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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

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.

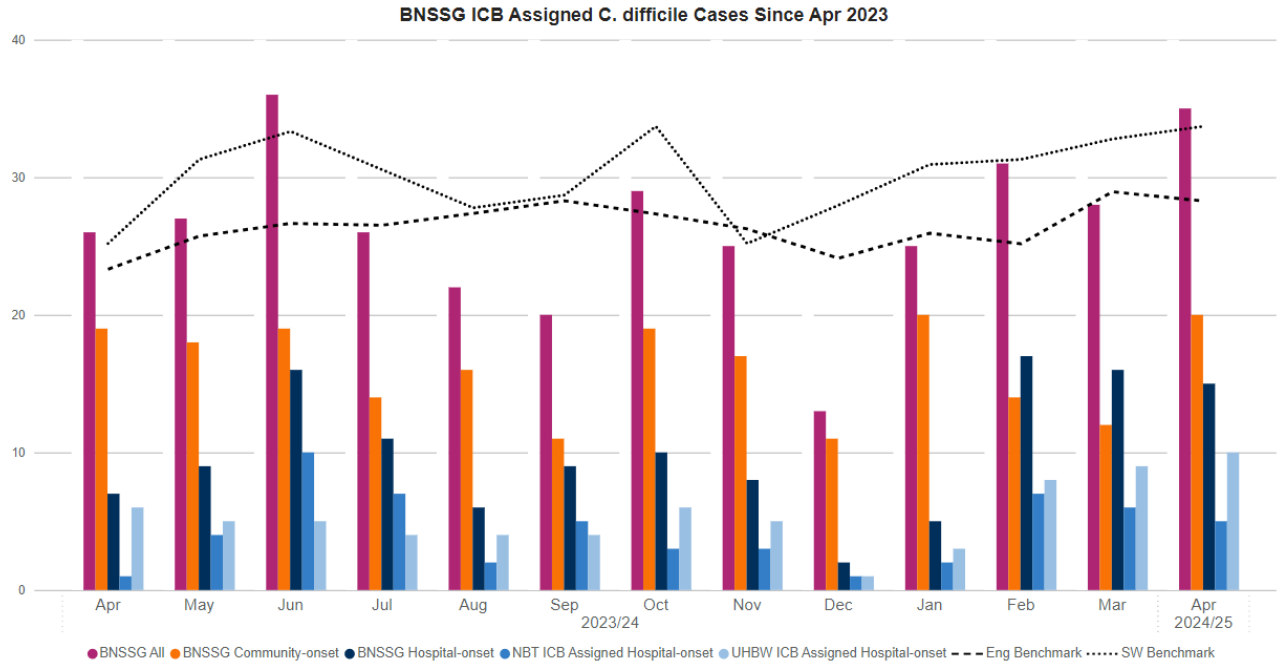
Infection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Threshold to Date	Cases YTD	Threshold	23/24 FYTD	22/23 FYTD
C. difficile	35													35		26	23
E. coli	53													53		37	42
Klebsiella spp	15													15		10	11
MRSA	3													3		1	4
MSSA	10													10		12	16
Pseudomonas aeruginosa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

