Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG ICB Board

Date: Thursday 2nd February 2023
Time: 12.30pm
Location: Futures Inn, Bond Street, Bristol BS1 3EN

Agenda Number:	7.1
Title:	Quality and Performance Report – Month 8 (November data)
Purpose: Discussion & Information	
Key Points for Discussion:	

The 2 attached reports provide an overview of November 2022 data to cover Month 8 activity for quality and performance. A summary is provided below.

The committee are asked to note the following areas.

Quality (Appendix 1)

System Quality Group (SQG) – summary overview

- **Children with complex mental health needs in ED** - Actions being embedded within the ICS Children's work programme. There is a key focus on developing alternative care provision for children not in need of Tier 4 but needing specialist residential support.
- **SQG December meeting** – Focused on rapid learning and a debrief in relation to the recent industrial action and system-wide pressures. Some immediate actions and key areas of future work were identified and will be planned for in 2023.
- **SQG January meeting** – The topic focussed on system "risk appetite" to manage current system pressures, considering ethical, current escalation and clinical priority frameworks. Areas of action have been identified and workstreams are currently being determined.

Industrial action (IA) mitigation and actions – patient safety perspective

The Trusts continue to work with respective unions on derogation of services for the current waves of industrial action. In addition, the following actions have helped mitigate pressures on strike and ensuing days.

- **SWASFT** – Redeployment of all senior clinical staff into the control room during the IA day resulted in diversion away of significant amount of caseload. This would not be sustainable

without significant changes to the model of care. Additional actions included incentives being offered to staff to cover shifts and enacting a taxi SOP.

- **NBT** – Some electives were cancelled and rebooked. All clinical areas were covered in accordance with derogations and enhanced discharge profiling improved discharge flow.
- **UHBW** – No electives cancelled. Capacity in the Children's hospital was challenged with some children having to be sent out of area. The use of private transport between hospital sites was implemented to alleviate pressures on SWASFT.
- **Sirona** – There was some re-alignment of clinical staff to areas in urgent and community care. Support on back door discharges from Acute sectors remains ongoing.
- **AWP** - A few patient transportation concerns noted but otherwise stable but involved in all communications relating to MH patients. The impact from the IA on 19 January 2023 is still to be fully determined at the time of writing
- **Local Authorities** – An emergency assessment tool was implemented to speed up discharges to ensure collaborative way of working and supporting back door discharges.

Healthcare Associated Infections

- **C.difficile –** BNSSG is currently around the regional and England average in terms of overall incidence, however numbers are still above pre-pandemic levels and recent work to age standardise this data is suggesting the system has higher levels than the regional average for older patients. In November 2023, 26 cases were attributed to BNSSG ICB which is an increase of 5 against the previous month. The CDI working group continues to work with system and regional partners to understand the drivers behind a higher prevalence and incidence of CDI. A refreshed work programme of post infection reviews in January 2023 will look across whole pathways but with a particular focus on primary care.
- **E. coli -** In November 2022, 41 cases of E.coli bacteraemia (a reduction of 3 from October) cases were assigned to BNSSG ICB. Case activity encouragingly remains below the thresholds set by NHSE, 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 –** (Methicillin-resistant Staphylococcus aureus) In November 2022, 18 cases of MSSA bacteraemia were assigned to BNSSG ICB (a reduction of 3 from the previous month). Case activity has been below the Southwest average since May 2021.
- **MRSA - (**Methicillin-resistant Staphylococcus aureus) In November, there were 4 cases of MRSA bacteraemia assigned to BNSSG ICB, which is an increase of 3 from October. 3 of these were community associated and 1 hospital. The community chlorhexidine pilot for people who inject drugs has been extended for a fuller evaluation at the end of the year.

Serious Incidents and Learning

In November 2022, 26 Serious Incidents (SIs) were reported across BNSSG providers. There were also two reported Never Events. Pressure injuries and treatment delay were the leading themes in

November. Treatment delay incidents have seen a significant increase in November with four reported, following none reported the month before. Overall, Treatment delays are the second top SI type reported this year so far, with 32 incidents reported since April 2022. The learning from the pressure injury incidents continues to be reviewed at the systemwide pressure injury group and identified themes and trends will feed the system improvement plan. For many of the incidents it appears through dialogue with partners that there continues to be an association with the current system pressures. Thematic analysis of SIs as shown in the attached Quality Report shows recurrent themes of policies not being followed correctly or a paucity of standard processes in place.

Never Events

In this current financial year there has been a 39% average increase in reported Never Events in comparison to the last two years. In particular, five Never Events have been reported in the last three months alone. The ICB hosted a Quality Insight and Improvement joint meeting with both acute providers on the 3rd of January 2023. Providers are sending out internal safety alerts; thematic analysis to date (which is being shared with providers) indicates the need to focus on improvement in work systems and standard operating practices.

Other system Learning

Following the launch of a deteriorating patient project in critical care outreach teams, data is currently suggesting less patient safety incidents concerning the deteriorating patient

Group A streptococcus infection (GAS) – system pressures and mitigation

System review meetings were stood down in mid-January following an effective system response to the increased incidence of GAS and challenges to antibiotic availability. The learning from the BNSSG response has determined that as part of the new Infection Prevention Management governance in the ICS, a new “High Consequence Infectious Disease (HCID) Response Group” is needed. IPM and EPRR partners will attend the inaugural meeting in late January to establish standard system approaches to common HCIDs as well as prepare for possible emerging ones.

Funded Healthcare

Adult Continuing Healthcare

28-day performance remains at 94% exceeding the target of 80%, despite a 15% increase in new referrals. There has been an exceptionally high (37%) increase in the number of new funded nursing care determinations in month. Further analysis of this will be undertaken in Q4 2022-23 to determine if this is unwarranted variation or a new trend.

Adult Fast Track End of Life

70% of fast tracks were determined within 2 working days in November compared to 69% in October, this is despite a reduction in staff from long term sickness in the Fast Track (FT) team.

Children and Young People’s Complex Care

The Children in Care (formerly known as Looked After Children (LAC)) caseload has increased to 112 and is predominantly Bristol cases. Further analysis is being undertaken to view the LAC cohort over time. While it is important that the needs of these children and young people are fully met the unforeseen increase in this cohort poses a financial risk to the Funded Care budget. Consideration

is being given to the creation of a position statement to support the decision-making around joint funding for children and young people with complex needs. In addition, extra capacity is being sought to be able to provide assurance of the quality of care to children placed out of area, where the ICB has funded health interventions.

BNSSG System COVID Medicine Delivery Unit (CMDU)
This month's quality report also provides an analysis and evaluation of the CMDU. This was set up to provide access to COVID treatments for non-hospitalised patients believed to be at greatest risk of disease progression, hospitalisation, or death. The service delivery model started with delivery in the acute trust supported with patient triage carried out by Sirona. Due to system pressures the model was refined in March 2022 following expressions of interest to GP practices. Through a series of step wise changes, the service transitioned to two GP practices for adult patients.

Since the service began, data shows that uptake appears lower in ethnic minority groups. The commissioning framework has been updated accordingly asking local systems to make efforts to show improvement in coverage in those groups who are less likely to be treated. The aim is to support those who are living in the most deprived areas, ethnic minorities, and other underserved communities to have as high an uptake as the population as a whole. Work has started with colleagues to address this locally and learning from other successful NHS programmes, such as the COVID-19 vaccination programme is being used to reduce barriers and increase awareness and uptake within the local populations. Where variation in triage and uptake is identified, action will be taken to focus local efforts to improving awareness and understanding of the pathway and improve uptake rates as appropriate.

BNSSG System Flu Update 2022/23
The quality slides also provide an overview on this year's flu vaccination programme. Data overall continues to show a positive uptake rate for the 65years and over cohort and the System has now achieved 83.4% as per 1st January (week 52). The 'at risk' cohort is showing an uptake of 51.3% with variation in uptake showing between the different 'at risk' cohorts as well as between PCNs. This is detailed in the slides.

Uptake in the 2- and 3-year-olds (49.6%) and pregnancy cohorts (39.8%) are showing slight improvements but remain as areas for potential improvement. The BNSSG uptake shows a similar uptake to the Southwest picture but a slightly higher uptake than England as a whole.

Despite best endeavours health care staff uptake remains lower than target. Social Care staff uptake also remains low. System partners have met to support uptake in this area and address any barriers to social care staff (both Care Home and Domiciliary staff) to come forward for vaccination. A cross-system film featuring staff members from most organisations within the BNSSG health system, across a wide range of roles was shared to support organisations in BNSSG with their staff vaccination campaigns. A follow up communications campaign has also been released which

included videos from local GPs: “Worried about having flu”, “Covid-19 vaccines together” and “Thank you for getting vaccinated”.

.

Performance (Appendix 2)

The performance report for this month is divided into 3 areas at request by the Chair. These areas are:

- Winter metrics dashboard
- Operating plan performance indicators
- Update on adult social care discharge fund indicators.

Winter Metrics Dashboard

The dashboard included is up to date as at 17 January 2023. The dashboard is based on the board assurance framework and relates to 6 key metrics as shown on the dashboard. In summary:

- 111 abandonment rate – some improvement with some days at less than 5%, however, not consistently achieved and part of contractual discussions with the provider.
- Mean 999 call answering time (seconds) – At the time of writing the SWASFT REAP level has decreased to red after 598 days. The mean 999 call answering shows the improvement in escalation level with mean call answering time since the start of the new calendar year averaging around 3 seconds to answer which meets national target and a significant improvement from December 2022.
- Category 2 90th percentile and mean response (minutes) – In line with the above and the improvement to SWASFT in escalation level BNSSG has improved Category 2 performance with most days since the start of the new calendar year being less than 30 minute mean response. This is in part to greater SWASFT resourcing, lowering of demand from the public which may be a change due to industrial action as well as actions from other parts of the system like the acute trusts in additional cohorting spaces being made available.
- Time lost to handover delays greater than 15 minutes – There is a general improvement to handovers within 15 minutes, however, this is not being consistently met with fluctuations in performance. However, actions taken by the acute trusts in terms of cohorting capacity as well as resourcing from SWASFT and a lowering of demand have made some days with exceptional performance.
- Percentage of G&A beds occupied – This is still greater than 95% across the BNSSG system which is not efficient to supporting flow and in the main relates to the levels of no criteria to reside. Acutes are permanently escalated to create flow. NBT have created additional beds as planned on Level 6 which will support flow.
- Percentage of G&A beds occupied by NCTR patients – There has been a reduction in NC2R at UHBW which is a system effort resulting from adult social care discharge fund and additional beds in the system as well as the number of community slots available and reduction in cancellations. A deep dive has taken place at NBT to understand why a similar reduction has not been experienced.

Operating Plan Performance Indicators

- NBT achieved A&E attendance plan in December 2022; UHBW had a greater than planned number of attendances.
- Total RTT Incomplete pathway waiting lists is above plan at each provider, including 52+week waits. However, both Trusts are exceeding the original operating plans in 78ww and 104ww.
- Diagnostics is on plan in most modalities apart from Endoscopy across both Trusts and Echocardiography at UHBW.
- The plan was not met for children waiting less than 18 weeks for a wheelchair.
- NBT has seen a significant improvement in number of patients waiting 63 days or more for cancer care. UHBW is meeting the revised trajectory put in place, however, Christmas with more bank holidays has been a challenge. However, we are assured that the revised plan will be met by end of January 23 with a reduction to original plan by end of March 23.
- There are still a number of mental health indicators not meeting plan including children and young people with eating disorders, access to specialist community perinatal mental health and people with a significant mental illness receiving a full annual physical health check and follow up interventions.

It should be noted that both trusts have seen an impact on elective wait times due to industrial action being taken across the system. Indicator loss of activity is shown below. It should be noted that industrial action in other non-health related areas like rail strikes has also impacted activity where insourcing arrangements are in place due to staff not being able to travel.

BNSSG

19th December to 8th January	
	Total volume of lost activity
IP	228
DC (inc. Endoscopy)	785
OP	477
Total	1490

9th January to 31st January

	Total volume of lost activity
IP	30
DC (inc. Endoscopy)	71
OP	0
Total	101

Adult Social Care Discharge Fund

At the time of writing this report the second submission demonstrating activity and spend against the above fund is being computed across the system on different templates than the first submission. The fund provides £3.2m to the three local authorities with £8.3m to the ICB.

The scheme is looking to provide additionality into the system to support flow. A range of schemes have been commissioned and include:

- Local recruitment initiatives
- Improve retention of existing workforce
- Assistive Technologies and Equipment
- Increase hours worked by existing workforce
- Additional or redeployed capacity from current care workers
- Home care or domiciliary care
- Reablement in a persons own home
- Bed based intermediate care services
- Residential placements
- Administration
- Homeless multiagency team

Last week, the ICB was notified of further monies into the system through the hospital discharge fund which is a release of a further £200m nationally resulting in approximately £3.39m to the BNSSG system. This fund mimics arrangements put in place through COVID-19 and is currently being worked through with system partners.

Recommendations:	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
Previously Considered By and feedback:	Discussed at Outcomes and Quality Committee on 26.01.2023 where discussion focussed on the system response to industrial action and the improvement on some elements of urgent care performance

Management of Declared Interest:	None declared
Risk and Assurance:	The report and appendices provide an update to the ICB Board in relation to key risks to performance and quality within the system and highlight supporting mitigations which are in place.
Financial / Resource Implications:	None referenced
Legal, Policy and Regulatory Requirements:	None referenced
How does this reduce Health Inequalities:	Not referenced
How does this impact on Equality & diversity	As above
Patient and Public Involvement:	Not applicable
Communications and Engagement:	The reports are provided to the ICB Board for information and discussion.
Author(s):	Caroline Dawe - Deputy Director of Commissioning (Performance Improvement) Gary Dawes - BI Manager, Performance, BNSSG ICB Michael Richardson, Deputy Director of Nursing and Quality, BNSSG ICB
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd, Chief Nursing Officer, BNSSG ICB Lisa Manson, Director of Performance and Delivery, BNSSG ICB

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

BNSSG Quality Report

January Report
for
Month 8
(November data) 2022/23

Contents

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

Quality - Current updates and emerging issues

System Quality Group (SQG) – overview

- **Children with complex mental health needs in ED** - Actions being embedded within the ICS Children's work programme. Key factor development of alternative care provision in system for children not in need of Tier 4 but needing specialist residential support. NOT in enhance surveillance.
- **SQG December meeting** – Focus on rapid learning and debrief in relation to the recent industrial action and system-wide pressures. Some immediate actions and key areas of future work were identified and will be planned for in 2023.
- **SQG January meeting** – A focus on system risk appetite to manage current system pressures, considering ethical, current escalation and clinical priority frameworks. Areas of action have been identified and workstreams are currently being determined.

Never events (NEs)

- There has been a further NE reported in the system in January. The majority of NEs are associated with wrong site surgery. A theme appears that incidents occur outside of the theatre environment (for instance in interventional radiology). The ICB and provider partners are currently involved in a thematic review which will be reported in March 2023.

System Learning

- Following the launch of a deteriorating patient project in critical care outreach teams data is currently suggesting less patient safety incidents concerning the deteriorating patient

Industrial Action (IA) – key issues from recent events

SWASFT – Redeployment of all senior clinical staff into control room during the IA day resulted in diversion away of significant amount of caseload. This would not be sustainable without significant changes to the model of care. Additional actions included incentives being offered to staff to cover shifts and enacting a taxi SOP.
NBT – Some electives were cancelled and rebooked. All clinical areas were covered in accordance with derogations and enhanced discharge profiling improved discharge flow.
UHBW – No electives cancelled. Capacity in the Children's hospital was challenged with some children having to be sent out of area. The use of private transport between hospital sites was implemented to alleviate pressures on SWASFT.
Sirona – There was some re-alignment of clinical staff to areas in urgent and community care. Support on back door discharges from Acute sectors remains ongoing.
AWP - A few patient transportation concerns noted but otherwise stable but involved in all communications relating to MH patients. The impact from the IA on 19 January 2023 is still to be fully determined at the time of writing
Local Authorities – An emergency assessment tool was implemented to speed up discharges to ensure collaborative way of working and supporting back door discharges.

Quality Report – Health Care Acquired Infections (HCAI) ICB Overview
Reporting Period – Month 8 2022/23 – November data
Information Source and date of information – UK Health Security Agency (UKHSA), ICS HCAI Lead as of January 2023

BNSSG Annual Standard

- Integrated Care Boards (ICB's) and secondary care providers 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 November 2022

- **CDI** = 26 HOHA=11 (NBT-2, UHBW-9), COHA=4, COCA=7, COIA=4
- **E. coli** = 41 HOHA=8 (NBT-5, UHBW-3), COHA=5 COCA=28, COIA=0
- **MRSA** = 4, HOHA=1 (NBT-0, UHBW-1), COHA=0, COCA=3, COIA=0
- **MSSA** = 18, HOHA=8 (NBT-6, UHBW-2) COHA=1 COCA=9 COIA= 0
- **Klebsiella** =19 HOHA=5 (NBT-1, UHBW-4) COHA=2, COCA=12, COIA= 0
- **Pseudomonas aeruginosa** = 2, HOHA=0 (NBT-0, UHBW-0), COHA=0, COCA=2, 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

The SPC data points for this month are within the upper and lower limits which shows the process (or the number of cases) is generally steady/within its expected bounds.

Special focus on Community Onsets HCAI this month.

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 progressed.

Commentary
- MRSA- Zero tolerance has not been achieved. There were four cases in November, three originating in the Community, one from UHBW.
- CDI- The 26 cases are currently categorised as follows: New infection (19), Continuing Infection (3), Repeat/Relapse (3), Unknown (1).
- E.coli- the majority of the 41 cases continue to be Community Onset (28).

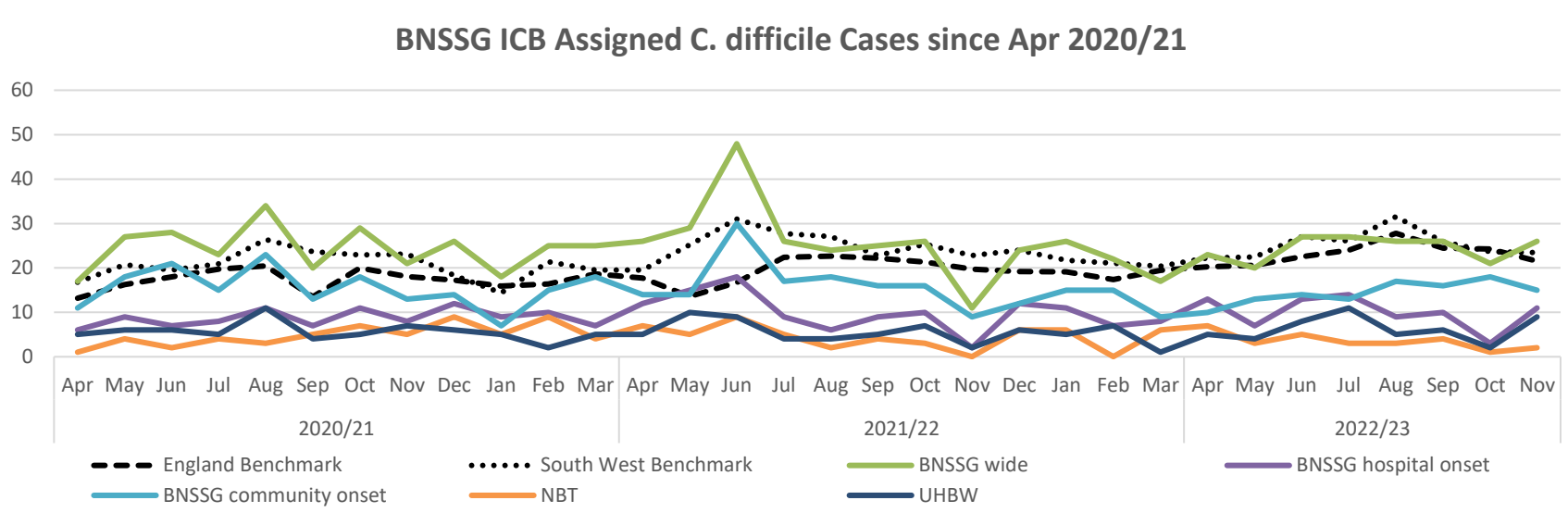
Assurance
- Comparison with all England and Southwest 2022/23 benchmarks is provided.

	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 8 position 21/22	Month 8 position 20/21
C. difficile	23	20	27	27	26	26	21	26					205	196	↓	215	199
E. coli	42	39	49	43	40	47	44	41					356	345	↓	379	401
MRSA	4	2	1	1	2	5	1	4					0	20		22	22
MSSA	16	12	10	17	13	18	22	18								107	122
Klebsiella spp	11	13	16	17	17	12	10	19					107	115	↑	121	105
Pseud A	3	5	7	6	7	9	6	2					42	45	↑	50	44

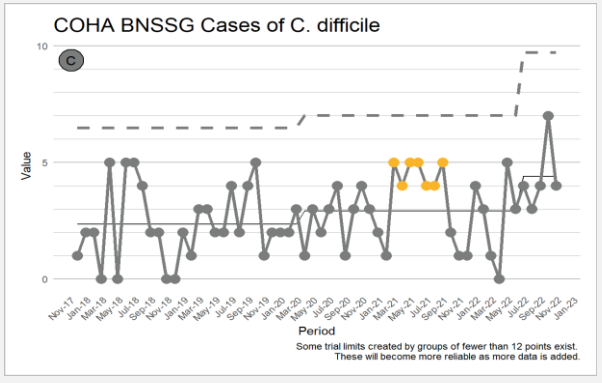
*The above table provides the monthly ICB assigned cases as well as the year to date total. The final columns are our benchmark against the 2020/21 and 2021/22 position.

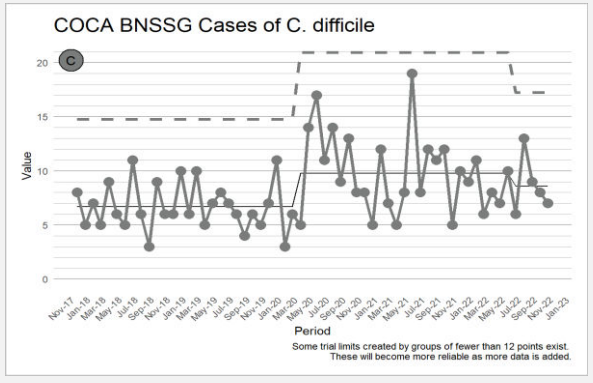
Quality Report - Healthcare Acquired Infections - Supporting Analysis

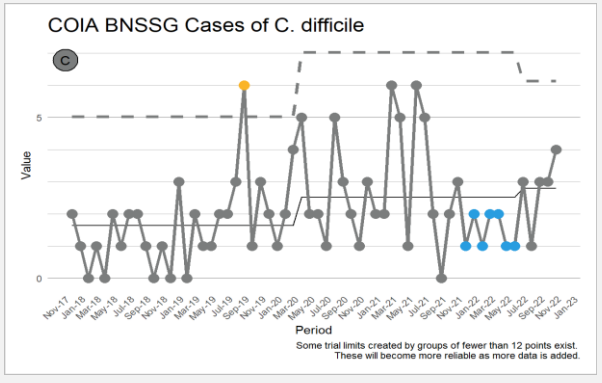
C. Difficile	26
HOHA	11 (NBT-2, UHBW-9)
COHA	4
COCA	7
COIA	4



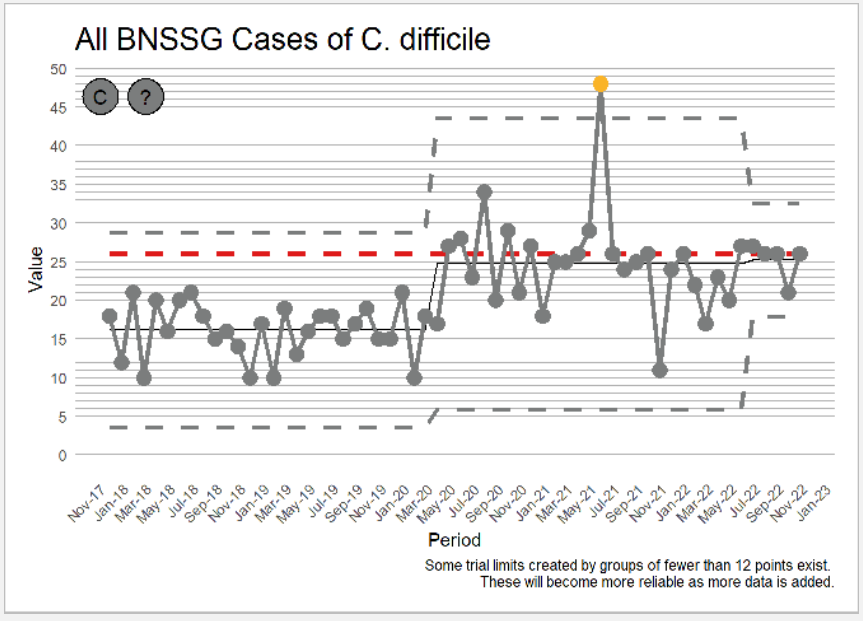
No significant change in data for Community Onset C. Difficile. Concerning variation would be if the data points exceeded Upper Limit (grey dashed line).





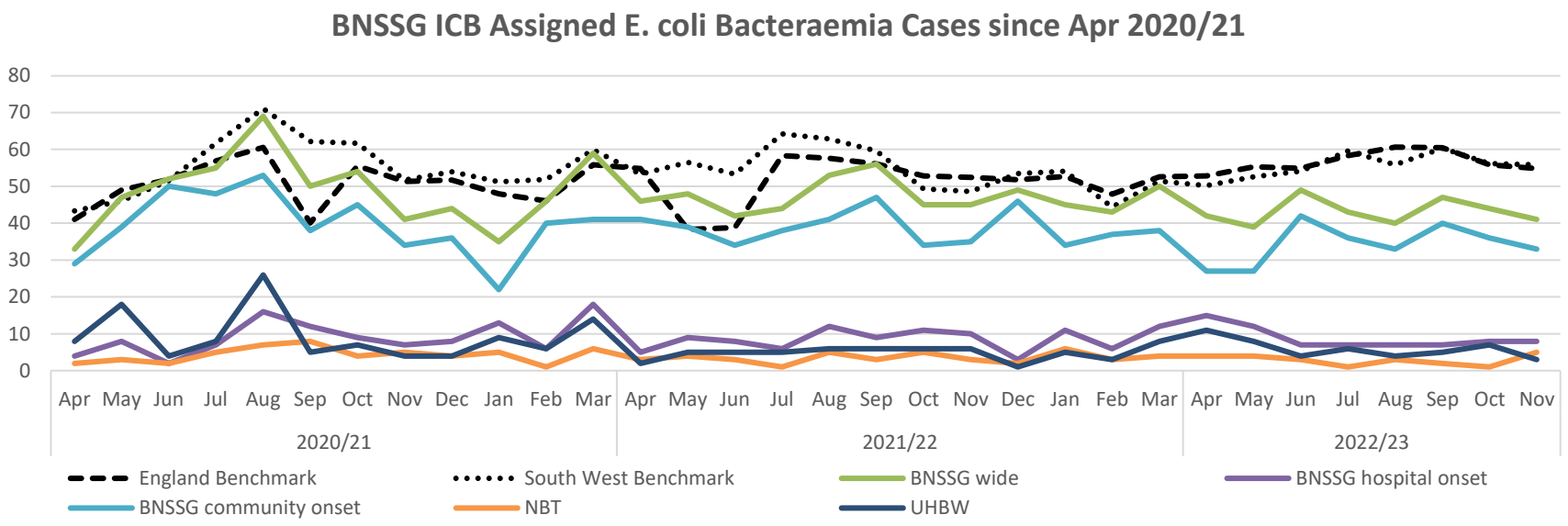


No significant change in data BNSSG Wide C. Difficile. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Consistently hits and misses threshold target. Nov-22 at threshold limit.

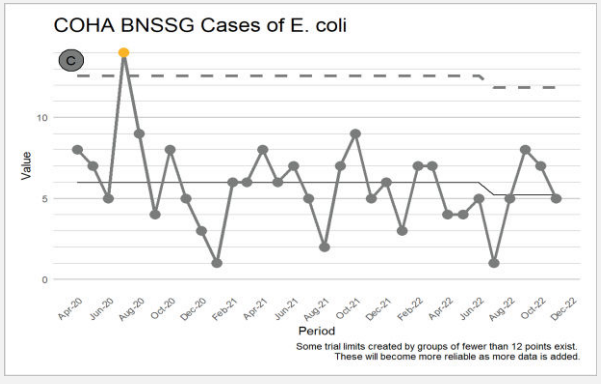


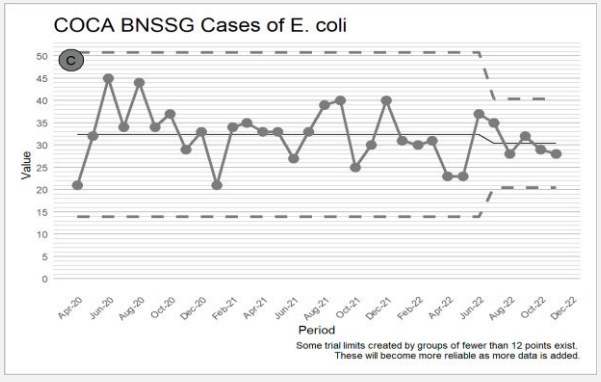
Quality Report - Healthcare Acquired Infections - Supporting Analysis

E. coli	41
HOHA	8 (NBT-5, UHBW-3)
COHA	5
COCA	28

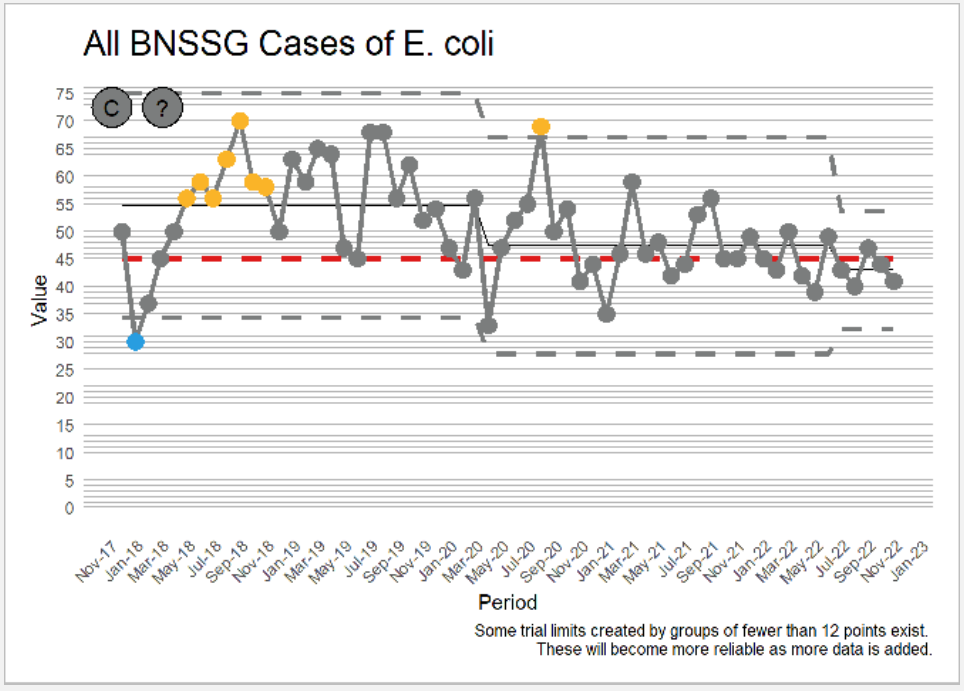


No significant change in data for Community Onset E. Coli. Concerning variation would be if the data points exceeded Upper Limit (grey dashed line).



