

Meeting of BNSSG ICB Board

Date: Thursday 6th July 2023

Time: 0900-1500

Location: Microsoft Teams

Agenda Number:	7.1	
Title:	Quality and Performance Report – Month 1 (April 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:		
<p>The 2 attached reports provide an overview of April 2023 data to cover Month 1 activity for quality and performance. A summary is provided below.</p> <p>The committee are asked to note the following areas.</p> <p>Quality (Appendix 1)</p> <p>Healthcare Associated Infections</p> <p>Integrated Care Boards (ICBs) and secondary care providers threshold levels for 2023/24 were released in May 2023 by NHS England and NHS Improvement. Slide 6 shows these values for the below reported data.</p> <ul style="list-style-type: none"> • C. Difficile – In April 2023, 26 cases were attributed to BNSSG ICB which is an increase of 12 against the previous month. The system has seen an improving picture for reported cases of C Diff over the last 5 months with HOHA cases showing a similar decline during this period. The BNSSG position for C Diff per 100k of population (2.46) remains above the Southwest and National average. The CDI working group continues to work with the system and regional partners to understand the drivers behind these numbers. • E.coli – In April 2023, 37 cases of E. coli bacteraemia cases (an increase of 12 from March) were assigned to BNSSG ICB. The BNSSG rate per 100k of population (3.50) continues to be below the average of 5.11 for the Southwest regions and 5.31 for England. 		

- **MSSA** – (Methicillin-resistant Staphylococcus aureus) In April 2023, 12 cases of MSSA bacteraemia were assigned to BNSSG ICB which is 1 case higher than the previous month. Case activity for MSSA per 100k of population (1.13) continues to be below the Southwest average of 1.75 and the national average of 1.67.
- **MRSA** - (Methicillin-resistant Staphylococcus aureus) In April 2023, there was 1 case of MRSA bacteraemia assigned to BNSSG ICB, which is 2 lower than the numbers reported in March 2023. The 1 reported case in April was attributed to 1 x hospital acquired (HOHA). Case activity for MRSA per 100k of population (0.09) is below the Southwest and National average, although it should be noted that there is a zero tolerance for numbers of reported MRSA cases.

The table below shows the numbers of reported cases by month, by infection and the numbers of reported cases YTD against the threshold.

Infection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Threshold to Date	Cases YTD	Threshold	22/23 FYTD	21/22 FYTD
C. difficile	26												24	26	284	23	26
E. coli	37												42	37	505	42	46
Klebsiella spp	10												12	10	147	11	14
MRSA	1												0	1	0	4	1
MSSA	12													12		16	19
Pseudomonas aeruginosa	5												5	5	60	3	7

Significant events/themes and trends and Learning

Overall, the top three themes being identified as causal factors from the investigation process for general SE's are 1) Communication /MDT 2) Risk Assessments and care planning and 3) Care delivery.

A deep dive is underway to understand the drivers behind the significant increase in care delivery events which have been seen. The outcome of the deep dive will be reviewed at the July 2023 learning panel which is led by the ICB and attended by system partners. The findings will then be shared at SQG in July 2023.

Learning Disability and Autism

Adults

- There continues to be an increase in CTR related activity, 51 Professionals meetings/ MDT's/ Safeguarding/Discharge planning meetings for adults.
- 3 individuals are identified as Delayed Discharge from ICB cohort, 1 individual identified as Delayed Discharge from Secure bed base. There are 4 individuals in the community on Section 17 leave.

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)

The performance report for this month is based on April 2023 information.

Urgent Care

- BNSSG performance narrowly missed the 75% A&E 4-hour performance standard.
- Ambulance handovers remain on track and met trajectory in April. Current performance is showing that June average handovers, despite increases in demand before industrial action is below trajectory. UHBW are starting a perfect week on ambulance handovers week commencing 19.06.23.
- Performance remained steady over the industrial action days in June (14-17) but demand across the country did increase mainly due to heat and did impact on urgent care performance. However, BNSSG did well to hold performance.
- The first service delivery unit for urgent care will take place in week commencing 19.06.23 and will also review the 29Forward report on urgent care.

Elective Care

- Weekly scrutiny of all long waits and detailed returns to NHSE and national team continues. System position on long waits relates to complex patients where mutual aid even with London providers is proving not to be successful. Industrial impact will be calculated by end of June but will have created further backlog and starting to impact on >65 week waiters.
- Endoscopy remains the biggest challenge in diagnostics to the system. Focussed action plans in implementation at both trusts including insourcing and outsourcing capacity. System working to try and conclude CDC negotiations.
- Industrial action impacting on cancer services in the short term for 63+ day waits but is being closely monitored and additional sessions being put on where the workforce is available.
- FDS is the key target this year and the improvements are being made.
- Key risk is skin pathways and an options appraisal in relation to tele dermatology is being worked up to present back to the Gateway panel.

Mental Health

- Small increase in dementia diagnosis rate which is positive.
- SMI annual checks significant improvement 62.2% ahead of the standard of 60.0%.
- CYP mental health access is steady and improving from pre-covid but below the standard of 34%.
- IAPT is recovering above 50% but below the planned roll out pace.
- Out of area placements has reduced but more recent data is showing an increase.

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 Board in relation to key risks to performance and quality within the system and highlight supporting mitigations which are in place. Previously discussed at Outcomes, Quality and Performance Committee 28.06.2023
Financial / Resource Implications:	None referenced
Legal, Policy and Regulatory Requirements:	None referenced
How does this reduce Health Inequalities:	Not referenced
How does this impact on Equality & diversity	As above
Patient and Public Involvement:	Not applicable
Communications and Engagement:	The reports are provided to the ICB Board for information and discussion.
Author(s):	Caroline Dawe - Deputy Director of Commissioning (Performance Improvement) Gary Dawes - BI Manager, Performance, BNSSG ICB 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


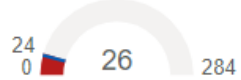

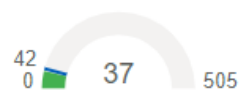







BNSSG Quality Report

**June Report on Month 1
(April data) 2023/24**

Quality Report – Health Care Acquired Infections (HCAI) Summary

Reporting Period – Month 1 2023/24 – April data

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

Infection	Rolling 12 Month Trend	2023/24 Thresholds	2023/24 YTD	2022/23 Position Month 1	2021/22 Position Month 1
C. difficile			26	23	26
E. coli			37	42	46
MRSA			1	4	1
MSSA			12	16	19
Klebsiella spp			10	11	14
Pseudomonas aeruginosa			5	3	7

Rates per 100k	South West Position									
	BSW	BNSSG	Kernow	Devon	Dorset	Glos	Somerset	SW	England	BNSSG
C. diff	2.24	2.46	1.83	1.73	1.95	3.84	2.18	2.26	2.00	6
E. coli	3.98	3.50	7.81	6.75	5.00	2.95	6.20	5.11	5.31	2
MRSA	0.10	0.09	0.00	0.16	0.24	0.00	0.00	0.10	0.11	4
MSSA	1.33	1.13	2.49	2.20	1.59	1.77	2.01	1.75	1.67	1
Pseud A	0.82	0.47	1.16	0.24	0.61	0.00	0.67	0.53	0.56	3
Kleb spp	2.04	0.95	1.16	1.26	1.95	1.77	1.17	1.47	1.51	1

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

Reporting Period – Month 1 2023/24 – April data

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

Performance for April 2023

- **CDI = 26, HOHA = 7 (NBT - 1, UHBW - 6), COCA = 6, COHA = 7, COIA = 6**
- **E. coli = 37, HOHA = 7 (NBT - 4, UHBW - 3), COCA = 24, COHA = 6**
- **MRSA = 1, HOHA = 1 (NBT - 0, UHBW - 1), COCA = 0, COHA = 0**
- **MSSA = 12, HOHA = 4 (NBT - 1, UHBW - 2, Other -1), COCA = 6, COHA = 2**
- **Klebsiella spp = 10, HOHA = 2 (NBT - 1, UHBW - 1), COCA = 8, COHA = 0**
- **Pseudomonas aeruginosa = 5, HOHA = 3 (NBT - 1, UHBW - 2), COCA = 2, COHA = 0**

HOHA – Hospital Onset, Hospital Associated

COHA – Community Onset, Hospital Associated

COCA – Community Onset, Community Associated

COIA – Community onset, Indeterminate Association

BNSSG Annual Standard

- Integrated Care Boards (ICBs) and secondary care providers threshold levels for 2023/24 were released in May 2023 by NHS England and NHS Improvement.
- Both ICB and secondary care threshold levels are specified in the below table:

Risks/Assurance Gaps

The SPC diagrams have switched from a monthly value to a 12-month rolling value. This is to remove the variation we find each month and to limit the impact of seasonality on the process. **Targets/Thresholds set are those set for 23/24.**

All infection types are improving relative to current upper and lower limits, many of them trending lower than a spike during the pandemic. MSSA is an exception with a continued increase over the previous 6-month period.

On 5 May 2023, the World Health Organisation declared the pandemic to no longer be declared a global emergency. We will reassess in the future if this has had an impact on the number of cases in BNSSG to require a rebase of the process limits and average.

Special focus on Hospital Onset HCAI this month.

Infection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Threshold to Date	Cases YTD	Threshold	22/23 FYTD	21/22 FYTD
C. difficile	26												24	26		284	23
E. coli	37												42	37		505	42
Klebsiella spp	10												12	10		147	11
MRSA	1												0	1		0	4
MSSA	12													12		16	19
Pseudomonas aeruginosa	5												5	5		60	3

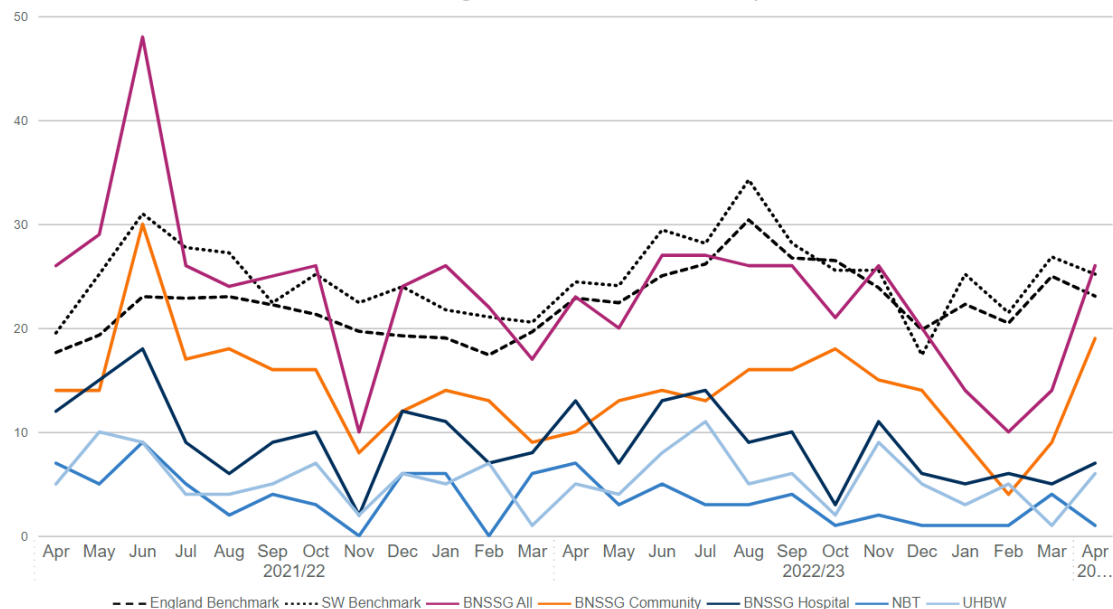
*The table provides the monthly ICB assigned cases as well as the year-to-date total. The 2 final columns are our benchmark against the 2022/23 and 2021/22 positions.

Commentary

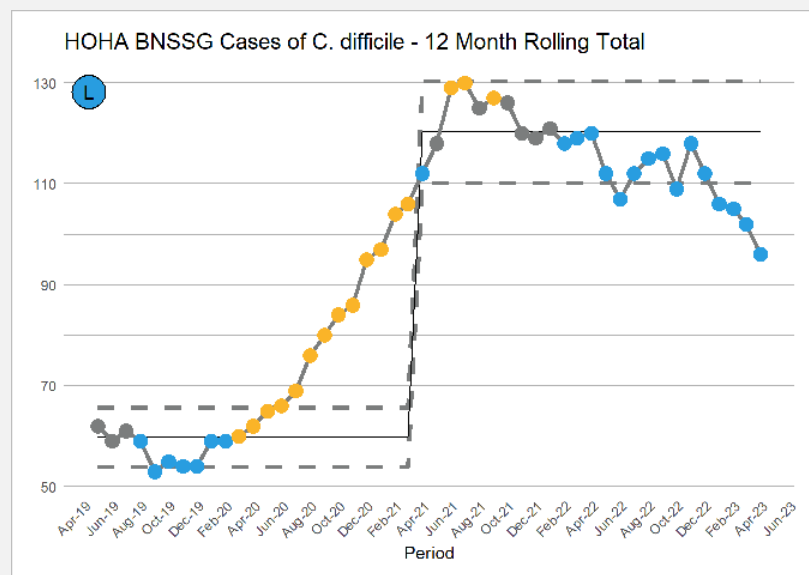
- MRSA- Zero tolerance has not been achieved. There was 1 case in April (HOHA).
- CDI- The 26 cases are currently categorised as follows: Continuing Infection (1), New infection (19), Repeat/Relapse (1), and Unknown (5).
- E.coli- the majority of the 44 cases continue to be Community Onset (30).

C. difficile	26
HOHA	7 (NBT - 1, UHBW - 6)
COCA	6
COHA	7
COIA	6

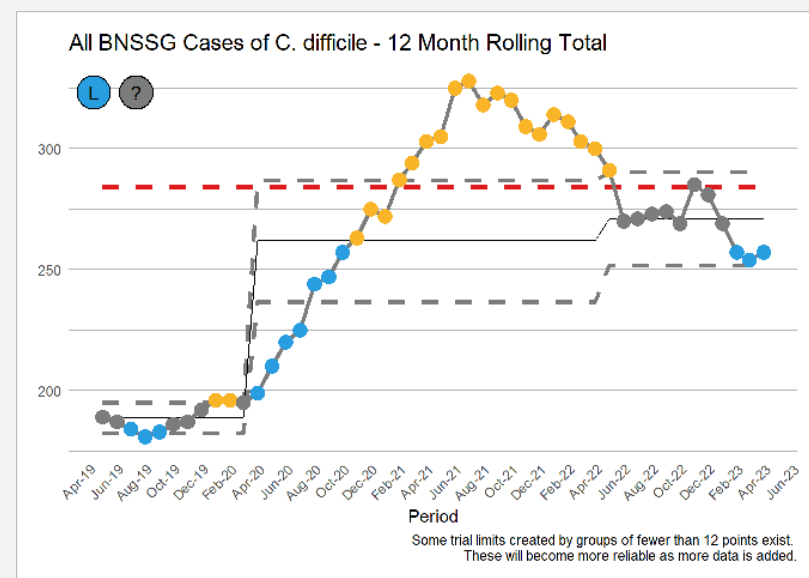
BNSSG ICB Assigned C. difficile Cases Since Apr 2021



Hospital Onset CDI has a variation of special cause concern low, with a decreasing trend below the lower control limit since the previous rebase.

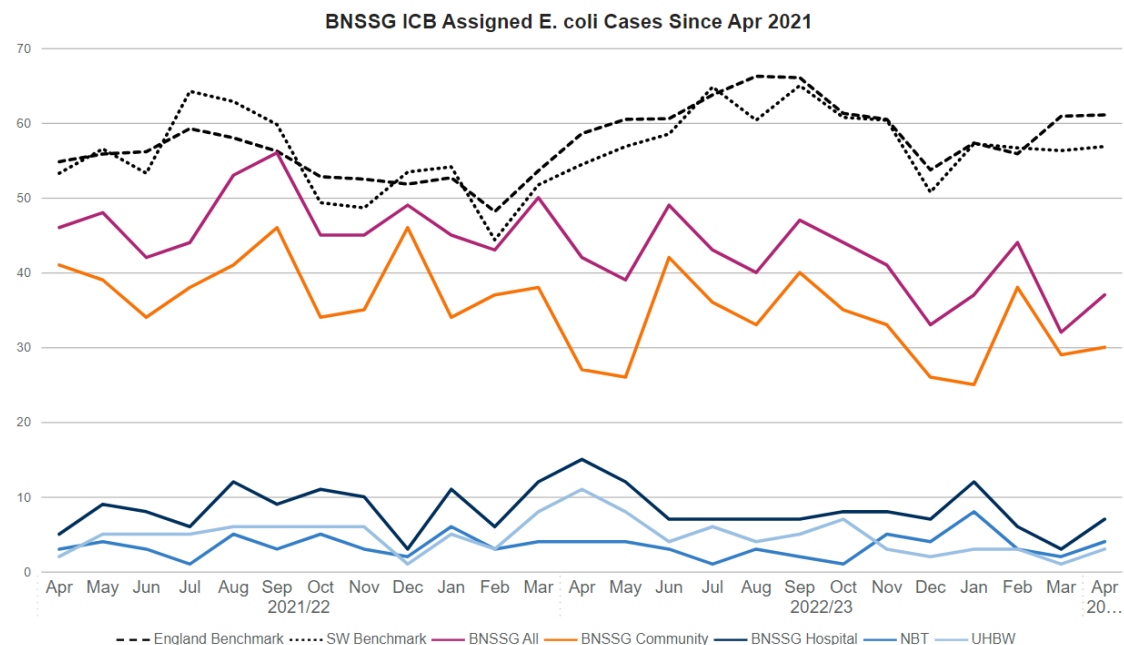


BNSSG Wide CDI has a variation of special cause concern low, trending towards the lower control limit since the previous rebase. Things are improving but the 23/24 target lies between the upper and lower bounds, the processes is expected to hit or miss this target.