Commentary

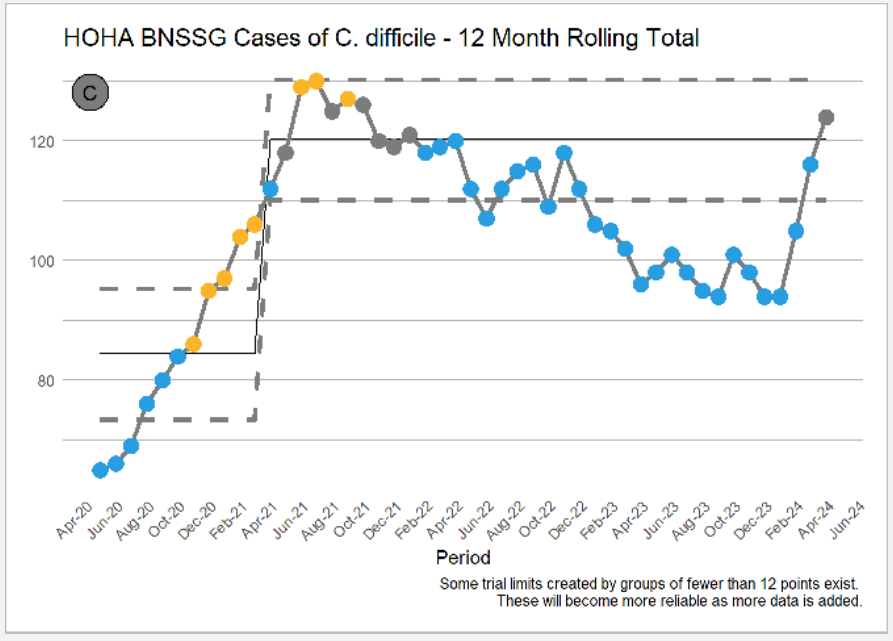
- MRSA- Zero tolerance has not been achieved. There were 3 cases in April (1 HOHA, 2 COCA).
- CDI- The 35 cases are currently categorised as follows: New infection (30), Continuing infection (2), Repeat/Relapse (2), Unknown (1).
- E.coli- the majority of the 53 cases continue to be Community Onset (43).

Quality Report – Healthcare Acquired Infections - Supporting Analysis

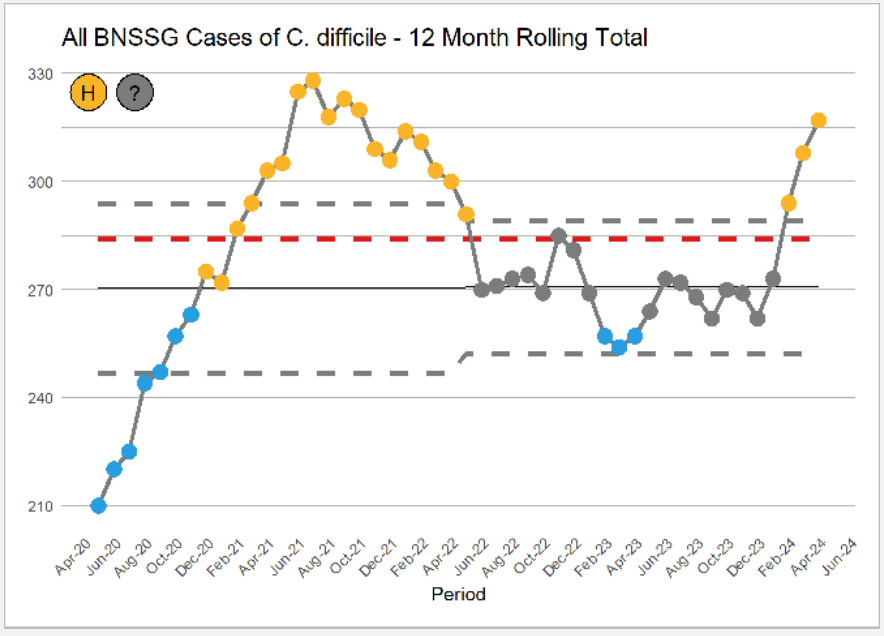
C. difficile	35
HOHA	15 (NBT - 5, UHBW – 10)
COCA	15
COHA	4
COIA	1
Unknown	0



HOHA CDI: Common cause variation indicating no significant change.

