

Meeting of BNSSG ICB BOARD

Date: Thursday 4th May 2023

Time: 09:30-1500

Location: Somerset Hall, The Precinct, Portishead, BS20 6AH

Agenda Number:	7.1.1	
Title:	Quality and Performance Report – Month 11 (February data)	
Confidential Papers	Commercially Sensitive	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	no
	Other (Please state)	No

Purpose: Discussion & Information

Key Points for Discussion:

The 2 attached reports provide an overview of February 2023 data to cover Month 11 activity for quality and performance. A summary is provided below.

The committee are asked to note the following areas.

Quality (Appendix 1)

Independent mental health provider -

- Quality improvement groups (QIG) continue every 4-6 weeks to monitor and support the improvement action plan for a mental health provider within the system.
- The improvement plan was reviewed at the QIG meeting on 14 April and the significant amounts of progress made in the last 6-9 months were recognised by the group.
- The provider currently remains in enhanced surveillance until there is confidence that the patient safety, quality and estate improvements are embedded (estimated to be until July 2023 with current rate of progress).

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



- The system continues to be under pressure from the waves of industrial action from the various health unions.
- A system Equality and Quality Impact Assessment (EQIA) is being continually refreshed to demonstrate the gaps in mitigation from the industrial action, and thus impact, and potential for harm.
- The EQIA will be an iterative process measuring cumulative impacts over time which will be shared in future versions of this report.
- A system preparation and planning continues for the next wave of RCN action which is currently scheduled for 30 April to 2 May 2023.

Healthcare Associated Infections

- C. diff – In February 2023, 10 cases were attributed to BNSSG ICB which is a decrease of 4 against the previous month and the second consecutive month that has seen a decrease in cases. The CDI working group continues to work with system and regional partners to understand the drivers behind a higher prevalence and incidence of CDI.
- E. coli - In February 2023, 44 cases of E. coli bacteraemia (an increase of 7 from January) cases were assigned to BNSSG ICB. Case activity encouragingly remains below the thresholds set by NHSE, below the Southwest benchmarking and below 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 with a working group taking this forward.
- MSSA – (Methicillin-resistant Staphylococcus aureus) In February 2023, 10 cases of MSSA bacteraemia were assigned to BNSSG ICB which is 13 lower than the previous month. Case activity has been below the Southwest average since May 2021.
- MRSA - (Methicillin-resistant Staphylococcus aureus) In February 2023, there were 3 cases of MRSA bacteraemia assigned to BNSSG ICB, which is an increase of 1 from January 2023. The 3 reported cases were attributed as 1 x hospital acquired (HOHA) and 2 x community cases (COCA).

Serious Incidents and Learning

In February 2023, 21 Serious Incidents (SIs) were reported across BNSSG providers. There were no reported Never Events. The leading themes from the reported incidents were Sub optimal care, Treatment delays and Pressure injuries. Overall, the top three themes being identified as causal factors from the investigation process for general SI's are 1) Communication /MDT 2) Risk Assessments and care planning and 3) Care delivery.

The learning from these incidents alongside the themes and trends are shared with the providers and discussed at the monthly learning panel which is attended by system partners. For many of the incidents it appears through dialogue with partners that there continues to be an association with the current system pressures.

Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LfPSE) progress within the ICS.

From September 2023, NHS partners are expected to work under the Patient Safety Incident Response Framework (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety events (incidents) for the purpose of learning and improving patient safety.

There is also a requirement for provider organisations to transfer uploading their patient safety events to the recently implemented national database LfPSE which replaces the historic national NRLS database.

The report contains an update (slide 18 & 19) on the current position for both PSIRF and LfPSE for the 5 largest partners within BNSSG.

Funded Healthcare

Adult Continuing Healthcare

- CHC overall caseload increased by 20 cases.
- 80% target for assessment within 28 days of referral met with the current position being 90%.
- 27 individuals met criteria for CHC funded care in month – 16 as a result of focused fast track reviews.
- Referrals up by 2% on the year-to-date average.

Adult Fast Track End of Life

- Caseload size reduced by 15% compared to January – resulting from focussed reviews and equates to a reduction of 63 cases.
- Number of cases in receipt of Fast Track funded care for more than 12 weeks has reduced from 163 (January) to 111 (February).

Learning Disability and Autism

Adults

- Continues to be an increase in CTR activity 44 Professionals meetings/ MDT's/ Safeguarding/Discharge planning meetings for adults.
- CCG commissioned placements remain below trajectory however SWPC (Secure) placements remain above the trajectory to reach the Long-Term Plan target.

CYP

- CETR and LEAP activity has been reduced significantly in last 2 months which aligns with the keyworker team being fully operational.
- The C(E)TR team are providing additional support to the Keyworker Team to triage requests.

Performance (Appendix 2)

- Trusts 4-hour performance improved from 67.8% to 70.7% in March and is better than the national average of 56.8% for Type 1 EDs. The system achieved the ambulance handover plan in February and is on target in April to do the same.
- The system continues to coordinate and oversee industrial action with all system partners including production of an EQIA as highlighted above in the Quality update to help the system understand cumulative impact of patient harm. Performance during the last BMA IA (11 to 15 April) was generally good from a system flow perspective with no criteria to reside patients in both acutes reducing including beddays, however, community no criteria to reside delays are starting to increase. Further RCN IA is planned on 30 April to 2 May. A debrief exercise from the first junior doctor strike has taken place and further debriefs planned in May.
- The number of out of area placements for mental health patients increased during the last BMA IA period and pressure was felt across the system in terms of supporting patient flow through places of safety.
- The Performance report concentrates on February and where available March information. For elective the system did well on 22/23-year end achievement of elective targets with zero 104 weeks wait capacity breaches, resulting in 9 breaches only mainly due to complexity of pathway – plastics and 258 78 week wait overall breaches, 163 due to complexity of pathway. NBT and UHBW achieved the 63+ day backlog cancer target. Industrial action impact on 78-week waiters and the 62d urgent cancer patients do not appear huge (16 long waits rescheduled and 78 cancer patients), however, these numbers do not reflect the less bookings made and therefore the total opportunity cost.

Industrial action will impact on long waiters and cancer patients and lists will deteriorate in April, also exacerbated by the number of bank holidays going into May.

Recommendations:	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
Previously Considered By and feedback:	Not previously considered
Management of Declared Interest:	None declared
Risk and Assurance:	The report and appendices provide an update to the Outcomes, Quality & Performance Committee 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 Outcomes, Quality, & Performance Committee for information and discussion.
Author(s):	Caroline Dawe - Deputy Director of Commissioning (Performance Improvement) Gary Dawes - BI Manager, Performance, BNSSG ICB Sandra Muffett Head of Patient Safety & Quality, 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

BNSSG Quality Report

**April Report on Month 11
(February data) 2022/23**

Contents

- **Current updates/emerging issues** **Slide 3**
- **Health Care Acquired Infections (HCAI)** **Slides 4– 12**
- **Serious Incidents (SI) and Never Events (NE)** **Slides 13 – 15**
- **PSIRF and LfPSE progress within the ICS** **Slides 16 – 17**
- **Funded Care – Continuing Healthcare** **Slides 18 – 20**

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

Quality - Current updates and any emerging issues identified since February 2023

Gynae 2ww:

The System is seeing an increase in demand on the 2ww pathway. It has been suggested that a contributory factor may be an increased usage of Hormone Replacement Therapy (HRT) and therefore increased post-menopausal bleeding referrals. A high number of these women could avoid the need for a 2ww referral/gynae Outpatient Appointment (OPA) if they had access to a prompt gynae ultrasound, however there is insufficient capacity in the NBT system to offer this due to a shortage of gynae ultrasonographers. Clinicians are agreed on a pathway to direct appropriate women straight to ultrasound, who are then managed in the community following clear guidance, however further work is exploring how this pathway can be delivered to provide an equitable model across the ICS.

E-Zec Non Emergency Patient Transport:

Following a Care Quality Commission (CQC) inspection E-Zec has been issued a notice for not meeting Regulation 12, section (1)(2)(a)(b), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. E-Zec have completed an improvement plan and will share with the ICB at the System Quality Group in April.

Mental Health Bed Availability:

Anecdotal information has been received following an incident involving patient harm that the system has seen a rise in delayed mental health act assessments and admissions due to national Mental Health bed shortages. Further analysis of the issue is currently being undertaken by the ICB with AWP and the Local Authorities to identify the scale and impact of the issue identified; this will then be taken to the SQG meeting for discussion and information.

Independent mental health provider:

Quality improvement groups (QIG) continue every 4-6 weeks to monitor and support the improvement action plan for a mental health provider within the system. The improvement plan was reviewed at the QIG meeting on 14 April and the significant amounts of progress made in the last 6-9 months were recognised by the group. The provider currently remains in enhanced surveillance until there is confidence that the patient safety, quality and estate improvements are embedded (estimated to be until July 2023 with current rate of progress).

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

The system continues to be under pressure from the waves of industrial action from the various health unions.

A system Equality and Quality Impact Assessment (EQIA) is being continually refreshed to demonstrate the gaps in mitigation from the industrial action, and thus impact, and potential for harm.

The EQIA will be an iterative process measuring cumulative impacts over time which will be shared in future versions of this report.

IA system preparation and planning continues for the next wave of RCN action which is currently scheduled for 30 April to 2 May 2023.

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

Reporting Period – Month 11 2022/23 – February data

Information Source and date of information – UK Health Security Agency (UKHSA), ICS HCAI Lead

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 February 2023

- **CDI** = 10 HOHA=6 (UHBW-5, NBT-1), COHA=2, COCA=1, COIA=1
- **E. coli** = 44 HOHA=6 (NBT-3, UHBW-3), COHA=4 COCA=34, COIA=0
- **MRSA** = 3, HOHA=1 (UHBW-1), COHA=0, COCA=2, COIA=0
- **MSSA** = 10, HOHA=3 (UHBW-1, NBT-2) COHA=2, COCA=5, COIA= 0
- **Klebsiella** =9, HOHA=2 (UHBW-1, Papworth-1) COHA=1, COCA=6, COIA= 0
- **Pseudomonas aeruginosa** = 2, HOHA=2 (NBT-1, UHBW-1), COHA=0, COCA=0, 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

Going forward the SPC diagrams will provide a 12-month rolling value instead of monthly values. This will remove the variation which is seen monthly and limit the impact of seasonal impacts on the process. Targets/Thresholds set are those set for 22/23.

The SPC data points for BNSSG ICB assigned cases this month are within the upper and lower limits which shows that the process (or the number of cases) is generally steady or within its expected bounds, although E.coli demonstrates a trend of improvement.

C. Difficile is exceeding its target and MRSA activity is deteriorating. The remaining infection targets are erratic and it is not possible to confirm if the year-end threshold target will be met.

In particular the numbers of MSSA HOHA cases are causing some concern in recent periods.

There is “special focus” on Hospital Onset HCAI this month.

Commentary

- MRSA- Zero tolerance has not been achieved. There were 3 cases in February. 1 in the Hospital and 2 in the Community.
- CDI- The 10 cases are currently categorised as follows: New infection (7), Repeat/Relapse (3).
- E.coli- the majority of the 44 cases continue to be Community Onset (34).

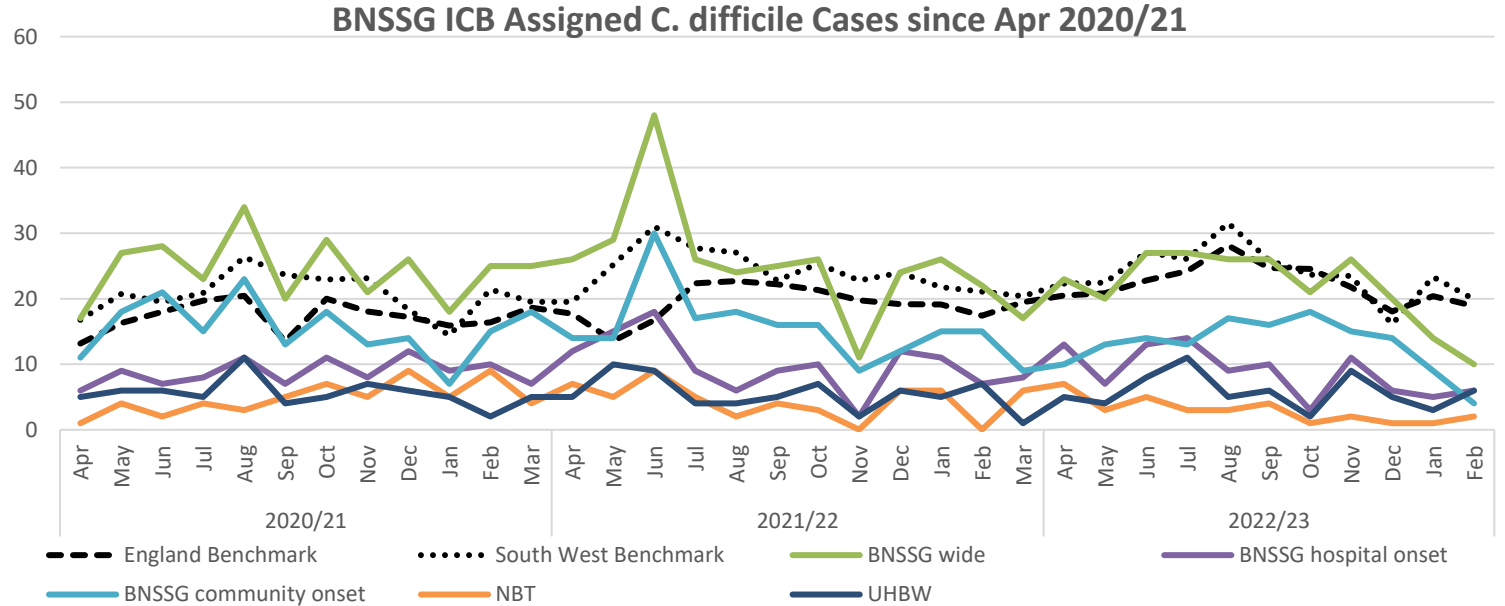
Assurance

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

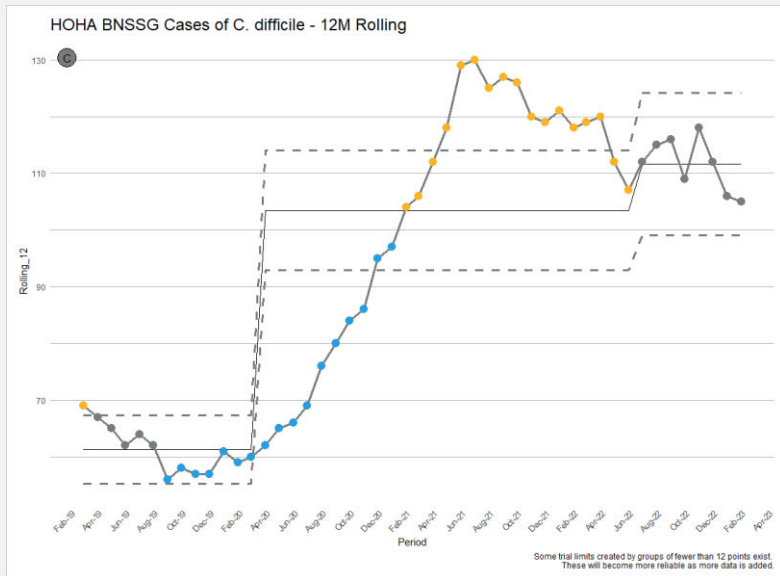
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Threshold to date	Assigned Cases 2022/23	Position against threshold	Month 11 position 21/22	Month 11 position 20/21
C. difficile	23	20	27	27	26	26	21	26	20	14	10		282	240	↓	287	268
E. coli	42	39	49	43	40	47	44	41	33	37	44		490	459	↓	516	526
MRSA	4	2	1	1	2	5	1	4	1	2	3		0	26		35	29
MSSA	16	12	10	17	13	18	22	18	23	23	10		182			152	166
Klebsiella spp	11	13	16	17	17	12	10	19	8	12	9		147	144	↓	149	139
Pseud A	3	5	7	6	7	9	6	2	4	4	2		58	55	↓	63	56

*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.

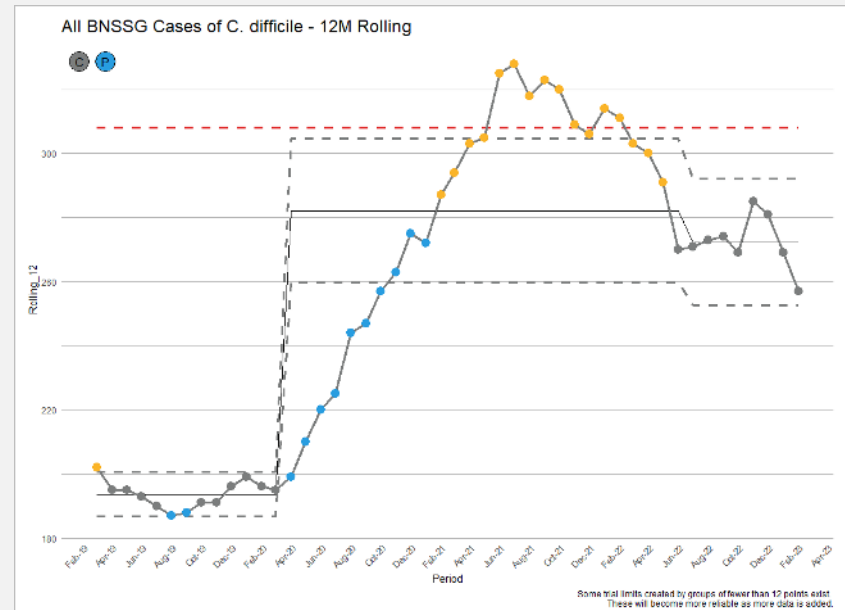
C. Difficile	10
HOHA	6 (NBT -1, UHBW-5)
COHA	2
COCA	1
COIA	1



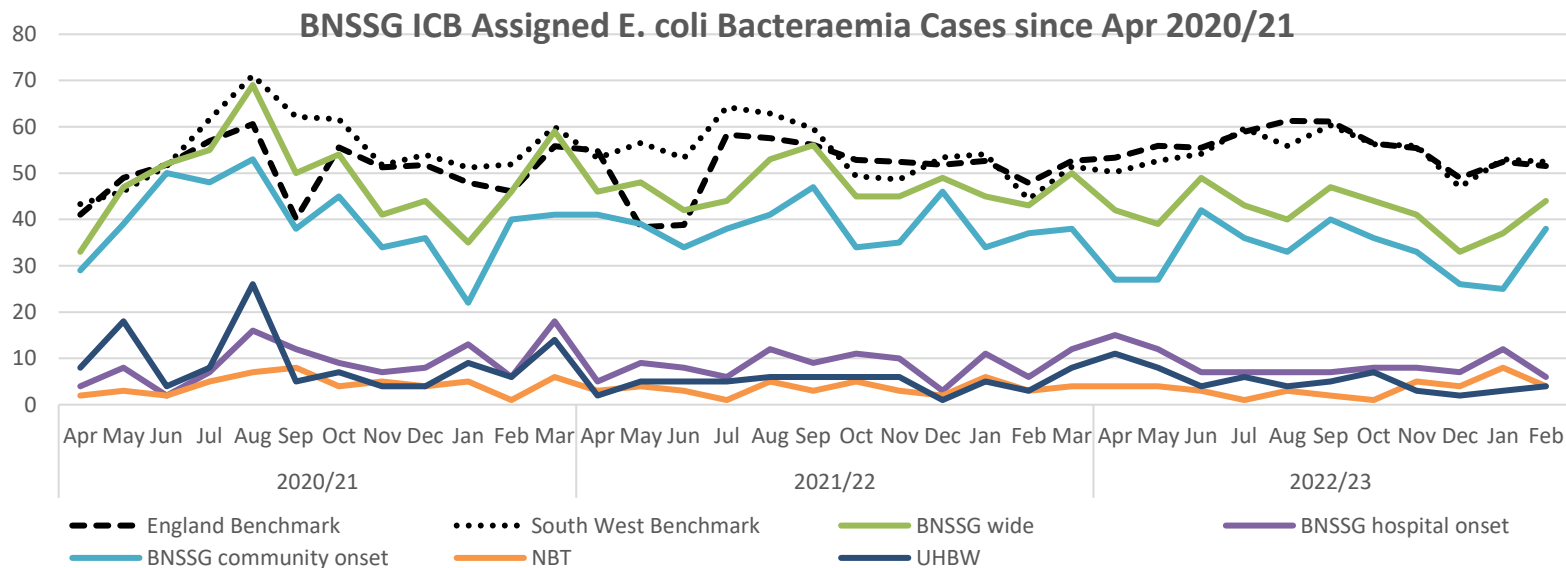
No significant change in data for Hospital Onset C. Difficile. Concerning variation would be if the data points exceeded Upper Limit (grey dashed line). Data will be more reliable with more data points.