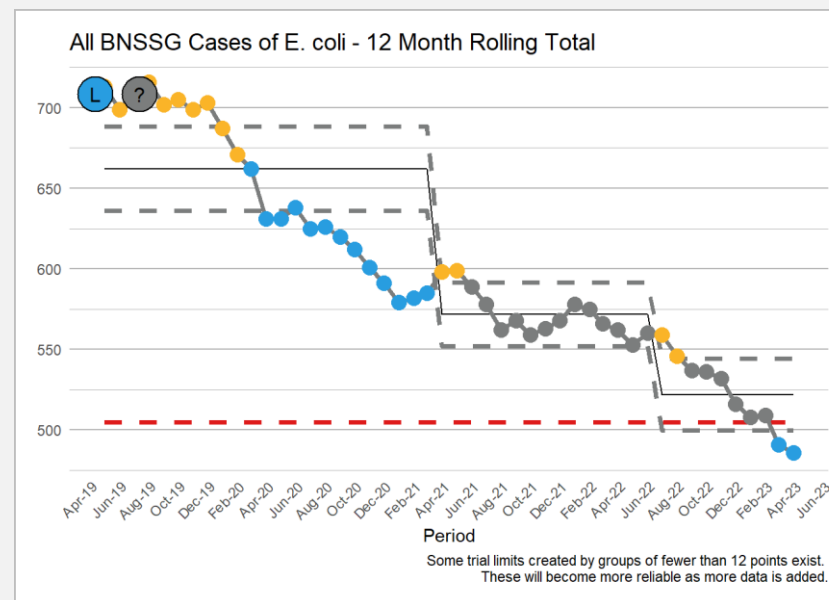
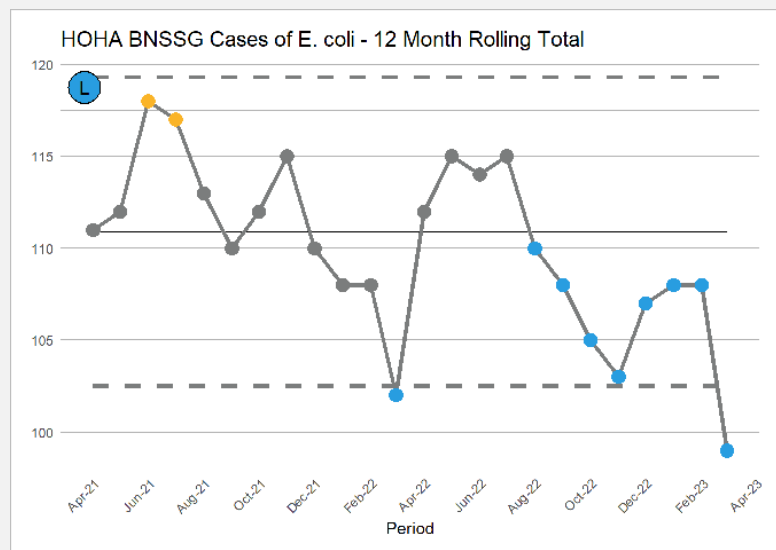
Quality Report - Healthcare Acquired Infections - Supporting Analysis

E. coli	37
HOHA	7 (NBT - 4, UHBW - 3)
COCA	24
COHA	6

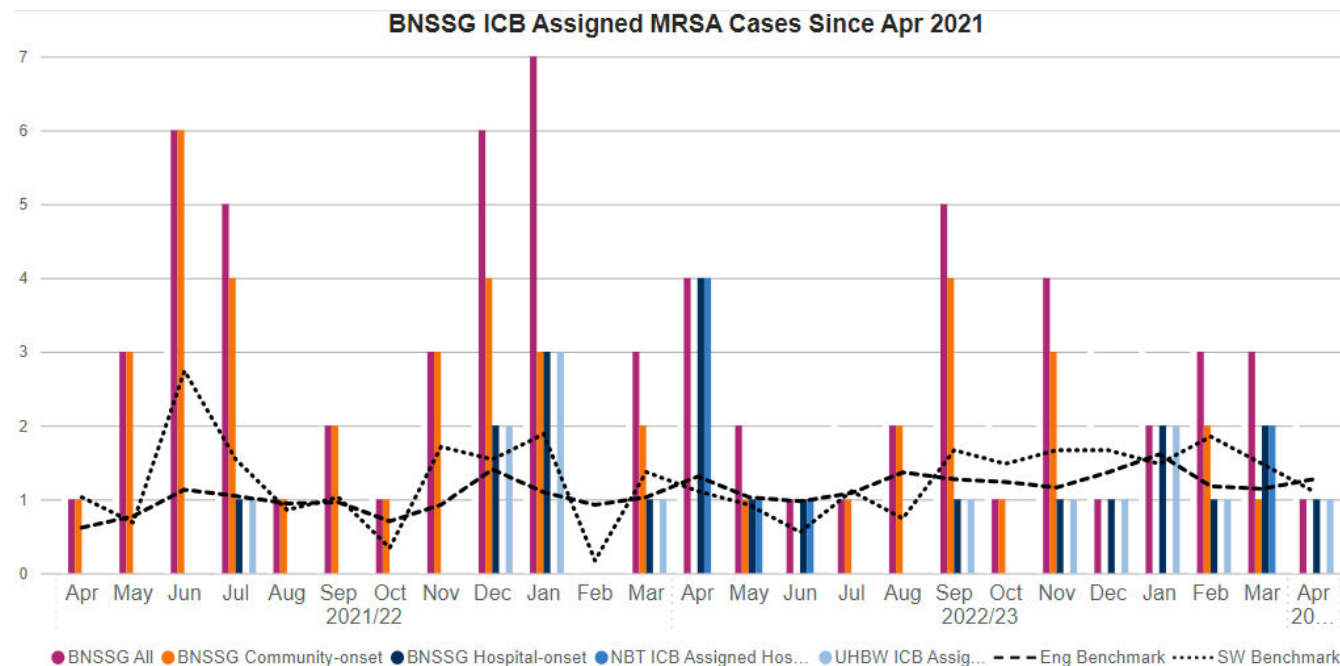


Hospital Onset E. coli has a variation of special cause concern low, trending below the average since Apr 21 and currently below the lower process limit.

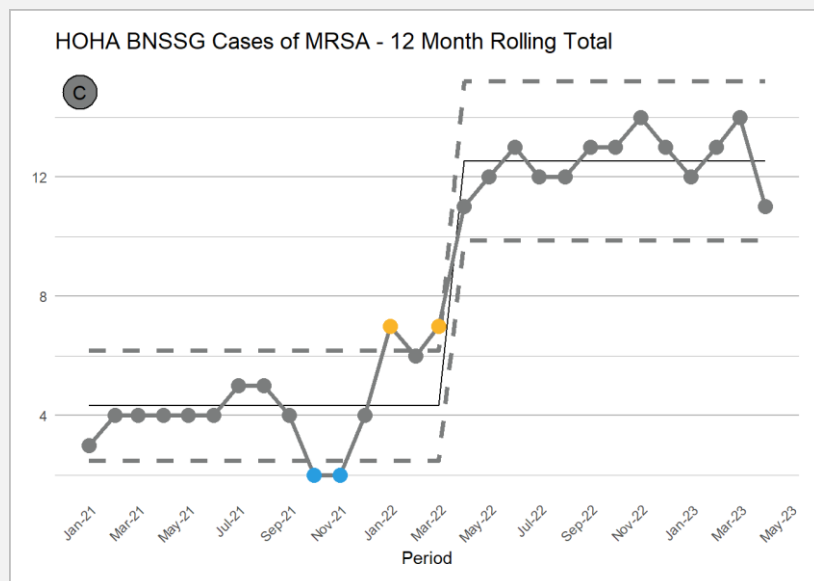
BNSSG Wide E. coli has a variation of special cause concern low, trending below the lower control limit since the previous rebase. Things are improving but the 23/24 target lies between the upper and lower bounds, the processes is expected to hit or miss this target.



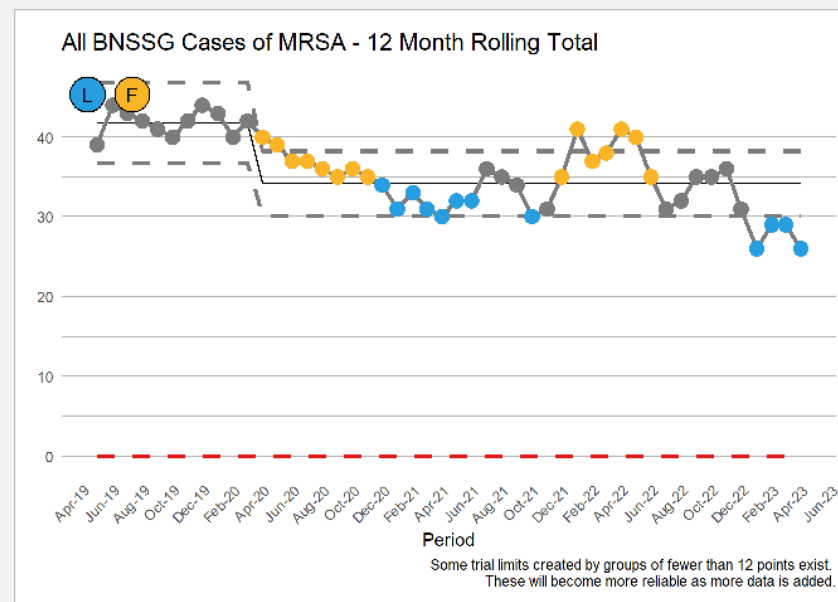
MRSA	1
HOHA	1 (NBT - 0, UHBW - 1)
COCA	0
COHA	0



Hospital Onset MRSA has a variation of common cause and has is not changing significantly since a rebase in Apr 22.

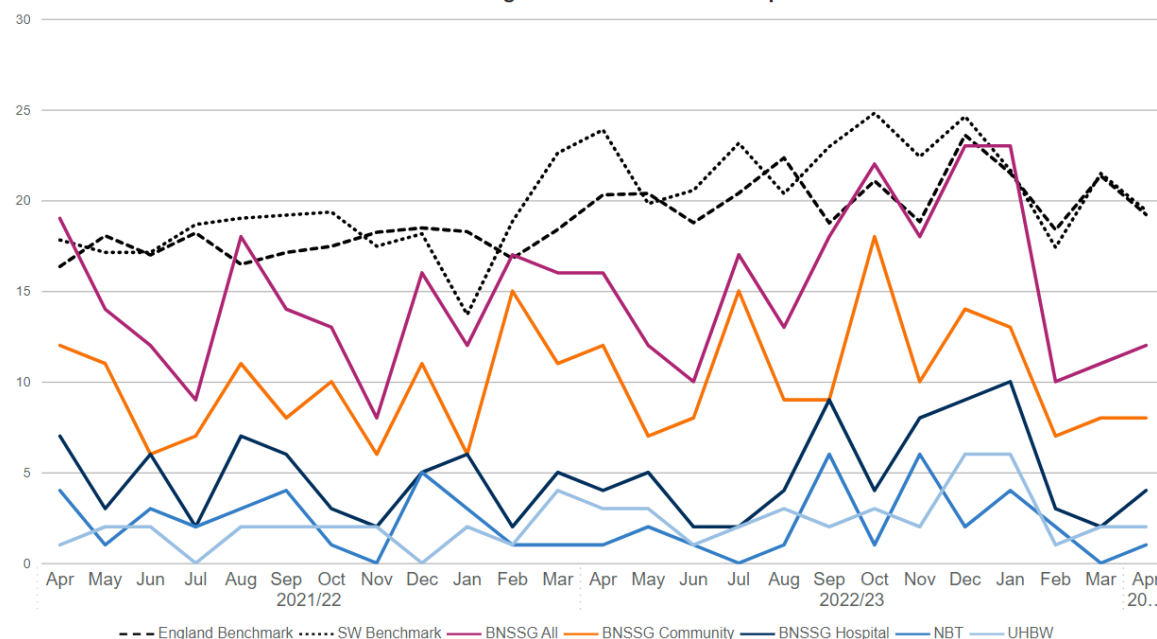


BNSSG Wide MRSA has a variation of special cause concern low, trending below the lower control limit since the previous rebase. Things are improving but have already exceeded threshold of 0 for 23/24.

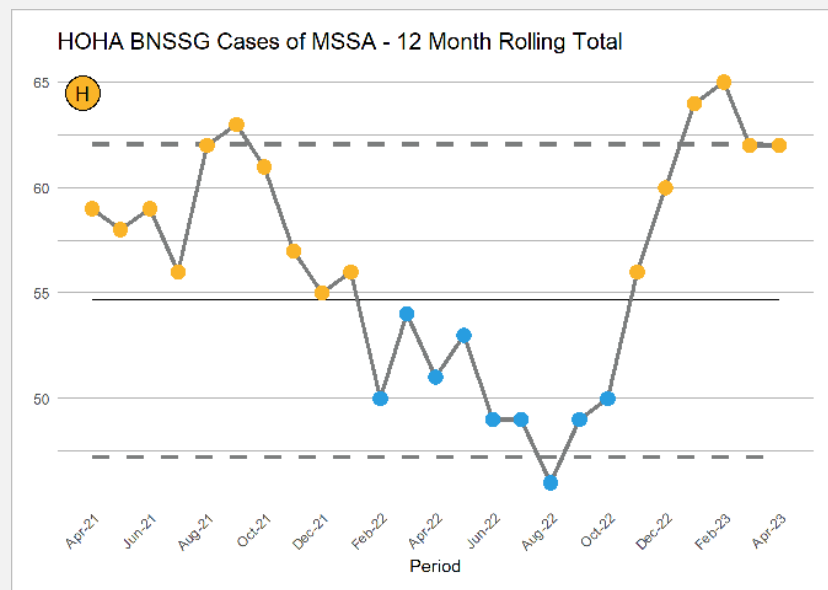


MSSA	12
HOHA	4 (NBT - 1, UHBW – 2, Worcester -1)
COCA	6
COHA	2

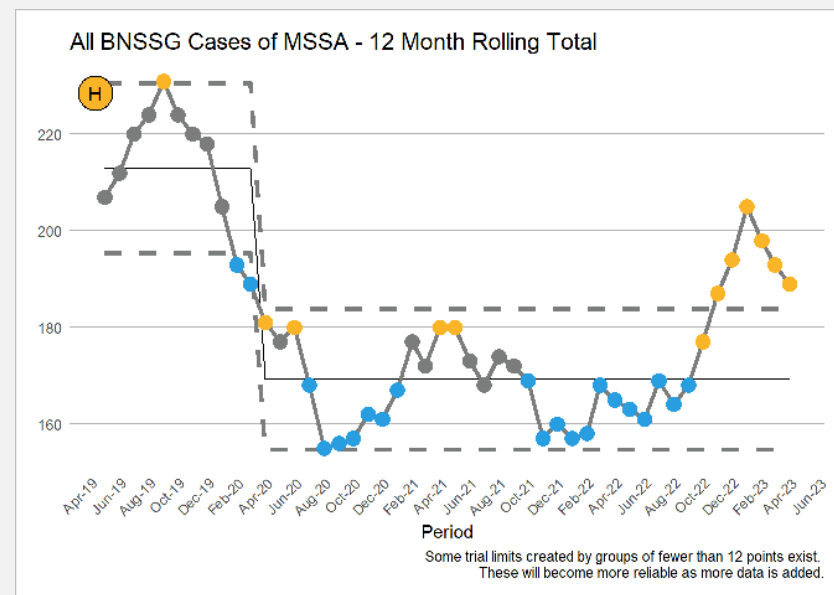
BNSSG ICB Assigned MSSA Cases Since Apr 2021



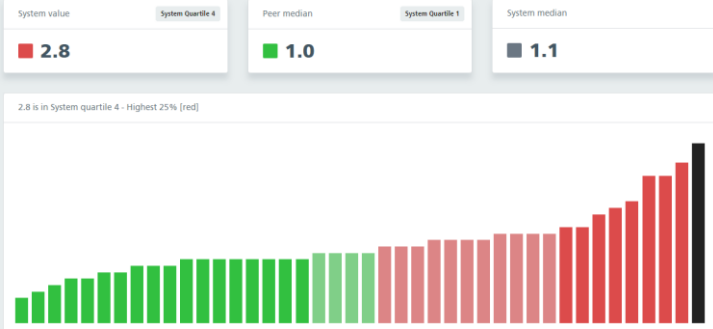
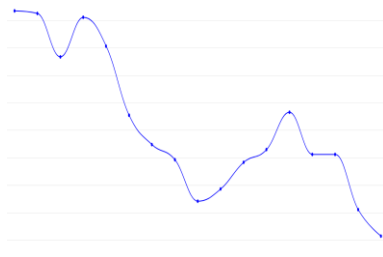

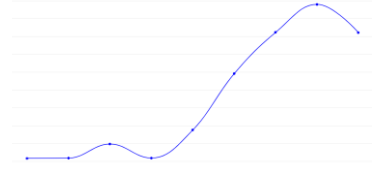
Hospital Onset MSSA is showing a variation of a concerning nature, a sharp increase over previous months.



BNSSG Wide MSSA has a variation of special cause concern high, trending above the upper control limit since the previous rebase. The past 3 months have decreased but this trend needs to continue.



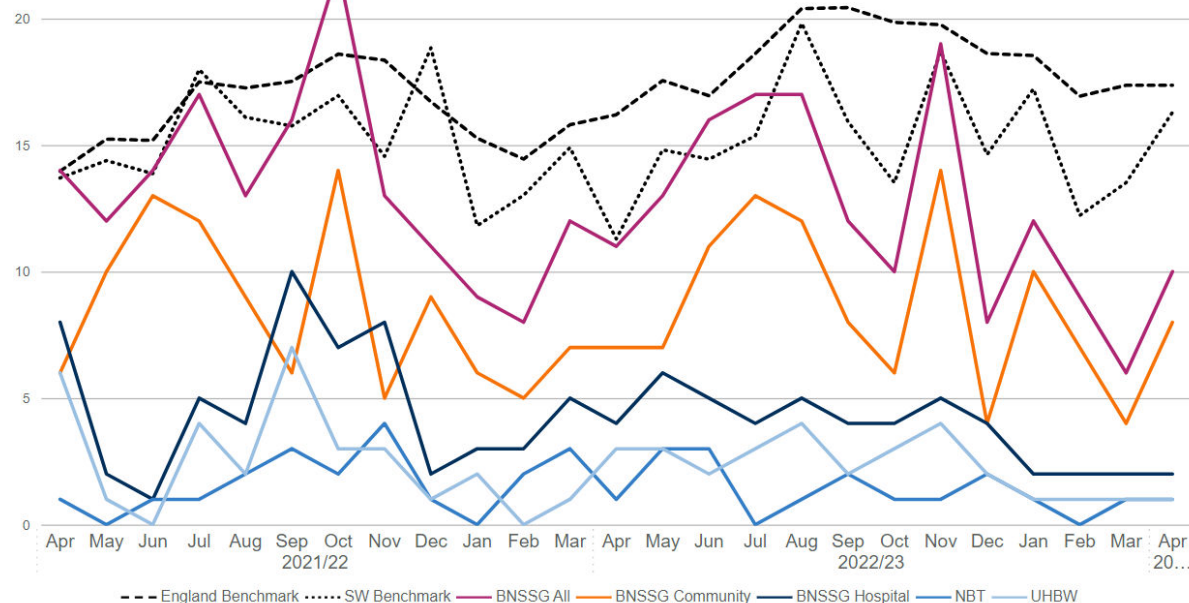
12 Months Rolling to Q4 2022/23 – All Systems

Infection	Onset / Sex	Age-sex standardised infection rates per 100k	Count of Infection (12 months rolling)	Comments
MRSA	All/All		<p>Q4 18/19 – Q4 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. System position same as Q3.
MSSA	COHA/Female		<p>Q4 20/21 – Q3 22/24</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 that has lowered in the most recent 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](#).

Klebsiella spp	10
HOHA	2 (NBT - 1, UHBW - 1)
COCA	8
COHA	0

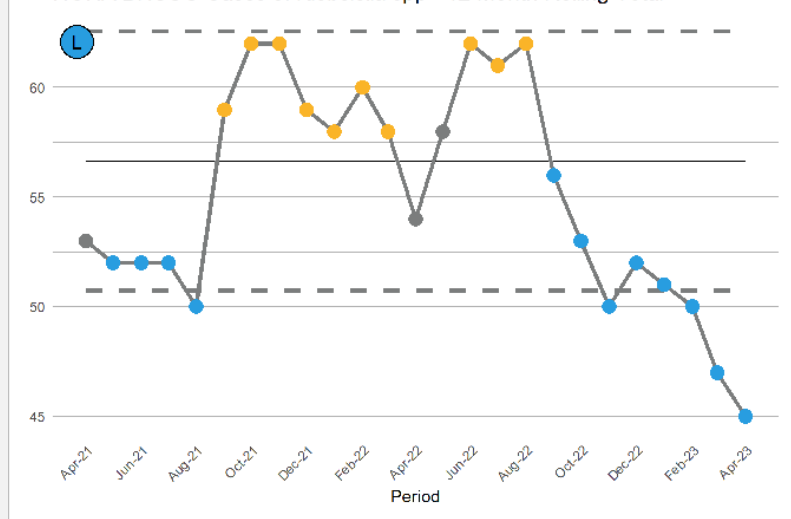
BNSSG ICB Assigned Klebsiella spp Cases Since Apr 2021



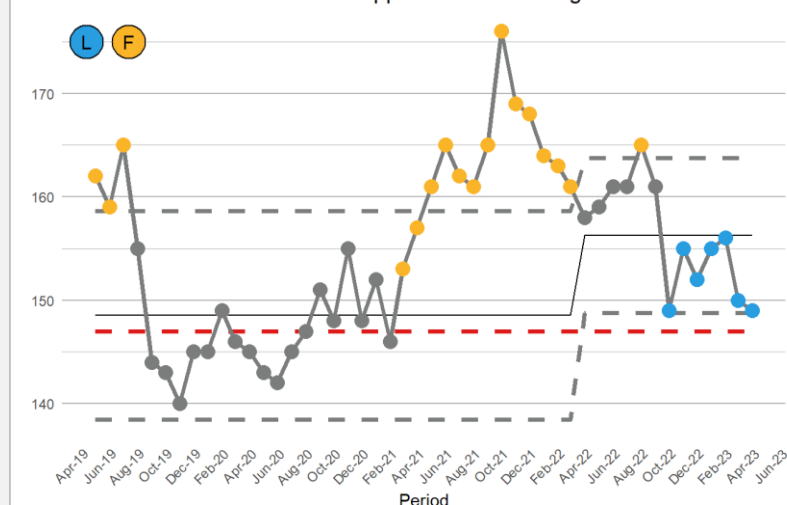
Hospital Onset Klebsiella spp is showing a variation of special cause concern low, trending below the average since Sep 22 and currently below the lower process limit.

BNSSG Wide Klebsiella spp has a variation of special cause concern low as it continues decreasing from its spike in 2021. At this rate, however, it is not expected to hit the 23/24 threshold target.

