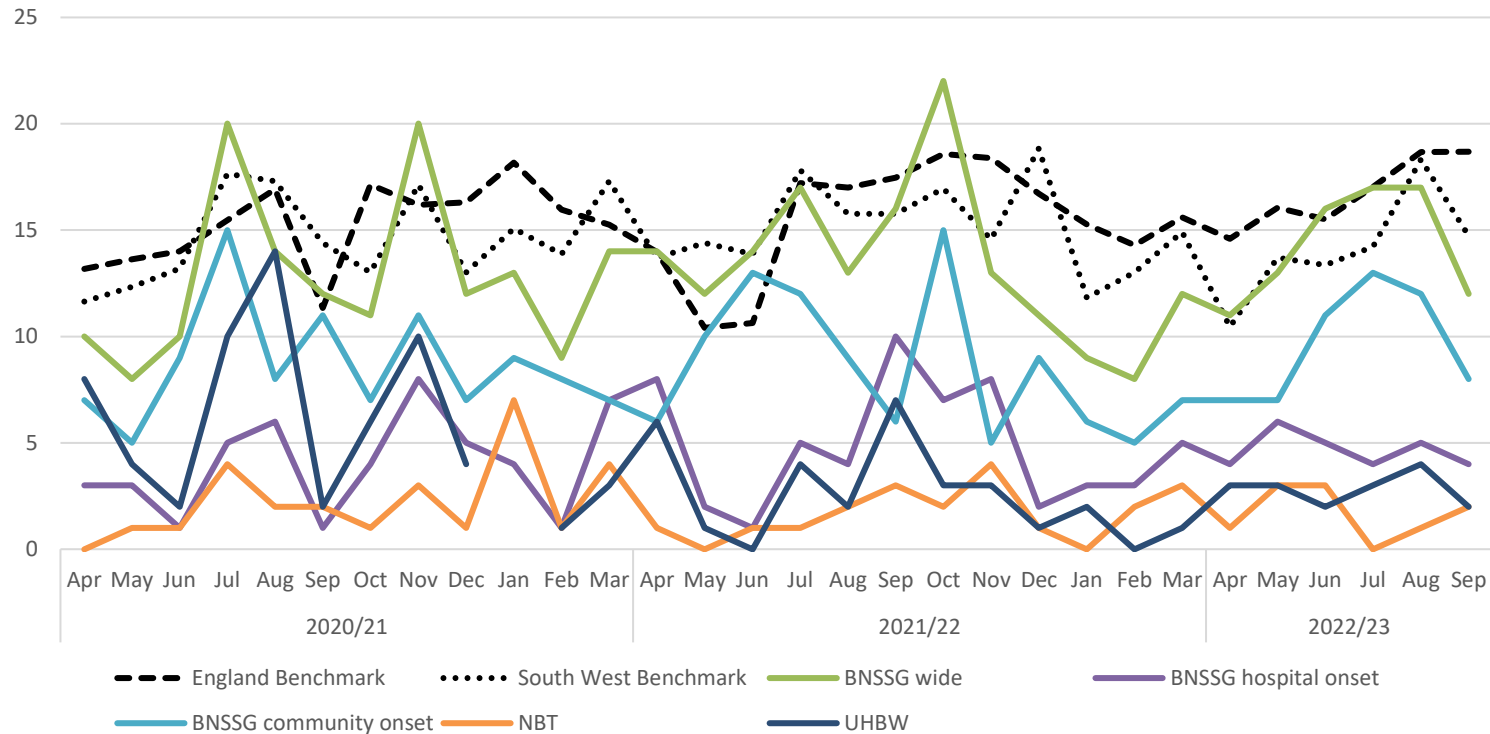


BNSSG Cases of MSSA - All

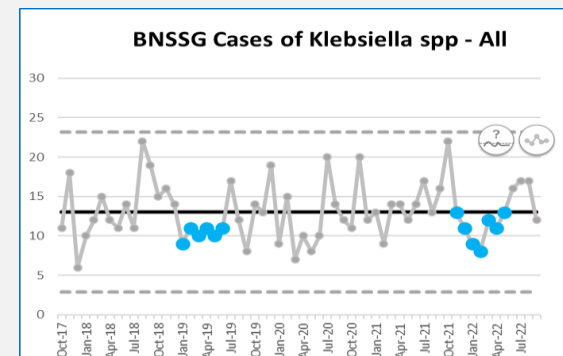
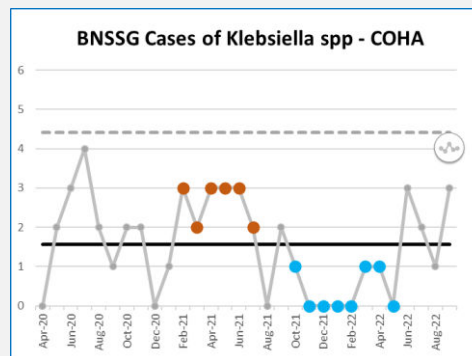
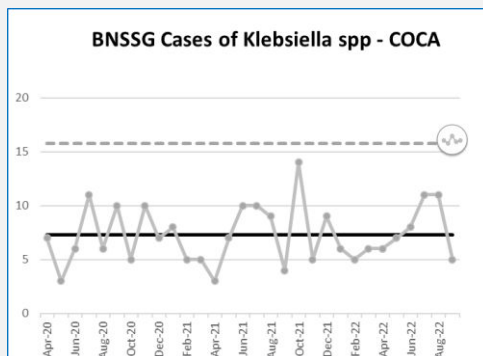