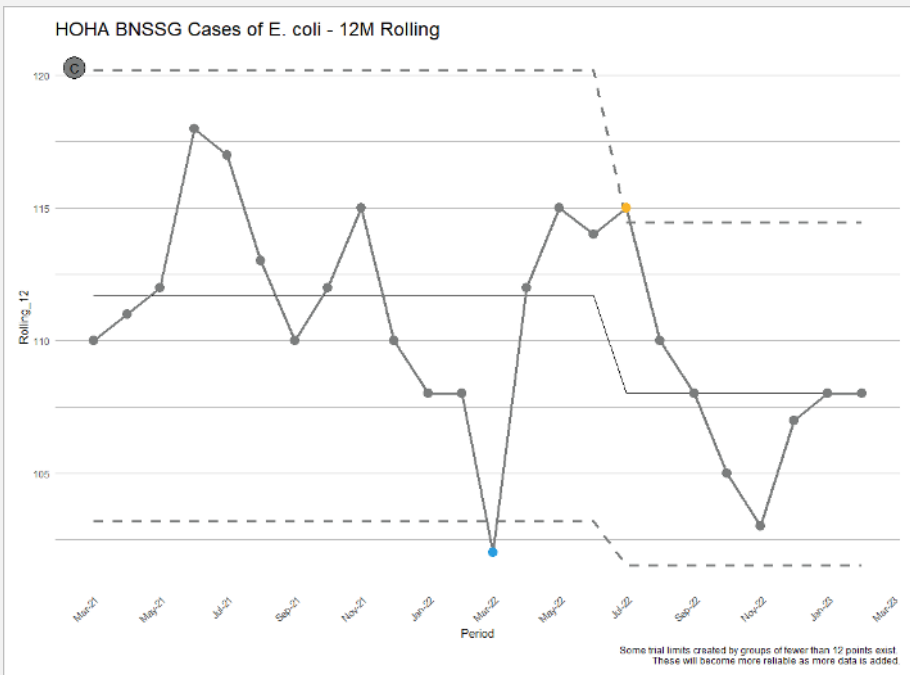
No significant change in data BNSSG Wide C. Difficile. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. 12-month position is passing the 22/23 target.



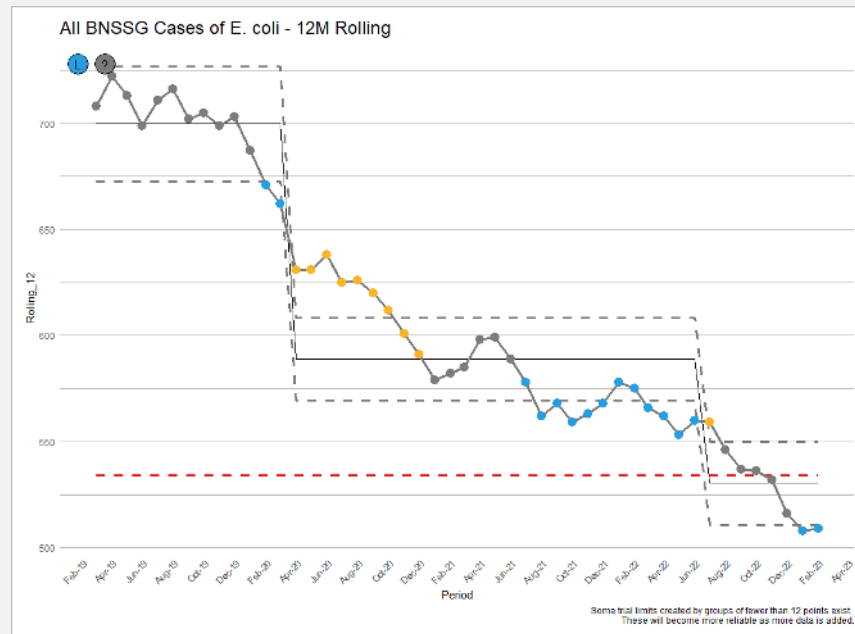
E. coli	44
HOHA	6 (NBT -3, UHBW-3)
COHA	4
COCA	34



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

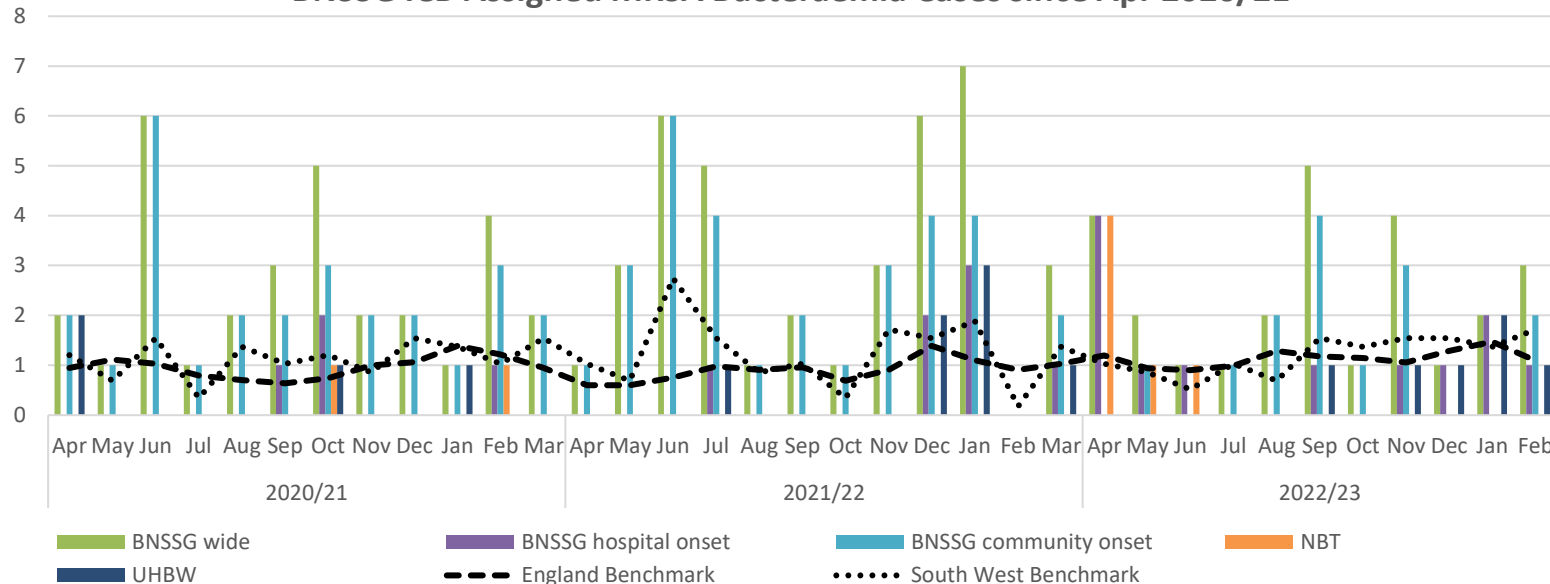


12 Month rolling position is improving for BNSSG Wide E. coli. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Passing target but as this lies between the 2 bounds it is classified as hit and miss.

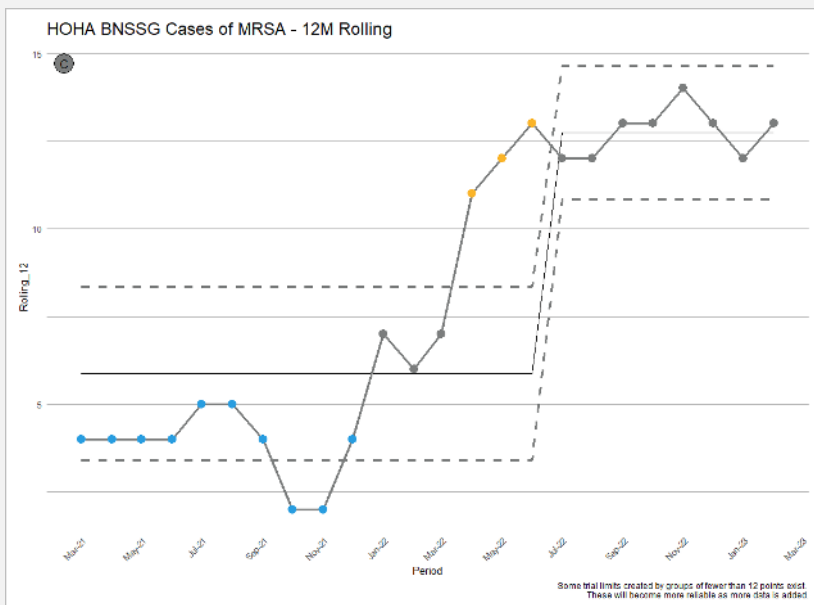


MRSA	3
HOHA	1 (UHBW-1)
COHA	0
COCA	2

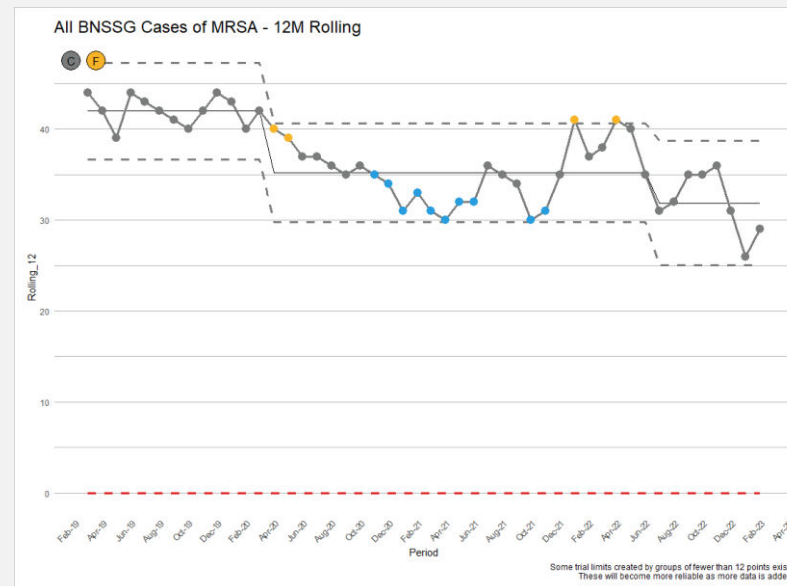
BNSSG ICB Assigned MRSA Bacteraemia Cases since Apr 2020/21



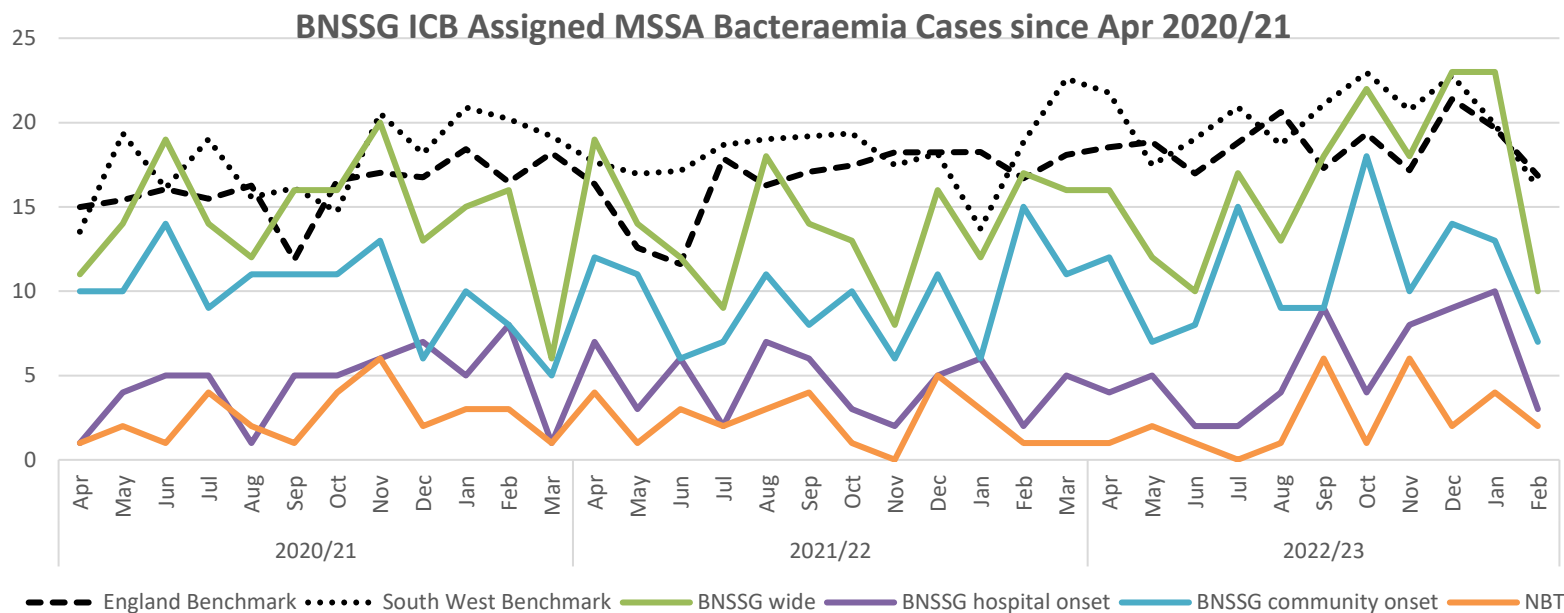
No significant change in data for Hospital Onset MRSA. Exceeding zero thresholds.



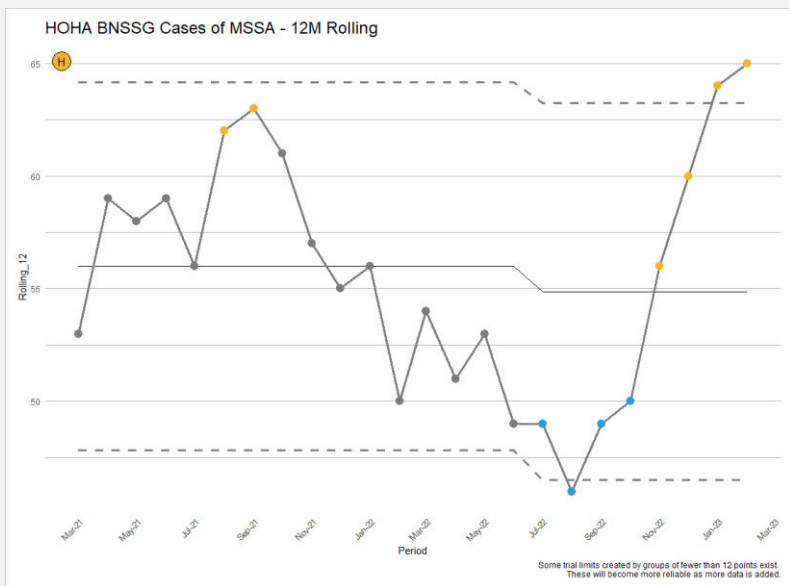
No significant change in data for BNSSG Wide MRSA. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Failing target of 0.



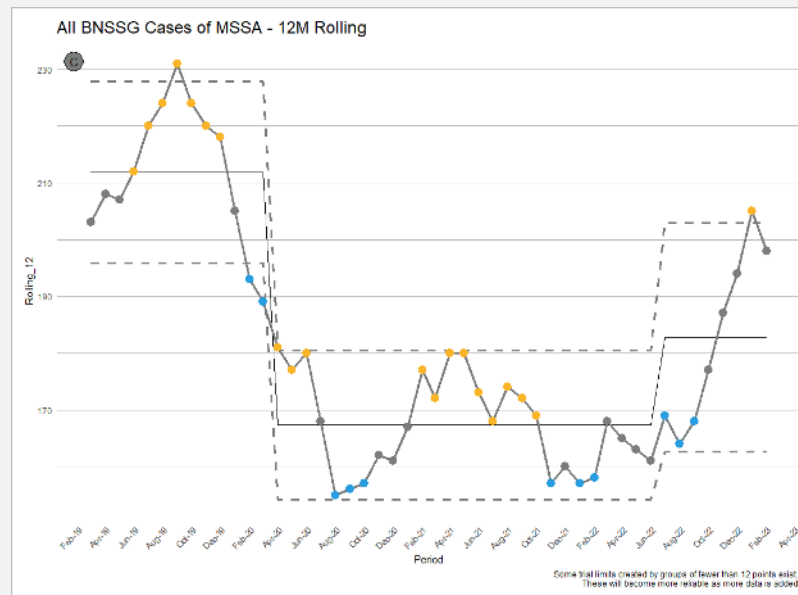
MSSA	10
HOHA	3 (NBT -2, UHBW-1)
COHA	2
COCA	5



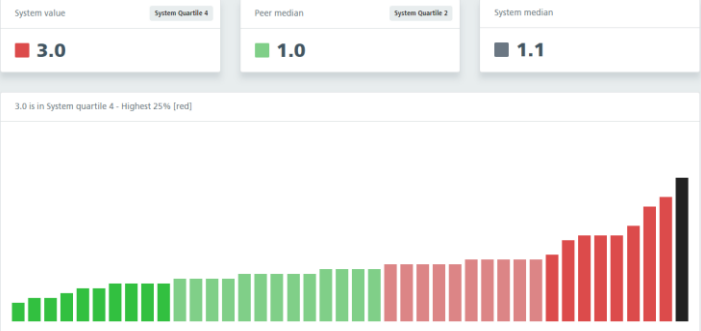
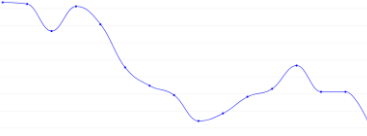
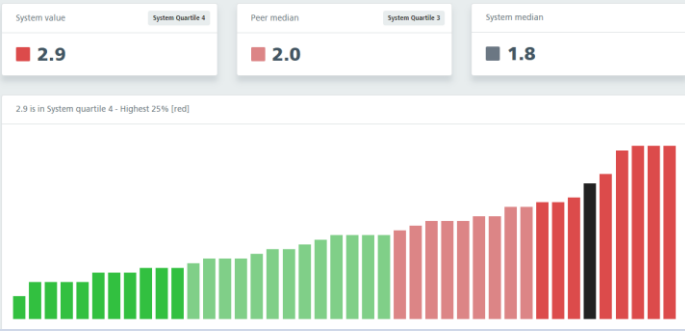
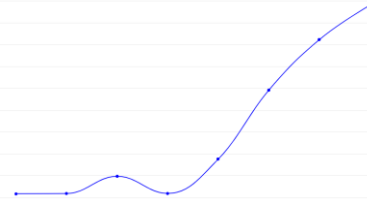
Hospital Onset MSSA is showing a variation of a concerning nature, a sharp increase over the previous 7 months. This metric is displaying a 12-month rolling total.



