BNSSG Quality Report

June Report on Month 1
(April data) 2024/25

Developed in June 2024 with contributions from across the Quality and Patient Safety Team.

Quality Report – Health Care Acquired Infections (HCAI) Summary
Reporting Period – Month 1 2024/25 – April data
Information Source and date of information – UK Health Security Agency (UKHSA), ICS HCAI Lead

Infection	Rolling 12 Month Trend	2024/25 Thresholds	2024/25 YTD	2023/24 Position Month 1	2022/23 Position Month 1
C. difficile			35	26	23
E. coli			53	37	42
MRSA			3	1	4
MSSA			10	12	16
Klebsiella spp			15	10	11
Pseudomonas aeruginosa			10	5	3

Rates per 100k	South West Position									
	BSW	BNSSG	Devon	Dorset	Glos	Kernow	Somerset	SW	England	BNSSG
C. diff	29.88	29.12	32.04	33.69	31.62	42.04	31.00	32.25	27.43	1
E. coli	58.44	54.83	84.50	87.16	37.08	79.93	83.61	69.49	68.66	2
MRSA	1.73	3.21	1.26	1.95	0.44	1.16	1.17	1.66	1.48	7
MSSA	20.60	20.42	29.68	26.73	14.04	29.25	29.32	24.32	21.91	2
Pseud A	7.95	5.58	5.50	8.91	3.69	5.82	7.04	6.36	7.24	3
Kleb spp	17.03	17.02	20.81	25.88	16.55	23.76	25.13	20.46	21.27	2

Quality Report – Health Care Acquired Infections (HCAI) ICB Overview
Reporting Period – Month 1 2024/25 – April data
Information Source and date of information – UK Health Security Agency (UKHSA), ICS HCAI Lead

Performance for April 2024

- **CDI = 35, HOHA = 15 (NBT - 5, UHBW - 10), COCA = 15, COHA = 4, COIA = 1**
- **E. coli = 53, HOHA = 10 (NBT - 6, UHBW - 4), COCA = 30, COHA = 13**
- **MRSA = 3, HOHA = 1 (NBT - 1, UHBW - 0), COCA = 2, COHA = 0**
- **MSSA = 10, HOHA = 4 (NBT - 2, UHBW - 2), COCA = 3, COHA = 3**
- **Klebsiella spp = 15, HOHA = 6 (NBT - 3, UHBW - 3), COCA = 6, COHA = 3**
- **Pseudomonas aeruginosa = 10, HOHA = 4 (NBT - 0, UHBW - 4), COCA = 5, COHA = 1**

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

BNSSG Annual Standard

- Thresholds for 2024/25 will be included when available.
- Both ICB and secondary care threshold levels will be 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.

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.

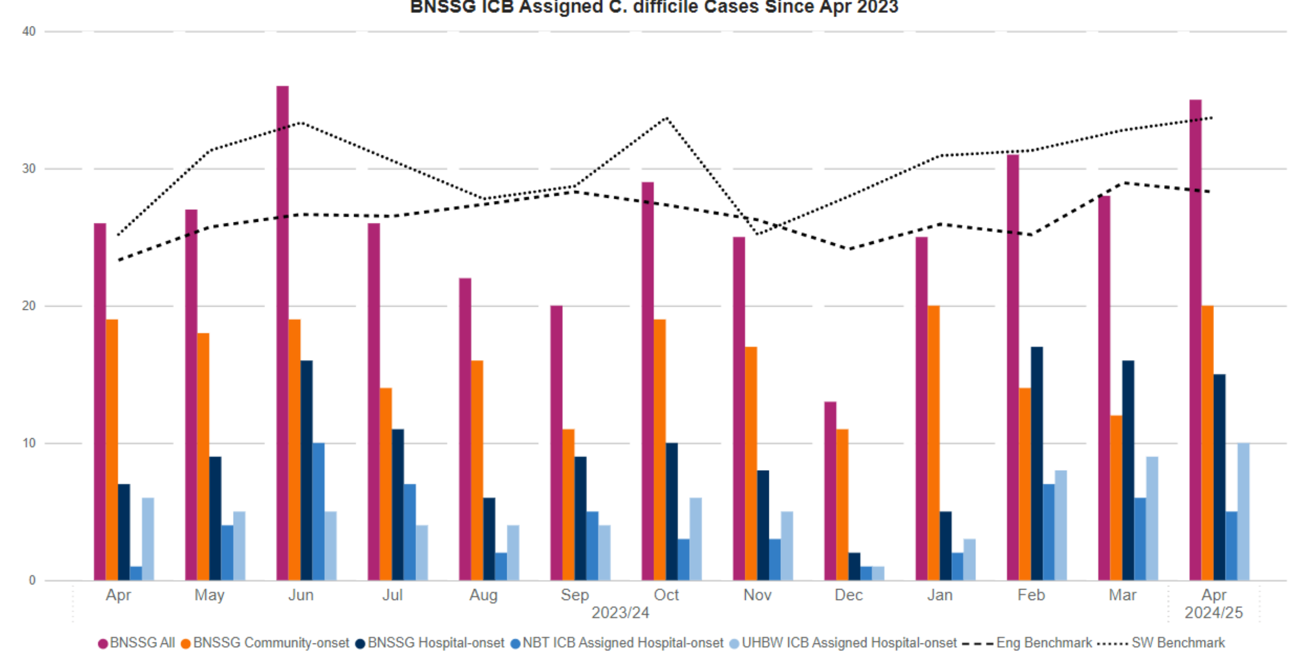
Special focus on Hospital Onset HCAI this month.

Infection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Threshold to Date	Cases YTD	Threshold	23/24 FYTD	22/23 FYTD
C. difficile	35													35		26	23
E. coli	53													53		37	42
Klebsiella spp	15													15		10	11
MRSA	3													3		1	4
MSSA	10													10		12	16
Pseudomonas aeruginosa	10													10		5	3

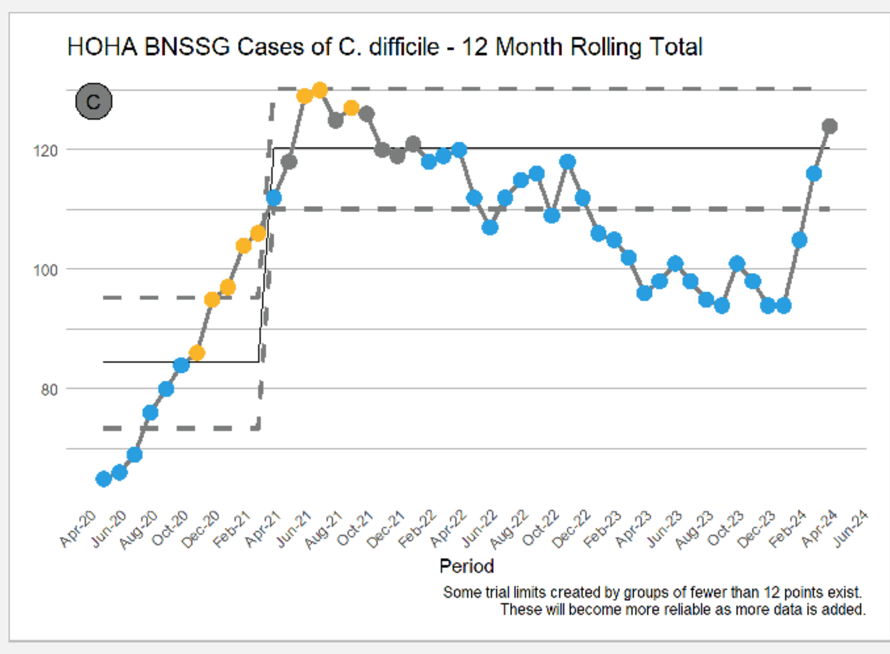
Commentary

- MRSA- Zero tolerance has not been achieved. There were 3 cases in April (1 HOHA, 2 COCA).
- CDI- The 35 cases are currently categorised as follows: New infection (30), Continuing infection (2), Repeat/Relapse (2), Unknown (1).
- E.coli- the majority of the 53 cases continue to be Community Onset (43).

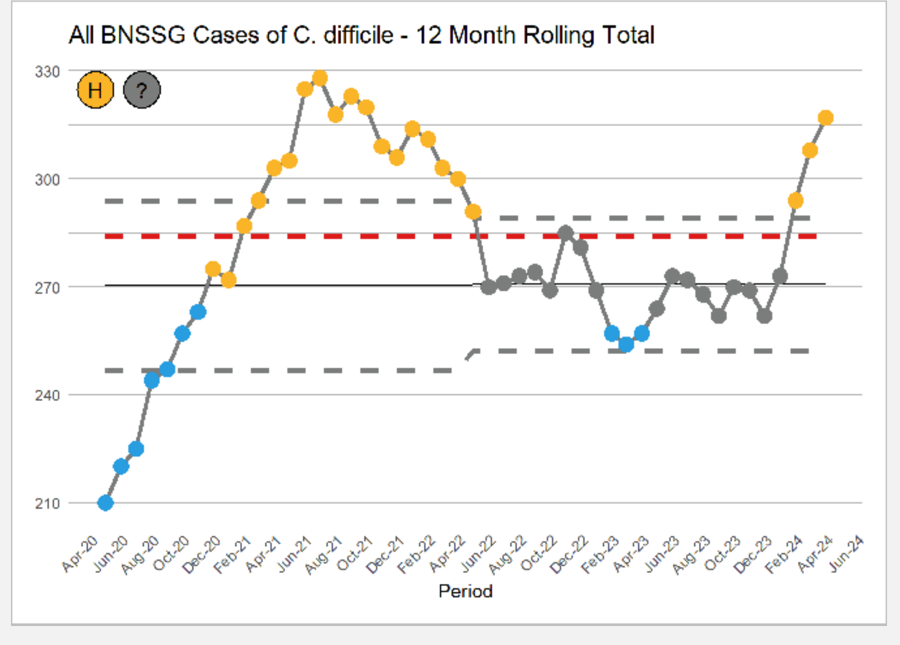
C. difficile	35
HOHA	15 (NBT - 5, UHBW – 10)
COCA	15
COHA	4
COIA	1
Unknown	0



HOHA CDI: Common cause variation indicating no significant change.

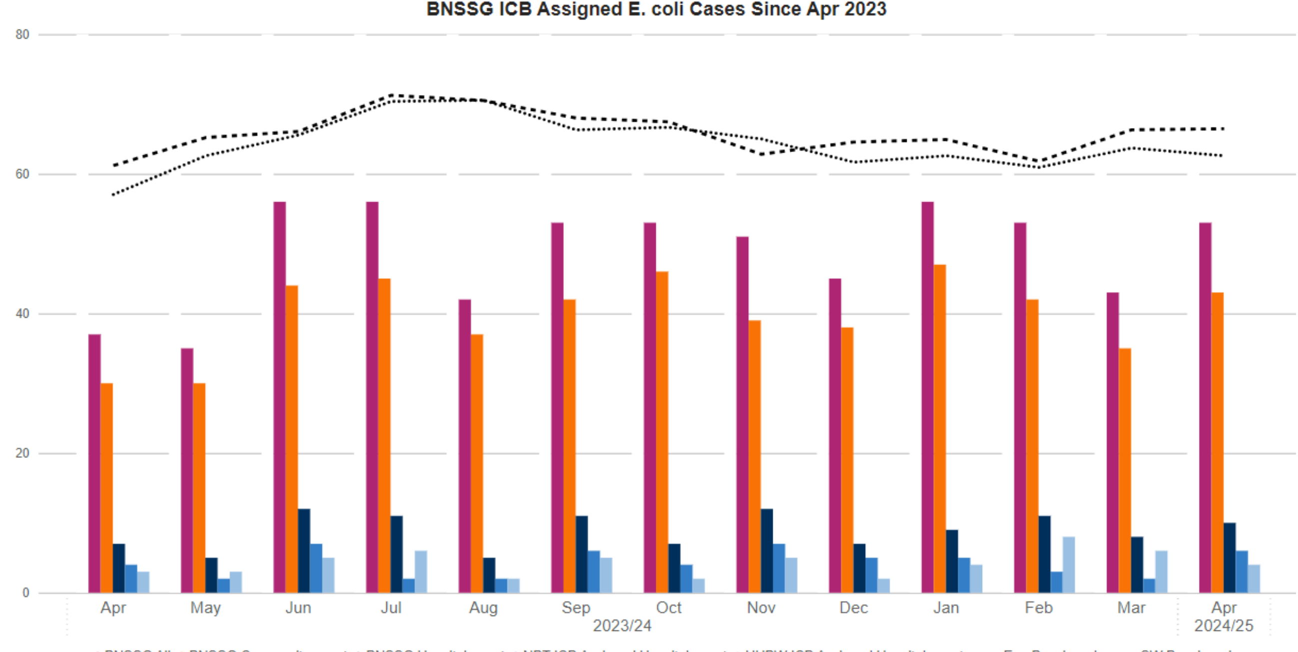


All BNSSG CDI: Special cause variation of concerning nature due to higher values, indicating inconsistently meeting/missing target.

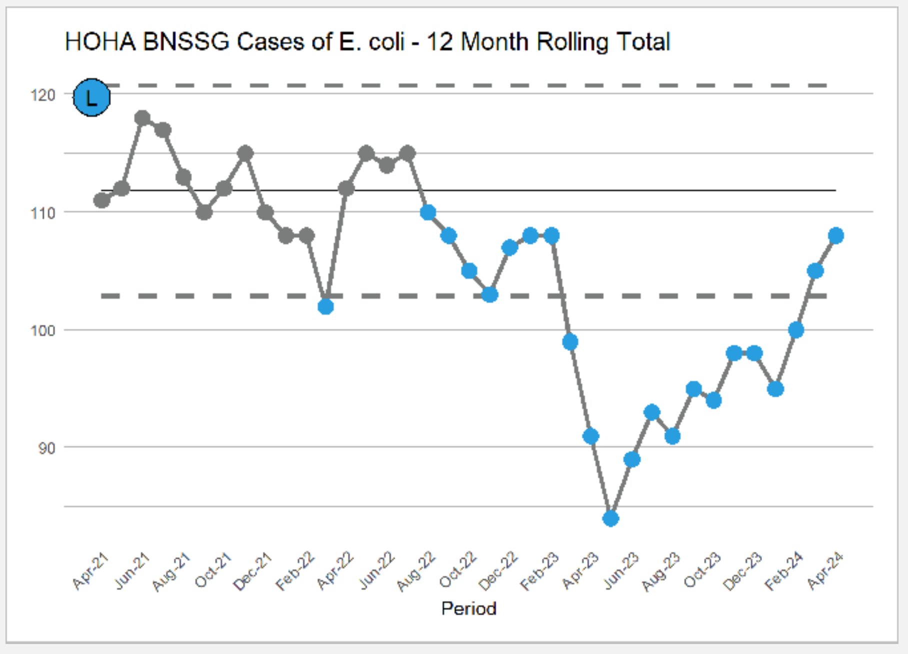


Quality Report – Healthcare Acquired Infections - Supporting Analysis

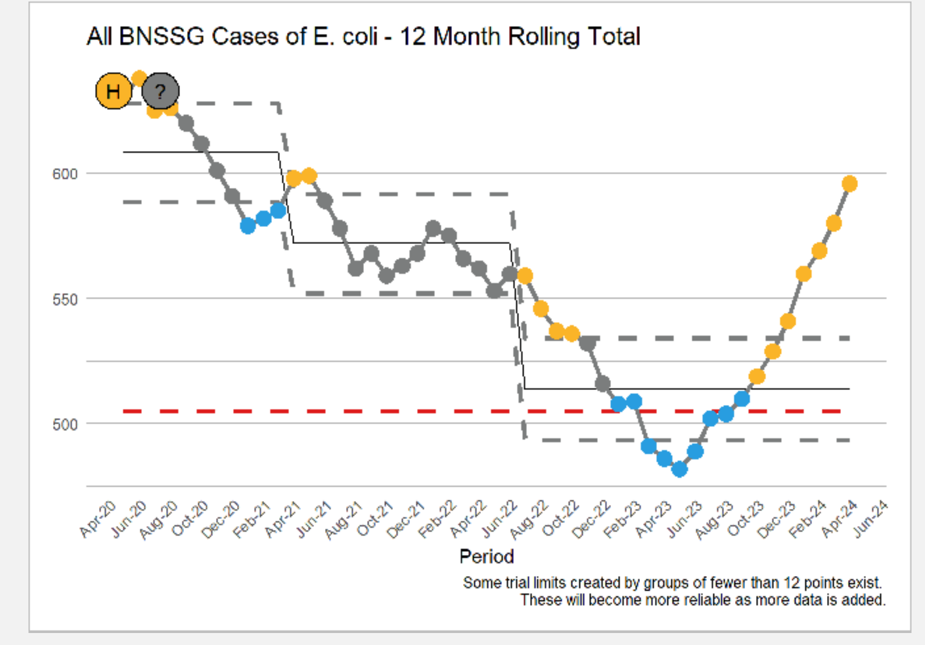
E. coli	53
HOHA	10 (NBT - 6, UHBW – 4)
COCA	30
COHA	13
COIA	0
Unknown	0



HOHA E. coli: Special cause variation of improving nature or lower pressure due to lower values.

