Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Board Meeting

Date: Thursday 5th October 2023
Time: 12:15pm
Location: Vassall Centre Gill Avenue, Bristol, BS16 2QQ

Agenda Number :	6.2
Title:	BNSSG Winter Submission Overview

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: For Information

Key Points for Discussion:

The presentation outlines the national approach to winter and BNSSG system response. Reflections from last year are included to inform future planning.

Key risk and next steps as discussed at the winter planning event held on 7 September with acute, community, mental health, primary care and local authority partners, are outlined in the pack including winter governance.

Further detail is included in the appendices including compliance with national requirement for a system coordination centre (SCC), local position on the new Operational Pressures Escalation Levels (OPEL) framework and self assessment undertaken on the current system position in key service areas e.g. frailty as part of the winter submission to NHSE.

Recommendations:	To discuss and note the systems response to winter.
Previously Considered By and feedback :	Urgent and Emergency Care Operational Delivery Group (UECODG)
Management of Declared Interest:	No declared interest

Shaping better health

Risk and Assurance:	Risks are detailed within the presentation in relation to service delivery over winter and current performance.
Financial / Resource Implications:	UEC and home first funding has been provided early in 2023 and investment has been made to allow earlier planning in services. No further funding is expected in relation to winter.
Legal, Policy and Regulatory Requirements:	Winter guidance from NHSE was released throughout the Summer 2023 in stages – maturity index through to demand and capacity modelling and supporting narrative.
How does this reduce Health Inequalities:	Our approach to planning of services has taken into consideration management of health inequalities.
How does this impact on Equality & diversity	Service developments undertake an equality and diversity impact assessment as part of changes made to service pathways.
Patient and Public Involvement:	There has not been direct patient and public involvement in the production of the overall winter plan but there has been at individual service level where service changes have been proposed.
Communications and Engagement:	Winter communications plan will be approached through the strategic systems communication group as well as through the operational delivery group
Author(s):	Caroline Dawe
Sponsoring Director / Board Member:	Jo Medhurst

Agenda item: 6.2

Report title: BNSSG Winter Submission Overview

1. Background

Each year guidance is released from NHSE to support systems in managing winter. Guidance in 2023 has been released earlier than previous years allowing investments to be made earlier and planning to take place to create headroom to cope with winter demand. Various submissions have been made to NHSE outlining the system approach including a self assessment of our maturity in key services to help manage flow, a demand and capacity model bringing as many parts of the system together as well as a narrative used to provide assurance on all key service areas.

The presentation is an overview of the approach to winter including feedback from the system winter planning event held on 7 September.

2. Presentation

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

BNSSG UEC ODG update: Winter Submission & Next Steps

14th September 2023

Greg Penlington, Head of UEC, BNSSG ICB

National winter guidance & BNSSG response to actions

<table>
<tr><th>Action</th><th>Response</th></tr>
<tr><td>1. Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place</td><td>Maturity matrix completed by all ICS partners. Support from NHSE universal offer requested for:
1) NHS@Home
2) Acute frailty
3) SDEC
4) ARI hubs

20+ ‘Recovery Champions’ nominated by the ICS and accessing webinar-based training.</td></tr>
<tr><td>2. Completing operational and surge planning to prepare for different winter scenarios</td><td>ICB scenario modelling completed. System review and input at Winter Workshop on 7th Sept. Submission to NHSE completed for 11th Sept (see separate document).

Numerical submission completed – see Appendix.</td></tr>
<tr><td>3. ICBs should ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.</td><td>BNSSG Operating Plan delivery – metrics now included in UEC performance and project reports.

System Coordination Centre in place and compliant with new national specification.

Updated Operational Pressures Escalation (OPEL) Framework now published – see Appendix. System plan to double run alongside existing OPEL framework.</td></tr>
<tr><td>4. Supporting our workforce to deliver over winter</td><td>Staff flu and covid vaccination. established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

NHS People Plan delivery.</td></tr>
</table>

What we did: BNSSG Winter Planning Session 7th Sept.