Overall, BNSSG Wide MSSA is showing no significant change. However due to the recalculation limit in July 2022, our upper and lower bounds of the moving range have widened significantly. **This increase appears to be a continued trend.**

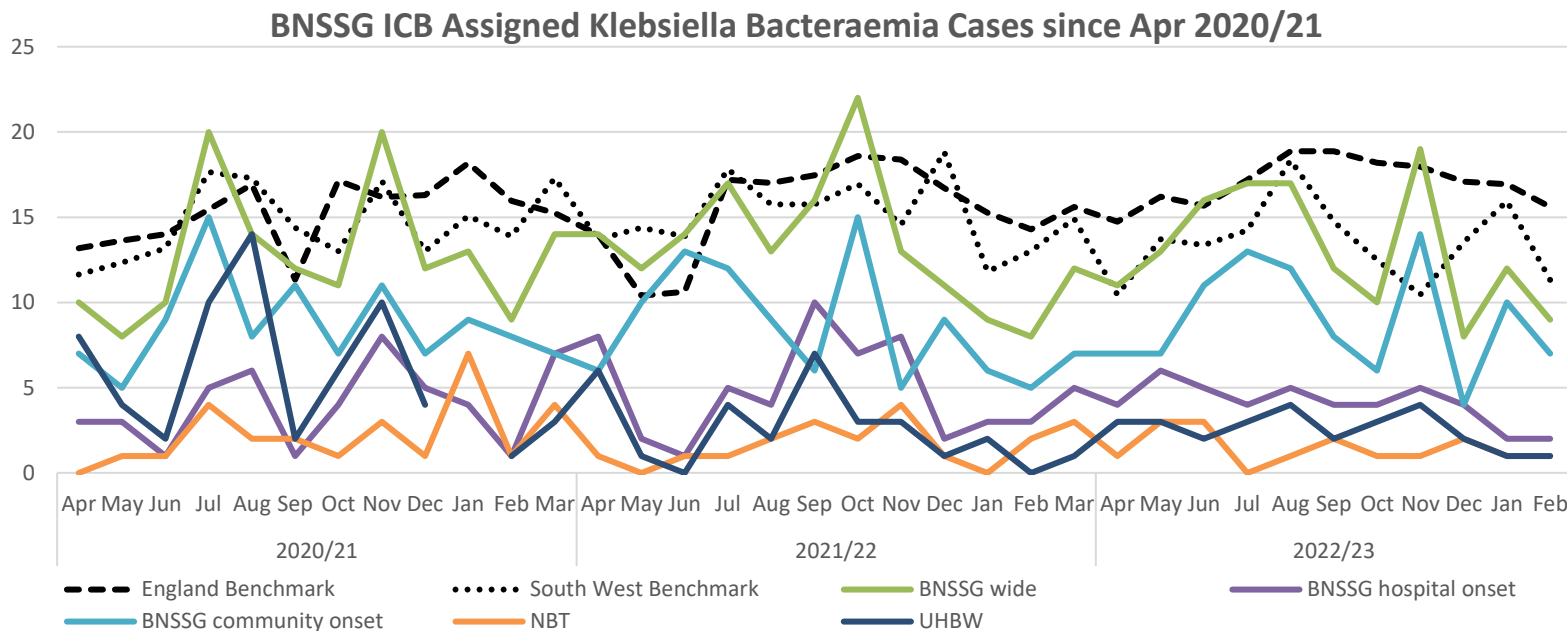


12 Months Rolling to Q3 2022/23 – All Systems

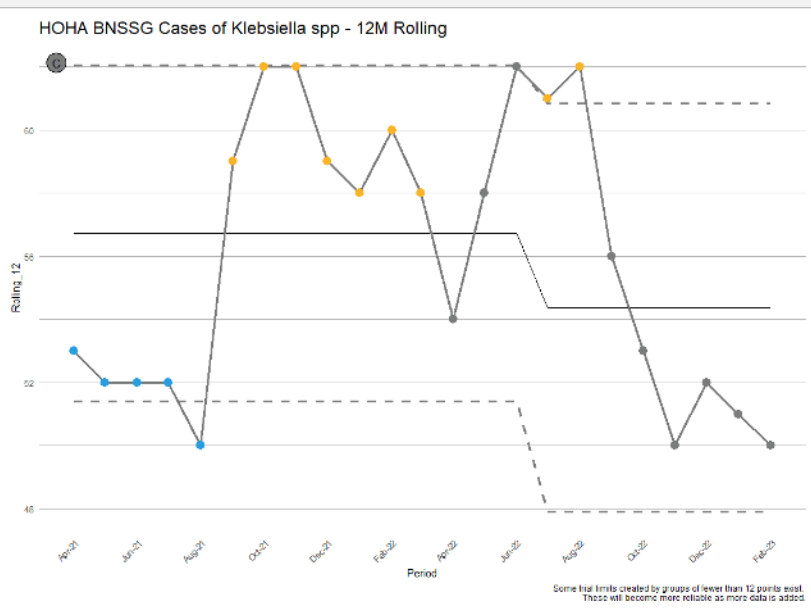
Infection	Onset / Sex	Age-sex standardised infection rates per 100k	Count of Infection (12 months rolling)	Comments
MRSA	All/All	 <p>System value: 3.0 (System Quartile 4) Peer median: 1.0 System median: 1.1</p> <p>3.0 is in System quartile 4 - Highest 25% [red]</p>	<p>Q4 18/19 – Q3 22/23</p> 	<ul style="list-style-type: none"> • Our system value is the highest of all ICBs in the country. • Trend of decreasing rate.
MSSA	COHA/Female	 <p>System value: 2.9 (System Quartile 4) Peer median: 2.0 System median: 1.8</p> <p>2.9 is in System quartile 4 - Highest 25% [red]</p>	<p>Q4 20/21 – Q3 22/23</p> 	<ul style="list-style-type: none"> • Our system value is in the 4th Quartile. • Our system value is above the national median. • Our system value is above the peer median (SW Region). • Trend of increasing rate.

The metrics that have been summarised in the above table have been selected as the most significant in relation to the quartile position and position above the national median. Their purpose is to encourage further investigation and is not meant to represent the definitive position of what is occurring within the system. In-depth details are provided in [Model Hospital](#).

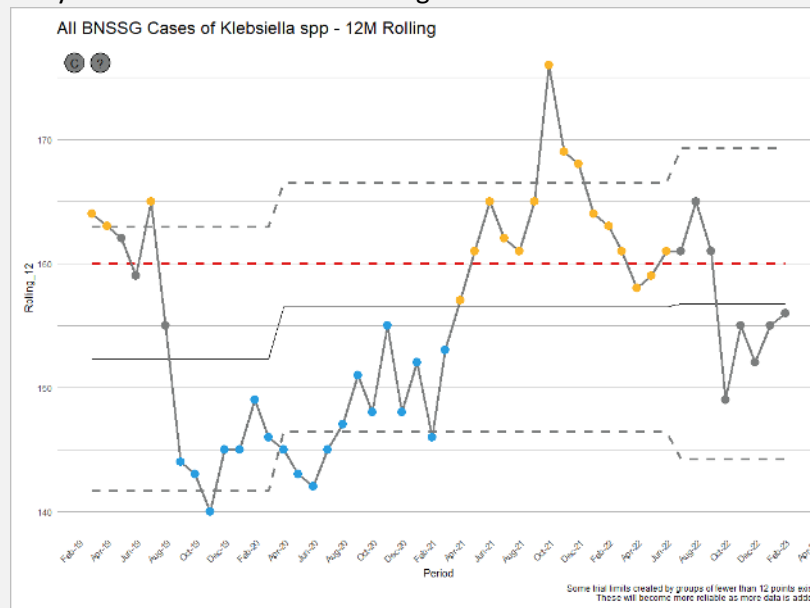
Klebsiella spp	9
HOHA	2 (UHBW-1, Papworth-1)
COHA	1
COCA	6



No significant change in data for Hospital Onset Klebsiella spp. Concerning variation would be if the data points exceeded the Upper Limit (grey dashed line).

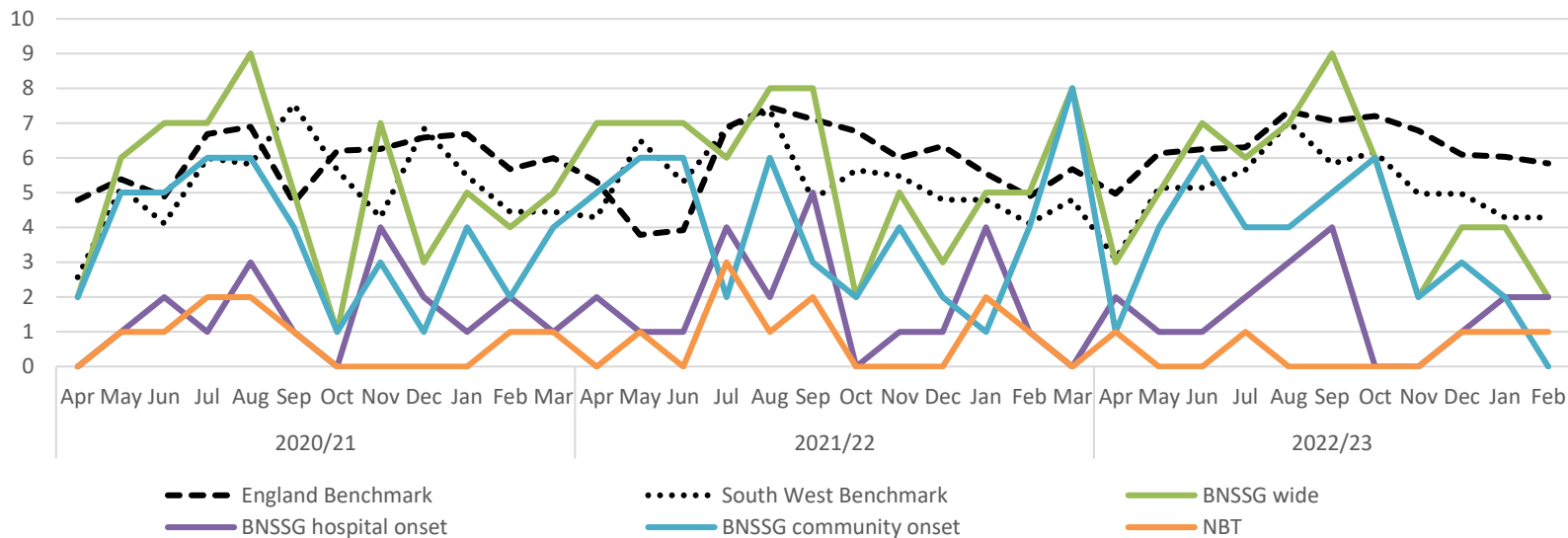


No significant change in data for BNSSG Wide Klebsiella Spp. Adjusted for COVID (Apr-20) and July 22 and this is reflected in the shape change of the upper and lower bounds. Consistently hits and misses threshold target.

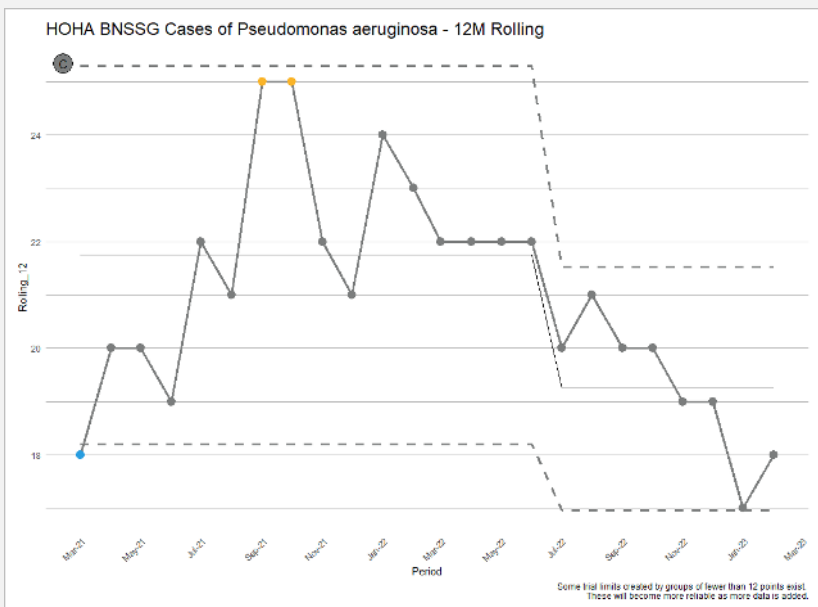


Pseud A	2
HOHA	2 (NBT -1, UHBW-1)
COHA	0
COCA	0

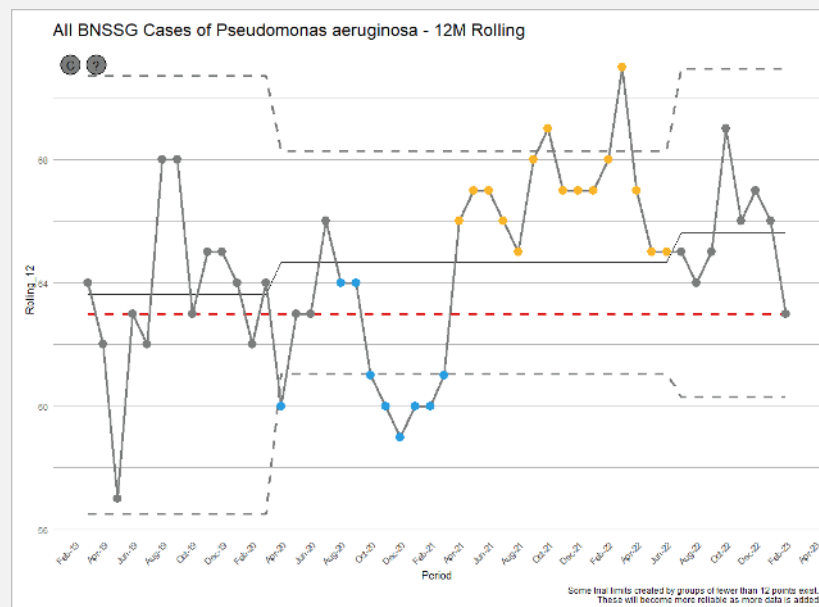
BNSSG ICB Assigned Pseudomonas Aeruginosa Bacteraemia Cases since Apr 2020/21



No significant change in data for Hospital Onset Pseud A. Concerning variation would be if the data points exceeded the Upper Limit (grey dashed line). COCA lies below moving average.



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.



12 Months Rolling to Q3 2022/23 – All Systems

Infection	Onset / Sex	Age-sex standardised infection rates per 100k	Count of Infection (12 months rolling)	Comments
Pseud A	All / Male		Q4 18/19 – Q3 22/23 	<ul style="list-style-type: none"> • Our system is in the 3rd Quartile. • Our system is above the national median • Our system is above the peer median (SW Region).
Pseud A	COCA / All		Q4 20/21 – Q3 22/23 	<ul style="list-style-type: none"> • Our system is in the 4th Quartile. • Our system is above the national median • Our system is above the peer median (SW Region). • Trend of increasing rate since the last quarter.

The metrics that have been summarised in the above table have been selected as the most significant in relation to the quartile position and position above the national median. Their purpose is to encourage further investigation and is not meant to represent the definitive position of what is occurring within the system. In-depth details are provided in [Model Hospital](#).

Nursing & Quality - Serious Incidents including Never Events

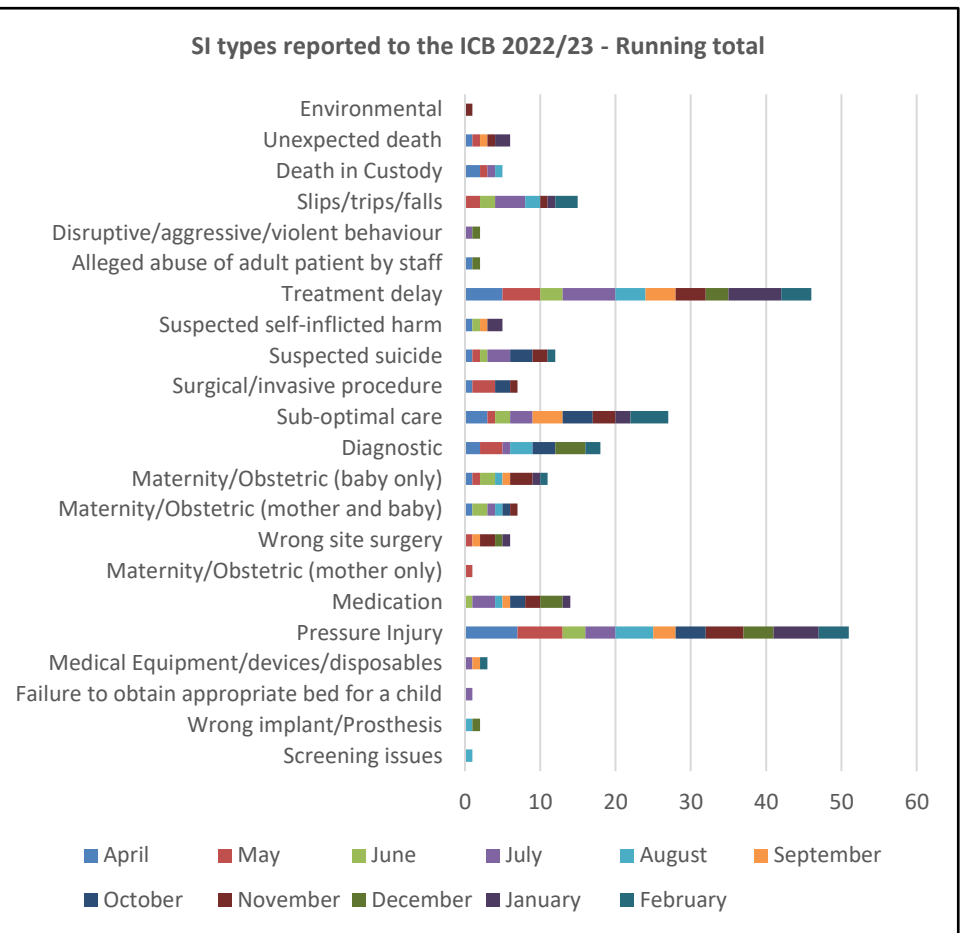
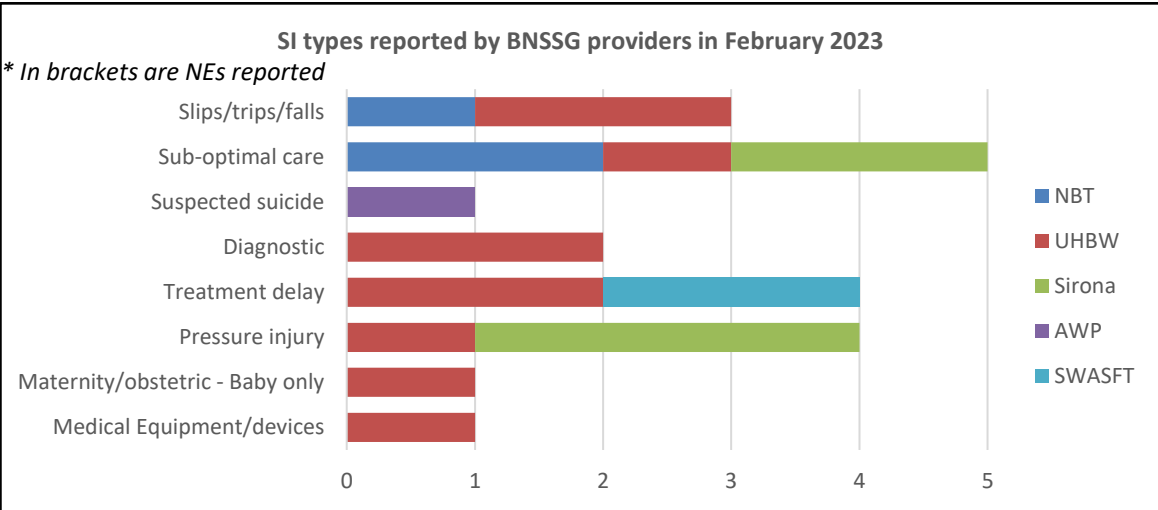
Reporting Period – Month 11 2022/23 – February data

Information Source and date of information – 14/04/2023

Current Month Overview

- In February 2023, 21 Serious Incidents (SIs) were reported across BNSSG partners. There were no Never Events reported this month.
- Sub-optimal care incidents are the leading theme for reported events in February,; this is a 25% increase against the total of the last three months.
- Pressure Injury (PI) incidents and Treatment Delays continue to remain two of the top reported incident types.