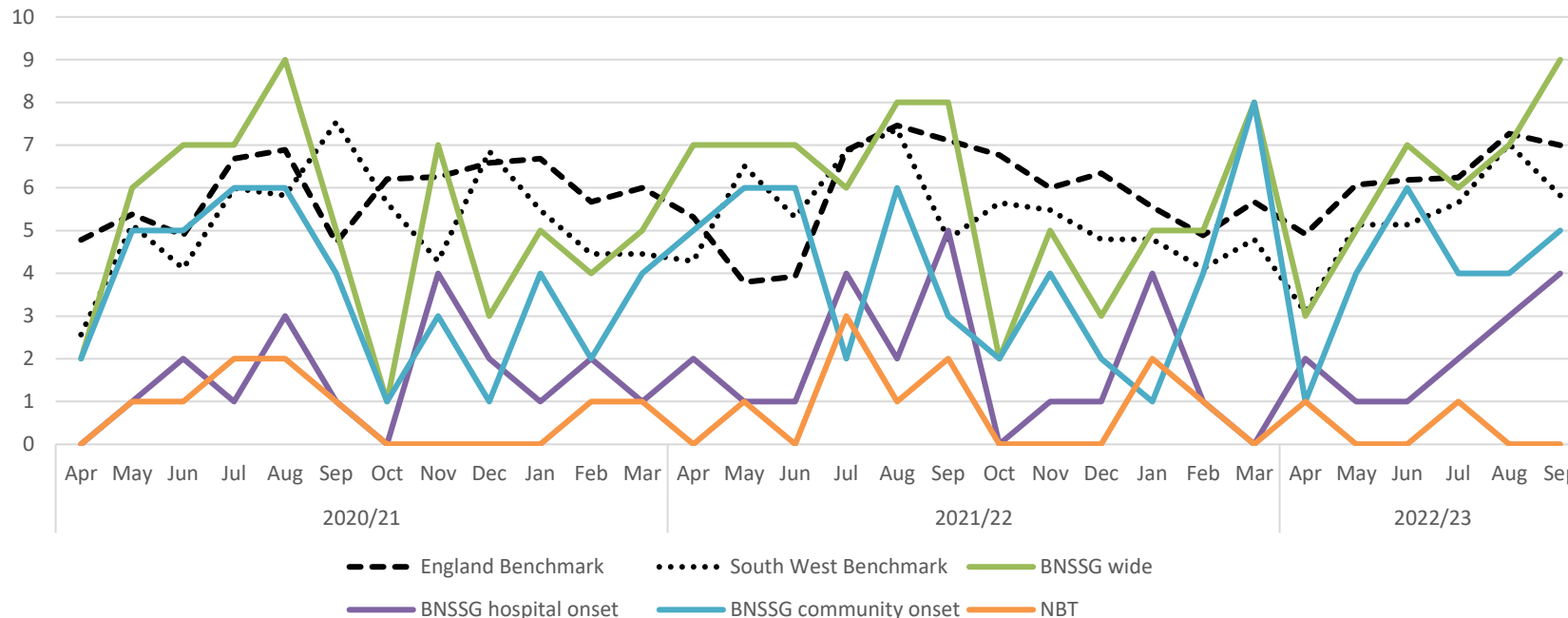
## BNSSG ICB Assigned Klebsiella Bacteraemia Cases since Apr 2020/21



**Klebsiella : 12 cases in September HOHA=4, (NBT-2, UHBW-2) Community 8, Community Onset, Hospital Associated (COHA) appears to be increasing rather than Community Onset, Community Associated (COCA) - see SPC charts**

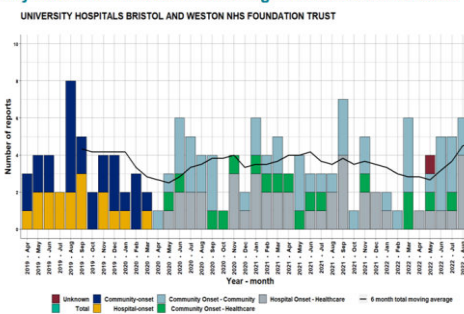


### BNSSG ICB Assigned Pseudomonas Aeruginosa Bacteraemia Cases since Apr 2020/21

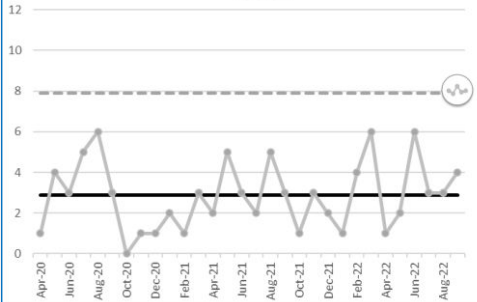


**Pseudomonas Aeruginosa : 9 cases in September HOHA=4 (NBT=0, UHBW=4), Community 5 Community Onset, Community Associated (COCA) appears to be increasing rather than Community Onset, Hospital Associated (COHA) - see SPC charts. The September data (UKHSA FES report attached FYI) reports an unusual and sustained increase in Pseudomonas aeruginosa bacteraemia cases at UHBW FT that are apportioned as HOHA.**