Objectives for the session:

1) Develop a shared numerical understanding of system inpatient capacity and potential gaps over winter, which we will share with NHS England on 11th September.
2) Agree a menu of considered mitigations to address potential shortfalls in system capacity over winter, which we will use during system escalation.
3) Recognise collectively our position on delivery against our 23_24 UEC and Home First investment schemes, noting these form the core of our winter response.
4) Reflect on past ways of working and amend system governance, monitoring and decision-making processes as required, including how we may respond to any ‘last minute’ non-recurrent winter funding.

What we are not doing:

- Detailed sharing and assurance of each other’s organisational winter plans – we trust each other and will have visibility of these via our winter plan narrative submission.

Emphasis on fact the core winter plan is already developed through 23/24 investment: we need to stress test this against our bed model, and scrutinise delivery, and collaborate on solutions.

Healthier Together

Washup – reflections on last winter

Positives	Opportunities
Getting 'under the skin' of NCTR issues and taking positive action – even if actions were not perfect (care hotel, EP bridging).	At times reactionary approach to patient safety. Need for system clinical leadership but lack of clarity about role of clinical cabinet / HCPE and where conclusive discussions could take place.
Movement on reverse queueing and cohorting approaches, towards consistent SOPs across both trusts.	Joint working approach to therapists in BNSSG did not get off the ground. How do we put the capacity in the best place for winter? Should CNOs lead this?
Vaccine uptake.	ARI hub response coming too late to support surge (strep etc). Need for planning 'runway'.
Impact of paeds minor stream in dealing with respiratory surge.	Burden of national reporting.
Improved relationships around back door including use of ION meetings.	Positive role of WDG and WEG for rapid decision making and responding to system flow issues, however felt momentum was lost over time and financial decision making became difficult.
Virtual ward mobilisation and uptake – 100 caseload in December.	
Impact of CYP community schemes and PH nursing approach.	

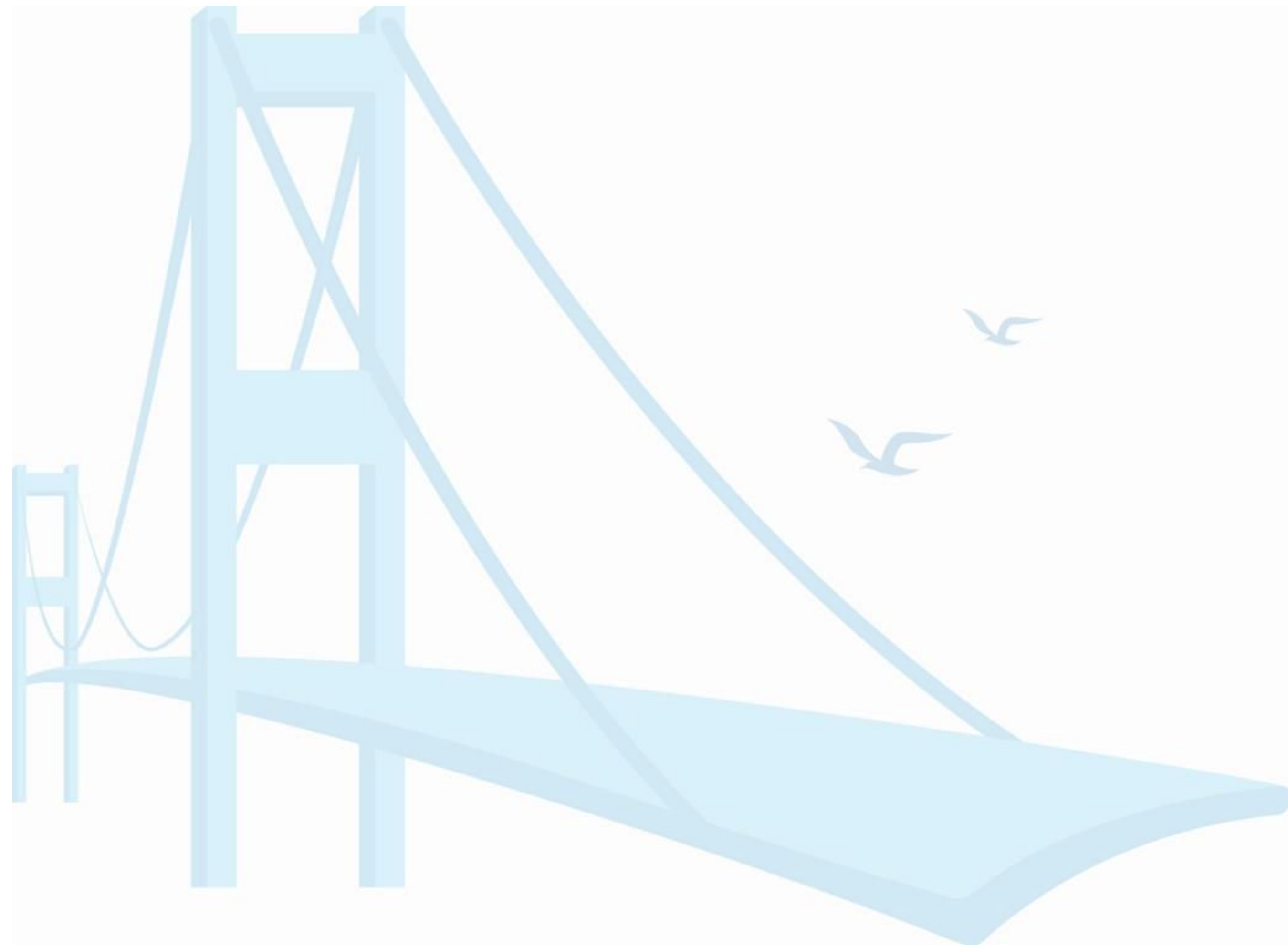
Key risks and next steps from the discussion (1/2)