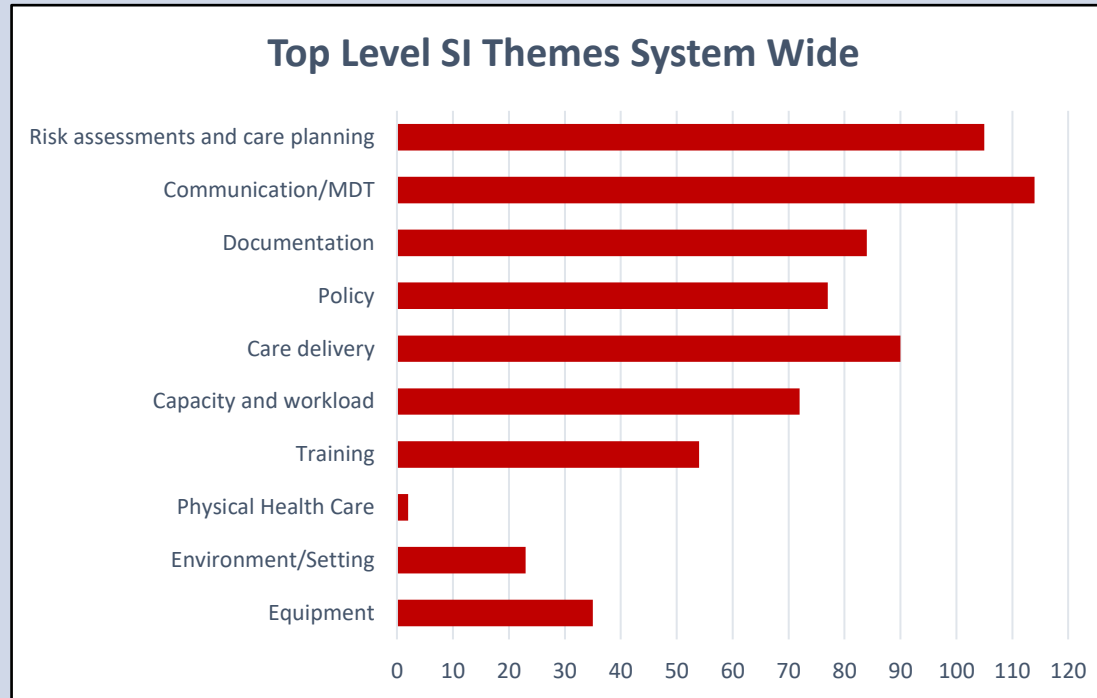
SIs reported across BNSSG 2022/23												
Provider	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD SIs
NBT	4 (1)	3 (1)	1	0	1	0	0	7 (2)	1 (1)	2 (1)	3	22 (6)
UHBW	7	10	7	15	11 (1)	4 (1)	8	6	9 (1)	10	10	97 (3)
Sirona	7	6	5	8	5	8	5	8	7	6	5	70
AWP	5	3	2	5	2	3	3	3	1	3	1	31
SWASFT	0	1	1	1	1	1	0	2	0	1	2	10
GP	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	3	1	1	0	1	3	0	0	1	0	13
Total	26 (1)	26 (1)	17	30	20 (1)	17 (1)	19	26 (2)	18 (2)	23 (1)	21	243 (9)



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)	18 (2)	23 (1)	21		243 (9) running total

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

The table below highlights the top-level themes identified through the investigation process for reported events and detailed in the submitted investigations over the last 13 months, when this data collection commenced.



Across the system, it is noted that the top two themes remain

- Communication/MDT
- Risk assessment and care planning.

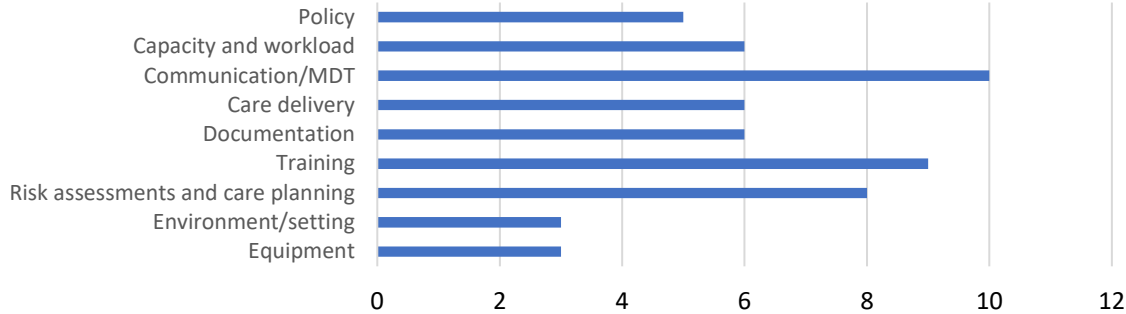
It has been noted that there is a significant increase in patient safety events related to care delivery and a “deep dive” is underway to understand the drivers behind the increase in events and the outcome will be shared at the monthly themes and trends meeting in June 2023.

Nursing & Quality – SI Themes and Trends across BNSSG partners

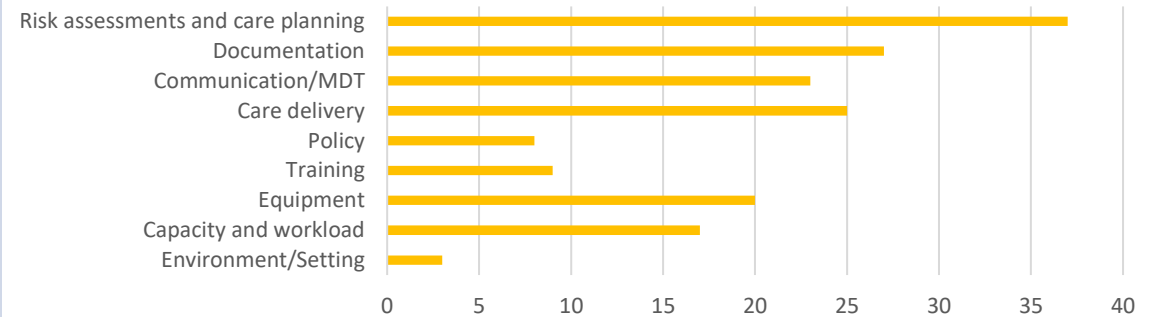
Reporting Period – Month 11 2022/23

Deep dives resulting from themes of shared investigation reports are detailed below. This intelligence is communicated back to individual partners to provide a focus to support potential improvement work and is also discussed at the monthly themes and trends meetings which are attended by multiple system partners and aids system wide learning.

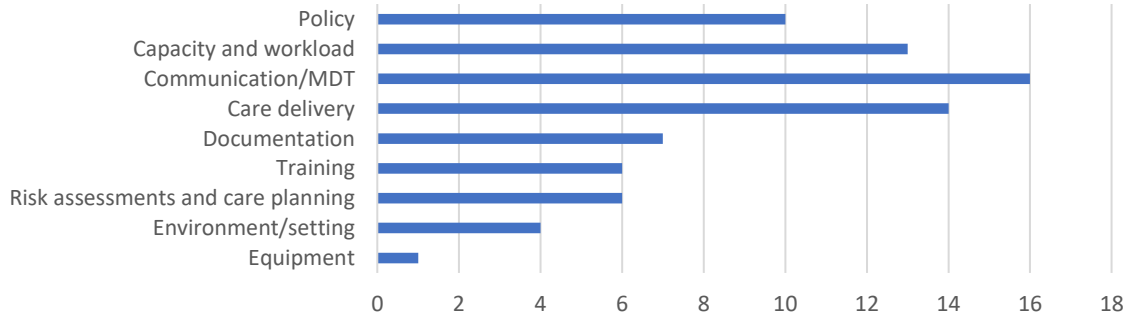
SI Themes for Sub-Optimal Care (All providers)



SI Themes for Pressure Injuries (All Providers)



SI Themes for Treatment Delay (All Providers)



Nursing & Quality – Patient Safety Incident Response Framework (PSIRF) progress within the ICS

Reporting Period – Month 11 2022/23 February data

Information Source and date of information – partner organisation updates

Transition progress with Partners from Serious Incident Framework (2015) to PSIRF

The requirement is that all NHS partners will work under the **Patient Safety Incident Response Framework (PSIRF)** which sets out the NHS’s approach to developing and maintaining effective systems and processes for responding to patient safety events (incidents) for the purpose of learning and improving patient safety. Currently partners are at differing timelines for implementation and progress is shown in the table below. The national requirement is for PSIRF to be in place by September 2023 with an accompanying **Patient Safety Incidence Response Plan (PSIRP)**.

PSIRF Progress by provider	NBT	UHBW	Sirona	AWP	SWASFT
Has work started on the workstream?	Earlier adopters, PSIRF on FuturesNHS.	Started the workstream towards completion of implementation of PSIRF and is expected to be completed by end of April 23.	Going live with PSIRF in September 2023.	PSIRF strategy was reviewed in March 2023 by partners and will be out soon.	Is expected to be completed by end of June 23. The trust is in the initiation phase of the project to adopt PSIRF and work has taken place on stakeholder mapping and communications in December 22. A new PSIRF lead has been identified and the Trust is currently recruiting a temporary clinical governance professional to provide support.
PSIRP completion	PSIRP on Trust website.	PSIRP has been agreed at Trust level at UHBW and has been sent to ICB.	Working towards completing their PSIRP by end of May 2023.	Due by end of April 2023.	PSIRP has been paused due to absences and other priorities.

Nursing & Quality – Learning from Patient Safety Events (LFPSE) progress within the ICS

Reporting Period – Month 11 2022/23 February data

Information Source and date of information – partner organisations/NHSE

In Spring 2021 a new national “Learn from patient safety events” (LFPSE) platform (previously called the patient safety incident management system – PSIMS) was introduced. The new system replaces the National Reporting and Learning System (NRLS). In most large provider organisations, such as NHS Trusts, staff will continue to record patient safety events on to their organisation’s local risk management system (LRMS) such as DATIX/Ulysses/RADAR which will then upload directly to the new LFPSE service .

In smaller organisations and within primary care, a dedicated LFPSE webpage on the NHSE website is available where patient safety events can be directly reported via the online recording service.

Requirements for implementation of LFPSE

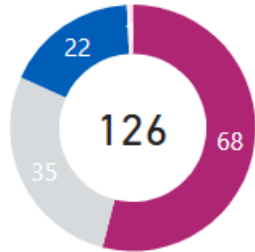
- An organisational change to support/explain to frontline teams across an organisation why the new patient safety questions are being introduced, what they mean and who completes them.
- A digital change that supports the above.

Partner organisation – current position with implementation of LFPSE

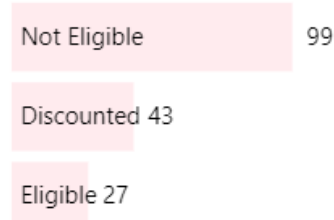
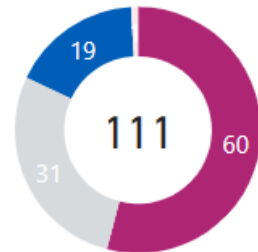
- **UHBW** – DATIX as LRMS and planning to go live on LFPSE in Q2 2023/24 as work required on Datix system to allow alignment with LFPSE.
- **NBT** – DATIX as the LRMS system and planning to go live mid/end of September 2023. Datix system requires refreshing to allow LFPSE compliance and the Trust is awaiting the schedule for this work.
- **Sirona** – Ulysses as LRMS and live on LFPSE
- **AWP** – Ulysses as LRMS and live on LFPSE
- **Primary Care** – Dissemination of the online recording service underway via Practice Manager networking
- **Independent sector (NHS funded patients) and smaller partner organisations** – no work undertaken as yet

Nursing & Quality – Funded Care – Adult Continuing Healthcare (CHC) Reporting Period – Month 11 2022/23 February data

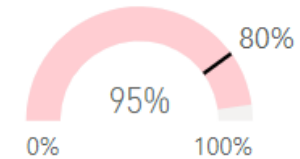
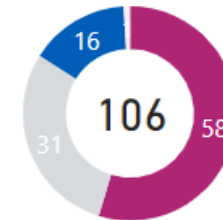
CHC Referrals Received



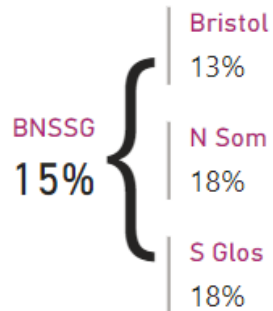
CHC Referrals Completed



CHC Decisions within 28 Days



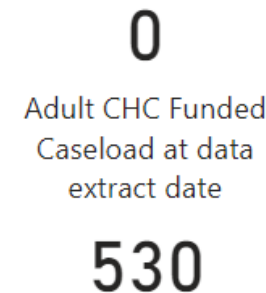
Conversion Rate



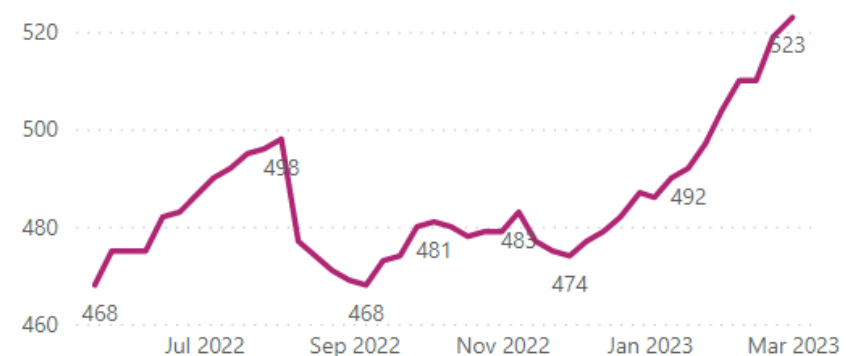
Mean Days to Decision



Open Referrals Exceeding 12 weeks at data extract date



Weekly Standard CHC Caseload

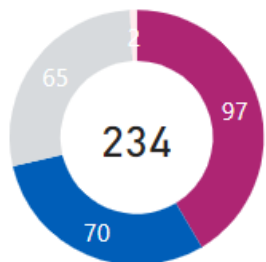


Narrative:

- Exceeding 28 day standard - 95% against 80% target.
- No cases over 12 weeks.
- 27 individuals met criteria for CHC funded care in month – 16 as a result of focused fast track reviews.
- Referrals up by 2% on the year to date average.
- Costs per case increasing.
 - Increased complex physical needs
 - Increasing number of LD cases made eligible (Specifically saw a spike in January). Audit and plans put in place for a pre-LD panel meeting
- Current reviews outstanding are 188 out of 531 caseload which is 35%.

Nursing & Quality – Funded Care – Adult CHC Fast Track End of Life Reporting Period – Month 11 2022/23 February data

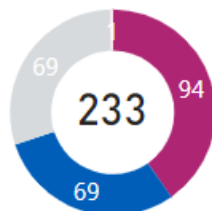
Fast Track Referrals Received



From February 2023

To February 2023

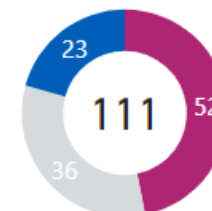
Fast Track Referrals Determined



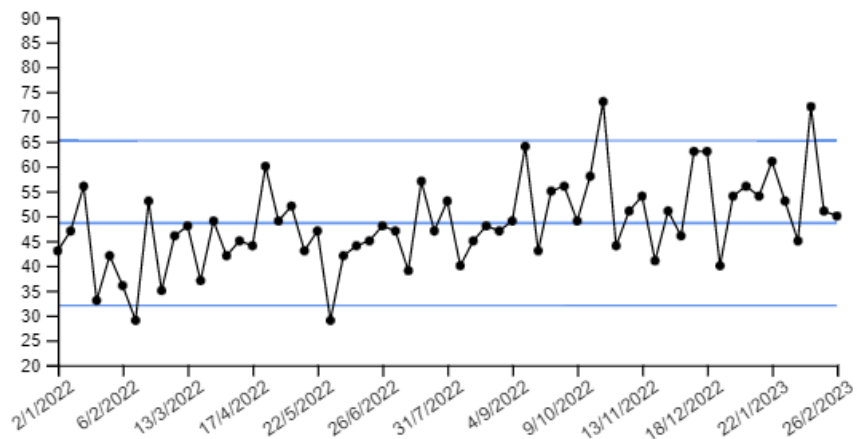
Eligible 205

Discounted 28

FT Decisions within 2 Working Days



SPC Chart of Weekly Fast Track Referrals Received



Weekly Fast Track Caseload



Narrative

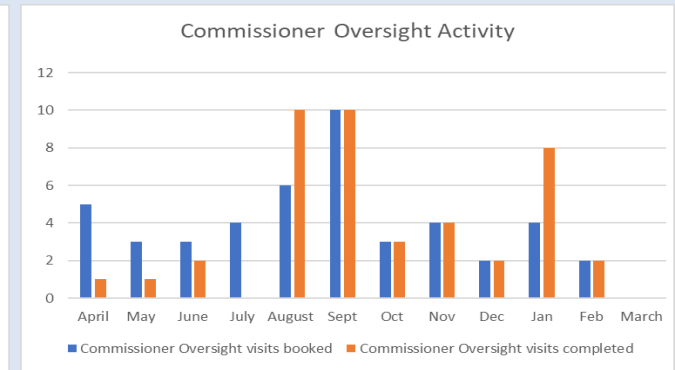
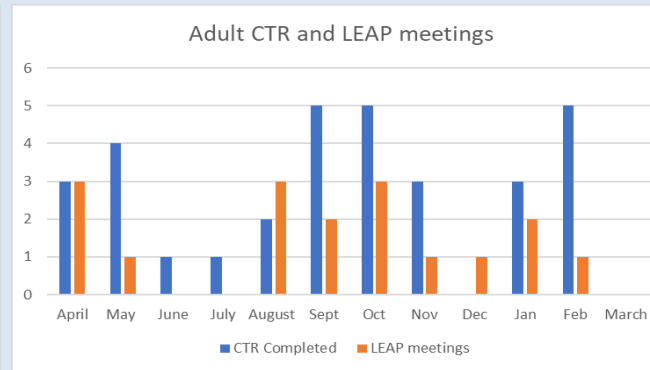
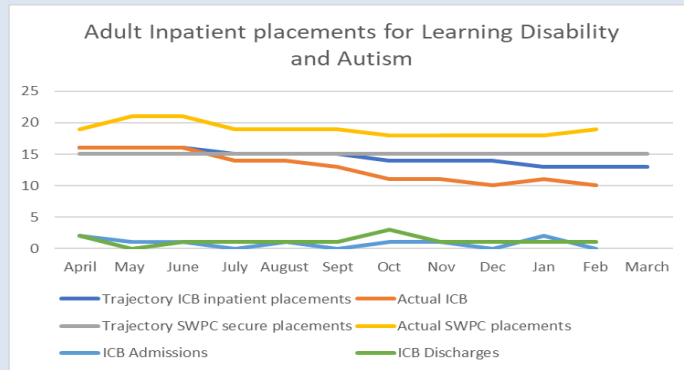
- Caseload size reduced by 15% compared to January – resulting from focussed reviews and equates to a reduction of 63 cases.
- Number of cases in receipt of Fast Track funded care for more than 12 weeks has reduced from 163 (January) to 111 (February).
- The percentage of Fast Track patients overdue for review has reduced from 36% to 31% and continues to drop into March.
- 52 Fast Track 10wk reviews were completed by the Fast Track Team in February – of which 51 were referred over for full assessment (98%) and 1 remained on fast track pending further review (2%) in line with planned trajectory.
- Audit under way to look at referral source of FT patients who come off funding after 12 weeks, with a view to identifying areas of poor practice in use of the Fast Track pathway.

Nursing & Quality – Funded Care – Assuring Transformation – Learning Disability and Autism

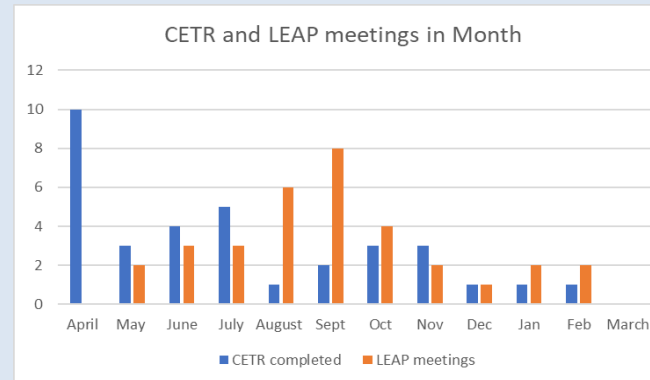
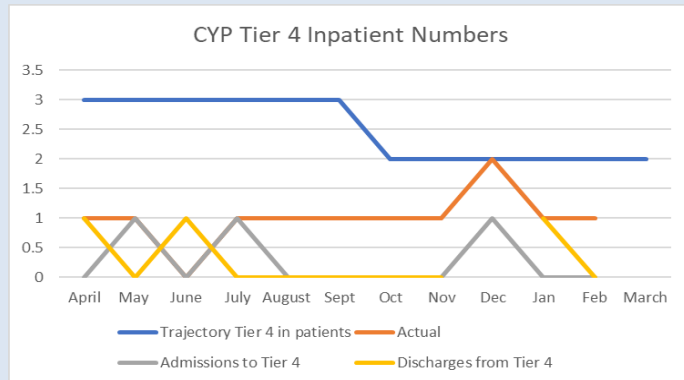
Reporting Period: February 2023

Performance/Data for 2022-2023

Adults



CYP



Adults

- Continues to be an increase in CTR activity 44 Professionals meetings/ MDT's/ Safeguarding/Discharge planning meetings for adults.
- CCG commissioned placements remain below trajectory however SWPC (Secure) placements remain above the trajectory to reach the Long Term Plan target.
- One admission to a secure setting in month due to community placement being unable to manage the level of forensic risk.
- 2 individuals are being managed through the court of protection (1 Community, 1 inpatient).
- 3 individuals are identified as Delayed Discharge from ICB cohort, 1 individual identified as Delayed Discharge from Secure bed base.