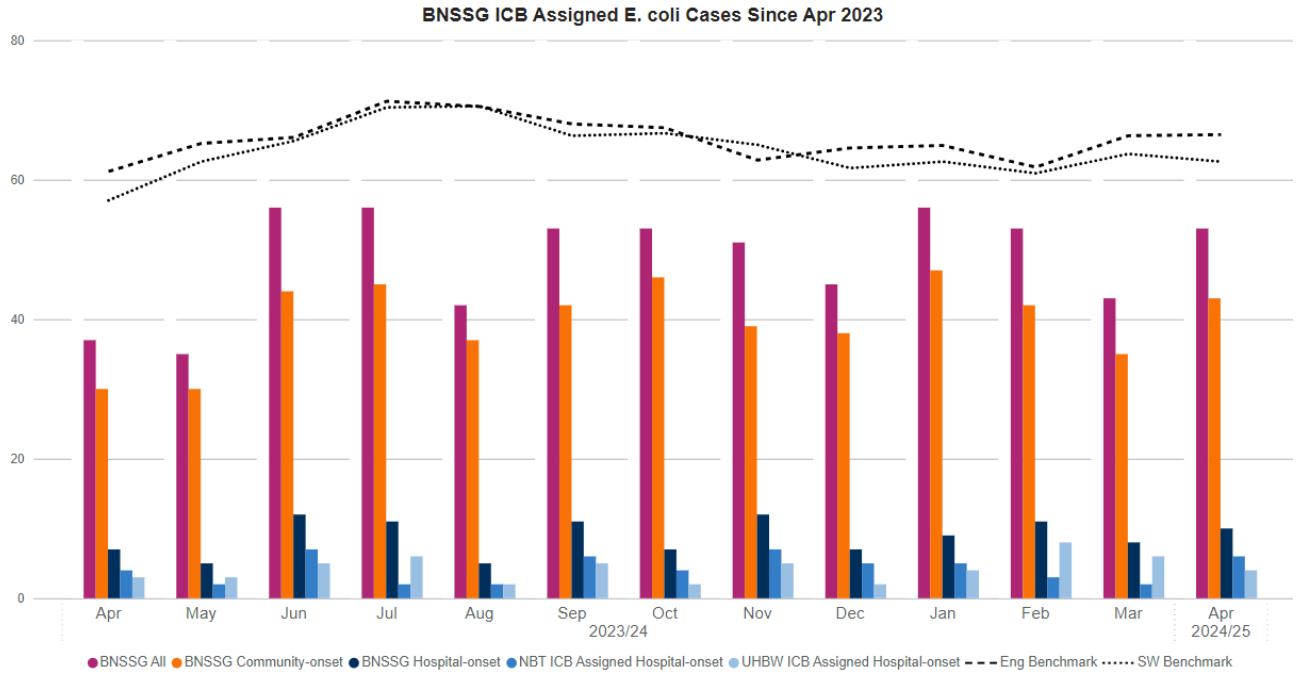


All BNSSG CDI: Special cause variation of concerning nature due to higher values, indicating inconsistently meeting/missing target.