- **D2A:** support for proposals made to D2A Board on 6/9 regarding P1 bridging, P2 beds etc; outstanding work to cost the proposal against the available £1.5m contingency. Contingency budget also being explored for use as mitigation for stroke programme (use of BIRU) – discussion still required.
- Agreement that potential system approach to therapies has not been landed in the past – can CNOs support a new approach this winter?
- Recognition a similar demand and capacity exercise is required for the mental health back door, pooling available data to see end-to-end delays across the pathway. Could be done through existing AWP RightCare programme.
- **NHS@Home:** Agreed need to prioritise step-up pathway as best way to drive up utilisation. Lots of potential with links from UCR and CAS. The service peaked at caseload of 100 in June, thought to be driven by 'ACE' community referrals. Currently circa 60 on caseload. Resetting comms with acutes also in plan.
- Struggling with B4/5 nurse recruitment – VW meeting today (8/9) to work through financial slippage options and use of agency and/or Doccla, noting need for this to be sustainable (i.e. not 'rob' staff).
- Revised bed impact trajectory to be shared with system and need to reflect slippage again operational plan.
- **UCR:** Staffing at 80-100% from Q3, plus additional capacity released through efficiencies working with VW team. Total impact is circa 25% increase in same day community nursing.
- Agreed need for better comms and mythbusting on UCR to system. Noted this impact is not in operational plan so is an 'upside' for winter.
- Benefits seen from NS Falls service implemented last winter – agreed to present at forthcoming SWAST Falls Summit.

Key risks and next steps from the discussion (2/2)

- **System CAS:** Service currently at circa 55% rota fill, separate to plan from October to move to 7/7 working. Significant risks to delivery based on need to draw in clinicians from wider system. System T&F group established by UEC ODG to resolve.
- Excitement about potential ACE model and ability for this to integrate myriad community services into most efficient and effective model (CAS, SPA, UCR, VWs, acute advice, CEMS).
- **SWAST:** Additional resourcing focussing on overnight period; online from January. Also extra clinical resourcing in EOC to deliver Cat.2 segmentation, plus move to 24/7 specialist paramedic service.
- Outstanding work to resolve ITK transfer of cases from 999 to 111 in BNSSG. Assurance also sought on rapid and responsive deployment of acute queueing SOPs (already developed).
- **Mental health:** Need to clarify Urgent Assessment Centre model and its potential to address s136 demand, and its source of funds. Ongoing work through the MH Crisis Board.
- **CYP**: to follow based on dedicated breakout session at workshop.
- **Governance:** Support for reintroduction of Winter Delivery Group reporting to WEG, as a forum bringing together key elements of winter (front door, back door, MH, community) and ability to rapidly escalate (similar to metallic structure). But it must retain tactical operational focus and an ability to make collective recommendations for WEG. A need therefore to reconcile WDG within the wider new system govance (E.g. versus ODGs).
- Agreed to review OPEL cards through this group.
- Recognised need to involve NHS@Home colleagues in winter groups.
- Feedback on system flow calls – in OPEL 2 are they necessary? But noted need for NHSE assurance.