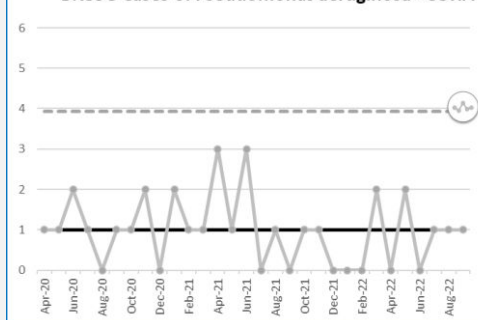
Monthly counts of Pseudomonas aeruginosa bacteraemia cases



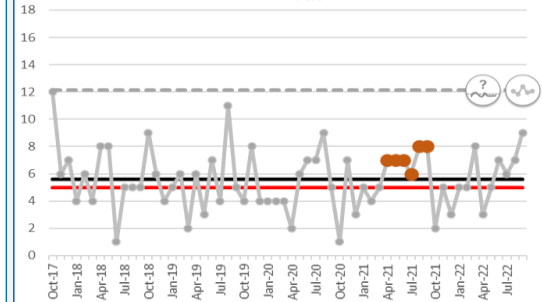
BNSSG Cases of Pseudomonas aeruginosa - COCA



BNSSG Cases of Pseudomonas aeruginosa - COHA



BNSSG Cases of Pseudomonas aeruginosa - All



# Quality Report – Infection Prevention Management (IPM) Cell

## Reporting Period – Month 6 2022/23 – September data

Information Source and date of information – IPM Cell Lead (TACTICAL)

### Current Month Overview

**Avian Influenza:** Cases have been identified in wild birds in Bristol and North Somerset, communications are being drawn up mirroring national guidance that the IPC Cell will input for a local response. No human cases to date have been identified.

**COVID-19:** Cases have levelled across all settings. Government guidance was updated to include a pause in asymptomatic testing in hospitals and care settings. This has been implemented across the system.

The Cell reviewed its hierarchy of risks and mitigations to reflect this and communication pieces for providers shared across the system. This was backed with a briefing paper shared with system senior colleagues. Outbreak and case reviews now provided as drop-in sessions with outbreak/incident meetings only taking place when requested by care homes. This has been well received by care providers as a shared learning opportunity and is much more time efficient for all participants.

**Diphtheria:** A small number of diphtheria cases have been identified in asylum seekers, including an outbreak in a processing centre. This is being monitored to understand any associated risk to the population due to vaccination levels in some age groups in BNSSG being less than the national average. Local Authorities are working with the strategic cell to promote vaccination uptake.

**Influenza:** Predictions on increased cases and earlier seasonal influenza this winter. The Cell has supported the delivery of a South West (SW) winter preparedness session and a local event for care providers. Winter preparedness action cards and the UK Health Security Agency (UKHSA) pack have been circulated to care settings.

**Invasive Group A Streptococcus (iGAS):** Levels have increased in all age groups and reflected in BNSSG. UKHSA are monitoring situation and exploring what might be driving this. To date, no increase in associated fatality has been identified.

**Monkeypox:** A steady decline in new cases. It is no longer classified as a disease of high consequence. System response was successful providing good learning points for future system collaborative working.

**Polio:** A national waste water testing for Polio detection was released to include Bristol, there are currently no known cases in Bristol. As with Diphtheria vaccination is an area for improvement as routine vaccination is a multi-valent vaccine i.e. for Diphtheria, Tetanus and Polio a minimum therefore if routine vaccination is missed all three protections are threatened.

**Other infections:** Infections such as Scarlet Fever and Pertussis have risen to pre-pandemic levels, reflective of the loss of wider protection afforded from pandemic restrictions that are no longer in place.

**Bed-Flow and Recovery:** The tactical and strategic cell has continued to support recovery supporting care homes and discharge teams with timely transfer out of hospital when medically fit for discharge, through liaison and risk assessment.

**Achievements:** The team presented the findings on improving hydration and its associated health benefits in residential care settings in older people through a poster presentation as part of the SW IPC Quality Improvement collaborative.

**2022/23 Planning:** Funding for the substantive team has been reviewed and options for service provision are being considered to support Local authorities and primary care whilst continuing to provide general Infection Prevention Management support across the ICB.

**Risks/Assurance Gaps:** Nil identified by exception at the time of reporting.

### Monthly activity and Year to Date position for IPC Cell

Meetings attended	No	Year Total	Email received trends	No	Year Total
IMTs/OMTs (Care settings 3, Acute 9, Primary Care 0)	15	80	NHS Cleaning Standards	1	42
IPC Strategic Cell and other IPC Regional / National meetings	7	47	Substantive Team Planning Meetings	2	7
Local Authority ASC IPM reviews	12	39	Visitor safety	2	11
UKHSA	11	17	Training delivery	2	27
Face to face site visits	2	17	Vaccination	0	5
Flu meetings	2	11	System support	2	30
Risk assessment/bed flow specific meetings	2	7	Guidance	2	71
Health Protection LA meetings	3	10	Primary Care related queries	4	37
Miscellaneous IPM requests	4	24	Testing	1	352
SW IPC Collaborative	2	14	Comms requests	5	22
Health Protection Assurance	1	9	Health Promotion	0	4
Monkeypox	0	5	Isolation issues	5	20
Training sessions	4	13	PPE queries	2	35
Bed Flow	6	16	IPC Audits	1	13
Comms preparation	2	19	System working	3	12
Conference presentations	1	1			