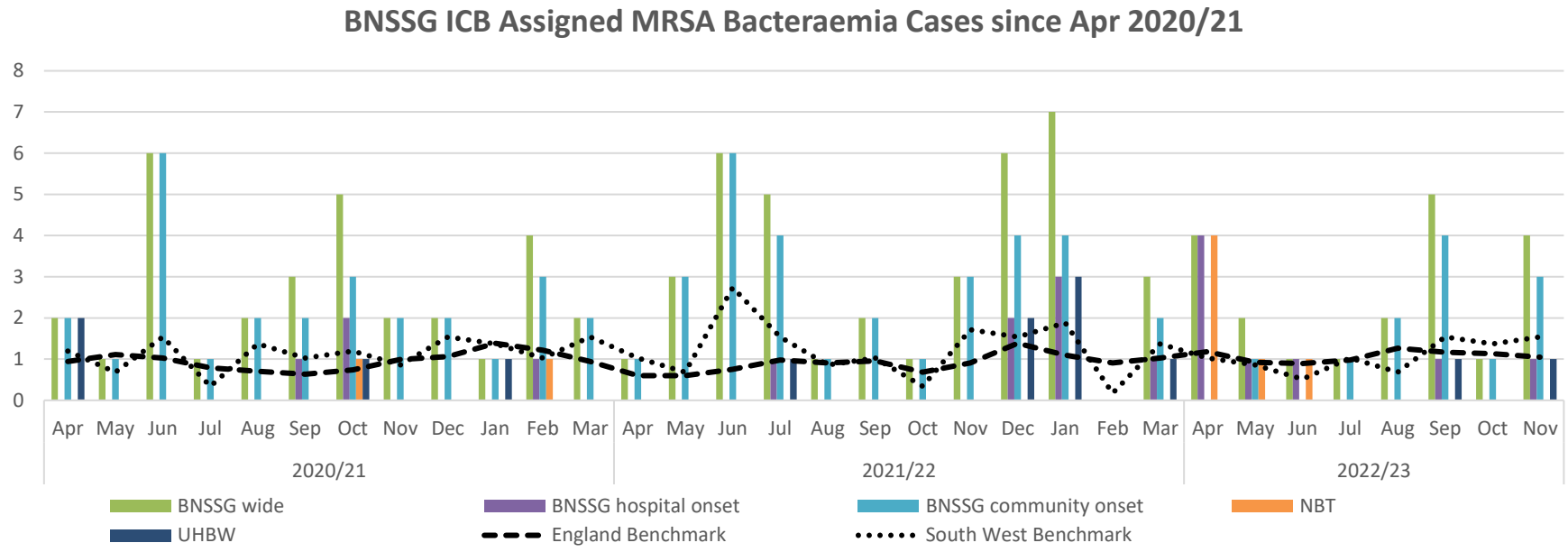


No significant change in data BNSSG Wide E. Coli. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds.

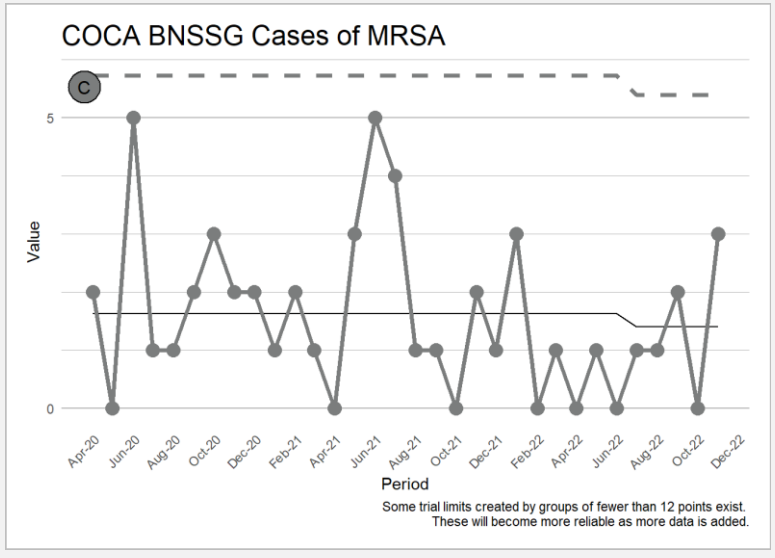


Quality Report – Healthcare Acquired Infections - Supporting Analysis

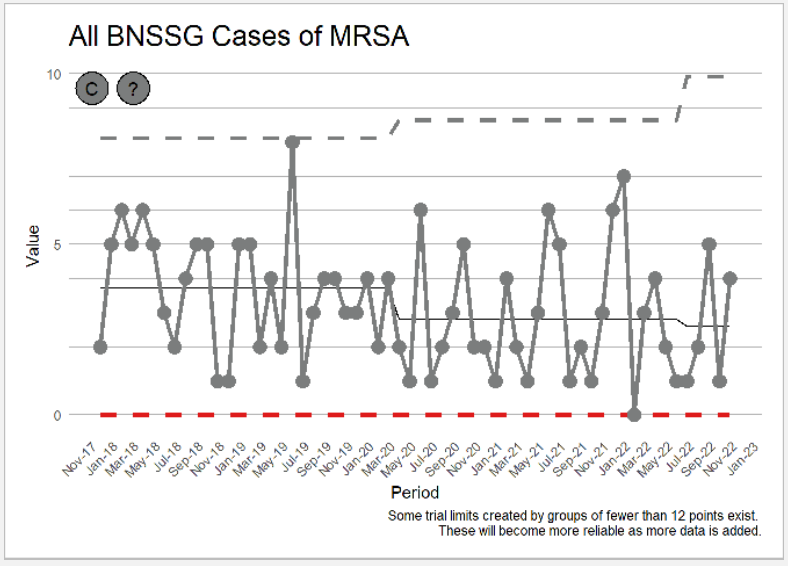
MRSA	4
HOHA	1 (UHBW)
COHA	0
COCA	3



No significant change in data for Community Onset MRSA. COHA is not included as 0 cases. Concerning variation would be if the data points continued above the mean (solid black line).

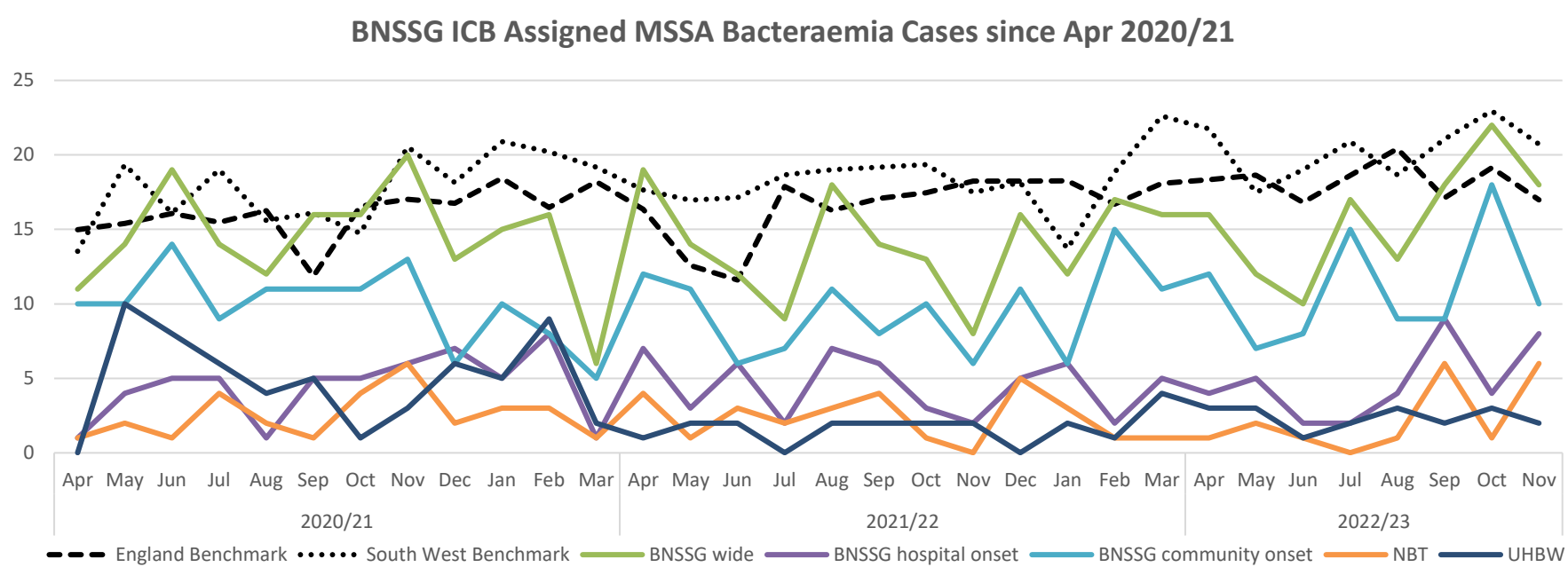


No significant change in data for BNSSG Wide MRSA. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Consistently fails to meet the target, currently above the mean and if this continues will become statistically significant.

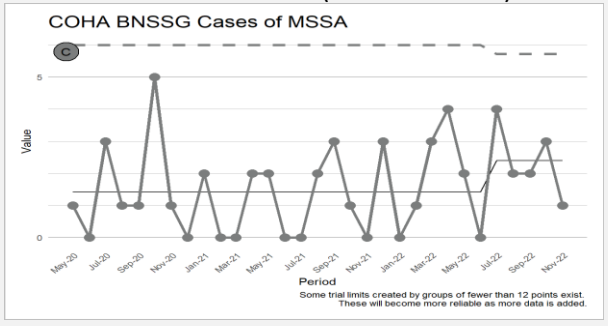


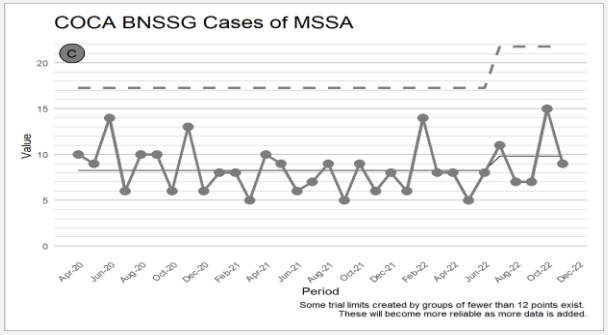
Quality Report – Healthcare Acquired Infections - Supporting Analysis

MSSA	18
HOHA	8 (NBT-6, UHBW-2)
COHA	1
COCA	9

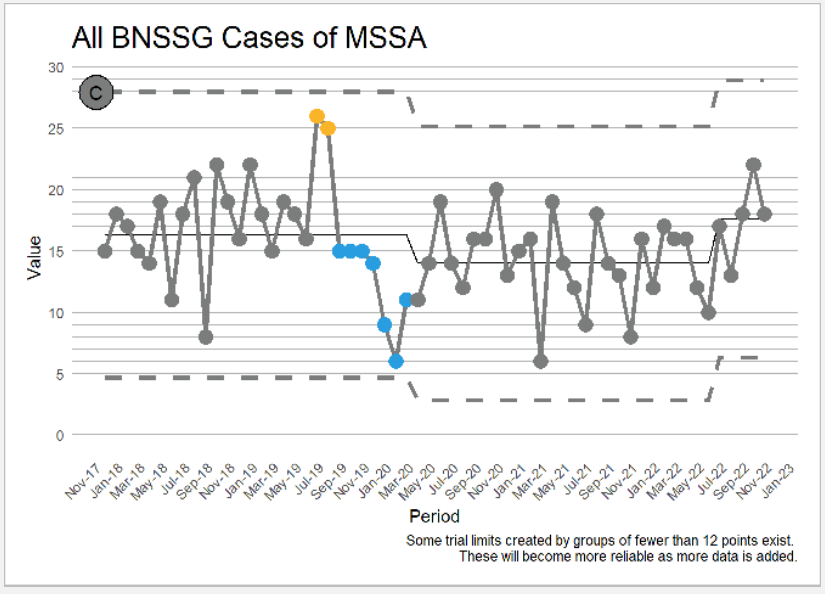


No significant change in data for Community Onset MSSA. Concerning variation would be if the data points exceeded Upper Limit (grey dashed line). This month values re below mean (solid black line).



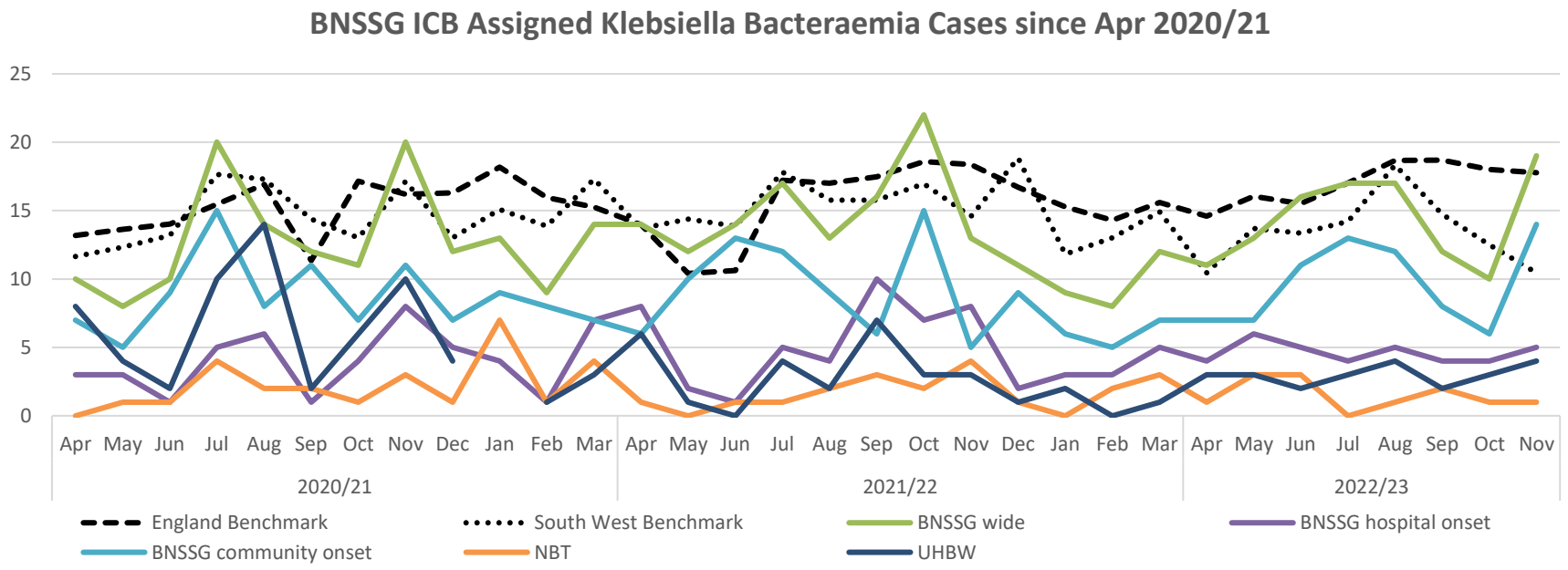


No significant change in data for BNSSG Wide MSSA. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Values are increasing above the moving average but still within upper and lower bounds, if this continues it could be a concern next month. There is no threshold.

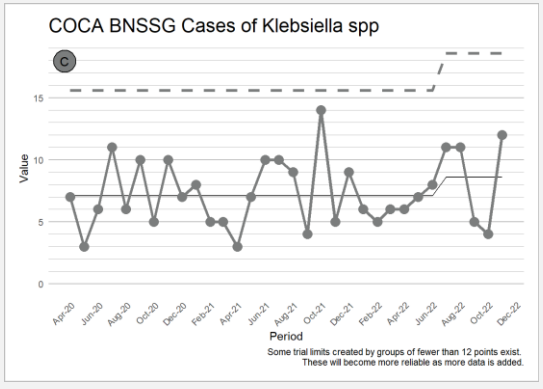


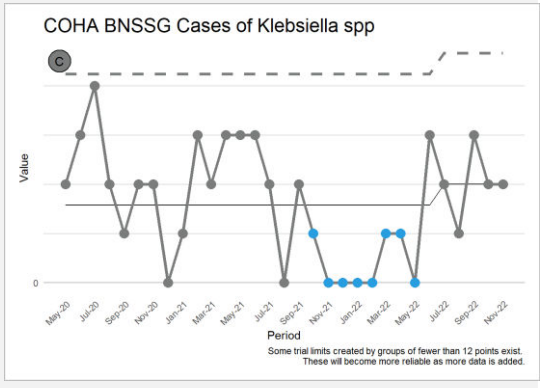
Quality Report - Healthcare Acquired Infections – Supporting Analysis

Klebsiella spp	19
HOHA	5 (NBT-1, UHBW-4)
COHA	2
COCA	12

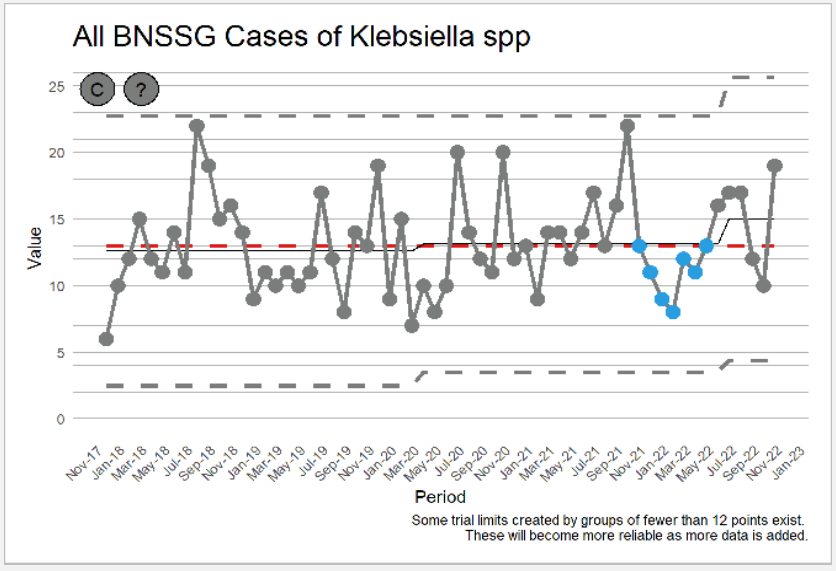


No significant change in data for Community Onset Klebsiella spp. Concerning variation would be if the data points exceeded the Upper Limit (grey dashed line). COCA sharp increase above mean (solid black line).



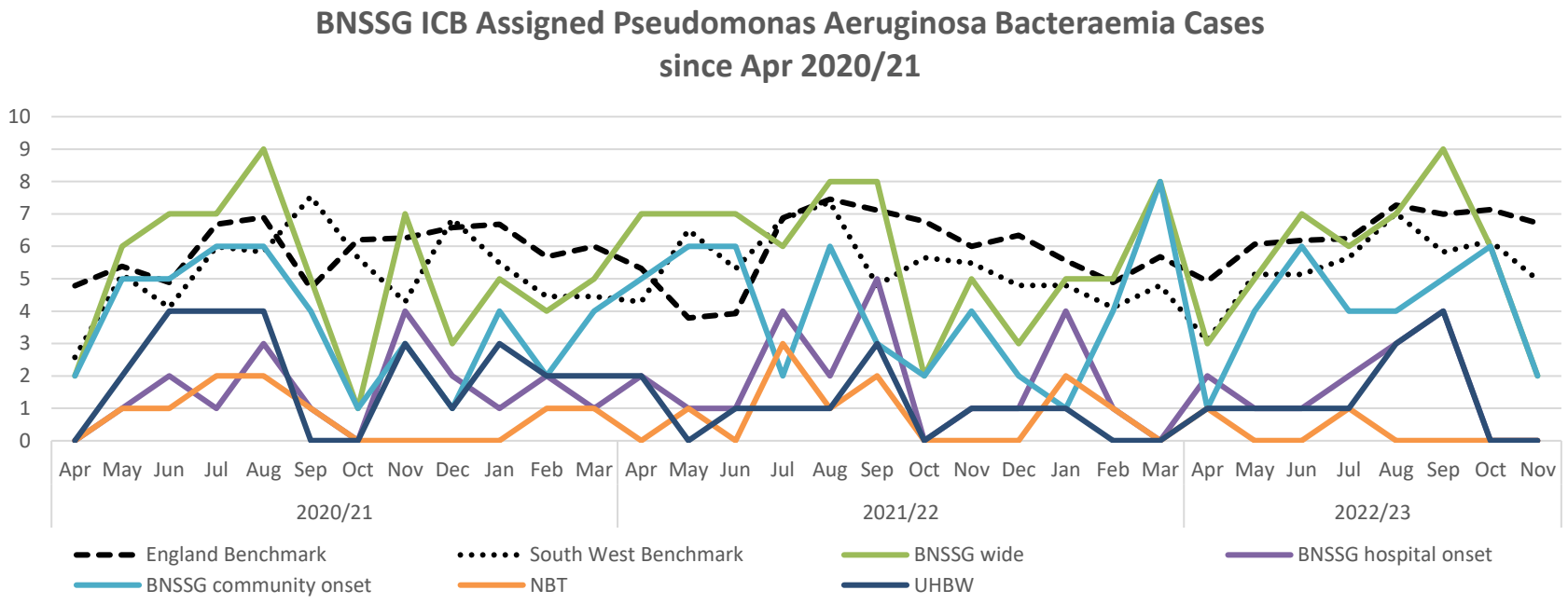


No significant change in data for BNSSG Wide Klebsiella spp. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Consistently hits and misses threshold target. Nov-22 is above target; if the value continues above the mean it will be categorized as special cause concerning.

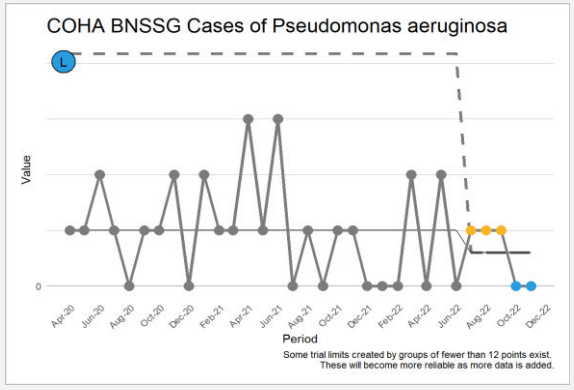


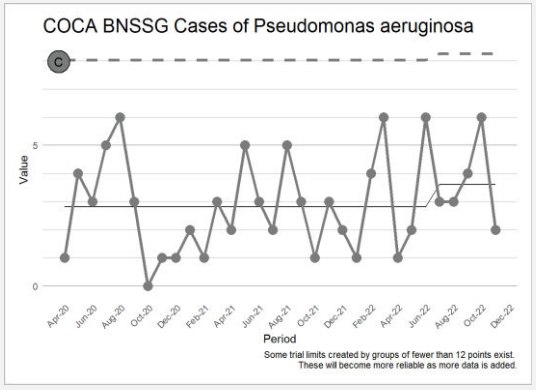
Quality report – Healthcare Acquired Infections - Supporting Analysis

Pseud A	2
HOHA	0
COHA	0
COCA	2

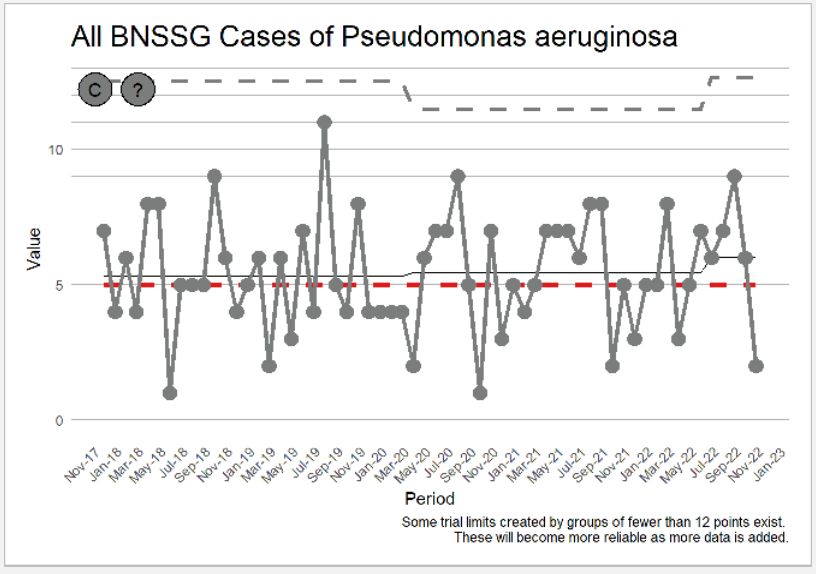


COHA category classed as special cause improvement due to 0 cases. The rebase since July has reduced the upper and lower limits though so just 1 case will change this to be statistically concerning. No significant change for COCA, value now below mean (solid black line).



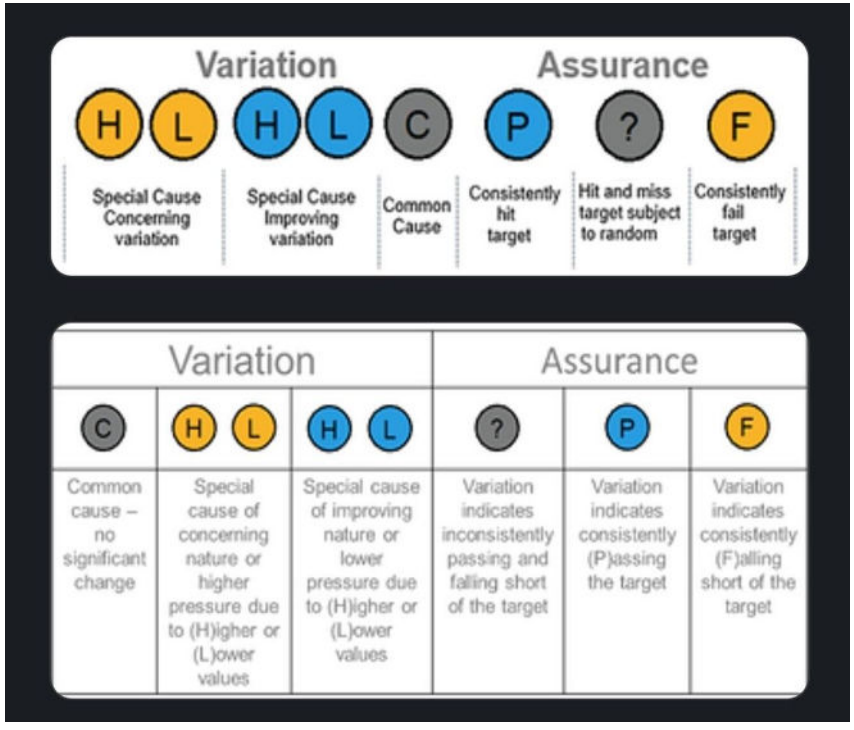


No significant change in data for BNSSG Wide Pseud A. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. A significant decrease below the mean and threshold, if this continues the process will be classed as special cause improving.



Quality report – Healthcare Acquired Infections - SPC Grid

		Passing			
		Assurance			
		Passing the target	Hit & miss	Falls below the target	Total
Improving					
Variation	Special Cause Improving	P1	H1	F1	0
	Common Cause	P2	H2 C. difficile Cases BNSSG Wide Klebsiella spp Cases BNSSG Wide MRSA Cases BNSSG Wide Pseudomonas aeruginosa Cases E. coli Cases BNSSG Wide	F2	5
	Special Cause Concerning	P3	H3	F3	0



All BNSSG HCI's with case thresholds lie in H2 of the SPC Matrix.

In terms of variation in the caseload this means:

This system or process is currently not changing significantly.

In terms of assurance against the threshold this means:

The process limits on SPC charts indicate the normal range of numbers you can expect from your system or process. ***If a target lies within those limits then we know that the target may or may not be achieved.*** *The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.*

This month the SPC Xmr diagrams were made using the NHS Plotthedots R Package and used slightly different icons.

Nursing & Quality - Serious Incidents including Never Events
Reporting Period –2022/23 – November data
Information Source and date of information – 15/12/2022

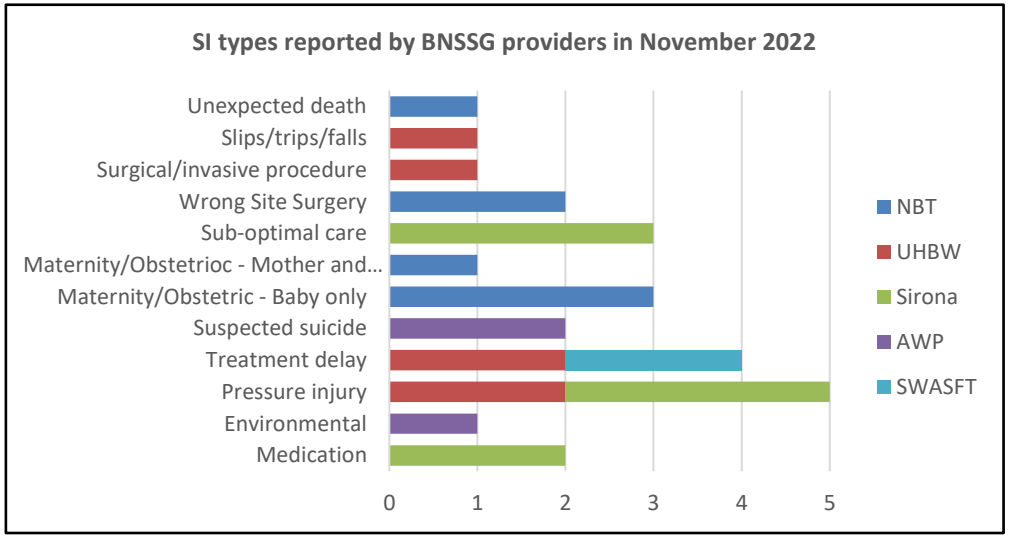
Current Month Overview

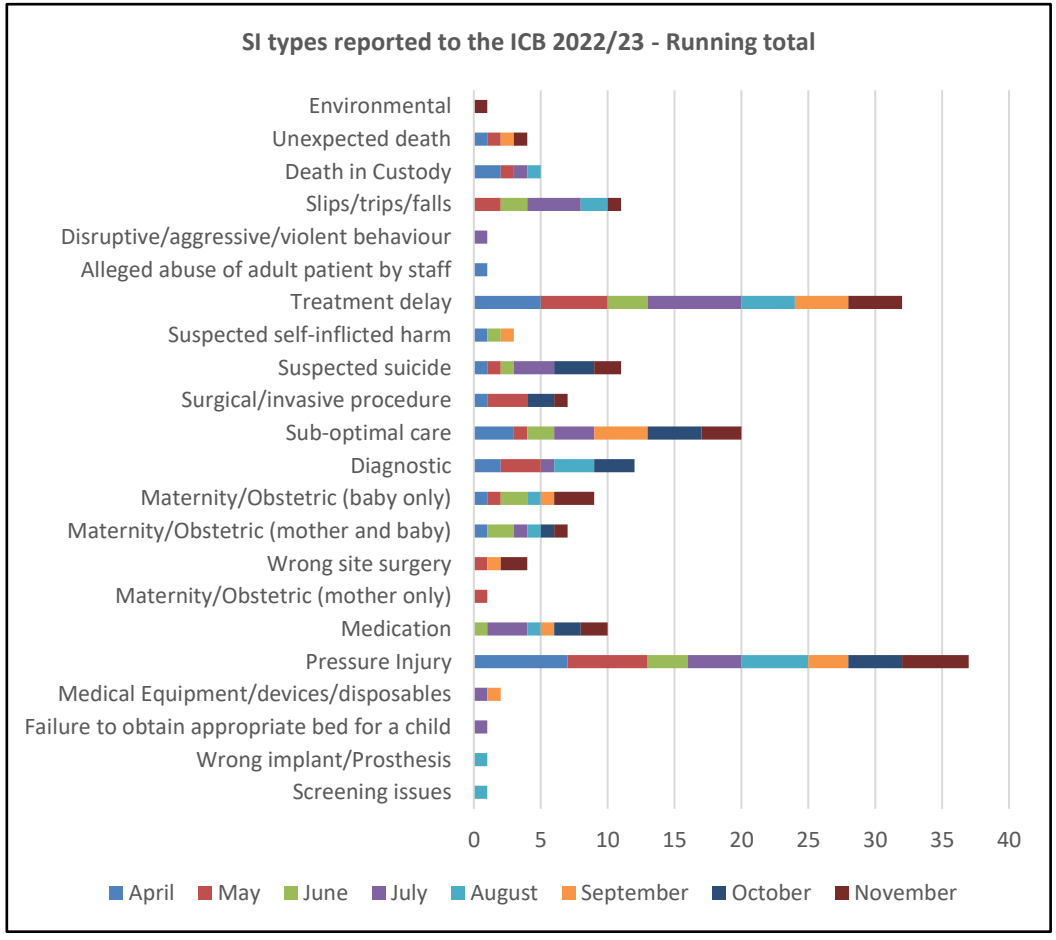
- In November 2022, 26 Serious Incidents (SIs) were reported across BNSSG providers. There were two Never Events (NEs) reported involving the same patient.
- The first NE relates to wrong site nerve block given following incorrect labelling of the admission x-rays, resulting to the second NE of hemiarthroplasty performed at the wrong side.
- Pressure Injury (PI) incidents remain the top reported type in November, with a small increase from the previous month. All reported PIs were unstageable PIs.
- Treatment delay incidents have seen a significant increase in November with four reported, following none reported the month before. Overall, Treatment delays are the second top SI type reported this year so far, with 32 incidents reported since April 2022.