HOHA BNSSG Cases of Klebsiella spp - 12 Month Rolling Total

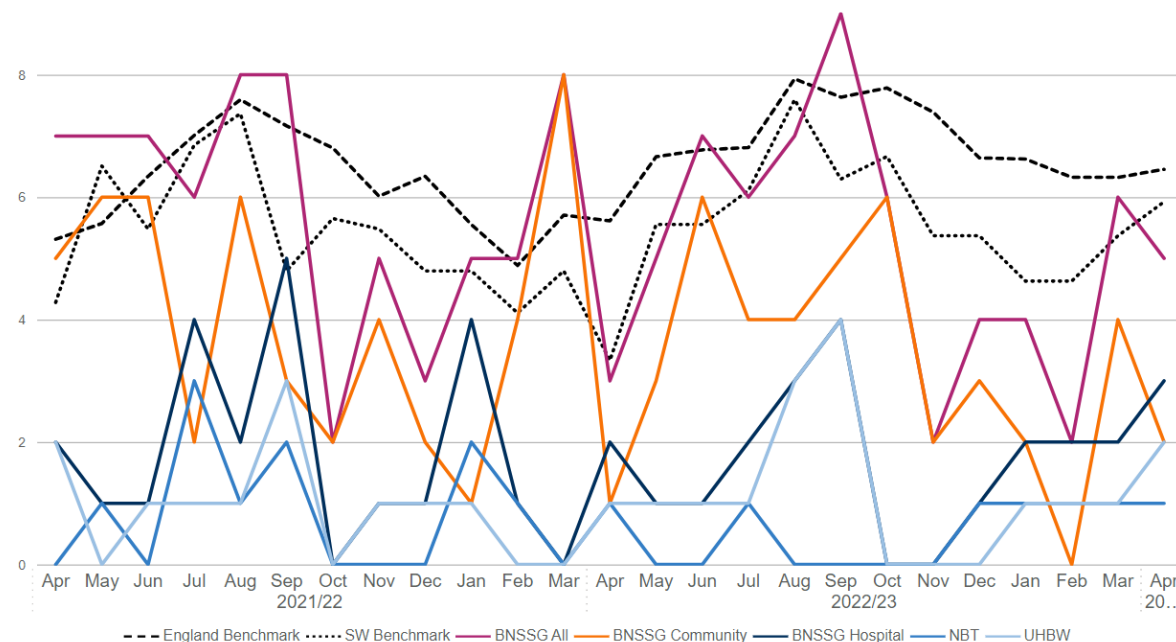


All BNSSG Cases of Klebsiella spp - 12 Month Rolling Total

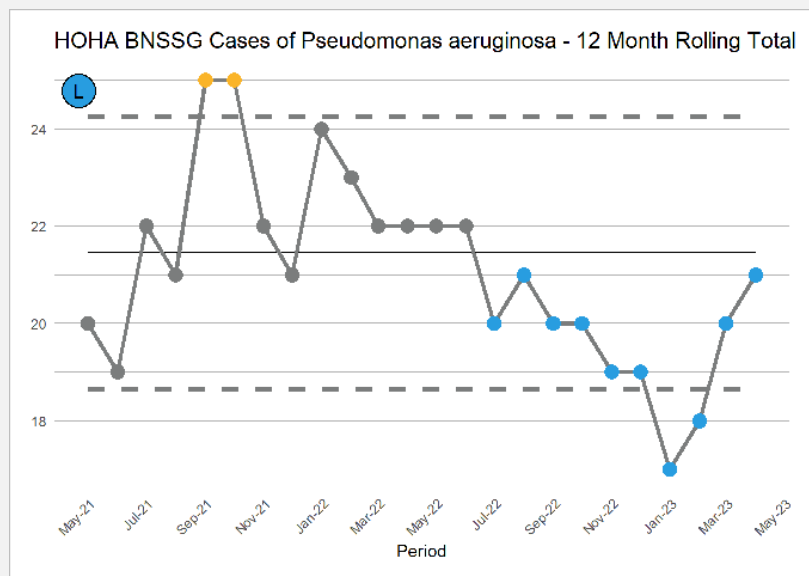


Pseudomonas aeruginosa	5
HOHA	3 (NBT - 1, UHBW - 2)
COCA	2
COHA	0

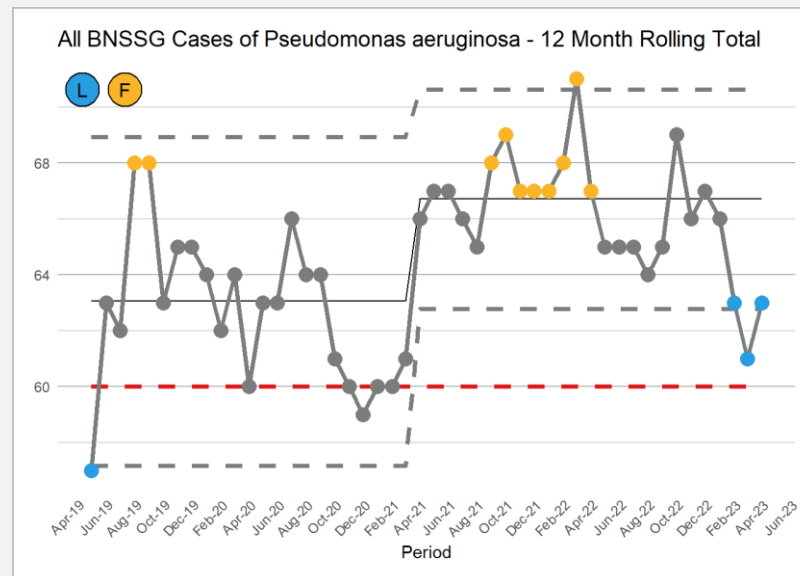
BNSSG ICB Assigned Pseudomonas aeruginosa Cases Since Apr 2021











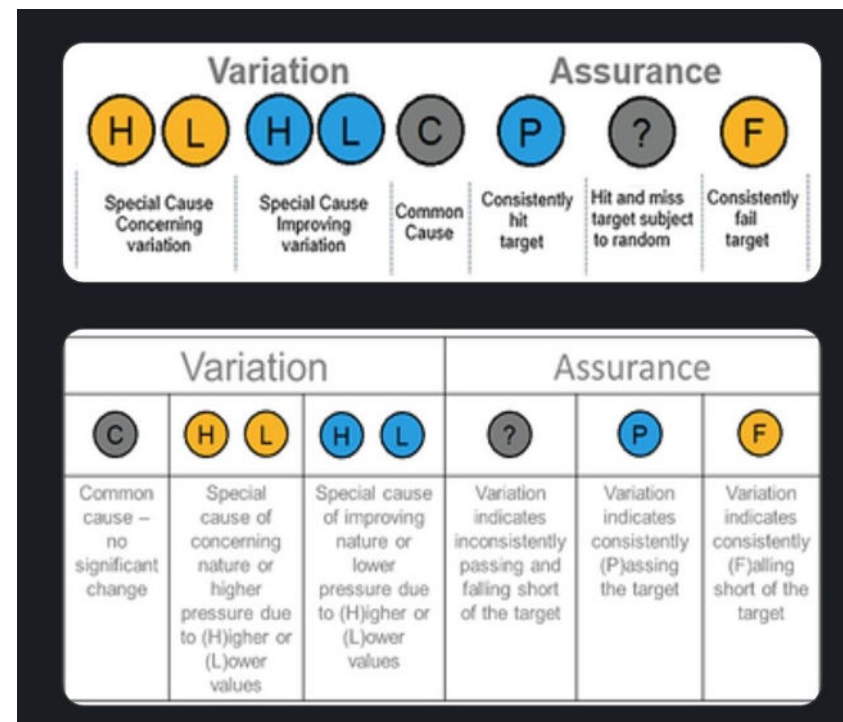
Hospital Onset Pseud A is showing a variation of special cause concern low, trending below the average since Jul 22 and currently below the lower process limit, although recently increasing.



BNSSG Wide Pseud A has a variation of special cause concern low, trending below the average since the previous rebase. The trend is decreasing however data from the previous 2 years suggests the 23/24 threshold won't be met.



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



SPC Xmr diagrams were made using the NHS Plottedots R Package. The icons above represent the meaning as above.

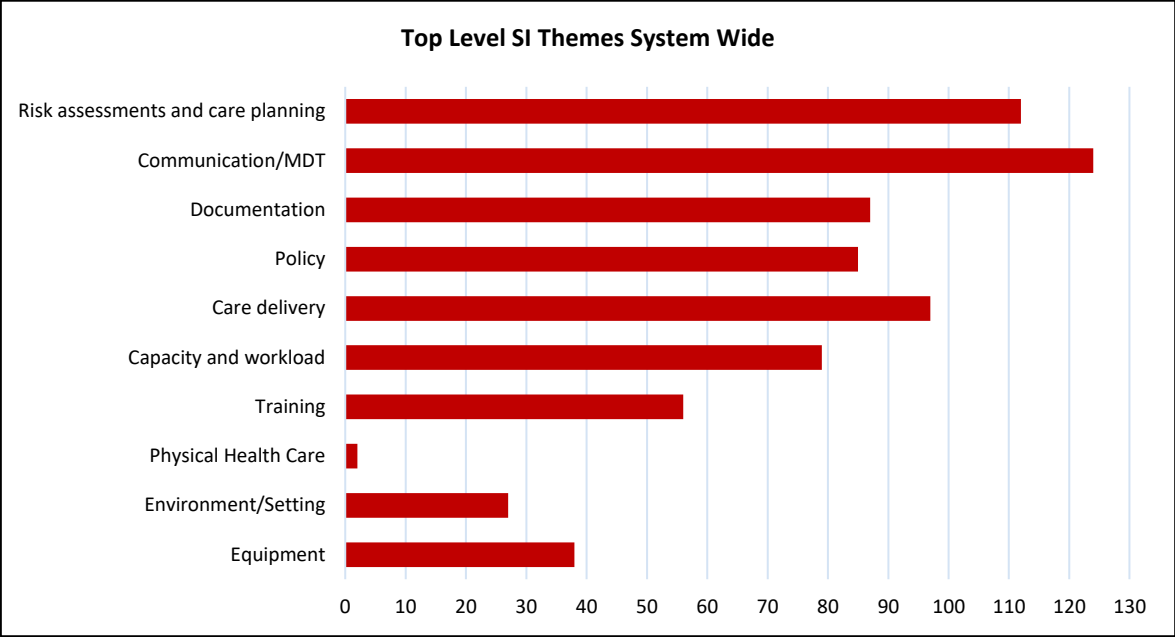
In terms of variation in the caseload, the SPC grid means:

- All infection types have an improving nature, mostly due to historical increases during the pandemic that the rates are now lowering from
- MSSA, not featured, has an increasing trend.

In terms of assurance against the threshold, this means:

- The process limits on SPC charts indicate the normal range of numbers you can expect from your system or process. **If a target lies within those limits then we know that the target may or may not be achieved.** The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random. This is the case for C. diff and E. coli which have new lower targets for 23/24 – further improvement is required to be assured they will be reached.
- MRSA has failed the threshold for 23/24 (0 cases). At the current rates Klebsiella spp and Pseud A will fail the 23/24 threshold.
- MSSA is not included as NHSE does not set a threshold.

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 15 months, when this data collection commenced.



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

- Communication/MDT
- Risk Assessment and Care Planning
- Care Delivery

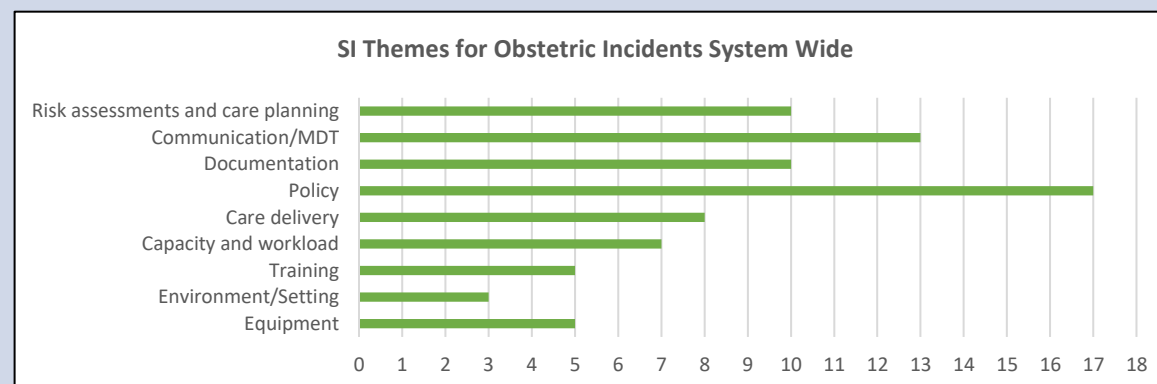
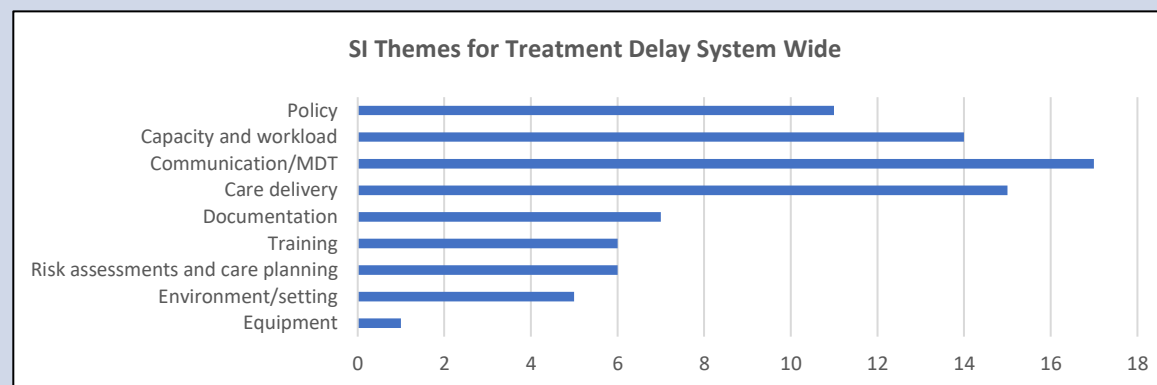
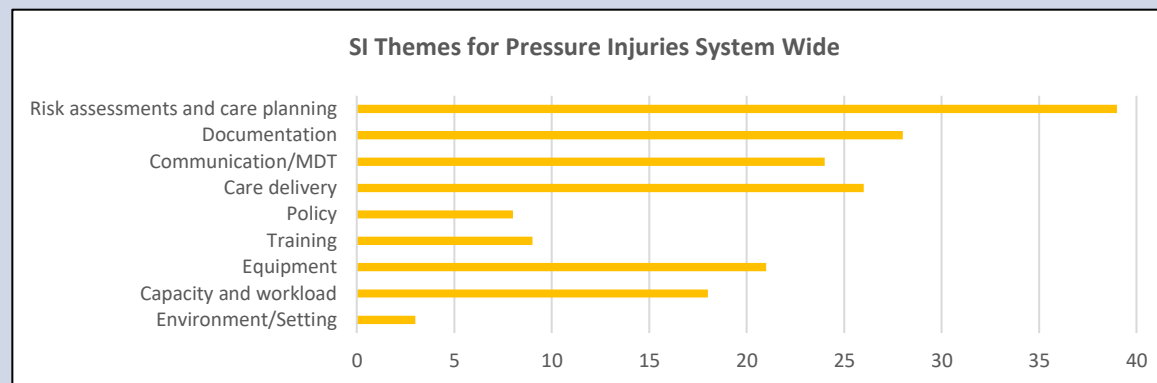
To understand the drivers behind the patient safety events related to these themes, “deep dives” are being undertaken and the outcomes will be shared in the coming months.

Nursing & Quality – SI Themes and Trends across BNSSG partners

Reporting Period – Month 1 2023/24 – April data

Since March 2022, when this data collection commenced, the running total of Serious Incident investigations reviewed by the Quality team is 228, please see table below for breakdown by type of incident. The graphs on the right show the themes identified through the reviews of the investigation reports of the top three SI types.

Serious Incident Types	Number of investigation reports reviewed per SI type
Pressure Injury	51
Treatment delay	26
Obstetric	23
Slips/trips/falls	21
Suspected suicide	19
Diagnostic	19
Sub-optimal care	15
Medication	13
Suspected self-inflicted harm	7
Wrong site surgery	6
Surgical procedure	5
Aggressive behaviour	4
HCAI/Infection control	3
Unexpected death	3
Medical equipment	2
Homicide	2
Alleged assault of patient	1
Misplaced naso or oro-gastric tubes	1
Retained object post procedure	1
Alleged assault of patient	1
Blood product/transfusion	1
Failed discharge	1
Screening issues	1
Wrong implant/prosthesis	1
Failure to obtain appropriate bed for child	1

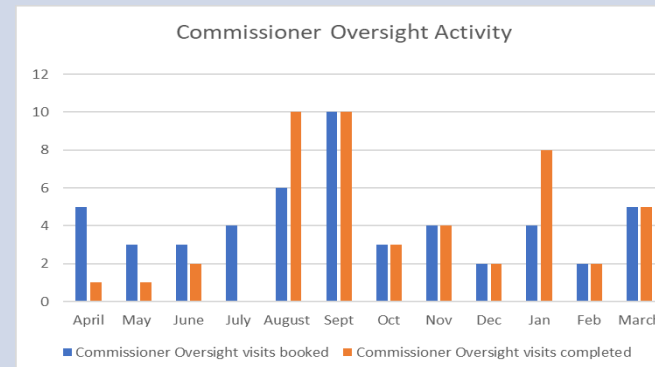
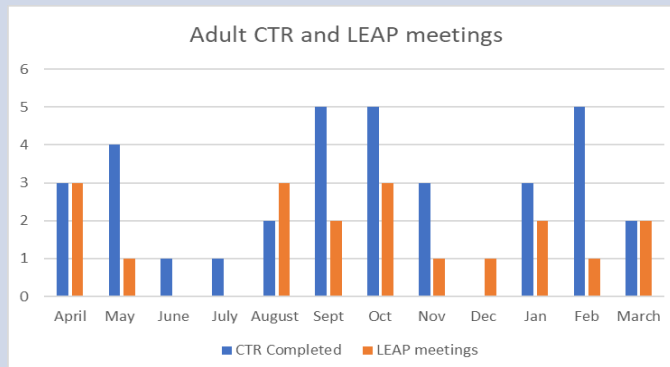
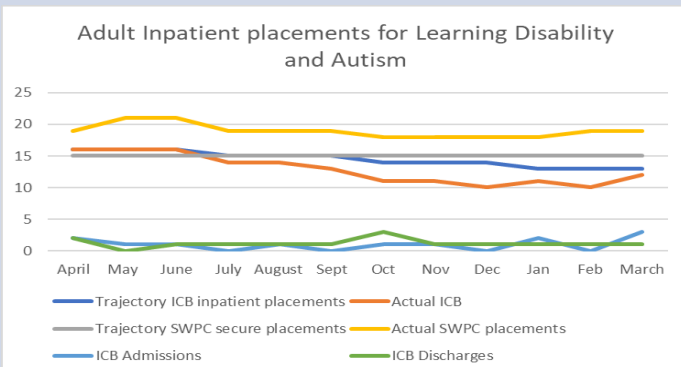


Nursing & Quality - Funded Care - Assuring Transformation –Learning Disability and Autism

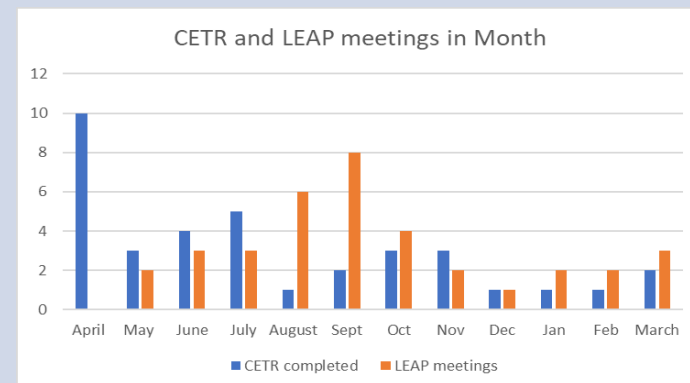
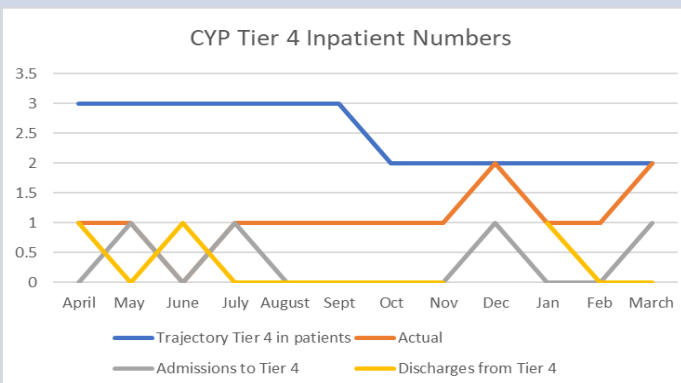
Reporting Period – Month 1 2023/24 – April data

Performance/Data for 2022-2023

Adults



CYP



Highlights

Adults

- There continues to be an increase in CTR related activity, 51 Professionals meetings/ MDT's/ Safeguarding/Discharge planning meetings for adults.
- ICB commissioned placements remain below trajectory, however SWPC (Secure) placements remain above the trajectory to reach the Long Term Plan target.
- 3 new admissions to AWP beds - no individuals were known to the team and no pre-admission CTR's were requested.
- 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. There are 4 individuals in the community on Section 17 leave.