Appendices



National requirements for System Coordination Centres

ID	Requirement	Section	Requirement Met	BNSSG Compliance
SCC – PE 1	SCC has identified board-level executive member and is supported by a Senior Responsible Officer (or equivalent).	4.2	Yes	SCC Executive lead and SRO: Lisa Manson
SCC – PE 2	SCC has sufficient resource to deliver day-to-day function in line with national operating model between 0800 & 1800 hrs.	5.2, 5.3 and 6.2.6	Yes	Mon-Fri 0800-1800: SCC delivered by UEC Performance Team (x3 team members). OOH and weekends: ICB on-call rota (strategic, tactical and call support). System clinical on call rota also in place 24/7.
SCC – PE 3	The ICB will ensure that they either have SCC room leadership with active clinical registration (GMC, NMC or HCPC), or an operating structure that enables input from senior clinicians in the ICB	5.4	Yes	System clinical on call rota in place 24/7 with role card descriptor, including a range of ICB clinicians.
SCC – PE 4	SCC Director on-call cover is in place between 1800 & 0800 hrs.	5.5	Yes	SCC director and tactical on-call cover 24/7, including out of hours and weekends. During in hours (0800-1800) they are on-call, however the SCC is managed by the UEC Performance Team.
SCC – PR 1	The SCC can demonstrate board-level presentation of SCC operations to the specification set out in the specification.	4.4	Yes	Lisa Manson SRO, ICB Board Member. SCC updates are provided as part of wider Winter assurance plans to various boards and committees and required.
SCC – PR 2	The SCC has membership of relevant clinical governance and quality assurance forums as required.	4.5	Yes	Lisa Manson is a member of the ICB Putcomes, Quality and Performance Committee. Work is live with the System Quality Group with a project to quantify and compare clinical risks in different parts of the system to inform SCC and provider decision making.
SCC – PR 3	SCC's role and responsibility are clearly laid out in system escalation and governance frameworks, including but not limited to surge management, ambulance handover process and incident management.	4.6	Yes	This information is detailed in the SCC System Management and Escalation policies and SOPs; which are available on Frontier (https://bnssg.my.faculty.ai/home) within document storage and published in the BNSSG ICBs on-call pack. In the event of an incident the BNSSG ICB Incident Response Plan (IRP) details additional responsibilities for the individual roles within the SCC. The IRP is available in the BNSSG ICBs on-call pack.
SCC – PR 4	SCC has an SOP in place that captures the daily operational cadence and reflects roles and responsibilities under the OPEL Framework. This will include the upload of the ICB OPEL onto the NHSE national database.	6.1 and 6.2	Yes	This information is detailed in the SCC System Management and Escalation policies and SOPs; which are available on Frontier (https://bnssg.my.faculty.ai/home) within document storage and published in the BNSSG ICBs on-call pack. This includes OPEL action cards for the system and providers, and standard cadences for system calls which occur 7/7 at 11am. This information is also outlined in the BNSSG ICBs on-call system management and escalation training slides.
SCC – PR 5	SCC will have SOPs to track, assure and validate submissions to NHS England national and regional teams as specified.	6.2	Yes	The SCC has an NHSE returns tracker and log in place. Data quality controls are in place for provider OPEL submissions, the metrics for which are updated every 6-12 months.
SCC – PR 6	SCC will maintain appropriate records in line with the NHS England's Corporate record management policy.	6.2.4	Yes	The SCC adheres to the BNSSG ICBs Records Management Policy, which aligns with the NHSE policy. This includes inbox management, note taking and action log tracking.
SCC – PR 7	SCCs will provide 7-day cover in-line with the regional/national operational model between 0800 and 1800 hrs, with a provision contained within a localised SOP to increase cover as required.	6.2.6	Yes	Mon-Fri 0800-1800: SCC delivered by UEC Performance Team (x3 team members). OOH and weekends: ICB on-call rota (strategic, tactical and call support). System clinical on call rota also in place 24/7. This is reviewed during periods of escalation or incident management. This information is detailed in the SCC System Management and Escalation policies and SOPs; which are available on Frontier (https://bnssg.my.faculty.ai/home) within document storage and published in the BNSSG ICBs on-call pack.
SCC – PR 8	SCC has real time digital software and a process to monitor in real time, the minimum key metric set detailed in section 7.2.1 to 7.2.10 to allow rapid identification of risks and required intervention. These will also be accessible to the DOC and relevant clinical support for the SCC.	7.2	Yes	The BNSSG System UEC Live Dashboard (Frontier) includes real time feeds for a number of providers across the system including SWAST, 111, AWP, acute trusts, NHS@Home and GPOOH. Frontier is accessible to the whole system, and has been promoted with all members of the ICB and provider on-call teams.
SCC – PR 9	SCC must have digital software that can add or evolve 'wider' system pathway metrics as part of real time process.	7.3.1	Yes	The ICB, through the Care Traffic Coordination Centre programme, is adding additional system pathway metrics including GP data, NCTR, UTC/MIU statuses, and social care data.
SCC – PR 10	SCC digital software must be accessible through both 'desktop' and mobile devices.	7.3.2	Yes	Frontier is available on both desktop and mobile devices.
SCC – PR 11	SCC digital software must have the capability to set notifications that alert / notify when pre-determined thresholds or parameters have been breached.	7.3.3	Yes	This is captured in the specification for CTCC and available in the Frontier system via Superset technology.