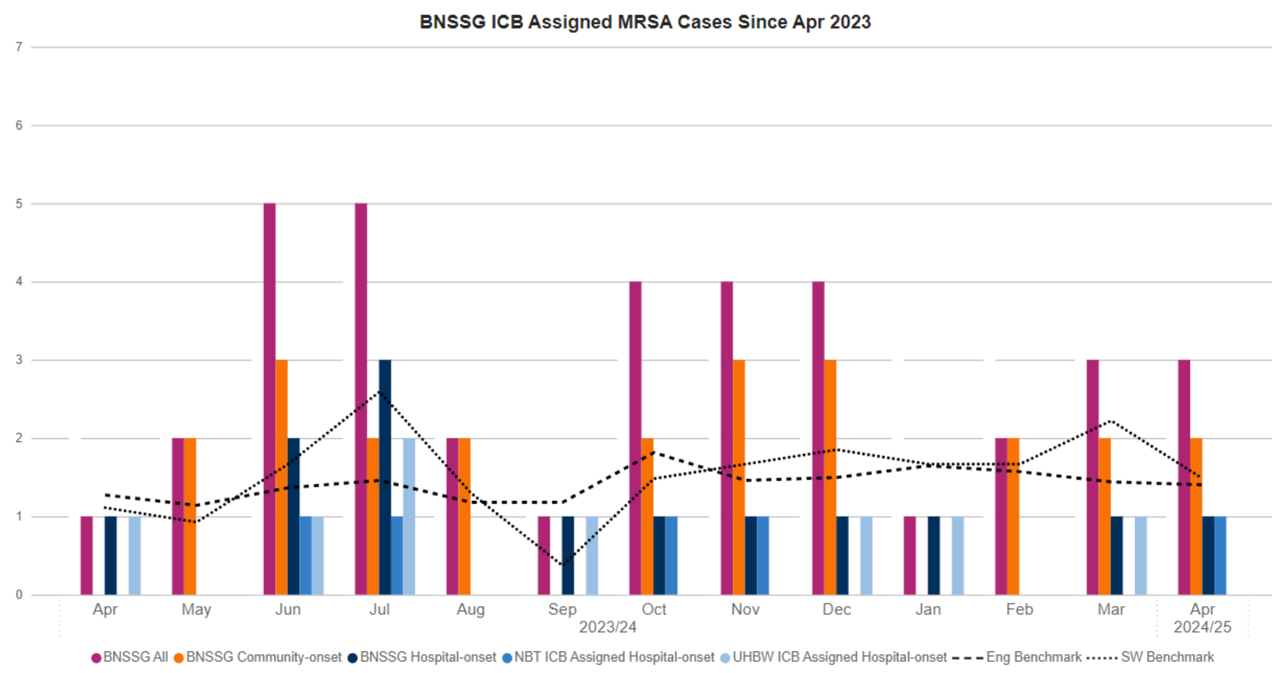


All BNSSG E. coli: Special cause variation of concerning nature or higher pressure due to higher values. Inconsistently passing and missing target.

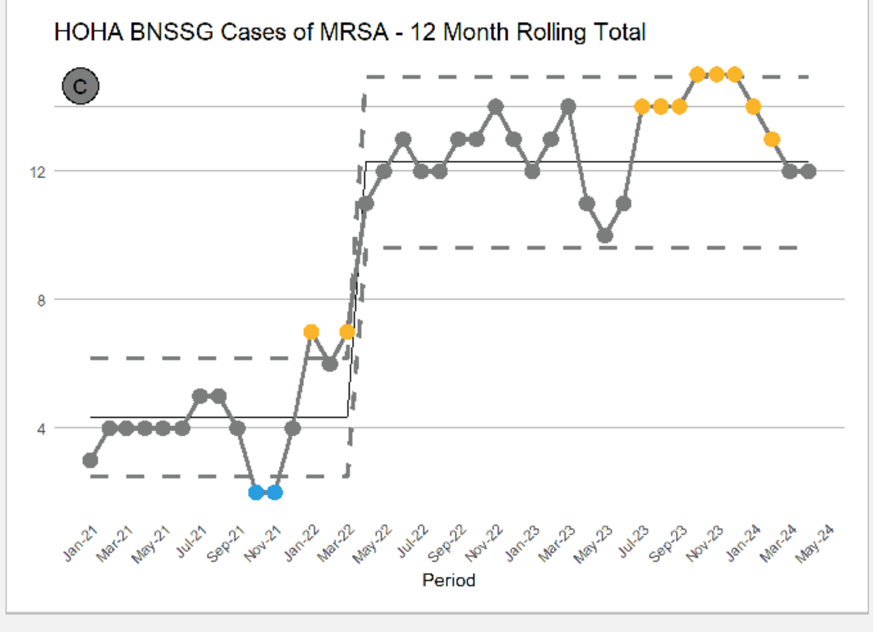


Quality Report – Healthcare Acquired Infections - Supporting Analysis

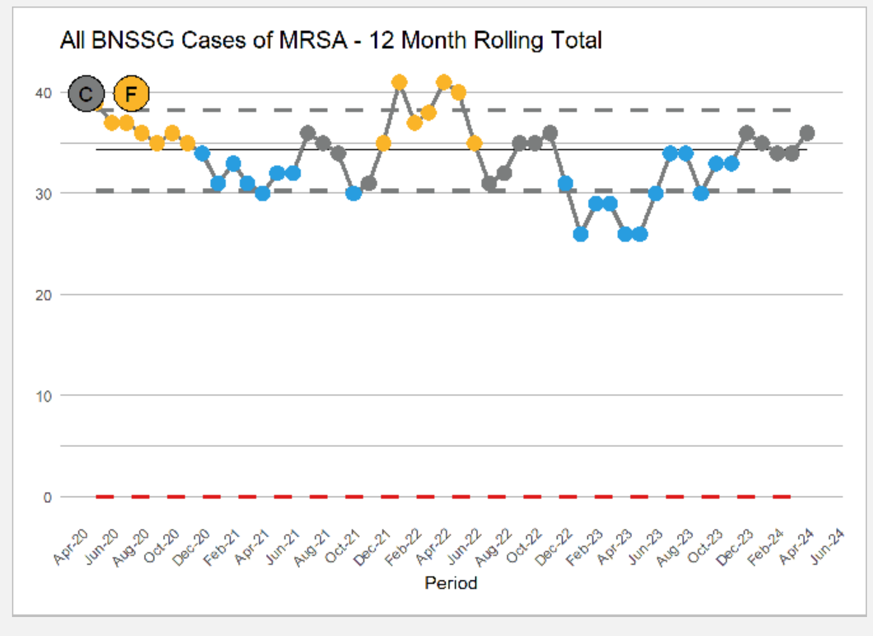
MRSA	3
HOHA	1 (NBT - 1, UHBW – 0)
COCA	2
COHA	0
COIA	0
Unknown	0



HOHA MRSA: Special cause variation of concerning nature or higher pressure due to higher values.

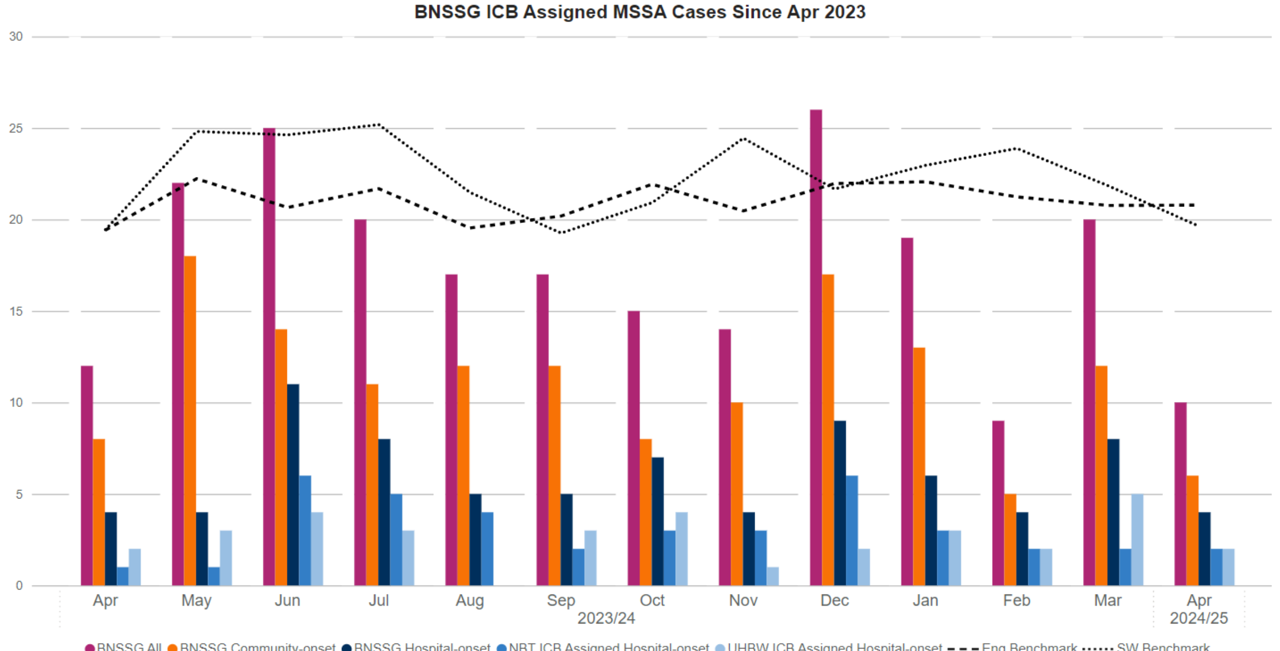


All BNSSG MRSA: Common cause variation indicating no significant change, however consistently falling short of the target.

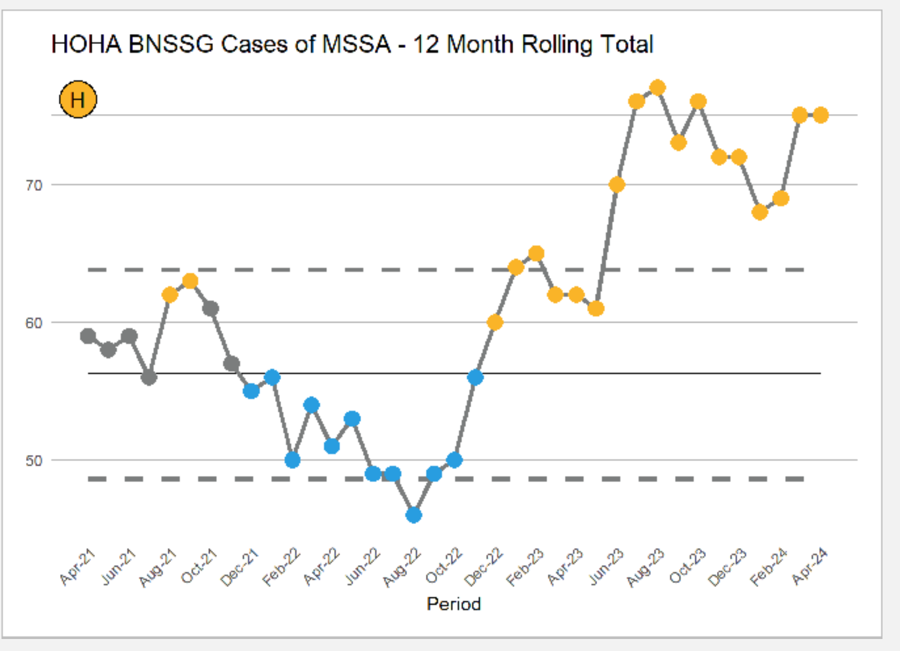


Quality Report – Healthcare Acquired Infections - Supporting Analysis

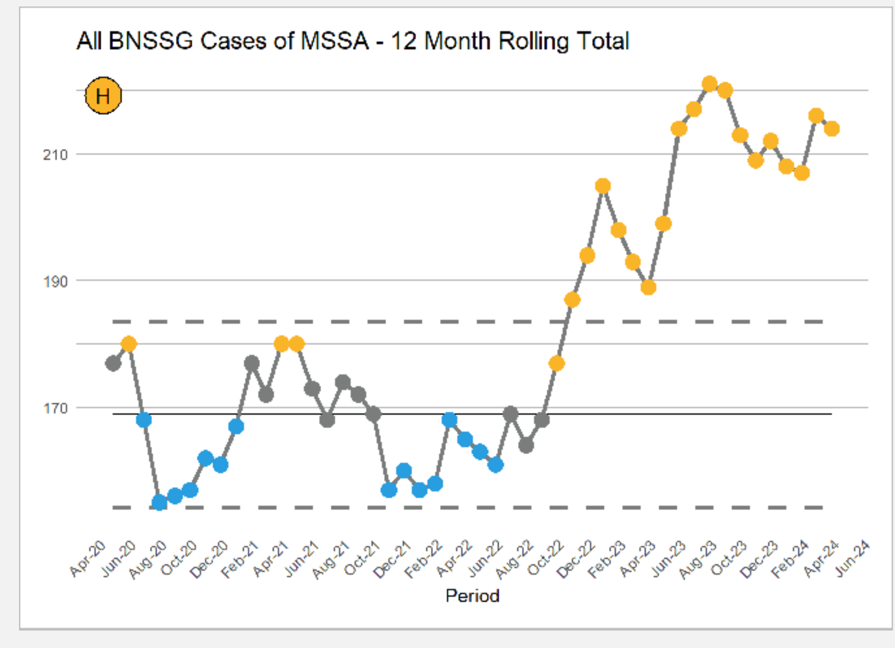
MSSA	10
HOHA	4 (NBT – 2, UHBW – 2)
COCA	3
COHA	3
COIA	0
Unknown	0