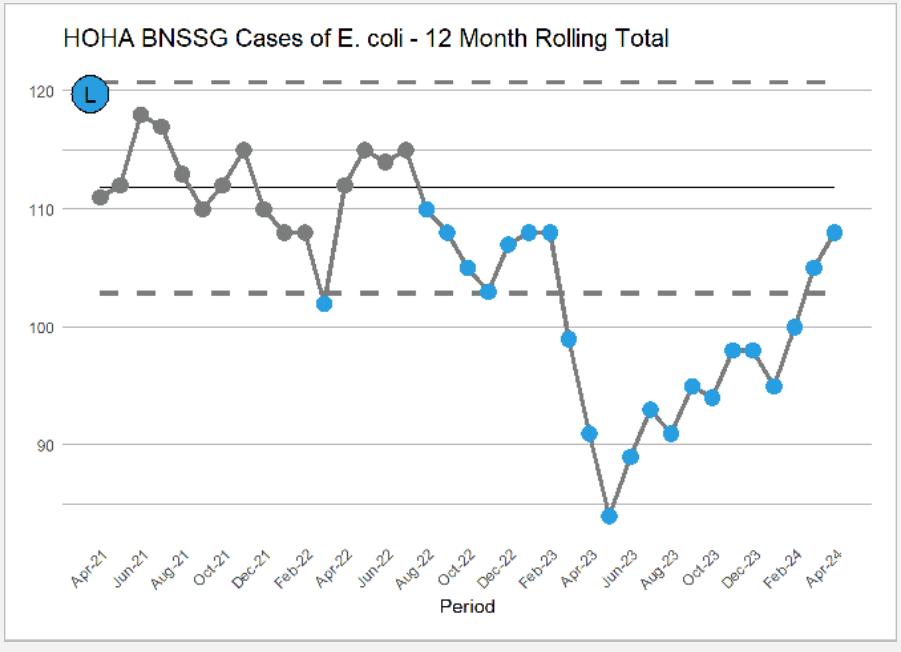


Quality Report – Healthcare Acquired Infections - Supporting Analysis

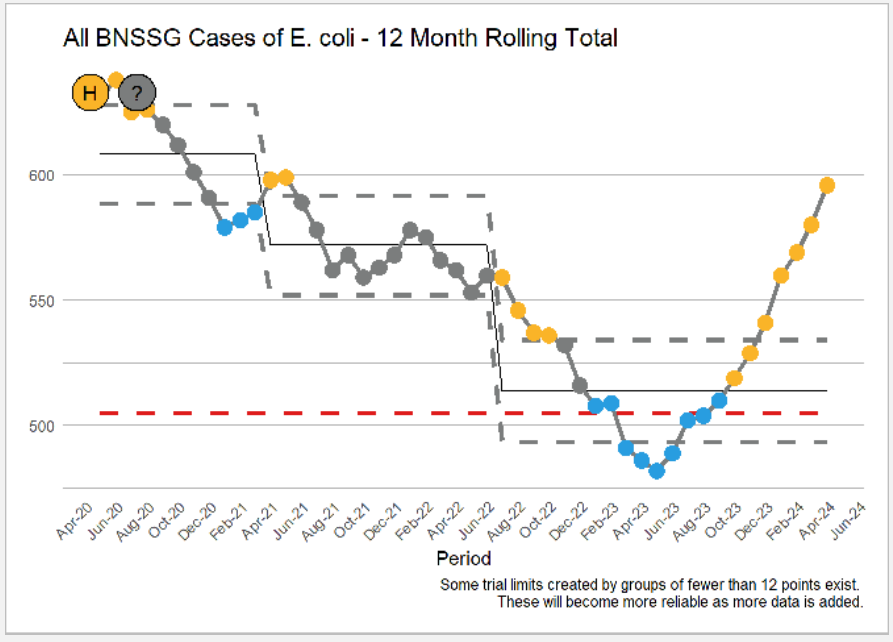
E. coli	53
HOHA	10 (NBT - 6, UHBW – 4)
COCA	30
COHA	13
COIA	0
Unknown	0