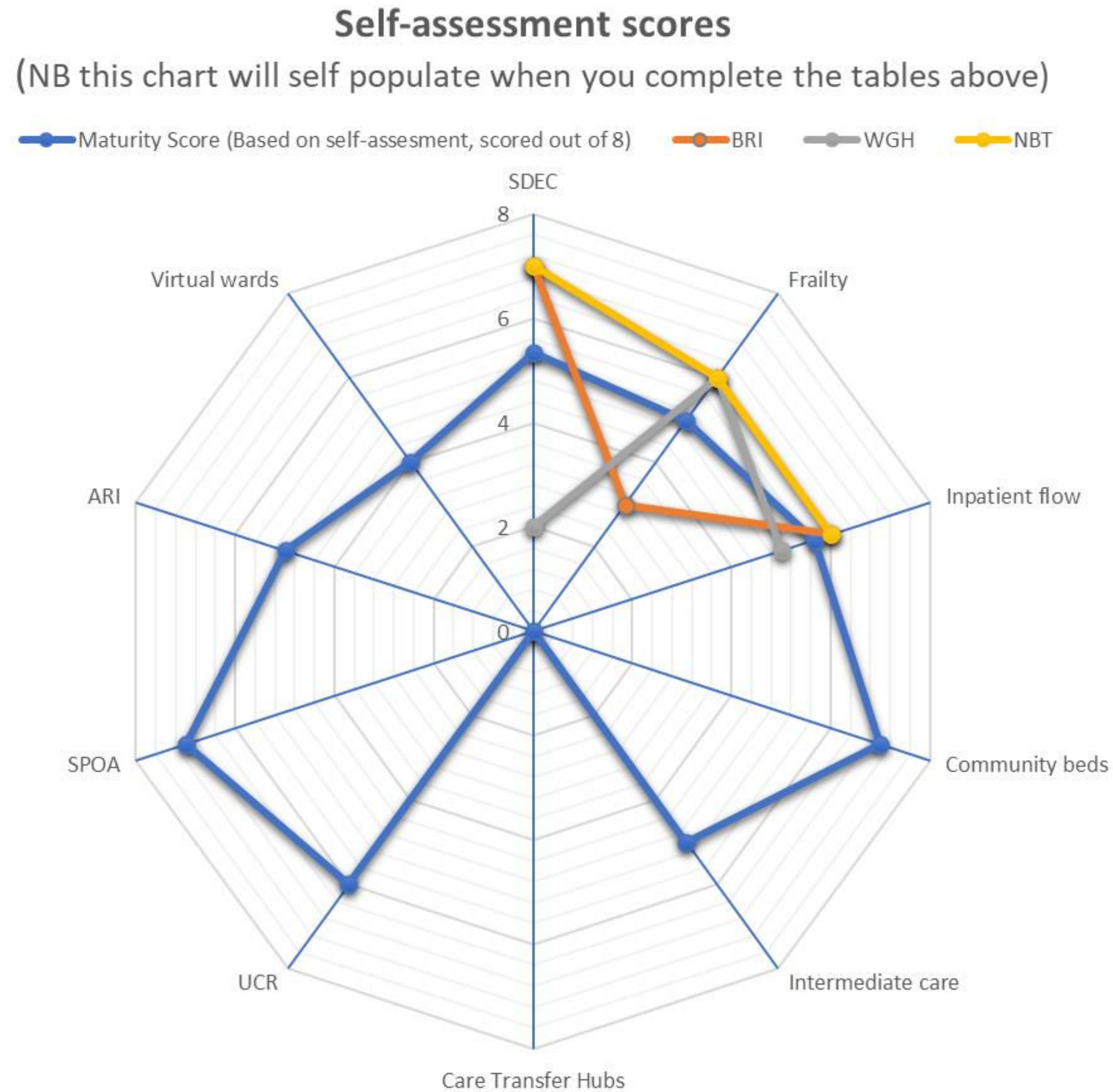
New OPEL framework – key points

- Nationally mandated approach based solely on 9 acute-focussed metrics as proxies for system flow. Exception is the inclusion of all types ED metrics (UTCs/MIUs) – but definitions to be confirmed.
- ICS OPEL score must be reported to NHSE as an aggregation of the 9 acute metrics only.
- Requirement to automate both data collection and submission to national systems.
- To be gathered daily by 10am at a minimum.