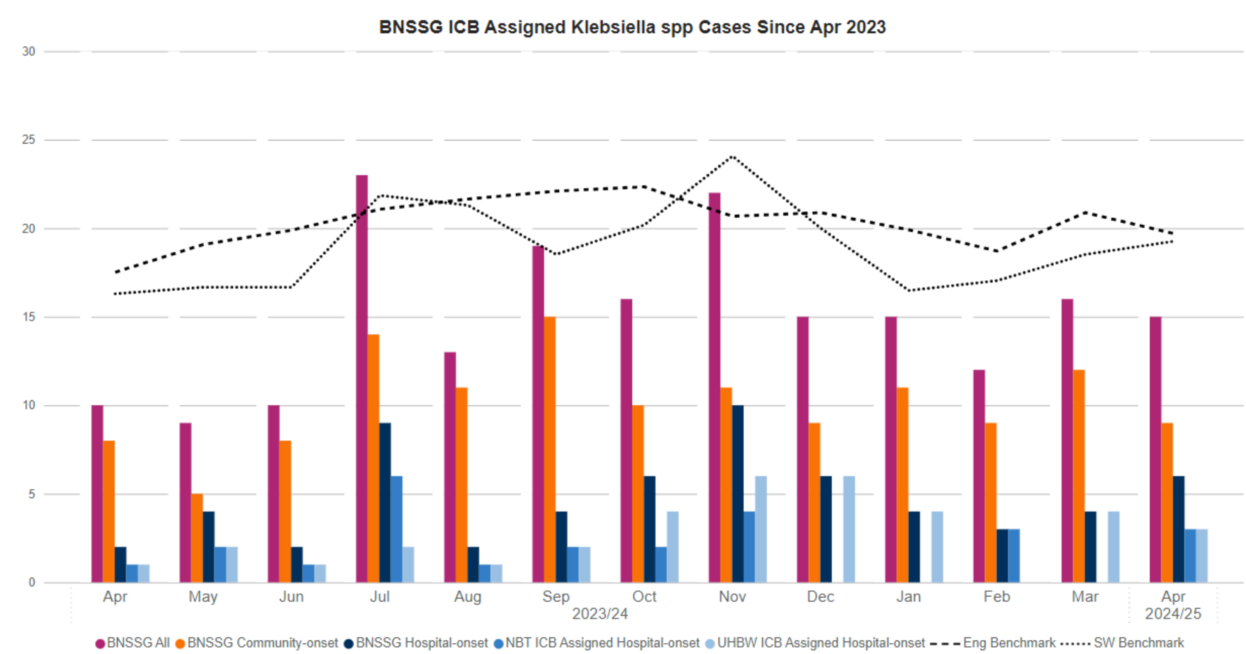
HOHA MSSA: Special cause variation of concerning nature or higher pressure due to higher values.



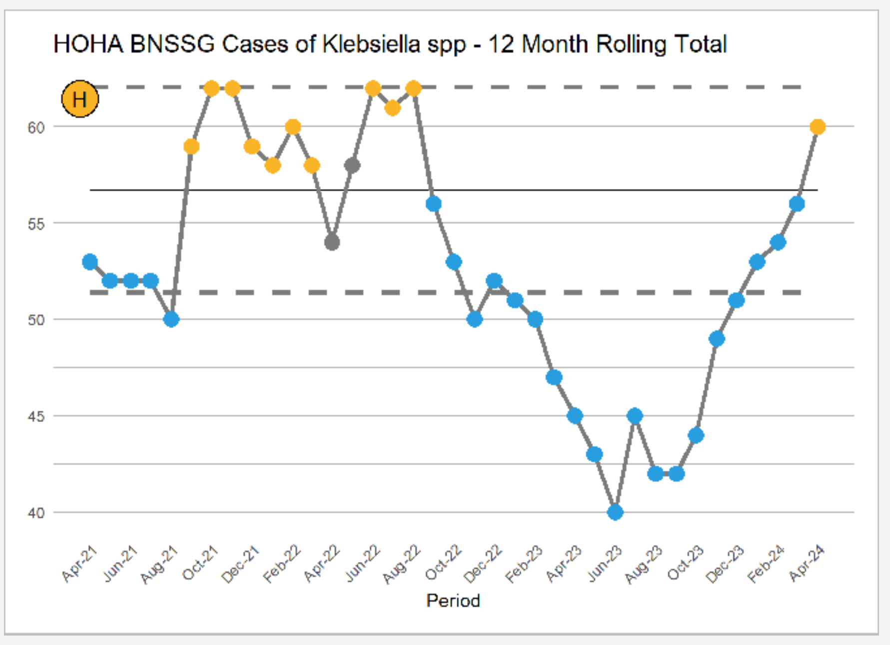
All BNSSG MSSA: Special cause variation of concerning nature or higher pressure due to higher values.



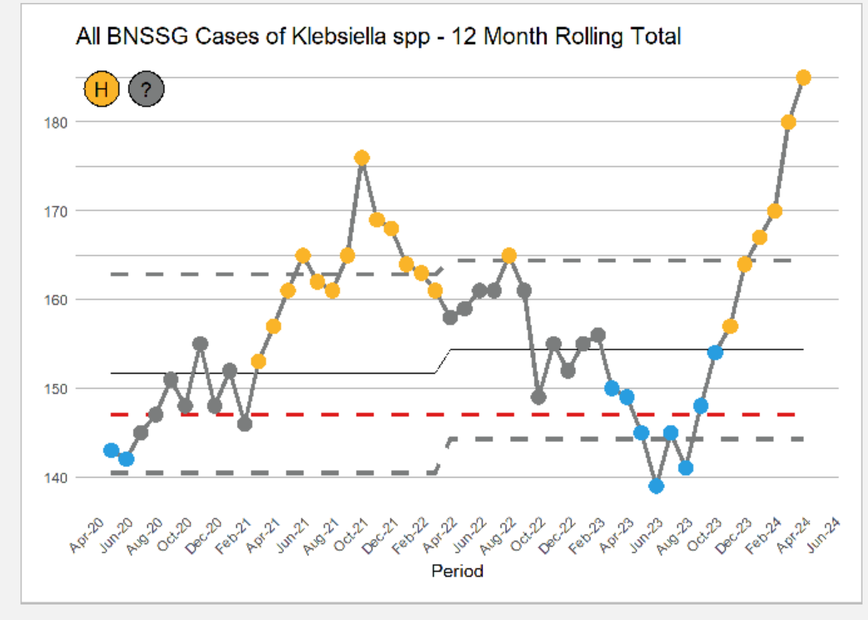
Klebsiella spp	15
HOHA	6 (NBT - 3, UHBW – 3)
COCA	6
COHA	3
COIA	0
Unknown	0



HOHA Klebsiella spp: Special cause variation of improving nature or lower pressure due to lower values.

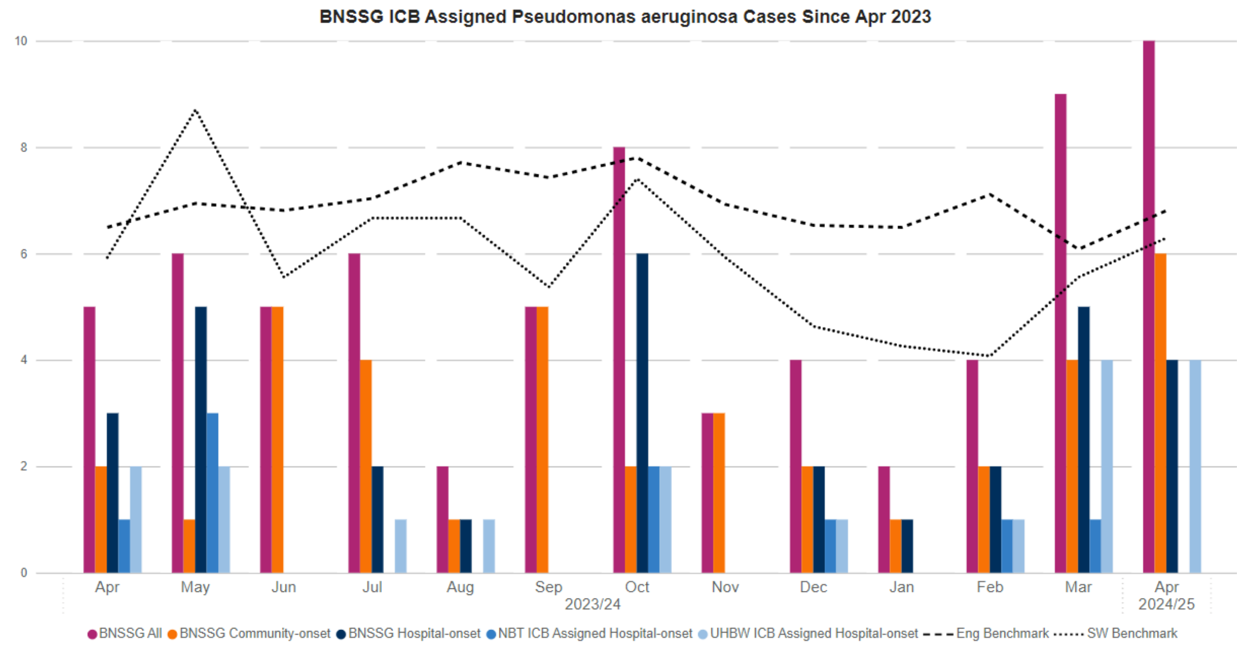


All BNSSG Klebsiella spp: Common cause variation indicating no significant change, however inconsistently passing and missing target.

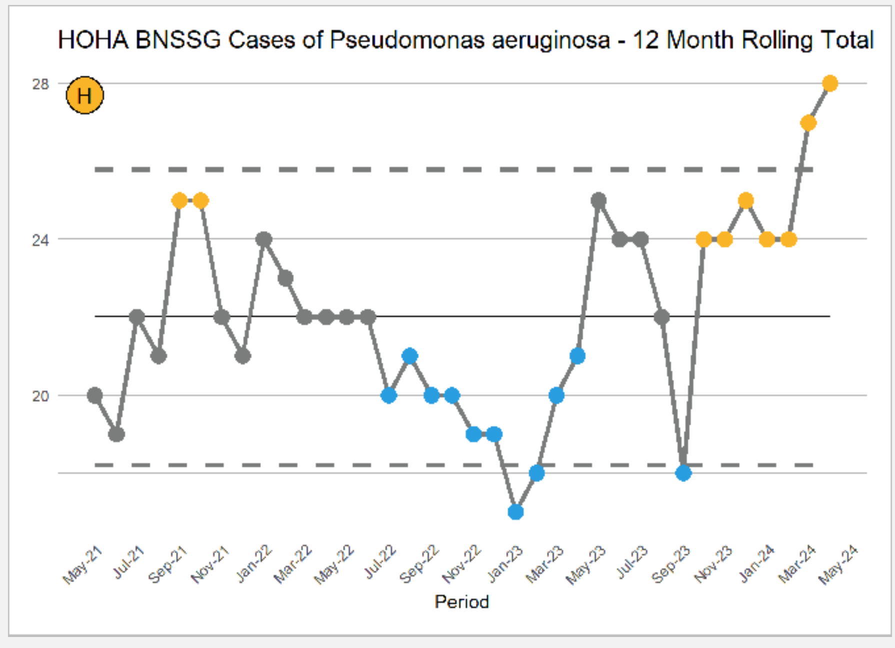


Quality Report – Healthcare Acquired Infections - Supporting Analysis

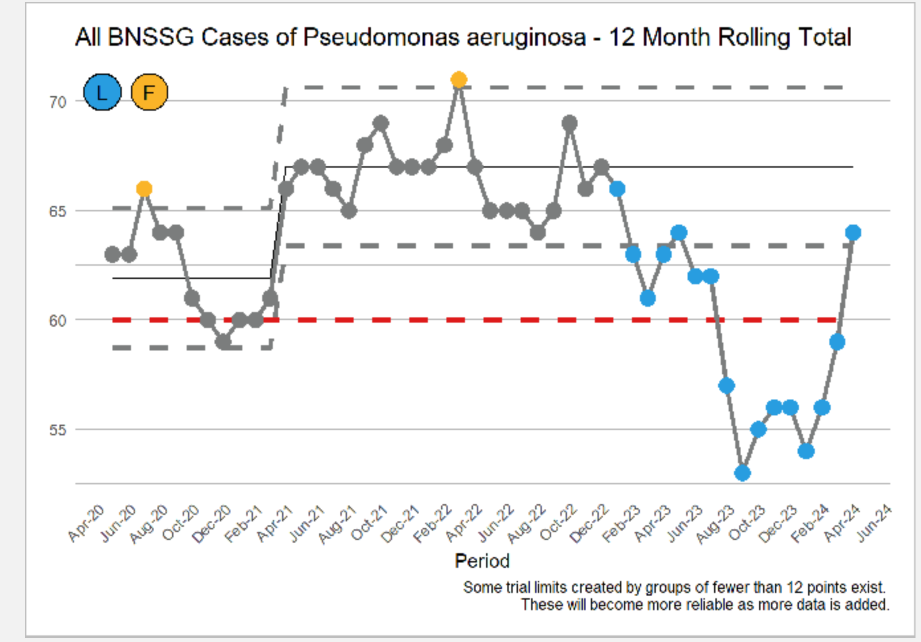
Pseudomonas aeruginosa	10
HOHA	4 (NBT - 0, UHBW – 4)
COCA	5
COHA	1
COIA	0
Unknown	0



HOHA Pseudomonas aeruginosa: Common cause variation indicating no significant change.



All BNSSG Pseudomonas aeruginosa: Special cause variation of improving nature or lower pressure due to lower values. Indicating consistently missing target.

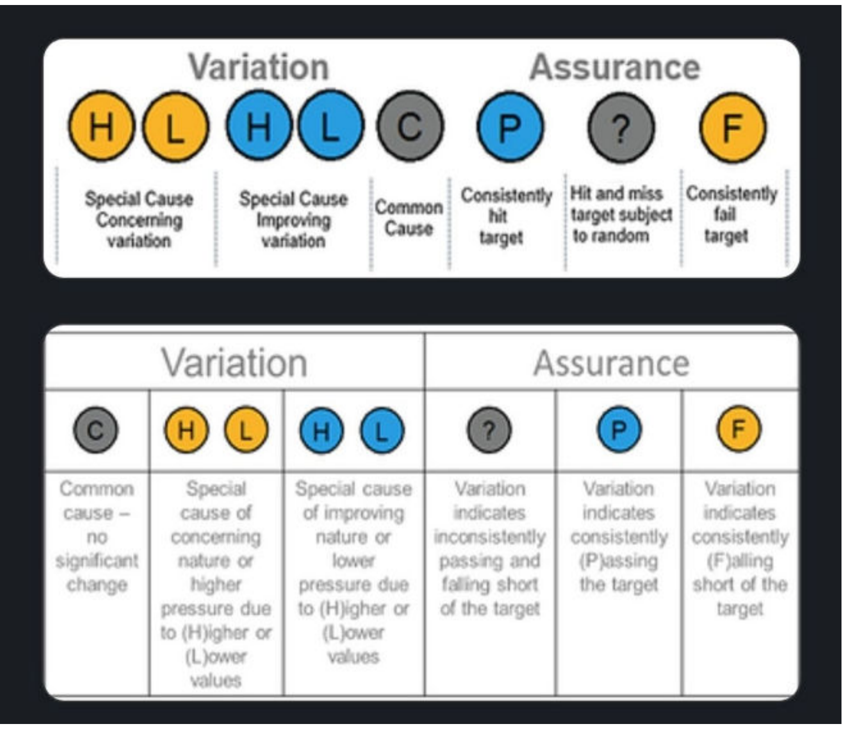


12 Months Rolling to Q4 2022/23 – All Systems

Infection	Onset / Sex	Age-sex standardised infection rates per 100k	Count of Infection (12 months rolling)	Comments
E. Coli	All/All	System value (CCG Quartile 1): 56.8 Peer median (CCG Quartile 2): 61.1 CCG median: 67.1 56.8 is in CCG quartile 1 - Lowest 25% (green)	Q1 20/21 – Q4 23/24	• Our system value is in the lowest quartile • Our peer systems are in the second quartile.
P.aeruginosa	All/All	System value (System Quartile 3): 2.6 Peer median (System Quartile 1): 1.6 System median: 2.5 2.6 is in System quartile 3 - Mid-High 25% (amber / red)	Q1 20/21 – Q4 23/24	• Our system is in the third quartile • Our regional peers are in the first quartile.