CYP

- CETR and LEAP activity has been reduced significantly in last 2 months which aligns with the keyworker team being fully operational.
- The C(E)TR team are providing additional support to the Keyworker Team to triage requests.

BNSSG Performance Report

April 2023

Created by

Gary Dawes

BI Performance Team

Contents

1. Executive Summary

2. Performance

2.1 South West Performance Benchmarking

2.2 Urgent and Emergency Care Summary

- UEC Key Performance Measures
- Care Homes Occupancy Report

2.3 Planned Care Summary

- RTT & Diagnostics & Cancer Key Performance Measures

2.4 Mental Health, Learning Disabilities and Autism Key Performance Measures

2.5 Sirona – Adults Community Services 18 Week Performance

2.6 Children's Performance - CYP Emergency Department Overview

3. Summary Scorecards

3.1 BNSSG ICB

3.2 NBT

3.3 UHBW

3.4 Non-Acute Providers

1 Executive Summary

- Overall, BNSSG Trusts' 4hr A&E performance improved from 67.8% to 70.7% in March and is better than the national average for Type 1 EDs of 56.8%. The BNSSG system ambulance handover plan was achieved in February 2023 and we are on target to meet the plan in April 2023.
- For planned admissions, the total waiting list size for the BNSSG population improved from 86,001 in January to 83,947 in February. BNSSG performance of 64.3% was ranked 8th out of 42 ICBs nationally (down from 7th January) 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 4,961 in January to 4,182 in February – 5% of the total waiting list. The number decreased at both NBT and UHBW. The BNSSG position is driven mainly by waits at NBT (2,076) and UHBW (1,712), with the remaining 394 breaches split across 47 other providers. Focused work to facilitate elective recovery ambitions are being implemented.
- The number of BNSSG patients waiting over 78 weeks decreased from 594 in January to 286 in February. The number decreased at both NBT and UHBW. The BNSSG position is driven mainly by waits at NBT (134) and UHBW (111). The remaining 41 breaches are split across 14 other providers, with the majority at Spire Bristol (13).
- The number of BNSSG patients waiting over 104 weeks decreased from 41 in January to 7 in February. The number decreased at both NBT and UHBW. The BNSSG position is driven by waits at NBT (6) and Spire Bristol (1).
- 2 week wait cancer performance improved in February to 65.2% for the BNSSG population. Performance improved at both NBT and UHBW. The 93% national standard has not been achieved at population level since June 2020.
- 28 day faster diagnosis standard for BNSSG cancer patients improved in January to 72% for the BNSSG population. Performance improved at both NBT and UHBW. NBT achieved the 75% standard for the first time. 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 February to 54.3%. Performance improved at both NBT and UHBW. The 85% national standard has not been achieved at population level since April 2019.

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%	Feb-23	41.04%	21.08%	9.83%	33.70%	24.56%	24.95%	33.61%	25.11%	7	2	1	6	3	4	5	4	→
A&E 4 Hour Performance	95%	Mar-23	71.19%	73.91%	72.32%	76.91%	76.41%	76.46%	63.26%	71.50%	6	4	5	1	3	2	7	2	→
A&E 12 Hour Trolley Waits	0	Mar-23	210	202	636	719	39	680	1593	39,671	3	2	4	6	1	5	7	4	↓
RTT Incomplete 18 Weeks	92%	Feb-23	61.47%	55.85%	71.21%	56.73%	61.34%	64.26%	52.78%	58.51%	3	6	1	5	4	2	7	2	→
RTT Incomplete Total		Feb-23	92,571	94,802	70,438	65,294	60,213	83,947	155,001	7,218,001	66.2%	72.1%	36.4%	83.5%	67.0%	65.1%	83.3%	69.1%	↑
RTT Incomplete 52 Week Plus	0	Feb-23	3,621	4,962	1,663	4,950	2,537	4,182	14,577	362,498	3	6	1	5	2	4	7	5	↑
RTT 52 weeks + (% of waiting list)		Feb-23	3.91%	5.23%	2.36%	7.58%	4.21%	4.98%	9.40%	5.02%	2	5	1	6	3	4	7	5	↑
RTT 78 weeks + (% of waiting list)		Feb-23	0.16%	0.32%	0.06%	1.20%	0.31%	0.34%	1.22%	0.41%	2	4	1	6	3	5	7	5	→
RTT 104 weeks+ (% of waiting list)		Feb-23	0.00%	0.00%	0.00%	0.12%	0.01%	0.01%	0.15%	0.01%	3	2	1	6	4	5	7	5	→
Cancer 2 Week (All)	93%	Feb-23	83.50%	78.83%	94.65%	77.83%	65.14%	65.15%	80.79%	86.10%	2	4	1	5	7	6	3	6	→
Cancer 2 week (Breast)	93%	Feb-23	93.82%	89.92%	99.15%	30.07%	55.63%	88.04%	79.07%	78.94%	2	3	1	7	6	4	5	2	↓
Cancer 31 Day Wait First Treatment	96%	Feb-23	90.13%	93.78%	97.01%	91.58%	86.61%	91.81%	93.62%	91.97%	6	2	1	5	7	4	3	6	↑
Cancer 31 Day Wait - Surgery	94%	Feb-23	76.15%	87.50%	78.18%	84.91%	72.37%	91.94%	82.56%	78.72%	6	2	5	3	7	1	4	7	↑
Cancer 31 Day Wait - Drug	98%	Feb-23	100.00%	100.00%	100.00%	100.00%	100.00%	98.81%	98.97%	98.04%	1	1	1	1	1	7	6	7	→
Cancer 31 Day Wait - Radiotherapy	94%	Feb-23	95.97%	97.00%	80.29%	100.00%	96.34%	99.34%	98.65%	89.35%	6	4	7	1	5	2	3	1	↓
Cancer 62 Wait Consultant	N/A	Feb-23	77.65%	78.31%	60.00%	61.76%	83.10%	78.26%	76.19%	73.55%	4	2	7	6	1	3	5	2	↓
Cancer 62 Wait Screening	90%	Feb-23	61.76%	62.07%	78.26%	66.67%	60.53%	71.43%	69.23%	63.91%	6	5	1	4	7	2	3	7	↑
Cancer 62 Day Wait - GP Referral	85%	Feb-23	64.87%	63.54%	49.06%	64.38%	51.46%	54.33%	53.96%	58.15%	1	3	7	2	6	4	5	7	↑
Cancer 28 FDS	75%	Feb-23	72.24%	71.62%	76.08%	74.54%	64.81%	72.01%	76.03%	75.03%	4	6	1	3	7	5	2	6	↑

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	Mar-23	00:17:54	00:16:00	00:18:30	00:24:18	00:19:12	00:14:00	00:18:30	00:18:12	3	2	4	7	6	1	4	1	➡
Category 1 - Average Duration (hr:min:sec)	00:07:00	Mar-23	00:09:48	00:08:30	00:09:54	00:12:42	00:10:12	00:08:00	00:10:06	00:09:48	3	2	4	7	6	1	5	1	➡
Category 2 - 90th Percentile Duration (hr:min:sec)	00:40:00	Mar-23	01:57:48	01:03:24	01:29:30	04:18:12	01:29:24	01:02:48	02:35:06	01:53:36	5	2	4	7	3	1	6	1	➡
Category 2 - Average Duration (hr:min:sec)	00:18:00	Mar-23	00:52:54	00:30:18	00:42:12	01:44:48	00:44:00	00:29:06	01:09:24	00:52:36	5	2	3	7	4	1	6	1	➡
Category 3 - 90th Percentile Duration (hr:min:sec)	02:00:00	Mar-23	07:38:48	03:59:36	07:13:48	09:17:12	05:13:06	04:20:12	09:13:12	06:19:12	5	1	4	7	3	2	6	1	⬇
Category 3 - Average Duration (hr:min:sec)		Mar-23	02:36:42	01:34:48	02:28:24	03:13:12	02:09:00	01:41:06	03:17:36	02:20:48	5	1	4	6	3	2	7	1	⬇
Category 4 - 90th Percentile Duration (hr:min:sec)	03:00:00	Mar-23	06:57:12	05:10:18	06:00:48	08:33:24	07:44:30	06:52:12	13:17:54	07:25:06	4	1	2	6	5	3	7	2	⬇
Category 4 - Average Duration (hr:min:sec)		Mar-23	02:32:18	02:00:18	01:56:36	03:55:42	03:01:30	02:01:18	03:55:06	02:46:24	4	2	1	7	5	3	6	2	⬇

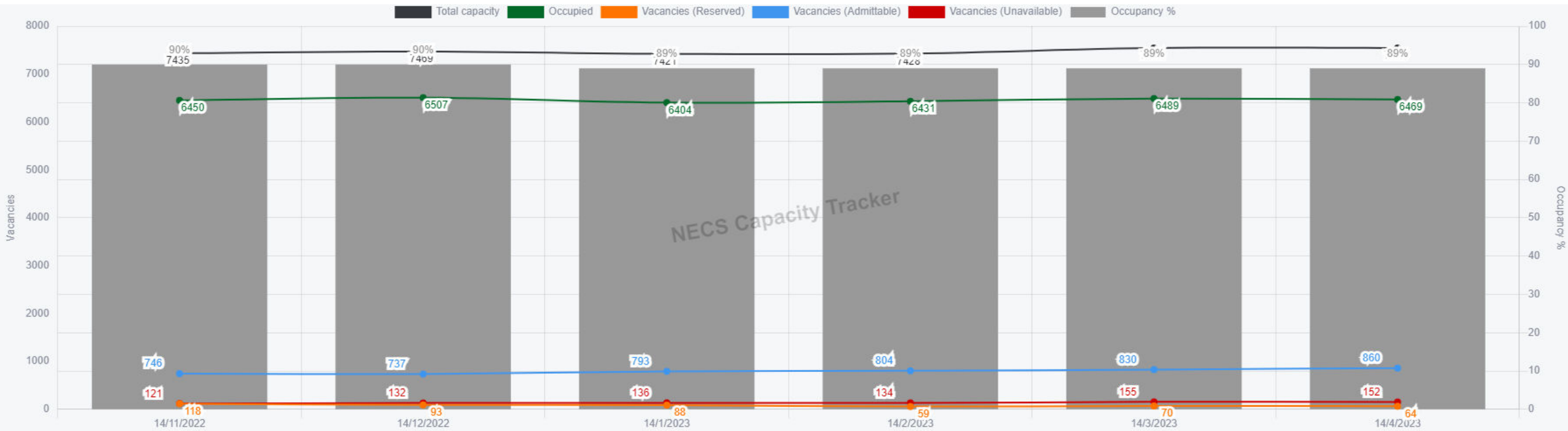
Measure	Standard	Performance/Activity								South West Ranking								Change	
		Recent Period	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	National	BSW	Dorset	Glos	Kernow	Somerset	BNSSG	Devon	Rank Last Month	
Average speed to answer calls (in seconds)	20	Feb-23	101	75	345	268	412	181	448	306	2	1	5	4	6	3	7	4	⬆
% Triage Calls receiving Clinical Contact	50%	Feb-23	59.2%	37.4%	42.7%	70.9%	68.1%	50.2%	45.3%	46.9%	3	7	6	1	2	4	5	4	➡
% of callers allocated the first service offered by DOS	85%	Feb-23	64.2%	68.4%	71.1%	82.0%	68.0%	71.4%	68.5%	63.1%	7	5	3	1	6	2	4	2	➡
% of Cat 3 or 4 ambulance dispositions validated within 30mins	50%	Feb-23	69.1%	60.3%	41.8%	40.1%	68.6%	42.4%	45.8%	35.7%	1	3	6	7	2	5	4	7	⬆
% of calls initially given an ED disposition that are validated	50%	Feb-23	67.1%	70.0%	15.5%	86.2%	72.7%	27.4%	12.1%	42.5%	4	3	6	1	2	5	7	5	➡
Abandonment Rate for 111 Calls	3%	Feb-23	7.2%	3.4%	26.6%	15.9%	25.5%	14.4%	19.0%	20.2%	2	1	7	4	6	3	5	5	⬆

2.2 Urgent Care – Summary Performance – March

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	Mar-23	5	7	6	1	▲	7	0	▲	▼
	Category 2 Response time - Mean (minutes)	BNSSG ICB	Mar-23	18	29	28	1	▲	27	2	▲	▼
	Category 2 Response time – 90th centile (minutes)	BNSSG ICB	Mar-23	40	63	61	3	▲	56	7	▲	▼
	Percentage of conveyances to ED by 999 ambulances	BNSSG ICB	Mar-23	N/A	45.3%	46.6%	-1.4%	▼	43.6%	1.7%	▲	▼
	Percentage of NHS 111 calls assessed by a clinicial or clinical advisor	BNSSG ICB	Mar-23	50%	49.3%	50.2%	-0.9%	▼	54.1%	-4.8%	▼	▲
	Percentage of NHS 111 Calls Abandoned	BNSSG ICB	Mar-23	3%	10.8%	12.2%	-1.5%	▼	42.8%	-32.0%	▼	▼
A&E	Percentage of Ambulance Handovers within 15 minutes	BNSSG Trusts	Mar-23	65%	22.5%	23.0%	-0.5%	▼	60.4%	-37.8%	▼	▲
	Ambulance Handovers - Average Time Lost per day >15 mins (Hours)	BNSSG Trusts	Mar-23	N/A	100	93	7	▲	13	87	▲	▼
	Time to Initial Assessment – percentage of patients assessed within 15 minutes of arival at A&E	NBT	Mar-23	N/A	78.8%	81.6%	-2.8%	▼	73.4%	5.4%	▲	▲
		BRI	Mar-23	N/A	60.2%	63.0%	-2.8%	▼	56.0%	4.2%	▲	▲
		Weston	Mar-23	N/A	43.6%	43.7%	-0.2%	▼	11.8%	31.8%	▲	▲
	Average (mean) time in Department – non-admitted patients (hh:mm)	NBT	Mar-23	N/A	3:13	3:06	0:07	▲	2:59	0:14	▲	▼
		BRI	Mar-23	N/A	4:43	5:18	-0:35	▼	3:25	1:17	▲	▼
		Weston	Mar-23	N/A	3:34	3:50	-0:16	▼	2:50	0:44	▲	▼
Hospital	Hospital Average (mean) time in Department – admitted patients (hh:mm)	NBT	Mar-23	N/A	7:09	5:28	1:40	▲	5:11	1:57	▲	▼
		BRI	Mar-23	N/A	7:27	7:55	-0:28	▼	4:38	2:49	▲	▼
		Weston	Mar-23	N/A	11:29	12:16	-0:47	▼	5:28	6:00	▲	▼
Whole System	Percentage of patients spending more than 12 hours from Arrival in A&E	NBT	Mar-23	2%	4.1%	1.2%	2.9%	▲	2.2%	1.8%	▲	▼
		BRI	Mar-23	2%	9.2%	9.5%	-0.2%	▼	2.1%	7.2%	▲	▼
		Weston	Mar-23	2%	9.8%	10.3%	-0.5%	▼	3.2%	6.6%	▲	▼
	Number of patients spending more than 12 hours in A&E from a Decision To Admit	BNSSG Trusts	Mar-23	0	680	436	244	▲	48	632	▲	▼
		NBT	Mar-23	0	135	9	126	▲	2	133	▲	▼
		UHBW	Mar-23	0	545	427	118	▲	46	499	▲	▼
	Percentage of patients waiting 4 hours or less in A&E	BNSSG Trusts	Mar-23	95%	70.7%	67.8%	2.9%	▲	80.0%	-9.3%	▼	▲
		NBT	Mar-23	95%	78.3%	79.7%	-1.3%	▼	80.2%	-1.8%	▼	▲
		UHBW	Mar-23	95%	66.9%	61.9%	5.0%	▲	79.9%	-13.1%	▼	▲

- 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

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 (273 / 273 / 273)	7545	1076	860	152	64	6469	11%	2%	1%	86%
General Residential	1777	330	251	72	7	1447	14%	4%	0%	81%
General Nursing	1841	272	224	22	26	1569	12%	1%	1%	85%
Dementia Residential	1561	222	181	31	10	1339	12%	2%	1%	86%
Dementia Nursing	1216	147	113	17	17	1069	9%	1%	1%	88%
Learning Disability Residential	562	47	40	4	3	515	7%	1%	1%	92%
Mental Health Residential	278	28	22	6	0	250	8%	2%		90%
Community Care	51	19	19	0	0	32	37%			63%
Mental Health Nursing	160	5	5	0	0	155	3%			97%
YPD - Young Physically Disabled	22	2	2	0	0	20	9%			91%
Learning Disability Nursing	73	3	2	0	1	70	3%		1%	96%
Transitional	4	1	1	0	0	3	25%			75%

2.3 Planned Care – Drivers and Priority Actions

Top Improvement Drivers: April 2023

Priority actions: April-May 2023

1. **National requirements to clear all remaining >78 week waiters and progress 23/24 trajectories for reducing 65+ww by year end. Noting April and May challenges as a result of industrial action (inc. lost opportunity through reduced booking, cancellations, and displaced activity) and bank holiday days lost.**
2. **Forward look for elective delivery**

1. Weekly scrutiny and detailed returns to Region/National team on 78ww breaches/breach risks continues. System focus shifting to 65+ww cohort.
 2. Working with national team for access to corneal graft material (where the system has long waiters as a result of the national shortage of material) and waiting list now decreasing.
Working with other NHS providers to continue/ establish mutual aid arrangements for complex cases. Working closely with the Independent Sector, to manage long waiting cohorts in the same robust way as the Trusts, and working with the IS to establish arrangements to support for some of the systems challenged areas – e.g. skin, colorectal.
Closely monitoring the ongoing impacts of industrial action on elective delivery and long wait recovery.
Continuation of recovery action plans established in 22/23, which include additional lists, weekend work and utilisation of additional capacity through insourcing and outsourcing arrangements
Validation activity continues in both Trusts and both are engaged in a Regional pilot with the CSU –focussing on RTT pathways.
2. BNSSG Elective Centre business case progressing. FBC stage underway.

3. Addressing Diagnostic **workforce capacity pressures** across system.
4. **Progress against regional ambitions** - to reduce to zero the number of people waiting >13weeks and at least 85% of people waiting <6 weeks for their test by 31/03/24.
5. **Forward look for diagnostics capacity and delivery**

3. System 'pool' of endoscopist workforce enabled through 'passporting' to work across all sites progressing; System preparing to engage in region Calderdale Framework training for imaging and Echo staff from April onwards.
4. Implementation of recovery action plans continues. 23/24 plans achieve the regional ambitions in totality (across all core modalities) although it is recognised that Endoscopy remains a significant challenge across the system. Focussed action plans are in implementation at both Trusts for endoscopy and include additional activity, utilisation and productivity improvement focus and the continued utilisation of insourcing and outsourcing capacity.
5. Business cases have been submitted for Endoscopy Capital funding for a programme of works to make necessary estate changes to the BRI site to enable the achievement of JAG accreditation; business case progressing to create a 5th endoscopy room at NBT. The system is working to conclude the contractual negotiations with the ISP partner for the CDCs in North Bristol and Weston areas.

6. **Reducing, validating and prioritising** patients on outpatient waiting lists
7. **Halting growth / reducing the volume of overdue follow ups**
8. Increasing availability and utilisation of **advice and guidance**.

6. Validation activity continues in both Trusts. Both Trusts will engage with the national drive on Outpatient productivity – initial meetings scheduled for the latter part of April. Initial meetings will be clinically-led and focused on outpatient productivity and the 65 and 52 week milestones set nationally.
7. Planning for follow up reductions and PIFU roll out to all specialities where clinically appropriate continues. Focussed work on reducing the volume of overdue follow ups continues – impacts of Industrial Action will affect performance in Q1
8. Work continues on A&G, including standardising processes to ensure consistent provision of A&G across all major specialties via eRS; monthly reporting now established and longer response rates escalated via EROG for investigation/action.

9. **Backlog position recovery** (63+day recovery metric)
10. **FDS improvement**
11. **Pathways of challenge** – (inc. focus on capacity/demand modelling, workforce, access to Diagnostics, referral management, space)

9. Both Trusts ended 22/23 with backlog volumes better than plan. This was the result of focussed recovery action plans that have included increasing capacity through WLI's, Super Saturdays and mega clinics, recruitment (substantive & locum), which continue in 23/24. It is recognised that Industrial Action is having significant impacts on long waits and cancer services which will impact the 63+ day position and the system is closely monitoring this – it is expected to impact performance in the short term.
10. The system is committed to focussing on improvements in FDS performance. 23/24 plans meet the national ambitions for this metric – April/May prioritises the implementation of plans, recognising the impacts of Industrial Action on lost activity.
11. Skin pathway - Trusts are implementing recovery plans at speciality level and as a system a group has been established to focus on skin pathway improvement – first phase to improve demand management through high quality images at the referral step of the pathway. Gynae pathway - investment in hysteroscopy continues. GI pathways - implementation of FIT changes bedding in and improvements will be made through extra capacity secured.