# Nursing & Quality - Serious Incidents including Never Events

## Reporting Period – Month 6 2022/23 – September & Q2 data

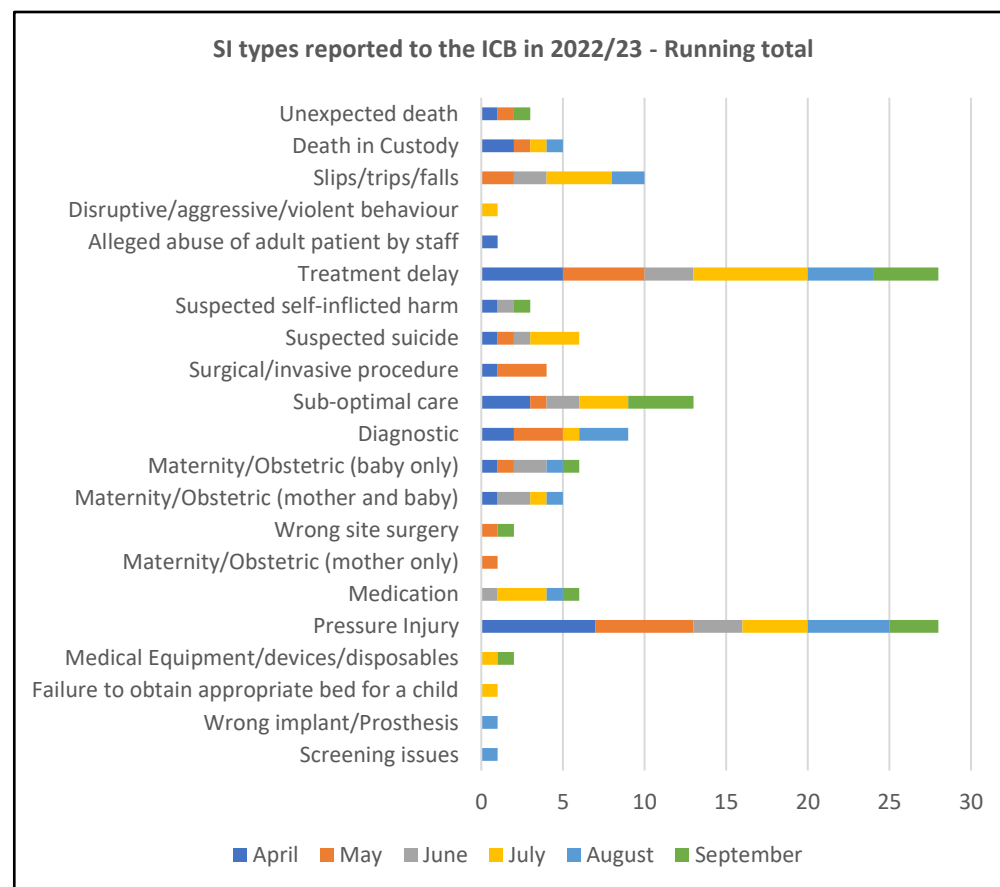
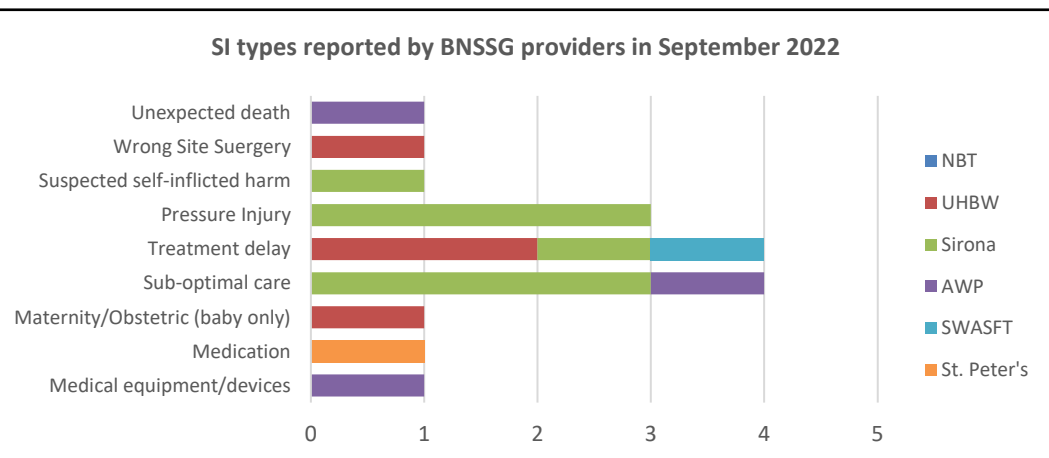
Information Source and date of information – BNSSG SI dedicated information site and trackers as of 11/10/2022

### Current Month Overview

- In September 2022, 17 Serious Incidents (SIs) were reported across BNSSG providers, including one Never Event (NE) submitted by UHBW Bristol relating to the administration a fascia iliac block under ultrasound guidance on the incorrect side; initial review suggests that the “Stop Before You Block” procedure was not followed. A full investigation is being undertaken.
- Treatment delay and Sub-optimal care were the leading SI reported themes in September.
- There has been a decrease of 40% in Pressure Injury incidents reported in September, but still remaining one of the top types of incidents submitted.