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.

		Passing			
		Assurance			Total
		Passing the target	Hit & miss	Falls below the target	
Improving / Variation	Special Cause Improving	P1	H1	F1 Pseudomonas aeruginosa Cases BNSSG Wide	1
Variation	Common Cause	P2	H2	F2 MRSA Cases BNSSG Wide	1
Variation	Special Cause Concerning	P3	H3 E. coli Cases BNSSG Wide Klebsiella spp Cases BNSSG Wide C. difficile Cases BNSSG Wide	F3	3



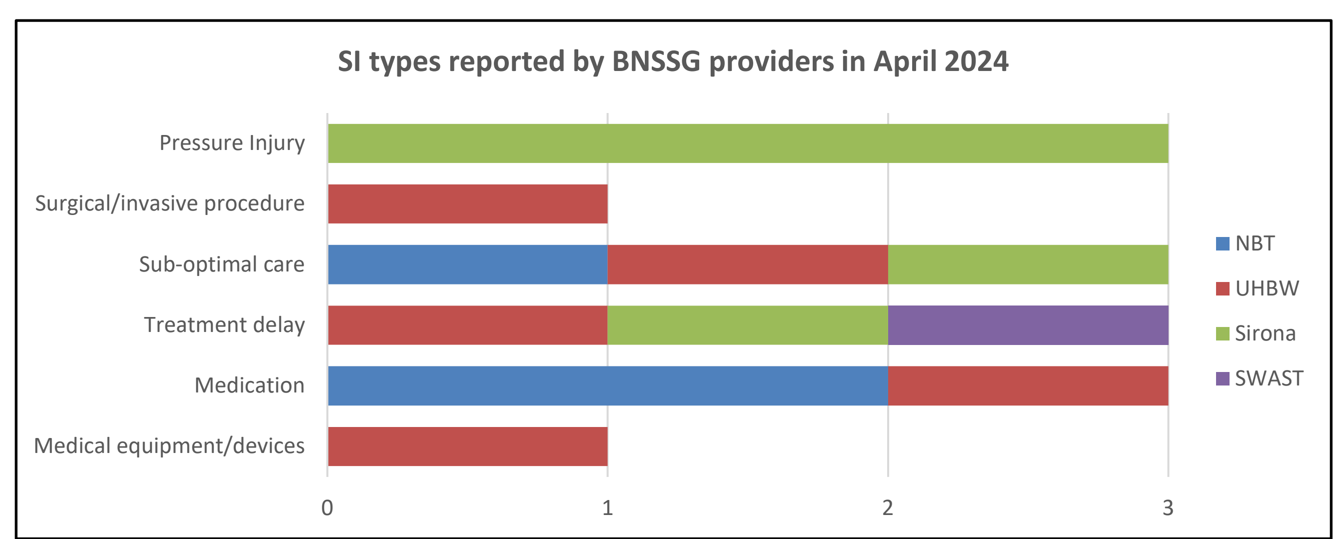
SPC Xmr diagrams were made using the NHS Plotthedots R Package. The icons above represent the meaning as above.

Nursing & Quality - Serious Incidents including Never Events
Reporting Period – Month 1 2024/25 – April data
Information Source and date of information – SI Tracker 14/06/2024

Current Month Overview
- In April 2024, 14 Significant Incidents (SIs) were reported across BNSSG partners.
- Pressure Injury and medication incidents were the leading themes for reported events in April.

SIs reported across BNSSG 2024/25		
Provider	**Apr**	**YTD SIs**
NBT	3	3
UHBW	5 (1)	5 (1)
Sirona	5	5
AWP	0	0
SWASFT	1	1
GP	0	0
Other	0	0
Total	14 (1)	14 (1)

** In brackets are NEs reported*

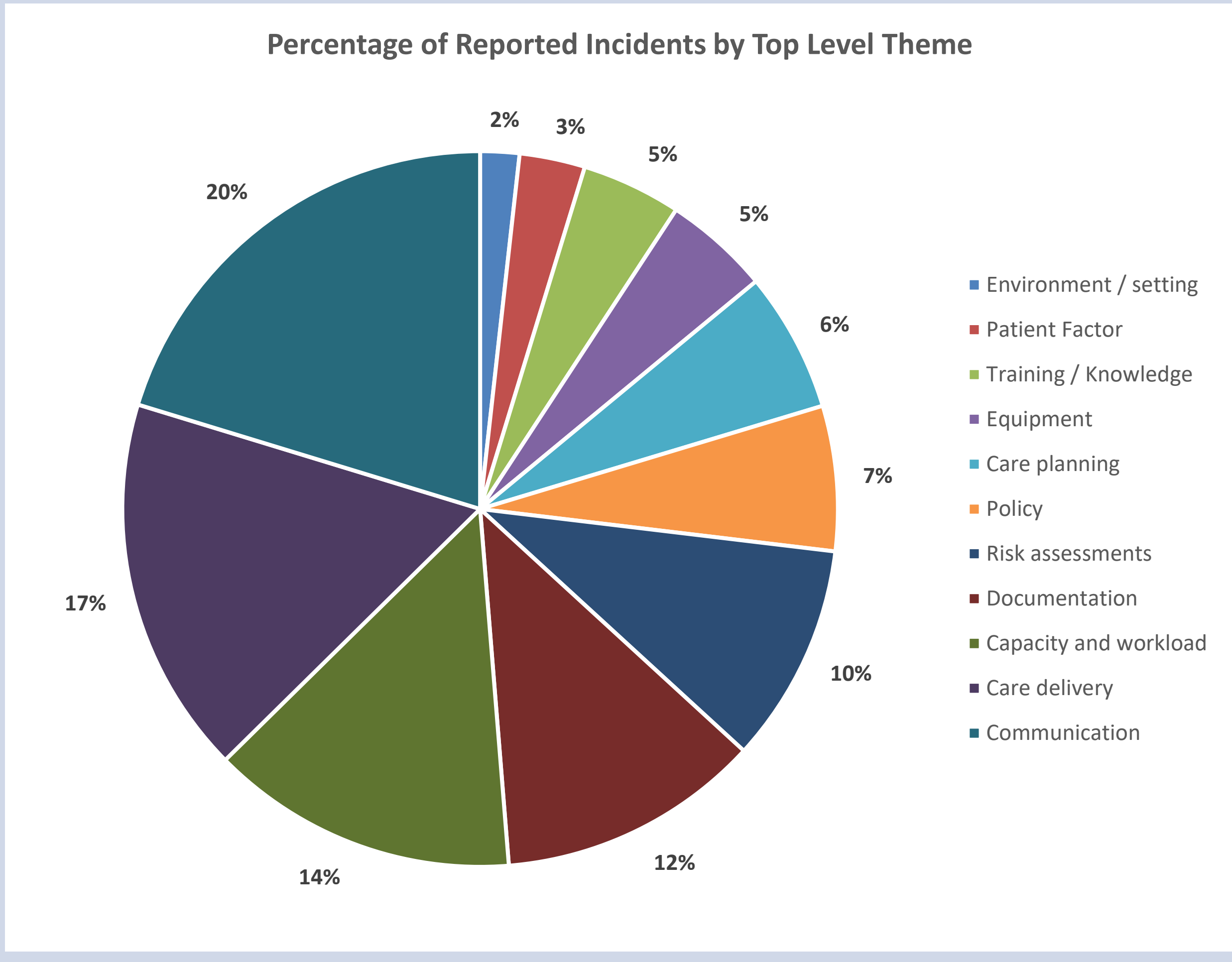


Year	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total SIs per Year
2023/2024	20	15	20	8	10	18 (2)	9 (1)	11 (1)	7	15	8	7	**148 (4)**
2024/2025	14 (1)												**14 (1)**

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

Nursing & Quality – SI Themes and Trends Highlights
Reporting Period – Month 1 2024/25 – April data
Information Source and date of information – Themes tracker 14/06/2024

The table below highlights the top-level themes identified across the System through the investigation process for reported events and detailed in the submitted investigations since March 2022, when this data collection commenced.



Across the system, it is noted that the themes remain consistent with the top two being Communication and Care Delivery, followed by Capacity and Workload. There is improvement being undertaken within the system on these themes as they form part of organisational PSIRPs.

Medicines optimisation update until June 2024

This report aims to provide the system an overview of the work undertaken by the Medicines Optimisation Team and provide assurances of system wide collaborative work across. This report can be used as a reference point to see key decisions that have been made through committees and an update on specific areas of focus. This report aims to give assurance and highlight an areas of concern to the committee.

BNSSG Area Prescribing Medicines Optimisation Committee (APMOC)
APMOC is the overarching committee that provides system leadership and oversight, making decisions to support the safe, effective, and efficient optimisation of medicines across the local health system and organisational interfaces. The group meets bimonthly and at recent meetings, the group has agreed updated and new pathways and guidelines, some of which are detailed below.

New guidance:
Ophthalmology treatment pathways for age related macular degeneration and diabetic macular oedema- These pathways are to agree the most cost-effective use of NICE Technology Appraisals in these areas
Adult treatment pathway for potassium binders in persistent hyperkalaemia- This is to facilitate the change from Red to Amber drugs and support primary care to prescribe them safely
Aspirin in the management of Lynch syndrome guidance- This is a new area where evidence has shown the use of aspirin in patients diagnosed with Lynch Syndrome can prevent development of cancer
Isotretinoin pathway- Further details in slide 3

Updated guidance:
Primary care heart failure treatment guideline and guidance for the use of SGLT2is in heart failure- Local guidance updated in line with NICE guidance
Blood glucose management guidelines for Type 1 and Type 2 diabetics- Guidance updated in line with National recommendations and to put a greater emphasis on the use of meters which test for ketones in Type 1 diabetic patients, which we have seen a rise in admissions locally due to diabetic ketoacidosis.
Primary care Antibiotic guidelines- Including update to otitis media treatment options and a change to treatment of COPD exacerbations for penicillin-allergic patients, in line with an MHRA alert. New diabetic foot infection guidelines were also approved.
All are uploaded to BNSSG Remedy website and communicated via the Medicines Optimisation newsletter and OneCare GP bulletin as appropriate. The group also gave strategic oversight to the Prescribing Quality Scheme, the Inclisiran LES, the financial position and all groups reporting to APMOC. A presentation was given regarding a potential medicines waste campaign, the group was in agreement this should be taken forward across BNSSG.

BNSSG Joint Formulary (JFG)
The BNSSG Joint Formulary Group, (membership includes representation from primary and secondary care, community providers and commissioners), develops, manages and produces the local formulary which is evidence based, considers clinical effectiveness, safety and reflects the needs of the local population and local affordability. The group met on the on 21st May 2024 for the Adult Joint Formulary Group meeting. 7 new drug applications were approved on the Joint Formulary:

- **Hexaminolevulinate (Hexvix) (TLS Red)** for use in patients with high or very high-risk non-muscle invasive bladder cancer to aid improved visualisation of bladder cancer
- **Bleomycin (IV) in combination with reversible electroporation of the spinal tumour as an electrochemotherapy treatment (TLS Red)** for treatment of metastatic spinal cord compression
- Second line options for hormonal contraception and an emollient product were also approved.

Medicines Optimisation- High Cost Drugs

High Cost Drugs Group

The BNSSG ICS High Cost Drugs (HCD) Group, (membership includes representation from ICB & secondary care to include clinicians, finance, contracting & planning), manages and supports implementation of High cost Drugs and Devices (HCDDs) across the ICS to ensure best value in treatment pathways and ensure timely and effective implementation of NICE Technology Appraisals (TAs). The BNSSG ICS HCD Group last met on 8th May 2024 and the following summarises the main areas that are being supported:

1. **System impact of NICE TAs & HCDDs-** The annual horizon scanning process for 24/25 has been completed and has identified a significant uplift on the total 2023/24 spend of approx. £5m required to implement NICE TAs. We are working closely with system colleagues to manage the financial risk, a paper will be submitted to the August HCPE to describe the challenges of NICE TA implementation such as regulatory requirement to implement NICE TAs versus the duty to seek system financial balance, and to ask HCPE for support and recommendations on whether NICE TA implementation should be done differently.
2. **Implementation of NICE TA875 Semaglutide in overweight and obesity** – a paper to support a phased rollout and criteria for a new weight management policy was supported by the HCPE Q1 24/25. Due to capacity issues within the Tier 3 weight management service at NBT, leading them to close their list to new referrals, we have worked with the weight management service, contract and finance teams to support the accreditation of Oviva, an on-line private weight management provider and the impact this will have locally.

3. **NICE guidance for hybrid closed loops (HCL) for patients with type 1 diabetes** – We are working with clinical teams and SW Diabetes network to form implementation over 5 years. The BNSSG implementation plan has been submitted to NHSE along with baseline diabetes tech device use to inform any reimbursement that we anticipated NHSE to provide. We are still awaiting further guidance from NHSE on devices and funding. Patient and clinician expectation of use is very high and there is likely to be a considerable financial risk if this is not managed within the financial allocation.

4. **Supporting the use of best value biologics in treatment pathways** - through the use of Blueteq (an IT based prior approval system for HCD) we are able to collate a repository of data to show which HCD are chosen first line and how this compares with local biologic treatment pathways, working with local specialist teams to support biologic pathway development in:
   a. **Gastroenterology** – on going meetings with clinical teams to discuss budgets, planning and treatment pathways.
   b. **Ophthalmology** – working with the retinal team to manage budget and pathway. Biologic pathways for nAMD and DMO now completed; will be revisited should any costs change.
   c. **Rheumatology** – on going system meetings scheduled with clinical teams to discuss budgets and planning. Continue working with the teams to update the biologic pathways as further new drugs are approved by NICE.
   d. **Dermatology** – biologic pathway agreed for atopic dermatitis and psoriasis. Implementation of first biologic treatment for alopecia areata has highlighted a possible financial risk and requirement of a new patient pathway and potentially larger numbers than anticipated.

5. **In-year management of HCD** – We closely monitor monthly HCDD spend - the month 12 position for 2023/24 on an annual budget of £42,862,475 shows an overspend of £3,178,916 and an Outturn for 23/24 of £46,041,391. This overspend was primarily driven by diabetes technology, ophthalmology and gastroenterology. We are working to put better systems in place for devices through learning from Trust Pharmacy systems and continued biologic pathway work. We are also working closely with system finance and planning to highlight and manage financial risks.

Medicines Quality and Safety

Medicines Quality and Safety (MQS)
There is a medicines quality and safety group which oversees and drives improvement in quality and safety surrounding the use and management of medicines across the BNSSG system. The group meets every 6 weeks and has representation from all relevant stakeholders. The following are a summary of the main themes that have been discussed.
As standing agenda items, all partners feedback around datix incident themes and current medication shortages, along with action for dealing with them. In addition, system partners presented their quarterly updates on their quality schedules, updates on the ongoing work around the NPSA alerts on valproate and antimicrobial stewardship. Some of the key areas of work

Emergency Hydrocortisone kits- Work is being undertaken to make emergency hydrocortisone kits for patients with adrenal sufficiency available from secondary care. Up until this point, this needed to be supplied from primary care however there was no way for GPs to prescribe the necessary needles and syringes for the patient, meaning the supply had to be made from practice stock. The short life working group has worked to make pre-made kits available from secondary care and is working through the final stages of the pathway and working on communication for primary care.