SIs reported across BNSSG 2022/23

Provider	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	YTD SIs
NBT	4 (1)	3 (1)	1	0	1	0	0	7 (2)	16 (4)
UHBW	7	10	7	15	11 (1)	4 (1)	8	6	68 (2)
Sirona	7	6	5	8	5	8	5	8	52
AWP	5	3	2	5	2	3	3	3	26
SWASFT	0	1	1	1	1	1	0	2	7
GP	0	0	0	0	0	0	0	0	0
Other	3	3	1	1	0	1	3	0	12
Total	26 (1)	26 (1)	17	30	20 (1)	17 (1)	19	26 (2)	181 (6)

** 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)	19	26 (2)					**181 (6) running total**

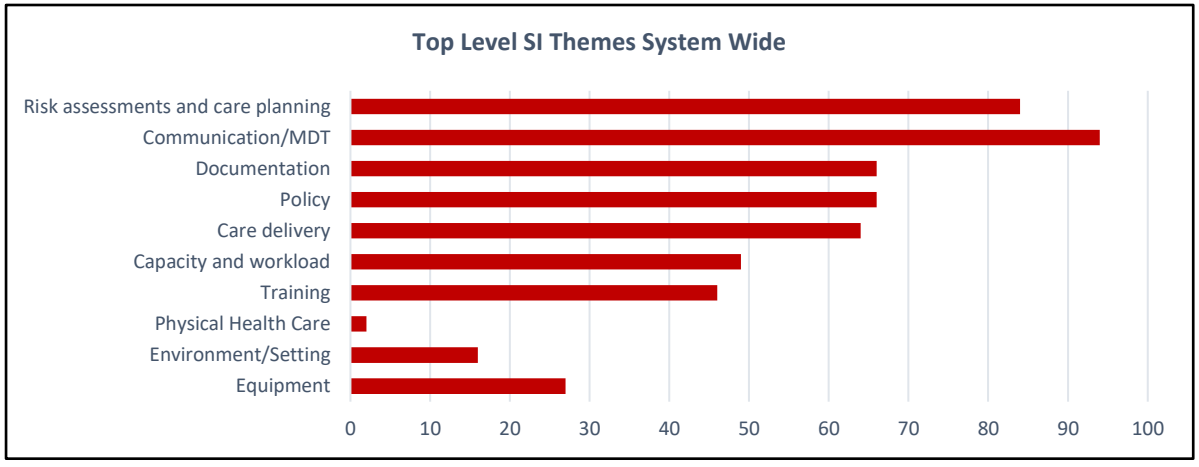
**The numbers in brackets indicate the number of Never Events reported. * From 2020/21, figures exclude the HCAI/Nosocomial COVID SIs*

Nursing & Quality – Serious Incidents including Never Events –Themes Overview
Reporting Period: 2022/23 Current data
Information Source and date of information – BNSSG SI dedicated information site and trackers as of 12/01/2023

From the beginning of this financial year to the end of December, the Quality team has reviewed 179 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 investigation reports reviewed per SI type
Pressure Injury	42
Obstetric	19
Treatment delay	19
Slips/trips/falls	18
Diagnostic	13
Sub-optimal care	13
Suspected suicide	13
Medication	9
Suspected self-inflicted harm	7
Aggressive behaviour	4
Surgical procedure	4
Wrong site surgery	3
HCAI/Infection control	3
Unexpected death	2
Medical equipment	2
Homicide	2
Alleged assault of patient	1
Misplaced naso or oro-gastric tubes	1
Retained object post procedure	1
Alleged assault of patient	1
Blood product/transfusion	1
Failed discharge	1

The table below shows the top-level themes identified through the review of the submitted investigations since March 2022. Across the system, it is noted that the top two themes remain Communication/MDT, Risk assessment and care planning, with Policy and Documentation equally remain a concern.

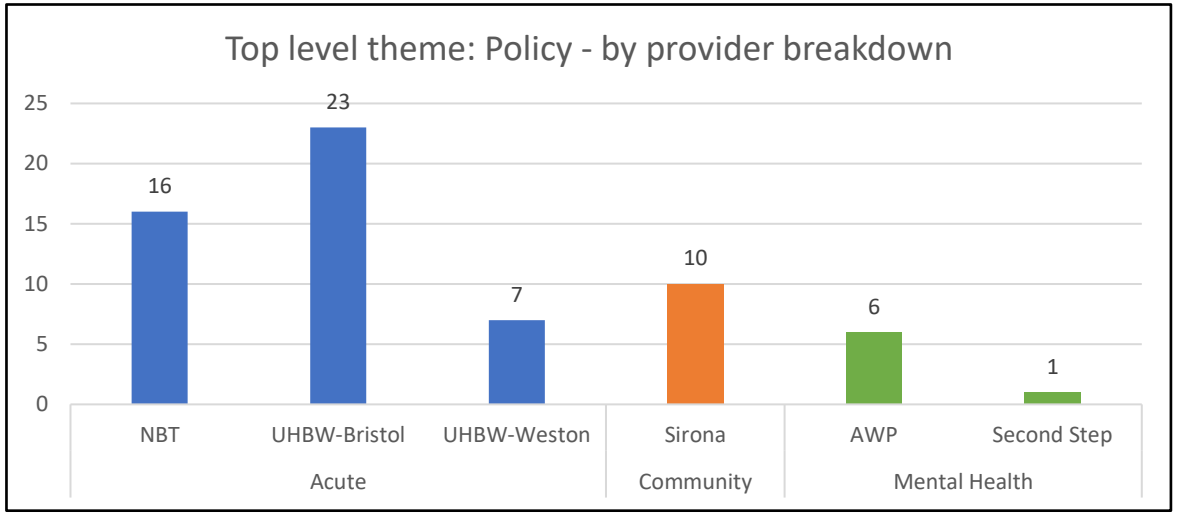


The top SI type of incidents reviewed are Pressure injuries, Obstetric, Treatment Delays and Falls. The themes that come through these reviews are quite consistent with the overall System Wide themes.

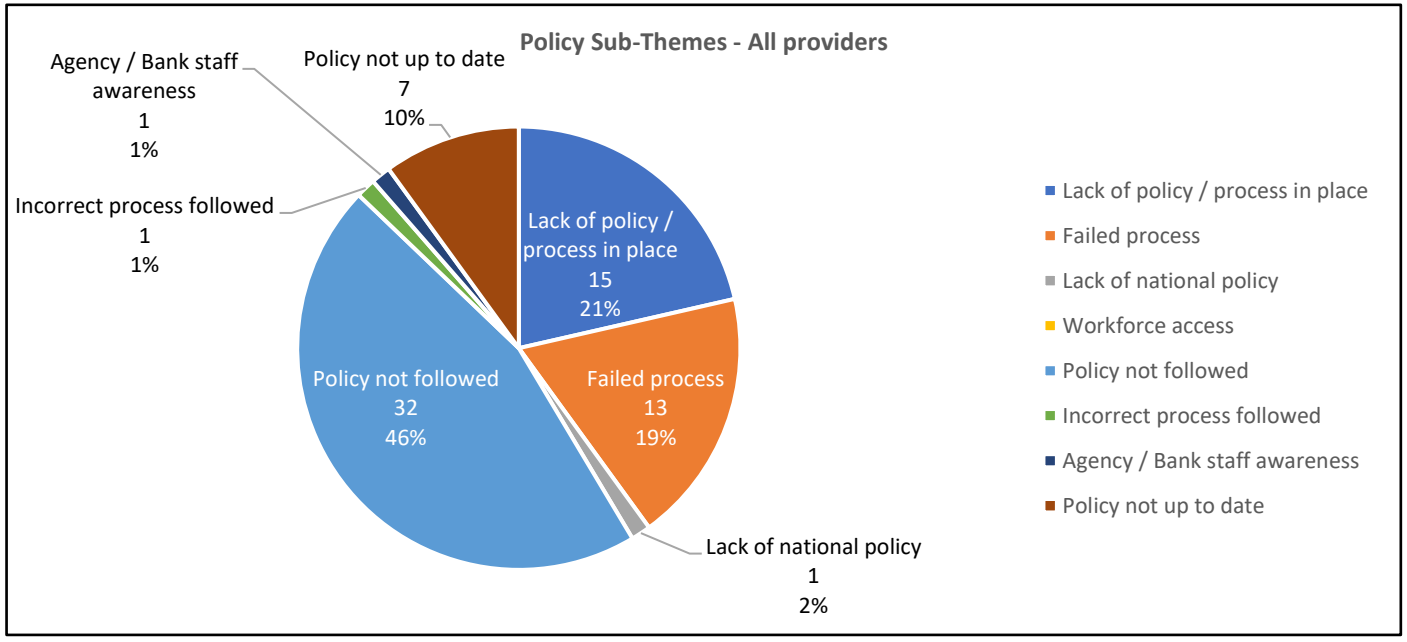
- For Pressure Injuries, Risk assessment and care planning followed by Documentation continue to be the two top lever themes.
- For Treatment Delay incidents, Communication has remained as one of the top top-level themes, followed equally by Capacity/Workload, Policy and Care Delivery.
- For Fall incidents, Risk assessment and care planning is identified as the top level theme, with Capacity/Workload and Care Delivery equally follow as emerging themes.
- For Obstetric incidents Policy and specifically not following Policy/process in place was the top theme.

Nursing & Quality – Serious Incidents including Never Events –Thematic Analysis – 'Policy'
Reporting Period: 2022/23 Current data
Information Source and date of information – BNSSG SI dedicated information site and trackers as of 12/01/2023

Since the beginning of the financial year, there have been 63 investigation reviews that identified 'Policy' as one of the top-level themes. The table below indicates the number of investigations reviewed per provider, where policy was one of the top-level themes identified. This was discussed at the December's Learning panel, where individual providers have agreed to undertake further internal reviews and to bring findings back to the February Learning panel for further review.

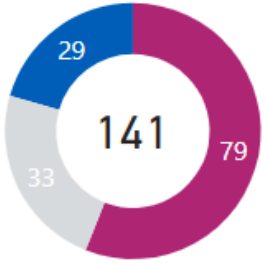


The table below provides the breakdown of 'Policy' onto sub-themes identified through these reviews, with 'Policy not followed' account to the majority.

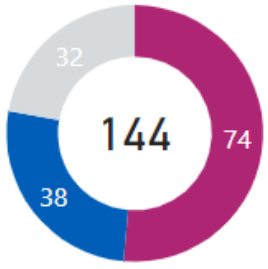


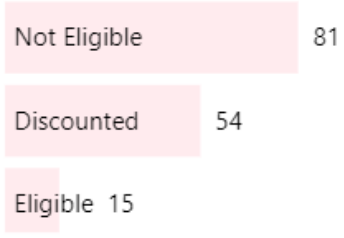
Nursing & Quality – Funded Care – Adult Continuing Health Care (CHC)
Reporting Period –2022/23 – November data

CHC Referrals Received

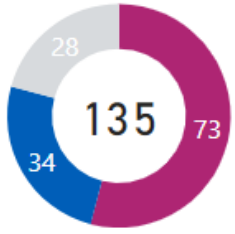


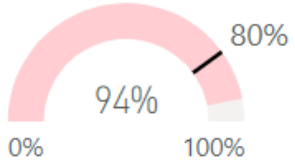
CHC Referrals Completed



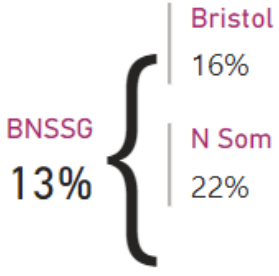


CHC Decisions within 28 Days

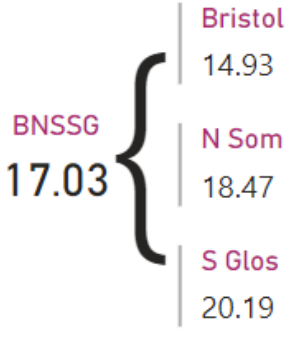




Conversion Rate



Mean Days to Decision



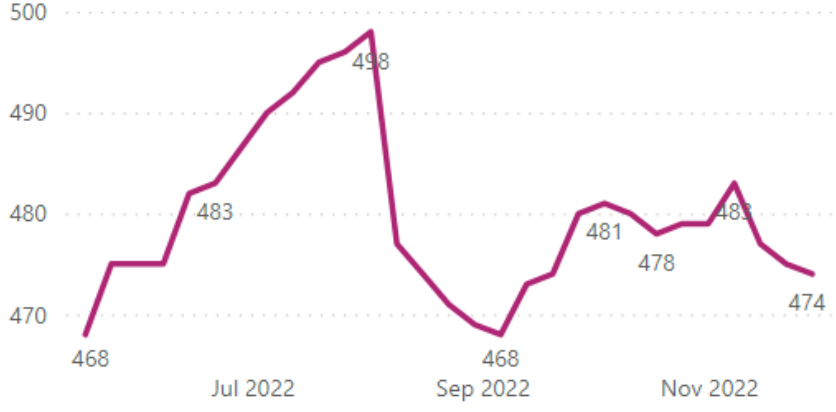
Open Referrals Exceeding 12 weeks at data extract date

1

Adult CHC Funded Caseload at data extract date

477

Weekly Standard CHC Caseload

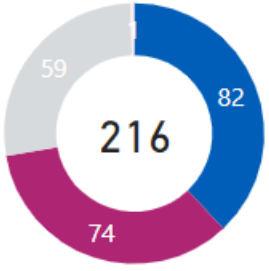


Narrative:

- 28 day performance remains at 94% exceeding the target of 80%, despite a 15% increase in new referrals.
- The overall eligibility conversion rate was 12% against national average of 23%.
- CHC Caseload at month end was 474. The split of the caseload by speciality was:
  - Physical disability – 62.3%
  - Learning disability – 30.8%
  - Mental health – 6.9%
- Exceptionally high (37%) increase in the number of new Funded Nursing Care determinations in month. Further analysis of this will be undertaken in Q4 2022-23 to determine if this is unwarranted variation or a new trend.

Nursing & Quality – Funded Care – Adult CHC Fast Track End of Life
Reporting Period –2022/23 – November data

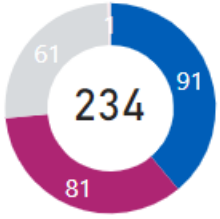
Fast Track Referrals Received



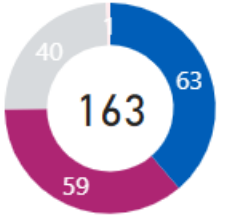
From November 2022

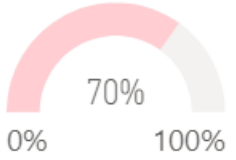
To November 2022

Fast Track Referrals Determined

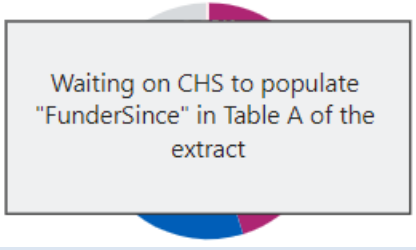


FT Decisions within 2 Working Days





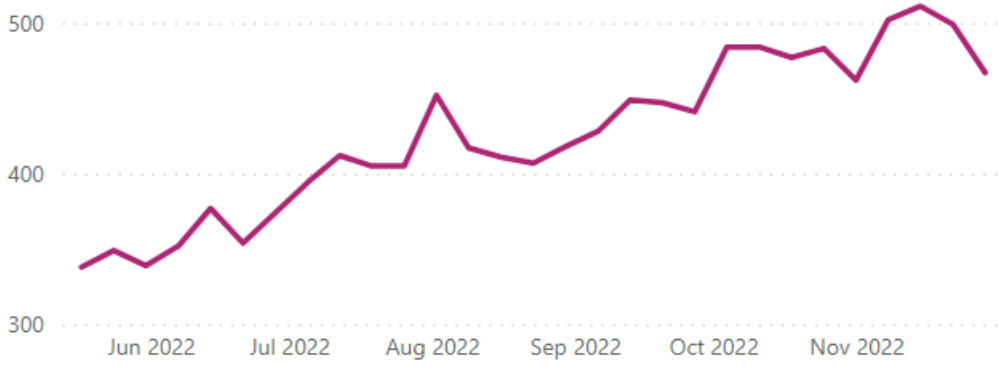
Fast Track Eligible for over 12 Weeks at Extract Date



Fast Track Review Caseload at date of data extract

446

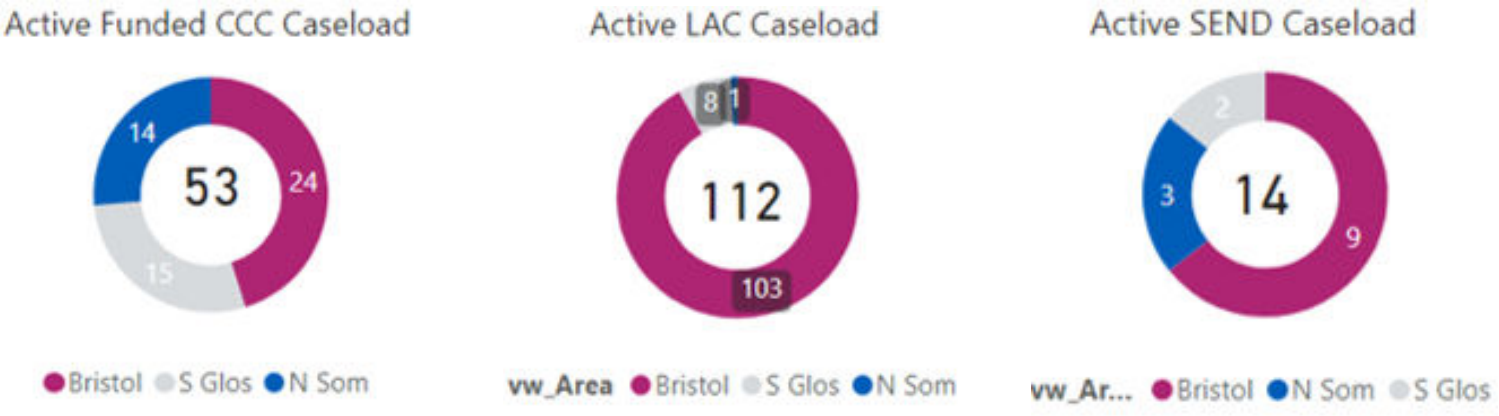
Weekly Fast Track Caseload

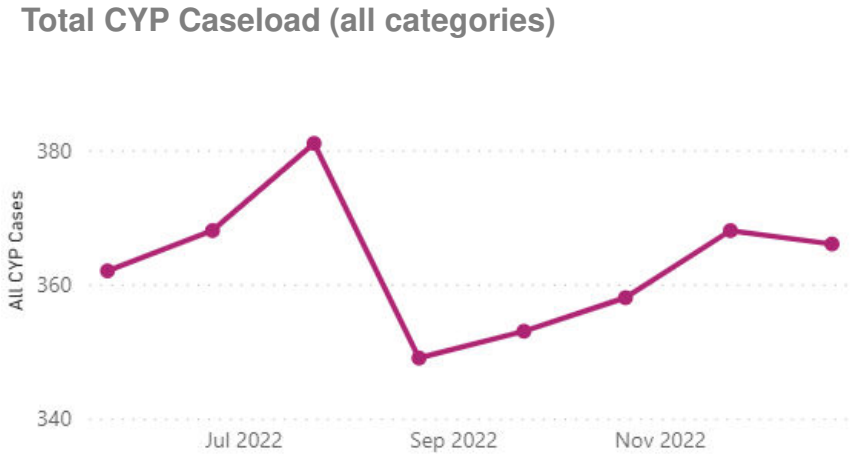


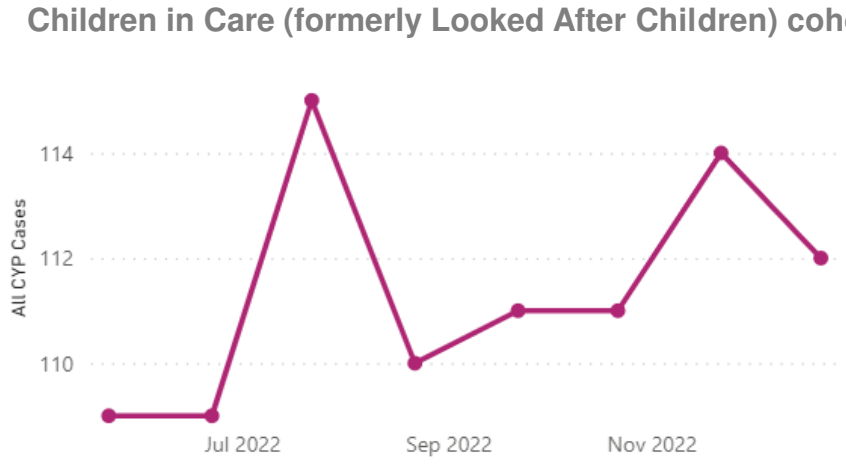
Narrative

- Determinations within 2 working days:
  - 70% of fast tracks were determined within 2 working days in November compared to 69% in October, this is despite reduction in staff from long term sickness in the Fast Track (FT) team currently.
- 234 FT determinations were made in total in November – which is one more than was made in October (235).
- 17 out of 234 fast tracks determined in November were discounted – which is 7%.
- Compared to 12 out of 235 determinations discounted in October – which is 5%.
- Reasons were inappropriate referral and death in hospital.

Nursing & Quality – Funded Care – Children and Young People's Complex Care
Reporting Period –2022/23 – November data







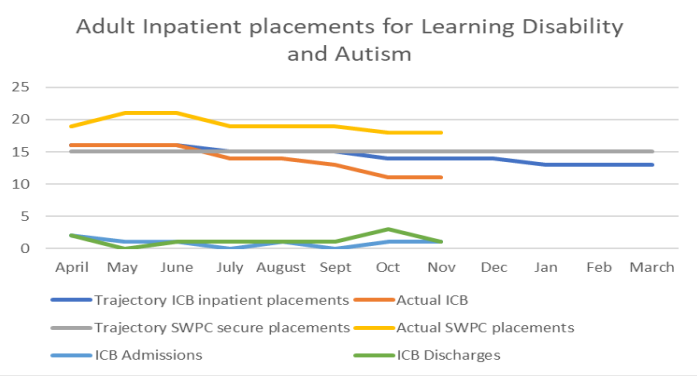
Narrative

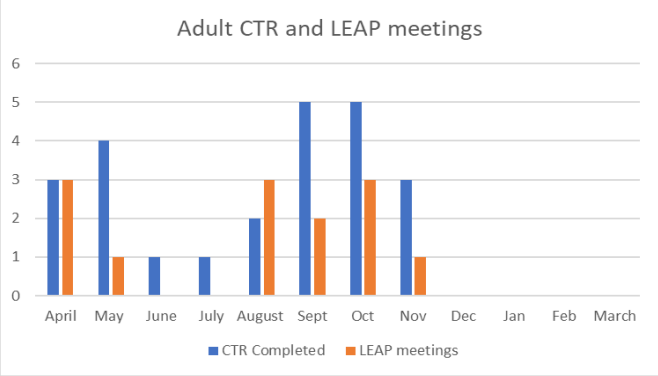
- Children in Care (formerly known as Looked After Children (LAC)) caseload has increased to 112 and is predominantly Bristol cases. Further analysis is being undertaken to view LAC cohort over time. The unforeseen increase in this cohort poses a financial risk to the Funded Care budget.
- Consideration is being given to the creation of position statement to support the decision-making around joint funding for children and young people with complex needs.
- Additional capacity is being sought to be able to provide assurance of the quality of care to children placed out of area, where the ICB has funded health interventions.

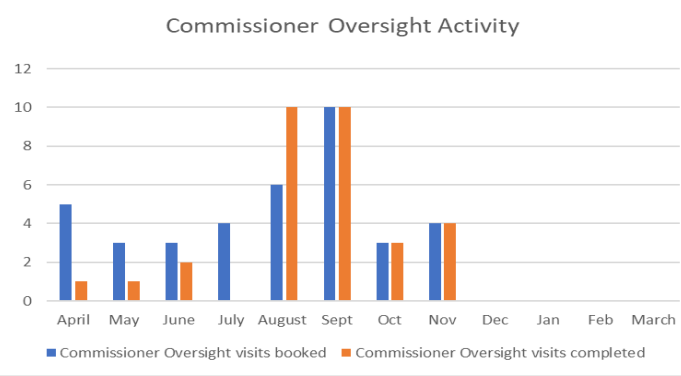
Nursing & Quality – Funded Care – Assuring Transformation – Learning Disability and Autism
Reporting Period –2022/23 – November data

Performance/Data for 2022-2023

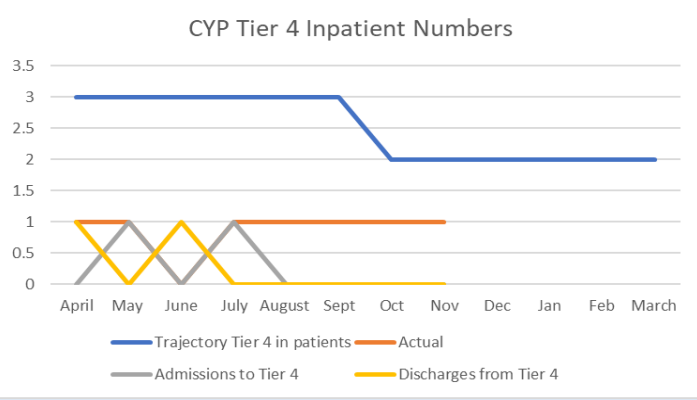
Adults

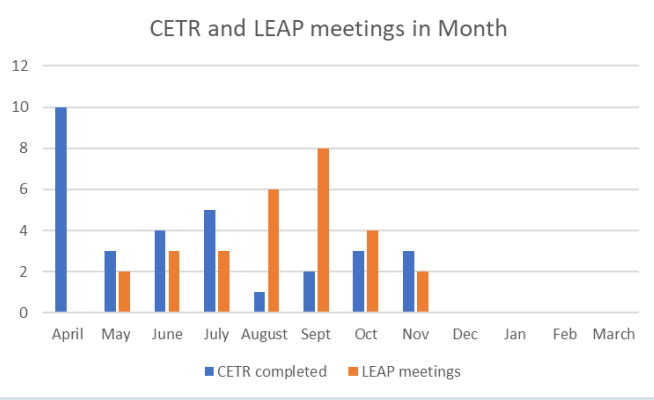






Children and Young People (CYP)





Adults

- There has been a decrease in Click-through rate (CTR) and Listening and Engagement Active Partnerships (LEAP) activity in November, but there has been 46 Professionals meetings / MDT's / Safeguarding / Discharge planning meetings for adults.
- ICB commissioned placements remain 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 this has been added to.
- There has been no new admissions to Tier 4 services.
- All Community Enhancing Recovery Team (CETR) meetings are being held as full day events in line with national guidance.
- LEAP activity has decreased.

BNSSG SYSTEM COVID Medicine Delivery Unit (CMDU) Service UPDATE 2022/23	Reporting Period: Up to 9th January 2023	
Governance: The CMDU service will send a report to BNSSG ICB Quality, Performance and Outcomes Committee on a monthly basis	**Report for assurance purposes and to escalate any issues**	**Written by:** Debbie Campbell and Lisa Pottenger

Background Since December 2021 CMDUs have been deployed based on National requirements to provide access to COVID treatments for non-hospitalised patients believed to be at greatest risk of disease progression, hospitalisation or death. As social contact returns to pre-pandemic levels there is likely to be a resurgence in COVID-19 activity in winter 2022 to 2023. The potential for co-circulation of influenza, COVID-19 and other respiratory viruses could add substantially to pressures in the NHS in 2022 to 2023. COVID vaccination and access to COVID treatments is an important priority to reduce morbidity and mortality associated with COVID-19.

National guidance

The Commissioning Framework: COVID-19 Therapeutics for Non-Hospitalised Patients was published on 9th December 2021 and updated 14th June further updated on 28th November which reprioritised the treatment options and further updated 22nd December . This highlights the eligible cohorts as defined in the Department of Health and Social Care commissioned for either oral antiviral treatments or intravenous (IV) antiviral treatment or neutralising monoclonal antibodies (nMABs). The updated Commissioning Framework from 22nd December asks that services are continued during the remainder of 2022/23 in additional planning for routine provision from April 2023. Within the updated framework we need to ensure we address surge planning and any health inequalities. ICBs are asked to ensure a CMDU service remains in place and lead planning for a more routine service from April 2023 with a named SRO and Deputy (Debbie Campbell and Geeta Iyer).

The updated Commissioning Framework sets requirements and standards that the ICB is expected to meet when determining and commissioning local delivery models for access to COVID-19 therapeutics.

Including:

- Ensuring timely access to treatments
- Managing any surges in demand on COVID-19 therapeutic treatment services to enable increases in service capacity as and when required
- An approach to health inequalities to support equitable access to services
- Provide proactive outreach to highest risk patients
- Data and reporting to ensure effective monitoring and support service improvement
- Our roles and responsibilities
- The additional support and resources available to the system

COVID Medicine Delivery Unit (CMDU) Service

BNSSG CMDU service delivery model started with delivery in the acute trust supported with patient triage carried out by Sirona. Due to system pressures the model was refined March 2022 following expressions of interest to GP practices. Through a series of step wise changes the service transitioned to two GP practices for adult patients. An SLA/MoU is in place with the practices until 31/3/23. Paediatric patients remain at Bristol Children's hospital for triage and treatment. CMDU service page on REMEDY platform found here with detailed information remedy pathway (bnssgccg.nhs.uk)

System wide CMDU service Groups BNSSG CMDU Clinical Steering Group and CMDU Clinical Governance Group have continued to meet frequently with representatives from Primary Care, Secondary Care, Sirona and ICB. Lessons have been reflected upon from the ongoing service provision and to address some of the issues highlighted. We are trying to ensure a synergistic approach to both the CMDU service and Covid vaccination campaigns. With cross system working across the ICS and significant representatives at the relevant groups.

Health Inequalities

Since the service began, from a local and national perspective data shows uptake appears lower in ethnic minority groups and a difference between male and females (see graphs slide 5-6). The updated commissioning framework has been updated accordingly asking local systems to make efforts to show improvement in coverage in those groups who are less likely to be treated compared to white British cohort to address this. With the aim to support those who are living in the most deprived areas, from ethnic minorities and other underserved communities to have as high uptake as the population as a whole.

Work has started with colleagues to address this locally and learning from other successful NHS programmes, such as the COVID-19 vaccination programme is being used to reduce barriers and increase awareness and uptake within the local populations. Where variation in triage and uptake is identified, action will be taken to focus local efforts to improving awareness and understanding of the pathway and improve uptake rates as appropriate.