SIs reported across BNSSG 2022/23							
Provider	Apr	May	Jun	Jul	Aug	Sept	YTD SIs
NBT	4 (1)	3 (1)	1	0	1	0	9 (2)
UHBW	7	10	7	15	11 (1)	4 (1)	54 (2)
Sirona	7	6	5	8	5	8	39
AWP	5	3	2	5	2	3	20
SWASFT	0	1	1	1	1	1	5
GP	0	0	0	0	0	0	0
Other	3	3	1	1	0	1	9
<b>Total</b>	<b>26 (1)</b>	<b>26 (1)</b>	<b>17</b>	<b>30</b>	<b>20 (1)</b>	<b>17 (1)</b>	<b>136 (4)</b>

\* In brackets are NEs reported



Year	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total SIs per Year
2021/2022	25 (2)	20	24	23(1)	12	20 (2)	15	24	15 (1)	19	18	21	236 (6)
2022/2023	26 (1)	26 (1)	17	30	20 (1)	17 (1)							136 (4) cumulative

\*The numbers in brackets indicate the number of Never Events reported

\* 2020/21 Figure excludes the HCAI/Nosocomial COVID SIs

# Nursing & Quality - Serious Incidents including Never Events – Q2 Themes Overview

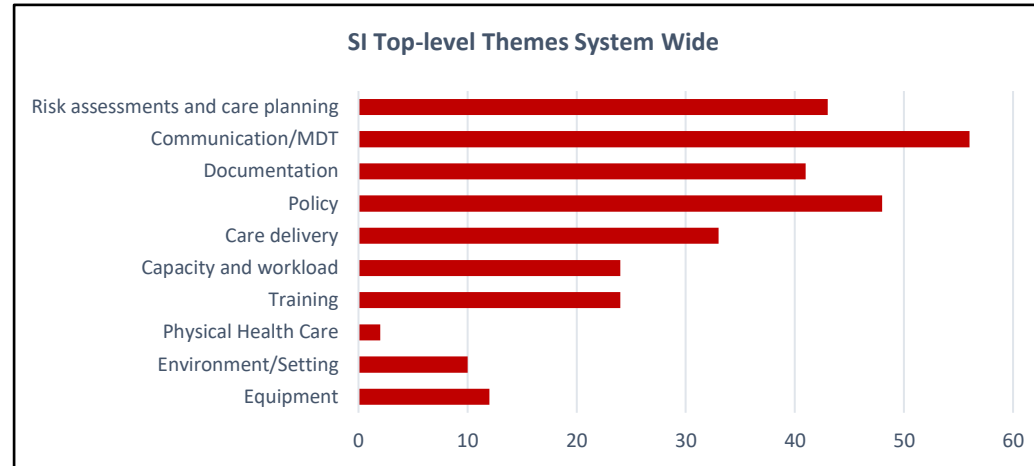
## Reporting Period – Month 6 2022/23 – September & Q2 data

Information Source and date of information – BNSSG SI dedicated information site and trackers as of 11/11/2022

At the end of quarter 2 of 2022/23, the Quality team has reviewed 117 SI investigations to identify the themes and trends and triangulate learning across the system. The SI types reviewed during this period were as follow:

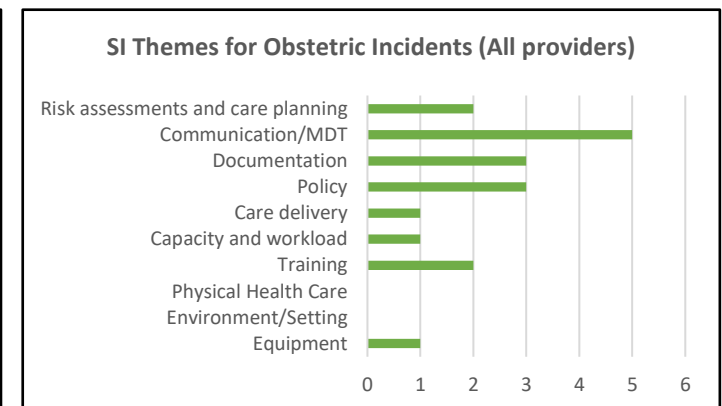
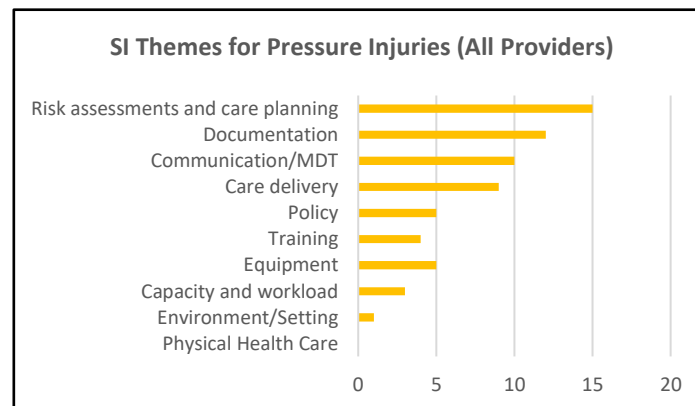
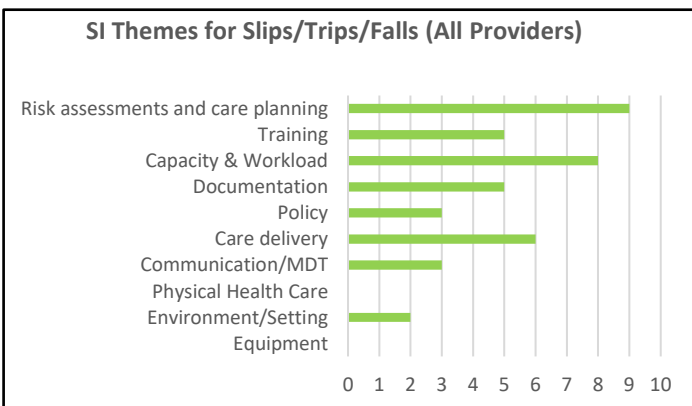
Serious Incident Types	Number of investigations received per SI type
Pressure Injury	23
Obstetric	16
Slips/trips/falls	15
Diagnostic	11
Treatment delay	10
Sub-optimal care	6
Suspected suicide	6
Medication	5
Suspected self-inflicted harm	5
Aggressive behaviour	3
Wrong site surgery	3
HCAI/Infection control	3
Medical equipment	2
Homicide	2
Surgical procedure	2
Alleged assault of patient	1
Unexpected death	1
Misplaced naso/oro-gastric tubes	1
Retained object post procedure	1
Alleged assault of patient	1