- Technical guidance including parameters/ thresholds not released – expected in time for delivery from end of calendar year.
- Current BNSSG OPEL approach is based on 19 acute metrics plus bespoke suite of metrics in all ICS provider organisations.
- Initial proposal is to integrate the new acute metrics into the existing OPEL approach, and so retain OPEL approach for all non-acute providers.

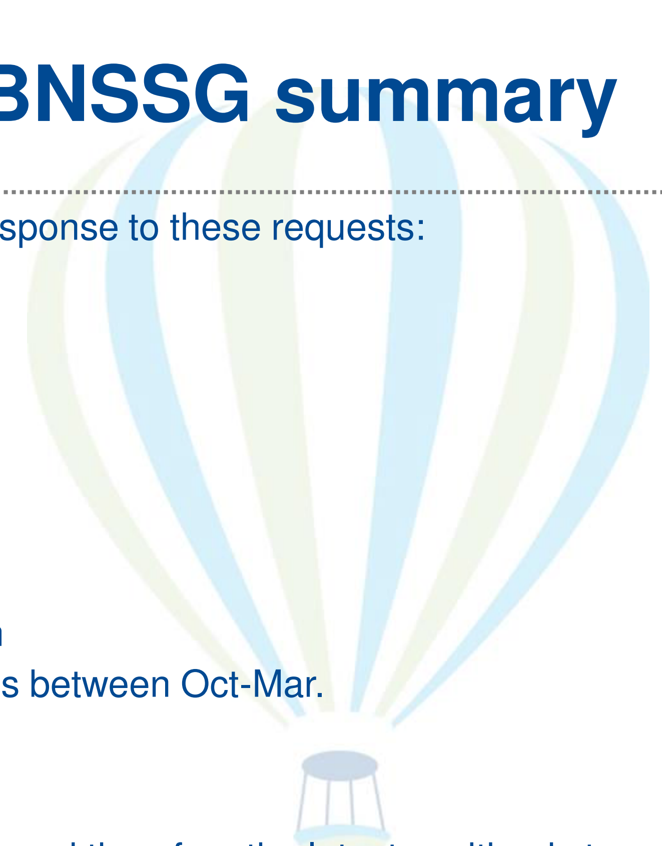
New OPEL framework – initial feasibility assessment