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

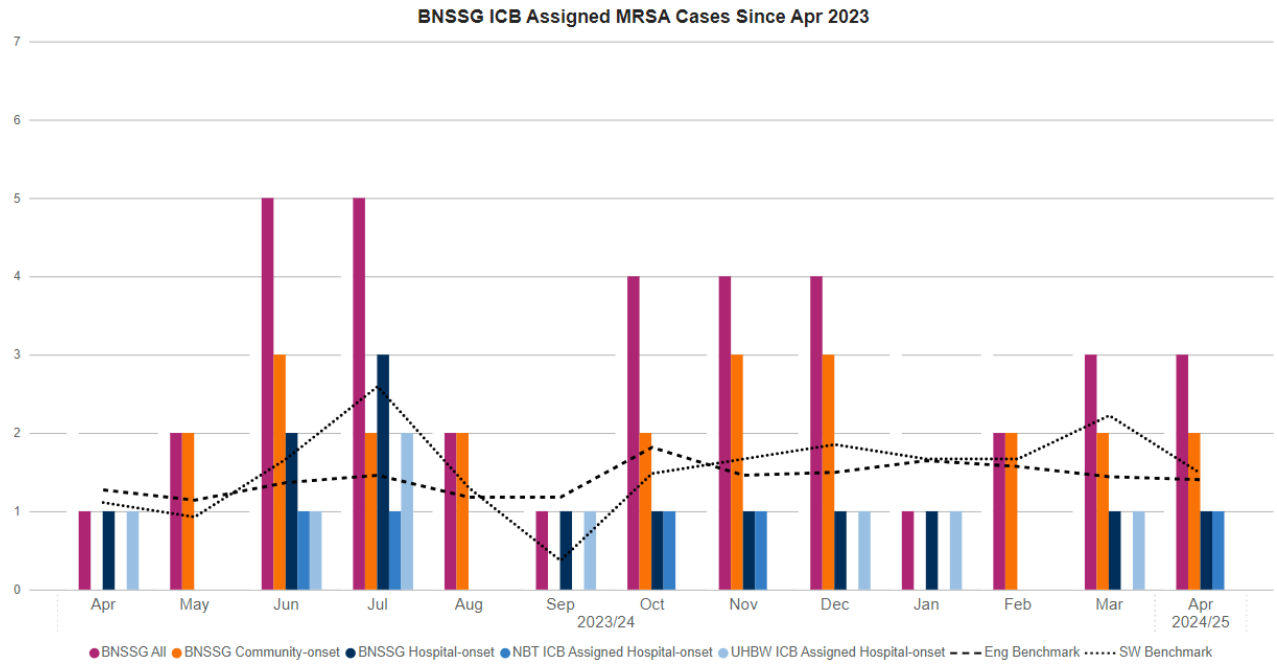


All BNSSG E. coli: Special cause variation of concerning nature or higher pressure due to higher values. Inconsistently passing and missing target.

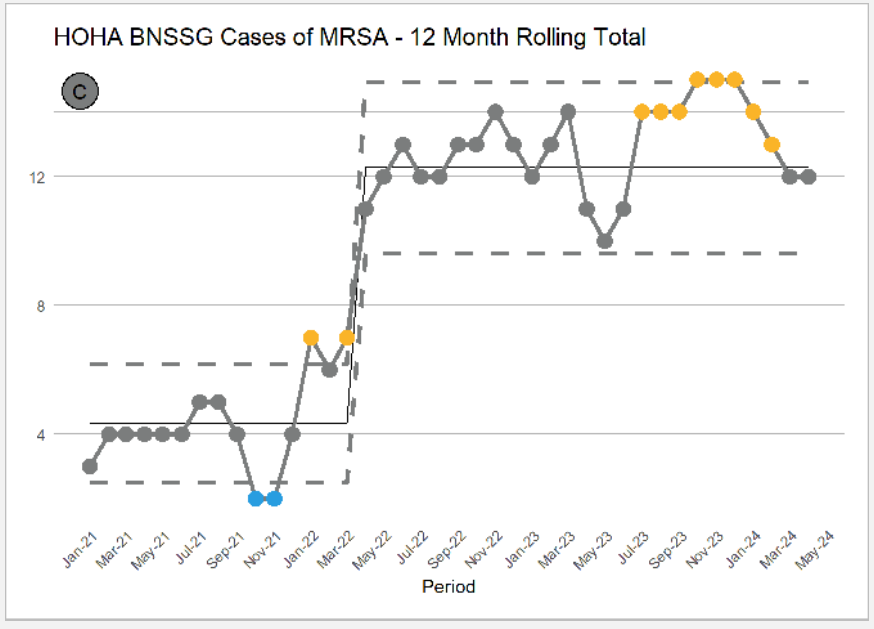


Quality Report – Healthcare Acquired Infections - Supporting Analysis

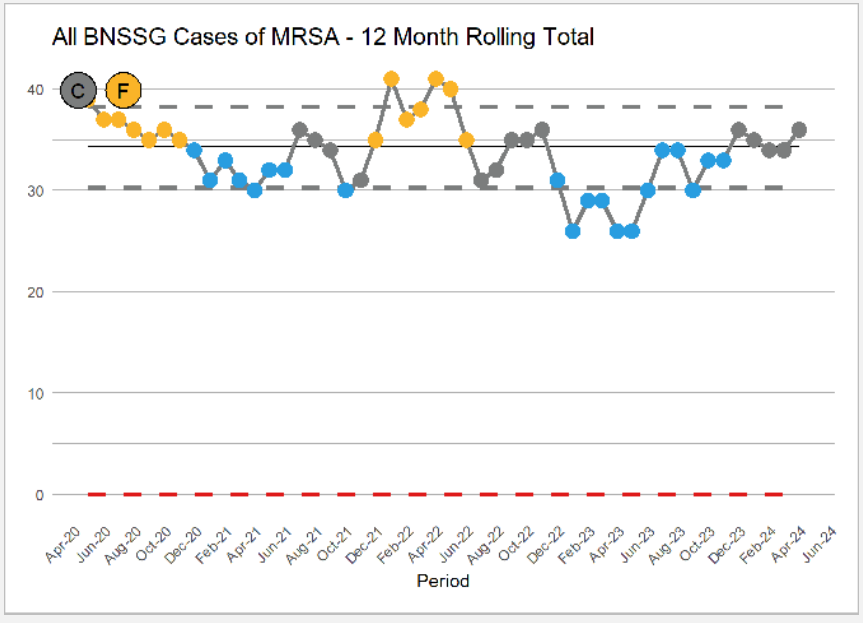
MRSA	3
HOHA	1 (NBT - 1, UHBW – 0)
COCA	2
COHA	0
COIA	0
Unknown	0