RTT

Diagnostics

Outpatients

Cancer

2.3 Planned Care – Summary Performance – February

BNSSG Population Level

RTT 18 week Incomplete	Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
Total Waiting List	83,947	86,001	-2,054	▼	55,363	28,584	▲
No. >18 weeks	29,999	30,859	-860	▼	7,889	22,110	▲
No. >52 weeks	4,182	4,961	-779	▼	38	4,144	▲
No. >78 weeks	286	594	-308	▼	N/A	N/A	N/A
No. >104 weeks	7	41	-34	▼	N/A	N/A	N/A
52ww as % of WL	5.0%	5.8%	-0.8%	▼	0.1%	4.9%	▲
% Performance	64.26%	64.12%	0.1%	▲	85.75%	-21.5%	▼

Diagnostics	Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
Total Waiting List	28,816	29,469	-653	▼	21,231	7,585	▲
No. >6 weeks	7,190	9,484	-2,294	▼	992	6,198	▲
No. >13 weeks	3,100	4,267	-1,167	▼	191	2,909	▲
% Performance	24.95%	32.18%	-7.2%	▼	4.67%	20.3%	▲

Cancer	Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
2 week waits	65.15%	56.34%	8.8%	▲	92.40%	-27.2%	▼
2w w breast	88.04%	87.88%	0.2%	▲	89.66%	-1.6%	▼
28 day FDS (All Routes)	72.01%	61.31%	10.7%	▲	N/A	N/A	N/A
31 day first treatment	91.81%	86.98%	4.8%	▲	96.96%	-5.1%	▼
31 day - Surgery	91.94%	59.32%	32.6%	▲	81.05%	10.9%	▲
31 day - Drugs	98.81%	91.40%	7.4%	▲	100.00%	-1.2%	▼
31 day - Radiotherapy	99.34%	99.40%	-0.1%	▼	98.32%	1.0%	▲
62 day	54.33%	43.10%	11.2%	▲	67.27%	-12.9%	▼
62 day - Screening	71.43%	47.50%	23.9%	▲	58.62%	12.8%	▲

NBT Total Provider

Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
46,327	46,266	61	▲	29,552	16,775	▲
16,738	16,717	21	▲	5,039	11,699	▲
2,556	2,742	-186	▼	17	2,539	▲
167	223	-56	▼	N/A	N/A	N/A
8	16	-8	▼	N/A	N/A	N/A
5.5%	5.9%	-0.4%	▼	0.1%	5.5%	▲
63.87%	63.87%	0.0%	▲	82.95%	-19.1%	▼

Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
12,679	13,437	-758	▼	10,758	1,921	▲
2,847	4,328	-1,481	▼	602	2,245	▲
1,497	2,459	-962	▼	114	1,383	▲
22.45%	32.21%	-9.8%	▼	5.60%	16.9%	▲

Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
63.52%	55.01%	8.5%	▲	89.9%	-26.4%	▼
87.50%	90.16%	-2.7%	▼	89.63%	-2.1%	▼
77.41%	62.66%	14.8%	▲	N/A	N/A	N/A
89.90%	82.41%	7.5%	▲	95.36%	-5.5%	▼
80.73%	52.21%	28.5%	▲	70.89%	9.8%	▲
93.75%	100.00%	-6.3%	▼	100.00%	-6.3%	▼
N/A	N/A	N/A	N/A	N/A	N/A	N/A
57.82%	41.54%	16.3%	▲	61.31%	-3.5%	▼
70.00%	54.22%	15.8%	▲	67.27%	2.7%	▲

UHBW Total Provider

Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
64,929	64,847	82	▲	42,254	22,675	▲
29,705	28,777	928	▲	7,283	22,422	▲
5,371	5,498	-127	▼	29	5,342	▲
471	678	-207	▼	N/A	N/A	N/A
0	8	-8	▼	N/A	N/A	N/A
8.3%	8.5%	-0.2%	▼	0.1%	8.2%	▲
54.25%	55.62%	-1.4%	▼	82.76%	-28.5%	▼

Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
17,080	16,731	349	▲	10,818	6,262	▲
4,762	5,709	-947	▼	409	4,353	▲
1,933	2,190	-257	▼	110	1,823	▲
27.88%	34.12%	-6.2%	▼	3.78%	24.1%	▲

Feb-23	Jan-23	Variance	Change	Feb-20	Variance	Change
60.49%	50.26%	10.2%	▲	95.3%	-34.8%	▼
N/A	N/A	N/A	N/A	N/A	N/A	N/A
58.46%	53.23%	5.2%	▲	N/A	N/A	N/A
92.83%	88.36%	4.5%	▲	96.75%	-3.9%	▼
93.55%	72.34%	21.2%	▲	93.75%	-0.2%	▼
99.39%	90.21%	9.2%	▲	100.00%	-0.6%	▼
99.42%	99.47%	0.0%	▼	98.51%	0.9%	▲
44.39%	42.91%	1.5%	▲	77.52%	-33.1%	▼
66.67%	40.00%	26.7%	▲	33.33%	33.3%	▲

Key to Tables

- Latest month = **February** Previous month = **January**
- 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

19/20 = **February 2020** (pre-covid comparison)

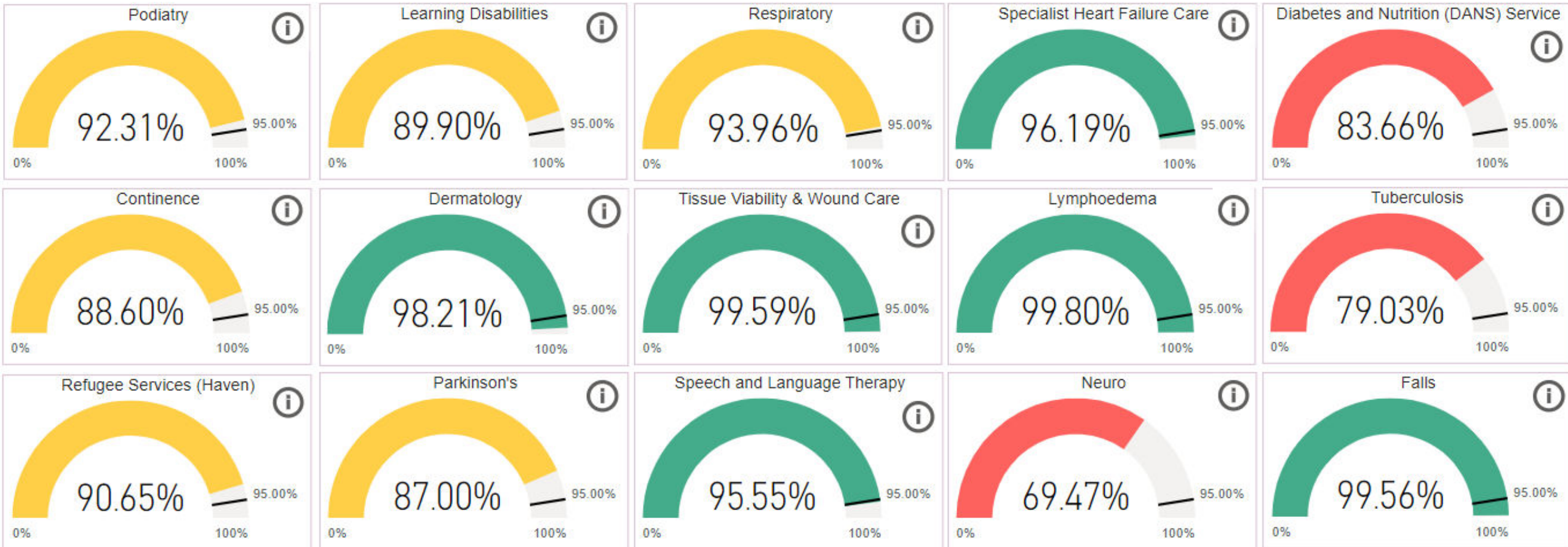
2.4 Mental Health – Summary Performance

Mental Health, Learning Disabilities & Autism	Period	Standard	Latest	Previous	Variance	Change	19/20	Variance	Change
Dementia Diagnosis Rate	Feb-23	66.7%	66.4%	66.6%	-0.2%	▼	68.7%	-2.3%	▼
EP - 2ww Referral	Dec-22	60%	62.5%	75.0%	-12.5%	▼	77.0%	-14.5%	▼
IAPT Roll out (rolling 3 months)	Jan-23	6.25%	4.32%	3.92%	0.40%	▲	3.8%	0.5%	▲
IAPT Recovery Rate	Jan-23	50%	50.6%	55.2%	-4.5%	▼	39.7%	10.9%	▲
IAPT Waiting Times - 6 weeks	Jan-23	75%	97.0%	97.2%	-0.2%	▼	82.3%	14.7%	▲
IAPT Waiting Times - 18 weeks	Jan-23	95%	99.4%	99.3%	0.1%	▲	99.0%	0.4%	▲
CYPMH Access Rate - 2 contacts (12m Rolling)	Jan-23	34%	32.4%	32.3%	0.1%	▲	23.6%	8.8%	▲
CYP with Eating Disorders - routine cases within 4 weeks	Q3 22-23	95.0%	96.0%	95.3%	0.6%	▲	86.4%	9.6%	▲
CYP with Eating Disorders - urgent cases within 1 week	Q3 22-23	95.0%	96.0%	95.0%	1.0%	▲	63.6%	32.4%	▲
SMI Annual Health Checks (12 month rolling)	Q4 22-23	60.0%	62.2%	50.9%	11.3%	▲	18.2%	44.1%	▲
Total Inappropriate Out of Area Placements (Bed Days)	Jan-23	N/A	90	120	-30	▼	1019	-929	▼
Percentage of Women Accessing Perinatal MH Services	Jan-23	8.6%	7.1%	7.1%	0.0%	◀▶	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in CCG beds	Mar-23	9	12	10	2	▲	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in NHSE beds	Mar-23	13	19	19	0	◀▶	N/A	N/A	N/A
LD Annual Health Checks delivered by GPs aged 14+ (YTD)	Mar-23	3825	3886	3614	272	▲	N/A	N/A	N/A
AWP Delayed Transfers of Care	Mar-23	3.5%	23.6%	21.9%	1.7%	▲	9.6%	14.0%	▲
AWP Early Intervention	Mar-23	60%	39.1%	73.3%	-34.2%	▼	30.0%	9.1%	▲
AWP 4 week wait referral to assessment	Mar-23	95%	95.65%	97.60%	-2.0%	▼	94.10%	1.6%	▲

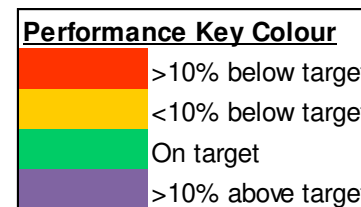
Key to Table

- 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

2.5 Sirona – Adults Community Services – % in 18 weeks – 2022/23 YTD

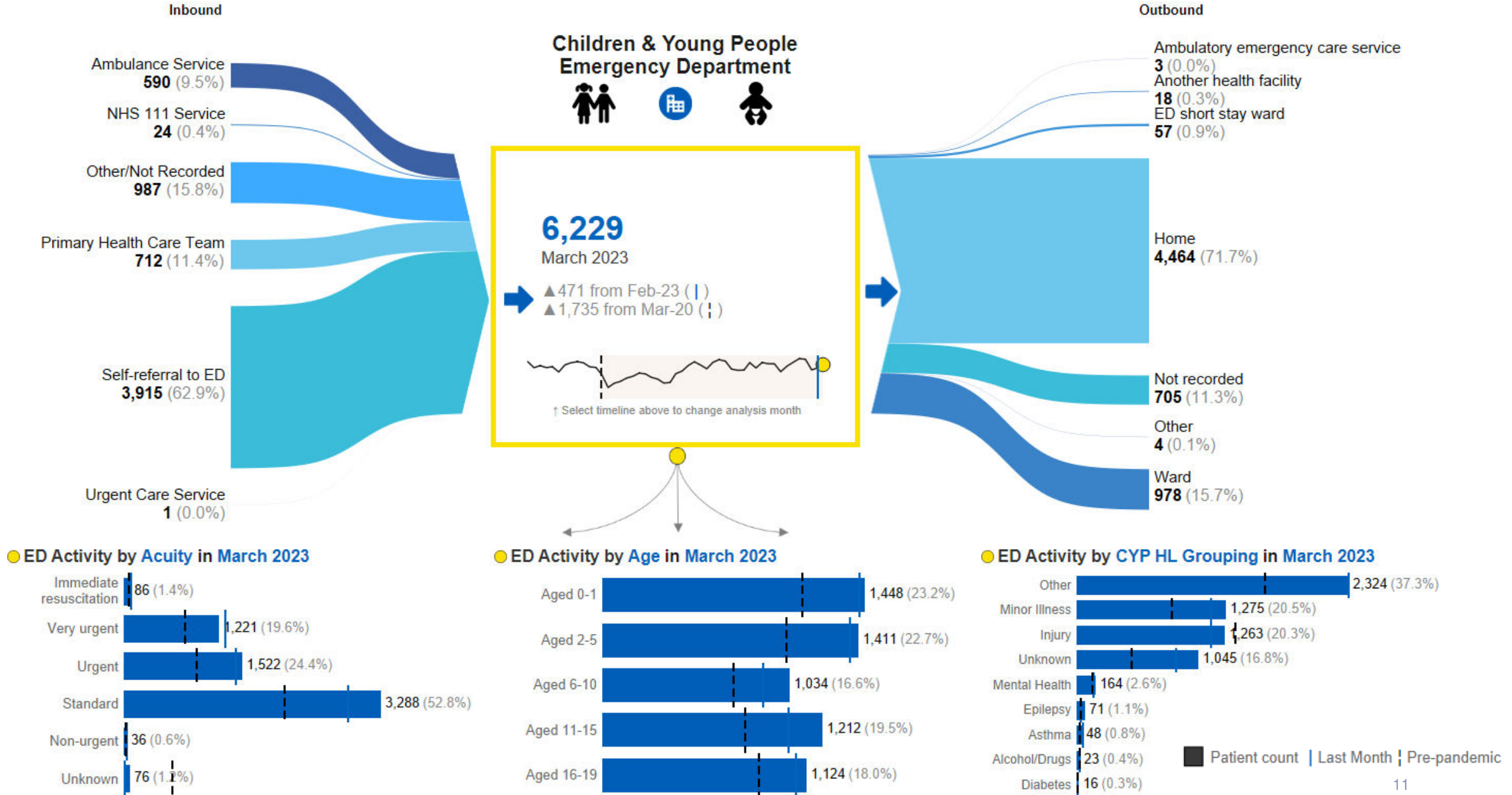


Percentage Targets



Please note: Data as at 13th April. This is provisional until the 15th Working day of April.

2.6 Children – CYP ED Overview BNSSG Trusts - March



3.1 BNSSG ICB Scorecard

Theme	Indicator	Standard	21/22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	22/23
Urgent Care	A&E 4hr Waits - BNSSG Footprint	95%	73.03%	67.04%	67.44%	65.76%	72.74%	69.21%	66.32%	61.78%	66.15%	64.95%	65.00%	63.10%	73.80%	74.50%	76.46%	68.46%
	A&E 4hr Waits - BNSSG Trusts	95%	64.98%	60.27%	59.73%	59.46%	65.46%	61.80%	57.10%	61.78%	60.07%	58.87%	56.72%	54.12%	66.27%	67.75%	70.70%	61.59%
	>12hr DTA breaches in A&E - BNSSG Trusts	0	7139	1211	1401	1169	755	873	1182	815	978	1423	1296	2003	1318	436	680	12928
Planned Care	RTT Incomplete - 18 Weeks Waits	92%	65.39%	65.93%	65.39%	65.75%	65.76%	66.17%	65.71%	65.75%	65.54%	66.25%	64.72%	62.55%	64.12%	64.26%		64.26%
	RTT Incomplete - Total Waiting List Size		74,505	71,772	74,505	75,720	76,803	80,749	85,720	87,320	86,771	87,481	80,290	85,246	86,001	83,947		83,947
	RTT Incomplete - 52 Week Waits		3779	3864	3779	4052	4164	4764	5134	5376	5302	5386	4761	5345	4961	4182		4,182
	RTT Incomplete - % of WL > 52 Weeks		5.07%	5.38%	5.07%	5.35%	5.42%	5.90%	5.99%	6.16%	6.11%	6.16%	5.93%	6.27%	5.77%	4.98%		4.98%
	Diagnostic - 6 Week Waits	1%	37.90%	36.86%	37.90%	41.09%	38.14%	38.46%	38.36%	41.30%	40.46%	36.03%	34.05%	35.13%	32.18%	24.95%		24.95%
	Diagnostic - Total Waiting List Size		32,024	30,517	32,024	32,109	31,592	31,976	31,991	31,480	33,279	33,598	32,634	30,471	29,469	28,816		28,816
	Diagnostic - Number waiting > 6 Weeks		12,136	11,250	12,136	13,193	12,049	12,298	12,273	13,000	13,464	12,105	11,111	10,705	9,484	7,190		7,190
	Diagnostic - Number waiting > 13 Weeks		6,623	6,465	6,623	7,543	7,539	7,597	7,099	7,067	7,503	7,009	6,033	5,456	4,267	3,100		3,100
Cancer	Cancer 2 Week Wait - All	93%	64.91%	70.34%	70.70%	61.38%	57.06%	48.91%	44.15%	44.78%	39.17%	39.58%	47.13%	53.08%	56.34%	65.15%		50.28%
	Cancer 2 Week Wait - Breast symptoms	93%	28.22%	16.87%	17.86%	21.35%	52.86%	22.83%	35.56%	4.88%	14.55%	20.83%	73.21%	90.74%	87.88%	88.04%		47.40%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	66.40%	73.56%	73.09%	67.96%	72.62%	69.30%	61.04%	53.13%	41.55%	45.75%	52.52%	53.60%	61.31%	72.01%		58.71%
	Cancer 31 Day first treatment	96%	92.45%	91.57%	88.79%	86.60%	89.02%	91.31%	93.53%	92.83%	89.69%	93.44%	91.74%	93.39%	86.98%	91.81%		90.92%
	Cancer 31 day subsequent treatments - surgery	94%	81.11%	81.37%	75.21%	71.00%	70.91%	68.48%	70.11%	67.02%	64.81%	85.29%	78.23%	83.33%	59.32%	91.94%		73.89%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	98.97%	99.32%	97.99%	97.66%	100.00%	95.83%	97.76%	100.00%	100.00%	100.00%	100.00%	100.00%	91.40%	98.81%		98.13%
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.68%	99.44%	100.00%	100.00%	100.00%	98.87%	100.00%	100.00%	98.61%	98.64%	98.84%	100.00%	99.40%	99.34%		99.39%
	Cancer 62 day referral to first treatment - GP referral	85%	68.74%	58.30%	65.99%	61.21%	57.96%	53.53%	56.90%	56.00%	59.56%	50.79%	51.13%	51.22%	43.10%	54.33%		53.92%
	Cancer 62 day referral to first treatment - NHS Screening	90%	59.57%	68.00%	63.89%	55.56%	82.14%	43.48%	62.16%	69.70%	54.55%	58.82%	54.17%	48.00%	47.50%	71.43%		59.59%
Quality	Total Number of C.diff Cases	308	303	22	17	23	20	27	27	26	26	21	26	20	14	10		240
	Total Number of MRSA Cases Reported	0	38	0	3	4	2	1	1	2	5	1	4	1	2	3		26
	Total number of Never Events	0	4	0	0	0	0	0	0	1	1	0	2	2	1	0		7
	Eliminating Mixed Sex Accommodation (BNSSG CCG)	0	2	0	1	1	0	2	1	1	1	0	1	3	3	0		13
	Eliminating Mixed Sex Accommodation (BNSSG Trusts)	0	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%	64.79%	65.39%	65.80%	65.88%	65.72%	65.92%	65.79%	66.09%	66.54%	67.19%	66.66%	66.60%	66.40%		66.40%
	EIP - 2ww Referral	60%	54.55%	54.55%	61.54%	76.92%	70.00%	66.67%	58.33%	69.23%	72.73%	77.78%	75.00%	62.50%				62.50%
	IAPT Roll out (rolling 3 months)	6.25%	4.33%	4.33%	4.73%	4.44%	4.66%	4.35%	4.24%	4.00%	3.92%	3.91%	4.00%	3.92%	4.32%			4.32%
	IAPT Recovery Rate	50%	53.22%	53.22%	54.73%	50.60%	51.81%	52.15%	51.71%	50.46%	46.15%	48.17%	52.60%	55.15%	50.63%			50.63%
	IAPT Waiting Times - 6 weeks	75%	91.53%	91.53%	90.34%	93.60%	92.42%	95.26%	95.69%	96.41%	95.68%	98.80%	96.61%	97.16%	96.97%			96.97%
	IAPT Waiting Times - 18 weeks	95%	99.44%	99.44%	99.52%	100.00%	99.49%	100.00%	99.52%	99.55%	99.46%	100.00%	99.44%	99.29%	99.39%			99.39%
	CYPMH Access Rate 2+ contacts (rolling 12m)	34%	26.41%	26.41%	26.73%	28.08%	30.54%	31.47%	31.97%	32.47%	31.82%	32.20%	32.61%	32.32%	32.38%			32.38%
	CYP with ED - routine cases within 4 weeks (quarterly)	95%	88.52%	88.52%		91.35%				95.31%		95.95%						95.95%
	CYP with ED - urgent cases within 1 week (quarterly)	95%	83.33%	83.33%		91.67%				95.00%		96.00%						96.00%
	SMI Annual Health Checks (quarterly)	60%	45.67%	45.67%		56.81%				55.40%		50.94%						62.24%
	Out of Area Placements (Bed Days)		420	420	465	450	470	455	330	265	175	65	120	120	90			90