Ref	OPEL Parameter Name	NHSE descriptor	BNSSG comments	Current feasibility
1	Mean ambulance handover time (mins)	Mean time from ambulance patient arrival to clinical handover within the last 60 minutes. Clinical handover is defined as handover of clinical information and transfer of patient to hospital trolley.	Data source needs to be from ambulance service. This feed is not setup in BNSSG, and not available through NACC or the SWASFT OL334. Support form NHSE required and BNSSG preferred method is to incorporate this into the NHSE NACC feed. Smarter SWASFT sharing of data requested amongst south west partners (open APIs etc).	Amber
2	ED all-type 4-hour performance	Percentage of all type attendances admitted, discharged or transferred within 4-hours since midnight. This is excluding booked appointments.	Need to confirm on BNSSG apportionment of type 3 A&E departments in this declaration. Live feed establishment from Sirona Adastra required ASAP to allow this.	Amber / Red
3	ED all-type attendances	The number of all-type attendances at the hospital within the past 60 minutes. This should be compared to the expected or anticipated number of attendances, which must be established and agreed locally based on historical demand. This can be a consistent hourly average or an average that considers varying attendances throughout a 24-hour period.	As above. BNSSG discussion and agreement required on attendance prediction profiles to use in this declaration e.g. rolling 6 versus ‘nowcasting’ from random forest methodology.	Amber / Green
4	Majors and resuscitation occupancy (adult)	Percentage occupancy of adult majors and resus at time of assessment. Occupancy should be calculated as the sum of all patients in adult ED who require a majors space (regardless of whether they are receiving care in a traditional space or an escalation area), divided by the maximum number of patients who can be cared for in major and resus areas, as stated in the acute hospital OPEL statement.	Acutes to provide	Amber / Green
5	Median time to treatment	Median total time between patient arrival at ED and the time that the patient is seen by a clinical decision-maker at time of review. Clinical decision-maker is a care professional who can define the management plan and discharge the patient or diagnose the problem and arrange or start definitive treatment as necessary.	Acutes to provide	Amber / Green
6	% of patients spending >12 hours in ED	Total number of patients spending over 12 hours in ED from time of arrival to time of review as a percentage of total number of patients in ED at time of review.	Acutes to provide	Amber / Green
7	% G&A bed occupancy	Percentage bed occupancy of hospital at time of OPEL assessment. To be calculated as the sum of patients occupying all open G&A beds (including assessment units). Below 92% occupancy should not be considered as a target, the correct level will vary locally. This should be considered alongside the other metrics.	Acutes to provide	Green
8	% of open beds that are escalation beds	Percentage of escalation beds as a proportion of the G&A bed base open at the time of OPEL assessment. Escalation beds are those considered in line with A&E SitRep definitions. The denominator should be the G&A beds in the acute hospital SitRep.	BNSSG comments on using a variable figure for nominator and fixed figure for denominator.	Amber / Green
9	% of beds occupied by patients no longer meeting C2R	Percentage of open beds occupied by patients NCTR at time of OPEL assessment. Denominator should be the number of beds on the acute hospital SitRep.	Acutes to provide. Dependent on frequency of NCTR ‘count’.	Amber

10 high impact interventions & BNSSG Maturity



23/24 Winter plan: numerical submission - BNSSG summary



The following details the requirements from the NHSE winter numerical return and our proposed response to these requests:

1. Restate plans for demand metrics, e.g., NEL admissions. [Optional]
    a. Response = The plans have been reviewed and no changes are suggested at this stage.

2. Restate actuals for activity metrics. [Optional]
    a. Response = No requirement to restate.

3. Review the split of G&A beds by core and escalation from the 23/24 operational plan submission
    a. Response = Both trust bed models did not include the requirement for any escalation beds between Oct-Mar.

4. Supply additional escalation capacity available by trusts
    a. Response = Latest trust plans do not require the use of any additional escalation capacity and therefore the latest position is to submit zero for this section. ***However, pending clarification from NHSE, this may be challenged on the basis it does not show the ability to flex capacity to meet unplanned levels of demand.***

5. Supply ICB level monthly plans for the community beds available
    a. Response = Submission will reflect current bed volumes for Oct-23 (313), then a reduction to 238 from Nov-23 for the remainder of the year, in line with D2A proposals and shift to non-bedded pathways.

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