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 continuing to provide additional support to the Keyworker Team to triage requests.

BNSSG Performance Report

June 2023

Created by

BI Performance Team

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1 Executive Summary

- Overall, BNSSG Trusts' 4hr A&E performance worsened from 73.9% to 68.5% in May and is better than the national average for Type 1 EDs of 60.4%.
- For planned admissions, the total waiting list size for the BNSSG population worsened from 85,444 in March to 99,101 in April. BNSSG performance of 63.8% was ranked 19th out of 42 ICBs nationally (down from 8th) and ranked 4th out of 7 ICBs in the South West (down from 2nd in March).
- The number of BNSSG patients waiting 52 weeks or more for planned treatment increased from 4,124 in March to 6,022 in April – 6.1% of the total waiting list. The number increased at both NBT and UHBW. The BNSSG position is driven mainly by waits at UHBW (3,476) and NBT (2,194), with the remaining 352 breaches split across 53 other providers. Focused work to facilitate elective recovery ambitions are being implemented.
- The number of BNSSG patients waiting over 65 weeks increased from 973 in March to 1,409 in April. The number increased at both NBT and UHBW. The BNSSG position is driven mainly by waits at UHBW (833) and NBT (470). The remaining 106 breaches are split across 24 other providers, with the majority at Nuffield Health Bristol (45).
- The number of BNSSG patients waiting over 78 weeks increased from 88 in March to 122 in April. The number increased at UHBW but fell at NBT. The BNSSG position is driven mainly by waits at UHBW (53) and NBT (49). The remaining 20 breaches are split across 5 other providers, with the majority at Nuffield Health Bristol (14).
- The number of BNSSG patients waiting over 104 weeks increased from 6 in March to 7 in April. The number decreased at UHBW but increased at NBT. The BNSSG position is driven by waits at NBT (6) East Kent Hospitals (1).
- 2 week wait cancer performance worsened in April to 42.9% for the BNSSG population. Performance worsened at both NBT and UHBW. The 93% national standard has not been achieved at population level since June 2020.
- 28 day faster diagnosis standard for BNSSG cancer patients worsened in April to 66.1% for the BNSSG population. Performance worsened at both NBT and UHBW. The 75% national standard has not been achieved at population level since reporting started in April 2021.
- 62 day referral to treatment time for BNSSG cancer patients worsened in April to 61.1.9%. Performance improved at UHBW but worsened at NBT. 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%	Apr-23	40.71%	22.47%	11.03%	38.82%	25.15%	23.12%	34.59%	27.56%	7	2	1	6	4	3	5	3	➡
A&E 4 Hour Performance	76%	May-23	71.57%	79.38%	75.01%	79.08%	78.65%	74.93%	64.51%	73.96%	6	1	4	2	3	5	7	2	↓
A&E 12 Hour Trolley Waits	0	May-23	200	74	1113	467	16	474	829	31,494	3	2	7	4	1	5	6	4	↓
RTT Incomplete 18 Weeks	92%	Apr-23	60.25%	54.63%	68.43%	58.26%	60.01%	59.45%	53.83%	58.31%	2	6	1	5	3	4	7	2	↓
RTT Incomplete Total		Apr-23	101,512	101,621	79,136	70,189	66,309	99,101	164,062	7,415,352	82.3%	84.4%	53.3%	97.3%	83.9%	94.9%	94.0%	68.0%	↓
RTT Incomplete 52 Week Plus	0	Apr-23	4,680	5,680	2,512	4,832	3,007	6,022	13,823	371,111	3	5	1	4	2	6	7	4	↓
RTT Incomplete 65 Week Plus	0	Apr-23	980	1,530	417	1,832	886	1,409	4,754	95,135	3	5	1	6	2	4	7		
RTT 52 weeks + (% of waiting list)		Apr-23	4.61%	5.59%	3.17%	6.88%	4.53%	6.08%	8.43%	5.00%	3	4	1	6	2	5	7	4	↓
RTT 65 weeks + (% of waiting list)		Apr-23	0.97%	1.51%	0.53%	2.61%	1.34%	1.42%	2.90%	1.28%	2	5	1	6	3	4	7		
RTT 78 weeks + (% of waiting list)		Apr-23	0.03%	0.13%	0.01%	0.65%	0.16%	0.12%	0.69%	0.15%	2	4	1	6	5	3	7	3	➡
RTT 104 weeks+ (% of waiting list)		Apr-23	0.00%	0.00%	0.00%	0.08%	0.01%	0.01%	0.07%	0.01%	3	1	2	7	4	5	6	5	➡
Cancer 2 Week (All)	93%	Apr-23	72.48%	64.64%	95.45%	53.09%	60.93%	42.85%	64.87%	77.71%	2	4	1	6	5	7	3	7	➡
Cancer 2 week (Breast)	93%	Apr-23	87.55%	94.55%	99.00%	20.44%	58.41%	50.00%	85.51%	72.19%	3	2	1	7	5	6	4	6	➡
Cancer 31 Day Wait First Treatment	96%	Apr-23	88.94%	94.28%	92.36%	88.30%	89.05%	89.18%	89.47%	90.48%	6	1	2	7	5	4	3	2	↓
Cancer 31 Day Wait - Surgery	94%	Apr-23	68.35%	79.49%	84.09%	82.50%	71.19%	85.87%	81.53%	76.78%	7	5	2	3	6	1	4	1	➡
Cancer 31 Day Wait - Drug	98%	Apr-23	98.55%	95.51%	100.00%	100.00%	99.19%	98.58%	98.74%	97.37%	6	7	1	1	3	5	4	4	↓
Cancer 31 Day Wait - Radiotherapy	94%	Apr-23	92.92%	96.84%	93.58%	96.58%	87.23%	98.62%	94.78%	86.32%	6	2	5	3	7	1	4	2	↑
Cancer 62 Wait Consultant	N/A	Apr-23	82.43%	72.34%	73.91%	65.22%	83.33%	75.00%	68.97%	74.44%	2	5	4	7	1	3	6	4	↑
Cancer 62 Wait Screening	90%	Apr-23	72.73%	66.67%	80.77%	62.16%	75.00%	55.56%	66.67%	67.82%	3	4	1	6	2	7	4	3	↓
Cancer 62 Day Wait - GP Referral	85%	Apr-23	65.31%	66.78%	64.08%	65.05%	69.84%	61.14%	62.37%	61.04%	3	2	5	4	1	7	6	5	↓
Cancer 28 FDS	75%	Apr-23	70.27%	71.16%	79.20%	68.68%	69.46%	66.12%	76.30%	71.35%	4	3	1	6	5	7	2	4	↓

Includes addition of new measure - RTT 65 Week Waits (Operational Plan 23/24)

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	May-23	00:17:24	00:15:36	00:17:36	00:21:06	00:20:12	00:13:54	00:17:42	00:17:24	3	2	4	7	6	1	5	1	➡
Category 1 - Average Duration (hr:min:sec)	00:07:00	May-23	00:09:36	00:08:24	00:09:42	00:11:06	00:10:42	00:07:54	00:09:30	00:09:24	4	2	5	7	6	1	3	1	➡
Category 2 - 90th Percentile Duration (hr:min:sec)	00:40:00	May-23	01:23:24	01:03:30	01:09:06	01:30:54	01:26:48	01:00:06	01:26:00	01:17:24	4	2	3	7	6	1	5	1	➡
Category 2 - Average Duration (hr:min:sec)	00:30:00	May-23	00:39:30	00:31:24	00:32:36	00:44:00	00:42:24	00:28:06	00:40:12	00:36:42	4	2	3	7	6	1	5	1	➡
Category 3 - 90th Percentile Duration (hr:min:sec)	02:00:00	May-23	04:56:42	03:26:12	03:12:30	02:51:00	05:34:18	04:18:00	04:59:30	04:18:36	5	3	2	1	7	4	6	4	➡
Category 3 - Average Duration (hr:min:sec)		May-23	01:52:18	01:25:00	01:23:00	01:16:18	02:06:42	01:34:42	01:56:18	01:40:18	5	3	2	1	7	4	6	2	⬇
Category 4 - 90th Percentile Duration (hr:min:sec)	03:00:00	May-23	05:40:24	07:50:12	06:02:54	02:15:48	11:34:18	07:50:36	07:28:12	06:56:48	2	5	3	1	7	6	4	5	⬇
Category 4 - Average Duration (hr:min:sec)		May-23	02:09:18	02:18:18	01:54:48	00:49:36	03:41:18	02:37:48	02:36:30	02:23:54	3	4	2	1	7	6	5	5	⬇

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	Apr-23	89	21	456	214	257	151	384	236	2	1	7	4	5	3	6	4	⬆
% Triageed Calls receiving Clinical Contact	50%	Apr-23	57.7%	38.0%	49.2%	75.9%	70.3%	53.3%	54.2%	43.9%	3	7	6	1	2	5	4	4	⬇
% of callers allocated the first service offered by DOS	80%	Apr-23	63.2%	69.0%	75.6%	82.6%	78.9%	78.1%	77.6%	66.8%	7	6	5	1	2	3	4	4	⬆
% of Cat 3 or 4 ambulance dispositions validated within 30mins	75%	Apr-23	68.8%	59.8%	43.0%	53.8%	57.9%	42.7%	50.5%	38.7%	1	2	6	4	3	7	5	5	⬇
% of calls initially given an ED disposition that are validated	50%	Apr-23	65.7%	75.2%	43.1%	86.5%	60.8%	26.2%	63.4%	43.4%	3	2	6	1	5	7	4	6	⬇
Abandonement Rate for 111 Calls	3%	Apr-23	7.2%	2.0%	18.3%	12.5%	11.4%	17.6%	16.7%	17.0%	2	1	7	4	3	6	5	6	➡

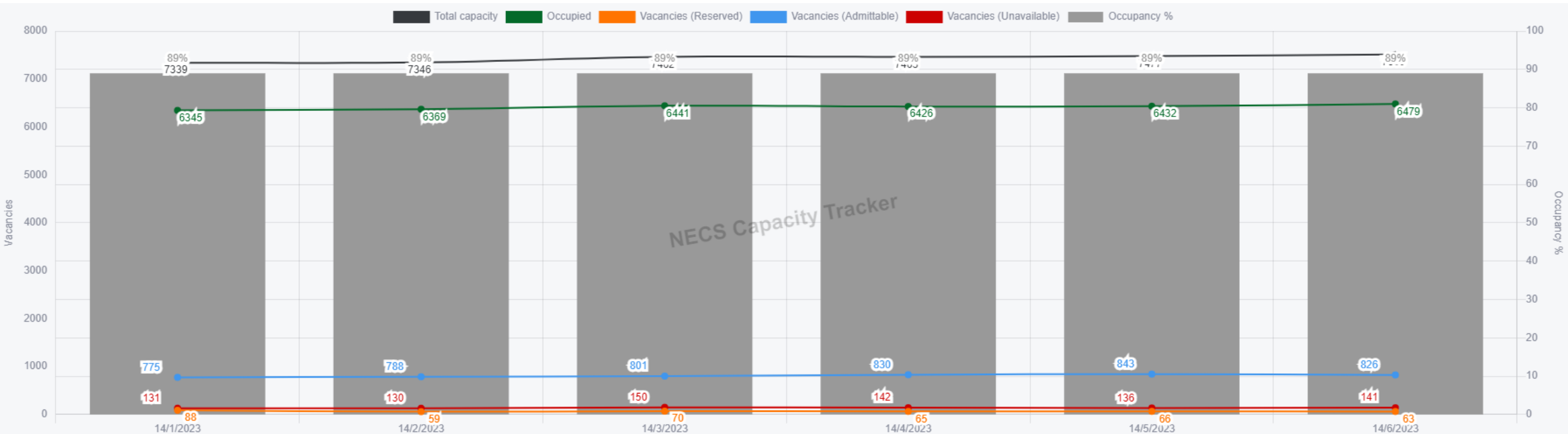
New standard for % of callers allocated the first service offered by DOS – 80% down from 85%.
New standard for % of Cat 3 or 4 ambulance dispositions validated within 30 mins – 75% up from 50%.

2.2 Urgent Care – Summary Performance – May

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	May-23	5	7	2	5	▲	6	1	▲	▼
	Category 2 Response time - Mean (minutes)	BNSSG ICB	May-23	30	28	23	5	▲	26	2	▲	▼
	Category 2 Response time – 90th centile (minutes)	BNSSG ICB	May-23	40	60	49	11	▲	57	3	▲	▼
	Percentage of conveyances to ED by 999 ambulances	BNSSG ICB	May-23	N/A	46.9%	48.1%	-1.3%	▼	49.6%	-2.8%	▼	▼
	Percentage of NHS 111 calls assessed by a clinician or clinical advisor	BNSSG ICB	Apr-23	50%	53.3%	49.3%	4.1%	▲	64.3%	-10.9%	▼	▲
	Percentage of NHS 111 Calls Abandoned	BNSSG ICB	Apr-23	3%	15.9%	10.8%	5.1%	▲	8.4%	7.5%	▲	▼
A&E	Percentage of Ambulance Handovers within 15 minutes	BNSSG Trusts	May-23	65%	26.9%	30.9%	-4.0%	▼	68.2%	-41.3%	▼	▲
	Ambulance Handovers - Average Time Lost per day >15 mins (Hours)	BNSSG Trusts	May-23	N/A	105	59	46	▲	10	95	▲	▼
	Time to Initial Assessment – percentage of patients assessed within 15 minutes of arrival at A&E	NBT	May-23	N/A	75.5%	80.3%	-4.8%	▼	69.2%	6.2%	▲	▲
		BRI	May-23	N/A	65.6%	67.2%	-1.7%	▼	56.0%	9.6%	▲	▲
		Weston	May-23	N/A	41.3%	48.5%	-7.2%	▼	6.9%	34.4%	▲	▲
	Average (mean) time in Department – non-admitted patients (hh:mm)	NBT	May-23	N/A	3:45	3:09	0:35	▲	3:24	3:24	▲	▼
		BRI	May-23	N/A	4:46	4:07	0:38	▲	3:42	1:03	▲	▼
		Weston	May-23	N/A	3:34	3:33	-0:01	▲	4:00	-0:26	▼	▼
Hospital	Hospital Average (mean) time in Department – admitted patients (hh:mm)	NBT	May-23	N/A	6:55	5:30	1:24	▲	5:10	1:44	▲	▼
		BRI	May-23	N/A	7:22	5:59	1:22	▲	5:16	2:05	▲	▼
		Weston	May-23	N/A	16:30	11:31	4:58	▲	5:28	11:01	▲	▼
Whole System	Percentage of patients spending more than 12 hours from Arrival in A&E	NBT	May-23	2%	3.2%	1.4%	1.9%	▲	0.0%	3.2%	▲	▼
		BRI	May-23	2%	7.4%	4.3%	3.1%	▲	1.3%	6.1%	▲	▼
		Weston	May-23	2%	10.9%	11.2%	-0.4%	▼	3.8%	7.1%	▲	▼
	Number of patients spending more than 12 hours in A&E from a Decision To Admit	BNSSG Trusts	May-23	0	474	326	148	▲	4	470	▲	▼
		NBT	May-23	0	39	2	37	▲	0	39	▲	▼
		UHBW	May-23	0	435	324	111	▲	4	431	▲	▼
	Percentage of patients waiting 4 hours or less in A&E	BNSSG Trusts	May-23	76%	68.5%	73.9%	-5.4%	▼	77.7%	-9.2%	▼	▲
		NBT	May-23	76%	70.7%	80.2%	-9.5%	▼	76.2%	-5.5%	▼	▲
		UHBW	May-23	76%	67.5%	70.7%	-3.2%	▼	78.5%	-11.0%	▼	▲

- 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 (270 / 270 / 270)	7509	1030	826	141	63	6479	11%	2%	1%	86%
General Nursing	1827	272	221	26	25	1555	12%	1%	1%	85%
General Residential	1736	287	214	60	13	1449	12%	3%	1%	83%
Dementia Residential	1559	241	199	32	10	1318	13%	2%	1%	85%
Dementia Nursing	1234	120	101	9	10	1114	8%	1%	1%	90%
Learning Disability Residential	570	47	39	5	3	523	7%	1%	1%	92%
Mental Health Residential	273	28	23	5	0	245	8%	2%		90%
Community Care	51	12	12	0	0	39	24%			76%
Mental Health Nursing	160	13	9	4	0	147	6%	3%		92%
YPD - Young Physically Disabled	22	4	4	0	0	18	18%			82%
Learning Disability Nursing	73	5	3	0	2	68	4%		3%	93%
Transitional	4	1	1	0	0	3	25%			75%

2.3 Planned Care – Drivers and Priority Actions

Top Improvement Drivers: June 2023		Priority actions: June-July 2023	
RTT	1. National requirements to clear all remaining >78 week waiters and progress 23/24 trajectories for reducing 65+ww by year end. Noting impacts will be showing in performance as a result of industrial action to date (inc. lost opportunity through reduced booking, cancellations, and displaced activity) and bank holiday days lost.	1. Weekly scrutiny and detailed returns to Region/National team on 78ww breaches/breach risks continues. System focus shifting to 65+ww cohort; Utilising national DMAS and Region NHSE support to try and secure mutual aid 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;	
	2. Forward look for elective delivery	2. 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; BNSSG Elective Centre business case progressing. FBC stage underway; Short stay ortho pathway to be trialled across both Trusts; Options appraisal for transformation of skin pathways to be completed.	
Diagnostics	3. 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.	3. 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. Histopathology performance improvement being cascaded from the National team, BNSSG will map current position and improvement opportunities.	
	4. Forward look for diagnostics capacity and delivery	4. Progress estate works enabled through the Endoscopy Capital funding at the BRI site to regain JAG accreditation; The system is working to conclude the CDC contractual negotiations; The system is working with SWETA and NHSE SW to look at novel ways to develop and expedite training for clinical endoscopists and develop a sustainable broader endoscopy workforce across nursing and administration roles.	
Outpatients	5. Reducing, validating and prioritising patients on outpatient waiting lists	5. Validation activity continues in both Trusts. Both Trusts will engage with the national drive on Outpatient productivity – initial meetings with NHSE have taken place and opportunities identified are being further explored. Initial priorities focus on outpatient productivity and the 65 and 52 week milestones set nationally. PIFU utilised where appropriate and roll out continues.	
	6. Increasing availability and utilisation of advice and guidance .	6. 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.	
Cancer	7. Backlog position recovery (63+day recovery metric)	7. It is recognised that Industrial Action continues to impact cancer services which will continue to impact the 63+ day position and the system is closely monitoring this – it is expected to impact performance in the short term.	
	8. FDS improvement	8. The system is committed to focussing on improvements in FDS performance. 23/24 plans meet the national ambitions for this metric – June/July continues to prioritise the implementation of plans, recognising the impacts of Industrial Action on lost activity.	
	9. Pathways of challenge – (inc. focus on capacity/demand modelling, workforce, access to Diagnostics, referral management, space)	9. 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.	