Future Provision

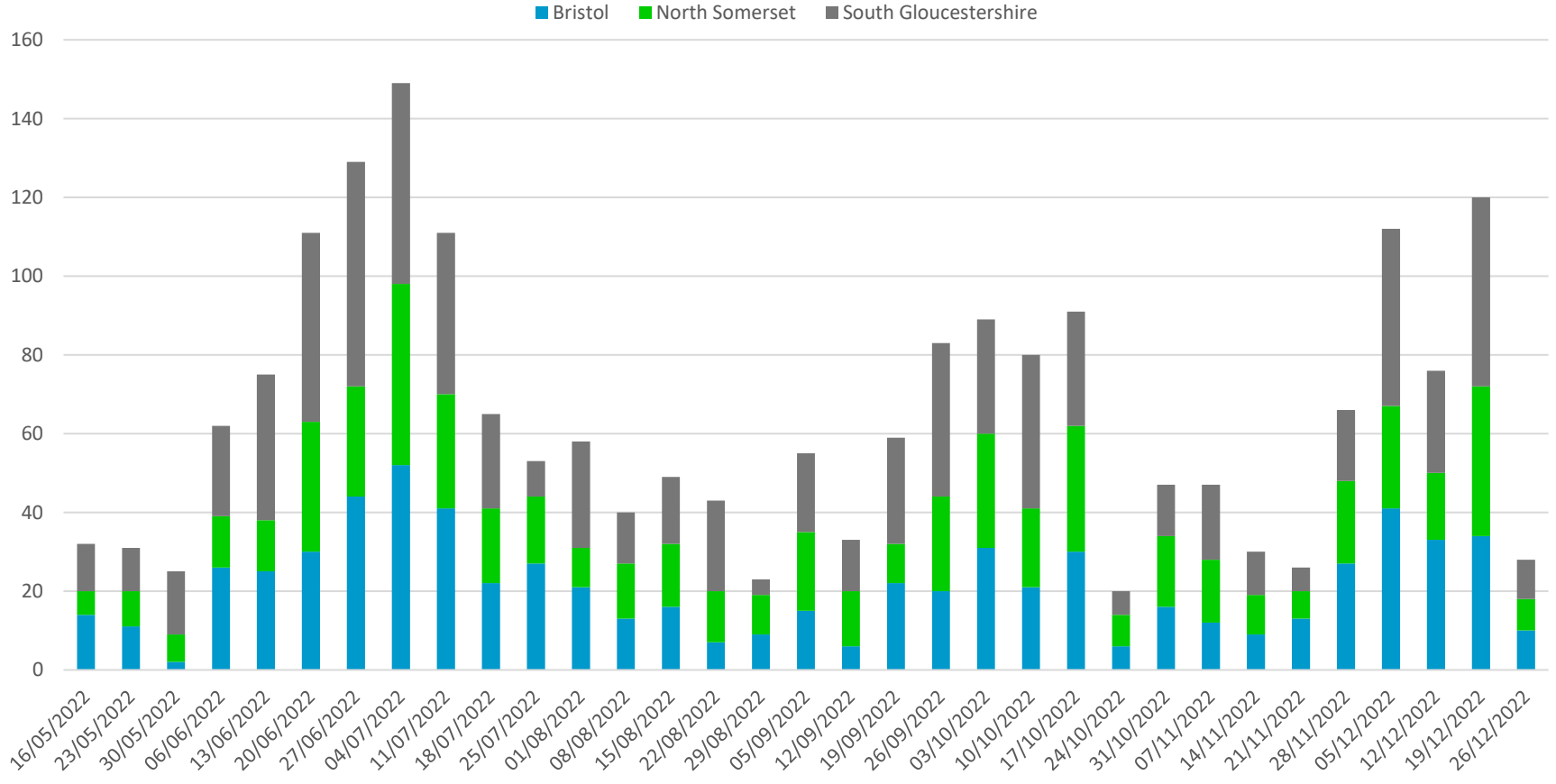
The longer-term ambition for the NHS is for access to COVID-19 therapeutics to become part of routine services, with the long-term preferred route of access through primary care and integrated urgent care. The preferred service delivery model should be determined by the ICB to meet the needs of the local population. These models may be based in primary, community or secondary care, or may be based on a hybrid model. Within these plans ICBs expected to support access to existing COVID-19 therapeutics, as well as new therapeutics as they become available. We are still awaiting more information from national team to support planning, but a loc l team is being established to take planning forward.

COVID Medicine Delivery Unit (CMDU) Service

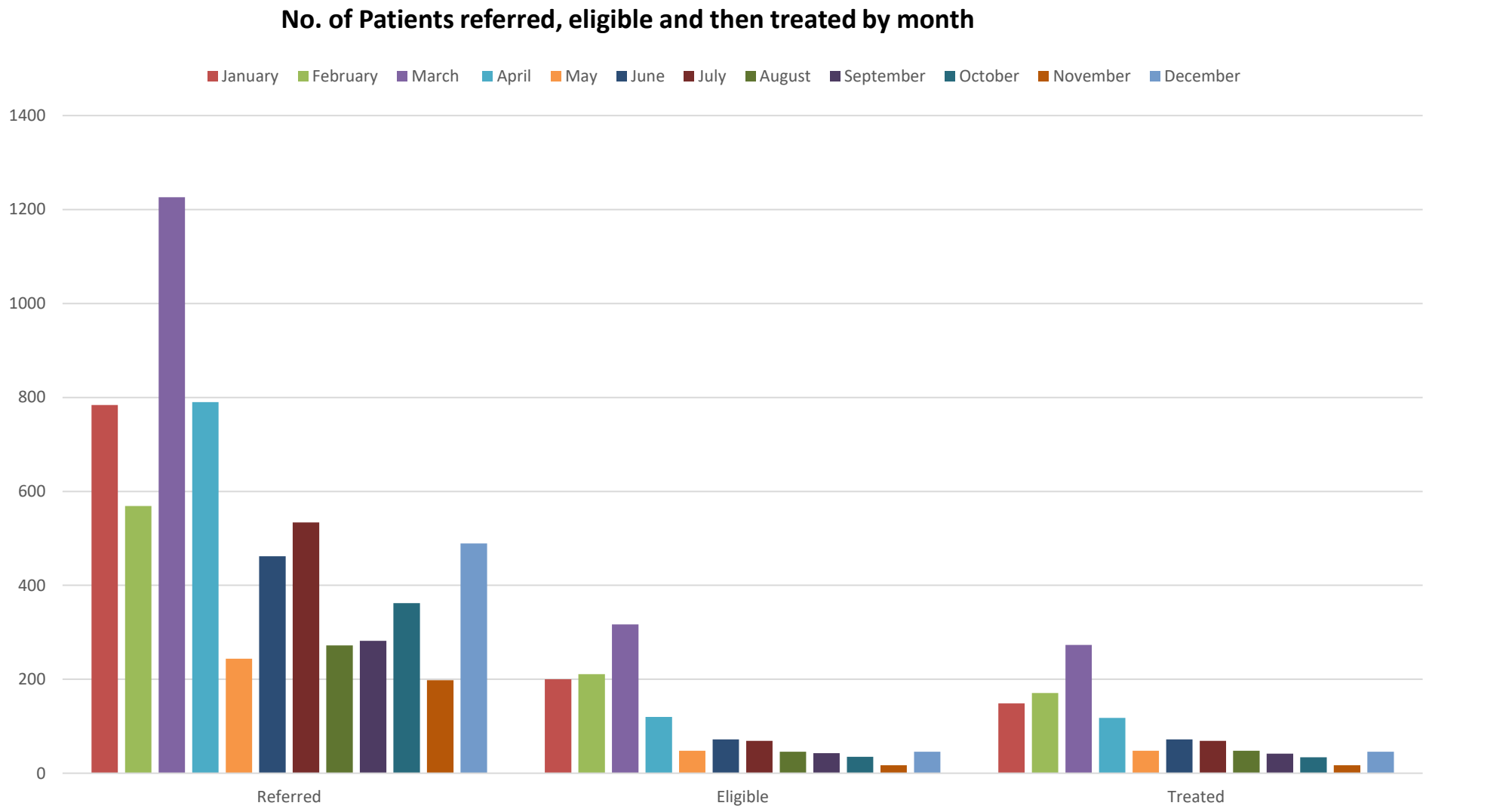
CMDU data

- To date (December 21- January 23) we have assessed approximately 5,000 patients and treated over 1347 patients in BNSSG
- The NHS COVID-19 data store and CMDU service data is available through the Foundry and the system wide dataset is monitored every two weeks
- An initial trajectory has been developed to support the identification of areas which would benefit from additional focus and support. This trajectory will be further developed following feedback, and as data becomes available.

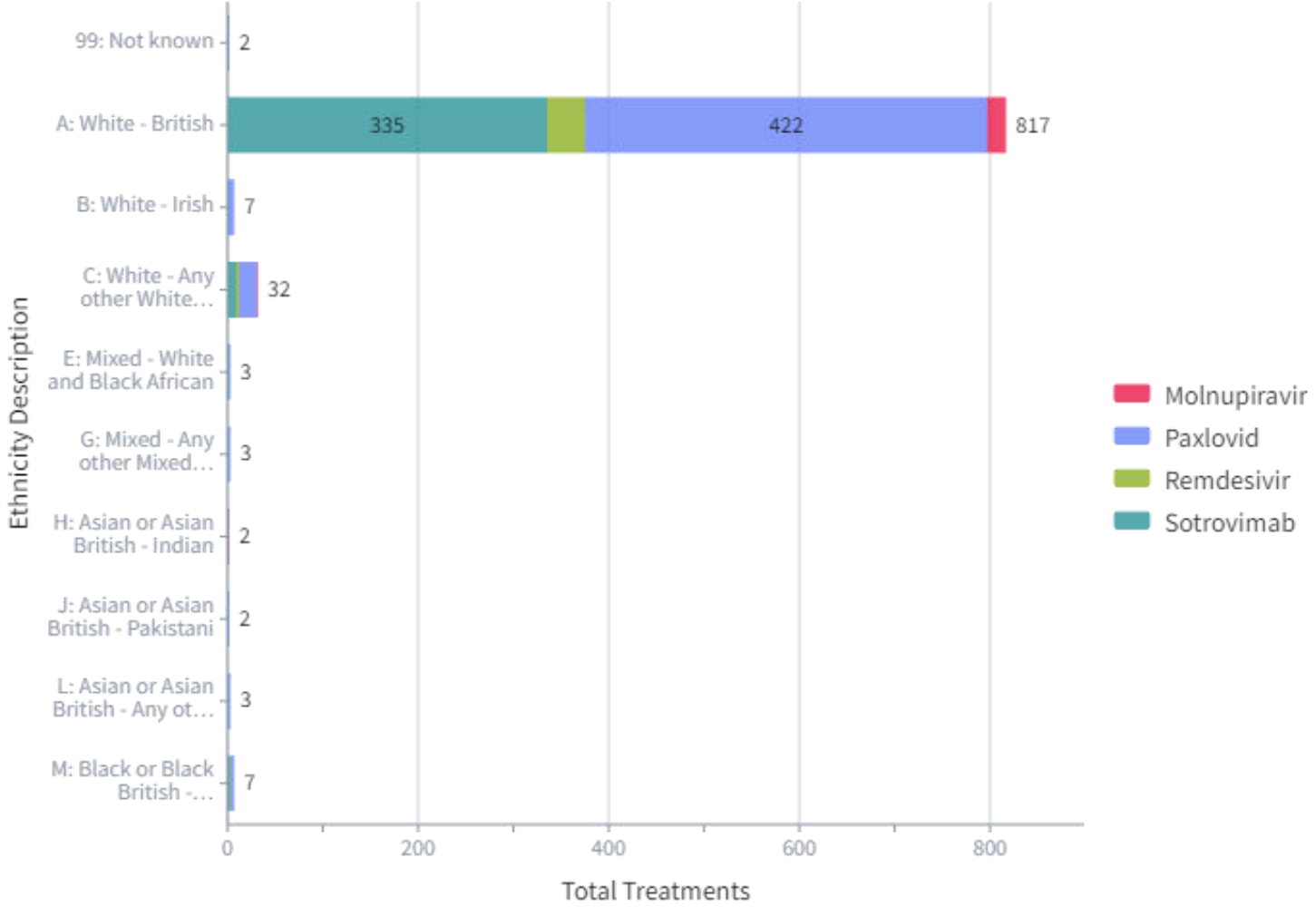
CMDU data and updates: Weekly Number of Referrals Across BNSSG by Area



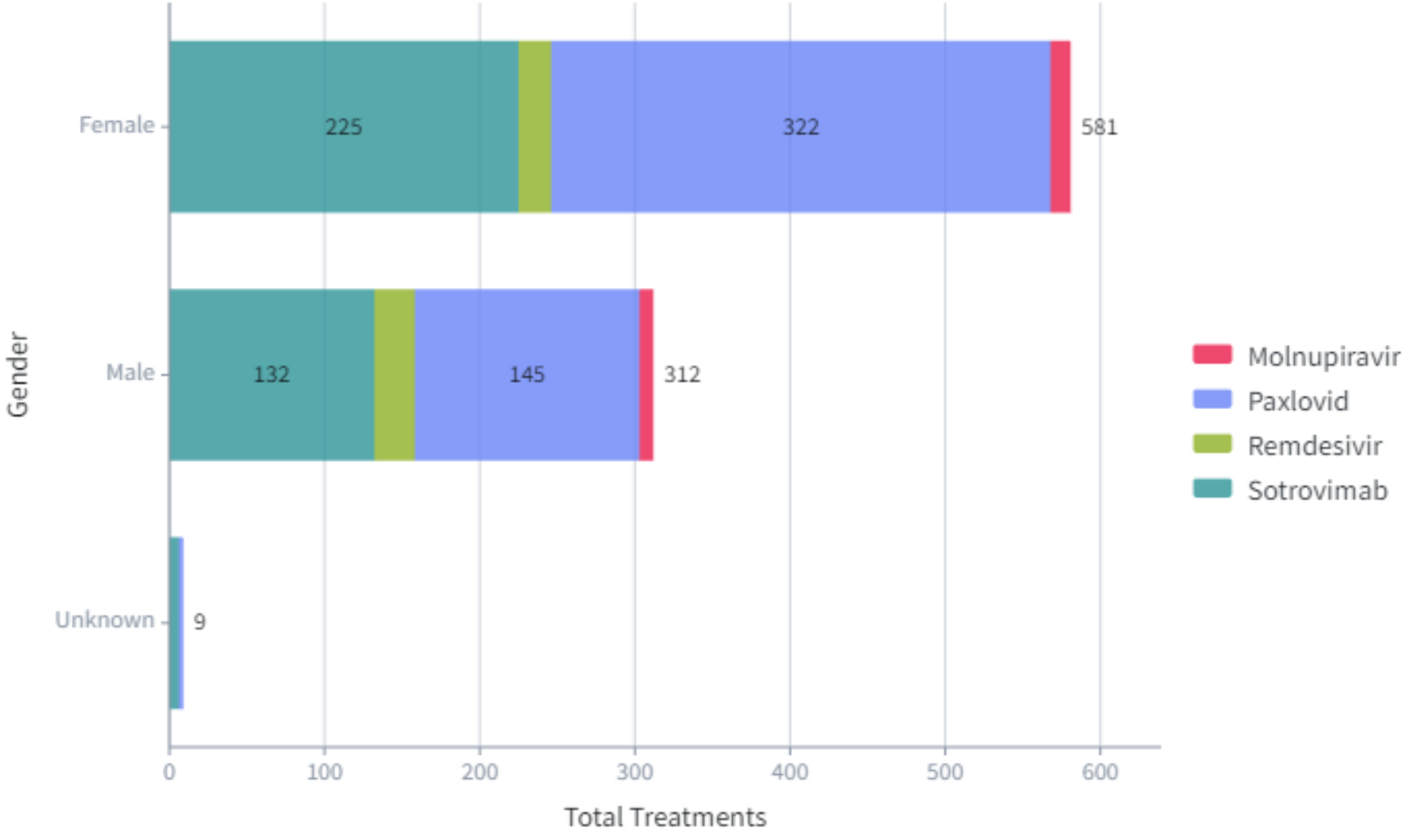
COVID Medicine Delivery Unit (CMDU) Service



CMDU data and updates: Treatments by Ethnicity 1 March 2022 to 9 January 2023



CMDU data and updates: Treatments by gender 1 March 2022 to 9 January 2023



COVID Medicine Delivery Unit (CMDU) Service HIGHLIGHT REPORT

Risks/ Issues (scoring 12 and above)

1. Model currently in place meets Commissioning Framework. Establish and maintaining timely access to COVID-19 therapeutics during the remainder of 2022/23 in preparation for routine provision from April 2023. Routine provision post 4/23 needs to be determined
2. There is a risk that the current model does not have the capacity to meet the demand. Mendip Vale have provided assurance that they have capacity to complete the numbers they have had to date. Numbers are currently manageable but will continue to monitor closely in line with surge planning particularly if numbers increase over what we have seen to date then further support may be required.
3. There are concerns raised regarding staff capacity , volume of work during this period as well as a risk if high staff absence due to Covid/Flu
4. Greater emphasis on health inequalities and ICB/ICS should support equitable access to services. This is an England wide ICS issue. This should consider how the service will maximise the accessibility of therapeutics to eligible patients most at risk of health inequalities despite work plans best indevers individuals may choose not to access treatment and health inequalities may present.
5. The therapeutic options have changed in the updated Interim Clinical Commissioning Policy on 28th November as a system we are determining the relevant options particularly with Remdesivir which has a National shortage supply problem and requires a three consecutive day IV infusion.

Finance

To date the system has used existing COVID-19 funds to run the CMDU service. Funding has now been allocated from October 22-April 23. This government allocated funding will support funding the current model, children's services and support planning post 4/23. In addition to this funding will be used for project support to plan post 4/23, surge planning and inequalities. The total allocation for NHS Bristol, North Somerset and South Gloucestershire ICB is £1,113,860 to cover operational delivery of the service from Oct to March 23 and planning future provision for April 23. It is yet unknown funding from April 23 onwards.

Surge Planning and Outbreak management

With any surges in demand on COVID-19 therapeutic treatment services the ICB will have robust plans in place that enable increases in service capacity as and when required. To aid surge planning, we will test local arrangements for different surge scenarios and have contingency plans to scale access to COVID-19 treatments e.g. mutual aid arrangements, centralised assessment and treatment and “sleeper arrangements”.

A local Issues and risk log contains the full details of all the risks/issues currently identified for the CMDU service is available.

COVID Medicine Delivery Unit (CMDU) Service

Assurances

1. BNSSG has a system wide CMDU service established with membership from all stakeholders with clear governance arrangements in place led by ICB. A system wide clinical governance team remain in place and work in collaboration across the ICS.
2. Continue to work with partners to determine the most appropriate COVID-19 therapeutics service model for BNSSG. Ensuring services are of high quality and use internal governance arrangements, to monitor and assure the quality of services.
3. Working collaboratively to ensure sustainable and scalable services are in place by April 2023, for ongoing access through an NHS business as usual model.
4. National funding agreed with Government as part of updated interim commissioning framework 30/9/22. Allocations have been made on a weighted population basis to fund existing model and planning for April 2023. The total allocation for NHS Bristol, North Somerset and South Gloucestershire ICB is £1,113,860.
5. Communications being used to promote the importance of vaccination and CMDU service to both patients and staff. Rates of circulating COVID-19 and CMDU service uptake also monitored regularly to help ensure a proactive approach can be taken.
6. Collaborating with Population Health Management team and COVID vaccination programme team to tackle health inequalities. In addition to this utilise NHS England's CORE20PLUS approach. Plan to provide targeted outreach to support access for potentially eligible patients at risk of health inequalities as part of transition to routine services by April 2023.
7. ICBs will be asked to submit a high level bi-monthly (every two months) report to NHS England, to: provide assurance that potentially eligible patients in each system continue to have timely access to assessment and treatment update NHS England on the ICBs progress towards transition out of pandemic-specific arrangements, to more routine and local access for patients in the longer-term from April 2023.

Next steps

- CMDU service short life working group established to determine model post 31/3/23
- CMDU service short life working group established to focus on health inequalities
- Ask QPOC members to continue with support from their organisations for this service and with ongoing planning for sustainable service from 4/23

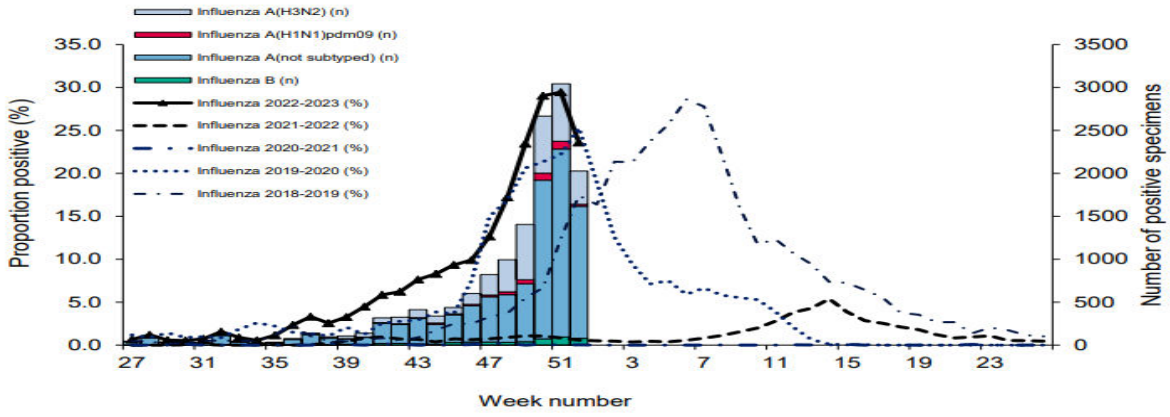
BNSSG SYSTEM FLU UPDATE 2022/23	Reporting Period: Up to 9th January 2023	
Governance: The BNSSG Flu Group will report to BNSSG Mass Vaccination Programme Partnership Board and BNSSG Outcomes, Performance & Quality Committee	**Report for:** Relevant internal/external committees.	**Written by:** Debbie Campbell, Lisa Rees, Mihai Diaconu

Key Highlights

- Circulating flu remains high, the following chart shows the positivity rates for England.

- Data overall continues to show a positive uptake rate for the 65years and over cohort and we have now achieved 83.4% as per 1st January (week 52). The 'at risk' cohort is showing an uptake of 51.3% with variation in uptake showing between the different 'at risk' cohorts as well as between PCNs. Uptake in the 2 and 3 year olds (49.6%) and pregnancy cohorts (39.8%) are showing slight improvements but remain as areas for potential improvement. The BNSSG uptake shows a similar uptake to the South West picture but slightly higher uptake than England.

Figure 10: Respiratory DataMart samples positive for influenza and weekly positivity (%) for influenza, England



- A pilot took place in November/December to deliver the flu vaccine to 2 and 3 year olds via clinics in children centres in Hartcliffe and Bedminster in collaboration with the Swift PCN. Also clinics in the Malcolm X Community Centre in collaboration the BNSSG programme vaccination team alongside the Sirona School Immunisation team were piloted. These clinics highlighted that the concept of a convenient, familiar setting for vaccination was acceptable. Although using the collaboration agreement allowed PCN working for the first time for this vaccine, further conversations are required with NHS England to ensure a vaccine offer that is accessible to all is available next season and this has been taken forward with NHS England.

- Despite best endeavours health care staff uptake remains lower than target. Social Care staff uptake also remains low. System partners have met to support uptake in this area and address any barriers to social care staff (both Care Home and Domiciliary staff) to come forward for vaccination. A cross-system film featuring staff members from most organisations within the BNSSG health system, across a wide range of roles was shared to support organisations in BNSSG with their staff vaccination campaigns. A follow up communications campaign has also been released which included videos from local GPs: Worried about having flu and Covid-19 vaccines together? and Thank you for getting vaccinated

- Ongoing positive results seen by the outreach work, with 425 adult Flu vaccinations being delivered as per 05/01/23.
Opportunistic Flu vaccines continue to be offered as a pilot at the UWE Vaccination Centre to those eligible people presenting for their Covid booster vaccination, this pilot received good uptake and feedback. Community pharmacy uptake data showing a positive uptake this season.

- The JVCI have now issued advice on the flu vaccines recommended for 2023/24, however, as NHS England has not yet issued their letter confirming reimbursement, providers have been advised if orders are placed with manufacturers for next flu season then they should be covered by a clause allowing amendment or cancellation of orders if needed.

FLU VACCINATION UPDATE

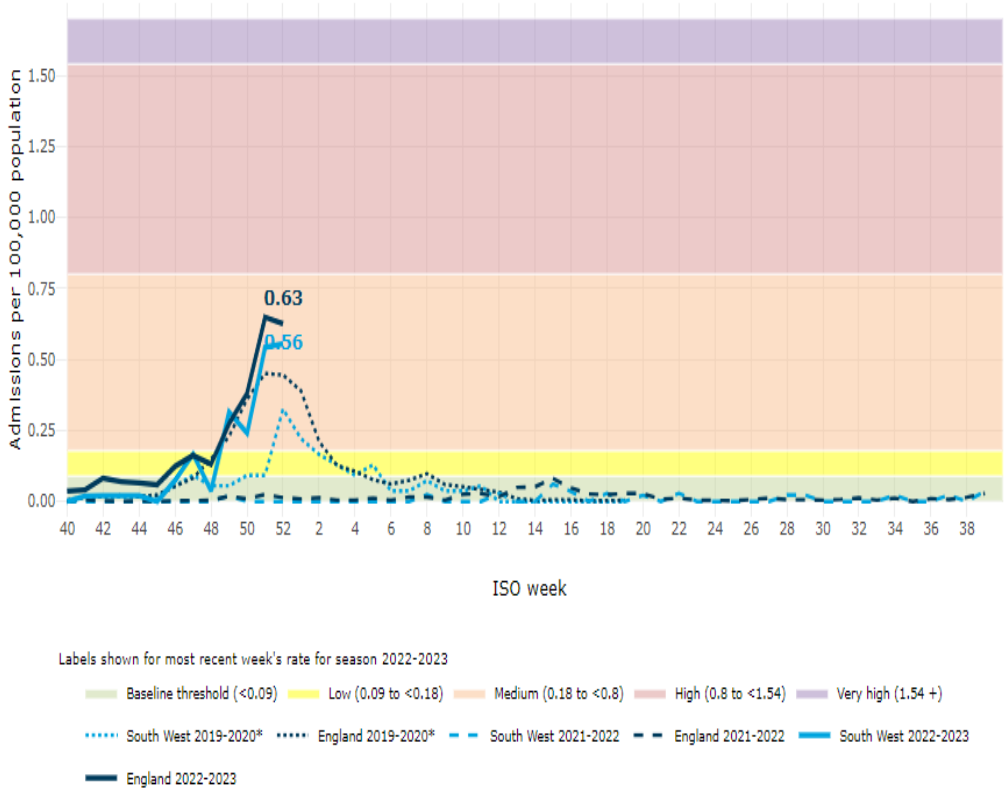
Influenza and ILI - South West Summary –Week 52 2022 (26/12/2022 to 01/01/2023)

- The percentage positivity for Influenza A decreased in the South West (28.0% to 20.7%), and in England (28.5% to 22.6%) between week 51 2022 and week 52 2022. The percentage positivity for Influenza B in the South West (0.3%) and England (0.9%) remained low.
- The number of cases of influenza A in week 50 (n=1308) decreased in the South West compared to the previous week (n=2558), whilst the number of cases of influenza B (n=16) increased slightly compared to the previous week (n=13).
- Hospital admission rates for confirmed influenza increased substantially in the South West (to 24.4 per 100,000 population), but decreased in England (to 8.3 per 100,000 population) in week 52.
- ICU/HDU admission rates for confirmed influenza remained stable in the South West (0.56 per 100,000 population) and slightly decreased in England (0.63 per 100,000 population).

Ref: UKHSA Regional Acute Respiratory Virus Report - 5/1/23.

Hospital admissions –ICU/HDU with confirmed Flu

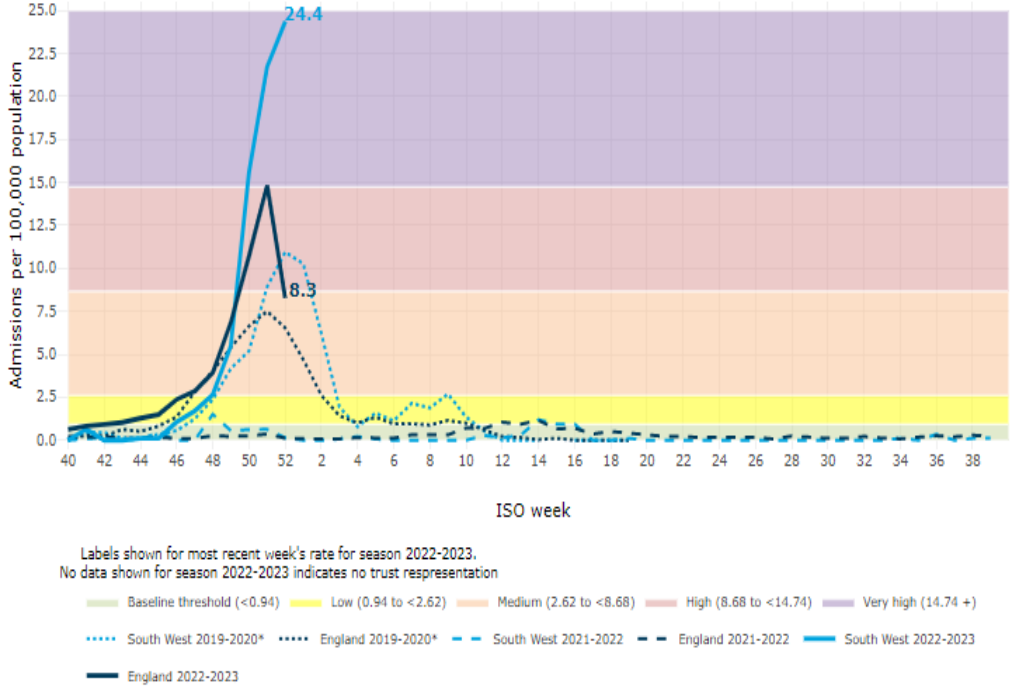
Figure 4. ICU/HDU admissions with confirmed influenza with MEM thresholds – SARI Watch (Mandatory Surveillance)



Hospital admissions with confirmed Flu

Figure 3. Hospital admissions with confirmed influenza with MEM thresholds – SARI Watch (Sentinel Surveillance)

Please note: Caution is needed in interpreting the most recent data as this may have been affected by reduced trust returns over the holiday period. Additionally, rates in some regions may not include all influenza surveillance sentinel sites from week to week.



FLU VACCINATION UPDATE

Frontline Health Care Worker (FHCW) vaccine uptake

- UHBW continue to offer both a roving vaccination and a clinic model and are tailoring their approach in response to what the data is showing. Vaccination slots have been offered between 07:30 - 18:00 to ensure all staff can access vaccination including night staff who could access vaccination either before or after their shift. Vaccination slots also available for weekend staff. A system has been put in place for staff to self declare if vaccinated elsewhere as well as support staff on maternity leave. A big focus is planned to promote the vaccine to staff in the last week in January.

- NBT offer a range of clinics as well as a roving model. They undertook a 5am trial where 75 staff members were vaccinated. Another 5am session will take place to support uptake. There have been weekend appointments for weekend staff (offer over last 6 weeks but numbers starting to decline now at weekend clinics). The next stage will be night session appointments to support night staff. Staff on maternity leave are also being contacted.

- AWP are utilising the Vaccination Track system to vaccinate staff via booked clinics as well as via peer vaccinators. AWP have offered a financial incentive to staff who come forward for vaccination this year. Communications are ongoing to staff and recoding of vaccinations via other providers e.g. GP are being recorded. Bespoke clinics continue and walk wards now in place to support their staff vaccination offer.

- Sirona's staff campaign is supported by the Vaccination Track system with staff being able to access the flu vaccine whilst receiving their Covid vaccination booster via community base clinics. Clinics allow drop in options to support uptake. Data breakdown is being reviewed regularly and targeted communications issued to staff. A roving model is now being considered to target those staff who are unable to be released from their clinical activities as well as an ongoing review of ESR data to offer vaccine to those on maternity leave and bank staff. A successful communications campaign has also taken place with weekly messaging to staff as well as internal review meetings.

- Health and Social Care staff employed by a registered residential care or nursing home or registered domiciliary care provider, employed by Direct Payments or by a voluntary managed hospice who are directly involved in the care of vulnerable patients or clients who are at increased risk from exposure to influenza are able to access Flu vaccinations via their GP or community pharmacies. A letter has been sent to care home staff to encourage them coming forward for vaccination and to highlight if they have any access issues. A drop in vaccination clinic for social care staff was offered by one GP practice in South Gloucestershire. Insight work is ongoing to understand any barriers in relation to domiciliary care staff accessing vaccinations and targeted communications issued.

Vaccine uptake as reported by providers

**Note delay on Immform system in relation to Trust data so reported data based on trust feedback.

Provider	Flu vaccination uptake
NBT	69% up to 10th January 23 (overall uptake figure covering all staff)
UHBW	57% as per 9th January 23 (overall uptake figure covering all staff)
SIRONA	76% as per 9th January 23 (overall uptake figure covering all staff)
AWP	51% as per 9th January 23 (overall uptake figure covering all staff)

Social care uptake

	Percentage vaccinated
Residents	86.9%
Staff (permanent)	22.2%
Staff (Agency)	11.4%
Staff (Dom Care)	12.6%

Data from Care Tracker as per 04/01/23

Note the Care Tracker data is subject to some limitations such as reporting delays, a reliance on staff informing their employer of vaccination elsewhere and the employer adding to system, however this is unlikely to have a significant effect on uptake.