The table below shows the top-level themes identified through the review of the submitted investigations from the beginning of the financial year to the end of Q2. Across the system, it is noted that the top themes that come through continue to be Communication/MDT, Policy and Risk assessments/Care planning, with Communication/MDT seeing the most significant increase of approximately 155% following the investigation reviewed in the second quarter.



The top three SI type of incidents reviewed are pressure injuries, obstetric and falls. Please see tables below for the emerging themes that came through these reviews.

In Q2 the ICB Quality team have opened the invitation for the Learning Panel to all system partners as permanent members of the Panel, to share intelligence in order to drive improvement programmes locally.



In quarter 2 of 2022/23 a total of 211 patient safety events were submitted onto Datix compared to 226 for the same period in 2021/22. There are a total of 274 open events on the Datix system relating to the Quality team and 36% of these open events are from events reported this quarter.

As a result of improvements made to the DATIX system the Quality team are now in a position to interrogate patient safety events further and these outcomes are communicated to wider teams to drive improvements both locally and at a system level.

The identified quarterly top themes have deep dives undertaken by the ICB quality team to identify if there are any patterns to the themes and this information is then used to identify potential areas for quality improvement.

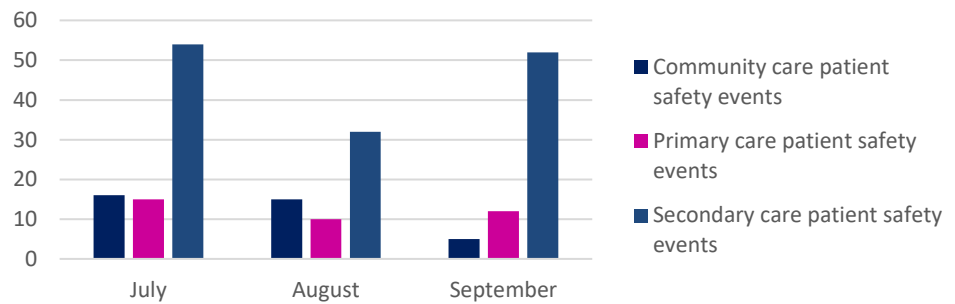
**Endoscopy services deep dive**

Patient safety events were raised by a secondary care provider about patients who were referred into the 2 week wait endoscopy service where it was queried if the patient met the referral criteria. The remedy guidelines for this particular pathway have been shared via the GP Bulletin. As part of this deep dive this has been shared with secondary care providers. The quality team are awaiting further feedback from the provider.

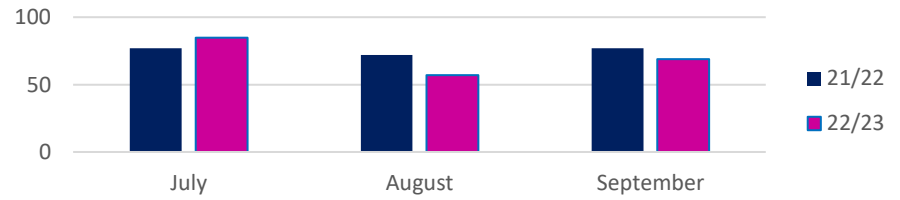
**Secondary care asking Primary care to complete onward referral deep dive**

Patient safety events were submitted by Primary care which detailed cases where patients who had been referred to secondary care required a further referral to be made to another speciality and secondary care requested that primary care to undertake this. As part of this deep dive this has been discussed at the quality assurance acute joint meeting and shared with secondary care medical directors. The BNSSG elective care access policy details how referrals should be made.