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

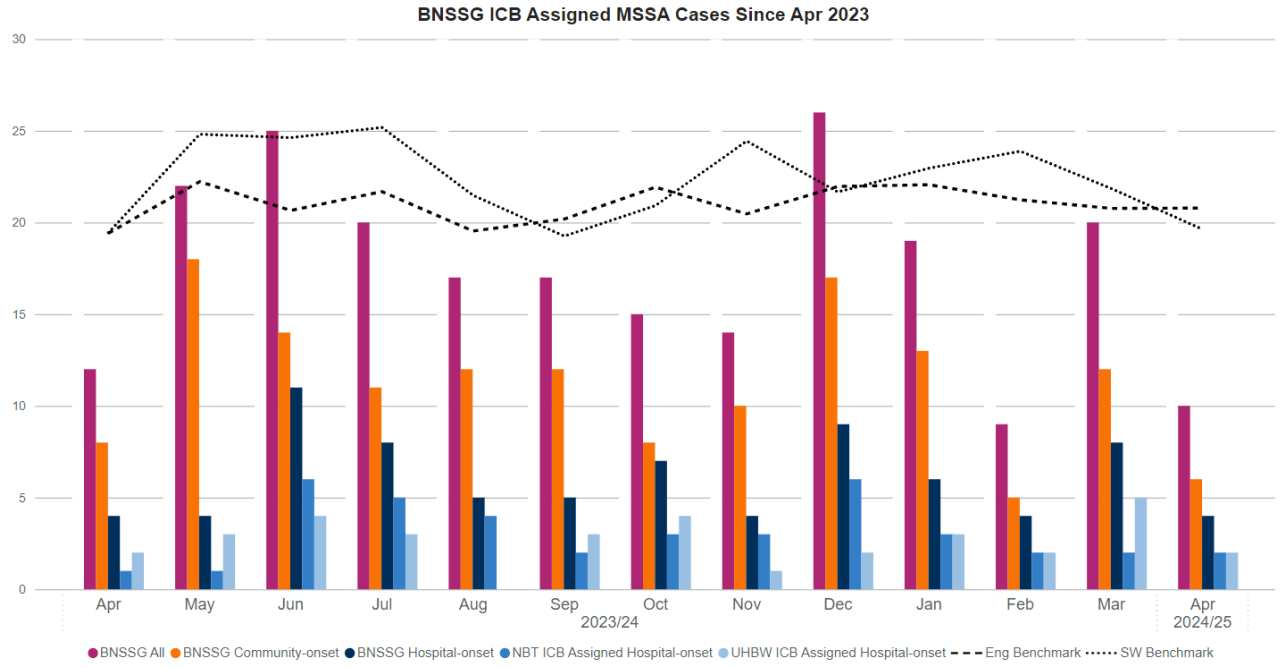


All BNSSG MRSA: Common cause variation indicating no significant change, however consistently falling short of the target.