Labelling of paediatric medicines- The group discussed the 2 significant cases of overdose of morphine solution in children highlighted nationally and whether local action is needed in terms of labelling of paediatric medicines. One area was the relative risks and benefits of labelling medications with either just Millilitres or milligrams and millilitres. It was acknowledged there is a range of different practice in this area and there is not yet a clear consensus in the paediatric pharmacy sphere. It was decided to wait for forthcoming national guidance from the National Paediatric Pharmacists Group, supported by research projects in this area.

Isotretinoin working group- This subgroup reported on the work that is ongoing to agree a system-wide pathway and review tools and processes to ensure compliance with MHRA recommendation on Isotretinoin prescribing. This pathway was subsequently agreed at APMOC.

Medication related patient safety incidents were discussed, including a never event where a patient overdose on methotrexate due to a lack of understanding of the written information on the medication label. Key actions agreed were to link in with community pharmacy lead about the use of translation software for medication labelling in community pharmacy.

Medicines supply issues- Key shortages/supply problems of Tier 2 and 3 severity are discussed including the forthcoming discontinuation of Pabrinex (Vitamins B and C) intramuscular and intravenous injection ampoules. It was noted this is set to be a very high impact supply disruption for secondary care.
The discontinuation of Insultard Innolet devices was also discussed, with the diabetes lead pharmacist linking up with system diabetes colleagues on how best to manage these patients.
Fluctuating supply of ADHD medications continue to cause issues nationally and locally. Guidance for primary care on how best to manage this shortage is available on Remedy and continues to be updated in line with the current supply position.
Additionally, a newly emerging shortage of Pancreatic Enzyme Replacement Therapy (PERT) medications for people with pancreatic enzyme insufficiency (including patients with cystic fibrosis) is expected to have a high impact. All licensed products are affected. Unlicensed alternatives may exist, but these have not yet been approved by the MHRA and may have a significant cost differential, as well as varying availability from community pharmacies. We are working with system partners to explore supply options and draft guidance for primary care.

Overall, managing drug shortages takes increased resource, increased overall cost and potential impact on planned savings programmes.

Medicines Quality and Safety- Sodium Valproate

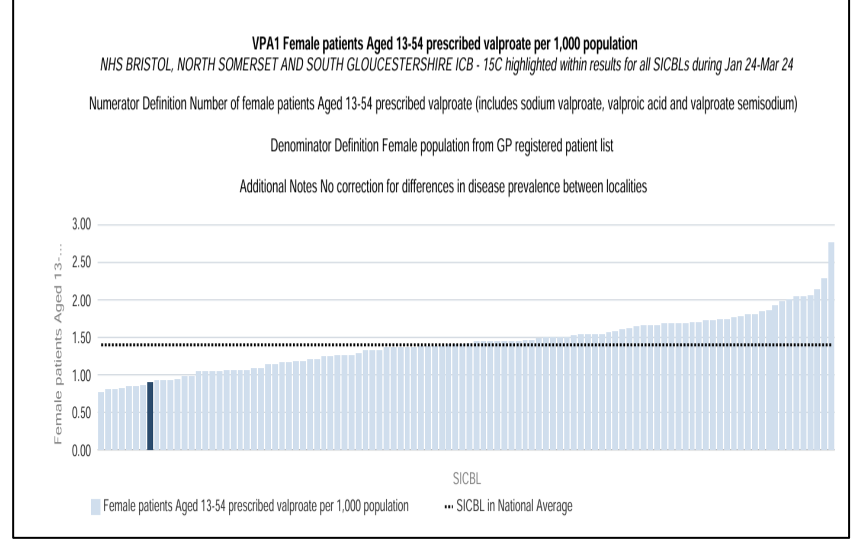
Valproate safety

In November 2023, a National Patient Safety Alert was issued to ICBs in England that highlighted the new MHRA regulatory measures relating to Valproate. These came into force in January 2024 for **oral** valproate medicines. These included that:

- Valproate must not be started in new patients (**male or female**) younger than 55 years, unless two specialists independently consider and document that there is **no other effective and tolerated treatment**, or there are compelling reasons that the reproductive risks do not apply; and
- At their next annual specialist review, **female patients** of childbearing potential and girls should be reviewed using the updated valproate Annual Risk Acknowledgement Form (ARAF), which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes.

The BNSSG Valproate safety working group includes representatives from NBT, AWP, Sirona and UHBW as well as primary care and local sexual health clinics.

The group supports the implementation of these measures as well as sharing learning from any any medication safety events in this area. Nationally, BNSSG benchmarks well in terms of rates of prescribing of valproate in females of childbearing age (see graph)
This is one of the national medicines optimisation opportunities and BNSSG benchmarks well however this does not show the compliance with the safety measures that need to be put in case. By being low prescribers, it shows we have put in place appropriate patient review mechanisms to reduce the overall number of valproate patients of child-bearing potential.



To support the safe use of valproate locally:

- Providers have developed standard operating procedures **(SOPs)** for prescribing valproate.
- **New national Risk Acknowledgment Forms** for females (ARAF) & new male patients (RAF) starting valproate have been shared with local clinicians.
- An overarching BNSSG ICS Valproate **system pathway** is in development.
- **Patient valproate reconciliation exercises** are in progress with NBT and UHBW BCH to ensure accurate valproate patient registers. This will support the timely recall of patients for annual reviews. AWP have updated their electronic registry to reflect the new regulatory changes.
- The **local valproate Shared Care Protocol** has been **updated** to reflect the regulations and the formulary traffic light status which is now **amber** for all indications, with off-label indications now non-formulary.
- Multilingual and easy read patient resources are available via the AWP website.

Further work is planned in relation to understanding local population data, coding and promoting effective contraception

Currently there are no regulatory actions required by the MHRA relating to **existing male patients** prescribed valproate despite increasing levels of concern for infertility, testicular toxicity, and current re-analysis of data exploring neurodevelopmental disorders in offspring. The MHRA intend to release 'Phase 2' regulatory changes later in 2024 to cover existing males.

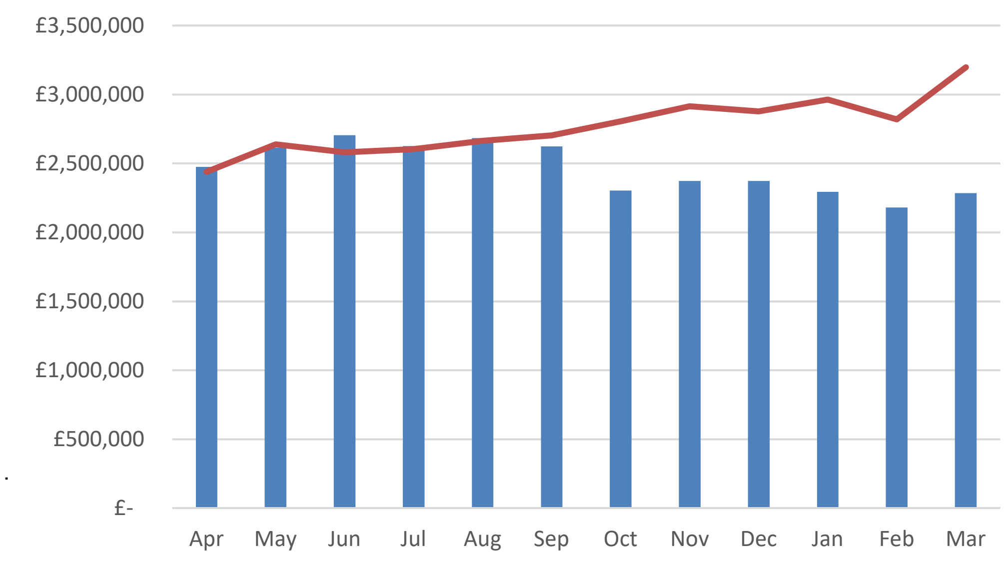
BNSSG OPQ is asked to note the work that has been undertaken and acknowledge that providers may need additional support should more extensive recommendations be published in relation to male patients taking valproate.

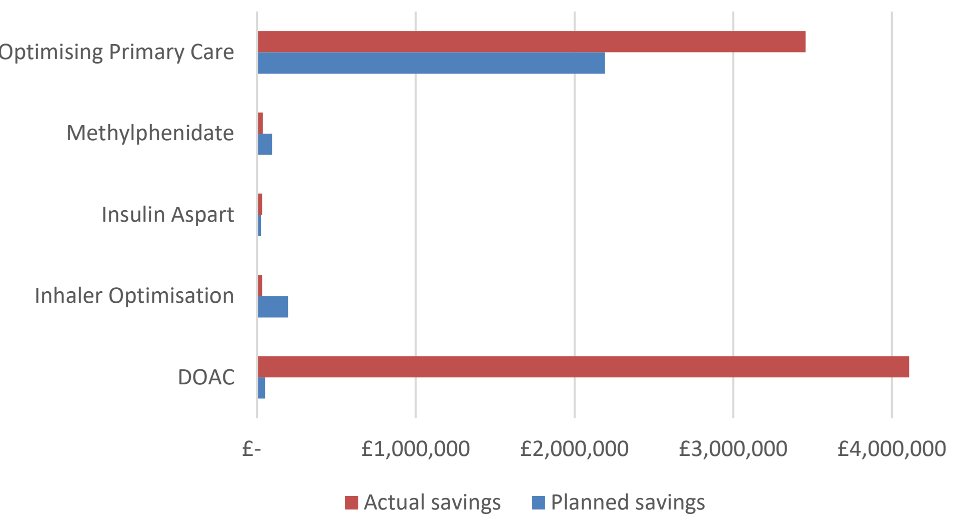
Medicines Optimisation Finance update

Finance At the beginning of each year a medicines budget is calculated using predicted cost pressures and savings for Primary Care. The Medicines Optimisation Team monitor and review prescribing spend throughout the course of the financial year and report to finance team monthly. The primary care prescribing position against allocated budget is reported in the primary care finance report on a monthly basis.

Predicted cost pressures. For 23/24 the over predicted spend growth did not increase at the rate we expected mainly due to an unexpected reduction in the cost of one of the anticoagulants. The growth predictions in other clinical areas were similar to actual growth indicating the methodology used to predict areas of growth is appropriate and can continue to be used for 24/25.
It also demonstrates that the increased growth in primary care spend will be due to other factors such as increases in the national Drug Tariff category M prices and price concessions.

Planned savings versus actual savings. The Medicines Optimisation Team plan and review what savings Primary Care are able to achieve each year. The graph 2 demonstrates significant actual savings versus the planned savings for 23/24. This is due to greater savings due to the optimising primary care work undertaken by the Medicines Optimisation Pharmacists in practices. An unscheduled price reduction to one of the direct acting oral anticoagulants (apixaban) also contributed. The savings plan for 24/25 has been agreed at £5.2M and in year savings opportunities will be continually reviewed.





Primary Care Prescribing

Positively, BNSSG ICB continues to meet both national antibiotic prescribing targets at the end of 23/24.

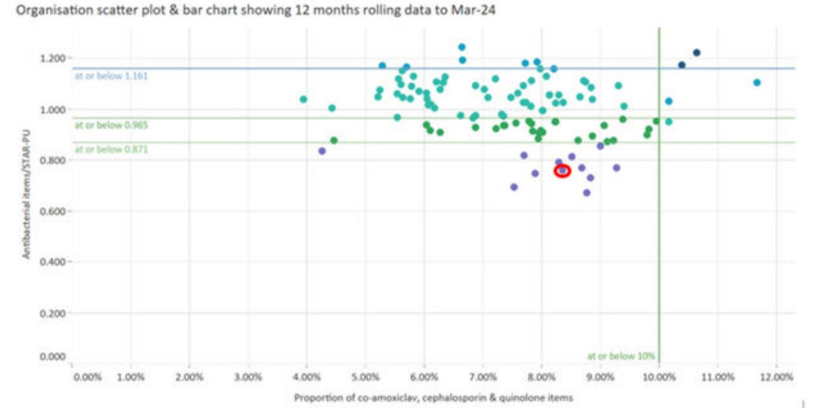
- Antibiotics/Star-PU (a measure of overall prescribing) being less than 0.871.

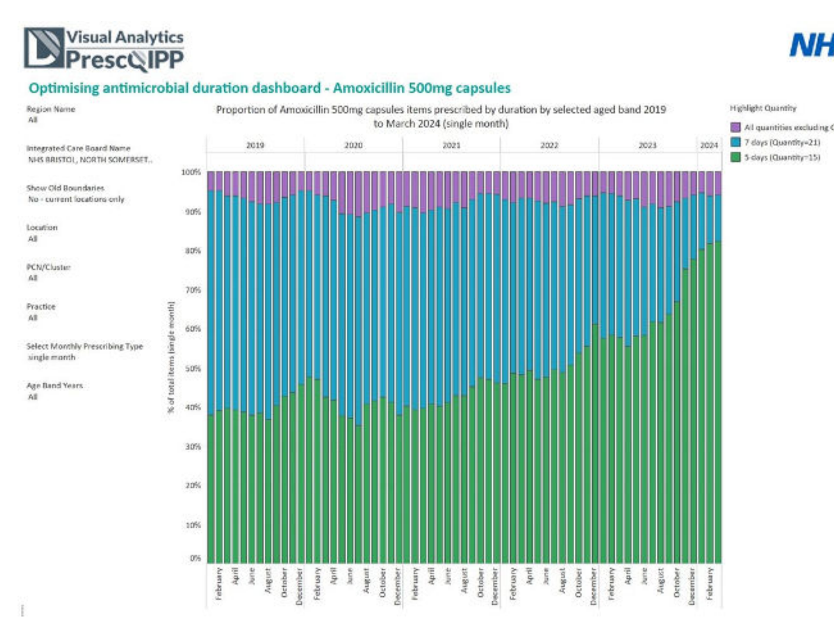
BNSSG was at 0.79

- Broad spectrum antibiotics being less than 10% of all antibiotics prescribed.

BNSSG was at 8.35%.

BNSSG is highlighted in red in the scatter plot of all ICBs and as can be seen was one of a handful of ICBs to meet both targets showing the continued good stewardship in primary care.





A national medicines optimisation opportunity for 23/24 was reducing course length of antimicrobial prescribing, specifically focused on amoxicillin 500mg.

A five day course length of amoxicillin is clinically appropriate for most infections and prescribing the shortest clinically appropriate course has the benefits of reducing selection pressure for antimicrobial resistance and inadvertent patient harm from antibiotic treatment.