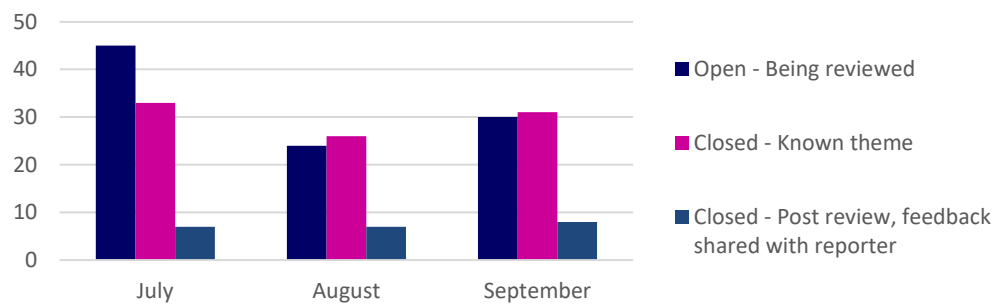
Patient Safety Events reported about each provider



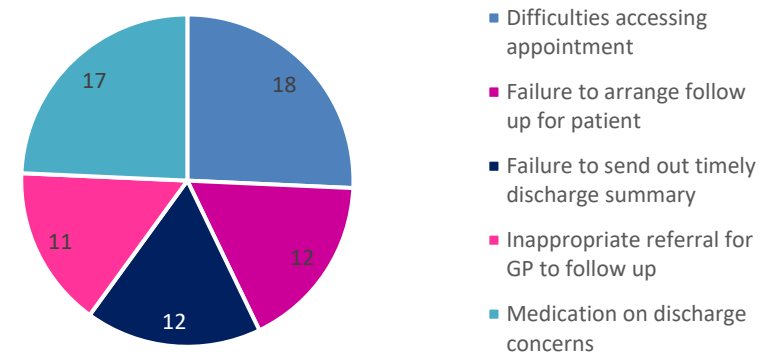
Quarter 2 Patient safety event comparison 2021 and 2022



Actions taken with each patient safety event



Top themes for Quarter 2





Scorecard 1: Adult Standard CHC

Bristol N Som S Glos

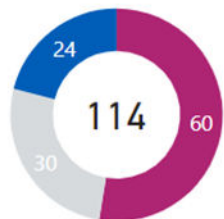
Data extract received on 18/10/2022

Select Month for CHC Referrals Received  
 2022 (Year) + September (...)

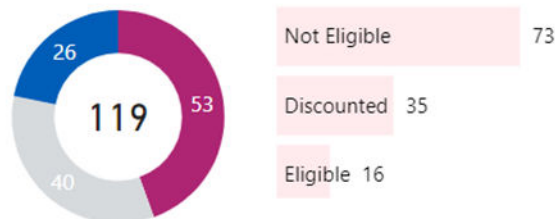
Select Month for all other visuals  
 2022 (Year) + September (...)

Select Area  
 All

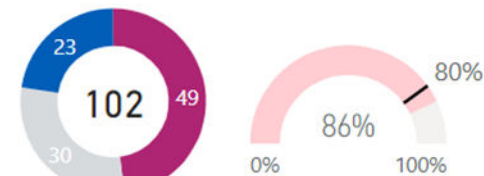
CHC Referrals Received



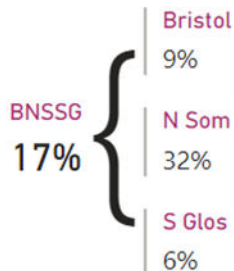
CHC Referrals Completed



CHC Decisions within 28 Days



Conversion Rate



Mean Days to Decision



Open Referrals Exceeding 12 weeks at data extract date

0  
 Adult CHC Funded Caseload at data extract date  
**478**

Weekly Standard CHC Caseload



Comments:

- CHC New within 28 days: 86% above target 80%. A percentage increase from 85% last month.
- Funded Nursing Care (FNC) New within 28 days: 99% above target 90%. A 3% increase from 97% last month.
- Total determinations undertaken within timescales: 69%, A 4% decrease from 73% last month. It was impacted by the review assessment activity commenced in the teams.
- CHC Caseload = 478 (+7) 37% overdue (static)
- FNC Caseload (SG & BR) = 1436 (-68) 5% overdue (down 2%)
- Complex Cases Caseload = 35.



Scorecard 2: Fast Track

Bristol N Som S Glos

Data extract received on 18/10/2022

Select Month for Fast Track Referrals Received

2022 (Year) + September (...)

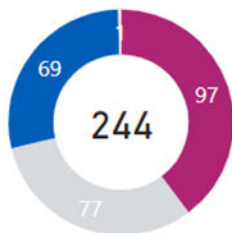
Select Month for all other visuals

2022 (Year) + September (...)

Select Area

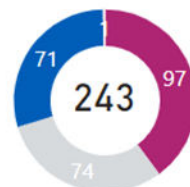
All

Fast Track Referrals Received



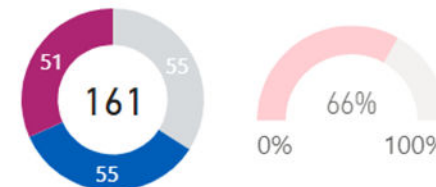
From September 2022  
To September 2022

Fast Track Referrals Determined

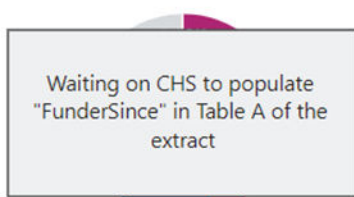


Eligible 229  
Discounted 14

FT Decisions within 2 Working Days



Fast Track Eligible for over 12 Weeks at Extract Date



Fast Track Review Caseload at date of data extract

476

Weekly Fast Track Caseload



Comments:

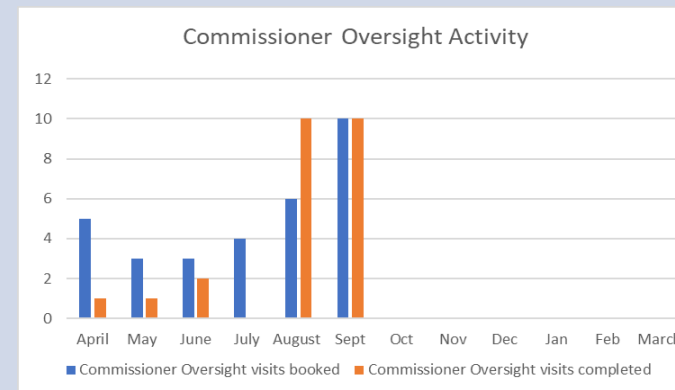
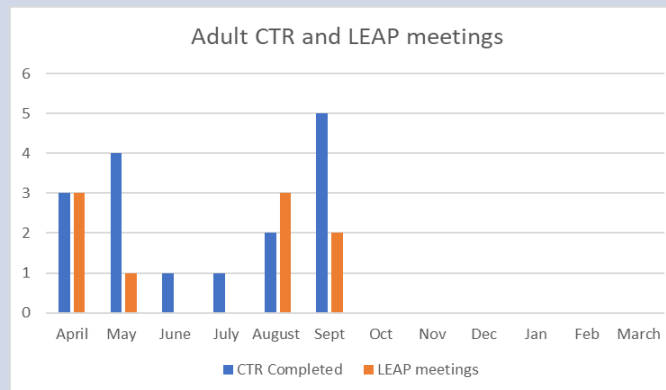
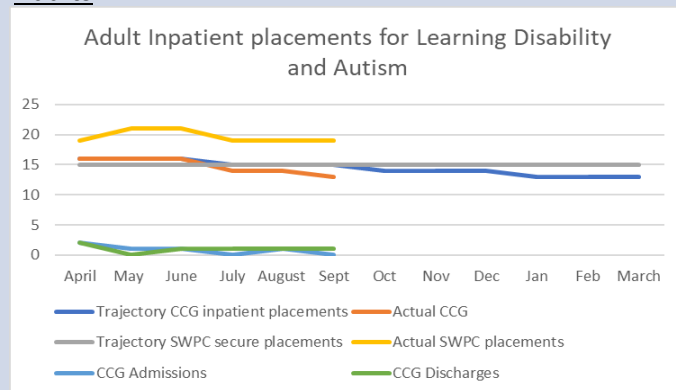
- 244 referrals received. On average, the service has received 255 referrals monthly, with the lowest referral rate at 201 in June. 65% are from community services.
- 94% referrals determined. 66% were determined within 2 working days across BNSSG. A significant step change improvement from 35% in July and 54% in August. This may be due to awareness training sessions for partners regarding eligibility criteria and improving the quality of referrals.
- Case load is currently 476. An 11% increase from last month.
- 40% (189) of the caseload was on funding for more than 12 weeks—a 5% increase from last month.

# Nursing & Quality - Funded Care - Assuring Transformation - Learning Disability and Autism

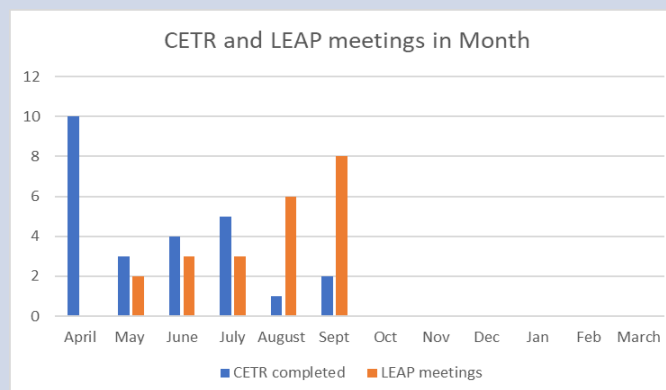
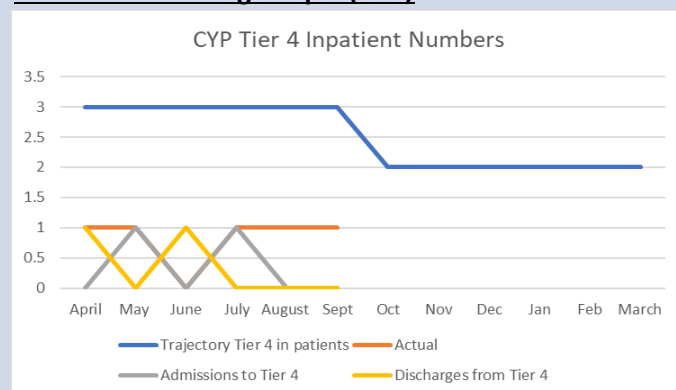
## Reporting Period – Month 6 2022/23 – September & Q2 data

### Performance/Data for 2021-2022

#### Adults



#### Children and Young People (CYP)



#### Highlights

##### Adults

- Commissioner Oversight visits have been completed as planned, future visits planned.
- There has been an increase in Click-through rate (CTR) activity and decrease in Listening and Engagement Active Partnerships (LEAP) activity in September.
- ICB commissioned placements are now on trajectory below trajectory however South West Property Centre (SWPC) (Secure) placements remain above the trajectory to reach the Long Term Plan target.

##### CYP

- Ongoing work to increase input to the CYP dynamic support register.
- There has been no new admissions to Tier 4 services.
- The LEAP requests remain above Community Enhancing Recovery Team (CETR) requests.

For both teams the current metrics are not reflecting the requests for MDT / Professionals meetings outside of the C(E)TR / LEAP process.