3.2 Provider Scorecard – NBT

Theme	Indicator	Standard	21/22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	22/23	
Urgent Care	A&E 4hr Waits - Trust	95%	61.48%	51.53%	52.74%	55.54%	72.71%	59.32%	50.99%	60.83%	56.43%	57.47%	57.87%	55.61%	71.94%	79.69%	78.35%	62.86%	
	A&E 4hr Waits - Footprint	95%	69.58%	59.36%	61.25%	61.71%	77.70%	66.62%	60.85%	60.83%	62.29%	63.12%	65.67%	63.82%	77.64%	83.37%	82.07%	68.92%	
	>12hr DTA breaches in A&E	0	1378	367	449	360	176	297	304	57	261	482	433	786	312	9	135	3612	
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	64.71%	65.17%	64.71%	64.23%	62.62%	64.80%	65.78%	65.82%	66.30%	66.31%	65.58%	62.05%	63.87%	63.87%		63.87%	
	RTT Incomplete - Total Waiting List Size	Op Plan	39,101	38,498	39,101	39,819	40,634	42,326	46,991	48,766	49,025	48,871	47,418	46,523	46,266	46,327		46,327	
	RTT Incomplete - 52 Week Waits	Op Plan	2242	2296	2242	2,454	2,424	2,675	2,914	3,131	3,087	3,062	2,980	2,984	2,742	2,556		2,556	
	RTT Incomplete - % of WL > 52 Weeks		5.73%	5.96%	5.73%	6.16%	5.97%	6.32%	6.20%	6.42%	6.30%	6.27%	6.28%	6.41%	5.93%	5.52%		5.52%	
	Diagnostic - 6 Week Waits	1%	40.25%	40.00%	40.25%	43.61%	40.13%	41.00%	42.75%	48.09%	48.27%	39.36%	38.62%	38.56%	32.21%	22.45%		22.45%	
	Diagnostic - Total Waiting List Size		17,111	16,469	17,111	17,114	17,166	17,504	17,124	16,928	16,690	17,286	16,740	14,988	13,437	12,679		12,679	
	Diagnostic - Number waiting > 6 Weeks		6,888	6,588	6,888	7,464	6,889	7,177	7,321	8,141	8,057	6,803	6,465	5,779	4,328	2,847		2,847	
	Diagnostic - Number waiting > 13 Weeks		4,097	3,951	4,097	4,664	4,780	4,897	4,718	4,844	4,971	4,627	4,204	3,663	2,459	1,497		1,497	
Cancer	Cancer 2 Week Wait - All	93%	51.63%	66.47%	69.78%	57.66%	46.16%	39.21%	40.99%	40.18%	35.85%	30.86%	47.53%	56.62%	55.01%	63.52%		46.43%	
	Cancer 2 Week Wait - Breast symptoms	93%	27.21%	14.55%	16.78%	14.94%	46.03%	18.95%	21.05%	2.50%	6.12%	11.94%	63.27%	97.83%	90.16%	87.50%		42.17%	
	Cancer 28 day faster diagnosis standard (All Routes)	75%	60.77%	72.01%	72.93%	66.82%	72.83%	70.87%	58.29%	48.83%	35.18%	42.88%	55.74%	55.48%	62.66%	77.41%		58.34%	
	Cancer 31 Day first treatment	96%	89.09%	89.91%	80.99%	81.82%	83.77%	85.53%	91.20%	87.36%	87.76%	90.39%	86.49%	87.16%	82.41%	89.90%		86.66%	
	Cancer 31 day subsequent treatments - surgery	94%	74.28%	80.68%	65.49%	62.77%	57.29%	51.85%	58.11%	43.84%	50.00%	75.51%	64.35%	73.85%	52.21%	80.73%		61.41%	
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	97.90%	100.00%	83.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.75%		98.89%
	Cancer 62 day referral to first treatment - GP referral	85%	64.36%	51.17%	58.66%	56.48%	50.15%	48.40%	45.10%	55.59%	58.90%	52.45%	48.86%	49.00%	41.54%	57.82%		51.21%	
	Cancer 62 day referral to first treatment - NHS Screening	90%	64.40%	72.22%	70.59%	63.64%	82.14%	51.02%	57.53%	74.24%	62.50%	57.38%	63.83%	51.02%	54.22%	70.00%		62.68%	
Quality	Total Number of C.diff Cases (HOHA + COHA)		62	1	6	7	7	7	7	5	6	6	6	6	4	2		63	
	Total Number of MRSA Cases Reported	0	0	0	0	4	1	1	0	0	0	0	0	0	0	0		6	
	Total Number of E.Coli Cases		48	3	5	7	5	7	4	6	5	6	8	4	9	6		67	
	Number of Klebsiella cases		24	2	3	2	3	4	2	1	4	2	2	2	1	2		25	
	Number of Pseudomonas Aeruginosa cases		10	1	0	2	1	0	1	2	1	0	0	4	2	1		14	
	Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
	Number of Never Events	0	1	0	0	0	0	0	0	0	0	0	2	1	1	0		4	
	VTE assessment on admission to hospital	95%		93.99%	92.63%	94.77%	94.69%	94.77%	92.24%	91.75%	91.79%	93.03%	94.17%	93.90%	93.53%				

3.3 Provider Scorecard – UHBW

Theme	Indicator	Standard	21/22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	22/23
Urgent Care	A&E 4hr Waits - Trust	95%	66.79%	64.83%	63.26%	61.51%	61.69%	63.04%	60.15%	62.31%	62.01%	59.59%	56.17%	53.41%	63.45%	61.90%	66.88%	60.94%
	A&E 4hr Waits - Footprint	95%	74.75%	70.88%	70.46%	67.81%	70.28%	70.47%	68.96%	62.31%	68.14%	65.86%	64.68%	62.77%	71.95%	70.29%	73.74%	68.23%
	>12hr DTA breaches in A&E	0	5761	844	952	809	579	576	878	758	717	941	863	1217	1006	427	545	9316
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	59.17%	59.50%	59.17%	58.65%	58.32%	58.76%	56.37%	55.56%	54.35%	55.33%	55.19%	54.36%	55.62%	54.25%		54.25%
	RTT Incomplete - Total Waiting List Size	Op Plan	55,021	54,305	55,021	57,019	57,940	60,404	60,738	62,010	61,870	62,462	63,041	64,359	64,847	64,929		64,929
	RTT Incomplete - 52 Week Waits	Op Plan	3,920	3,604	3,920	4,362	4,654	5,298	5,591	5,970	6,141	5,989	5,888	6,011	5,498	5,371		5,371
	RTT Incomplete - % of WL > 52 Weeks		7.12%	6.64%	7.12%	7.65%	8.03%	8.77%	9.21%	9.63%	9.93%	9.59%	9.34%	9.34%	8.48%	8.27%		8.27%
	Diagnostic - 6 Week Waits	1%	39.05%	37.48%	39.05%	42.11%	39.90%	38.78%	36.50%	37.79%	35.54%	34.66%	31.49%	34.21%	34.12%	27.88%		27.88%
	Diagnostic - Total Waiting List Size		16,610	15,576	16,610	16,521	15,819	16,042	16,426	15,387	17,577	16,952	16,692	16,339	16,731	17,080		17,080
	Diagnostic - Number waiting > 6 Weeks		6,486	5,838	6,486	6,957	6,311	6,221	5,996	5,815	6,246	5,875	5,256	5,589	5,709	4,762		4,762
	Diagnostic - Number waiting > 13 Weeks		3,372	3,349	3,372	3,799	3,697	3,616	3,245	2,968	3,294	3,062	2,317	2,307	2,190	1,933		1,933
Cancer	Cancer 2 Week Wait - All	93%	82.37%	75.41%	66.51%	63.02%	67.99%	57.22%	44.62%	45.18%	41.14%	49.06%	41.57%	41.93%	50.26%	60.49%		50.94%
	Cancer 28 day faster diagnosis standard (All Routes)	75%	76.33%	77.86%	73.83%	72.02%	73.19%	67.40%	64.56%	57.28%	50.54%	46.76%	42.78%	45.98%	53.23%	58.46%		57.52%
	Cancer 31 Day first treatment	96%	92.90%	89.62%	93.50%	89.58%	90.61%	92.88%	93.92%	93.92%	91.01%	94.61%	93.36%	98.33%	88.36%	92.83%		92.62%
	Cancer 31 day subsequent treatments - surgery	94%	85.07%	80.00%	82.09%	83.33%	76.27%	80.00%	88.89%	85.94%	87.69%	84.21%	88.71%	87.23%	72.34%	93.55%		84.66%
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	99.28%	99.33%	99.35%	97.67%	100.00%	94.77%	98.53%	100.00%	100.00%	100.00%	99.44%	100.00%	90.21%	99.39%		97.98%
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.53%	100.00%	100.00%	99.38%	100.00%	99.48%	99.38%	100.00%	99.37%	98.73%	98.99%	99.29%	99.47%	99.42%		99.42%
	Cancer 62 day referral to first treatment - GP referral	85%	76.05%	70.18%	78.05%	67.81%	70.95%	61.83%	69.42%	52.16%	64.85%	47.95%	46.37%	53.98%	42.91%	44.39%		56.59%
	Cancer 62 day referral to first treatment - NHS Screening	90%	50.28%	60.00%	55.56%	0.00%	33.33%	25.00%	50.00%	50.00%	50.00%	85.71%	44.44%	75.00%	40.00%	66.67%		50.59%
Quality	Total Number of C.diff Cases (HOHA + COHA)	89	82	8	2	6	8	12	13	7	9	6	13	7	5	8		94
	Total Number of MRSA Cases Reported	0	7	0	1	0	0	0	0	0	1	0	1	1	2	1		6
	Total Number of E.Coli Cases	119	75	5	9	15	13	6	8	7	11	13	9	5	5	6		98
	Number of Klebsiella cases		48	1	1	3	4	5	6	9	5	5	10	3	3	1		54
	Number of Pseudomonas Aeruginosa cases		15	0	0	1	2	1	2	4	5	1	0	0	3	1		20
	Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
	Number of Never Events	0	3	0	0	0	0	0	0	1	1	0	0	1	0	0		3
	Rate of slips, trips and falls per 1,000 bed days	4.8	4.83	4.85	5.51	5.55	4.79	4.11	3.27	6.63	4.49	5.86	5.34	4.71	5.11	5.23		5.01
	No. of Pressure Ulcers grade 2, 3 & 4 per 1,000 bed days	0.4	0.174	0.1	0.301	0.248	0.089	0.093	0.089	0.118	0.061	0.23	0.18	0.088	0.086	0.1		0.126
	VTE assessment on admission to hospital (Bristol)	95%	83.3%	82.60%	82.20%	81.3%	81.9%	82.4%	82.1%	83.7%	83.5%	84.0%	84.9%	81.3%	85.3%	84.50%		83.2%

3.4 Non-Acute Provider Scorecard

Provider	Indicator (BNSSG level - except ambulance handovers)	Standard	21/22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	22/23
SWASFT	Category 1 - Average Duration (hr:min:sec)	0:07:00	0:08:48	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	0:08:18	0:07:54	0:08:00	0:09:24
	Category 1 - 90th Percentile Duration (hr:min:sec)	0:14:00	0:15:54	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	0:14:36	0:14:12	0:14:00	0:16:18
	Category 2 - Average Duration (hr:min:sec)	0:18:00	1:10:00	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	0:30:06	0:27:54	0:29:06	0:57:42
	Category 2 - 90th Percentile Duration (hr:min:sec)	0:40:00	2:54:24	5:01:42	3:06:18	1:28:54	2:17:48	2:47:00	1:29:18	1:43:12	2:35:54	1:55:30	7:25:12	1:05:24	1:00:30	1:02:48	2:13:42
	Category 3 - 90th Percentile Duration (hr:min:sec)	2:00:00	9:11:06	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	2:58:00	3:40:18	4:20:12	7:43:36
	Category 4 - 90th Percentile Duration (hr:min:sec)	3:00:00	8:00:06	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	4:21:54	3:27:18	6:52:12	7:39:54
	Ambulance Handovers - % within 15 minutes at NBT	65%	25.0%	14.7%	16.8%	21.0%	16.8%	13.5%	18.2%	17.6%	11.9%	13.1%	9.6%	19.5%	26.7%	23.0%	17.5%
	Ambulance Handovers - % within 30 minutes at NBT	95%	56.8%	38.3%	44.4%	53.9%	45.5%	42.8%	56.2%	51.5%	38.6%	40.3%	29.6%	54.7%	70.9%	67.5%	50.1%
	Ambulance Handovers - % within 60 minutes at NBT	100%	75.3%	57.2%	66.2%	77.2%	68.0%	67.5%	80.9%	75.9%	62.2%	66.2%	48.8%	78.9%	94.7%	89.1%	73.5%
	Ambulance Handovers - % within 15 minutes at BRI	65%	22.2%	11.7%	11.6%	13.9%	17.5%	9.7%	12.0%	13.3%	10.3%	11.4%	7.5%	12.1%	11.9%	14.2%	12.2%
	Ambulance Handovers - % within 30 minutes at BRI	95%	41.6%	23.3%	25.3%	34.7%	42.9%	26.2%	30.7%	36.1%	27.7%	33.7%	17.8%	33.5%	37.1%	44.6%	32.8%
	Ambulance Handovers - % within 60 minutes at BRI	100%	60.0%	39.3%	44.2%	56.0%	65.2%	48.1%	51.2%	58.4%	49.7%	60.8%	36.1%	58.7%	69.1%	72.8%	56.2%
	Ambulance Handovers - % within 15 minutes at WGH	65%	32.6%	17.6%	16.9%	25.0%	23.5%	15.0%	19.0%	16.3%	14.2%	12.4%	5.8%	11.0%	19.4%	13.8%	16.2%
	Ambulance Handovers - % within 30 minutes at WGH	95%	60.0%	40.9%	40.5%	52.4%	55.9%	36.3%	47.5%	46.6%	44.0%	37.1%	23.7%	38.6%	58.9%	52.6%	44.9%
Ambulance Handovers - % within 60 minutes at WGH	100%	75.2%	60.2%	58.1%	71.2%	72.7%	56.0%	65.0%	66.2%	65.2%	63.0%	42.4%	59.4%	85.5%	82.9%	66.2%	
SevernSide IUC	Average speed to answer calls (in seconds)	20 Sec	227	325	318	274	756	713	723	271	453	381	2054	269	181	152	526
	% of calls abandoned	3%	12.8%	16.0%	16.1%	13.5%	30.0%	28.4%	29.2%	14.0%	20.6%	18.0%	43.3%	14.9%	12.2%	10.8%	21.7%
	% Triaged Calls receiving Clinical Contact	50%	55.9%	50.4%	50.0%	48.5%	48.4%	48.8%	37.3%	51.5%	52.1%	51.0%	51.9%	50.3%	50.2%	49.3%	49.4%
	% of callers allocated the first service offered by DOS	85%	67.5%	70.5%	70.0%	68.7%	69.3%	70.2%	68.8%	70.1%	68.8%	67.7%	70.9%	73.0%	71.4%	73.4%	70.3%
	% of Cat 3 or 4 ambulance dispositions validated within 30mins	50%	59.5%	47.8%	53.1%	45.8%	38.0%	45.0%	58.5%	66.2%	60.9%	56.3%	38.0%	44.8%	42.4%	33.0%	48.4%
	% of calls initially given an ED disposition that are validated	50%	61.7%	30.6%	24.2%	13.2%	13.8%	13.4%	17.9%	22.5%	23.9%	21.0%	27.0%	24.1%	27.4%	29.8%	21.7%
AWP	Delayed Transfers of Care	3.5%	10.7%	11.1%	10.3%	13.4%	10.6%	12.7%	15.8%	18.4%	20.4%	21.5%	23.9%	23.9%	21.9%	23.6%	
	Early Intervention	60%	49.1%	61.9%	76.9%	55.0%	63.1%	81.8%	76.1%	73.3%	81.8%	62.5%	64.2%	28.5%	73.3%	39.1%	
	4 week wait Referral to Assessment	95%	80.7%	80.7%	78.9%	76.9%	76.9%	84.3%	82.9%	75.0%	84.2%	83.0%	90.3%	90.5%	97.6%	95.6%	

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 saw an exceptional increase in calls received by NHS 111, with demand close to that seen in March 2020. Service providers attribute much of the increase to winter pressures, including widespread public concern about Group A Streptococcus infections

March IUC and AWP data is provisional and subject to change.

BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 30th March, 1400-1630, on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Jeff Farrar	Chair, BNSSG ICB	JF
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Sue Geary	Healthwatch	SG
Hugh Evans 1410	Executive Director, Adults & Communities, Bristol City Council	HE
Sarah Weld	Director of Public Health, South Gloucestershire Council	SW
In attendance		
Dr Jon Hayes	Chair GP Collaborative Board	JH
Prof Jonathan Ives 1500-1530	Professor of Empirical Bioethics, Centre for Ethics in Medicine, University of Bristol	JI
Dr Kathy Ryan	Medical Director, Brisdoc	KR
Denise Moorhouse	Deputy Director of Nursing, BNSSG ICB	DM
Michael Richardson 1435	Deputy Director of Nursing, BNSSG ICB	MR
Jodie Stephens (notes)	Executive PA, BNSSG ICB	JST
Apologies		
Paul May	Non-Executive Director, Sirona	PM
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sue Balcombe	Non-Executive Director, UHBW	SB
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB

	Item	Action
1	<p style="color: #0056b3;">Welcome and Apologies</p> <p>ED welcome and apologies were noted as above.</p>	




	Item	Action
	<p>ED explained to the committee that we are here to scrutinize, support and provide assurance to the Integrated Care Board that there's an effective system of quality and performance governance.</p> <p>The key aims of the ICB are the following:</p> <ul style="list-style-type: none"> • Improve outcomes in population health and healthcare. • Tackle inequalities in outcomes, experience and access. • Enhance productivity and value for money. • Help the NHS support broader social and economic development. <p>ED asked LM for an update regarding BNSSG Operational Plan. LM explained that the operational plan has gone through Finance Estates and Digital committee and will be discussed at ICB on 6th April. There are still areas of operational delivery that we are working through, particularly regarding some of the elective performance around diagnostics with some of the changing arrangements around the community diagnostic centres and landing some of our assumptions and planning around discharge and urgent care. So, from April, we will have the operational plan and its requirements in terms of operational delivery,</p> <p>LM explained that the intention is from April we will be able to give a summary regarding where we are and what we are doing to move us as a system into a different segment in terms of the NHS operating framework, and to allow us as part of our recovery trajectory within that. LM stated it is a work in progress particularly in terms of making sure we've got some measurable outcomes and obviously we want to start to migrate both in terms of our monitoring against the operational plan as well to look at those outcomes.</p> <p>SW asked LM if the outcomes are the ICB ones, LM replied that we are using the outcomes framework that went through as part of the Memorandum of Understanding to start to build in outcomes that we can pick up in our reporting. SW understood that the Strategic Intelligence Collaborative was doing some work on that as well and so. LM stated that she will engage with CB outside of this meeting to discuss who is involved regarding developing this set of metrics.</p> <p>RS also explained to ED that we need to pull in the maternity metrics as we have metrics that we need to make sure we have for our mothers and babies.</p> <p>ACTION 82: LM to link in with CB to discuss who is involved regarding developing, linking in measurable outcomes and maternity metrics with the Strategic Intelligence Collaborative.</p>	LM
2	<p>Declarations of Interest</p> <p>No new declarations noted.</p>	

	Item	Action
3	<p>Minutes of February 2023 meeting</p> <p>Minutes of the previous meeting were agreed as a correct record, noting items highlighted in yellow are for CLOSED minutes only.</p>	
4	<p>Healthwatch Responses</p> <p>SG explained that at February's committee meeting it was discussed how to include the patient voice within meetings. SG has put together a few case studies as an example of the responses Health Watch are receiving. In 2022 they received 1,500 pieces of feedback and are looking to receive a lot more in 2023. SG stated that the most topic feedback received is access to Primary Care and access to NHS dentistry. The case studies included:</p> <ul style="list-style-type: none"> • Older gentleman living in sheltered accommodation his medication does not get delivered. He can't leave the house due to mobility issues and feels it is difficult to get hold of his doctor's surgery. • Patient says he was referred after a visit to A&E - the hospital splinted his hand and provided a leg cast and told him he needed to make a GP appointment to have these checked within five days. He says that he cannot get to see a GP at his surgery. Often, he waits on the phone for over an hour before they answer and if you visit the surgery, they will tell you to use e-Consult which is frequently unavailable and says that all the appointments have been taken. • Feedback from patient's brother, the patient had an appointment for an intervention that required using local anaesthetic before the surgery. Their brother and the family were not allowed to interpret for someone under local anaesthetic. There was no interpreter provided. The family were told to ring City Council for an interpreter. By 3pm the hospital cancelled the surgery. They also incurred costs for travelling and parking for 3 hrs. <p>ED asked if the responses were being highlighted to colleagues within the Trust's and ICB? SG replied Healthwatch produce quarterly reports which are shared, MR attended the last meeting and his report reflects the same data. Healthwatch Chief Executive also met with MR and members of his team in the last quarter so are linked in that way. We also have quarterly prioritization panels which involve our local authority colleagues and the area any contract relates to them and then we do several in depth reports every year. SW added in South Gloucestershire, feedback is heard within the Health Overview and Scrutiny meeting. We do it this way because national policy says that we should and is vital for improving the patient voice. JF explained that he will be speaking to the</p>	

	Item	Action
	<p>ICB Non-Executive Directors this afternoon and will also link in with various committee's and voluntary sector exec membership to make sure the patient voice is heard at meetings. JF stated that it is harder inviting the public to committee meetings as these are not public so will need to discuss going forward.</p> <p>JH stated that there needs to be system integration as well and is a good example that the hospital telling a patient to book an appointment with a GP in five days when everybody knows that the that GP access is under massive pressure. JH explained that as a GP we can't refer anybody to hospital by just telling them to ring the hospital and book an appointment in five days' time, so JH thinks that system integration is useful exercise to explore.</p> <p>RS informed the group that RS has meet with Chief Nursing Officer's from the system about what we think should be some of our core quality priorities for the system for this coming year. So, it'd be helpful to include some of these examples as we think about the transfer of care piece. RS feedback on the case study regarding translation services, we live in a in a multicultural city, 16% of our population in Bristol are from the global majority and 36% in Inner City and East. So, we must have a good set of translation services, it's unacceptable if we don't. LM explained to committee members that LM and RS will take the above case studies to the responsible ICB Executives for them to action. For example, primary care, will be to Dave Jarrett and regarding the contracts, it will be Sarah Truelove.</p> <p>HE explained that Bristol City Council along with Bristol Healthwatch, has just started a piece of work to try and assess and develop a policy regarding co production for older people and disabilities, autism, mental health within the Changing Futures work. We need to be much more systematic and anything that we can do jointly in that regard, HE thinks would be greatly beneficial. HE discussed that Bristol City Council have a strong older people's forum, Age UK and Disability Equalities Commission. ED and HE discussed how we bring it together in systematize, how do we look at what we do in our areas and apply the learning from those to other areas where we're less developed in this way? HE stated we used local user groups to develop their own capacity and then we support them. We are going to have our CQC inspection soon and when they do, HE wants to be able to say we have excellent conversations going on with the people of Bristol and we work together to produce our activity, our policy and activity not just as Bristol City Council but as an ICS.</p> <p>RS discussed good conversations that took place with Clinical and Care Leaders this week, one was primarily a professional nursing conversation about patient safety priorities, but also some work we can do across health and social care such as transfer of care. As discussed at previous meetings the Health and Care</p>	

	Item	Action
	<p>Professional Executive and System Quality Group members met to test the “bow tie” risk model with some worked examples. One example of which was the impact of CQC inspections on local authorities including if one of them resulted in external management.</p> <p>SW stated we should not under underestimate the culture change that this requires to really listen to and build on patient and user stories and say it requires training and dialogue internally. Gloucestershire Learning Disabilities Partnership Board is an example of good practice, there are grants which are issued by users and we can build on that. Also, that health and scrutiny have a crucial role in this, SW explained that she is bringing in voices of elected Members and residents to meetings. Dave Jarrett and colleagues have been in our Health Overview and Scrutiny meeting today and a good reflection on how individual voice can come into a public meeting.</p> <p>ED stated that this was a good initial conversation, we need to make sure that when a piece of work starts on a journey explore where we need to land within local groups system wide. RS explained we need to draw this through all our programs of work, to make sure we are thinking about who the system partners are we work with, rather than doing anything individually.</p> <p>ACTION 83: LM and RS will take the Healthwatch case studies to Dave Jarrett and Sarah Truelove to follow up and action.</p>	LM/RS
5	<p>CNO/CMO Update</p> <ul style="list-style-type: none"> • Emerging Risks • Quality Report (highlights and exceptions) • Updates from SQG & HCPE • Minutes from SQG & HCPE for information <p>RS updated committee members regarding the Junior Doctor industrial action strikes planned for Tuesday 11th April to Saturday 15th April. RS added that there is significant risk to our population due to the timing of the strikes as effectively 10 days of bank holiday service. JF stated he was in discussions with Shane regarding standing up an extraordinary meeting of ICB Board due to the Junior Doctor industrial action as this will disable services for 10 days and will involve 50% of our system doctors.</p>	

	Item	Action
	<p>RS also updated the group regarding productive sessions with senior nurse and therapy leaders which involved developing shared quality and patient safety priorities. This will support the system meet the requirements of the patient safety strategy and the delivery of the system Quality Account. RS recently led a session using the Bow Tie model to work through some current system risk issues.</p> <p>RS shared that she and the team are undertaking clinical site visits as part of the quality oversight process. RS has had a recent visit to Weston General Hospital and feedback the positive changes that have been made there especially with regard to clinical leadership. Health Education England have also visited recently visit and UHBW are awaiting the decision about the return of junior doctors to the site.</p> <p>RS updated the group about information received regarding excess mortality rates in the South-West and across BNSSG. JM will be linking with the Strategic Intelligence Collaborative and bringing through HCPE, SQG and JM will also bring update to future committee meeting once information has been digested.</p> <p>RS introduced DM who updated committee members regarding the Equality and Quality Impact Assessment of the impact of industrial action, in this instance in relation to the Junior Doctors IA. DM explained that BNSSG are planning for anticipated industrial action in March by various unions. This EQIA reviews the impact on quality of care for the population during potential Industrial Action. This has been prepared specifically to prepare for potential Industrial Action (IA) by both Junior Doctors and the (currently suspended) RCN. This may be adapted to assess the impact of planned Industrial Action by other professional groups or other scenarios.</p> <p>The template has been adapted to reflect the nature of the scenario and to draw together the Quality Impact Assessment (QIA) alongside the Equality Impact Assessment (EIA) based on responsibilities upon NHS funded services to deliver safe and effective care in line with the NHS constitution and the NHS outcome framework. Additionally, the template describes the impact that will occur on Local Authority partners as they support mitigation planning.</p> <p>An assessment of the impact the IA will have on the ability of system partners to deliver treatment and care as outlined in the five domains in the NHS Outcomes framework March 2022. The inability to sustain a full suite of services adversely affects BNSSG partners ability to deliver a quality of care to the population in line with the NHS constitution January 2021. See attached paper.</p>	

	Item	Action
	 <p>05 EQIA RCN IA System . v7 March 20:</p> <p>LM explained that timing of action has been deliberately planned for maximum effect, conversations are taking place regarding cancelling planned annual leave. DM finished by reminding members that the EQIA document is a live document that we will continue to review, work up and improve.</p>	
6.1	<p>Performance and Quality Update</p> <p>LM updated members regarding BNSSG performance position in which urgent care continues to improve. In February we met the ambulance handover trajectories and we have been on target delivering our elective recovery despite the cancellations that have taken place during industrial action. We are making satisfactory progress and moving towards our operational plan standards, we have had some challenges regarding cancer performance, but we are generally making good progress. We know we have a problem regarding dermatology and there is a piece of work that has been started to redesign our dermatology pathway to ensure that we can optimize our cancer performance and ensure that we get the right patients in to see the specialists as quickly as possible. Regarding the rest of elective care, we're obviously working through with Sirona to make sure we are doing that overarching delivery.</p> <p>LM explained that within the performance report we have included community data and performance regarding our specialist services of 18 weeks and making sure that we are capturing our ongoing delivery in all areas. Regarding mental health, we are making satisfactory progress and have invested significantly to ensure that we meet the access rate as part of next year's operational plan we have ongoing issues around our dementia diagnosis rate and will be one of our transformation programs as we work through 23/24. We are making progress in terms of our children and young people's access rate, particularly around eating disorders. One of our core challenges around children and young people is being able to recruit the appropriate CAHMS professionals to make those numbers stack up despite having the money available to do that. We have invested in our mental health support teams in schools to deliver and improve reporting position, but not to just improve reporting position but to make sure we've got something in terms of being able to access support at the right time at the right appropriate level as opposed to needing to escalate up into camps.</p> <p>ED asked that the one key function of this group is the measurement of the system against the operational plan and secondly performance so if committee members going forward can look at areas of support or challenges.</p>	

	Item	Action
	<p>JF stated that overall, the report shows improvement in many areas and hugely different to what it was twelve months ago. JF will be speaking to Shane Devlin regarding overall performance i.e., financial, workforce and the details within the performance report itself.</p> <p>JF asked RS for an update regarding AWP, RS explained that the improvement notice has been presented through system committees and a Quality Improvement Group has been stood up in line with National Quality Board guidance. This group will receive AWP recovery plans, provide support and gain assurance then RS will report back to committee. LM added it has been suggested that we have an overarching board but very targeted. So, there is clear sight in terms of the responses, CQC actions, the financial undertakings which AWP sit within alongside their workforce issues. RS stated through the Quality Improvement Group we will include NHSE and CQC, so that AWP have consistency for their quality improvement work. LM explained in response to effectively developing the integrated performance report we are discussing how we trial that within the health and care improvement groups. We don't have the same collation of data coming across from all our providers, but we need to work that through. JF agreed we need to make sure that there's an oversight from the five committees otherwise we will have duplicate information or different information, at different committees and that doesn't add any value.</p> <p>ED asked LM for an update regarding Sirona's performance, LM replied that Sirona remains challenged regarding their workforce, but are prioritising all their community nursing visits in both red and amber. They are doing audit work to make sure any patients that are deferred do not come back in terms of becoming ED attendances. That data isn't reported in the report, but workforce remains one of Sirona's key challenges, most particularly in nursing. They are in line with AWP in terms of the scale of vacancies across the board.</p> <p>ED agreed with JF comments regarding overall performance has improved but has concerns regarding cancer two-week rate wait figures which are extremely poor. LM explained the core issue is dermatology, which is a combination of demand and workforce. We know that we can make efficiencies in how patients are referred, being able to triage effectively by using teledermatology and making sure that we've got clear line of sight in terms of making sure the most urgent patients are sitting in the two-week wait pathway. There is a current program of transformation work to develop that pathway and learning from national best practice. ED asked when would we expect to see performance improve? LM replied would expect it to be the by September. ED wanted to discuss 104 and 78 week waits within Sirona, LM explained we currently going through a validation process with Sirona because we believe those numbers are incorrectly reported we believe the numbers will have decreased by the end of March.</p>	

	Item	Action
	<p>Quality</p> <p>MR explained that Quality Improvement Groups are part of the NQBs approach to enhance surveillance and support from ICB's and wider system partners to providers. NHSE have been keen to use our work in this area as examples of good practice to help other systems to develop this approach due to the success we have achieved with our system partners. There are two proactive pieces of work going on, one in infection control and one with "Red Card" patients attending emergency departments. The other proactive pieces of work that have produced a lot of learning from are the Monkeypox and Strep A system responses. There had been some gaps in initial responses which are being rectified by the setting up of a high consequence infectious diseases group. This group will review all the pathways for possible high consequence infectious diseases and will be completed by the end of July.</p> <p>MR highlighted that in January the Clostridium difficile rates were high. The initial view was that this was due to a higher proportion of older patients in our system however additional scrutiny regarding standardised infection rates indicates the need for additional urgent work in the C difficile working group. RS explained that the importance of this is the high mortality rate, especially for frail older people, associated with C difficile. It was agreed that once the work has been done that MR return to June committee to update. MR explained that one of the main causes of C difficile is inappropriate antibiotic prescribing particularly if people have been given a broad-spectrum antibiotics for various infections.</p> <p>ED highlighted to RS and LM data within the SEND report, South Gloucestershire have two outstanding areas of significant weakness from 2017 that have been carried forward and are meeting NHSE & DFE on the 28th of April. ED asked for assurance that from an ICB perspective we have sight of the progress that's being made and can provide assurance that everything's on track for the improvements that needed?</p> <p>LM responded that one of the key areas is in demonstrating the results in terms of the key stage 4 attainment, which is only measured once a year. Good progress is being made on the other 2 APP areas. LM stated regarding Bristol we have one area in the WSOA which is the piece of work we're doing around our accelerated progress plan around engagement with families and children and with North Somerset, we had two of the five areas remaining.</p> <p>We are working with North Somerset and will be meeting with NHS E & SFE in in June, but progress is underway in each of those as we work forward. We are working in partnership with all our local authority partners.</p>	

	Item	Action
6.2	<p>REAF -The Risk & Ethics Advisory Forum</p> <p>KR and JI joined the meeting to discuss the Risk & Ethics Advisory Forum (REAF). KR is a GP and the Medical Director of Brisdoc and JI is a Professor of Empirical Bioethics at the Centre for Ethics in Medicine, University of Bristol and a member of NICE highly specialized Technology Evaluation Committee.</p> <p>REAF evolved from the BNSSG Health and Care Risk Group and is in the process of being set up. REAF was formed in 2020 to consider risk during the height of Covid. REAF is advisory, acting as a sounding board and forum for discussion, providing direct advice on specific issues upon request. REAF is not a decision-making space. The aims and purpose of REAF is to provide critical analytical thinking concerning risk and associated ethics which may arise from strategic and operational decision making. REAF is not there to provide legal or clinical advice, but legal and clinical opinions may be expressed during deliberations. REAF does not replace available committee structures and should be seen as complementary to them.</p> <p>In terms of reporting pathways. JI explained that this is nearly finalized, but as it currently stands, we are an advisory Group directly accountable to the Office of the Chief Medical and Nursing Officers. REAF will provide an annual report to HCPE. In terms of referrals, they can be made from any forum within the ICB, but it will usually be at the direction of the CMO and CNO office to enable the referrals to be prioritized and triaged. In terms of membership, there will be a chair, deputy chair and administrative support, but we're looking for a range of members from across the system clinical or non-clinical.</p> <p>RS stated that this advisory forum is a key role within the system and an example of how it might be used would be to address how we manage the meeting the needs of our most complex citizens in their own homes within our financial and workforce availability and meeting our statutory duties. How would we manage the balance of somebody's human rights to a family life versus our ability or inability either in health or social care, to be able to maintain them safely at home. How would we start to set some caps on, for our population going forward. It is that area which would be so helpful to have that broader conversation that takes it out of the responsibility of the individual clinician to make a case-by-case decision into a broader population conversation.</p> <p>JF stated essential to have this independence to look at ethical decision making but asked JI regarding identified specialist skills around healthcare law, health economics and consider the diversity of that group. JI replied the diversity membership is something we've struggled with within the Health and Care Risk group. So, the aim is to try and get diversity in the membership across all areas. We are very aware of the need to have a diverse membership getting it is harder. JI has discussed widely regarding true diversity. There's a significant risk that the</p>	

	Item	Action
	<p>same people are identified as being able to represent a particular group and they get asked to be on everything and we want to avoid that. JF replied that he is establishing an independent advisor group which will start with the topic of race, but it will be all areas of equality and will be advertising for the chair of that group in the next couple of weeks.</p> <p>LM wanted to highlight the governance regarding REAF due to it being accountable to the CMO/CNO and not part of the system governance, particularly if it is making recommendations which feed into policy and processes. RS explained CMO/CNO are there to support with the referral process, but the governance will be through the HCPE and then back into this committee. LM replied we just need to make sure that it is clear particularly if we're making decisions that we're placing reliance on the work that REAF do. RS will contact Ellie Wetz ICS Development Programme Manager to update the decision-making framework regarding REAF governance.</p> <p>SW asked how we promote REAF and make sure the right questions are being asked and how we are assured that the recommendations implemented or acknowledged are implemented. How do we prioritize against other calls on resource? JI replied we need the administrative resource to deal with referrals and then to manage the meeting, currently this is KR executive assistant within Brisdoc. KR stated not sure how much resource does it take currently but the members of REAF will do their homework and if the answer is vast, then it will require review.</p> <p>RS explained that REAF would provide advice into the system governance arrangements and the relevant forum would need to consider the advice from REAF for their decision making. SW agreed important that this is stated in framework and the timescale are right and as SW mentioned earlier in the meeting the Strategic Intelligence Collaborative SW think there's the role for this group as will have some of the right people in the room in terms of providing data and evidence.</p> <p>DM agreed that REAF will be extremely helpful once a process and governance are agreed. It will also add to the ethical framework decision making process and we can be confident in our decision making going forward. HE stated regarding involvement, public health and principal social workers would be good to get them involved in the conversations, more broadly and to do it systemwide is going to be a lot more positive and beneficial.</p> <p>ED thanked KR and JI for speaking to committee members for what was an extremely useful conversation especially the governance and look forward to hearing some of the outcomes of your involvement.</p>	

	Item	Action
	<p>ACTION 84: RS to contact Ellie Wetz ICS Development Programme Manager to update the decision-making framework regarding REAF governance.</p> <p>ACTION 85: C Difficile update to be added to June OPQ Committee meeting agenda.</p>	<p>RS</p> <p>JST/ MR</p>
7	<p>Committee Action Log</p> <p>Action log updated as attached.</p>	
8	<p>Items for information</p> <p>8.1 Safeguarding – Quarter 3 8.2 SEND - Quarter 3 8.3 Safeguarding Governance Group Minutes 8.4 System Quality Group Minutes</p>	
9	<p>AOB</p> <p>Committee members discussed that if deep dives are listed on OPQ Committee agenda other committees need to be aware of that and they either need to adopt a similar approach or we need to make sure that conversations are taking place having to ensure that where deep dives are listed, they are the most appropriate and adding the most value.</p> <p>ED discussed with members that at the end of every meeting it is agreed what our first deep dive should be. Shane highlighted as an area of focus, no criteria to reside is something that is very system wide and it crucial within our entire system.</p> <p>RS proposed that at OPQ Committee in April maternity is listed as the deep dive subject then will go to ICB Board in May. SW replied it is important if we do deep dives that we have clear parameters around it in terms of what do we mean by a deep dive, what's the role of this committee. RS informed the group that MR and the BNSSG System Quality Group will devise a template and will share with OPQ Committee in June.</p> <p>ACTION 86: Maternity deep dive to be listed on agenda for OPQ Committee in April.</p> <p>ACTION 87: BNSSG System Quality Group to devise a template to be used within deep dive agenda items going forward and to update OPQ committee in June.</p>	<p>JST</p> <p>MR</p>

	Item	Action
	Date of next meeting: Thursday 27 th April, 1400-1630	

Jodie Stephens
Executive PA
March 2023