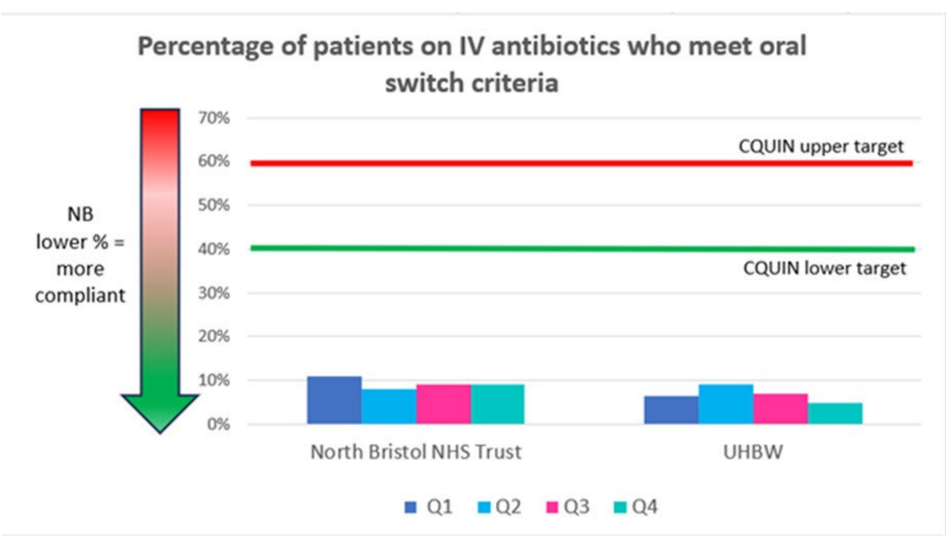
Due to the work carried out with practices, in March 24 BNSSG benchmarked the highest ICB nationally for 5 day amoxicillin 500mg courses. This rapid adaption to a new area of stewardship highlights the engagement of the primary care workforce with AMS.

BNSSG ICB remains the lowest prescribers of antibiotics to children nationally. This highlights the continued stewardship for infections that do not routinely require antibiotics for example otitis media and sore throats. Antibacterial items prescribed per 1,000 children aged 0-9, 12 months to March 24. BNSSG is highlighted in dark blue.

Secondary Care Prescribing

The national target for secondary care during 23/24 was to reduce broad spectrum antibiotics (WHO watch and reserve category antibiotics) by 10% from a 2017 baseline. At the end of quarter 4 both trusts had met the target. NBT with a reduction of 11.3% and UHBW with a reduction of 10.06%. Significant amounts of work was undertaken at both trusts to meet these targets.

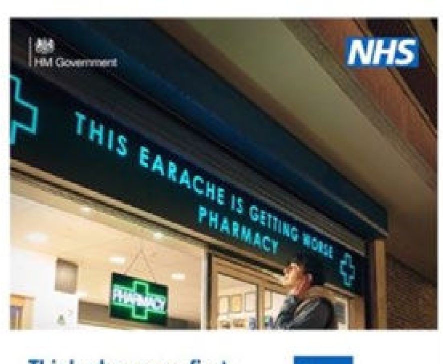
An IV to oral switch CQUIN supported the national medicines optimisation target to reduce unnecessary IV antibiotics during 23/24 . A switch to oral has many benefits including releasing nursing time, environmental benefits and enables catheters to be removed leading to reduced line infections. Both trusts significantly met the lower CQUIN target of 40% or less of patients that meet the IV to oral switch criteria remain on IVs. Despite this good attainment with the CQUIN BNSSG benchmark poorly on the national medicines optimisation opportunity of switching intravenous antibiotics to oral. The national benchmark takes the proportion of patients on IV antibiotics. Whilst work is ongoing to understand why this is initial opinion is that it is due to the patient population in our hospitals with a significant proportion in patient groups that require IV antibiotics such as immunocompromised patients, the IV to oral switch CQUIN shows patients do not remain on IV antibiotics unnecessarily.



UHBW and NBT have worked closely together to start to align antibiotic guidelines. This has initially focused on urinary tract infections.
Both trusts and primary care collaboratively reviewed and altered prescribing guidelines in response to the MHRA alert on Fluroquinolone safety ensuring the most appropriate, safe prescribing across the system. Collaborative work has occurred to support the supply of immunoglobulin for measles contacts.

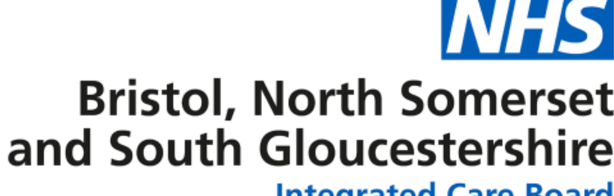
Pharmacy First

Pharmacy First which enables antibiotics to be given via PGD for minor conditions from a pharmacy started in quarter 4 of 23/24. This national advanced service is an expansion of the conditions the previous local PGD service.
The new service covers otitis media, impetigo, infected insect bites, shingles, sinusitis, sore throat and urinary tract infections (for women aged 16-64).
A review of the antibiotics supplied will occur to ensure there is no overall increase in antibiotics prescribed in the system.



Summary

- This report is to provide a summary of key work currently being undertaken by the Medicines Optimisation Team.
- The key areas of concern continue to the continued system impact of medicines supply issues and the financial risk to allocated budgets.
- Current areas of focus include our system-wide response to the Valproate NPSA alert, cardiovascular disease including diabetes, tackling inappropriate polypharmacy, implementation of NICE TAs, including for weight management (e.g. semaglutide NICE TA implementation) and hybrid close loops.
- There is a continued risk from medicine shortages. The current high impact shortages we are working on with processes in place to support the system are Pancreatic Enzyme Replacement Therapy (PERT), GLP-1 agonists, ADHD medicines and Salbutamol nebules. We require continued support from clinicians for system wide guidance. The management of these also presents a financial risk.
- The year-end financial position on primary care prescribing budget was better than initially forecast. This was due to improved savings as highlighted in the report. However, the volatility of the Category M pricing mechanism may continue to present a risk in this financial year.
- We would value feedback on the content and presentation of this report. The next report will include a focus on Controlled Drugs, medication incident reporting trends and an update on our position against the National Medicines Optimisation Opportunities.



Meeting of BNSSG ICB Outcomes, Quality & Performance Committee

Date: 26/06/24
Time: 14:00 – 16:25
Location: Via MST

Agenda Number:	5.1	
Title:	Quality and Performance Report – Month 1 (April – May 2024/25)	
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	Yes
	Other (Please state)	No
Purpose: Discussion & Information		
Key Points for Discussion:		

The attached Quality report (appendix 1) provides an overview of June 2024 data whilst the performance report (appendix 2) provides an overview of April and May 2024 performance. A summary is provided below.
The committee are asked to note the following areas.

Quality (Appendix 1)

Healthcare Associated Infections

- **C. Difficle –** There were 35 cases of C. Difficle attributed to BNSSG ICB in April 2024, which is higher than the position at the same time in 2023/24, although the SPC graph for Hospital Onset Hospital Acquired (HOHA) cases on slide 6 suggests that there is no significant change. The 2nd graph on page 6 looking at all cases of C. Difficle does indicate that there is a concern related to inconsistently meeting/missing the targets. The BNSSG position for C Diff per 100k of population (29.12) is the lowest rate in the Southwest (SW average 32.25) but is higher than the National average (27.43). Attendance at the Southwest CDI collaborative regional group continues to actively engage with system colleagues and continue the work of the HCAI-CDI workstream sprints to learn from system data review processes and coding initiatives for CDIs.

- **E. coli –** There were 53 cases of E. coli bacteraemia assigned to BNSSG ICB in April 2024 compared to 56 in Jan 2024. The supporting SPC graphs on slide 7 demonstrate that overall, the numbers of reported cases despite being lower than trajectory rose steadily over 2023/24 within BNSSG; there is work underway within the community and the acute trusts to focus on catheter care and antibiotic stewardship. The current BNSSG rate per 100k of population at 54.83 is below the Southwest region average of 69.49 and the National average of 68.66. BNSSG was ranked 2nd in the Southwest ICB position for cumulative rate per 100K populations in 2023/24.
- **MSSA –** (Methicillin-sensitive Staphylococcus aureus) in April 2024 there were 10 cases of MSSA bacteraemia assigned to BNSSG ICB; all 10 were HOHA cases. The graphs on slide 9 demonstrate that whilst the reported cases are still above the target range the numbers have been decreasing since late 2023. Case activity for MSSA per 100k of population is 20.42 and continues to be below the Southwest average of 24.32 and the national average of 21.91.
- **MRSA - (**Methicillin-resistant Staphylococcus aureus) In April 2024, there were 3 cases of MRSA bacteraemia assigned to BNSSG ICB, which is higher than this time last year when 1 case was assigned to the ICB. Two of the cases were community onset community acquired cases and one was a HOHA. The SPC graph on slide 8 demonstrates that the HOHA numbers of reported cases is consistent but that the target is consistently not being met. The overall numbers of MRSA being reported across BNSSG are however showing an overall decline. Case activity for MRSA per 100k of population at 3.21 is above the Southwest (1.66) and National (1.48) average.

The table below shows the performance of BNSSG ICB against other ICB's in the Southwest by infection per 100K of population.

Rates per 100k	South West Position								
	BSW	BNSSG	Devon	Dorset	Glos	Kernow	Somerset	SW	England	BNSSG
C. diff	29.88	29.12	32.04	33.69	31.62	42.04	31.00	32.25	27.43	1
E. coli	58.44	54.83	84.50	87.16	37.08	79.93	83.61	69.49	68.66	2
MRSA	1.73	3.21	1.26	1.95	0.44	1.16	1.17	1.66	1.48	7
MSSA	20.60	20.42	29.68	26.73	14.04	29.25	29.32	24.32	21.91	2
Pseud A	7.95	5.58	5.50	8.91	3.69	5.82	7.04	6.36	7.24	3
Kleb spp	17.03	17.02	20.81	25.88	16.55	23.76	25.13	20.46	21.27	2

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 during February 2024 are 1) Communication 2) Care Delivery and 3) Capacity & Workload.

Further work is being undertaken to breakdown the factors associated with the top three themes. The outcome of the breakdown is shared with system partners for dissemination of the learning. The draft system human factors taxonomy to enable identification of system wide themes and trends is currently being piloted by partners. Upon agreement and implementation of this taxonomy it will support system wide learning and improvement by producing comparative data.

Medication Optimisation update

The Medication Optimisation update report provides an overview of the work being undertaken by the Medicines Optimisations team and provides assurance of system wide collaborative work.

The report contains issued new guidance, updated guidance and changes/additions/removals from the BNSSG Joint Formulary and updates from the High-Cost Drugs Group.

The Medicines Quality and Safety section contains a summary of improvements being driven by the Medicines Quality & Safety group which includes review of medication related incidents and agreement of required key actions. Medicine supply issues, along with safety alert responses also form part of the report.

A finance section is contained within the report and looks at predicted cost pressures and planned savings v actual savings.

Key points

- The key areas of concern continue to be the continued system impact of medicines supply issues and the financial risk to allocated budgets.
- Current areas of focus include the system-wide response to the Valproate NPSA alert, cardiovascular disease including diabetes, tackling inappropriate polypharmacy, implementation of NICE TAs, including for weight management (e.g. semaglutide NICE TA implementation) and hybrid close loops.
- There is a continued risk from medicine shortages. The current high impact shortages being worked on are Pancreatic Enzyme Replacement Therapy (PERT), GLP-1 agonists, ADHD medicines and Salbutamol nebules: processes are being worked on to put in place to support the system. Continued support from clinicians for system wide guidance is required. The management of these also presents a financial risk.
- The year-end financial position on primary care prescribing budget was better than initially forecast. This was due to improved savings as highlighted in the report. However, the volatility of the Category M pricing mechanism may continue to present a risk in this financial year.

Performance (Information available through Power BI)

The performance report for this month is based on April and May 2024 information. Please note that for some mental health metrics there are national issues with April and May 2024 data which will not be updated by NHS Digital until July 2024, therefore some mental health metrics may still reflect March 2024.

The power BI tool roll out is now complete within performance and delivery. The performance and delivery teams are continuing to use the tool in the service delivery units to triangulate intelligence between performance, quality, contracting and business intelligence. The tool can be demonstrated at the Committee if required. To aid members of the committee a performance summary slide set aligned with the power BI corporate delivery report in terms of format is attached as Appendix 1.

Urgent Care

- Mean category 2 ambulance response time in May is averaging 32 minutes, against the 29 minute target. This is better than national average performance, but the target has not been met due to at least a 10% increase in ambulance activations which is resulting in increased admissions at both acute trusts and greater use of escalation capacity.
- ED 4 hour performance at 66% in May 2024 which is lower than the operational plan target of 68.89%. General and acute bed occupancy levels are on plan which probably demonstrates the increase in escalation beds being utilised. Type 1 ED performance is the best in the South west at 63.3% against a target of 66%.
- Overall system flow has remained challenged and work to date is being focussed on the system ambition to deliver 78% ED performance by end of March 25 whilst decreasing the levels of no criteria to reside which will result in an overall level of occupancy for general and acute beds in the acute trusts. A driver diagram shows the respective areas of work comprising of front door, internal flow in acutes and the back door. System workshops on D2A pathways including the modelling work undertaken by Whole System Partnership and a front door workshops have now outlined the work that will be delivered over the next few weeks and months to deliver the system ambition. It is key that these workstreams are delivered over the summer months to also help prepare for winter.
- Focus within urgent care but also EPRR is now on preparing for industrial action taking place from 27 June at 0700 to 2 July at 0700. This provides an opportunity for the system to bring some of the actions which link with the system ambition work into earlier delivery or test ways of working. Actions related to review P2 beds in South Gloucestershire and South Bristol Rehabilitation Unit as well as building care coordination capability through greater use of F-ACE, integration with CEMs, NHS at home and SWASFT. Additional staffing to support place based urgent care in the community is also being sought including for recovery days after the industrial action.
- Urgent care response is still above target and performing well; virtual ward occupancy still needs to improve with recruitment remaining a challenge.

Elective Care

- A further submission as part of the operational plan for 2024/25 was submitted in June resulting in an improved trajectory for NBT with clearance of 78ww by August 2024, 20 65ww waiters in September 2024 and 0 65ww by March 2025. This is the result of focussed work in relation to the DIEP pathway looking at alternative ways to follow up, repatriations and potential use of a provider in London.
- At an ICB level for Mary 2024 we are meeting our 65ww plan and currently ahead of the target of 324.
- Risks to 78ww and 65ww performance are industrial action, consultant capacity to be able to catch up on activity and for UHBW supply of corneal graft material.
- Diagnostic test performance within 6 weeks is still the best in the South West and currently at 86% with the aim to achieve 95% by the end of the financial year. Most modalities are performing well including gastroscopy, colonoscopy, MRI and other areas with challenges

e.g. dexa and non-obstetric ultrasound. NBT have committed to performing better than the national target at 99%.

- CDCs are open at both sites in Weston and near North Bristol Trust, mainly working through mobile units. Not all services have started due to equipment and recruitment time lags but most are now up and running in June 2024. Once performance data is available this will be added into this performance report. IT still remains a challenge with different systems across InHealth and the acutes but is being worked through.
- Cancer FDS performance has slightly deteriorated in April compared to March. This is partly due to demand being seen in certain areas like skin. UHBW are achieving the 75% FDS position in April 2024. FDS may deteriorate further due to bank holidays in May as well as industrial action in June and July.
- The 62 day combined target is being achieve at Trust and ICB levels for April 2024.

Mental Health (relates to March and April 2024 performance)

- Access to perinatal services is showing an upward trend over the last 4 months since the single point of access has opened.
- The new talking therapies targets are now included in the power BI report for April 2024 and reliable recovery and reliable improvement rate are both above targets of 50% and 69% respectively.
- Dementia diagnosis rate target of 68.6% continues to be met.
- LDA annual health checks are only fractionally below target.
- Children and young peoples access to mental health is still below target at end of March. Much of this is related to alignment of ADHD and Autism reporting to NHS England's data specifications. Work is underway to make this change.
- Reliance on inpatient care for adults and children LDA is included in a separate report as part of this months committee pack.