2.3 Planned Care – Summary Performance – April

BNSSG Population Level

RTT 18 week Incomplete	Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
Total Waiting List	99,101	85,444	13,657	▲	50,061	49,040	▲
No. >18 weeks	40,188	30,899	9,289	▲	5,726	34,462	▲
No. >52 weeks	6,022	4,124	1,898	▲	18	6,004	▲
No. >65 weeks	1,409	973	436	▲	N/A	N/A	N/A
No. >78 weeks	122	88	34	▲	N/A	N/A	N/A
No. >104 weeks	7	6	1	▲	N/A	N/A	N/A
52ww as % of WL	6.1%	4.8%	1.3%	▲	0.0%	6.0%	▲
% Performance	59.45%	63.84%	-4.4%	▼	74.47%	-15.0%	▼

NBT Total Provider

Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
47,861	47,287	574	▲	27,995	19,866	▲
17,873	17,319	554	▲	4,150	13,723	▲
2,684	2,576	108	▲	19	2,665	▲
591	547	44	▲	N/A	N/A	N/A
65	69	-4	▼	N/A	N/A	N/A
9	7	2	▲	N/A	N/A	N/A
5.6%	5.4%	0.2%	▲	0.1%	5.5%	▲
62.66%	63.37%	-0.7%	▼	71.82%	-9.2%	▼

UHBW Total Provider

Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
66,543	66,379	164	▲	34,290	32,253	▲
31,501	30,899	602	▲	3,652	27,849	▲
5,472	5,383	89	▲	14	5,458	▲
1,549	1,533	16	▲	N/A	N/A	N/A
182	165	17	▲	N/A	N/A	N/A
0	1	-1	▼	N/A	N/A	N/A
8.2%	8.1%	0.1%	▲	0.0%	8.2%	▲
52.66%	53.45%	-0.8%	▼	70.58%	-17.9%	▼

Diagnostics	Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
Total Waiting List	27,783	29,335	-1,552	▼	21,311	6,472	▲
No. >6 weeks	6,424	6,152	272	▲	839	5,585	▲
No. >13 weeks	1,789	2,186	-397	▼	37	1,752	▲
% Performance	23.12%	20.97%	2.2%	▲	3.94%	19.2%	▲

Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
11,878	12,415	-537	▼	10,157	1,721	▲
2,072	1,990	82	▲	434	1,638	▲
740	939	-199	▼	15	725	▲
17.44%	16.03%	1.4%	▲	4.25%	13.2%	▲

Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
16,589	17,333	-744	▼	11,672	4,917	▲
4,671	4,450	221	▲	475	4,196	▲
1,310	1,484	-174	▼	23	1,287	▲
28.16%	25.67%	2.5%	▲	4.09%	24.1%	▲

Cancer	Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
2 week waits	42.85%	59.81%	-17.0%	▼	89.52%	-46.7%	▼
2ww breast	50.00%	69.63%	-19.6%	▼	89.74%	-39.7%	▼
28 day FDS (All Routes)	66.12%	74.50%	-8.4%	▼	N/A	N/A	N/A
31 day first treatment	89.18%	92.86%	-3.7%	▼	95.89%	-6.7%	▼
31 day - Surgery	85.87%	87.50%	-1.6%	▼	89.38%	-3.5%	▼
31 day - Drugs	98.58%	99.37%	-0.8%	▼	98.52%	0.1%	▲
31 day - Radiotherapy	98.62%	99.42%	-0.8%	▼	96.02%	2.6%	▲
62 day	61.14%	63.90%	-2.8%	▼	86.55%	-25.4%	▼
62 day - Screening	55.56%	75.76%	-20.2%	▼	92.31%	-36.8%	▼

Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
41.63%	56.84%	-15.2%	▼	84.89%	-43.3%	▼
42.86%	67.16%	-24.3%	▼	93.37%	-50.5%	▼
68.05%	78.17%	-10.1%	▼	N/A	N/A	N/A
79.58%	91.04%	-11.5%	▼	93.07%	-13.5%	▼
72.97%	79.79%	-6.8%	▼	80.00%	-7.0%	▼
83.33%	100.00%	-16.7%	▼	100.00%	-16.7%	▼
N/A	N/A	N/A	N/A	N/A	N/A	N/A
55.29%	61.62%	-6.3%	▼	83.84%	-28.5%	▼
57.14%	73.58%	-16.4%	▼	93.33%	-36.2%	▼

Apr-23	Mar-23	Variance	Change	Apr-19	Variance	Change
41.36%	59.02%	-17.7%	▼	93.35%	-52.0%	▼
N/A	N/A	N/A	N/A	N/A	N/A	N/A
60.03%	65.42%	-5.4%	▼	N/A	N/A	N/A
93.14%	92.92%	0.2%	▲	95.38%	-2.2%	▼
88.68%	83.61%	5.1%	▲	95.92%	-7.2%	▼
98.67%	98.72%	-0.1%	▼	100.00%	-1.3%	▼
99.37%	99.50%	-0.1%	▼	96.45%	2.9%	▲
68.03%	67.42%	0.6%	▲	86.34%	-18.3%	▼
25.00%	85.71%	-60.7%	▼	71.43%	-46.4%	▼

Key to Tables

- Latest month = **April** Previous month = **March** 19/20 = **April 2019** (pre-covid comparison)
- Variance: between latest month and previous month or latest month and same period in 19/20
- Change: Is the latest month better (Green Icon) or worse (Red icon) when compare to the previous month or the same period in 19/20.
- RAG colours are based on comparison to national standards: **GREEN** = Achieved, **RED** = not achieved

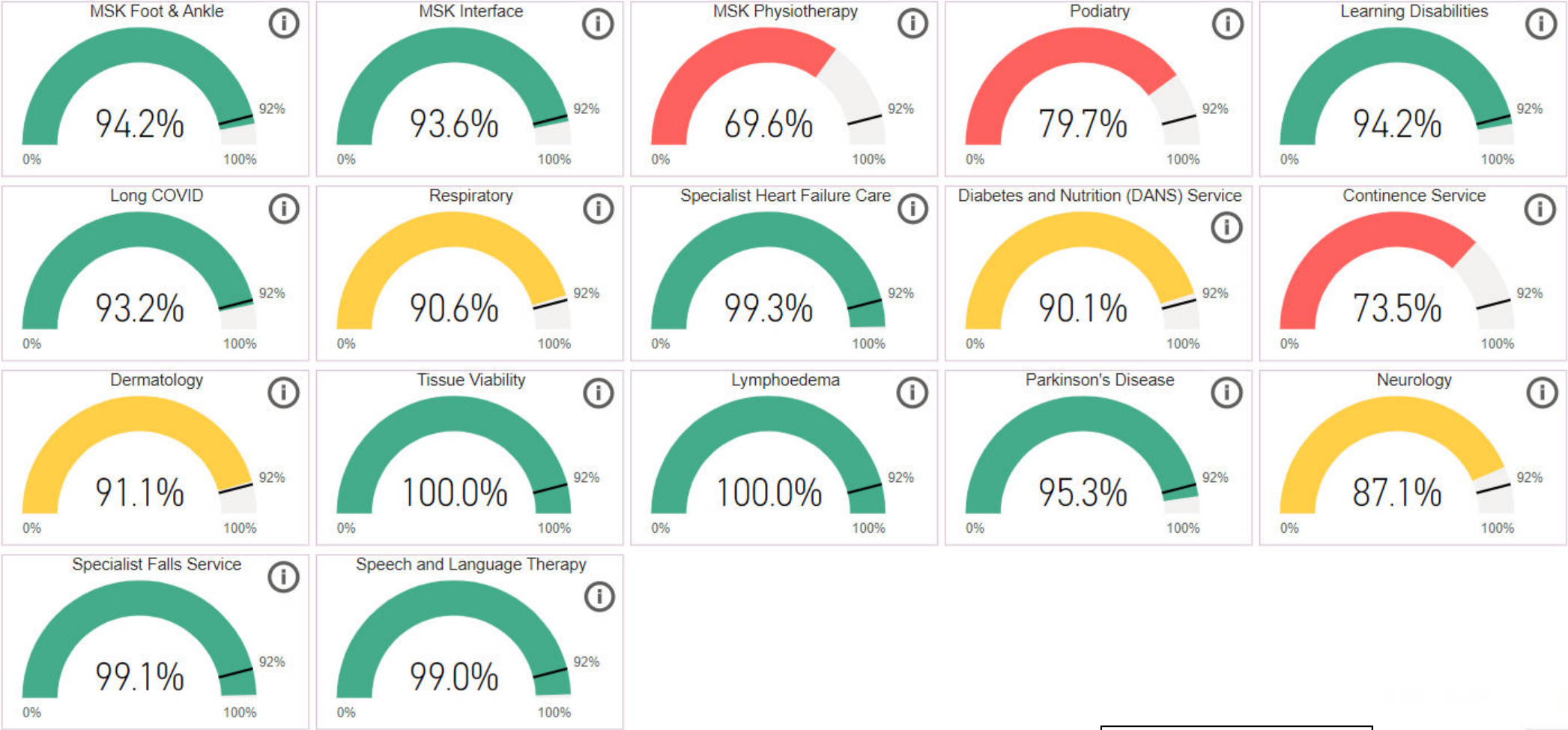
2.4 Mental Health – Summary Performance

Mental Health, Learning Disabilities & Autism	Period	Standard	Latest	Previous	Variance	Change	19/20	Variance	Change
Dementia Diagnosis Rate	Apr-23	66.7%	66.5%	66.4%	0.1%	▲	66.4%	0.1%	▲
EIP - 2ww Referral	Dec-22	60%	62.5%	75.0%	-12.5%	▼	75.0%	-12.5%	▼
IAPT Roll out (rolling 3 months)	Mar-23	6.25%	4.53%	4.20%	0.33%	▲	3.8%	0.7%	▲
IAPT Recovery Rate	Mar-23	50%	52.5%	52.7%	-0.2%	▼	39.7%	12.8%	▲
IAPT Waiting Times - 6 weeks	Mar-23	75%	97.8%	97.1%	0.7%	▲	82.3%	15.5%	▲
IAPT Waiting Times - 18 weeks	Mar-23	95%	100.0%	100.0%	0.0%	◀▶	99.0%	1.0%	▲
CYPMH Access Rate - 2 contacts (12m Rolling)	Mar-23	34%	32.4%	32.3%	0.1%	▲	27.0%	5.4%	▲
CYP with Eating Disorders - routine cases within 4 weeks	Q4 22-23	95.0%	95.5%	96.0%	-0.5%	▼	89.8%	5.7%	▲
CYP with Eating Disorders - urgent cases within 1 week	Q4 22-23	95.0%	95.2%	96.0%	-0.8%	▼	55.2%	40.1%	▲
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)	Mar-23	N/A	80	90	-10	▼	1172	-1092	▼
Percentage of Women Accessing Perinatal MH Services	Mar-23	8.6%	7.3%	7.2%	0.1%	▲	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in CCG beds	May-23	6	11	10	1	▲	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in NHSE beds	May-23	12	19	19	0	◀▶	N/A	N/A	N/A
LD Annual Health Checks delivered by GPs aged 14+ (YTD)	Apr-23	3825	130	0	130	▲	N/A	N/A	N/A
AWP Delayed Transfers of Care	May-23	3.5%	24.0%	23.1%	0.9%	▲	5.2%	18.8%	▲
AWP Early Intervention	May-23	60%	68.1%	41.1%	27.0%	▲	80.0%	-11.9%	▼
AWP 4 week wait referral to assessment	May-23	95%	92.19%	93.70%	-1.5%	▼	96.00%	-3.8%	▼

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 – 2023/24 YTD



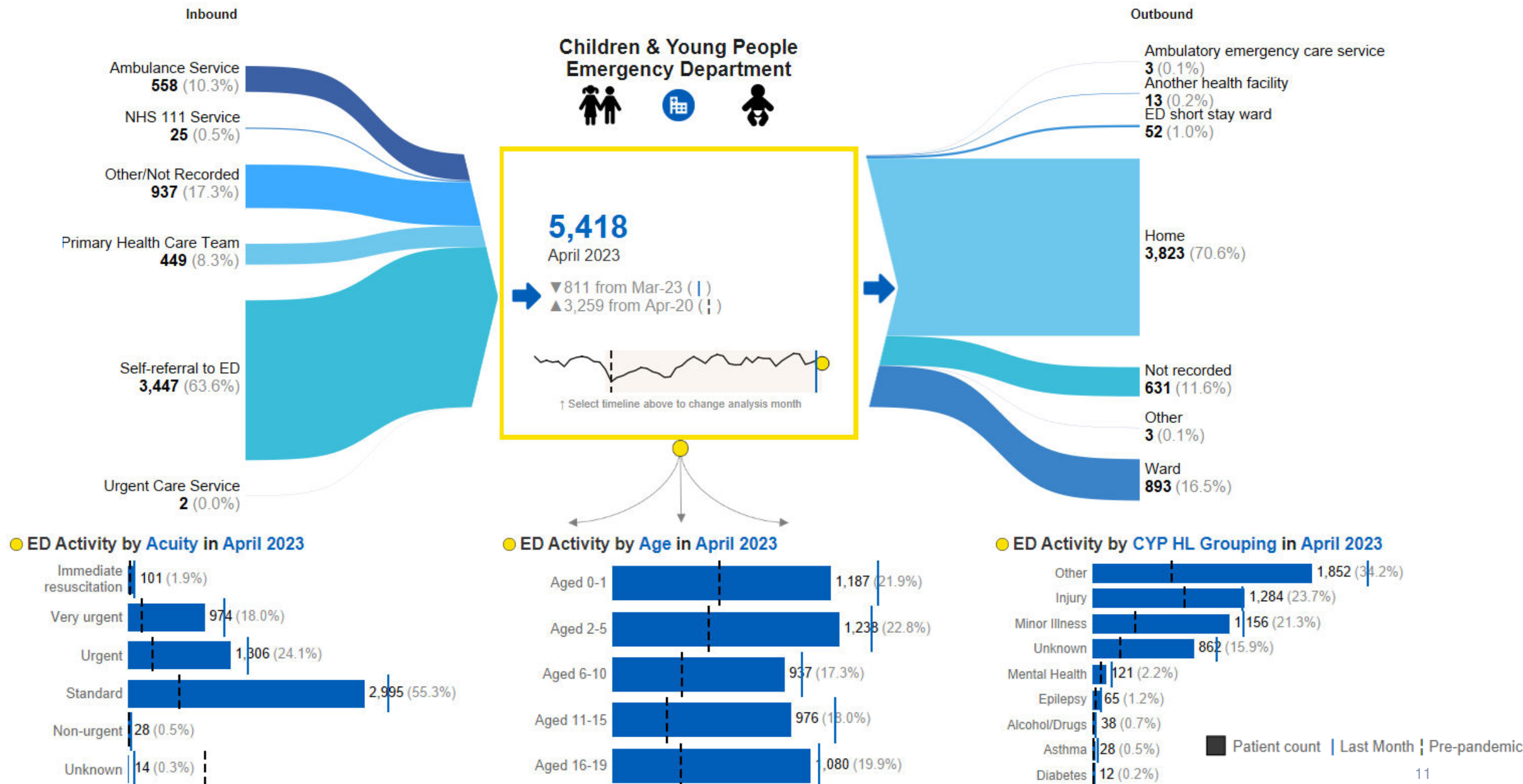
Performance Key Colour

Red	>10% below target
Yellow	<10% below target
Green	On target
Purple	>10% above target



Please note: Data as at 9th June. This is provisional until the 15th Working day of June.

2.6 Children – CYP ED Overview BNSSG Trusts - April



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

3.1 BNSSG ICB Scorecard

Theme	Indicator	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Urgent Care	A&E 4hr Waits - BNSSG Footprint	95%	65.76%	72.74%	69.21%	66.32%	61.78%	66.15%	64.95%	65.00%	63.10%	73.80%	74.50%	76.46%	79.52%	74.93%
	A&E 4hr Waits - BNSSG Trusts	95%	59.46%	65.46%	61.80%	57.10%	61.78%	60.07%	58.87%	56.72%	54.12%	66.27%	67.75%	70.70%	73.92%	68.54%
	>12hr DTA breaches in A&E - BNSSG Trusts	0	1169	755	873	1182	815	978	1423	1296	2003	1318	436	680	326	474
Planned Care	RTT Incomplete - 18 Weeks Waits	92%	65.75%	65.76%	66.17%	65.71%	65.75%	65.54%	66.25%	64.72%	62.55%	64.12%	64.26%	63.84%	59.45%	
	RTT Incomplete - Total Waiting List Size		75,720	76,803	80,749	85,720	87,320	86,771	87,481	80,290	85,246	86,001	83,947	85,444	99,101	
	RTT Incomplete - 52 Week Waits		4052	4164	4764	5134	5376	5302	5386	4761	5345	4961	4182	4124	6,022	
	RTT Incomplete - % of WL > 52 Weeks		5.35%	5.42%	5.90%	5.99%	6.16%	6.11%	6.16%	5.93%	6.27%	5.77%	4.98%	4.83%	6.08%	
	Diagnostic - 6 Week Waits	1%	41.09%	38.14%	38.46%	38.36%	41.30%	40.46%	36.03%	34.05%	35.13%	32.18%	24.95%	20.97%	23.12%	
	Diagnostic - Total Waiting List Size		32,109	31,592	31,976	31,991	31,480	33,279	33,598	32,634	30,471	29,469	28,816	29,335	27,783	
	Diagnostic - Number waiting > 6 Weeks		13,193	12,049	12,298	12,273	13,000	13,464	12,105	11,111	10,705	9,484	7,190	6,152	6,424	
	Diagnostic - Number waiting > 13 Weeks		7,543	7,539	7,597	7,099	7,067	7,503	7,009	6,033	5,456	4,267	3,100	2,186	1,789	
Cancer	Cancer 2 Week Wait - All	93%	61.38%	57.06%	48.91%	44.15%	44.78%	39.17%	39.58%	47.13%	53.08%	56.34%	65.15%	59.81%	42.85%	
	Cancer 2 Week Wait - Breast symptoms	93%	21.35%	52.86%	22.83%	35.56%	4.88%	14.55%	20.83%	73.21%	90.74%	87.88%	88.04%	69.63%	50.00%	
	Cancer 28 day faster diagnosis standard (All Routes)	75%	67.96%	72.62%	69.30%	61.04%	53.13%	41.55%	45.75%	52.52%	53.60%	61.31%	72.01%	74.50%	66.12%	
	Cancer 31 Day first treatment	96%	86.60%	89.02%	91.31%	93.53%	92.83%	89.69%	93.44%	91.74%	93.39%	86.98%	91.81%	92.86%	89.18%	
	Cancer 31 day subsequent treatments - surgery	94%	71.00%	70.91%	68.48%	70.11%	67.02%	64.81%	85.29%	78.23%	83.33%	59.32%	91.94%	87.50%	85.87%	
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	97.66%	100.00%	95.83%	97.76%	100.00%	100.00%	100.00%	100.00%	100.00%	91.40%	98.81%	99.37%	98.58%	
	Cancer 31 day subsequent treatments - radiotherapy	94%	100.00%	100.00%	98.87%	100.00%	100.00%	98.61%	98.64%	98.84%	100.00%	99.40%	99.34%	99.42%	98.62%	
	Cancer 62 day referral to first treatment - GP referral	85%	61.21%	57.96%	53.53%	56.90%	56.00%	59.56%	50.79%	51.13%	51.22%	43.10%	54.33%	63.90%	61.14%	
	Cancer 62 day referral to first treatment - NHS Screening	90%	55.56%	82.14%	43.48%	62.16%	69.70%	54.55%	58.82%	54.17%	48.00%	47.50%	71.43%	75.76%	55.56%	
Quality	Total Number of C.diff Cases	308	23	20	27	27	26	26	21	26	20	14	10		26	
	Total Number of MRSA Cases Reported	0	4	2	1	1	2	5	1	4	1	2	3		1	
	Total number of Never Events	0	0	0	0	0	1	1	0	2	2	1	0	0	0	
	Eliminating Mixed Sex Accommodation (BNSSG CCG)	0	1	0	2	1	1	1	0	1	3	3	0	5	10	
	Eliminating Mixed Sex Accommodation (BNSSG Trusts)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Mental Health	Dementia Diagnosis Rate - People 65+	66.7%	65.80%	65.88%	65.72%	65.92%	65.79%	66.09%	66.54%	67.19%	66.66%	66.60%	66.40%	66.40%	66.50%	
	EIP - 2ww Referral	60%	76.92%	70.00%	66.67%	58.33%	69.23%	72.73%	77.78%	75.00%	62.50%	N/A	N/A	N/A		
	IAPT Roll out (rolling 3 months)	6.25%	4.44%	4.66%	4.35%	4.24%	4.00%	3.92%	3.91%	4.00%	3.92%	4.32%	4.20%	4.53%		
	IAPT Recovery Rate	50%	50.60%	51.81%	52.15%	51.71%	50.46%	46.15%	48.17%	52.60%	55.15%	50.63%	52.73%	52.54%		
	IAPT Waiting Times - 6 weeks	75%	93.60%	92.42%	95.26%	95.69%	96.41%	95.68%	98.80%	96.61%	97.16%	96.97%	97.09%	97.81%		
	IAPT Waiting Times - 18 weeks	95%	100.00%	99.49%	100.00%	99.52%	99.55%	99.46%	100.00%	99.44%	99.29%	99.39%	100.00%	100.00%		
	CYP MH Access Rate 2+ contacts (rolling 12m)	34%	28.08%	30.54%	31.47%	31.97%	32.47%	31.82%	32.20%	32.61%	32.32%	32.38%	32.29%	32.44%		
	CYP with ED - routine cases within 4 weeks (quarterly)	95%	91.35%			95.31%			95.95%			95.95%				
	CYP with ED - urgent cases within 1 week (quarterly)	95%	91.67%			95.00%			96.00%			96.00%				
	SMI Annual Health Checks (quarterly)	60%	56.81%			55.40%			50.94%			62.24%				
	Out of Area Placements (Bed Days)		450	470	455	330	265	175	65	120	120	90	90	80		