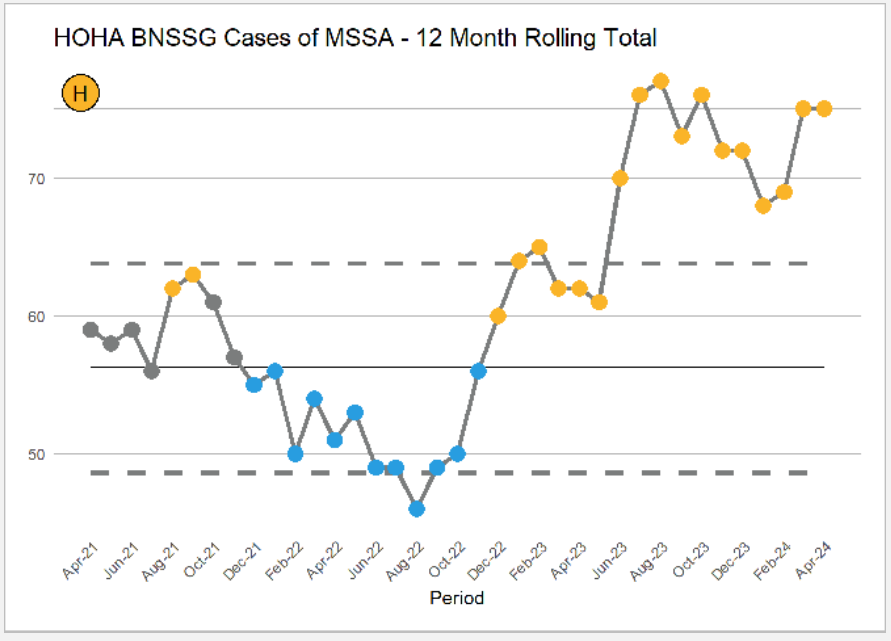


Quality Report – Healthcare Acquired Infections - Supporting Analysis

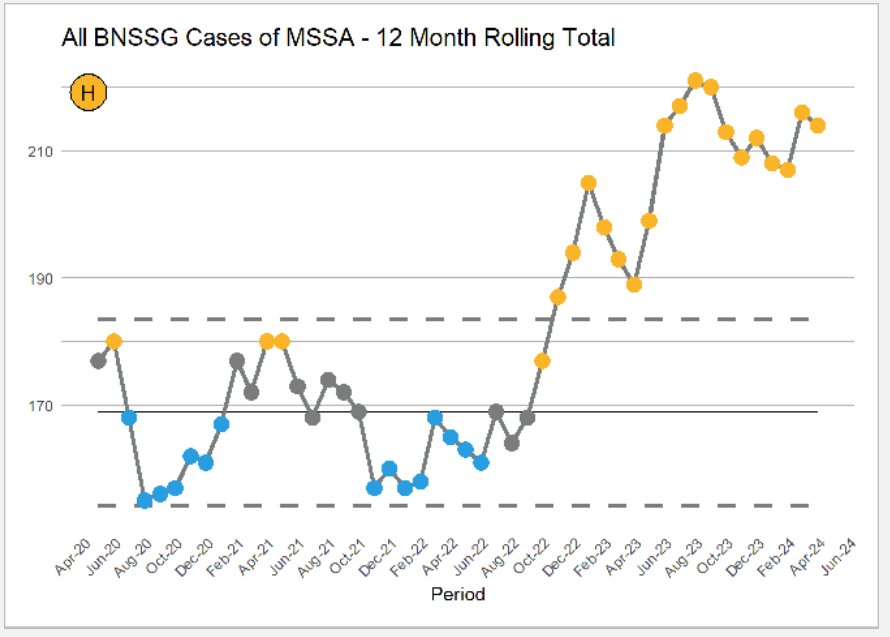
MSSA	10
HOHA	4 (NBT – 2, UHBW – 2)
COCA	3
COHA	3
COIA	0
Unknown	0