Community

- Sirona waiting list for adults 52ww is at 1 compared to a target of 0.
- Sirona waiting list 52+ weeks is below target at 4174 for April 2024 and shows a good reduction from March 2024.
- Community beds occupied has seen a reduction over the past 4 months currently at 95% for May 2024.
- P1 capacity is still not always utilised and this is generally due to last minute cancellations which cannot be filled due to patients becoming medically unfit.
- P2 and P3 capacity is above target, although waits for P2 are still high resulting in a review with the system to support a lowering of this position before industrial action.
- As mentioned in the urgent care section, work is ongoing with Whole Systems Partnership modelling on how recovery can be made over the next few months to deliver the system ambition to reduce NC2R and meet a lower general and acute bed occupancy in the acutes.

This may require additional capacity to be made available in P1 and P3 subject to workforce considerations as well as support and feasibility from local authority partners.

Children

- The children's community services operational metric has changed from waiting list size to number of children waiting over 52 weeks. The target for this metric has been set by Sirona and is a realistic plan reflecting the limited improvement in waiting time expected to be made in 2024/25.
- The number of children waiting over 52 weeks is not, however, considered acceptable and significant effort continues with work to maximise resources available and transformation of services.
- 4173 children were waiting over 52 weeks in April 2024, representing approximately 50% of the overall waiting list.
- The long waits are driven by high numbers of ADHD and Autism assessment referrals, which outstrip capacity. Children are waiting 2 years for an ADHD assessment and, unless triaged as urgent, significantly longer for an Autism assessment.
- Increasing capacity to meet this demand has been attempted via 'waiting list initiatives' and sub-contracting with private providers, however, this approach is unworkable both from a staffing and finance perspective.
- The accelerated design of a new neurodiversity pathway will be trialled from August 2024, subject to system approval. The impact of this test on the current waiting lists is currently unknown but it is not envisaged that waits will significantly reduce in the shorter term.
- Simultaneously, Community Paediatrics are taking actions to improve the efficiency of their service and continuing to clinically validate the waiting list. Whilst this has reduced the waiting list (c.4000 children) by approximately 700 patients, the waiting list far exceeds the capacity available to see children in an appropriate timeframe.
- Next steps include developing a clear communications plan to share these issues (and long waits) with all stakeholders including parent carers, children, education and NHSE alongside other system colleagues, continue neurodiversity transformation programme and actions to improve efficiency.
- Childrens ED performance is achieving the operating plan target of 78% in May 2024.
- BNSSG ICB has the potential to meet the mental health access target by aligning Autism and ADHD reporting to NHS England's data specifications, via the mental health data set. Work is underway to work with system partners to make this change.
- Improvement actions underway to continue to increase access to mental health services with a particular focus on Mental Health Support Teams in schools to ensure they achieve intended benefits.

Update on Segmentation Quarter 4 2023/24

A segmentation review for quarter 4 took place with NHSE as part of the oversight framework. The outcome of this review was to retain the ICB in segment 3 for quarter 4 2023/24. This was

based on the following oversight metrics: Cancer (FDS), Elective (78ww and 65ww), mental health (CYP, perinatal), LDA (Inpatients), Community (virtual wards) and finance (agency spend). The committee needs to note that data used for quarter 4 is out of date due to reporting processes and at this present time UHBW is not part of tier 2 elective, and neither NBT nor UHBW are tiered for Cancer. Both Trusts achieved the FDS target in March 2024 and perinatal access has significantly improved. Attached in Appendix 2 are letters from NHSE outlining the segmentation review process and results for the ICB, NBT and UHBW.	
Recommendations:	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
Previously Considered By and feedback:	Not previously considered
Management of Declared Interest:	None declared
Risk and Assurance:	The report and appendices provide an update to the Outcomes, Quality & Performance Committee in relation to key risks to performance and quality within the system and highlight supporting mitigations which are in place.
Financial / Resource Implications:	None referenced
Legal, Policy and Regulatory Requirements:	None referenced
How does this reduce Health Inequalities:	Not referenced
How does this impact on Equality & diversity	As above
Patient and Public Involvement:	Not applicable
Communications and Engagement:	The reports are provided to the Outcomes, Quality, & Performance Committee for information and discussion.
Author(s):	Caroline Dawe - Deputy Director of Performance and Delivery, BNSSG ICB 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 Joanne Medhurst, Chief Medical Officer, BNSSG ICB David Jarrett, Chief Delivery Officer, BNSSG ICB

Shaping better health

Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

BNSSG Outcomes, Quality and Performance Committee

Draft Minutes of the meeting held on Wednesday 24th April 14:00-16:25 on MST

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Jeff Farrar	Chair, BNSSG ICB	JF
Paul May	Non-Executive Director, Sirona Care & Health	PM
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Hugh Evans	Executive Director, Adults and Communities BCC	HE
Sarah Weld	Director of Public Health, SGC	SW
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
In attendance		
Marie Cox – item 7.1	Senior Specialist for LD and Autism, CQC	MC
Adwoa Webber -item 7.3	Head of Quality and Clinical Excellence	AW
Dr Viv Harrison item 7.3	Consultant in Public Health – Population Health, BNSSG	VH
Rosanna James - item 5	D2A Programme Director, BNSSG	RJ
Tina Mostert (Notes)	Executive PA, BNSSG ICB	JS
Fiona Igbokwe – item 7.2	Programme manager for LDA, CSU	FI
Debbie Campbell	Chief Pharmacist (representing Jo Medhurst), BNSSG ICB	DC
Denise Moorhouse	Deputy Chief Nursing Officer, BNSSG ICB	DM
Apologies		
Sue Geary	Healthwatch	SG
Aishah Farooq	Non-Executive Director BNSSG ICB	AF
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sue Balcombe	Non-Executive Director, UHBW	SB
Jonathon Hayes	Chair of General Practice Collaborative Board	JH

	Item	Action
1.	**Welcome and Apologies** ED welcomed attendees to the meeting and apologies were noted as above. ED introduced the agenda and highlighted that NCTR is one of the biggest challenges facing the BNSSG system. ED also noted that DJ would give an update on the segmentation process and position. DJ reported that the LDA element of Segmentation is of particular interest and that Fiona Igbokwe, LDA Programme Manager, would join the meeting for item 7.2. Additionally, ED noted that the Audit committee had identified two audits with only partial assurance and that RS would update on these and three emerging risks. ED explained that the Performance Report has been replaced by Power BI and requested that DJ discuss the suitability of the on-line tool for this committee with representatives from BI. ED noted that Primary Care was not represented at the meeting and asked DJ to investigate whether JH would be able to attend in future or if a different representative was required. **ACTION: DJ to discuss suitability of Power BI report for this committee with representatives from BI, and whether a paper would be more appropriate.** **ACTION: DJ to discuss with JH whether he will attend this meeting in future or if a different representative should be invited from Primary Care.**	
2.	**Declarations of Interest** PM stated that he is a councillor for BANES, a cabinet member for CYP and chair of Health and Wellbeing Board.	
3.	**Minutes of February 2024 committee** AM requested clarity on the reference to SQG attendance at the top of page 4 and whether the review should be an action or Business as Usual. It was agreed that the minutes would be amended to show an action for RS and MR to review the SQG TORs and return to Committee with an update. With the amendment described, the Committee approved the minutes from 29th February 2024 SW commented that SGC would like to determine how to best input to SQG and RS explained that DAS, DCS and DPH are always in attendance thereby all LAs are represented.	
4.	**Committee Action Log** The action log was updated to be circulated with the minutes and the following points were raised: • ED expressed concern regarding action 92 that there remain IT and Staff training issues. DJ agreed to update before the next committee on the operational status of the CDCs.	

	Item	Action
	• It was suggested that system COOs should join the June committee meeting and ED requested that their input be co-ordinated so that it would be an effective piece of work. • Assurance was gained that the System Outcomes Framework is being utilised by SEG and referenced as BAU in the work of the Children's and Community HCIGs. • SW updated that the BNSSG Strategy Network has been brought together again and suggested a future agenda item. It was agreed to add this to the forward planner for SW to indicate when it becomes appropriate. ED referred to the Audit Reviews and noted that the audits for Funded Care and Safeguarding had only partial assurance. Regarding Funded Care, ED queried how the overspend was being addressed and what the role for this committee would be. Regarding Safeguarding, ED noted that the report highlighted a lack of scrutiny, particularly on the transformation of safeguarding, and suggested a regular agenda item and more detailed minuting to address this. ED also highlighted the possibility of other statutory items being in the papers to note rather than items for discussion and proposed bringing the review of the committee's effectiveness forward so that the June Committee can be updated. RS suggested that an update on the action plans resulting from the Audit Reviews should be brought to June Committee and explained that, whilst some sit with the CNO, others span the ICB requiring input from multiple teams and others involve ICS partners and will be part of ongoing system working. RS reported that the risk of Funded Care expenditure is well known and discussed, with regular Executive oversight. Modelling is helping the understanding of what is in the control of the ICB and what is due to wider issues such as population issues. There is an inter-relationship with LA social care spend so the conversation should include partner organisations to establish the impact throughout the system of any shift in funding or impact of changed pathways. Regarding Safeguarding, RS similarly noted that some of the actions are the responsibility of the CNO although the transformation work is not internal but rather focussed on how the ICB works with LAs and the Police to address system safeguarding in the longer term. Meetings are scheduled with the transformation team to progress this. ED requested clarity on the role of the Committee and DM responded that the Funded Care Audit had focussed specifically on business functions rather than the eligibility part of the service, so will lead to work on process and policies rather than changing the way that care is commissioned for individuals. DM noted that the team oversee through the Funded Care Risk, Audit and Governance meeting which will oversee delivery and offered to update the June Committee on the overarching plan. HE added that Funded Care for Adults and Children with complex or enduring needs is the single most difficult issue facing all three LAs due to the increased demand, local market shortfalls and finance. There is work underway to develop	

	Item	Action
	market sufficiency and accommodation resolutions but the answers to the problems will be through joint working across system partners. HE reported that a multi-agency Safeguarding Hub is being developed and the aim is to have it in place by the end of the summer. Currently RS and HE are discussing funding shortfalls. There is a risk that, given that this has been a system priority for a series of years, non-implementation could become a regulatory liability. AM thanked RS for taking subjects to Audit Review which highlighted important problems and noted the actions for both items under discussion, suggesting that proposed actions be subject to the lens of impact upon the population. AM commented that the Audit Review noted that there is no MOU for joint system working on Safeguarding and raised a concern about the impact on the population from there not being such a system wide agreement in place. RS summarised that system working will be explored in more detail through the transformation project but that a MOU for the system is not proposed at this time and would need to reflect the statutory responsibilities of the LA. The audit report is a mixture of internal ICB issues and system ones the latter can only be delivered with partnership sign up. AM recommended RS reviewed revised timelines to ensure deliverability. **ACTION: RS to bring forward the review of Committee effectiveness to report back in June meeting, including the proposal to move Statutory items to be discussed rather than noted.** **ACTION: RS to amend the Audit Review Action Plan to identify which actions are internal to ICB and which will be addressed by the system.**	
5.	**No Criteria to Reside Update** DJ introduced this item, noting: • Improvement of the NCTR position is a key performance area for BNSSG and there is a significant amount of work happening across system, with three separate workshops this week looking at different elements such as discharge, admission avoidance and flow, to improve pathways. • The NCTR position has improved on previous years but is still much higher than desired. There were much lower rates last summer but, despite best efforts, the system has not been able to resolve recent increases. • It will be necessary to reduce complexity of cases arriving at the acute settings whilst also improving processes once individuals are ready for discharge. • A clear ambition and trajectory have been set and there is support from a number of areas to meet these. • Benchmarking shows that BNSSG is 40th out of 42 regarding NCTR nationally, but the Southwest is generally poor. • BNSSG benchmarks well on overall LOS and LOS within the D2A pathway. • Bed occupancy has improved even despite no improvement in NCTR.	

	Item	Action
	• Across the Southwest, NBT was an outlier whereas UHBW was within the pack. • Cat 2 ambulance response time has reduced from 54 mins to 30 mins over the year and this is the most significant reduction in the Southwest. • A&E performance has improved compared to other regions in the Southwest this year and average LOS has reduced from 9.1 to 7.6. • DJ summarised that, overall, the situation in BNSSG is improving. RJ explained that a diagnostic review in Summer 2022 had noted that delays had been driven equally by capacity and process issues and it is recognised that this results in poor outcomes with missed opportunities to return individuals to home and an over prescription of bedded care pathways. RJ shared a presentation detailing a stock-take of the first year of D2A and highlighted: • 128 acute beds have been saved and work is ongoing to increase to 200. • The community bed stock has been reduced to within the financial envelope so is more resilient for longer term needs. • Social care demand has been reduced leading to a healthier system and more effective intermediate care service. • Between March 23 and 24 the equivalent of 73 beds have been closed. • Most of the pathway shift has been sustainably taking people out of the P3 pathway, with some moving to P1 and some to P2. • The ambition to continue with the pathway shift should lead to bed reductions by Q3. • The changing case mix has led to a higher concentration of complexity in beds and strategies will be needed to address this. • P1 has been adjusted and Health and Social Care teams are working together to integrate services and increase capacity, having achieved a target of under 10 days on P1. • There is still work to do to join up data and track availability and this is in progress through the SDU. • Admission avoidance plans include expansion of same day Urgent Care in Sirona, extension of FACE, opportunities within NHS@home to achieve 160 caseload target and investment in hospital same day emergency care which has been equivalent to saving 32 beds. These actions are already in place but not yet fully delivering. • The Transfer of Care Hubs (TOCH) model of working where operational process have been adjusted and are now becoming BAU. There has been significant improvement in P1 which is the highest volume pathway leaving the acutes. More work is needed to further improve the processes. • Work is underway to look at clarity of coding where small changes can have a significant impact. • If community LOS can be stabilised it will be more likely that spending can be contained within the financial envelope and NCTR issues can be resolved. • Support is being given by the Department for Health and Social care for improvement plans. • MDTs have been increased to focus on individuals approaching delay days.	

	Item	Action
	• Workforce is being used creatively to reduce backlogs when there is capacity. • The D2A programme has been working alongside MH teams to replicate successes in MH discharge pathways. • Using funding from the Better Care Support Fund, a model for out of hospital care has been commissioned which is due to be finalised next week. This will give visibility on the impact of reducing NCTR in acutes on flow and on NCTR in Sirona and Social Care. ED raised a concern that there have been lots of successes in the work on NCTR but that the overall position has not improved. DJ explained that it is now important to continue with the new models and processes which are working well and focus efforts on areas which will have a direct and measurable impact, even if this requires re-prioritisation. The next stage of Capacity and Demand modelling will inform this process. ED requested confirmation of the timeline for the modelling and anticipated impact upon NCTR. RJ commented that the model will be completed next week and be taken to Board in May. Step changes are expected at the end of Q1 and Q2, with factors other than the D2A programme feeding in. Then a reassessment will take place to review the impact. ED thanked the team for their hard work on NCTR. RS noted that the workshop sessions should discuss changing the conversation from D2A to Home First. Well established that a person's own home should be prioritised for as much care as possible with a shift from a bed-based model to one focussing on independence. Community based pathways should be prioritised, and this will reduce NCTR through admission avoidance. RS highlighted the risk of more individuals moving to Funded Care Pathways if patients have longer LOS as this reduces their independence. PM added that NCTR was discussed at the Sirona Quality Committee and noted that the whole system is now working together on the issue. AM made the following comments: • That a greater part of the presentation could be given over to NCTR in MH settings and that the MH trust needs the same support for NCTR as the acutes. Also, NCTR in MH has a direct impact upon individuals with MH issues presenting at A&E. • A proposal that benchmarking compare BNSSG against high performing organisations to identify different models. • That it would be useful to consider patient experience and outcomes for individuals who have been NCTR. • Whether NCTR is now a whole system priority, since the priority actions are focussed on the input from the Health Sector. • That there also needs to be a focus on individuals who do have Criteria to Reside and are in inpatient settings, to gain confidence that there is enough focus and productivity on them too.	