3.2 Provider Scorecard – NBT

Theme	Indicator	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Urgent Care	A&E 4hr Waits - Trust	95%	55.54%	72.71%	59.32%	50.99%	60.83%	56.43%	57.47%	57.87%	55.61%	71.94%	79.69%	78.35%	80.16%	70.65%
	A&E 4hr Waits - Footprint	95%	61.71%	77.70%	66.62%	60.85%	60.83%	62.29%	63.12%	65.67%	63.82%	77.64%	83.37%	82.07%	83.86%	76.06%
	>12hr DTA breaches in A&E	0	360	176	297	304	57	261	482	433	786	312	9	135	2	39
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	64.23%	62.62%	64.80%	65.78%	65.82%	66.30%	66.31%	65.58%	62.05%	63.87%	63.87%	63.37%	62.66%	
	RTT Incomplete - Total Waiting List Size	Op Plan	39,819	40,634	42,326	46,991	48,766	49,025	48,871	47,418	46,523	46,266	46,327	47,287	47,861	
	RTT Incomplete - 52 Week Waits	Op Plan	2,454	2,424	2,675	2,914	3,131	3,087	3,062	2,980	2,984	2,742	2,556	2,576	2,684	
	RTT Incomplete - % of WL > 52 Weeks		6.16%	5.97%	6.32%	6.20%	6.42%	6.30%	6.27%	6.28%	6.41%	5.93%	5.52%	5.45%	5.61%	
	Diagnostic - 6 Week Waits	1%	43.61%	40.13%	41.00%	42.75%	48.09%	48.27%	39.36%	38.62%	38.56%	32.21%	22.45%	16.03%	17.44%	
	Diagnostic - Total Waiting List Size		17,114	17,166	17,504	17,124	16,928	16,690	17,286	16,740	14,988	13,437	12,679	12,415	11,878	
	Diagnostic - Number waiting > 6 Weeks		7,464	6,889	7,177	7,321	8,141	8,057	6,803	6,465	5,779	4,328	2,847	1,990	2,072	
	Diagnostic - Number waiting > 13 Weeks		4,664	4,780	4,897	4,718	4,844	4,971	4,627	4,204	3,663	2,459	1,497	939	740	
Cancer	Cancer 2 Week Wait - All	93%	57.66%	46.16%	39.21%	40.99%	40.18%	35.85%	30.86%	47.53%	56.62%	55.01%	63.52%	56.84%	41.63%	
	Cancer 2 Week Wait - Breast symptoms	93%	14.94%	46.03%	18.95%	21.05%	2.50%	6.12%	11.94%	63.27%	97.83%	90.16%	87.50%	67.16%	42.86%	
	Cancer 28 day faster diagnosis standard (All Routes)	75%	66.82%	72.83%	70.87%	58.29%	48.83%	35.18%	42.88%	55.74%	55.48%	62.66%	77.41%	78.17%	68.05%	
	Cancer 31 Day first treatment	96%	81.82%	83.77%	85.53%	91.20%	87.36%	87.76%	90.39%	86.49%	87.16%	82.41%	89.90%	91.04%	79.58%	
	Cancer 31 day subsequent treatments - surgery	94%	62.77%	57.29%	51.85%	58.11%	43.84%	50.00%	75.51%	64.35%	73.85%	52.21%	80.73%	79.79%	72.97%	
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.75%	100.00%	83.33%	
	Cancer 62 day referral to first treatment - GP referral	85%	56.48%	50.15%	48.40%	45.10%	55.59%	58.90%	52.45%	48.86%	49.00%	41.54%	57.82%	61.62%	55.29%	
	Cancer 62 day referral to first treatment - NHS Screening	90%	63.64%	82.14%	51.02%	57.53%	74.24%	62.50%	57.38%	63.83%	51.02%	54.22%	70.00%	73.58%	57.14%	
Quality	Total Number of C.diff Cases (HOHA + COHA)		7	7	7	7	5	6	6	6	6	4	2		4	
	Total Number of MRSA Cases Reported	0	4	1	1	0	0	0	0	0	0	0	0	2	0	
	Total Number of E.Coli Cases		7	5	7	4	6	5	6	8	4	9	6		8	
	Number of Klebsiella cases		2	3	4	2	1	4	2	2	2	1	2		1	
	Number of Pseudomonas Aeruginosa cases		2	1	0	1	2	1	0	0	4	2	1		1	
	Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of Never Events	0	0	0	0	0	0	0	0	2	1	1	0	0	0	
	VTE assessment on admission to hospital	95%	94.75%	94.68%	94.68%	92.23%	91.68%	91.76%	93.01%	94.08%	93.91%	94.23%	94.15%	92.97%		

3.3 Provider Scorecard – UHBW

Theme	Indicator	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Urgent Care	A&E 4hr Waits - Trust	95%	61.51%	61.69%	63.04%	60.15%	62.31%	62.01%	59.59%	56.17%	53.41%	63.45%	61.90%	66.88%	70.67%	67.48%
	A&E 4hr Waits - Footprint	95%	67.81%	70.28%	70.47%	68.96%	62.31%	68.14%	65.86%	64.68%	62.77%	71.95%	70.29%	73.74%	77.37%	74.38%
	>12hr DTA breaches in A&E	0	809	579	576	878	758	717	941	863	1217	1006	427	545	324	435
Planned Care	RTT Incomplete - 18 Weeks Waits	1%	58.65%	58.32%	58.76%	56.37%	55.56%	54.35%	55.33%	55.19%	54.36%	55.62%	54.25%	53.45%	52.66%	
	RTT Incomplete - Total Waiting List Size	Op Plan	57,019	57,940	60,404	60,738	62,010	61,870	62,462	63,041	64,359	64,847	64,929	66,379	66,543	
	RTT Incomplete - 52 Week Waits	Op Plan	4,362	4,654	5,298	5,591	5,970	6,141	5,989	5,888	6,011	5,498	5,371	5,383	5,472	
	RTT Incomplete - % of WL > 52 Weeks		7.65%	8.03%	8.77%	9.21%	9.63%	9.93%	9.59%	9.34%	9.34%	8.48%	8.27%	8.11%	8.22%	
	Diagnostic - 6 Week Waits	1%	42.11%	39.90%	38.78%	36.50%	37.79%	35.54%	34.66%	31.49%	34.21%	34.12%	27.88%	25.67%	28.16%	
	Diagnostic - Total Waiting List Size		16,521	15,819	16,042	16,426	15,387	17,577	16,952	16,692	16,339	16,731	17,080	17,333	16,589	
	Diagnostic - Number waiting > 6 Weeks		6,957	6,311	6,221	5,996	5,815	6,246	5,875	5,256	5,589	5,709	4,762	4,450	4,671	
	Diagnostic - Number waiting > 13 Weeks		3,799	3,697	3,616	3,245	2,968	3,294	3,062	2,317	2,307	2,190	1,933	1,484	1,310	
Cancer	Cancer 2 Week Wait - All	93%	63.02%	67.99%	57.22%	44.62%	45.18%	41.14%	49.06%	41.57%	41.93%	50.26%	60.49%	59.02%	41.36%	
	Cancer 28 day faster diagnosis standard (All Routes)	75%	72.02%	73.19%	67.40%	64.56%	57.28%	50.54%	46.76%	42.78%	45.98%	53.23%	58.46%	65.42%	60.03%	
	Cancer 31 Day first treatment	96%	89.58%	90.61%	92.88%	93.92%	93.92%	91.01%	94.61%	93.36%	98.33%	88.36%	92.83%	92.92%	93.14%	
	Cancer 31 day subsequent treatments - surgery	94%	83.33%	76.27%	80.00%	88.89%	85.94%	87.69%	84.21%	88.71%	87.23%	72.34%	93.55%	83.61%	88.68%	
	Cancer 31 day subsequent treatments - anti-cancer drugs	98%	97.67%	100.00%	94.77%	98.53%	100.00%	100.00%	100.00%	99.44%	100.00%	90.21%	99.39%	98.72%	98.67%	
	Cancer 31 day subsequent treatments - radiotherapy	94%	99.38%	100.00%	99.48%	99.38%	100.00%	99.37%	98.73%	98.99%	99.29%	99.47%	99.42%	99.50%	99.37%	
	Cancer 62 day referral to first treatment - GP referral	85%	67.81%	70.95%	61.83%	69.42%	52.16%	64.85%	47.95%	46.37%	53.98%	42.91%	44.39%	67.42%	68.03%	
	Cancer 62 day referral to first treatment - NHS Screening	90%	0.00%	33.33%	25.00%	50.00%	50.00%	50.00%	85.71%	44.44%	75.00%	40.00%	66.67%	85.71%	25.00%	
Quality	Total Number of C.diff Cases (HOHA + COHA)	89	6	8	12	13	7	9	6	13	7	5	8	6	12	
	Total Number of MRSA Cases Reported	0	0	0	0	0	0	1	0	1	1	2	1	1	1	
	Total Number of E.Coli Cases	119	15	13	6	8	7	11	13	9	5	5	6	6	9	
	Number of Klebsiella cases		3	4	5	6	9	5	5	10	3	3	1	1	2	
	Number of Pseudomonas Aeruginosa cases		1	2	1	2	4	5	1	0	0	3	1	1	2	
	Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of Never Events	0	0	0	0	0	1	1	0	0	1	0	0	0	0	
	Rate of slips, trips and falls per 1,000 bed days	4.8	5.55	4.79	4.11	3.27	6.63	4.49	5.86	5.34	4.71	5.11	5.23	5.14	5.29	
	No. of Pressure Ulcers grade 2, 3 & 4 per 1,000 bed days	0.4	0.248	0.089	0.093	0.089	0.118	0.061	0.23	0.18	0.088	0.086	0.1	0.147	0.032	
	VTE assessment on admission to hospital (Bristol)	95%	81.3%	81.9%	82.4%	82.1%	83.7%	83.5%	84.0%	84.9%	81.3%	85.3%	84.50%	83.50%	82.00%	

3.4 Non-Acute Provider Scorecard

Provider	Indicator (BNSSG level - except ambulance handovers)	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
SWASFT	Category 1 - Average Duration (hr:min:sec)	0:07:00	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	0:07:36	0:07:54
	Category 1 - 90th Percentile Duration (hr:min:sec)	0:14:00	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	0:13:30	0:13:54
	Category 2 - Average Duration (hr:min:sec)	0:30:00	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	0:23:06	0:28:06
	Category 2 - 90th Percentile Duration (hr:min:sec)	0:40:00	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	0:48:30	1:00:06
	Category 3 - 90th Percentile Duration (hr:min:sec)	2:00:00	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	3:19:18	4:18:00
	Category 4 - 90th Percentile Duration (hr:min:sec)	3:00:00	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	4:34:24	7:50:36
	Ambulance Handovers - % within 15 minutes at NBT	65%	16.8%	21.0%	16.8%	13.5%	18.2%	17.6%	11.9%	13.1%	9.6%	19.5%	26.7%	23.0%	34.9%	29.2%
	Ambulance Handovers - % within 30 minutes at NBT	95%	44.4%	53.9%	45.5%	42.8%	56.2%	51.5%	38.6%	40.3%	29.6%	54.7%	70.9%	67.5%	79.2%	70.7%
	Ambulance Handovers - % within 60 minutes at NBT	100%	66.2%	77.2%	68.0%	67.5%	80.9%	75.9%	62.2%	66.2%	48.8%	78.9%	94.7%	89.1%	96.1%	91.4%
	Ambulance Handovers - % within 15 minutes at BRI	65%	11.6%	13.9%	17.5%	9.7%	12.0%	13.3%	10.3%	11.4%	7.5%	12.1%	11.9%	14.2%	24.5%	18.7%
	Ambulance Handovers - % within 30 minutes at BRI	95%	25.3%	34.7%	42.9%	26.2%	30.7%	36.1%	27.7%	33.7%	17.8%	33.5%	37.1%	44.6%	61.4%	48.0%
	Ambulance Handovers - % within 60 minutes at BRI	100%	44.2%	56.0%	65.2%	48.1%	51.2%	58.4%	49.7%	60.8%	36.1%	58.7%	69.1%	72.8%	87.6%	74.1%
	Ambulance Handovers - % within 15 minutes at WGH	65%	16.9%	25.0%	23.5%	15.0%	19.0%	16.3%	14.2%	12.4%	5.8%	11.0%	19.4%	13.8%	14.7%	16.2%
	Ambulance Handovers - % within 30 minutes at WGH	95%	40.5%	52.4%	55.9%	36.3%	47.5%	46.6%	44.0%	37.1%	23.7%	38.6%	58.9%	52.6%	54.3%	54.7%
	Ambulance Handovers - % within 60 minutes at WGH	100%	58.1%	71.2%	72.7%	56.0%	65.0%	66.2%	65.2%	63.0%	42.4%	59.4%	85.5%	82.9%	83.3%	78.2%
SevernSide IUC	Average speed to answer calls (in seconds)	20 Sec	318	274	756	713	723	271	453	381	2054	269	181	152	151	
	% of calls abandoned	3%	16.1%	13.5%	30.0%	28.4%	29.2%	14.0%	20.6%	18.0%	43.3%	14.9%	12.2%	10.8%	0.0%	
	% Triage Calls receiving Clinical Contact	50%	50.0%	48.5%	48.4%	48.8%	37.3%	51.5%	52.1%	51.0%	51.9%	50.3%	50.2%	49.3%	53.3%	
	% of callers allocated the first service offered by DOS	80%	70.0%	68.7%	69.3%	70.2%	68.8%	70.1%	68.8%	67.7%	70.9%	73.0%	71.4%	73.4%	78.1%	
	% of Cat 3 or 4 ambulance dispositions validated within 30mins	75%	53.1%	45.8%	38.0%	45.0%	58.5%	66.2%	60.9%	56.3%	38.0%	44.8%	42.4%	33.0%	42.7%	
	% of calls initially given an ED disposition that are validated	50%	24.2%	13.2%	13.8%	13.4%	17.9%	22.5%	23.9%	21.0%	27.0%	24.1%	27.4%	29.8%	26.2%	
AWP	Delayed Transfers of Care	3.5%	10.3%	13.4%	10.6%	12.7%	15.8%	18.4%	20.4%	21.5%	23.9%	23.9%	21.9%	23.6%	23.1%	24.0%
	Early Intervention	60%	76.9%	55.0%	63.1%	81.8%	76.1%	73.3%	81.8%	62.5%	64.2%	28.5%	73.3%	39.1%	41.1%	68.1%
	4 week wait Referral to Assessment	95%	78.9%	76.9%	76.9%	84.3%	82.9%	75.0%	84.2%	83.0%	90.3%	90.5%	97.6%	95.6%	93.7%	92.2%

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

BNSSG Outcomes, Performance and Quality Committee

Minutes of the meeting held on Thursday 27th April, 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
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Colin Bradbury 1400-1530	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Jonathan Hayes	Chair GP Collaborative Board	JH
Sarah Weld	Director of Public Health, South Gloucestershire Council	SW
In attendance		
Sarah Jones 1610-1620	Director of Nursing, AWP	SJ
Dani Sapsford	Head of Performance Improvement	DS
Phil Cooper 1610-1620	Head of Governance, AWP	PC
Glenda Beard	GP and Clinical Lead Cancer BNSSG ICB	GB
Vicky Marriott	Healthwatch (Representing Sue Geary)	VM
Layla Toomer	Patient Safety Lead Maternity and Neonatology, BNSSG ICB	LT
Jodie Stephens (notes)	Executive PA, BNSSG ICB	TM
Apologies		
Paul May	Non-Executive Director, Sirona	PM
Sue Balcombe	Non-Executive Director, UHBW	SB
Sue Geary	Healthwatch	SG
Denise Moorhouse	Deputy Chief Nursing Officer, BNSSG ICB	DM
Hugh Evans	Executive Director, Adults & Communities, Bristol City Council	HE
Michael Richardson	Deputy Chief Nursing Officer, BNSSG ICB	MR

	Item	Action
1	<p>Welcome and Apologies</p> <p>ED welcome and apologies were noted as above.</p> <p>ED also stated the key aims of the ICB which 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 explained agenda item 6.3 2WW Cancer GP Referral/Consultant is not a deep dive but an opportunity to look at an area of performance in a bit more detail.</p>	
2	<p>Declarations of Interest</p> <p>No new declarations noted.</p>	
3	<p>Minutes of March 2023 meeting</p> <p>The following changes were noted and added to March minutes:</p> <p>Agenda Item 4 – Healthwatch Responses Action: LM and RS will take the Healthwatch case studies to Dave Jarrett and Sarah Truelove to follow up and action.</p> <p>ED asked LM to discuss in more detail Dermatology cancer referrals and to update Sirona's 104/78 week wait. The Dermatology update will take place within agenda item 6.3 in today's meeting.</p>	
4	<p>Healthwatch Responses.</p> <p>VM shared with the group feedback from patients as outlined below:</p> <ul style="list-style-type: none"> • Positive feedback regarding service and after care for family member at Weston General Hospital and 111. • GP access to care at Bradley Stoke Surgery – 30mins wait on phone to get through to GP once they do only can book a phone call but would like to see GP face to face. • Access to assessment – Patient is currently in dementia nursing home awaiting an assessment from social worker, but patient does not have 	

	Item	Action
	<p>dementia. Patient cannot even go outside in gardens because staff not available to escort. Fees will now have to be paid due to the amount of time patient in care home.</p> <ul style="list-style-type: none"> Mendip Vale Medical Practice- Patient submitted an e-consultation but still not received any response after 3 weeks despite chasing twice. <p>JH asked VM what happens to the feedback and whether Healthwatch contacts the services and escalates issues. VM explained quarterly reports are produced by Healthwatch and shared with the request for feedback, this is occasionally received. Healthwatch also use the feedback to inform their own work plans and use the themes to identify in depth work, an example being the recent work on ageing well. JH asked VM if there was a quality improvement opportunity for a specific practice or group of patients and how patients directly raise their concerns with the provider. VM explained that Healthwatch would give advice and contact information to the patient but don't make contact on behalf of the patient.</p> <p>ED asked committee members how we benchmark against other areas. RS explained that practices take part in a patient survey every year which is benchmarked with other systems.</p> <p>ED asked how that is used to support quality improvement. LM explained that every practice reports into GPAD and that the information is shared with ICB Primary Care Operational Group which is led by David Jarrett team and reported to ICB Primary Care Committee.</p>	
5	<p>CNO/CMO Update</p> <ul style="list-style-type: none"> Emerging Risk Quality Report (highlights and exceptions) BNSSG Commissioning Policy – Update Updates from SQG & HCPE Minutes from SQG & HCPE for information <p>RS briefed committee members about the planned RCN industrial action which is due to take place from 20.00 Sunday 30th April to 20.00 Tuesday. The risk profile is increasing with each round of industrial action and with this action taking place over the weekend and bank holiday where there is less infrastructure to lean into compared to a normal working day. The feedback is that some other parts of the country have a higher RCN membership and so maybe more affected than both the SW and BNSSG. Specific areas of concern include Bristol Childrens Hospital, especially the emergency department and high dependency unit caring for children with burns and neurological conditions. There are also concerns about adult critical care areas and Emergency Departments where there will be a significant shortfall in registered nurses creating a</p>	