FLU VACCINATION DATA

Vaccination data and updates

Eligible cohort	Uptake as per 01/01/23	South West Average uptake as per 01/01/23	England Average uptake as per 01/01/23	BNSSG Uptake at end of 21/22 season
65 years and above	83.4%	82.3%	78.4%	83%
At risk	51.3%	51.8%	46.3%	55.7%
Pregnancy	39.8%	39.4%	33.2%	42%
2 and 3 year olds	49.6%	49.2%	41.1%	55.3%
50-64 years	55.3%	46.7%	38.8%	58.3%

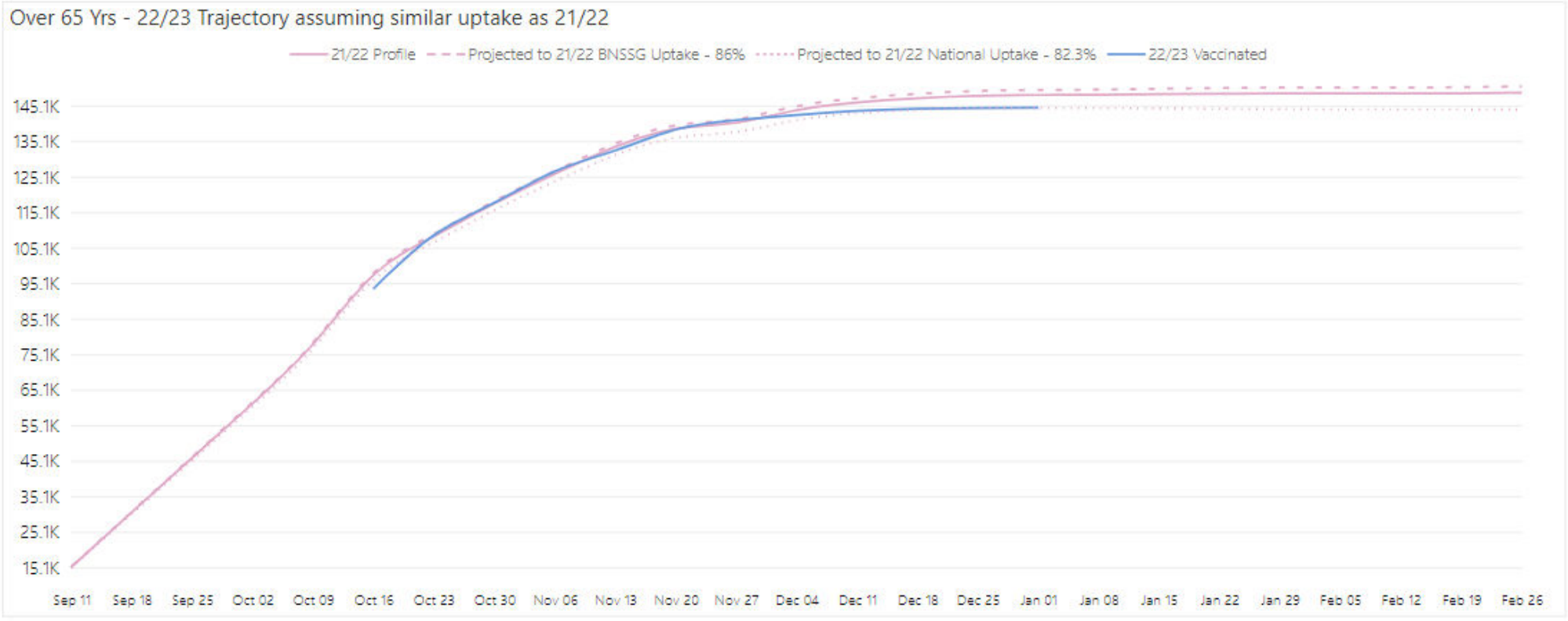
- Data as per week ending 01/01/2023, Immform

FLU VACCINATION DATA

Vaccination data and updates

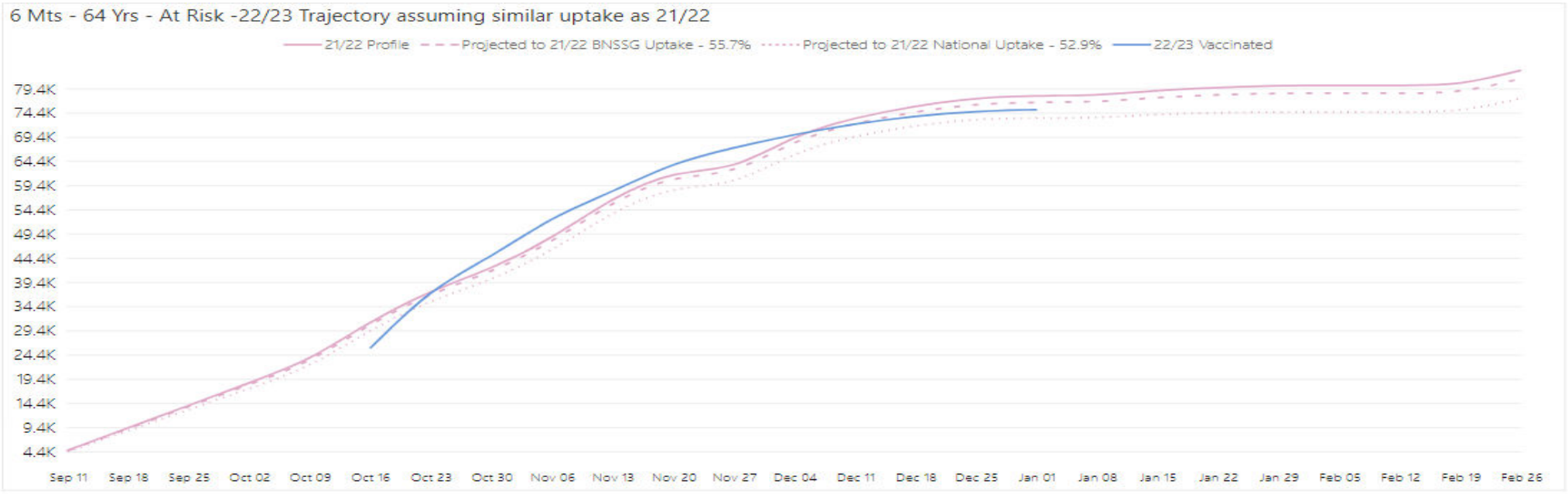
- Intention to reporting flu and Covid booster vaccination data together, with delivery trajectories, supported by matrix working between system analysts from the ICB BI team, OneCare and the PHE Screening and Immunisation team
- Vaccination data is also available through the PHE Immform website and the system wide dataset.
- A trajectory has been developed to support the identification of areas which would benefit from additional focus and support.
- The uptake pattern is derived from the 21/22 uptake rate using data from the Immform database. It has been adjusted to reach the 22/23 target.
- The data below reflect the information on Immform as per 01/01/2023

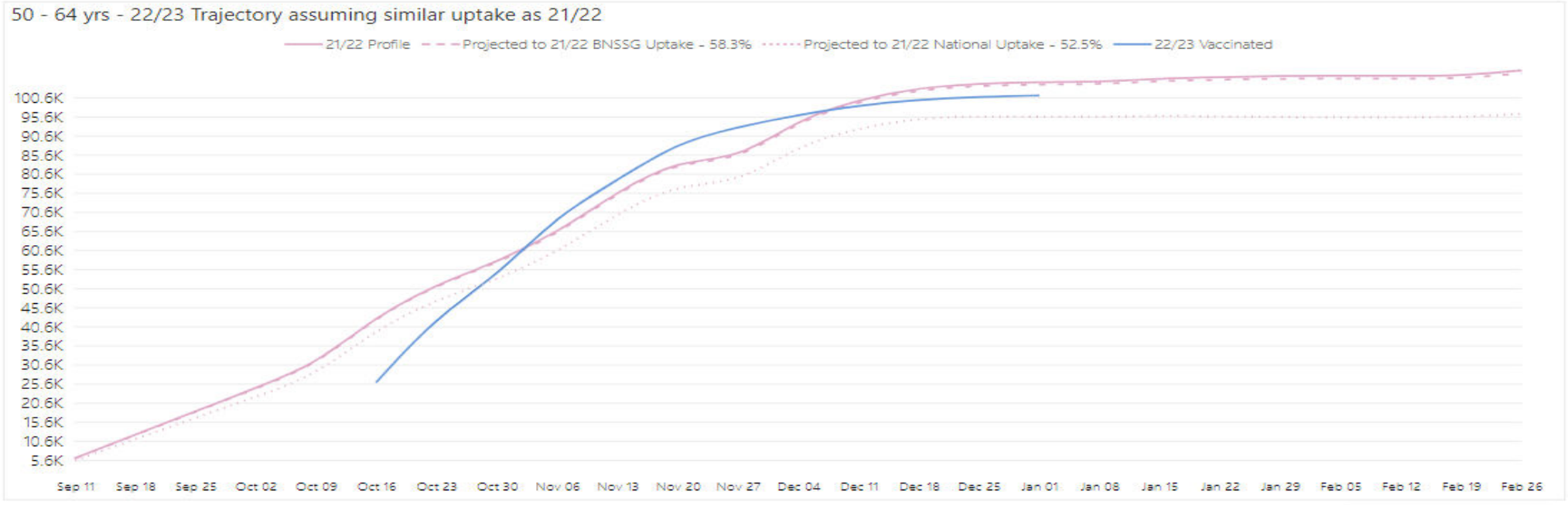
<u>65 years and above</u>



FLU VACCINATION IN PRIMARY CARE

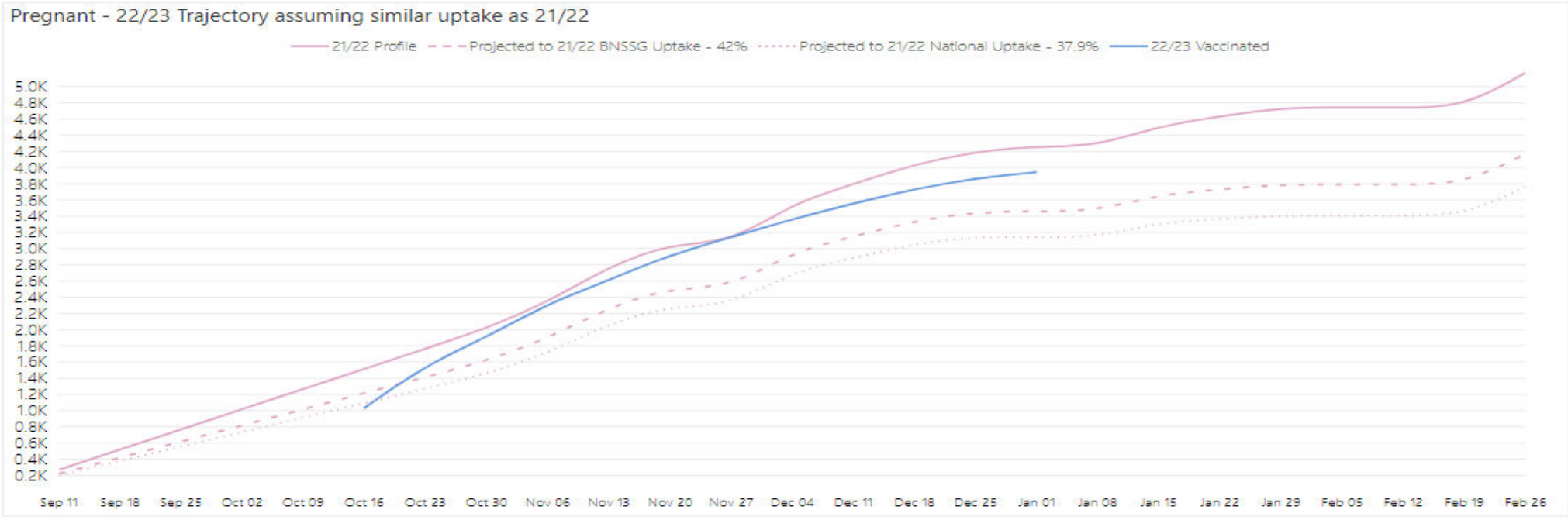
Vaccination data and updates

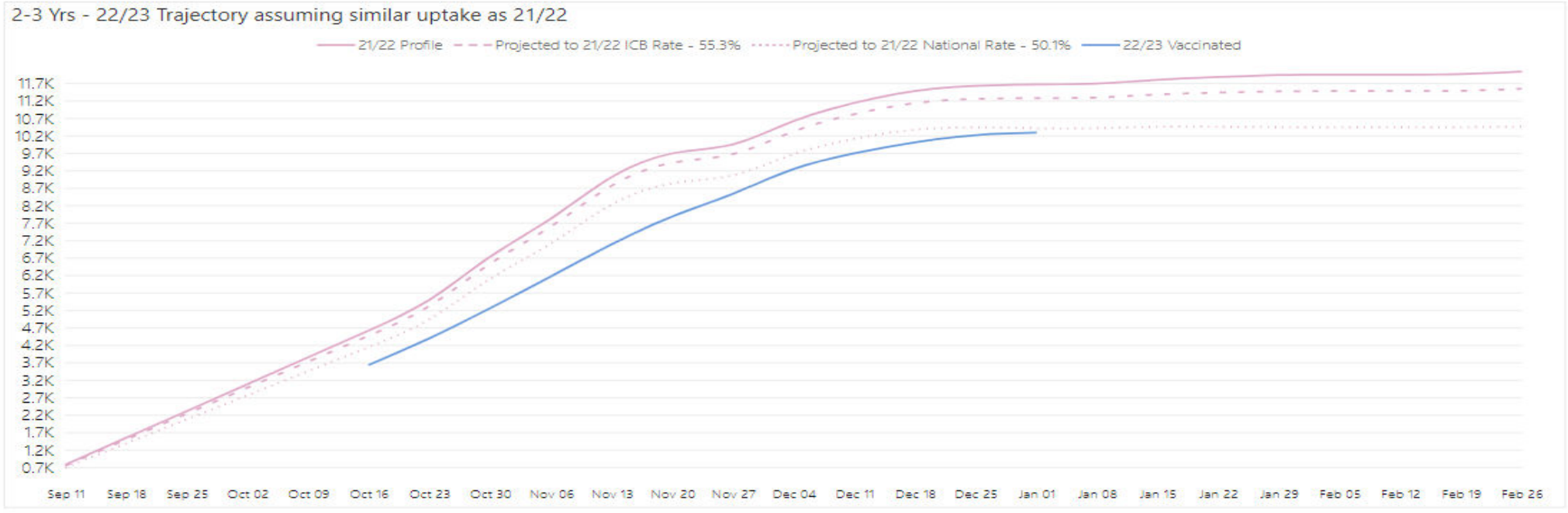




FLU VACCINATION IN PRIMARY CARE

Vaccination data and updates





FLU VACCINATION UPDATE

Communication plans

This season, we have brought together communication planning activity for flu and mass vaccination messaging, and share channels and collateral and resource to continuously develop messaging and tactics. Our aims for communication and engagement this year are to:

- Support our system to meet targets for take-up of the flu vaccination among priority groups
- Ensure equitable uptake among BAME communities, hard-to-reach groups and people living in the most deprived areas
- Encourage staff to have the flu vaccination and act as 'ambassadors' for the vaccination to patients.

Recent communications have included the development of a cross-system film featuring staff members from most organisations within the BNSSG health system, across a wide range of roles. This film includes their personal reasons for getting vaccinated. Based on evidence of lower vaccination uptake among some minority ethnic communities (staff and members of the public) there is an emphasis on black and minority ethnic staff members. As vaccine uptake continues to remain low further resources have been developed to continue to promote vaccination as the first line of defence this winter. This includes videos from local GPs: Worried about having flu and Covid-19 vaccines together? and Thank you for getting vaccinated
Local questions and answers have been developed and shared addressing concerns about the Covid-19 and flu vaccinations. This has been translated into 10 core languages spoken in our area, plus British Sign Language.

A campaign to support the 2 and 3 year old flu campaign has also been developed 'Flu: 5 reasons to vaccinate your child' which highlights the importance of having a flu vaccination to protect not just your child, but also your friends and family and minimise the impact that flu can have on both home and work life. This includes: Artwork that can be printed as a poster or leaflet, a PowerPoint presentation for use display screens (available in English, Arabic, Mandarin, Urdu, Somali, Polish and Romanian) as well as newsletter copy and social media posts. This work has been further supported by a news report on the BBC and on ITV which involved a case study of a child who needed to be admitted to PICU due to Influenza A.

Other communications undertaken included a local GP being interviewed on BBC Radio Bristol's drivetime show, covering Covid-19 and flu vaccination. A BBC Points West piece also encouraging people 'at risk' and aged 50-64 years to come forward for vaccination by vaccinating a gentleman who is immunosuppressed as part of the piece. A press release on vaccinations has also been written using the world cup angle to ensure different patient groups are targeted. Social media has also been used to promote vaccination to those in clinical at-risk groups as well as pregnant women.

Further communications are planned in January to highlight that it isn't too late to get vaccinated, especially those with long term conditions.

FLU VACCINATION UPDATE

Maximising Access

It has been agreed that it would be important to continue the outreach flu vaccine clinic work from last season working in conjunction with the outreach team delivering the covid vaccinations. In order to do this most effectively, there are representatives from the BNSSG System Flu group who are part of the maximising access programme group to ensure both vaccination programmes are aligned and that lessons learnt are taken forward.

Currently there are a small number of community pharmacists who have been supporting the provision of flu vaccine at outreach covid clinics with the co-delivery of flu vaccines.

425 Adult Flu vaccines have been provided since the start of the 2022/23 flu season to 05/01/23 via the outreach vaccination clinics.

A pilot took place at the UWE vaccination centre to offer Flu vaccination opportunistically alongside the Covid vaccination and positive feedback has been received from those who used the clinic. NHS England have also recently agreed for the Flu vaccine to be offered from the UWE outreach sub clinics to support uptake.

The Sirona School Immunisation team have held a successful flu vaccination clinic in the Totterdown Mosque in addition to their usual school clinics to ensure good vaccine access to all communities. Catch up clinics are available in a variety of clinic venues to ensure accessibility.

A small number of vaccination pilot clinics have taken place in November/December to support the uptake of flu vaccination in the 2 and 3 year old cohort. One pilot looked at offering the flu vaccine from Children Centres in Hartcliffe and Bedminster in collaboration with Swift PCN. The programme vaccination team supported the Bedminster clinic. The pilot also reviewed the offer of flu vaccine from the Malcolm X Community Centre supported by the BNSSG Programme Vaccination team and Sirona School Immunisation team. This clinic currently offers the covid vaccination and so the flu vaccination was an addition and tested a ‘family clinic’ model. Initial feedback from the children's centre clinics suggested that the accessibility and familiarity of the children's centre to families was seen as a positive feature of these clinics. These clinics had support from Caafi Health and translated resources to best support the local communities.
Discussions around other vaccines in addition to Flu also took place which was helpful to support families and alleviate any worries. Due to additional vaccine stock, drop-in clinics were also held at the UWE vaccination centre over the festive period to further support the vaccination offer to this cohort.

FLU VACCINATION HIGHLIGHT REPORT

Mitigation plans

- Ongoing monitoring of vaccine uptake has allowed us to make data led interventions for our local population. This has included targeted communications to the groups where uptake is lower and the delivery of pilot clinics in different settings to GP practices to try and improve uptake in 2-3 year olds. Also targeted communications have been issued to support at risk groups and the pregnancy cohort.
- Flu is now integrated within the maximising access group for delivery, and this group looks at delivering both vaccines in outreach settings. Work will be ongoing to embed much of the innovation from the maximising uptake work and learning from this Flu season into integration plans following BNSSG being selected as a 'demonstrator' sites for integrated vaccinations.

Outbreak management

Every year, the local antiviral pathway is reviewed to ensure it is robust and current for the forthcoming flu season. An Expression of Interests exercise was undertaken offering a contract for a longer period of 2.5 years, as a result the current provider was offered the contract and the local pathway updated . A scenario exercise with stakeholders is planned for mid January. Following the recent high levels of influenza circulation, a small number of care home outbreaks have been noted and actioned.

Risks/ Issues (scoring 12 and above)

1. Risk that covid and flu infections will increase, which may affect uptake rates as both staff and patients may miss appointments due to illness. This risk may be increased as the national service specification no longer includes vaccination of staff and that this would now fall under an occupational health offer (with the exception of some groups). If staff are not vaccinated there is a risk they could contract flu.

2. There is a risk of continued low vaccine uptake in all health and social care staff in particular in the social care staff group that could lead to high staff sickness and impact on service provision and direct impact on patients.

3. Pregnancy cohort showing lower vaccine uptake, risk may not increase, putting them at increased risk of illness.

Assurances

1.Communications being used to promote the importance of vaccination to both patients and staff. Rates of circulating flu and vaccine uptake also monitored regularly to help ensure a proactive approach can be taken. Patient and staff feedback also monitored.

2.All stakeholders working together to try to increase social care uptake and identify and barriers to vaccination. Communications issued. Plans already in discussion for 23/24 season.

3. Targeted communications such as leaflet including all pregnancy related vaccinations, Also ensure offer of vaccination via midwifes as well as pharmacies and GPs.

A local Issues and risk log contains the full details of all the risks/issues currently identified for the flu vaccination programme.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Performance & Activity Report

January 2023

Created by

Gary Dawes

BI Performance Team

Contents

1 Executive Summary

- Overall, BNSSG Trusts' 4hr A&E performance worsened from 56.7% to 54.1% in December but is better than the national average for Type 1 EDs of 49.6%. 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 87,481 in October to 80,290 in November. BNSSG performance of 64.7% was ranked 8th out of 42 ICBs nationally (down from 7th in October) 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 5386 in October to 4,761 in November – 5.9% of the total waiting list. The number decreased at both NBT and UHBW. The BNSSG position is driven mainly by waits at NBT (2,440) and UHBW (1,831), with the remaining 490 breaches split across 48 other providers. Focused work to facilitate elective recovery ambitions are being implemented.
- The number of BNSSG patients waiting over 78 weeks decreased from 799 in October to 552 in November. The number decreased at NBT but increased at UHBW. The BNSSG position is driven mainly by waits at NBT (249) and UHBW (240). The remaining 63 breaches are split across 16 other providers, with the majority at Spire Bristol (23) and RUH (11).
- The number of BNSSG patients waiting over 104 weeks decreased from 99 in October to 16 in November. The number decreased at both NBT and UHBW. The BNSSG position is driven by waits at NBT (9), UHBW (3), Emersons Green (2) and Royal Devon (2).
- 2 week wait cancer performance improved in November to 47.13% for the BNSSG population. Performance improved at NBT but worsened at UHBW. The 93% national standard has not been achieved at population level since June 2020.
- 28 day faster diagnosis standard for BNSSG cancer patients improved in November to 52.52% for the BNSSG population. Performance improved at NBT but worsened at 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 November to 51.13%. Performance worsened at both NBT and UHBW. The 85% national standard has not been achieved at population level since April 2019.
- **Please note:** The four bullet points above regarding RTT waiting lists show the nationally published November figures. However, the November figures do not represent the true number as Sirona Care and Health did not make an RTT submission in November and therefore their figures are not included in the BNSSG totals shown above. In October, Sirona reported the following: Total waiting list of 5,959, 389 x 52+ week waiters, 168 x 78+ week waiters and 69 x 104+ week waiters. The actual reduction in the BNSSG waiting list and long waiters between October and November is less than officially reported.

2.1 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%	Nov-22	41.37%	19.47%	17.42%	39.18%	22.72%	34.05%	35.65%	26.87%	7	2	1	6	3	4	5	4	→
A&E 4 Hour Performance	95%	Dec-22	68.98%	70.83%	68.85%	72.05%	68.53%	63.10%	55.72%	65.05%	3	2	4	1	5	6	7	6	→
A&E 12 Hour Trolley Waits	0	Dec-22	461	382	781	681	165	2003	1674	54,532	3	2	5	4	1	7	6	6	↓
RTT Incomplete 18 Weeks	92%	Nov-22	61.65%	57.56%	70.98%	57.96%	61.75%	64.72%	52.94%	60.07%	4	6	1	5	3	2	7	2	→
RTT Incomplete Total		Nov-22	93,634	93,234	65,013	65,186	58,791	80,290	159,864	6,926,635	68.2%	69.2%	25.9%	83.2%	63.0%	57.9%	89.0%	72.0%	↑
RTT Incomplete 52 Week Plus	0	Nov-22	4,294	4,536	1,472	4,961	2,820	4,761	16,270	379,316	3	4	1	6	2	5	7	6	↑
RTT 52 weeks + (% of waiting list)		Nov-22	4.59%	4.87%	2.26%	7.61%	4.80%	5.93%	10.18%	5.48%	2	4	1	6	3	5	7	5	→
RTT 78 weeks + (% of waiting list)		Nov-22	0.25%	0.49%	0.12%	1.45%	0.51%	0.69%	1.86%	0.65%	2	3	1	6	4	5	7	5	→
RTT 104 weeks+ (% of waiting list)		Nov-22	0.01%	0.01%	0.01%	0.18%	0.02%	0.02%	0.26%	0.02%	2	3	1	6	5	4	7	5	↑
Cancer 2 Week (All)	93%	Nov-22	75.65%	62.63%	87.84%	72.87%	52.71%	47.13%	69.67%	78.77%	2	5	1	3	6	7	4	7	→
Cancer 2 week (Breast)	93%	Nov-22	87.47%	93.90%	96.75%	65.60%	48.37%	73.21%	48.80%	75.26%	3	2	1	5	7	4	6	7	↑
Cancer 31 Day Wait First Treatment	96%	Nov-22	90.49%	96.34%	94.32%	95.07%	91.44%	91.74%	91.81%	91.56%	7	1	3	2	6	5	4	6	↑
Cancer 31 Day Wait - Surgery	94%	Nov-22	86.79%	81.52%	78.02%	84.55%	85.26%	78.23%	87.05%	81.04%	2	5	7	4	3	6	1	2	↓
Cancer 31 Day Wait - Drug	98%	Nov-22	100.00%	100.00%	99.41%	99.47%	99.24%	100.00%	96.61%	98.18%	1	1	5	4	6	1	7	1	→
Cancer 31 Day Wait - Radiotherapy	94%	Nov-22	97.24%	99.20%	88.31%	100.00%	98.04%	98.84%	98.18%	90.21%	6	2	7	1	5	3	4	1	↓
Cancer 62 Wait Consultant	N/A	Nov-22	75.70%	82.24%	73.08%	66.67%	81.91%	81.55%	62.26%	75.47%	4	1	5	6	2	3	7	6	↑
Cancer 62 Wait Screening	90%	Nov-22	92.31%	74.47%	89.29%	47.62%	86.67%	54.17%	64.71%	67.06%	1	4	2	7	3	6	5	6	→
Cancer 62 Day Wait - GP Referral	85%	Nov-22	66.56%	66.44%	63.64%	67.71%	50.00%	51.13%	63.31%	61.00%	2	3	4	1	7	6	5	7	↑
Cancer 28 FDS	75%	Nov-22	71.40%	65.86%	76.68%	71.94%	62.10%	52.52%	70.77%	69.68%	3	5	1	2	6	7	4	7	→

2.1 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	Dec-22	00:24:18	00:21:18	00:24:24	00:30:18	00:25:30	00:19:12	00:22:54	00:23:42	4	2	5	7	6	1	3	1	→
Category 1 - Average Duration (hr:min:sec)	00:07:00	Dec-22	00:13:30	00:11:48	00:13:36	00:16:42	00:14:06	00:11:30	00:12:48	00:13:12	4	2	5	7	6	1	3	2	↑
Category 2 - 90th Percentile Duration (hr:min:sec)	00:40:00	Dec-22	08:02:36	04:07:54	04:44:48	09:39:00	05:04:30	07:25:12	07:27:42	06:39:36	6	1	2	7	3	4	5	4	→
Category 2 - Average Duration (hr:min:sec)	00:18:00	Dec-22	03:10:06	01:41:48	01:57:48	03:38:30	02:14:06	02:49:24	03:01:12	02:39:12	6	1	2	7	3	4	5	3	↓
Category 3 - 90th Percentile Duration (hr:min:sec)	02:00:00	Dec-22	15:21:06	12:28:54	13:01:00	13:09:12	15:51:06	16:56:54	18:15:00	15:34:42	4	1	2	3	5	6	7	7	↑
Category 3 - Average Duration (hr:min:sec)		Dec-22	05:25:30	04:41:18	04:58:36	05:05:06	06:28:00	06:20:36	06:39:42	05:45:06	4	1	2	3	6	5	7	6	↑
Category 4 - 90th Percentile Duration (hr:min:sec)	03:00:00	Dec-22	13:26:54	10:17:36	15:05:54	08:57:06	00:58:00	14:35:36	17:38:48	14:35:36	2	1	4	7	6	3	5	5	↑
Category 4 - Average Duration (hr:min:sec)		Dec-22	05:57:00	03:30:00	05:52:54	08:30:12	06:39:18	04:46:48	06:01:12	05:28:06	4	1	3	7	6	2	5	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	Nov-22	210	80	299	55	348	381	240	388	3	2	5	1	6	7	4	7	→
% Triaged Calls receiving Clinical Contact	50%	Nov-22	0.0%	36.9%	44.9%	74.8%	73.0%	51.0%	43.1%	47.5%		6	4	1	2	3	5	3	→
% of callers allocated the first service offered by DOS	85%	Nov-22	0.0%	67.7%	68.2%	33.2%	66.2%	67.7%	64.5%	55.6%		2	1	6	4	3	5	2	↓
% of Cat 3 or 4 ambulance dispositions validated within 30mins	50%	Nov-22	0.0%	70.6%	63.4%	47.8%	71.5%	56.3%	65.0%	25.7%		2	4	6	1	5	3	5	→
% of calls initially given an ED disposition that are validated	50%	Nov-22	0.0%	80.0%	17.4%	93.8%	69.5%	21.0%	18.7%	39.7%		2	6	1	3	4	5	4	→
Abandonement Rate for 111 Calls	3%	Nov-22	9.8%	3.7%	22.2%	2.8%	21.3%	19.4%	9.9%	20.3%	3	2	7	1	6	5	4	5	→

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.