	Item	Action
	JF commented that patient focus is the lever for all system partners to work together and queried the level of confidence in all aiming towards being patient focussed in plans, whilst working with current system pressures. DC referred to the work of Primary Care in admission avoidance, where step-up pathways need to work together, as well as step-down, suggesting that more could be done in Primary Care to prevent individuals presenting at the acutes. DC shared anecdotal evidence regarding dependence where individuals lose their independence to administer their own insulin whilst they are in hospital as it is quicker and easier for staff to undertake this when the wards are pressurised. DC noted that, if colleagues were educated and trained on pathways together, it would enhance the understanding of working collectively. PM reiterated that, in his position as a NED, he is seeing Sirona working more closely with system partners than at any previous time. DJ responded to comments: • Acknowledging that consideration will be given to MH and Community NCTR, particularly as there have been recent significant waits of MH patients in the acute settings. • Noting that the Discharge and Oversight Group is supporting with benchmarking and has devised the whole system partnership demand and capacity model. DJ is working with this group to find more peer benchmarking and best practice. • Regarding step-up, all system partners have committed to the trajectory. • Undertaking to involve the patient lens in NCTR improvement work. • The Driver Diagram covers A&E and inpatient wards so looks at impact upon the whole flow package. • Whist ensuring that parameters are manageable, the engagement of Primary Care will be improved. ED thanked DJ and RJ for the honesty and scrutiny offered and requested that trajectories be set realistically, with points when direction can be reviewed and discussed with this committee if targets are not being achieved. DJ noted that the oversight and performance management of the work will be through Performance Escalation Group to SEG, and that this committee will continue to be sighted via the performance report. **ACTION: DJ to bring a short update on progress to June Committee that should include trajectories and performance against the trajectory.**	
6	**Chief Delivery Officer Update** • **Performance Report – to include GIRFT productivity.** • **Operational Plan Update** • **EPRR Policy Update** <u>Performance Report</u> DJ highlighted the following points from the Performance Report: • That following the national focus on the 4-hour standard in March, BNSSG delivered at 73% against a national figure of 74% despite the challenges of significant operational pressures and being in OPEL 4 in the second week, which was a notable achievement for providers.	

	Item	Action
	• There is a commitment to reach 78% by March 2025 in line with the national target. • Cat 2 times remain good and are currently very low given pressures. • Elective is strong on both 104 and 78 week waits. • Regarding the 68-week wait there is a residual speciality issue and NHSE are supporting in the management of this. • Cancer work continues to perform at a high level. • Pressures in the MH bed base and Out of Area placements are partly due to NCTR, with 6 patients now OOA. There is good system work underway to improve that position with LA colleagues engaged, looking at housing options and different models of flow. • System COOs will be invited to June Committee to talk about GIRFT productivity. ED noted the good news regarding elective, cancer and Cat 2 improvements. <u>EPRR Policy Update</u> DJ introduced the annual review of the EPRR policy and asked for any key concerns or questions so that the Committee could approve it. ED noted the last desk-top review and requested assurance that the last full review had been held as required. **DECISION: the Committee agreed to approve the annual review of the EPRR policy.** **ACTION: DJ to confirm when the last full review of the EPRR policy had been held.**	
7	**Items for Discussion**	
7.1	**CNO / CMO Update** • **Emerging Risk** • **Quality Report** • **Maternity and Neonatal Equity and Equality Action Plan 2023-2025** • **“How you see me matters” and “Who I am matters” CQC** <u>How you see me matters and Who I am matters</u> MC explained that Who I Am Matters had come about as a result of the Oliver McGowan Review and gave an opportunity to hear from people with lived experience in a way not normally available in routine inspections. Five themes were identified through a multi-agency review undertaken into how hospitals support people with LD, and the experiences of the individuals, by visiting hospitals with varying demographics. This has helped to frame what expectations of providers are which, although seemingly obvious, in the current climate can be affected by time, skills and resources needed. When those expectations are not met, individuals do not access the care they need. Providers are expected to ensure that staff have knowledge and skills and enough time to give the supported needed. The report discusses adjustments, with a focus on communication and, since the report has been published, the reasonable adjustments flag has been introduced.	

	Item	Action
	It was noted that, for in-hospital care, when staff went above and beyond it made a significant positive difference but when adjustments were not made there was a negative impact on care. Additionally, communication and engagement also need to be with service users' circles of support. Regarding protected characteristics and equity of care, most staff know what they were but could not translate their knowledge into meeting the needs of an individual and the terms LD and Autism were still interchanged. Staff ability to understand the whole person is important and the potential for diagnostic overshadowing is still relevant. Additionally, even if staff understand the theory, they need practical training to apply it. It was also noted that specialist staff are often only available in office hours so the whole workforce needs to be able to meet the needs of this cohort. The How You See Me Matters report investigated the way that autistic people use primary care services, understanding the different ways in which they may see and hear the world. Autistic people have a shorter life expectancy so the importance of Primary Care services getting their offer right cannot be overstated. The report contains real experiences from autistic people when using GP and Dental services. Findings have been shared with both the National Autistic Society and individuals with lived experience. People, provider and system factors have been identified with the anxiety experienced by autistic people noted as creating delays in access to primary care. An example was given of the perception of pain and describing it, with autistic people not believed as their facial expressions did not match what they were saying. Provider factors include staff with poor understanding having stereotypical views. Autistic people without LD are sometimes not taken seriously by providers regarding their need. Work is underway to review statutory autism guidance to provide a consistent roadmap for expectations. ED expressed the thanks of the committee for the presentation and noted that this work now needs to be included in existing workstreams. RS extended an invite for MC to present at LDA ODG or MHLDA HCIG. <u>Quality Report</u> RS highlighted the main points from the Quality Report: • There have been two significant discussions at SQG since the last Committee regarding two cases where individuals had sepsis. The first national case in which a patient died of sepsis following a cycling injury and where a campaign has led to a new Call for Concern system being implemented so that families concerned about deterioration of a patient are entitled to request a second opinion. The second discussion was about Maddie Lawrence who also had concerns raised by her parents whilst she was in NBT and where, although staff knew how to do observations and report them, there was still a lack of response to the complex set of symptoms. The two trusts will collaborate on learning and developing a consistent approach and evaluating it. RS assured the Committee that Call for Concern is being implemented.	

	Item	Action
	• SQG has also discussed learning from PHSO regarding escalations and complaints from patients, looking at reviews by peers, non-exec peers and experts by experience, with a view to improving consistency of practice. An Experience of Care Group is being created to be a subgroup to SQG. • Escalation from SQG: AWP are in enhanced surveillance and a recent QIG undertook a deep dive into quality and safeguarding. This work is not yet complete with a second phase to come back to QIG in early May. Following this the intention is to close down QIG and move to an Enhanced Contractual Oversight process. This will be preceded by a quality deep dive and diagnostic to take into the oversight process reporting into the Improvement Board. • Independent reviews into Fromeside and Riverside will be commissioned by the Provider Collaborative and NHSE will discuss the TORs for these. BSW ICB will be invited into the conversation to progress this. • RS advised Committee that there is a backlog in LeDeR reviews. Previously these had been completed in a timely manner but there has been difficultly with the capacity commissioned to complete them recently. Extra support has now been commissioned from CSU on a short-term basis and the ICB is now going out to procurement for future providers. • There is detail about the Funded Care situation in the report with an overview in the cover paper. The Funded Care team has performed well against external measurements but there is a significant overspend which is a risk to the ICB and system. This is caused by a number of factors including an increase in Funded Nursing Care caseload and complexity. ST and DM are meeting regularly, and a recovery plan is in place overseen by FED. <u>Maternity and Neonatal Equity and Equality Plan</u> RS asked the Committee to note this action plan which will be live on the ICB website on Friday 26th May. The plan has been revised and refreshed and built upon the needs assessment. ED raised concerns about Safeguarding, referring to the Rapid Reviews and Children in Care, asking for clarity on the system approach to progressing work on any findings identified and whether there are any immediate actions for the system. ED noted that Children in Care Health Assessments are not in line with the Statutory Framework and asked for assurance that there is a clear plan to resolve this. RS commented that some of the Rapid Reviews are due to the recent cases of knife crime, with the children involved spanning all three LA areas, and all are progressing to Child Safeguarding. Immediate actions have been taken by system partners and the police have implemented diversionary activities. The reviews will highlight issues, particularly about attendance in education. Conversations are also underway involving SEND. There will also be learning taken from CSPRs. Regarding Children in Care Health Assessments, RS reported that there have been challenges to access the information which Sirona need from the LAs and that notifications to Sirona have not always been timely. RS will discuss this	

	Item	Action
	with the Directors of Children's Services again. RS summarised that progress is being made but that further work is needed. PM added that initial health assessments should be undertaken within 25 days, but that late arrival of information affects this, with problems mainly being seen in NS, and therefore there is an impact upon results. There is potential to call a summit of all Children's Services providers to talk about Education, Health and well-being of Young People. These issues are being seen nationally. AM noted that there were no serious incidents reported in UHBW or NBT in February but eight in Sirona. RS and AM acknowledged that there has been a change in reporting to PSIRF and this may need to come back to Committee to understand the change in process. Sirona has not moved to PSIRF yet. PM referred to the eight SIs in Sirona and confirmed that all are being reviewed with a formal report to be taken to the Quality Committee and a Critical Case Review planned. AM asked for assurance that BNSSG is learning from other systems and requested that future updates contain information on plans to resolve issues. AM noted the variation across the LAs on Funded Care mean-days-to-decision and asked if this Committee should note this as an issue. AM commented on the level of narrative reporting in the Quality Report with insufficient focus on actions underway to resolve. RS agreed to review the content of the report for future committees. ED requested clarification on the timing of the AWP Improvement Board. **ACTION: RS to ensure that actions being taken are reflected in the report.** **ACTION: LeDeR Recovery and Annual report to be on June agenda** **ACTION: RS to confirm timing of AWP Improvement Board**	
7.2	**Segmentation Improvement Update** **– included in Performance Report item 6** • **Mental Health** • **Learning Disabilities and Autism (inpatients)** DJ explained that the NHS System Oversight Framework is a process by which NHSE provide a level of assurance across ICBs and providers, with each allocated to a Segment. BNSSG ICB are currently in Segment 3 and continue to update to NHSE as required. The Q4 assessment against Segment has recently been completed so there will be a formal update for the June Committee. On key items: Cancer and Elective are improving, there is better planning on agency spend and better utilisation of Virtual Wards, all of which have been highlighted by NHSE. However, LDA inpatients is not forecast to meet target. In order to ensure that Committee is sighted on key issues regarding LDA inpatients and planning in place to improve, DJ noted the following points: • A report was taken to NHSE on three areas: annual health checks and two issues regarding inpatients.	

	Item	Action
	• Most problems with LDA inpatients are with the adult cohort. • Performance data is a month out of date due to the reporting cycle. • Work is underway to look at the reliance on inpatient beds commissioned by the ICB and also by NHSE or the Provider Collaborative. • The target for the ICB is 6 against an actual of 15, for NHSE / Collab the target is 12 and there are 19. • The 34 individuals in inpatient beds is one of the highest figures in the South West. DJ gave assurance that the rationales behind this figure are being investigated, noting that this is not a recent increase. • Themes emerging are delays in discharge due to allocation of social workers or care co-ordination and workforce recruitment. Work is underway with community projects and BCC regarding accommodation. • Contracts, particularly with Sirona, are being reviewed to understand response to referrals for individuals with Autism only, mild conditions and Out of Area placements. • A LDA strategy will enable some issues to be resolved. **ACTION: DJ to report back to June Committee on Segmentation.**	
7.3	**BNSSG Mortality Annual Report** VH introduced the paper and explained that July 2023 Committee received a report on Local Mortality and Regional Trends. Following this, a BNSSG Mortality Surveillance Group was created. The group has reviewed reports and is using quantitative mortality data triangulated with data from the Medical Examiner Service to understand issues and opportunities for improvement. The group has a wide representation and will report annually and through regular CNO/CMO reports. VH highlighted some of the work which the group has undertaken: • Regarding Liver Disease, a regional report has identified major causes of death and median age of death in the most and least deprived populations, showing significant gaps. The analysis has been replicated locally and shown a sixteen-year earlier age of death in the most deprived populations against eight years nationally. Unlike other causes of death, numbers are rising. Data on the population living with Chronic Liver Disease, and at risk, is being interrogated to determine opportunities for improving outcomes. Once the analysis is complete it will be reported back to the CMO. • From reviewing mortality reports and trends from other sources linked with child mortality, national trends are replicated locally but with lower figures so this will remain in oversight. • Review of a recent regional report on mortality highlighted preventable and treatable causes as being in line with the ICS strategy regarding early treatment for cancer and CBD. • Next steps will include a consistent dashboard reporting tool for mortality, to monitor trends and gain an understanding of causes, which will compliment current dashboards. A proposal for this has been taken to the group and a draft report will return there.	

	Item	Action
	AM commented that this work affirms the purpose of the ICB having links to PCNs and communities, and that a strong model can emerge regarding system mortality reviews. Other ICBs are beginning to monitor this as a system risk. AM noted that work could be done in-place to mitigate issues raised and referred to an emerging mortality risk associated with A&E waits of over 5 hours. ED asked for clarification on the timing of the Mortality Surveillance Group reporting to the CMO and actions which could make a difference to the lives of the population. VH responded that reporting for Liver Disease is already in place as the work has utilised existing reviews, and noted that the principal causes are Alcohol, non-alcoholic Fatty Liver Disease and Hepatitis. An iterative process of understanding services and finding opportunities has been proposed. SW suggested that themes, recommendations and actions from the output of the group should be part of the annual report to Committee. ED reflected on the mortality of individuals with long waits in A&E and proposed a report on this to Committee in the future. **Action: Report regarding mortality of individuals associated with long waits in A&E to be listed at future OQP Committee.**	
7.2	**Working with the Pharmaceutical Industry** DC reported that the Corporate Policy had been updated and that, although the intended audience is ICB staff, it is recommended that GPs also work under this policy, which they often do to avoid duplication. Other providers have their own internal policies. DC suggested that LAs could also adopt this policy. Updates from the previous version are about the UK Disclosure Database and are also applicable to working with Third-party companies often sponsored by the pharmaceutical industry. Other, minor updates are detailed on the introduction page. AM noted that the reference to Corporate Secretary on page 165 needs altering to reflect the new structure and that the reference to Governing Body on page 195 needs amending to better reflect the ICB. ED requested clarification on the risks noted in the policy. DC responded that there are not risks for the content of the policy but there are many risks if it is not adhered to. PM queried the appropriateness of a two-year review date and DC clarified that material changes would require immediate updating. **ACTION: DC to discuss with Rob Hayday the inclusion of risks in the Corporate Pharma policy.** **DECISION: the Committee endorsed the Corporate Pharma Policy and the review date of two years with the caveat that it could return before that time should there be material changes.**	
8 8.1	**Items for Information** **Healthcare Acquired Infection Group**	

	Item	Action
8.2 8.3 8.4	**Health and Care Professional Executive March Minutes** **BNSSG System Quality Group March Minutes** **APMOC Minutes April** It was noted that items for information may need to be part of the discussion in the future should they contain issues of a statutory nature.	
9	**AOB** There was no other business.	
	Meeting Dates 2024 • **Wednesday 26th June 1400-1625 MST** • **Thursday 26th September 1400-1625 MST** • **Thursday 28th November 1400-1625 MST**	

Tina Mostert Executive PA April 2024