	Item	Action
	<p>very risk profile. There is an escalation process in place which had been agreed between NHSE and the RCN. Trusts are being asked to complete any requests for Critical Safety Mitigations which are to be signed off at trust level, then RS and then region. Legal action is being heard in the High Court this afternoon and anticipate feedback by Friday 28th April.</p> <p>JM highlighted the BNSSG Commissioning Policy paper which outlines the policies recommended for adoption or removal following the Clinical Policy Review Groups (CPRG) in January and May 2022. These policies were not approved in 2022 due to the transition from Clinical Commissioning Group (CCG) to Integrated Care Board (ICB). The CCG Governance arrangements were stood down in June 2022 and the new Governance arrangements post-CPRG meeting were not agreed until January 2023. The Commissioning Policy Development (CPD) team, Clinical Lead and Policy Officers have reviewed the 14 policies recommended for adoption and three for removal. Following risk stratification JM approved the proposed changes as deemed low risk reputationally and within the financial limits laid out in the decision making framework. Changes to the policies were approved at a meeting between the CPD team and JM in April 2023. JM explained that an overview of the new governance arrangements can be found in appendix one within the paper. ED asked JM to clarify that JM is not asking this committee to scrutinise, challenge or to provide any assurance but to note the process which has taken place, JM confirmed to committee members that was correct.</p> <p>JF asked JM to confirm if there is a written criteria for escalation to committee or ICB Board using autism as an example that has had a lot of press attention. He asked at what point does JM decides between making a decision as Chief Medical Officer or escalating to committee or ICB Board for assurance. JM stated that this would be based on the risk and decision-making framework signed off at Board and if JM was in any doubt would agree with JF to bring to ICB Board.</p> <p>Life expectancy has deteriorated for the first time in over 50 years during Covid, this had started to improve but now appears to be stalling. JM will report back to committee both the outcome of the analytic work and the system approach to addressing this issue.</p> <p>SW referred to Action 76 on the committee action log which was assigned to her in relation to BNSSG excess mortality rates. SW proposed that the action be assigned to JM but that SW would support along with Director of Public Health colleagues. JM agreed. SW asked JM if the analytic data which was produced and at regional meeting yesterday could be shared with SW and ED asked for the data to be included in the report which JM is due to bring to OPQ Committee.</p> <p>JM updated members that she had attended a Women's Health conference covering all aspects of women's health e.g., reproductive, menopause, gynaecology, and</p>	

	Item	Action
	<p>urology. JM and system Directors of Public Health will scope a piece of work aimed at addressing inequalities in relation to women's health.</p> <p>RS highlighted to committee of two other emerging concerns access to interpretation and translation services and safeguarding issues with the growing numbers of refugees and asylum seekers in BNSSG. The safeguarding issues had originally been observed in South Gloucestershire but are now being experienced in Bristol and North Somerset. Dave Jarrett will be leading a systemwide refugee and asylum-seeking group and MR will join that from a safeguarding perspective.</p> <p>RS also updated that Health Education England have visited Weston General Hospital and have reported good progress and now are hoping to return some medical trainees to Weston General Hospital in 2023.</p> <p>ED praised the excellent news regarding Weston General Hospital which has been a collaborative approach from the system and should be highlighted to ICB Board and Shane Devlin including lessons learned.</p> <p>ACTION 88: JM to share excess mortality analytic data which was circulated at Regional CMO meeting with SW and JM to include that data within the update at July OPQ Committee.</p>	
6.1	<p>BNSSG ICB Strategy – Update</p> <p>CB updated committee on the developing ICS Strategy. The current draft has been discussed in detail with the ICB Executive recently focussing on the strategic direction of the system and how the Health and Care Improvement Groups will take oversight of the delivery of the strategic objectives. The draft document is based on the outputs of the joint seminar of the ICB Board and BNSSG strategic network at the end of March. The strategic framework was signed off by ICP in December 2022 and prioritisation of core objectives is underway. CB highlighted that feedback was that the current draft was too narrow and needs to reflect issues such as prevention, workforce challenges, service sustainability and access and use an asset-based approach. CB advised that an Editorial Board has been set up within the ICB which is working on version 2.0.</p> <p>ED asked Executive members for an update regarding the Health and Care Improvement Groups as they are a key vehicle for delivery. LM stated that the first two Health and Care Improvement Groups which are Primary and Community and Mental Health and Learning Disabilities will be meeting in May and focus on Terms of Reference and governance. Primary and Community will be chaired by Ruth Taylor and Julie Sharma and Mental Health and Learning Disabilities will be chaired by Jo Walker and Dominic Hardisty. The groups will report into the system Chief Executive Group and assurance will be through this committee and ICB Board.</p>	

	Item	Action
	<p>JH stated to the group that early diagnosis and prevention is what the system has aspired to but whilst the number of acute care consultants have increased over the years there has been a decrease both nationally and locally in General Practice, despite recruitment, so if early diagnosis and disease prevention is part of the strategic plan then allocation of resource will need to be addressed. JM discussed that prevention is included in the long-term plan and we need to show progress and its prevention of smoking, weight management, obesity, alcohol and drug misuse. JM explained that JM and Directors of Public health are doing a piece of work on how we manage some of the wide cross cutting prevention and the good news is that there is finance allocated for health inequalities. CB thanked committee members for ongoing engagement and informed colleagues the second draft of the strategy will be distributed in the middle of May and then to ICB Board in June.</p> <p>JF stated that we should try and confine the strategy into what to do in BNSSG as a system there are emerging issues that are being discussed and we have intervention from outside of our system and as chair of ICB Board JF wants to have a clear sight.</p> <p>ED thanked CB for attending committee and welcomed further updates at committee.</p> <p>6.2 BNSSG Maternity - Update</p> <p>RS provided context of the maternity update being to ensure a clear line of sight with regards to quality and safety of maternity services through to the ICB Board, as recommended in the Ockenden review. She introduced Layla Toomer who is the Patient Safety Lead for Maternity and Neonatology and who joined BNSSG ICB in January 2023. RS asked LT to report on her first ninety days in BNSSG regarding maternity and neonatology services. RS also confirmed to the group that this did not include RUH at Bath as comes under Swindon and Wiltshire. LT explained that she attended the maternity and neonatal summit in Leeds in March which set the strategic direction for maternity services for the next three years. LT presented slides to the group which included the below key highlights:</p> <ul style="list-style-type: none"> • Acknowledgement of the amazing work delivered through the LMNS transformation programme and the good position of BNSSG as it is already progressing all areas outlined in the Single Delivery Plan and is leading in some areas. • Stillbirth rates continue to reduce nationally. • Concerning increase in suicide in postnatal period. • Equity and equality front and centre to ensure we centre care around the most vulnerable. • Strong emphasis of strengthening quadrumvirate working and the joint working across maternity and neonatology • Service user voice needs to be amplified. 	

	Item	Action
	<ul style="list-style-type: none"> • Maternity Voices Partners to include neonatology and become Maternity and Neonatology Voices Partners • Changing culture – safe, supportive and learning. • Right workforce, right place, right time, right funding. <p>LT advised committee that the LMNS is developing a maternal death overview process which BNSSG are leading on for the Southwest. JM asked LT if there was any insight into maternal death rates in the black and ethnic minority community as a recent headline was that four times as many black and ethnic minority mothers die during pregnancy and childbirth than white mothers and any information regarding teenage mothers. LT confirmed will review data regarding teenage mothers and feed back to committee but regarding black and ethnic minority, work is being carried out at NBT and once finished a deep dive will take place and information will be presented at committee. RS assured committee members that every maternal death is investigated fully by the trust and each of those investigation outcomes is reviewed by our LMNS Consultant Obstetrician along with LT and the LMNS Patient Safety Group.</p> <p>LT discussed the Single Delivery Plan brings together actions from Ockenden, East Kent, Long Term Plan and Maternity Programme and the four main chapters were the following:</p> <ul style="list-style-type: none"> • Listening to and working with women and families with compassion. • Growing, retaining, and supporting our workforce. • Developing a culture of safety, learning and support. • Standards and structures that underpin safer, more personalised, and more equitable care. <p>LT is working on a BNSSG dashboard which will give an overview of where we are and where we benchmark as a system. LT explained that UHBW go live with a new patient record system, BadgerNet in July and UHBW will be live in September, and this will improve the quality of data. LT then discussed the Saving Babies Lives Care Bundle v2, V3 has been delayed by NHS England. The five elements listed below are the what the maternity system is working towards:</p> <ol style="list-style-type: none"> 1. Reducing smoking in pregnancy 2. Foetal growth: risk assessment, surveillance and management 3. Raising awareness of reduced foetal movement 4. Foetal monitoring in labour 5. Reducing preterm births and optimising perinatal care 6. Management of pre-existing Diabetes in pregnancy <p>LT picked key issues from the slide deck:</p>	

	Item	Action
	<ul style="list-style-type: none"> Maternal death data within the slide pack was from January and February 2023 showing an increase of maternal deaths linked to blood clots on the lung and leg not just in BNSSG, this is being seen nationally and a potential link to COVID being explored. A local guideline to reduce the risk has been developed. Laptops with 5G have been provided for community midwives and reported connection issues are being addressed. BNSSG NICU admission rate at term is 6% in February, this was almost synonymous with January (7%). Deep dive is underway within trusts. Work is being carried out within the trust regarding accessibility of maternity services of non-English speakers starting from booking the first appointment with midwife through to hospital then community. NBT was non-compliant with the Maternity Safety Incentive Scheme but have an action plan in place to resolve this which is shared at Trust Board and the LMNS. UHBW are fully compliant with the MSISNBT have been nominated for an award for work on bereavement care and pregnancy loss. One to one care in labour has improved. Permanent funding for the lead neonatal advanced nurse practitioner secured along with a band 7 governance role and an additional band 6 education role in NICU. UHBW's 2022 national maternity survey results saw an improvement in many areas when compared to the results from 2021. <p>LT concluded that excellent examples of team working seen, work that's happening from a quality point of view is positive. BadgerNet is going to improve data collection, accuracy, and assurance of saving Baby's Lives V3. Area of concern is maternity triage within both NBT and UHBW but is being focused on and strategies put in place within the Trusts but may be noted in any upcoming CQC inspection. Links with neonatology colleagues need to be stronger which LT and RS are embedding with LMNS.</p> <p>ED thanked LT for an excellent presentation and assurance's regarding maternity within BNSSG. LT to come back to future committee to update on CQC inspections and update regarding BadgerNet.</p> <p>ACTION 89: LT to attend OPQ Committee to update post CQC inspections and Badgernet implementation.</p>	
6.3	<p>Cancer 2ww Referral/Consultant</p> <p>ED explained to committee members that cancer performance was discussed at ICB Board in April. Data shows 56% of patients in BNSSG were seen within 2WW compared to 86% nationally. ED requested assurance from ICB Cancer Lead and Head of Performance Planned Care at BNSSG ICB.</p>	

Item	Action															
<p>GB advised recovery of cancer performance is a local and national priority. There are agreed recovery trajectories and remedial action plans for both providers. These have been agreed with input from the ICB, the SWAG Cancer Alliance and the Southwest Regional NHSE team. There has been year on year growth in the number of patients referred on a 2 week wait cancer pathway with the following table showing the BNSSG patients seen on a 2ww and 6d pathway between 19/20 and 22/23.</p> <table><tr><th></th><th>19/20 Sept-Feb</th><th>22/23 Sept-Feb</th><th>Variance</th><th>% +/-</th></tr><tr><td>2ww</td><td>22,605</td><td>24,766</td><td>+2161</td><td>+9.50%</td></tr><tr><td>62d</td><td>1,423</td><td>1,492</td><td>+69</td><td>+4.80%</td></tr></table> <p>GB stated there are two parameters which have been highlighted:</p> <p>Cancer 2 week wait– % of people seen within two weeks (GP to consultant appointment)</p> <p>GB advised the February performance against this target has risen by 8.8% to 65.15%. There has been sustained improvement in Q3 and Q4 of 22/23. The February position remains below the national target of 93% and just under 21% below the national average. The 2ww performance in breast was low but additional investment in clinical capacity such as weekend mega clinics alongside reductions in referral demand enabled performance to be recovered such that the 2ww standard was achieved in December 2022. The breast 2ww performance has since dropped slightly and was at 88% in the February data (which equates to 11 people breaching the 14 days). The focus going forward is on maintaining capacity to meet the demand to ensure delivery. It was highlighted that the national focus in 23/24 is on the 28-day faster diagnosis standard (FDS). Both trusts have developed plans that meet the national ambitions for the coming year. It is anticipated that the 2ww standard will be removed as patient pathways are being a focus on meeting the FDS. This focus on confirming/ruling out cancer should provide an improved patient experience. This does not mean that we can discount the 2ww standard but meeting this should not be prioritised over meeting the FDS.</p> <p>Cancer 62 day wait - GP referral, where cancer treatment should begin within 62 days from GP referral.</p> <p>GB advised February 62 day performance improved by 11.2% reaching 54.33% which is 3.8% below the national average and below the standard threshold of 85%. The 62-day performance needs to be considered in the context of volume of backlog clearance that has been achieved in Q3&4 of 22/23, acknowledging that where activity is focused on clearing the backlog, performance drops. This is because the performance measure looks at the number of people seen/treated within the wait time threshold as a percentage of the total of people seen/treated each month. In August 2022 the system peaked at 1161 patients >62days on the PTL. From this point there has been a sustained improvement trend and the 22/23-year end position was 319</p>		19/20 Sept-Feb	22/23 Sept-Feb	Variance	% +/-	2ww	22,605	24,766	+2161	+9.50%	62d	1,423	1,492	+69	+4.80%	
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	Item	Action
	<p>patients >62days on the PTL which is better than the nationally set targets and plan trajectories for both Trusts.</p> <p>GB explained there is work across many pathways to improve performance with recruitment of locum and substantive workforce as well as use of any qualified provider (AQP) capacity. The system actions are directed to the most challenged pathways for example.</p> <ul style="list-style-type: none"> • The system dermatology group is working to improve the pathway for patients referred with possible skin cancer with a focus on image capture to enable remote dermatology assessment. • Increased use of qFit testing in primary care is supporting primary care clinicians to not refer patients for lower GI investigation due to the high level of sensitivity of this test for CRC in certain patient groups. • Gynaecology have invested in additional hysteroscopes and are working on improved information to support patients to be managed outside of the cancer pathway where appropriate. <p>There continues to be significant focus on, and improvement in, cancer performance with an expectation of continued improvement against the agreed trajectories. With an aging population and the widely acknowledged workforce challenges there is a need to identify areas in which productivity can be improved which includes booking and utilisation of slots in endoscopy, productivity in diagnostics and surgery as well as in histopathology and outpatient's services. The support for this focus on productivity would be welcomed with expected improvement in outcomes for patients both on cancer and non-cancer pathways.</p> <p>JM confirmed that assurance was given from a 2ww pathway referral perspective, but the 62-day target assurance is in the paper from GB and DS with proposals in summary.</p> <p>LM advised that pathway redesign in dermatology is needed to create sustainable improvement, and this is currently work in progress supported by the transformation team. GB advised of the significant work underway upskilling primary care colleagues and the use of dermatoscopes to reduce the number of unnecessary referrals. ED asked GB if there is any support that committee can provide. GB responded that there is positive support from relevant stakeholders, so no further support required from committee at the moment.</p> <p>SW asked GB and DS what work was underway to measure equalities, inequalities, and access to services. GB described the work of the BNSSG Cancer Inequalities group where the focus has been on early diagnosis, symptom awareness, screening and access through primary care and onward referral mapped to the 2ww pathway. DS advised work was underway to map health inequality breakdown within waiting lists but acknowledged further work to be undertaken with this.</p>	

	Item	Action
	<p>ED thanked GB and DS for attending committee to provide assurance and noted the significant improvement in breast cancer performance. GB and DS will update re dermatology at a future committee meeting.</p>	
6.4	<p>Joint Forward Plan</p> <p>LM described how the Joint Forward Plan provides the linkages between the system strategy, the Long-Term Plan, the strategies of the Health and Wellbeing Boards and the ICS strategy. The operational plan spans our key deliverables for 23/24 and the monitoring arrangements for the 35 key measures which have been set nationally for all systems. The plan will be reported through to this committee and on to ICB Board. LM advised that the Health and Care Improvement groups will drive improvement in the metrics that relate to their work areas and support progress against the Joint Forward Plan and the Long-Term Plan. SW advised of work underway to review and revise the outcome metrics for the system which is being led by Directors of Public Health. ED asked that the Operational Plan to be added to the agenda for May committee.</p>	
6.5	<p>AWP- Action 29a Update</p> <p>RS gave an update regarding progress with the section 29a improvement notice issued to AWP by CQC on 24th January 2023. The first Quality Improvement Group (QIG) is taking place on Tuesday 2nd May, stood up in accordance with National Quality Board guidance. The QIG will be in place until members are assured that improvement and processes have been. SJ outlined the approach that AWP are taking to deliver the improvement needed. SJ advised that weekly insight meetings are taking place where a three-stage process of checking that improvement has taken place and is being embedded. There has been support from ICB, trust and NHS England colleagues to provide robust assurance that the issues are being addressed. SJ advised that AWP held a board meeting today and as part of that meeting a seminar was held where learning was explored. SJ stated AWP have reviewed the Well Led CQC approach and in future will be holding these reviews in May, June and July to support AWP learning and approach. RS will provide updates regarding progress via QIG.</p> <p>ED thanked SJ and PC for attending and given assurance to the committee on AWP approach and learning to date. ED was interested to learn about AWP board seminar and asked if subject could come to future committee meeting.</p>	
7	<p>Committee Action Log</p> <p>Action log updated as attached.</p>	
8	<p>Items for information</p> <p>8.1 LeDeR Q4 Activity Report</p>	

	Item	Action
	<p>RS stated that 82% people who are on Learning Disability registers in primary care have had their annual health checks in the 22/23 period and 98% of them had a health action plan, which is the highest performance in the Southwest and contributes to reducing the health inequalities being experienced by this vulnerable group.</p> <p>8.2 Quality & Performance Report including:</p> <ul style="list-style-type: none"> • CMDU Highlight Report • Flu Highlight Report <p>8.3 BNSSG Area Prescribing Medicines Optimisation Committee (APMOC)</p> <p>8.4 BNSSG ICS Infection, Prevention & Management Strategic Group (IPaMS)</p>	
9	<p>AOB</p> <p>High court have made decision that the RCN nurse strike must end at midnight on Monday 1st May.</p>	
	<p>Date of next meeting: Thursday 25th May, 1400-1625</p>	

Jodie Stephens

Executive PA April 2023

BNSSG Outcomes, Quality and Performance Committee

Minutes of the meeting held on Thursday 25th May, 1400-1625, on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Jeff Farrar	Chair, BNSSG ICB	JF
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Jonathon Hayes	Chair of General Practice Collaborative Board	JH
Sarah Weld	Director of Public Health, South Gloucestershire Council	SW
In attendance		
Denise Moorhouse	Deputy Chief Nursing Officer, BNSSG ICB	DM
Caroline Dawe (item 6.3)	Deputy Director of Performance and Delivery	CD
Ellie Wetz (item 6.1)	ICS Development Manager, BNSSG ICB	EW
Tina Mostert (notes)	Executive PA, BNSSG ICB	TM
Apologies		
Paul May	Non-Executive Director, Sirona	PM
Sue Balcombe	Non-Executive Director, UHBW	SB
Julie Sharma	Chief Executive, Sirona	JS
Sue Geary	Healthwatch	SG
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Hugh Evans	Executive Director, Adults and Communities, BCC	HE

	Item	Action
1	<p>Welcome and Apologies</p> <p>Ellen Donovan (ED) welcomed attendees and apologies were noted as above.</p>	
2	<p>Declarations of Interest</p>	

	Item	Action
	There were no new declarations of interest.	
3	<p>Minutes of April 2023 meeting</p> <p>Minutes of the previous meeting were agreed as a correct record with the following amendment:</p> <p>Jonathon Hayes (JH) noted that the figure of 17% given on page 6 regarding numbers of GPs was anecdotal rather than official. Jo Medhurst (JM) added that the national figure was 4% reduction despite recruitment.</p> <p>ACTION: TM to amend wording of minutes to reflect this clarification.</p> <p>There were no matters arising from the minutes of the previous meeting.</p>	
4	<p>Committee Action Log</p> <p>ED explained that only action 82 was due for this meeting.</p> <p>Lisa Manson (LM) updated that a meeting is set for this piece of work to be undertaken with Sarah Weld and Colin Bradbury.</p> <p>Rosi Shepherd (RS) requested that Saving Babies' Lives be included in future Performance reporting. A full set of Maternity metrics is available by Trust but not by System. Layla Toomer is working with BI to obtain this feed into the design work being undertaken by Debs El-Sayed (DES).</p> <p>ED queried whether this should therefore be a separate action.</p> <p>There was a discussion about disaggregating the data and LM suggested returning to OQPC with a proposal for reporting, noting that the Children's metrics are included in the baseline data but that the information supplied for this meeting has been extracted to give total numbers.</p> <p>Sarah Weld (SW) reported that SGC have completed a detailed Children's and Young People (CYP) Needs Assessment and that the data mapping could be useful.</p> <p>ACTION 90: LM/RS to bring proposal to future OQPC regarding reporting Children's data, and outcomes with the assistance of SW.</p>	
5	<p>CNO/CMO Update</p> <p>ED requested that the CNO report include updates on MRSA, and Endoscopy. Also, that the CMO report update on Virtual Wards (VW) and occupancy levels regarding learning lessons prior to the next winter planning beginning.</p>	