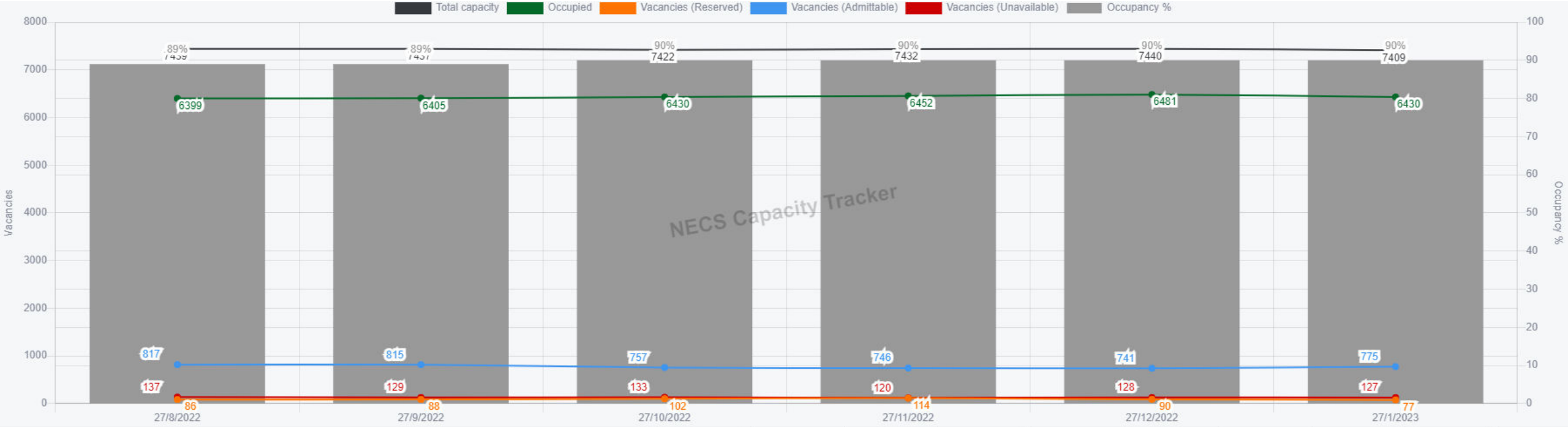
2.2 Urgent Care – Summary Performance - December

Theme	Urgent and Emergency Care metrics	Reporting level	Period	Standard	Latest	Previous	Variance	Change	19/20	Variance	Change	Better is…
Pre hospital	Mean 999 call answering time (seconds)	SWASFT	Dec-22	5	126	27	99	▲	9	117	▲	▼
	Category 2 Response time - Mean (minutes)	BNSSG ICB	Dec-22	18	169	50	119	▲	30	139	▲	▼
	Category 2 Response time – 90th centile (minutes)	BNSSG ICB	Dec-22	40	445	116	329	▲	64	381	▲	▼
	Percentage of conveyances to ED by 999 ambulances	BNSSG ICB	Dec-22	TBC	30.7%	41.0%	-10.3%	▼	50.0%	-19.3%	▼	▼
	Percentage of NHS 111 calls assessed by a clinicial or clinical advisor	BNSSG ICB	Dec-22	50%	52.7%	51.0%	1.7%	▲	51.8%	0.9%	▲	▲
	Percentage of NHS 111 Calls Abandoned	BNSSG ICB	Dec-22	3%	48.8%	18.0%	30.8%	▲	6.7%	42.1%	▲	▼
A&E	Percentage of Ambulance Handovers within 15 minutes	BNSSG Trusts	Dec-22	65%	11.0%	16.1%	-5.1%	▼	61.4%	-50.4%	▼	▲
	Ambulance Handovers - Average Time Lost per day >15 mins (Hours)	BNSSG Trusts	Dec-22	TBC	413	208	205	▲	7	18	▲	▼
	Time to Initial Assessment – percentage of patients assessed within 15 minutes of arival at A&E	NBT	Dec-22	TBC	64.3%	68.2%	-3.9%	▼	66.8%	-2.5%	▼	▲
		BRI	Dec-22	TBC	52.0%	54.7%	-2.7%	▼	57.7%	-5.7%	▼	▲
		Weston	Dec-22	TBC	33.3%	36.6%	-3.3%	▼	8.1%	25.1%	▲	▲
	Average (mean) time in Department – non-admitted patients (hh:mm)	NBT	Dec-22	TBC	4:55	4:20	-0:25	▼	3:03	1:51	▲	▼
		BRI	Dec-22	TBC	6:27	5:32	-0:34	▼	3:35	2:51	▲	▼
		Weston	Dec-22	TBC	4:58	4:45	0:12	▲	3:27	1:30	▲	▼
Hospital	Hospital Average (mean) time in Department – admitted patients (hh:mm)	NBT	Dec-22	TBC	17:21	12:28	-0:03	▼	7:11	10:09	▲	▼
		BRI	Dec-22	TBC	11:27	8:56	-1:33	▼	6:00	5:27	▲	▼
		Weston	Dec-22	TBC	19:23	15:40	-1:33	▼	7:31	11:52	▲	▼
Whole System	Percentage of patients spending more than 12 hours from Arrival in A&E	NBT	Dec-22	2%	15.8%	11.0%	4.8%	▲	4.0%	11.8%	▲	▼
		BRI	Dec-22	2%	15.7%	10.8%	4.9%	▲	3.4%	12.4%	▲	▼
		Weston	Dec-22	2%	19.6%	16.6%	3.0%	▲	7.4%	12.2%	▲	▼
	Number of patients spending more than 12 hours in A&E from a Decision To Admit	BNSSG Trusts	Dec-22	0	2003	1296	707	▲	134	1869	▲	▼
		NBT	Dec-22	0	786	433	353	▲	2	784	▲	▼
		UHBW	Dec-22	0	1217	863	354	▲	132	1085	▲	▼
	Percentage of patients waiting 4 hours or less in A&E	BNSSG Trusts	Dec-22	95%	54.1%	56.7%	-2.6%	▼	74.7%	-20.5%	▼	▲
		NBT	Dec-22	95%	55.6%	57.9%	-2.3%	▼	74.6%	-19.0%	▼	▲
		UHBW	Dec-22	95%	53.4%	56.2%	-2.8%	▼	74.7%	-21.2%	▼	▲

- 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

Data source: NECS Capacity Tracker

2.2 Urgent Care – Care Homes Occupancy Report



Sub ICB	Maximum Capacity	Vacancies (Total)	Vacancies (Admittable)	Vacancies (Unavailable)	Vacancies (Reserved)	Occupied	Admittable %	Unavailable %	Reserved %	Occupied %
NHS Bristol, North Somerset and South Gloucestershire ICB - 15C (272 / 272 / 273)	7409	979	775	127	77	6430	10%	2%	1%	87%
General Residential	1730	304	248	47	9	1426	14%	3%	1%	82%
General Nursing	1803	248	205	24	19	1555	11%	1%	1%	86%
Dementia Residential	1533	196	147	36	13	1337	10%	2%	1%	87%
Dementia Nursing	1191	120	83	12	25	1071	7%	1%	2%	90%
Learning Disability Residential	565	49	41	3	5	516	7%	1%	1%	91%
Mental Health Residential	278	30	22	5	3	248	8%	2%	1%	89%
Community Care	51	19	19	0	0	32	37%			63%
Learning Disability Nursing	73	7	4	0	3	66	5%		4%	90%
Mental Health Nursing	159	3	3	0	0	156	2%			98%
YPD - Young Physically Disabled	22	2	2	0	0	20	9%			91%
Transitional	4	1	1	0	0	3	25%			75%

2.3 Planned Care – Summary Performance – November

BNSSG Population Level

RTT 18 week Incomplete	Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
Total Waiting List	80,290	87,481	-7,191	▼	56,065	24,225	▲
No. >18 weeks	28,330	29,523	-1,193	▼	7,947	20,383	▲
No. >52 weeks	4,761	5,386	-625	▼	21	4,740	▲
No. >78 weeks	552	799	-247	▼	N/A	N/A	N/A
No. >104 weeks	16	99	-83	▼	N/A	N/A	N/A
52ww as % of WL	5.9%	6.2%	-0.2%	▼	0.0%	5.9%	▲
% Performance	64.72%	66.25%	-1.5%	▼	85.83%	-21.1%	▼

Diagnostics	Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
Total Waiting List	32,634	33,598	-964	▼	21,148	11,486	▲
No. >6 weeks	11,111	12,105	-994	▼	1,227	9,884	▲
No. >13 weeks	6,033	7,009	-976	▼	96	5,937	▲
% Performance	34.05%	36.03%	-2.0%	▼	5.80%	28.2%	▲

Cancer	Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
2 week waits	47.13%	39.58%	7.5%	▲	92.20%	-45.1%	▼
2ww breast	73.21%	20.83%	52.4%	▲	92.68%	-19.5%	▼
28 day FDS (All Routes)	52.52%	45.75%	6.8%	▲	N/A	N/A	N/A
31 day first treatment	91.74%	93.44%	-1.7%	▼	96.16%	-4.4%	▼
31 day - Surgery	78.23%	85.29%	-7.1%	▼	89.62%	-11.4%	▼
31 day - Drugs	100.00%	100.00%	0.0%	◀▶	99.17%	0.8%	▲
31 day - Radiotherapy	98.84%	98.64%	0.2%	▲	97.04%	1.8%	▲
62 day	51.13%	50.79%	0.3%	▲	79.10%	-28.0%	▼
62 day - Screening	54.17%	58.82%	-4.7%	▼	75.68%	-21.5%	▼

NBT Total Provider

Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
47,418	48,871	-1,453	▼	28,351	19,067	▲
16,320	16,466	-146	▼	4,939	11,381	▲
2,980	3,062	-82	▼	14	2,966	▲
319	375	-56	▼	N/A	N/A	N/A
17	27	-10	▼	N/A	N/A	N/A
6.3%	6.3%	0.0%	▲	0.0%	6.2%	▲
65.58%	66.31%	-0.7%	▼	82.58%	-17.0%	▼

Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
16,740	17,286	-546	▼	11,304	5,436	▲
6,465	6,803	-338	▼	1,007	5,458	▲
4,204	4,627	-423	▼	64	4,140	▲
38.62%	39.36%	-0.7%	▼	8.91%	29.7%	▲

Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
47.53%	30.86%	16.7%	▲	90.2%	-42.7%	▼
63.27%	11.94%	51.3%	▲	92.00%	-28.7%	▼
55.74%	42.88%	12.9%	▲	N/A	N/A	N/A
86.49%	90.39%	-3.9%	▼	93.24%	-6.8%	▼
64.35%	75.51%	-11.2%	▼	79.80%	-15.5%	▼
100.00%	100.00%	0.0%	◀▶	100.00%	0.0%	◀▶
N/A	N/A	N/A	N/A	N/A	N/A	N/A
48.86%	52.45%	-3.6%	▼	71.62%	-22.8%	▼
63.83%	57.38%	6.5%	▲	81.43%	-17.6%	▼

UHBW Total Provider

Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
63,041	62,462	579	▲	41,229	21,812	▲
28,246	27,902	344	▲	6,966	21,280	▲
5,888	5,989	-101	▼	11	5,877	▲
755	763	-8	▼	N/A	N/A	N/A
33	39	-6	▼	N/A	N/A	N/A
9.3%	9.6%	-0.2%	▼	0.0%	9.3%	▲
55.19%	55.33%	-0.1%	▼	83.10%	-27.9%	▼

Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
16,692	16,952	-260	▼	10,222	6,470	▲
5,256	5,875	-619	▼	326	4,930	▲
2,317	3,062	-745	▼	49	2,268	▲
31.49%	34.66%	-3.2%	▼	3.19%	28.3%	▲

Nov-22	Oct-22	Variance	Change	Nov-19	Variance	Change
41.57%	49.06%	-7.5%	▼	95.1%	-53.6%	▼
N/A	N/A	N/A	N/A	N/A	N/A	N/A
42.78%	46.76%	-4.0%	▼	N/A	N/A	N/A
93.36%	94.61%	-1.3%	▼	97.05%	-3.7%	▼
88.71%	84.21%	4.5%	▲	91.23%	-2.5%	▼
99.44%	100.00%	-0.6%	▼	99.21%	0.2%	▲
98.99%	98.73%	0.3%	▲	96.84%	2.2%	▲
46.37%	47.95%	-1.6%	▼	85.71%	-39.3%	▼
44.44%	85.71%	-41.3%	▼	53.85%	-9.4%	▼

Key to Tables

- Latest month = **November** Previous month = **October** 19/20 = **November 2019** (pre-covid comparison)
- 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 the same period in 19/20.
- RAG colours are based on comparison to national standards: GREEN = Achieved, RED = not achieved

Please note: RTT BNSSG November figures represent the published data. However, this does not include Sirona Care and Health data as they did not make an RTT submission in November. The true BNSSG figures for November will be higher than shown and the reductions compared to October will be less than shown.

2.4 Mental Health – Summary Performance

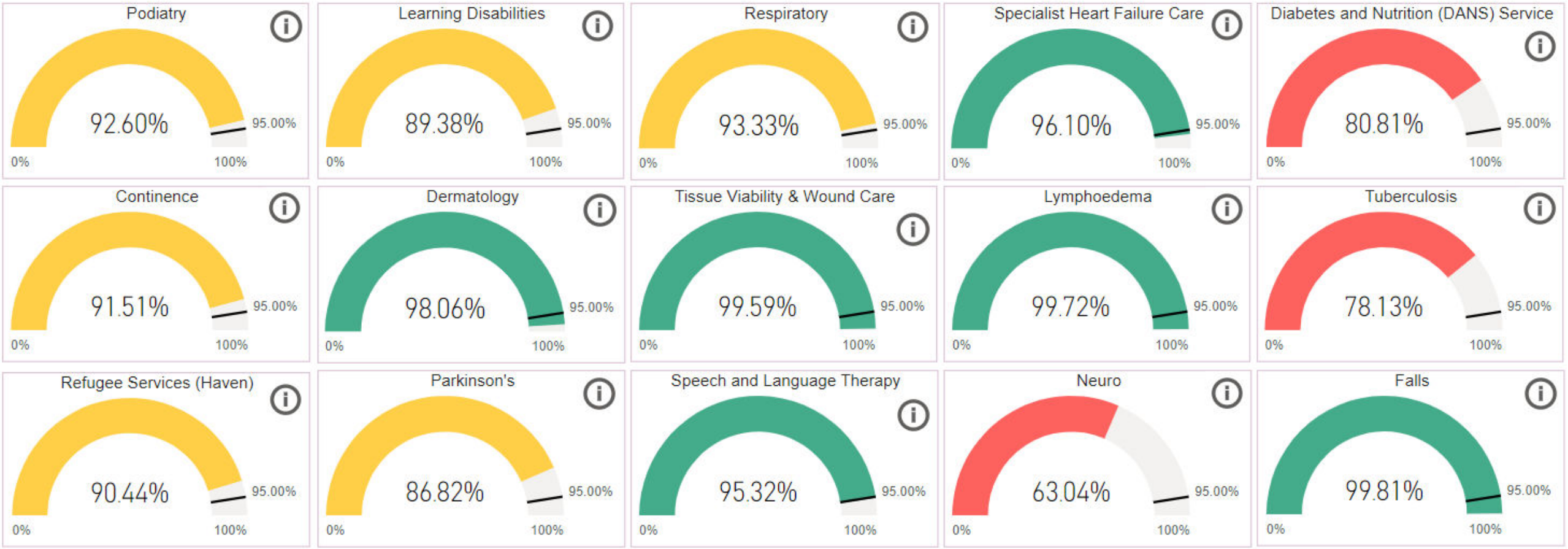
Mental Health, Learning Disabilities & Autism	Period	Standard	Latest	Previous	Variance	Change	19/20	Variance	Change
Dementia Diagnosis Rate	Oct-22	66.7%	66.5%	66.1%	0.4%	▲	68.5%	-2.0%	▼
EIP - 2ww Referral	Jun-22	60%	66.7%	70.0%	-3.3%	▼	85.0%	-18.3%	▼
IAPT Roll out (rolling 3 months)	Oct-22	6.25%	3.91%	3.92%	-0.01%	▼	4.2%	-0.3%	▼
IAPT Recovery Rate	Oct-22	50%	48.2%	46.2%	2.0%	▲	N/A	N/A	N/A
IAPT Waiting Times - 6 weeks	Oct-22	75%	98.8%	95.7%	3.1%	▲	N/A	N/A	N/A
IAPT Waiting Times - 18 weeks	Oct-22	95%	100.0%	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)	Q3 22-23	60.0%	50.9%	55.4%	-4.5%	▼	20.4%	30.6%	▲
Total Innapropriate Out of Area Placements (Bed Days)	Oct-22	N/A	65	175	-110	▼	541	-476	▼
Percentage of Women Accessing Perinatal MH Services	Jul-22	8.6%	6.3%	6.2%	0.1%	▲	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in CCG beds	Dec-22	9	10	11	-1	▼	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in NHSE beds	Dec-22	13	18	18	0	◀▶	N/A	N/A	N/A
LD Annual Health Checks delivered by GPs aged 14+	Dec-22	2869	2484	2211	273	▲	N/A	N/A	N/A
AWP Delayed Transfers of Care	Dec-22	3.5%	23.9%	20.9%	3.0%	▲	6.4%	17.5%	▲
AWP Early Intervention	Dec-22	60%	64.2%	62.5%	1.7%	▲	57.1%	7.1%	▲
AWP 4 week wait referral to assessment	Dec-22	95%	90.31%	83.03%	7.3%	▲	97.40%	-7.1%	▼

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 (grey shaded cells), BNSSG ICB performance is only available up to June/July in the monthly data releases of the 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.

2.5 Sirona – Adults Community Services – % in 18 weeks – December YTD

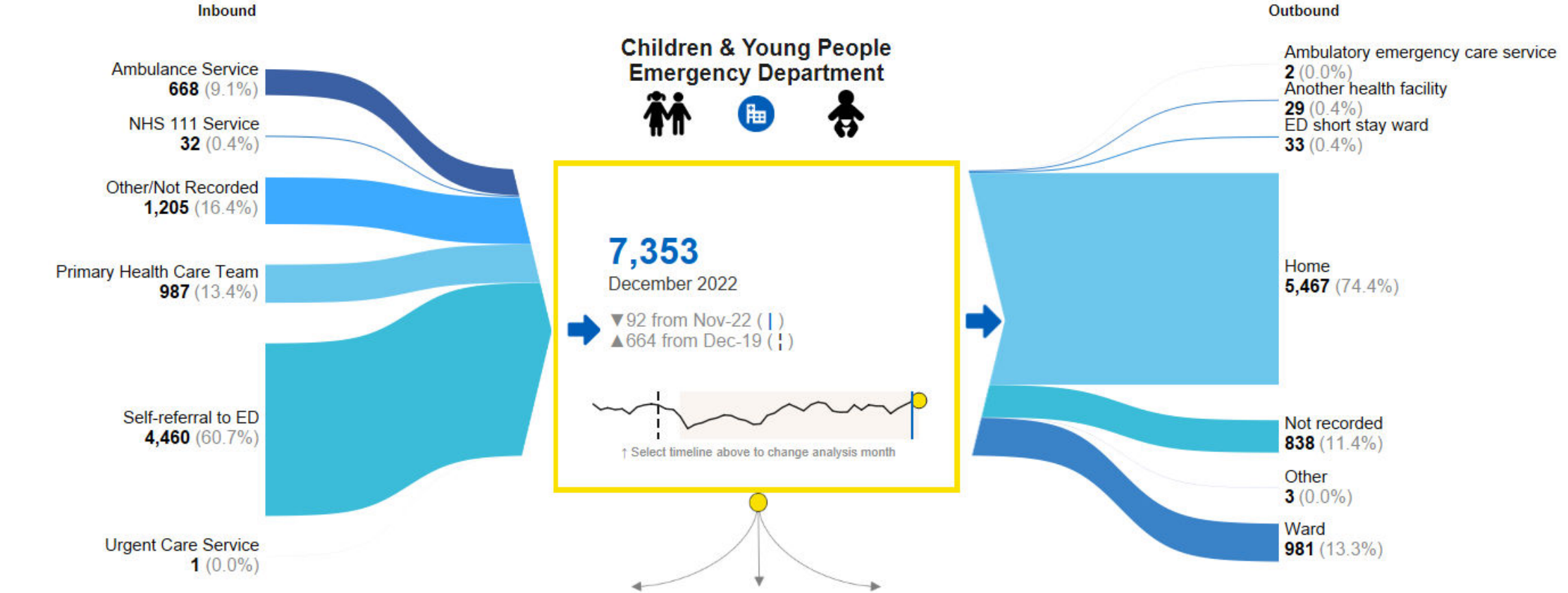


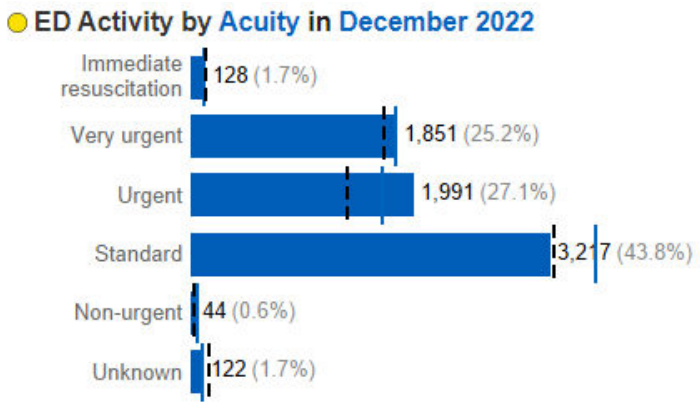
Performance Key Colour
>10% below target
<10% below target
On target
>10% above target

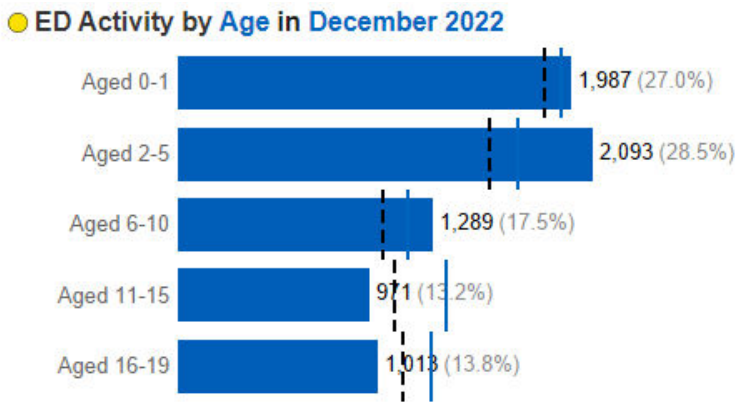
Please note: Data as at 10th January. This is provisional until the 15th Working day of January.

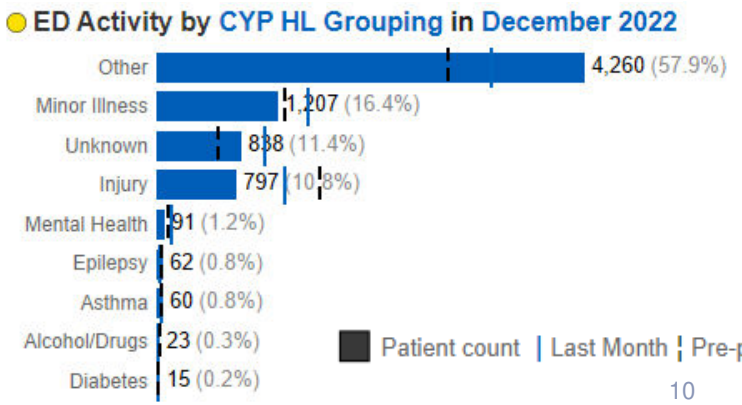
Data source: Sirona Adults Contractual Reporting Dashboard 2022/23 – Percentage of patients seen within 18 weeks compared to 95% Target

2.6 Children – CYP ED Overview BNSSG Trusts









Data source: NHSEI Children and Young People Emergency Department Dashboard (Ages 0-19)

3.1 BNSSG ICB Scorecard

Theme	Indicator	Standard	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	22/23
Urgent Care	A&E 4hr Waits - BNSSG Footprint	95%	73.03%	70.71%	70.55%	71.55%	67.04%	67.44%	65.76%	72.74%	69.21%	66.32%	61.78%	66.15%	64.95%	65.00%	63.10%	66.30%
	A&E 4hr Waits - BNSSG Trusts	95%	64.98%	62.65%	63.04%	64.19%	60.27%	59.73%	59.46%	65.46%	61.80%	57.10%	61.78%	60.07%	58.87%	56.72%	54.12%	59.49%
	>12hr DTA breaches in A&E - BNSSG Trusts	0	7139	765	696	1071	1211	1401	1169	755	873	1182	815	978	1423	1296	2003	10494
Planned Care	RTT Incomplete - 18 Weeks Waits	92%	65.39%	67.98%	66.04%	65.53%	65.93%	65.39%	65.75%	65.76%	66.17%	65.71%	65.75%	65.54%	66.25%	64.72%		64.72%
	RTT Incomplete - Total Waiting List Size		74,505	71,134	70,653	70,869	71,772	74,505	75,720	76,803	80,749	85,720	87,320	86,771	87,481	80,290		80,290
	RTT Incomplete - 52 Week Waits		3779	3791	3902	4020	3864	3779	4052	4164	4764	5134	5376	5302	5386	4761		4,761
	RTT Incomplete - % of WL > 52 Weeks		5.07%	5.33%	5.52%	5.67%	5.38%	5.07%	5.35%	5.42%	5.90%	5.99%	6.16%	6.11%	6.16%	5.93%		5.93%
	Diagnostic - 6 Week Waits	1%	37.90%	36.09%	40.13%	40.79%	36.86%	37.90%	41.09%	38.14%	38.46%	38.36%	41.30%	40.46%	36.03%	34.05%		34.05%
	Diagnostic - Total Waiting List Size		32,024	28,809	29,304	30,640	30,517	32,024	32,109	31,592	31,976	31,991	31,480	33,279	33,598	32,634		32,634
	Diagnostic - Number waiting > 6 Weeks		12,136	10,398	11,760	12,498	11,250	12,136	13,193	12,049	12,298	12,273	13,000	13,464	12,105	11,111		11,111
	Diagnostic - Number waiting > 13 Weeks		6,623	5,118	5,875	6,345	6,465	6,623	7,543	7,539	7,597	7,099	7,067	7,503	7,009	6,033		6,033
Cancer	Cancer 2 Week Wait - All	93%	64.91%	64.50%	67.27%	54.62%	70.34%	70.70%	61.38%	57.06%	48.91%	44.15%	44.78%	39.17%	39.58%	47.13%		47.38%
	Cancer 2 Week Wait - Breast symptoms	93%	28.22%	6.25%	11.84%	8.82%	16.87%	17.86%	21.35%	52.86%	22.83%	35.56%	4.88%	14.55%	20.83%	73.21%		30.58%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	66.40%	69.69%	65.99%	55.43%	73.56%	73.09%	67.96%	72.62%	69.30%	61.04%	53.13%	41.55%	45.75%	52.52%		57.33%
	Cancer 31 Day first treatment	96%	92.45%	88.51%	84.56%	87.44%	91.57%	88.79%	86.60%	89.02%	91.31%	93.53%	92.83%	89.69%	93.44%	91.74%		91.13%
	Cancer 31 day subsequent treatments - surgery	94%	81.11%	79.66%	70.83%	69.42%	81.37%	75.21%	71.00%	70.91%	68.48%	70.11%	67.02%	64.81%	85.29%	78.23%		72.22%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	98.97%	98.68%	100.00%	95.89%	99.32%	97.99%	97.66%	100.00%	95.83%	97.76%	100.00%	100.00%	100.00%	100.00%		98.93%
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.68%	99.42%	100.00%	99.37%	99.44%	100.00%	100.00%	100.00%	98.87%	100.00%	100.00%	98.61%	98.64%	98.84%		99.34%
	Cancer 62 day referral to first treatment - GP referral	85%	68.74%	74.47%	69.33%	61.43%	58.30%	65.99%	61.21%	57.96%	53.53%	56.90%	56.00%	59.56%	50.79%	51.13%		55.71%
	Cancer 62 day referral to first treatment - NHS Screening	90%	59.57%	61.36%	47.22%	39.47%	68.00%	63.89%	55.56%	82.14%	43.48%	62.16%	69.70%	54.55%	58.82%	54.17%		60.76%
Quality	Total Number of C.diff Cases	308	303	10	24	26	22	17	23	20	27	27	26	26	21	26		196
	Total Number of MRSA Cases Reported	0	38	3	6	7	0	3	4	2	1	1	2	5	1	4		20
	Total number of Never Events	0	4	0	0	0	0	0	0	0	0	0	1					2
	Eliminating Mixed Sex Accommodation (BNSSG CCG)	0	2	0	0	0	0	1	1	0	2	1	1	1	0			6
	Eliminating Mixed Sex Accommodation (BNSSG Trusts)	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
Mental Health	Dementia Diagnosis Rate - People 65+	66.7%	65.39%	64.35%	64.16%	64.33%	64.79%	65.39%	65.34%	65.41%	65.31%	65.65%	65.62%	65.90%				65.90%
	EIP - 2ww Referral	60%	54.55%	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%	4.88%	4.50%	4.80%	4.33%	4.73%	4.44%	4.66%	4.35%							4.35%
	IAPT Recovery Rate	50%	53.22%	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%	87.36%	88.62%	89.67%	91.53%	90.34%	93.60%	92.42%	95.26%							95.26%
	IAPT Waiting Times - 18 weeks	95%	99.44%	98.90%	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%	25.04%	25.24%	25.94%	26.41%	26.73%	28.08%	30.54%	31.47%	31.97%						31.53%
	CYP with ED - routine cases within 4 weeks (quarterly)	95%	88.52%	86.09%			88.52%			91.35%			95.31%					95.31%
	CYP with ED - urgent cases within 1 week (quarterly)	95%	83.33%	79.17%			83.33%			91.67%			95.00%					95.00%
	SMI Annual Health Checks (quarterly)	60%	45.67%	31.44%			45.67%			56.81%			55.40%			50.94%		55.40%
	Out of Area Placements (Bed Days)		420	450	465	465	420	465	450	470	455	330	265	175	65			65

3.2 Provider Scorecard – NBT

Theme	Indicator	Standard	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	22/23
Urgent Care	A&E 4hr Waits - Trust	95%	61.48%	60.17%	61.80%	60.78%	51.53%	52.74%	55.54%	72.71%	59.32%	50.99%	60.83%	56.43%	57.47%	57.87%	55.61%	58.63%
	A&E 4hr Waits - Footprint	95%	69.58%	68.10%	68.82%	68.03%	59.36%	61.25%	61.71%	77.70%	66.62%	60.85%	60.83%	62.29%	63.12%	65.67%	63.82%	64.98%
	>12hr DTA breaches in A&E	0	1378	59	20	295	367	449	360	176	297	304	57	261	482	433	786	3156
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	64.71%	69.68%	66.67%	65.61%	65.17%	64.71%	64.23%	62.62%	64.80%	65.78%	65.82%	66.30%	66.31%	65.58%		65.58%
	RTT Incomplete - Total Waiting List Size	Op Plan	39,101	37,297	37,264	37,210	38,498	39,101	39,819	40,634	42,326	46,991	48,766	49,025	48,871	47,418		47,418
	RTT Incomplete - 52 Week Waits	Op Plan	2242	2128	2182	2284	2296	2242	2,454	2,424	2,675	2,914	3,131	3,087	3,062	2,980		2,980
	RTT Incomplete - % of WL > 52 Weeks		5.73%	5.71%	5.86%	6.14%	5.96%	5.73%	6.16%	5.97%	6.32%	6.20%	6.42%	6.30%	6.27%	6.28%		6.28%
	Diagnostic - 6 Week Waits	1%	40.25%	40.32%	44.30%	45.45%	40.00%	40.25%	43.61%	40.13%	41.00%	42.75%	48.09%	48.27%	39.36%	38.62%		38.62%
	Diagnostic - Total Waiting List Size		17,111	15,768	15,872	16,790	16,469	17,111	17,114	17,166	17,504	17,124	16,928	16,690	17,286	16,740		16,740
	Diagnostic - Number waiting > 6 Weeks		6,888	6,357	7,031	7,631	6,588	6,888	7,464	6,889	7,177	7,321	8,141	8,057	6,803	6,465		6,465
	Diagnostic - Number waiting > 13 Weeks		4,097	2,913	3,501	3,948	3,951	4,097	4,664	4,780	4,897	4,718	4,844	4,971	4,627	4,204		4,204
Cancer	Cancer 2 Week Wait - All	93%	51.63%	53.75%	58.38%	41.42%	66.47%	69.78%	57.66%	46.16%	39.21%	40.99%	40.18%	35.85%	30.86%	47.53%		41.84%
	Cancer 2 Week Wait - Breast symptoms	93%	27.21%	6.15%	11.54%	6.90%	14.55%	16.78%	14.94%	46.03%	18.95%	21.05%	2.50%	6.12%	11.94%	63.27%		22.75%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	60.77%	66.29%	57.52%	47.10%	72.01%	72.93%	66.82%	72.83%	70.87%	58.29%	48.83%	35.18%	42.88%	55.74%		55.62%
	Cancer 31 Day first treatment	96%	89.09%	86.94%	79.59%	79.18%	89.91%	80.99%	81.82%	83.77%	85.53%	91.20%	87.36%	87.76%	90.39%	86.49%		86.76%
	Cancer 31 day subsequent treatments - surgery	94%	74.28%	65.77%	65.59%	55.66%	80.68%	65.49%	62.77%	57.29%	51.85%	58.11%	43.84%	50.00%	75.51%	64.35%		58.81%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	97.90%	100.00%	100.00%	92.31%	100.00%	83.33%	100.00%	100.00%	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%	74.07%	67.52%	56.88%	51.17%	58.66%	56.48%	50.15%	48.40%	45.10%	55.59%	58.90%	52.45%	48.86%		51.98%
	Cancer 62 day referral to first treatment - NHS Screening	90%	64.40%	68.75%	53.25%	50.00%	72.22%	70.59%	63.64%	82.14%	51.02%	57.53%	74.24%	62.50%	57.38%	63.83%		64.16%
Quality	Total Number of C.diff Cases		62	1	6	6	1	6	7	7	7	7	5	6	6	6		51
	Total Number of MRSA Cases Reported	0	0	0	0	0	0	0	4	1	1	0	0	0	0	0		6
	Total Number of E.Coli Cases		48	3	2	6	3	5	7	5	7	4	6	5	6	8		48
	Number of Klebsiella cases		24	4	3	2	2	3	2	3	4	2	1	4	2	2		20
	Number of Pseudomonas Aeruginosa cases		10	0	0	2	1	0	2	1	0	1	2	1	0	0		7
	Eliminating Mixed Sex Accommodation	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	2		2
	VTE assessment on admission to hospital	95%		93.84%	94.55%	93.80%	93.99%	92.63%	93.44%	93.42%	93.78%	90.81%	90.18%	90.25%	89.56%			

3.3 Provider Scorecard – UHBW

Theme	Indicator	Standard	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	22/23
Urgent Care	A&E 4hr Waits - Trust	95%	66.79%	63.90%	63.69%	66.01%	64.83%	63.26%	61.51%	61.69%	63.04%	60.15%	62.31%	62.01%	59.59%	56.17%	53.41%	59.93%
	A&E 4hr Waits - Footprint	95%	74.75%	71.98%	71.41%	73.34%	70.88%	70.46%	67.81%	70.28%	70.47%	68.96%	62.31%	68.14%	65.86%	64.68%	62.77%	66.95%
	>12hr DTA breaches in A&E	0	5761	706	676	776	844	952	809	579	576	878	758	717	941	863	1217	7338
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	59.17%	60.25%	58.60%	58.73%	59.50%	59.17%	58.65%	58.32%	58.76%	56.37%	55.56%	54.35%	55.33%	55.19%		55.19%
	RTT Incomplete - Total Waiting List Size	Op Plan	55,021	53,328	53,253	53,909	54,305	55,021	57,019	57,940	60,404	60,738	62,010	61,870	62,462	63,041		63,041
	RTT Incomplete - 52 Week Waits	Op Plan	3,920	3,318	3,558	3,599	3,604	3,920	4,362	4,654	5,298	5,591	5,970	6,141	5,989	5,888		5,888
	RTT Incomplete - % of WL > 52 Weeks		7.12%	6.22%	6.68%	6.68%	6.64%	7.12%	7.65%	8.03%	8.77%	9.21%	9.63%	9.93%	9.59%	9.34%		9.34%
	Diagnostic - 6 Week Waits	1%	39.05%	34.60%	38.86%	39.45%	37.48%	39.05%	42.11%	39.90%	38.78%	36.50%	37.79%	35.54%	34.66%	31.49%		31.49%
	Diagnostic - Total Waiting List Size		16,610	14,307	14,525	15,154	15,576	16,610	16,521	15,819	16,042	16,426	15,387	17,577	16,952	16,692		16,692
	Diagnostic - Number waiting > 6 Weeks		6,486	4,950	5,644	5,979	5,838	6,486	6,957	6,311	6,221	5,996	5,815	6,246	5,875	5,256		5,256
	Diagnostic - Number waiting > 13 Weeks		3,372	2,949	3,180	3,240	3,349	3,372	3,799	3,697	3,616	3,245	2,968	3,294	3,062	2,317		2,317
Cancer	Cancer 2 Week Wait - All	93%	82.37%	80.30%	78.30%	71.03%	75.41%	66.51%	63.02%	67.99%	57.22%	44.62%	45.18%	41.14%	49.06%	41.57%		50.95%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	76.33%	75.68%	78.65%	70.03%	77.86%	73.83%	72.02%	73.19%	67.40%	64.56%	57.28%	50.54%	46.76%	42.78%		59.16%
	Cancer 31 Day first treatment	96%	92.90%	84.18%	89.51%	91.11%	89.62%	93.50%	89.58%	90.61%	92.88%	93.92%	93.92%	91.01%	94.61%	93.36%		92.59%
	Cancer 31 day subsequent treatments - surgery	94%	85.07%	84.21%	86.00%	73.53%	80.00%	82.09%	83.33%	76.27%	80.00%	88.89%	85.94%	87.69%	84.21%	88.71%		84.47%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	99.28%	98.72%	100.00%	97.28%	99.33%	99.35%	97.67%	100.00%	94.77%	98.53%	100.00%	100.00%	100.00%	99.44%		98.82%
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.53%	99.47%	98.65%	97.89%	100.00%	100.00%	99.38%	100.00%	99.48%	99.38%	100.00%	99.37%	98.73%	98.99%		99.42%
	Cancer 62 day referral to first treatment - GP referral	85%	76.05%	80.00%	73.12%	68.09%	70.18%	78.05%	67.81%	70.95%	61.83%	69.42%	52.16%	64.85%	47.95%	46.37%		59.98%
	Cancer 62 day referral to first treatment - NHS Screening	90%	50.28%	23.08%	55.56%	39.13%	60.00%	55.56%	0.00%	33.33%	25.00%	50.00%	50.00%	50.00%	85.71%	44.44%		47.54%
Quality	Total Number of C.diff Cases (HOHA)	89	82	3	6	6	8	2	6	8	12	13	7	9	6	13		74
	Total Number of MRSA Cases Reported	0	7	0	2	3	0	1	0	0	0	0	0	1	0	1		2
	Total Number of E.Coli Cases	119	75	8	2	7	5	9	15	13	6	8	7	11	13	9		82
	Number of Klebsiella cases		48	4	2	3	1	1	3	4	5	6	9	5	5	10		47
	Number of Pseudomonas Aeruginosa cases		15	2	2	1	0	0	1	2	1	2	4	5	1	0		16
	Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
	Number of Never Events	0	3	0	0	0	0	0	0	0	0	0	1	1	0			2
	Rate of slips, trips and falls per 1,000 bed days	4.8	4.83	4.57	5.20	5.54	4.85	5.50	5.54	4.78	4.09	3.27	6.63	4.49	5.86			4.97
	No. of Pressure Ulcers grade 2, 3 & 4 per 1,000 bed days	0.4	0.174	0.159	0.255	0.256	0.1	0.3	0.248	0.089	0.093	0.089	0.118	0.061	0.23			0.133
	VTE assessment on admission to hospital (Bristol)	95%	83.3%	84.3%	83.2%	83.8%	82.60%	82.20%	81.3%	81.9%	82.4%	82.1%	83.7%	83.5%	84.0%			82.8%

3.4 Non-Acute Provider Scorecard

Provider	Indicator (BNSSG level - except ambulance handovers)	Standard	21/22	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	22/23
SWASFT	Category 1 - Average Duration (hr:min:sec)	0:07:00	0:08:48	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	0:08:48	0:11:30	0:09:48
	Category 1 - 90th Percentile Duration (hr:min:sec)	0:14:00	0:15:54	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	0:15:18	0:19:12	0:16:54
	Category 2 - Average Duration (hr:min:sec)	0:18:00	1:10:00	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	0:50:24	2:49:24	1:07:18
	Category 2 - 90th Percentile Duration (hr:min:sec)	0:40:00	2:54:24	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	1:55:30	7:25:12	2:38:48
	Category 3 - 90th Percentile Duration (hr:min:sec)	2:00:00	9:11:06	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	8:51:24	16:56:54	9:05:12
	Category 4 - 90th Percentile Duration (hr:min:sec)	3:00:00	8:00:06	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	14:35:00	14:35:36	9:00:54
	Ambulance Handovers - % within 15 minutes at NBT	65%	25.0%	18.7%	16.4%	15.1%	14.7%	16.8%	21.0%	16.8%	13.5%	18.2%	17.6%	11.9%	13.2%	9.7%	15.6%
	Ambulance Handovers - % within 30 minutes at NBT	95%	56.8%	51.3%	44.7%	38.6%	38.3%	44.4%	53.9%	45.5%	42.8%	56.2%	51.5%	38.7%	40.4%	29.7%	45.2%
	Ambulance Handovers - % within 60 minutes at NBT	100%	75.3%	75.2%	65.0%	58.3%	57.2%	66.2%	77.2%	68.0%	67.5%	80.9%	75.9%	62.2%	66.3%	48.9%	68.6%
	Ambulance Handovers - % within 15 minutes at BRI	65%	22.2%	14.2%	14.1%	10.9%	11.7%	11.6%	13.9%	17.5%	9.7%	12.0%	13.3%	10.3%	11.6%	7.6%	12.0%
	Ambulance Handovers - % within 30 minutes at BRI	95%	41.6%	33.4%	29.2%	22.5%	23.3%	25.3%	34.7%	42.9%	26.2%	30.7%	36.1%	27.6%	33.8%	18.0%	30.8%
	Ambulance Handovers - % within 60 minutes at BRI	100%	60.0%	57.4%	47.6%	37.8%	39.3%	44.2%	56.0%	65.2%	48.1%	51.2%	58.4%	49.7%	60.9%	36.4%	52.5%
	Ambulance Handovers - % within 15 minutes at WGH	65%	32.6%	17.5%	19.5%	21.3%	17.6%	16.9%	25.0%	23.5%	15.0%	19.0%	16.3%	14.2%	12.4%	5.9%	16.7%
	Ambulance Handovers - % within 30 minutes at WGH	95%	60.0%	40.6%	48.4%	53.7%	40.9%	40.5%	52.4%	55.9%	36.3%	47.5%	46.6%	44.0%	37.1%	23.8%	43.0%
	Ambulance Handovers - % within 60 minutes at WGH	100%	75.2%	63.8%	70.9%	74.5%	60.2%	58.1%	71.2%	72.7%	56.0%	65.0%	66.2%	65.2%	63.0%	42.6%	62.6%
SevernSide IUC	Average speed to answer calls (in seconds)	20 Sec	227	327	228	166	325	318	274	756	713	723	271	453	381	1794	595
	% of calls abandoned	3%	12.8%	15.1%	11.4%	9.3%	16.0%	16.1%	13.5%	30.0%	28.4%	29.2%	14.0%	20.6%	18.0%	48.8%	25.1%
	% Triaged Calls receiving Clinical Contact	50%	55.9%	56.9%	59.6%	53.6%	50.4%	50.0%	48.5%	48.4%	48.8%	37.3%	51.5%	52.1%	51.0%	52.7%	49.2%
	% of callers allocated the first service offered by DOS	85%	67.5%	72.2%	70.0%	69.9%	70.5%	70.0%	68.7%	69.3%	70.2%	68.8%	70.1%	68.8%	67.7%		69.2%
	% of Cat 3 or 4 ambulance dispositions validated within 30mins	50%	59.5%	64.8%	69.4%	51.3%	47.8%	53.1%	45.8%	38.0%	45.0%	58.5%	66.2%	60.9%	56.3%		52.9%
	% of calls initially given an ED disposition that are validated	50%	61.7%	73.3%	78.3%	49.3%	30.6%	24.2%	13.2%	13.8%	13.4%	17.9%	22.5%	23.9%	21.0%		18.8%
AWP	Delayed Transfers of Care	3.5%	10.7%	10.4%	11.4%	13.4%	11.1%	10.3%	13.4%	10.6%	12.7%	15.8%	18.4%	20.4%	20.9%	23.9%	
	Early Intervention	60%	49.1%	38.4%	33.3%	72.7%	61.9%	76.9%	55.0%	63.1%	81.8%	76.1%	73.3%	81.8%	62.5%	64.2%	
	4 week wait Referral to Assessment	95%	80.7%	81.1%	70.0%	80.6%	80.7%	78.9%	76.9%	76.9%	84.3%	82.9%	75.0%	84.2%	83.0%	90.3%	

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 November.

December data for IUC ad AWP is provisional and subject to change.

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 27 October 2022, 0900-1130, on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Paul May	Non Executive Director, Sirona	PM
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
In attendance		
Jeff Farrar	Chair, BNSSG ICB	JF
Caroline Dawe	Deputy Director of Commissioning (Performance Improvement), BNSSG ICB	CD
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Sandra Muffett	Head of Quality & Patient Safety, BNSSG	SM
Freda Morgan (notes)	Executive PA, BNSSG ICB	TM
Apologies		
Michael Richardson	Deputy Director of Nursing & Quality, BNSSG ICB	MR
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Sue Balcombe	Non Executive Director, UHBW	SB
Hugh Evans	Executive Director, Adults & Communities, Bristol City Council	HE

	Item	**Action**
01	**Welcome and Apologies** Apologies were recorded as above. PM was welcomed to his first meeting. JF noted the value of having Non-Executive Directors from other parts of the system in attendance to challenge, scrutinise, and feed back to their own organisations.	

	Item	Action
	ED reminded members of the purpose of this committee, as detailed in the Terms of Reference and noted there are still vacancies for members to represent Mental Health, Primary Care and Patient Voice. RS said a nomination has been received from Healthwatch for Patient Voice. Public Health colleagues are discussing the most appropriate representative. Patient Care. RS has approached AWP for Mental Health but they have not been able to identify any resource. JF concurred that further follow up is needed with AWP. **ACTION: FM to request an update on outstanding members from Sarah Carr.** **ACTION: FM to arrange individual meetings between ED, RS and external members.** **ACTION: FM to obtain confirmation of attendance in advance for all meetings of the Committee**	**FM** **FM** **FM**
02	**Declarations of Interest** PM noted he is a Councillor on B&NES Council which is a neighbouring area. **ACTION: FM to ask the BNSSG Corporate Team to send Declarations of Interest forms to all members for completion**	**FM**
03	**Minutes of September 2022 meeting** Minutes of the previous meeting were agreed as a correct record	
	CLOSED SESSION	
04	**System Quality Group (SQG) Update** Minutes of 13 September 2022 SQG were noted for information. RS updated on discussions at the September SQG as follows. NBT have undertaken a good piece of work to make changes to urgent care flow to reduce the significant ambulance queues and waiting times in ED. This was clinically led and well risk assessed and has made improvements to balance the risk across the organisation. The national team have cited this as an example of good practice. RS noted this work is often represented as boarding, but the full process is much broader and aims to spread the risk across the clinical pathway as part of a broader risk assessment. RS and Steve Hams (Chief Nursing Officer, NBT) are happy to discuss further to provide oversight of the whole piece of work. **ACTION: RS to share the NBT risk matrix with ED**	**RS**

	Item	Action
	There have been concerns about Out of Hospital harm, where patients are alone at home and potentially not receiving the care they need from health or Local Authority services. The September System Quality Group held a deep dive with St Peter's Hospice, South Gloucestershire Council and Sirona presenting. Significant quality intelligence work needs to be done, and a better way of describing the impact of pressure in community services. The discussion highlighted that whereas waiting lists in acute services are well documented, there is less visibility of the impact of waiting times in community settings. **New and Emerging Risks** There are currently three risk escalation processes under way in line with national quality board guidance. The third risk escalation, which was not discussed last month, is an apparent but not yet proven, change in the number of young people with previously undiagnosed conditions who are presenting in crisis at ED. The most recent incident resulted in a serious assault on a member of staff at Bristol Royal Children's Hospital. Partners working closely together to maximise the use of preventive care pathways and are sharing good practice. Further work needed to understand if there is a changing pattern in presentation and any gaps in service delivery such as intensive support in the community. There has been good engagement from all system partners and the police. PM said there needs to be consideration of effective early intervention for these young people. He noted that paediatric waiting lists at Sirona are high, and the organisation is thinking about how to engage effectively with families and young people across the board. ED said this subject might be something we want to bring to the ICB Board for consideration of what short, medium and long-term plans can be put in place. RS said she had spoken to Helena Fuller (Deputy Director of Commissioning) and suggested carrying out a deep dive on children's services, to expose the issues and what is in train to resolve them. Some of the problems lie wider in the system. Local Authorities are under financial pressure, and the children who are getting stuck in the system are those who need Local Authority support rather than health care. Collaborative work is needed to get the right care in place. ED said she believed the items that will be brought to board will be the difficult issues that are system-wide. RS agreed. She said there is a lot of time taken discussing adult waiting lists and cancer waits, but there are also children's waiting lists and tertiary work carried out by UHBW which impact beyond the BNSSG area.	

	Item	Action
	PM suggested further work is needed to understand how young people are contacted, by GPs, Local Authority, Sirona or Acute Services, to identify the gaps in communication that are leading to undiagnosed young people presenting to hospital. JM said there has been a lot of discussion recently about concentrating on flow and winter as key priorities. There needs to be honesty about what are the highest priorities as if everything is done at the same time, it will not be done well and there will be no traction on the items agreed for top priority. **ACTION: RS to consider how and when to address these challenges and add to the forward planner, to be taken on to the ICB board for discussion.** JM updated on infection rates.	
	OPEN SESSION	
05	**Standing Items**	
05.1	**Quality & Performance Report** ***Performance Report*** CD presented this report, which focussed three areas: ambulance handover position, access for children and young people, and echocardiography and endoscopy diagnostics. *Ambulance Handovers* Ambulance handovers remain a significant issue. Partners are working collaboratively as a system and supporting each other when there are flow issues, however supporting one part of the system can often cause a decline in performance in another area. Preventative measures need to be put in place as these issues will only exacerbate if this continues into winter. There has been a change in approach from acute partners who are now looking at whether patients can be differentiated and queued in a more safe way. A lot of work has been done on direct admission pathways and Same Day Emergency Care (SDEC), and on ensuring paramedics have equal access to services as other clinical professionals. There is close working with SWAST on protocols. CD said it would be helpful to work more closely with Michael Richardson to understand clinical risk matrices that describe the current picture and include these in the ambulance handover meeting that takes place every three weeks.	

	Item	Action
	ACTION: CD and MR to meet to discuss clinical risk matrices, to feed into the regular ambulance handover meeting	**CD**
	ED asked what system partners need to focus on to drive performance. CD said there needs to be more work with urgent care response teams in the community, better access for paramedics, more consistency, better staffing, and some of the winter letters suggest checking that current basic provisions are right. RS said there also needs to be a focus on admission avoidance, as this will contribute to breaking the cycle. There is still work to do on improving flow in P0 and P1, and supporting a complicated discharge process that is causing delays. CB said key drivers need to be shared across the system so that all partners own a bit of the problem. It appears that most issues lead back to workforce. He asked how this committee could link with the People Committee on these issues, as there is a clear workforce issue. PM noted the use of agency staff affects not only the quality but also the cost of what is being provided. Use of agency staff by Local Authorities and Sirona has become increasingly expensive and quality issues have been identified. He asked how sufficient workforce can be recruited without having to pay out a lot of money for poor quality agency staff. CB asked if there was a possibility of using voluntary sector partners differently to assist with workforce issues. RS said there is a need to focus on out of hospital system workforce as a priority. NHS staff are currently being used to work with No Criteria to Reside (NCTR) patients, who would be better off being cared for at home with community based care. The resolution of NCTR patients in hospital would have a significant impact on hospital performance, it has to be recognised though that Local Authorities are in a significantly challenged financial position. ED said she believed workforce issues belong with the organisation first before bringing to committee level, and asked JF for his thoughts on how to move forward. JF said the ICB is still at an early stage, and it is important to bring committee chairs together rather than trying to tackle these challenges in isolation. JF will be attending the People Committee on Wednesday 2 November. *Access for Children and Young People* CD said there is need to strengthen overall performance reporting for children and young people and this remains work in process. At present it feels that provision	

	Item	Action
	is declining, and there are issues with workforce and recruitment to teams. There is increased acuity of patients within AWP and acute services. There are capacity issues within community teams which is impacting on the ability to deliver patient care.. *Diagnostics – Endoscopy and Echocardiography* CD described performance challenges in endoscopy but that all expected actions have been taken by partners. Provision is being expanded, PPG have opened up as an additional provider and Trusts are still insourcing from other companies. A piece of work has been set up with regional colleagues to work with providers on training and to create more posts. Clinical Leads are involved and have been fully supportive. There are national problems with echocardiography which are again workforce related and a regional workshop has been held to discuss what actions can be taken. There are fewer providers in the system with capacity to assist, and a reliance on existing staff which has again impacted on the waiting list. RS noted there is a smaller number of people who require echocardiography, but the health impact of not receiving this treatment is significant in terms of long term outcomes. She noted the need to be careful not to only focus on areas which impact a large number of people and ignore the smaller areas which may be more vulnerable. ED thanked CD for her report and said she was happy to focus in detail on three key areas like this at every meeting. PM said there is a significant integrated care workforce in all organisations but they currently work in competition with each other. He said there should be a move towards integrating these functions to enable the HR process to make progress going forward. ED noted the benchmarking data shows breast cancer 2-week performance is currently at 4%, compared to a national figure of 70%. JM said the benchmarking data are figures for that month only. There remains a backlog for breast cancer treatment, but current metrics show the waiting time has reduced from 45 days to 27 days, which is a significant improvement, although still not the 14 days which is the aim. The team have also looked at demand coming in and are matching to capacity. BNSSG operates a “one stop shop” system for breast cancer and has a good level of treatment. ED asked for more specific detail like this to highlight the background to poor performance statistics in future reports. ED asked if it is possible to have more up to date data in the report, noting these reports contain data which is three months old. JM said she would like to see	

	Item	Action
	timelines to show trends and variation. CD said that Gary Dawes and the BI team are working on including timelines. She said availability of data will depend on the source and validation. It may be possible to get more recent data but it may not show a validated position. **ACTION: CD to ask Gary Dawes and the BI team if it is possible to include more up to date data in the performance report, and to include timelines to show trends and variation.** ***Quality Report*** RS presented the Quality report. During discussions at SQG on out of hospital work, it was noted there are Quality Intelligence pieces to be carried out about falls and falls prevention, and pressure injuries. Further discussion is needed between RS and JM on diabetes and diabetes management and waiting lists, and more information will be included in the next report. ED asked if Deborah El-Sayed should be invited to the meeting to talk about how this information can be gained from Local Authorities and Sirona. RS said her team needs to ask the BI team to carry out a gap analysis, following which Deborah El-Sayed would be involved if transformation work is needed.	**CD**
06	**Items for Discussion**	
06.1	**Maternity – Kirkup Report** RS asked members to receive Dr Bill Kirkup's Independent Investigation into East Kent Maternity and Neonatal Services which was published last week. This is the second big maternity review commissioned by the national team in the last couple of years, and a third report ("Ockenden 2") is also expected. The report focusses very much on the culture inside teams, and the recommendations are for national teams, regulators and professional bodies. The first recommendation is for the prompt establishment of a task force and talks about not having easily comparable data to understand performance variation. RS said there is work to do within BNSSG to make sure the best data is available. Each trust reviews their own data carefully, but a reliable and consistent view is not yet available at system level.	

	Item	Action
	The second recommendation looks at team work and what training is needed to improve this. There was a key issue in the Ockenden report about how maternity staff work together around mothers and babies. There are interesting observations in this report about the behaviour of senior consultants and how to address this. The third recommendation is about organisational behaviour and relates back to being careful about how data is used and understanding where there are changes in trends. The fourth recommendation is about transparency and pushes the government to bring forward a bill for duty around openness and transparency. RS has spoken to the Chief Nursing Officers at UHBW And NBT who will be presenting this to their boards. A report will be brought back to this committee in January for onward presentation to the ICB Board in February. **ACTION: FM to add Kirkup report to Committee forward planner for January.** JM said she and RS had reflected the need to be able to scrutinise, consider regulation and recommend change for safety, and to have the ability and permission within the system to explore this. The need to include the patient voice was noted. **ACTION: RS and CB to discuss including patient feedback in the November Strategy Report**	**FM** **RS/CB**
06.2	**Quality & Safety in Inpatient Settings** RS presented a letter received from Claire Murdoch, National Mental Health Director. This follows exposure of abuse at an NHS mental health hospital in Manchester and asks for assurance around our own patients in these settings. Adrian Childs, AWP CNO, has been asked for an update from AWP. There are also around 400 people who are supported in the community either singly or jointly with Local Authorities, and DM is preparing feedback on their care. There is also a broader more complex piece which is about our oversight of people placed in care settings in our system, but who are not commissioned by BNSSG. A report in further detail will come back to this committee in November **ACTION: FM to add Quality & Safety in Inpatient Settings to forward planner for November**	**FM**

	Item	Action
	PM noted inpatient care of children is often out of area and requested children's services be considered in the November report. DM said work is ongoing to understand the arrangements for these children. A group of children have been selected who have requested additional health funding and using these to inform what is needed. The overarching desire is to not place children out of area.	
06.3	**Winter Plan Update** ED noted the paper received was similar to that received for the September meeting. She asked CD to update on two areas: provision of beds and progress against the six key metrics from the winter letter. CD said reporting to NHSE against the winter assurance framework has now commenced. This includes local and national bed schemes. The first return is due at the end of next week. A daily summary has been produced showing a seven day rolling average for each of the six national metrics. There has been a decrease in 111 call abandonment which is an improvement. The national standard is less than 3% abandonment rate. There have been local issues with workforce shortage, following the provider taking on a number of contracts very quickly. PPG have also taken on Devon, but there has not been as much local impact from this. Current performance has varied between over 35%, which is a point of failure, to 15% and on some days lower than 5 %. The seven day rolling average sits at 15%. ED noted the speed to answer was around 700 seconds, versus 34 seconds nationally. CD said this is not included in the national metrics, but the answering time is expected to decrease in line with the lowering of the call abandonment rate. ED asked if there were any requests for the support from this committee or the wider system to improve performance. CD said the Winter Delivery Group is monitoring performance, serving contract notices and working through remedial actions. This work is still in progress but has led to the improvement in the call abandonment rate. The mean 999 call answering time has decreased during October from around 18 seconds to 11 seconds, but is still behind the aim on 10 seconds. SWAST have invested in the workforce with additional call handlers. This performance will also be impacted by demand in the system.	

	Item	Action
	Category 2 mean response time has increased to 76 minutes against a standard of 18. Most ambulance providers nationally are struggling with their Category 2 response times. Bed occupancy by No Criteria to Reside (NCTR) patients is 25-30%. ED noted that elsewhere in the paper it states there is 10% occupancy available in community settings and asked where these statistics are reviewed to ensure full use of available beds. **Action: CD to discuss local bed schemes with JM to ensure there is full use of available beds.** ED said asked if there was assurance that the system is on track to deliver the number of beds requested. CD said the system is behind trajectory for virtual ward progression. The most recent highlight report shows 50 virtual ward beds open, which are not always occupied, but the total should be at 100 by the end of October. The impact of Discharge to Assess (D2A) was not factored into the plan until October but the system is still not performing to the levels of P1 activity which were contractually agreed. There are 90 P3 and 68 P2 beds open. Spot purchase beds, which have not always been fully supported by therapy staff, have been reduced where there is space to do so. NBT continue to work on Same Day Emergency Care (SDEC) provision, which will not have an impact until later in the year. There are some concerns about workforce recruitment. Another 30 beds are expected to open at NBT, including 11 stroke beds, and the system is on track to deliver community services. A scheme is in place at AWP to deliver integrated medical and physical assessments to patients in ED but this will not have any impact until December JF asked what scrutiny is felt by partners from the ICB in respect of performance, or if they are held to account only by NHSE. CD said there is a weekly Winter Delivery Group which comprises Deputy Chief Operating Officers and Directors of Adult Social Services. Part of the remit of this group is to understand current performance and consider actions for improvement. This group reports to the Winter Escalation Group, where scrutiny and direct questions in relation to performances are picked up with Chief Operating Officers. JF asked if this placed enough pressure on partners, as historically this would have been done through contract monitoring meetings. CD said that the ICB works in collaboration to support partners, and the Winter Delivery Group is an official forum to focus on things that are not currently working as well as she should. JM said that her presentation will cover the huge amount of work that has been carried out recently in collaboration with partners. As a collective group there has	**CD**

	Item	Action
	been a shift to more action-oriented work, working with leaders across the system to find solutions. The role of the Chief Nursing and Medical Officers is to hold partners to account and escalate to Shane Devlin and the ICB Board. RS said her team continue to have regular conversations about Quality Assurance. CB said the ICB Executive Team have discussed the development of key messages to explain how the ICB is different from the CCG. The ICB is no longer a commissioning organisation, and there is a need to explain where responsibilities sit.	
06.4	**Hospital at Home Update** JM presented this item which arose from a previous meeting action to talk about community pathways. In the past few weeks there has been an increasing anxiety and awareness that the community pathways are not operating as the system would like. JM said she has been struck in recent paperwork that people use different language for the same thing, which is causing confusion about how these pathways are described. She has shared this with medical directors and found it helpful to go back to basics. Levels 1, 2, 3, 4a and 4b are the community pathways, with 1 being prevention and 4b being "Hospital at Home", also known as the Virtual Ward. Local Authorities talk about the same things in a different framework. JM talked through the presentation circulated with meeting papers, which gives examples of the different levels. A consultant has been brought in working two days per week to clarify the driver diagram and ensure there are actions and metrics to demonstrate impact. Currently the process is muddled and it is difficult to hold anyone to account. On Thursday there were 700 NCTR patients in the Acutes and Sirona, and as a result of this poor flow, there were 19 ambulances queuing at UHBW. There is a sense of urgency as the system enters a difficult winter with a potential flu epidemic and cost of living crisis. ED asked if the Winter Task Group is part of the escalation process described by CD. JM said it is included in the same top level executive governance. One of the objectives is to clarify whether that makes sense, as there has been feedback that there is currently duplicate reporting to multiple committees and groups because there is no clear management structure. ED praised the idea of simplifying and streamlining the processes.	

	Item	Action
	JM said that what she is asking people to consider for Winter are the mitigating actions. At the Winter Group last week there was a discussion on creative problem solving, and CD was tasked with identifying which actions are high impact and low cost to start with, so an achievable plan of action can be drawn up. RS said there needs to be a focus on NCTR patients as well as prevention work. CD noted the need to clarify what is operationally not being done quite right, and how it can be done better, and get this right first. JM said there needs to be honesty and transparency about challenges to drive improvements. PM said the Sirona Board have discussed the Discharge to Assess programme. ED said she noted in the benchmarking that BNSSG were bottom in April last year on 9 metrics, and now have moved to just 4, with an increase of green performance, and said she hoped this was a positive move forward. ED thanked JM for her report and her enthusiasm to make improvements.	
07	**Items for information** **7.1 Corporate Risk Register** **7.2 Committee Forward Planner** Items noted for information.	
08	**Action log** The Action log was updated as attached	
09	**AOB** JM noted that the first meeting of the ICB Health and Care Professional Executive (HCPE) is this afternoon. A report from JM and JF will come to this committee each month to cover improvement and celebration, and she suggested that every month the public quality papers of each provider were reviewed so there is some peer review and benchmarking. **Items to be taken to Board** There is no ICB Board in November. It was agreed for the following items to be brought to the December Board: Workforce, NCTR, Children's services.	

	Item	Action
	Date of next meeting: Thursday 24 November 0900 - 1130	

Freda Morgan
Executive PA
27 October 2022

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 21 November 2022, 0900-1130, on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sue Balcombe	Non-Executive Director, UHBW	SB
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Hugh Evans	Executive Director, Adults & Communities, Bristol City Council	HE
Paul May	Non-Executive Director, Sirona	PM
In attendance		
Michael Richardson	Deputy Director of Nursing & Quality, BNSSG ICB	MR
Caroline Dawe	Deputy Director of Commissioning (Performance Improvement), BNSSG ICB	CD
Jeff Farrar	Chair, BNSSG ICB	JF
Denise Moorhouse	Associate Director of Nursing & Quality, BNSSG ICB	DM
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Julie Bacon	Interim Chief People Officer, BNSSG ICB	JB
Anne Wray (observing)		
Freda Morgan (notes)	Executive PA, BNSSG ICB	TM
Apologies		
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sandra Muffett	Head of Quality & Patient Safety, BNSSG	SM

	Item	Action
01	**Welcome and Apologies** Apologies were recorded as above. SB and HE were welcomed as new members and AW was welcomed to observe. ED summarised the key challenges discussed in previous meetings, including workforce issues and the high number of No Criteria to Reside (NCTR) patients	

	Item	Action
	which has a knock-on effect on ambulance handover times and waiting times for elective care. The Committee are keen to look at long term plans, and CB's paper on the BNSSG strategy will be welcomed today. *Committee membership* ED noted members are still outstanding to represent Mental Health, Primary Care, and the Patient Voice. JF said he had met with Shane Devlin (Chief Executive, BNSSG ICB) this week to discuss how to incorporate the patient voice, both in committees and in the ICB Board meeting, and is waiting for more suggestions to ensure consistency across committees and the board. He said he is happy for RS to continue to pursue Healthwatch for this committee, as their involvement is much appreciated. **ACTION: RS to chase Healthwatch for Patient Voice representation.** **ACTION: JF to chase Mental Health representation.**	**RS** **JF**
02	**Declarations of Interest** PM noted he is a councillor on B&NES Council which is a neighbouring area and is also Cabinet Member for resources at B&NES Council.	
03	**Minutes of September 2022 meeting** Minutes of the previous meeting were agreed as a correct record. PM said there was a good minute around children's services and young people and asked if a timescale could be put on this. RS said this would be appropriate to be held as a deep dive conversation, to include Sirona. **ACTION: RS and LM to discuss timing for a deep dive conversation about children's services, and inform FM for the forward planner**	**RS/LM**
04	**CNO/CMO Update** RS presented this verbal report. There has been an area of notable practice with work carried out following the LeDeR Review into the death of Oliver McGowan and the investigations into his death. David Harling (National Delivery Director for Learning Disability Nursing, NHSE) carried out a two-day visit to review the actions, one day spent in 360 Bristol with national reviewers to demonstrate coproduction work on things including annual health checks, which were co-produced with people living in our community. The second day was a visit to NBT where David Harling walked through what would now be Oliver's pathway, and NBT shared the work they are	

	Item	Action
	doing inside the hospital in co-production with people from the Learning Disabilities and Autism (LDA) community. This was an exposition of what should be done to bring people to work alongside us, and what we should be doing to meet their needs. The then CCG funded inreach community teams inside NBT and UHBW seven days a week, to work with people with LDA to ensure reasonable adjustments were provided to meet their needs. Following this visit, NHSE are producing a report which should enable the independent review and MAR on Oliver to be brought to ICB Board for sign-off. Verbal feedback from David Harling was that this was exemplary, gold standard work. He acknowledged that there is always further work required, but there is a passionate team working on this across the system, and it was a great exposition of citizen co-working within the system. There is a need to be mindful that Local Authorities are working closely to share their financial position, and to not underestimate the impact of this on the system and our population. RCN ballot for the nurses strike has gone through, and all providers in the system have nurses who have voted to strike. A strike is anticipated before Christmas, which may not be aligned to other strike. This will be a significant risk to manage as although there is derogation to allow nurses to continue working in critical areas, understanding needs to be reached with RCN about what these critical areas are. Regular conversations with RCN are taking place, facilitated by HEE. There was an in depth debate last month about the NICU business case being produced by the provider collaborative to make changes to neonatology ICU provision across the system. There is aspiration to have all NICU beds at St Michael's, so they are more closely located with paediatric services. This has been in development for several years and is complex and increasingly expensive. There was discussion about the impact on the clinical pathway, maternity services and the workforce level needed. There are still issues to be mitigated, including high vacancy rates in neonatology, and the impact on the maternity care pathway needs to be understood. Based on what has been received from central government funding, there is an approximate shortfall of £20 million. There is a Health and Care Professional Leadership Workshop taking place on Wednesday 30 November, coordinated by a leading health coach, which will look at leadership across the system and how this feeds through the system decision making process. Work is still needed to build trusted relationships across healthcare professional leaders to collectively risk manage. The Chief Nursing and Medical Officer senior leadership teams are reviewing the ICB risk and decision making framework alongside the ethical framework and integrated clinical governance framework, to understand where decisions should	

	Item	Action
	be made as a system but also where individual organisations need to make decisions to meet their statutory requirements. At System Quality Group last week there was an in-depth discussion about the Kirkup report and understanding this in the context of broader workforce culture. Both acute trusts are working through what they need to do to respond, and this will be followed through by the LMNS. BNSSG's response to the Clare Murdoch letter was discussed, and updates received on the three Quality Improvement Groups. ED thanked Rosi for her report and asked her to pass on formal congratulations to the team for their system work on LeDeR. **ACTION: RS to pass on formal congratulations from this committee to the team for their work on LeDeR.** ED said the LeDeR work was a good example of system working. RS said she would like to bring the LeDeR work back more formally to a future meeting, and this committee will need to sign off the independent review. **ACTION: LeDeR Review to be added to forward planner for January** ED asked if, when the LeDeR work is taken to board, it could be used as an example when talking about looking forward at a strategic way of working.	**RS** **FM**
05	**Operational Report – Winter** LM presented. Monitoring continues against the six winter trajectories. There has been improvement against 999 call answering but not against 111 performance. There has been no improvement on handover delays, which exceeded trajectory for November on Monday 21 November, and around 200 hours per day are being lost in total. There has been limited improvement in NCTR, where actions are being taken forward as discussed at previous meetings. UHBW and NBT are streamlining processes and starting to plan discharge from the point of admission. NBT are converting non-clinical space to create an additional 35 beds on Level 6. Capital work is underway alongside additional recruitment. NBT have redeployed existing team leaders to pull teams together to ensure these additional beds are staffed accordingly. There is also commitment to fund additional Same Day Emergency Care (SDEC) with specialty review in ED and additional speciality support in Cardiac in UHBW and additional surgery in NBT. This will go live in December and should give a 32 bed benefit.	