	Item	Action
	<p>RS reported that there are no new and emerging risks.</p> <p>Regarding providers and current enhanced surveillance:</p> <ul style="list-style-type: none"> • Kewstoke is doing well and the view from the ICB Health Partners and the CQC is that they can step out of enhanced surveillance in July and return to Business as Usual (BAU). • The Sherwood Lodge enhanced surveillance is being led by Dorset ICB. The situation there is improving and the improvements now need to be embedded in BAU. • Ezec are being overseen through contract meetings. • AWP had their first Quality Improvement Group following the CQC Poor rating for the Section 29A Ward Service, which was a positive meeting. RS reported that the CDiff situation is stable. MRSA rates are decreasing but will still be reported as Red as the threshold is zero. Work has been undertaken in the community to assess the impact of intravenous drug users being issued with Chlorohexidine Wipes and an update can be brought to OQPC when it is ready. The low incidence of MRSA infections means that a slight shift can skew the overall trend. JM added that there are no concerns being raised about MRSA regionally or nationally. <p>SW highlighted the Southwest Infection Control Conference where it was noted that there is a risk in the ongoing funding for community infection prevention and control, as the BNSSG team which is funded by LAs from Public Health budgets and is hosted by the ICB, is only funded to March 2024.</p> <p>JM added that the Level 3 status invoked during COVID has reverted to Level 2.</p> <p>JM reported that there have been cases of Avian Bird Flu in humans which is an area of focus for the UKHSA teams. It appears to have a low level of infectivity and low pathology. There have been no cases in the Southwest.</p> <p>RS reported that the RCN are out to ballot for further strike action between June and December which would be an all-out strike not by employer as previously. There will be no overlap with the June Junior Doctors Strike. RS described the frustration of the workforce both those that wish to take industrial action or those that are unable to.</p> <p>JM added that consultants have also been balloted on strike action and that the cumulative effect would be significant.</p> <p>JM reported that utilisation and numbers of beds in Virtual Wards (VW) in the Southwest are below the national trajectory. This was discussed at the MD group and Sirona are bringing VW leads into a meeting on 30.5.23. Initial indications are that there are multiple factors having an impact. This has received national attention and the regional MD is being held to account to investigate whether it is justifiable and reasonable.</p>	

	Item	Action
	<p>LM commented that three issues are having an impact upon VW utilisation:</p> <ul style="list-style-type: none"> • Capacity is being affected by being behind the recruitment trajectory and the system has agreed to recruit substantial roles. • MADE events and Industrial Action have highlighted the lack of clinical confidence in VWs. Clinical champions on the wards result in a higher uptake. • Using the wards for prevention of admission as much as discharge without admitting patients purely to achieve targets. <p>JM explained that Dave Jarrett (DJ) is the SRO for VW as they are within the remit of integrated care. JM will prepare a briefing with DJ to bring to July OPQC.</p> <p>LM noted that the VW are part of the overall work covering discharge and as such are normally discussed in Discharge Groups and escalated to the Winter Escalation Group (WEG)</p> <p>ACTION 91: JM / DJ to brief OPQC in July on VW under-utilisation</p> <p>LM advised that Endoscopy is the most challenged area regarding diagnostics. Significant capacity was lost during COVID because of IPC restrictions and the use of endoscopy areas for recovery. Endoscopy is twofold demand with the initial diagnosis followed by monitoring. There is a programme of work to expand capacity and improve productivity. The suites at the BRI and NBT have been expanded and the community diagnostic programme will provide additional capacity.</p> <p>ED asked if there is a set of milestones to measure against as this is identified as a system challenge. LM explained that endoscopy is monitored weekly at the elective oversight group.</p> <p>ED suggested a briefing on endoscopy and utilisation of the CDC in the Autumn.</p> <p>JH queried why organisations such as Prime are not able to accept two week wait referrals. LM advised that the national guidance limits those able to accept the referrals since the independent sector does not have the correct level of accreditation. Clinical infrastructure is also a limiting factor in the independent sector, so accreditation is not an option. ED queried whether other systems are using independent providers. LM noted that there is not anything that is structured and that it would need an understanding of the difference between the Prime Endoscopy Model and CDC.</p>	

	Item	Action
	<p>ACTION 92: LM to bring briefing paper to QQPC in September on Endoscopy and utilisation of the CDC.</p> <p>JM gave a verbal update from HCPE explaining that the meetings would be monthly rather than fortnightly going forward. The mid-May meeting was used to put clinical input into the Joint Forward Plan (JFP), and to receive a presentation from NBT and UHBW on inequalities and elective care. This will build on the work to have a systems inequalities group. The meeting this morning discussed mortality data, which will be brought to QQPC in June / July and setting up a mortality surveillance group. Draft TORs have gone out for comment. There was a general debate about the digital strategy and shared access to data being a good enabler of care. Additional meetings will be a quarterly face to face session to create long term prevention commitments, starting with smoking. JM summarised that there is lots of work underway in multiple places.</p> <p>ACTION 93: RS/ JM to meet with Ellie Wetz / Nic Saunders to bring an overview of the work and clinical leadership decision making process to a future OPQC, tying it into the work on Risk Matrices from the last workshop.</p> <p>ACTION 94: JM will present written update on smoking prevention workshop as part of June's report.</p>	
5.1	<p>Director of Performance & Delivery</p> <ul style="list-style-type: none"> Performance Data <p>LM highlighted the following points:</p> <ul style="list-style-type: none"> A&E performance is improving and either on, or exceeding, target. Progress is being made in Urgent Care, through a combination of different pathways and demand being more manageable. 12-hour trolley waits have been reduced Ambulance performance is improving and is routinely within 30 minutes. The next focus is to get it to 18 minutes. Elective achieved the end of year targets for 104 and 72 week waits. Breaches on 104-week waits are due to patient choice, predominately in children's or a patient requesting a particular consultant. Mutual aid is being investigated for specialist surgery. Work will be undertaken through this year's plan to reduce all waits further. BNSSG is an outlier in the inclusion of data on choice in reporting, but it is felt that it is important to understand this factor. 	

	Item	Action
	<ul style="list-style-type: none"> Improvements are being seen in cancer, particularly for breast and urology. Increasing issue regarding dermatology for 2-week waits and treatment incl surgery, however the faster diagnosis standard for this year will be achieved and this is the overarching target that we are monitoring against. Achievement of the Dementia Diagnosis Rate but this is mainly based around Bristol, so a programme of work is needed to redesign services for the whole of BNSSG. Achieving the range of MH standards but still need to look at inappropriate placements. Access rates for Children's and Young People's MH have been improving but the satisfaction rating is not seeing a corresponding improvement. <p>RS requested clarification about mixed sex accommodation as NBT and UHBW score cards indicate that there is none. LM advised that this reporting ceased in 2020 but that the scorecards have not been revisited to remove it.</p> <p>ED asked about the provision of care and safety and whether a concern should be raised about mixed-sex accommodation as it has a significant impact on the patient experience and was raised as a safety point in the AWP CQC inspection. RS agreed to take this to regional colleagues for discussion.</p> <p>ACTION 95: RS to discuss mixed-sex accommodation with regional colleagues and report back to OQPC.</p> <p>LM reported that significant progress had been made on Out of Area placements for AWP and that this continues to be a focus of work to ensure clear and rational reasons for using them and clear therapeutic pathways. The aim is to prevent people being placed for long stays, so the data is being reviewed daily. It has been identified that some patients are delayed in discharge due to lack of accommodation and wrap around support in the community. AWP needs to run at a lower bed occupancy in order to manage discharges proactively. James Eldridge is leading work this year, equivalent to the D2A programme in physical health, to ensure patients are going to the correct physical place upon discharge from AWP.</p>	
6.1	<p>Health and Care Improvement Groups</p> <ul style="list-style-type: none"> Mental Health Primary Care and Community <p>LM noted that the Children's HCIG has had its first meeting.</p>	

	Item	Action
	<p>EW was introduced to the meeting and explained that her purpose was to provide understanding of the process and how HCIGs are working.</p> <p>EW confirmed that the Acutes HCIG has yet to meet so LM is meeting with SD, Maria Kane, and Eugene Yafele on 2/5/23 to organise it.</p> <p>EW presented the following points:</p> <ul style="list-style-type: none"> • The Initial meetings of each HCIG have been treated as soft launches and have invited all who were on previous meeting circulations. • The next stage of the decision-making framework will go to Board in July and will describe the decision-making authority conferred on HCIGs and their members. • The substructure beneath the HCIGs will filter what goes to the HCIGs to enable them to ensure that the system functions. • There has been a standardised agenda to reflect on TORs, give opportunity to have a deep dive into the purpose of the HCIG and its role in the ICS. • The HCIGs are intended to have system oversight to ensure that system partners work together collectively to undertake operational plans and achieve strategic objectives. • They are driven by the principle of person-centred improvements in population health. • There are two partner chairs for each HCIG, all being Chief Execs except for Childrens which is still being worked through. • Actions previously sitting with the groups which have now become the HCIGs have been taken forward. <p>At each group which has already met the following points were discussed:</p> <ul style="list-style-type: none"> • Level and representation of membership. Currently the existing steering groups have been utilised with their broad memberships, but it is expected that this will be refined with some attending the Subgroups. • The role of the locality partnerships and how they will fit in. • The role of the transformation hub and SDUs in support of HCIGs. • HCIGs needing an overview of system risk how this will fit with SQG. • ICB support for HCIGs with the assets already in the system such as BI. <p>LM noted that work is underway to map information and data which will go to each sub-group so that none is lost. HCIGs will be used to escalate and unblock issues and prioritise strategy within their areas.</p> <p>The Acutes HCIG may be different as the intention is to keep most of the work out of the hospital space.</p> <p>ED raised a concern about the amount of governance and potential duplication and asked about understanding of the interaction between and with committees.</p>	

	Item	Action
	<p>LM explained that the balance will be correct when we recognise that committees are there to provide assurance to Board and HCIGs are the executive function which takes action. HCIGs are not for assurance but are for making sure transformation is happening and issues around quality are being raised. Committees can task HCIGs to take forward work. This will mean that some things will be duplicated in order to provide assurance to Board.</p> <p>Regarding the underpinning structure, the important issue is to ensure that conversations happen about pathways and between HCIGs for overlapping issues.</p> <p>LM noted that part of the process for developing new ways of working is for things to go wrong as they are tested.</p> <p>ED requested a report back to OPQC as the HCIGs progress and unlock the understanding of how they will function.</p> <p>ACTION 96: LM to report back to OPQC on development of HCIGs.</p>	
6.2	<p>Childrens Services</p> <ul style="list-style-type: none"> Childrens Performance Data <p>ED noted that there had been a challenge from Julie Sharma (JS) at Board about sufficient consideration being given to children's services at OQPC reporting.</p> <p>LM reported the following points:</p> <ul style="list-style-type: none"> The dashboard brought to this meeting highlights where there are issues in children's and that they are part of the total data, rather than being isolated. RTT performance in key areas has been shown in terms of commission. Community paediatrics is a challenge as is paediatrics in the acutes. It is hard to recruit to community paediatricians, so it is not possible to solve the challenge by simple expansion of services. Investments have been made in Community Therapies in North Somerset to expand the portfolio so that children are seen within the 18-week standard. There has been year-on-year investment in CAMHS with 71% of CAMHS referrals now being seen within 18 weeks. However, the feedback from families is that it is difficult to be seen so there is a disconnect between the data and the experience. A deep dive is underway to understand this and find out if it is partly due to the change in criteria. All of the headline metrics point to improved access. Data is fed into Children's Operational Delivery Board for oversight, along with input from parent carer forums at SEND which gives real time feedback. 	

	Item	Action
	<p>ED asked about the scale of the community paediatrics challenge, what it means and what other systems are doing to address the issues. LM commented on the work which is being done on redesign of the autism pathway, prioritising more urgent referrals over routine. Sirona have plans for dedicated community paediatricians associated with SEND in each area. Recruitment drives have not solved the issues so Sirona are working on redesigning the role to ensure that paediatricians are only doing what they alone can do. This is expected to be challenging.</p> <p>JH noted that it is hard to monitor consequences of the service not being able to deliver, and hidden activity which happens elsewhere in the system. Harm is caused because of delay and patients spill into primary care.</p> <p>LM added that elective delays have a resulting effect on other parts of the system so children should be able to utilise different parts of the system in parallel rather than sequentially. LM explained that the work is currently going through the gateway process and is in Gateway 0 for the discovery phase, looking at other places and systems. LM is the lead for Children performance and DES is the lead for Transformation.</p> <p>RS queried the information on the slide deck which shows paediatrics in totality rather than by specialty as would happen with adult services noting that, if it were broken down it would be easier to understand where reinvestment is needed. LM advised that the elective waiting list for Children is monitored by individual speciality and sub-speciality and that this shows that the biggest wait in Children's is for dentistry, so action is being taken to both recruit specialists and to send patients out of area for surgery so that they are treated in a timely way. However, the information shared at this meeting has been collated to bring a summary dashboard. Weekly conversations take place with the national team at the detailed level of individual children. However, that level of visibility is not available in community paediatrics. Previous iterations of the dashboard have shown the splits and the data is available.</p> <p>LM noted a concern about the growth in referrals over waits and that they represent a different mixture of issues.</p> <p>RS highlighted that HCPE want to understand the changing morbidity of children so that the system can make planning decisions to prevent further deterioration as they become adults to mitigate future risks.</p> <p>RS also noted the necessity of understanding the different data sets needed at Committees and HCIGs.</p>	

	Item	Action
	<p>JH commented on the secondary care dental waits asking if performance data were available from community dentistry and LM confirmed that it would be available in the future.</p> <p>LM asked that OQPC task the Children's HCIG to determine and obtain the data which needs to come to committee and investigate cross-cutting themes, giving the example of Children's access to NHS dentistry being a cause of the requirement for Secondary Dentistry services, and that Dentistry is technically overseen by the Community HCIG.</p> <p>LM reported that CAMHS and continence have not been included in the data and noted that some of the increase in waiting list could be due to cleaner data and the increase in referrals.</p> <p>JM referred to the email received from JS regarding the data context and that part of the picture is about the story behind the issue. JM highlighted that the OQPC need to be part of the story, so background information is needed to gain a wider picture before narrowing down into a consensus of top concern and noted that Charlie Kenward is leading work on this.</p> <p>LM suggested that education and social care should be included in collection of data, particularly for immunisations. LM asked the OQPC to task the HCIG to work to gain a clear understanding of the information needed. For example, a key issue is the ability to access MH services which affects feedback, access rates and is creating a steady trend of children into ED via 111 and 999</p> <p>ED suggested a debate outside committee between the execs and data teams to ensure no duplication. ED requested that the execs have a conversation with SD to determine the right way to progress this and bring back to OPQC in the Autumn. LM added that it should be a wider system conversation to consider other aspects of Childrens work.</p> <p>Jeff Farrar (JF) reflected on the conversation at the away-day regarding scrutiny at committee and the necessity of a conversation by exec members prior to committee, so that a united voice is given by those delivering the service. JM reported that different questions are being asked of execs by different people during this period of working out the relationships between Chief Execs, whose thinking is still evolving and emerging. Since HCIGs have only met once questions do not have clarity or focus yet. JM also noted that the committee structure can be used for leverage. JM identified the need for Key Lines of Enquiry (KLOEs) for OPQC and understanding of the reason and background for questions being asked.</p> <p>RS noted that, as HCIGs develop, they will have more focus and direction.</p>	

	Item	Action
	<p>LM highlighted that Children's is equivalent to adults but there is only one HCIG for Children's and three for adults.</p> <p>ACTION 97: LM HCIG and OPQC to have oversight of children's work and progress to be brought back to committee later in the year.</p>	
6.3	<p>Operational Plan – Update</p> <ul style="list-style-type: none"> Flow Indicators <p>Caroline Dawe (CD) explained that there are thirty-five key metrics to be monitored which have been set at a national level and a funding profile to work through. The Operational Plan attempts to give clarity to the work of the ICB and where there are gaps in system provision or performance. It includes a clear statement regarding the information available and should allow BNSSG to return to Segment 2 as a system and by provider. The plan highlights where BNSSG are not achieving against 92% bed occupancy, over 65-week elective care waits (although these have an agreed plan) and the 75% early diagnosis ambition for cancer waits.</p> <p>JH asked for clarification on UDAs being categorised as green when there is not data available yet. LM explained that this is in line with transfer of 22/23 performance on delegation from NHS England. In regard to ARRS – for 22/23, BNSSG drew down all of our Additional Roles Reimbursement Scheme (ARRS) funding, so we have all of the ARRS in place, but we are only reporting on month one. LM noted that some sections are only reported on annually in line with the Operational Data Definitions. However, the Operational Plan will return to OPQC monthly for oversight of delivery and challenges.</p> <p>ED raised the issue of there only being two metrics for health inequalities. LM commented that those are the metrics used in the national plan and that, as an ICB, we can decide to delivery against additional ones. In the NHS 23-24 objectives there are three metrics within the domain of Health Inequalities, two focus on the management of hypertension and lipid lowering therapies. JM added that those metrics drive the worst outcomes and excess mortality so could give the most impact quickly to increase life expectancy.</p> <p>ED noted that both metrics are red. JM commented that these key strategic objectives will drive a campaign and there is lots of work underway. However, given the amount of work already done with little improvement seen, we need to go into an improvement cycle, and then a trajectory can be created.</p> <p>ED asked if either needed escalation or added support from the committee. LM commented that it could be useful to do a deep dive into perinatal mental health which, although not being high profile, has a significant impact when it is not</p>	

	Item	Action
	<p>functioning. UHBW undertake some provision internally which has created a discrepancy. ED suggested a light touch briefing.</p> <p>ACTION 98: LT to work with LM team to produce a timeframe for reporting back to OQPC on perinatal mental health.</p> <p>JF highlighted the issue of the poorer outcomes for BAME women who are five times more likely to die during their pregnancy or childbirth. RS advised that the LMNS has an Equity and Equality Plan comes to the LMNS for reporting and can be included in the onward reporting to this committee.</p> <p>LM suggested that, following the perinatal mental health work coming back to OQPC, JM suggested that in the future the committee could have focus on areas that have a high-volume impact such as hypertension, as part of a wider discussion on how best to design the committee agenda.</p> <p>ACTION 99: JM will work on this with RS, LM and suggest a way forward to ED. To begin JM suggested a focus on hypertension- Adwoa Webber to action.</p> <p>JH highlighted Primary Care and that historically there was data from some parts such as Out of Hours and Severnside but that data from GP practices has been more difficult to capture and collate. Practices are now seeing the benefit of sharing data to demonstrate where activity is happening and be able to direct resources to supporting service delivery across the wider system. Dentistry is a significant concern in BNSSG, with a deficit in Primary Care service delivery exacerbated by inequalities, which has a knock-on effect on secondary care demand.</p> <p>ED asked for clarification about measuring against the four high level objectives in the operational plan. LM responded that those are high level objectives and that the HCIGs will have a set of nested metrics to include work underway in terms of Primary Care access and recovery plans including dentistry. Since dentistry is under the remit of DJ, OQPC will need a line of sight and clarification of which committee it reports to.</p> <p>ED reported that this committee will move to bi-monthly from September and on the alternate months ED will sit on Primary Care Committee to give all execs the opportunity to attend both.</p> <p>ACTION 100 – RS / LM / JM / DJ to agree new process from September.</p>	
7	Items for Information	

	Item	Action
	<p>7.1 Customer Services & Complaints Quarterly Report</p> <p>7.2 LeDeR Governance Group Minutes – April</p> <p>7.3 System Quality Group Minutes - April</p> <p>7.4 Health and Care Professional Executive Minutes - April</p> <p>All the documents were addressed on the agenda.</p>	
8	<p>AOB</p> <p>Membership</p> <p>ED suggested a review of OQPC membership and the following points were raised:</p> <ul style="list-style-type: none"> • One DAS representing all 3 LAs. • Timing and date of OPC • Voluntary attendance for NEDs • Co-opted attendance to cover specific items by execs. • NEDS not being accountable for delivery but rather holding others in the system to account. • Possibility of another Chief Nurse from within the system joining on a rotating basis. • The necessity of being different to performance committees in place within the acutes, by looking at issues which can only be solved as a collective. • Ensuring the agenda is appropriate for the audience. <p>ACTION 100: JF, ED, RS, JM and LM to bring to discussion at further meeting.</p>	
	<p>Date of next meeting:</p> <p>Wednesday 28th June 1300-1525</p>	

Tina Mostert
Executive PA
May 2023