	Item	Action
	An assessment centre is being set up for patients with mental health needs, and a mental health rapid response vehicle is in place which is activated through either 999 calls or through police contacting the 136 suite. Flow and ambulance handover delays are inextricably linked, and further work is needed to support NCTR. Conversations have been held with Directors of Social Service about how agency social workers could be funded to undertake annual review and assessments. 160 extra care sector beds have already been commissioned to support flow. Tim Whittlestone (Medical Director, NBT) is looking at a solution to support discharge medication to be available at weekends which is part of the challenge for care sector colleagues. A listening event was held last week with the care sector, and a further event is being held today with domiciliary care workers to understand where the barriers lie and how they can be unblocked. The Frailty Virtual Ward is coming on line and the Living Carer Model is coming into Bristol to support patients to come home, as we know this is the best place for the majority of patients. A further allocation of £11.5 million is to be split across the three Local Authorities and the ICB, and a further meeting is to be set up to discuss what can be done in within the system. It has been noted that domiciliary care workers are the lowest paid resource in the system, but are the workforce that the system relies on to deliver flow, and there has been discussion about what can be done to ensure they receive a fair wage and a guaranteed income. HE noted that beds in the longer term is a challenge, as bedded care capacity costs money, so these beds need to be easily manageable. There is a review taking place on intermediate care, and recommendations from this will come to the ICB Board in December. He reiterated the point regarding domiciliary care pay and said that there needs to be a system wide approach to this issue, so as to not divert capacity away from some organisations. **ACTION: HE to consider solutions to working together to enable throughput to community beds** SB said UHBW are working on increased use of discharge lounges and monitoring use of SDEC, however the real issue is stopping people coming to ED, and there needs to be more work with SWAST to ensure that only those people who really need to come to ED attend. Concentrating more effort on the front door will relieve the back door issues. SB cited work Somerset have done on admission avoidance, with use of rapid response teams and virtual wards. CB said the ICB strategy looks at the provision of acute beds in the system and will work with the Acute Care Provider Collaborative on how many beds are required, and how to ensure the optimum distribution across sites. There is more to be done on admission prevention.	**HE**

	Item	Action
	ED praised LM for her innovation in identifying plans to support improvement. She noted BNSSG is a very complex system and said she would welcome more new ideas that may support the system. LM said the issues around pay rates for domiciliary care workers has significant financial impact on local authorities and is not a decision that can be made as a single organisation. She said that what SB described is a symptom of the system's inability to connect things up; There is rapid response on the front door, two-hour admission avoidance from Sirona and SWAST are the lowest conveyor of all the ambulance services, but it has not been possible to connect these. October was the first month ED attendances exceeded 2019/20 levels, which means SDEC is working, but something more needs to be done to make this part of a universal system. Similarly, when rapid response was introduced for mental health patients, the police were given a number to call for advice, but this took 10 minutes to pick up rather than 3 seconds, so there needs to be a way to ensure a timely and efficient response. SB said she was not aware that Sirona provided rapid response. She said she was interested to hear that SWAST have the lowest conveyance rates, as considering the number of patients sitting outside ED and the number that are admitted, it makes you question why they are being picked up. The key is to join up these innovations. LM said there is a vicious circle; with the delays paramedics experience particularly in reaching category three patients, who have already waited 4 hours for an ambulance to arrive, and then needing to call the community response team. There needs to be connectivity and a clinical relationship of trust needs to be built so the connection is right every time. RS said there is also a difference in what an experienced ED doctor can do compared to a paramedic in prescribing and diagnostics, so a decision needs to be made about how much is invested in community response, and whether some of that investment should be in senior medical input. Stopping patients coming in is less risky but the Sirona rapid response model would then need to be 7 days per week, which would require a shift of model in the system. SB said that other systems have senior medics in rapid response. The next phase of a pilot would be enhanced paramedics with prescribing ability. PM said it is important to have a network in place so the community can easily access the Urgent Care Centres, as if people are able to access these easier, it would leave ED to deal with real emergencies.	

	Item	Action
	LM updated on Arctic Willow. An exercise was taken across three days to test industrial action not only by the health service, but the impact of teachers or fire service strikes and how these may affect ambulance responses to road traffic incidents if they run concurrently, and if coupled with power outages, what can be done. The lessons learned exercise and debrief focussed on the impact across the system and the need to have contingencies in place, including uninterruptable power supplies for key workers working at home, such as the 111 service, and setting up equipment stores for the elderly with no heating, to hold emergency equipment bags. **ACTION: Operation Arctic Willow to be added to the forward planner for December** ED asked how some of these ideas and experiences can be captured in current thinking. LM said every Friday the Directors of Adult Social Services and Chief Operating Officers meet with clinical leaders, and she will feed back to that meeting. PM offered to work with HE and SB on acute and community services to support LM **ACTION: PM, HE and SB to work on ideas for acute and community services to support LM**	**FM** **PM/HE /SB**
06	**Items for Discussion**	
06.1	**BNSSG ICB Strategy Update – to include Patient Voice and Health Inequalities** CB presented this item. The move to an ICS presents the opportunity to work in a more integrated and holistic way and having a system strategy for the population is a great step forward. The Integrated Care Partnership (ICP) will be publishing a framework based on work done so far, which is scheduled for public consideration on 16 December. This will build on work carried out by the Health and Wellbeing board through Integrated Locality Partnerships and through individual provider organisations. Patient, service user and carers voice will be included in the discussion. This is part of the overarching aim to improve on the four aims of the ICS, and CB said he wants this strategy to have a measurable impact on these four aims, and to deliver real change. One of the things to consider carefully is prioritisation, and to not try to do things simultaneously, but to maintain core	

	Item	Action
	standards while focussing on a rolling programme of work at strategic level to deliver change. The approach will be to build on the work already done in within the system and focus on a small number of agreed evidence-based strategic priorities. There is an opportunity to work very differently with the community sector, empowering service users and carers at every step, and on a different level, delivering value for the taxpayer will be important. Health inequalities need to be addressed intelligently. There is a group of people in our population who have multiple disadvantages or multiple high care health needs, and the integrated care model allows more scope to talk about these in a more holistic way. ED thanked CB for his paper and asked for this to be on the agenda as a standing item going forward. **ACTION: ICB Strategy to be added to the forward planner as a standing item** CB requested the Committee to note this update and support the development of the prioritisation framework and agree the immediate next steps. ED said bringing this strategy to life is important and will keep the focus on what it is going to deliver for the public. CD said he would be interested in reflections. He said he is keen to agree the prioritisation process so partners can be agreed on what priorities are being defined, what objectives are to be delivered, and how the impact of actions will be measured. PB said this document was a good start, and unless there is structure in place, there will be a series of initiatives but no long term improvement. He asked if the Health and Wellbeing boards were sufficiently resourced and empowered to have control over their localities, noting there is a very diverse set of communities in the BNSSG areas, and there is a risk of delivering an out of balance provision. CB said the locality leaders are on the Health and Wellbeing Boards, and there is a strong argument to say that given the diversity of the population, the localities are a key building block. They have been working through the process of prioritisation at local level and coming up with something grounded in the “Live Well” methodology. The populations within all localities are profoundly different, and that can mask inequalities within the areas, so it is right that the people on the locality partnerships are also on the wellbeing board and the Integrated Care Board, to ensure this thread runs through.	**FM**

	Item	Action
	HE said that comparing the experience of working in this ICB area with that of colleagues in other parts of the country, this ICB is very mature and has significantly higher involvement with Local Authorities than other areas. The localities are well established and some of the work has shown that different localities will do things in different way. There is scope to work from the bottom up and determine in their own ways how things should be. SB said that the acute providers will have to translate the demands, needs and expectations from all the localities, and what it means for them. For the public to be able to hold the ICB to account there needs to be measurable outcomes. CB said one of the other things to look at is commitment. There needs to be a candid conversation about what it would really take to solve problem, and to get commitment to the steps needed to make that change. Covid proved that if we want to do something, it can be done. HE said that for the first time, this appears to be a chance to have a strategy that feels real to people, and if it is used as a working document over the next years, it will have real value. PM said the one issue is that workloads tend to vary within the localities according to community needs, and there needs to have a corporate structure to respond to workloads.	
06.2	**Impact on performance and Quality of Service of Workforce Issues** JB was welcomed to the meeting to present this item. ED noted there is a system People Committee that reports into the ICB Board on workforce issues, however as workforce has featured greatly in discussions in this committee, it is important to understand how we work with other committees and the Executive Team on workforce issues. JB said the ICB is in its infancy in working through these arrangements and suggested bringing this report to the committee on a regular basis. The People Committee focusses one month on the ICB, and the following month on system workforce. There are plans to increase the workforce, particularly in nursing, with an aspiration to bring in almost 500 additional nurses and midwives and 200 support workers over the coming year, but this is unlikely to be delivered, mainly due to attrition rates, and it is important people understand this trajectory as it will impact how staff can be deployed over winter. The people programme needs to refocus on thing which will need system collaborative effort to deliver. The People Committee will try to balance short and medium term approaches, including education places, apprenticeships, and better career paths.	

	Item	Action
	JB asked if this committee wanted a data- or narrative-based relationship, noting that both RS and JM are members of the ICS People Committee. She said the People Committee is looking to manage the risk of workforce delivery, and also the risk of managing the impact on outcomes, safety, and quality. RS said she had met with JB yesterday, and discussed the need to understand the risk profile, and make sure there is good connection with the People Committee and the risk and issues within the workforce. System Chief Nursing Officers have discussed that workforce data is at system or provider level, which hides some pockets of risk which have been discussed at this committee, such as small niches teams which are at risk when they lose only one or two people. She said there needs to be understanding of the risk profile in larger workforce groups such as nursing or midwifery, and how that ties in to work with Health Education England (HEE). There has been good discussion with system colleagues to establish alignment on the biggest priorities, and the Chief Nursing Officers had good ideas about what actions could be taken quickly particularly about retention and making inroads into the operating plan. Further discussion is needed on what can be done in the short term about retention, including student and workforce experience and some of the pay models, but this needs to be looked at as a system. RS and JB are working to ensure that those working on workforce are aligned to the urgent priorities and the art of the possible on some of the retention options being put forward, and to explore further about productivity. JB clarified that productivity is not only about individual members of staff, but is system related, eg: staff on Covid absence, or dealing with higher acuity patients. RS added that patients being cared for in the wrong environment will also affect staff being able to do their roles. ED made reference to the 2ww cancer breast figure in the performance report and asked what the 14% represents. LM said this is the number of patients seen within 2 weeks. ED said this has been discussed at this Committee since its inception in July, and the figure has wavered up and down. She asked how this can be resolved when we know the problem is due to workforce. LM said the system needs to improve the ability to highlight where there are known clinical or care gaps in specialist area, eg: for breast cancer this is radiology and radiographers. Within specialisms there is a need to influence training and to align capacity and work planning. Flexibility in the working day needs to be considered; it is known that there are paramedics who are leaving to work in primary care because the hours are more regular, but for other staff, working shift patterns are more effective.	

	Item	Action
	JB said there is a need to triangulate workforce and performance data more clearly and identify if there is a recruitment or retention issue, and what support the ICB can give. MR said there is also a need to triangulate the student experience and data within the workforce issue. At the meeting with HEE yesterday, it was evident that a lot of the student experience is a direct reflection of wider workforce issues. JF reported he had recently met with Elizabeth O'Mahony (South West Regional Director, NHSE), and had discussed the role of the ICB, which is not to performance manage, but to identify what needs to be escalated. The ICB needs to identify where to focus whole system attention and not spend time managing individual organisations. ED said that although assurance actions are in place, if nothing has changed in six months, there needs to be discussion on what needs to be done differently. JF added and whether a problem is being addressed in the right areas. The role of the ICB is to facilitate the conversation, but accountability needs to be across the organisation, which is why we need people from partner organisations at this committee to ask questions. SB said that UHBW have had similar discussions about the overlap between quality and performance. She noted that sonographer performance on UHBW cannot improve the 32 week requirement, due to workforce capacity. If there are no discussions about where specific workforce issues relate to outcomes, the risks will continue to sit within individual organisations. ED thanked JB for her paper and asked her to come back again to the January Committee to discuss further actions. **ACTION: JB to return to the January Committee with a follow-up Workforce Report** PM said that although systems are being integrated as best as possible across the BNSSG area, there is at some stage the need for accountability from individual organisations.	**FM**

	Item	Action
06.3	**Quality and Safety in Inpatient Settings** DM presented the report to update colleagues on the response to the letter from Clare Murdoch (National Mental Health Director, NHS England) following the televised BBC Panorama programme showing a level of abuse taking place in a NHS Care facility for people with mental health needs, and which challenged organisations to ensure care for people in similar environments is of a standard they would be happy with. This will be a system piece of work requiring a system-wide mapping of where this population resides. Some are in NHS facilities, some with private providers, and some with micro-providers. The proposal is to map where the individuals are who are funded by the ICB, AWP and Local Authorities, and carry out a desk top review to understand where we have assurance and where we may need to dedicate some focus. The desktop exercise will include such things as checking CQC, registration and complaints, and will triage how colleagues are deployed to visit the providers. There are some providers where AWP have a strong and consistence presence, but detailed work may be needed with smaller providers where there is no regular insight or presence. AWP have already provided feedback on the process they are taking in response to this letter. The quality assurance work will require staff resource, and the committee was alerted to the risks and mitigations outlined in the paper. DM highlighted that the committee recognise this is not a quick piece of work, and will be something that where the aim is it will be done once, done well, and will put in place what further actions are needed. The paper was supported by the SQG. There is also the potential to look at domiciliary care provision for the same cohort, which will take learning from the first phase of this work. ED asked what the timescale will be to take assurance, and if there is anything that can be done in the short term for a quick level of assurance. DM said the mapping has almost concluded, and the desktop review will be completed month, and she will report back to the December Committee. **ACTION: FM to add Quality and Safety in Inpatient Settings to the forward planner for December.**	**FM**

	Item	Action
07	**Quality and Performance Report** LM updated on the performance report. NBT are likely to be moved out of national Tier 1 regulation on cancer due to the improvements they have made particularly around 2www Breast. Mega-clinics have been run with additional weekend shifts to move people forward through their journey, which demonstrates the work NBT have done both on validation and in offering additional capacity. There are two core areas of complaints. One is ADHD waiting times, which are significant and, in some cases, patients are waiting up to four years. This is a complex problem to solve, and there is work being carried out with patients to understand what they want from this service, as well as with clinical teams to understand what is possible, and a new model is being developed at Primary Care Network (PCN) level for the least complex patients, and a specialist model with AWP for those with multiple diagnoses. Arising from this work with users and carers is the importance of the diagnosis to them personally, not just providing treatment, but fundamental to their own support and linking them in with services. Once there is a plan for the future model of provision, a path will be mapped out, including waiting list initiatives, use of the independent sector, and making sure this is a whole system piece of work. The second area is autism diagnosis, particularly for children who can be waiting up to a year for diagnosis. Various pilots have been carried out, and a Children's Autism Hub has been created in Bristol. There has been significant interest in referrals, and BNSSG are national outliers. This is a more complicated piece of work as the diagnosis releases a number of things in a child's journey alongside the needs, and a redesign process is being started to think about what the needs of these children are, with interaction from education and children's social care. ED said this should be included in the deep dive report on children and young people, and asked what communication there is with those people who are on the waiting list. LM said that part of the work being carried out is validation, as the AWP system does not allow information to be recorded in the same way. LM summarised the key challenges as follows: improving flow, preparation for winter, NCTR patients. ED asked what would have the biggest impact and would be affected by being taken to the ICB Board. LM said it would be NCTR, as one of the other papers to this month's Board is for the authority for additional allocation of Adult Social Care funding, which would link in to NCTR. RS said she would like to raise awareness of the Kirkup report. Both UHBW and NBT are looking at this report, but the message to escalate to the ICB board is	

	Item	Action
	that it is not just about maternity, every organisation should look at the report and the context about what we hear about the care we provide, and how we look at the culture within our teams. Although this report is specifically about the maternity service, the culture issues are spread across the NHS, and she would encourage all partners to think about what Kirkup means to them in terms of MDT working and culture. RS will bring a report on this back to the Committee in February when the acute partners have completed their governance. MR said the two key points from the quality reports are the triangulation of serious incident themes and learning with performance, with a key theme of treatment delay. There is age standardised work being carried out on C. Diff which is below the regional England average, but not at a satisfactory level. A national call raised that C. Diff infection is spreading round the country, so there is some concern as mortality is high, particularly for frail elderly who have had Covid or flu.	
07	**Items for information** **7.1 Corporate Risk Register** **7.2 Customer Services & Complaints Quarter 2 Report** **7.3 Minutes: LeDeR Governance Group July 2022** **7.4 Committee Forward Planner** Items noted for information. ED asked if members had any items to note from these. ED said she thought the Customer Service report was very good, and noted the scale of Mental Health complaints, and asked for RS and LM to cover these in their reports. These complaints particularly focussed on waiting lists. ED noted there appears to be challenge around response times for AWP. She also noted the new process for Executive Directors to oversee complaints and the CEO to be involved in matters. MR said this is working well, and RS added the speed of complaint response is better and the quality of responses improved as they are now sitting with the Director responsible. RS said patient experience is one of the three pillars of quality, along with clinical effectiveness and safety, and there are clear arrangements for patient and public involvement which sit within the communications team. There is a clear structure in the ICB for clinical effectiveness and safety, but a gap in the middle about experience. RS and JM have discussed bringing teams together to work on this.	

	Item	Action
	LM said that currently primary care complaints come directly to the ICB, and it is expected this will continue when the ICB takes on delegated responsibility for community dentistry and pharmacy. SB said there is rich data held by providers and asked whether there is a need to look at trend data on a quarterly basis to understand where the focus should be. HE said Bristol City Council has done specific work with groups, particularly those with Learning Disabilities and Autism. The localities have a key part to play and he questioned whether there should be someone in each of the localities to oversee these interactions. PM said all the organisations have links with the People's Council and pick up issues about complaints and asked whether there may be a role for the Non-Executive Directors of organisations to be involved in dealing with complaints. MR said there needs to be a balance, as if there is too much data, this leads to measurement rather than action, but there does need to be themes from learning. Going forward, the Customer Services Team will be working with quality and safety colleagues to elicit themes from providers. JB noted the new mandatory Oliver McGowan training which has been brought in nationally and should have a positive impact. **ACTION: RS and MR to consider the gaps in patient experience and feedback, and how to move forward** **ACTION: Corporate Risk Register to be a substantive item at December Committee**	**RS/MR** **FM**
08	**Committee Action Log** As the meeting was overrunning due to healthy discussions on earlier topics, it was agreed for outstanding actions to be chased outside of this meeting. **ACTION: FM to chase colleagues for updates on outstanding actions.**	**FM**
09	**AOB** The Committee was asked by Sarah Carr, Corporate Secretary, to review the Terms of Reference. ED said she was happy to take discussions offline, but it is important to highlight what powers have been delegated to this committee. RS said she understood decision making sits with the Executive Leads who attend this committee, and for ED to hold them to account.	

	Item	Action
	ACTION: RS to review Terms of Reference and ensure they enable the ICB to carry out its statutory duties **ACTION: Terms of Reference to be reviewed again in January.** JF said he would speak to Sarah Carr. The Executive Team have to be responsible for delivery within the organisation and beyond. Delegation of responsibilities to committees will be done on an "as and when" basis. ED thanked SB, HE and PM for their contributions today.	**RS** **FM**
	Date of next meeting: Thursday 24 November 0900 - 1130	

Freda Morgan
Executive PA
27 October 2022

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 15 December 2022, 0900-1130, on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Jeff Farrar	Chair, BNSSG ICB	JF
Paul May	Non-Executive Director, Sirona	PM
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Hugh Evans	Executive Director, Adults & Communities, Bristol City Council	HE
Sarah Weld	Director of Public Health, South Gloucestershire Council	SW
In attendance		
Sandra Muffett	Head of Quality & Patient Safety, BNSSG	SM
Denise Moorhouse	Associate Director of Nursing & Quality, BNSSG ICB	DM
Geeta Iyer		GI
Freda Morgan (notes)	Executive PA, BNSSG ICB	TM
Apologies		
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Michael Richardson	Deputy Director of Nursing & Quality, BNSSG ICB	MR
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Sue Balcombe	Non-Executive Director, UHBW	SB
Sue Geary	Healthwatch	SG

	Item	Action
01	**Welcome and Apologies** Apologies were recorded as above. ED welcomed members to the meeting, and noted the decision was made to hold a shorter meeting this month, due to system pressures. Any issues arising will be tabled for January and February. ED said that two issues stood out to her in the papers for today's meeting. She asked RS to provide a short update on safeguarding, as the quarterly report	

	Item	Action
	mentioned a risk in the ICB's ability to fulfil statutory functions due to designated nurse availability and limited capacity in the team. ED asked LM to update no Sirona performance, particularly 78 and 104 week waits, and if the trend was a cause for concern.	
02	**Declarations of Interest** No new declarations noted	
03	**Minutes of September 2022 meeting** Minutes of the previous meeting were agreed as a correct record.	
04	**Board Assurance Framework** LM introduced the Board Assurance Framework (BAF) which is a statement of progress and deliver concerns against the first part of the Winter Plan, which was signed off at the October Board. Key items to note are as follows: There has been a delay in opening beds at NBT, resulting in a 35 bed delay. The expansion of SDEC has gone live at both UHBW and NBT. There has been a delay in the rollout of the Discharge to Assess (D2A) pathway 1 activity, which has been compensated by buying additional nursing home and care sector beds and the establishment of virtual wards which are now monitored weekly. ED asked how this framework is being used by the Executive. LM said the BAF is discussed at the Winter Escalation Group as part of the review of the winter plan schemes. Membership of this group is Chief Operating Officers, Directors of Adult Social Services, Chief Nursing Officer, Chief Medical Officers, LM and her deputies. The group reviews what schemes are working or delayed and what else can be done. BNSSG is significantly behind on all trajectories for delivery both for general acute beds, and ambulance handover delays and 111 call abandonment rate, and the group are working on what additional mitigations can be identified and delivered. ED asked if there was a reason BNSSG is behind on trajectory, for example were the plans too ambitious, or was there not system-wide sign-on to delivery. LM said the NBT wards were dependent on capital works which have been delayed in going live and will complete this month. A team is in place to staff these wards. Virtual Wards were delayed due to an issue about agreeing recurrent funding which was escalated late by the programme director. The Chief Executives have now signed off the funding. The D2A delays are due to workforce issues and difficulty recruiting reablement staff. Mitigations are in place including live-in carers to backfill arrangements. ED asked how progress is fed back to NHSE regional colleagues. LM said a monthly return is completed, and a check and challenge exercise is completed with regional colleagues.	

	Item	Action
	JF said the challenges he receives from regional and national colleagues are about how the system is managing performance, which is reported into the audit committee. He asked if the BAF is also presented to the audit committee. LM said that this document is a national template and comes to this committee and to the ICB Board as required. PM asked if the team are able to pick up at regional meetings what is happening in other areas. LM said that there is scrutiny on BNSSG Actions, but there is also learning taken from what other areas are doing. ED asked how often performance is reviewed by the team. LM said that urgent care flow is reviewed weekly. ED asked LM if the trajectory is likely to improve. LM said a performance notice has been issued to Severnside about 111 call abandonment rate due to an unacceptably low service level. Ambulance handovers are so far behind trajectory that extraordinary actions need to be taken across the region to open extra cohorting areas to ensure ambulances can be released and reduce handover delays. Up until a week ago CQC had been clear this should not be done, but these actions are now being taken to improve flow. Progress has been made in call answering and 999. There had been progress made on No Criteria to Reside, but this has now stalled. ED asked if there was any ask of partners to support with unblocking. LM said there is no one organisation blocking progress, but there is a need to ensure each part of the programme is streamlined. ED asked RS and LM if they had any feedback on the Winter Escalation. RS said it is a good place for discussion, but she and LM need to ensure the right seniority of attendees at the Friday meeting so as to not repeat Wednesday conversations.	
05	**Winter Resilience** Discussion covered in item 04 above.	
06	**Better Care Fund** LM presented. An allocation of £11.5 million has been received across the three local authorities in the ICB, and a paper is being taken for board approval by Chief Executives this afternoon about how this money will be used to support discharges into winter. The allocation has been split into three categories. Stabilisation, including bringing forward a pay award for domiciliary care staff from April to now to stabilise and sustain the workforce, and incentive payments for retention. Administration – how to ensure the capacity tracker is kept up to date and live so that availability in care and residential sectors can be monitored and supporting the brokerage team to deliver more placements through increased capacity, and the employment of agency social workers to release existing staff from annual	

	Item	Action
	reviews and carry out care act assessments. Additionality – being able to accelerate discharges in terms of bed days. This will be monitored on a fortnightly basis and returned to the national team. A monthly summary will be brought to this committee. HE said that he understands from colleagues that this has been a good collaborative piece of work which is functional and give a good chance of success. JF said he had spoken with Marvin Rees (Mayor of Bristol) about Better Care Fund allocations and given him assurance the allocations will be reviewed and will feed this back to him. HE said this is the winter discharge money which is in addition to the Better Care Fund, and colleagues are keen to agree allocation of the main Better Care Fund. SW said that from a South Gloucestershire perspective this has been well received but the ambition to review the Better Care Fund more generally remains. ED asked for an update on how this work is performing to be brought to the January or February Committee. **ACTION: Better Care Fund update to be added to the forward planner for January or February** HE said it was good to note that community oriented and social elements are included in these plans. He noted that timescales and national expectations to feedback can be onerous, but the system is moving in the right direction. **ACTION: LM to share Better Care Fund papers with FM for circulation after this meeting**	**FM** **LM/FM**
07	**Emergency Planning update** LM asked the committee to note the letter from NHSE showing substantial assurance following the annual EPRR assurance process. The key challenge to retain full assurance is in relation to counter measures, the ability to deploy at scale and the need to be able to, for example, administer antibiotics to a large population or respond to a chemical incident. Similar exercises have been carried out in reality, such as the provision of diphtheria immunisations and antibiotics for the asylum community, and dealing with a measles outbreak, but this cannot be tested until national guidance is received.	

	Item	Action
	An assurance exercise for emergency planning is undertaken with each organisation. Sirona and UHBW have had their assurance score reduced, and the team are working with these organisations so they can meet full compliance for next year's assurance process. LM said she had also included feedback and outputs from Arctic Willow which was a combined national exercise for both industrial action and power failure, and there a number of actions arising from this, including preparation for planned power outages to identify which sites have generators and how long they will work and arrangements to support vulnerable people in their home environment as much as possible. PM asked if there is any message he should take back to Sirona. LM said action and training plans are in place, and the team are working to support, including working through an evacuation plan and carrying out a desktop exercise. There needs to be evidence these have been completed, and there is confidence these plans are being worked through. SW asked if the assurance exercises include the local authorities. LM said that it does, including the civil contingencies team and adult social care, so the whole system is covered. SW said that South Gloucestershire Council carried out an exercise this week on national power outages which showed the interdependencies between health and social care.	
08	**Committee Action Log** Action log updated as attached	
07	**Items for information** **7.1 Safeguarding Quarter 2 Report** **7.2 Quality and Performance Report** Items noted for information.	
09	**AOB** ED asked RS to update on any quality issues. The RCN held their first strike today. Both acute trusts have had a significant number of nurses on strike but have been able to cover clinical areas this morning. There are significant risks attached but these appear to have been mitigated. The second strike is planned for next week, and there are reports of a large number of	

	Item	Action
	people joining the union to be able to strike on future dates. Three 24 hour strikes are planned for January. The ambulance service is also striking next week. BNSSG has been running with a small safeguarding team, which is at approximately 50% of the capacity recommended in the intercollegiate guidance. This is a legacy position that the ICB have been in for some while. An additional designated children's nurse has been appointed using contingency funding, and broader work is needed on the structure of teams to mitigate risk in the safeguarding team. There is no immediate resolution. Statutory duties are being met by the team but not at pace, so while the team are fulfilling their duties to respond to rapid and safeguarding reviews and attending safeguarding meetings within the system, the issue is that BNSSG are slower than would be wished to implement improvements and ongoing learning assurance. ED asked for a response to some for these challenges to be brought to the February committee. **ACTION: Update on Safeguarding Challenges to be brought to the February committee** PM said Sirona and the Local Authorities have their own safeguarding teams, and asked if there has been an attempt to maximise effectiveness across the board. RS said there has been a discussion with directors of children's services about what can be done to mitigate collective challenges, and whether to continue with three different sets of safeguarding arrangements in the three local authorities. She said she believed partners are minded to review these arrangements to maximise efficiency. SW said that as Chair of the West of England Child Death Overview Panel (CDOP), she would like to ask why there has been no attendance from the ICB at this meeting, and whether this is due to capacity. RS said that Anne Fry, the previous Designated Nurse for Children's Safeguarding used to attend. **ACTION: SW to follow up attendance from the ICB to the West of England CDOP and copy in RS and FM** PM said the Royal College of Nursing survey did not include community services, and Sirona are working effectively across the board to try and help the situation. RS said the ICB are managing the system response to industrial action with all system partners. LM updated on Sirona performance. In the interest of being clear and transparent across all aspects of elective waiting time, Sirona and AWP planned care performance is being reported. NHSE only monitor activity in the acute partners, so during Covid a lot of elective work within Sirona was stood down as part of the national mandated changes, so there are now delays in elective work. As data improves, there is more clarity in arrangements, and the same process will be undertaken to address these waiting list as has been done in the acute partners. The ICB needs to be clear where the challenges sit outside the acute sector and	**FM** **SW**

	Item	Action
	is working on what mitigations can be put in place to reduce these waiting times to an acceptable level. ED asked if there was anything further to highlight from the performance report. LM said the children's dashboard has been included as the increased demand for children's care is a cause for concern. ED thanked external partners for their contributions and noted that all contributions are welcome, not just those from their own areas of expertise. It was agreed that representation from all areas is important at this committee.	
	Date of next meeting: Thursday 26 January 2023, 1400-1630	

Freda Morgan
Executive PA
15 December 2022