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

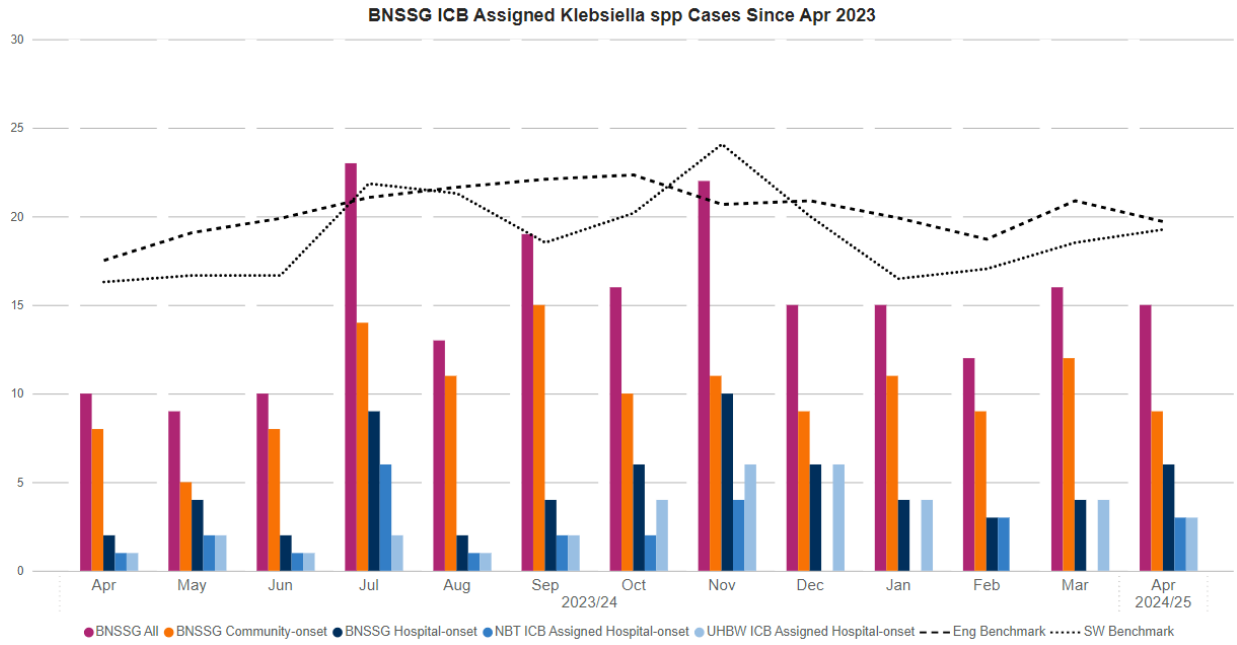


All BNSSG MSSA: Special cause variation of concerning nature or higher pressure due to higher values.

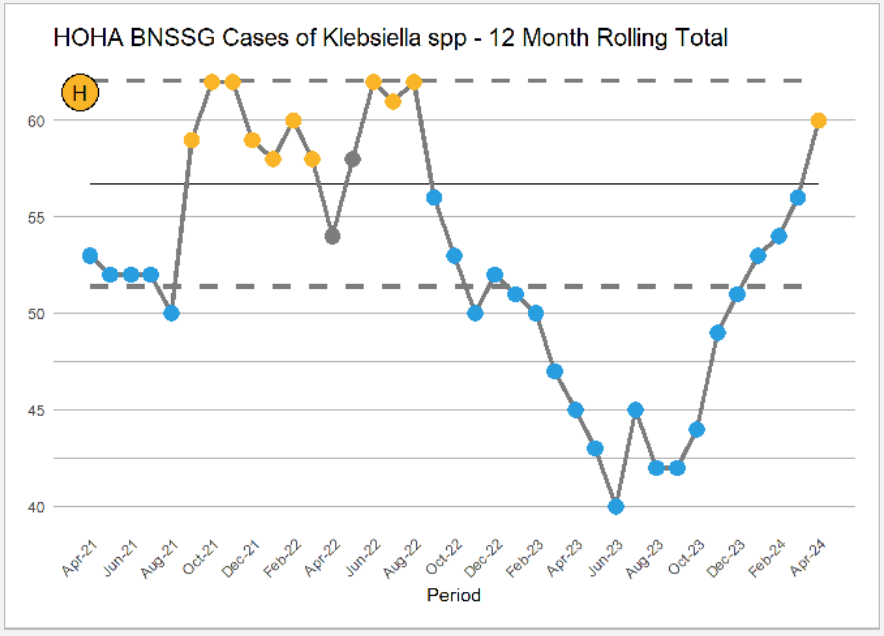


Quality Report – Healthcare Acquired Infections - Supporting Analysis

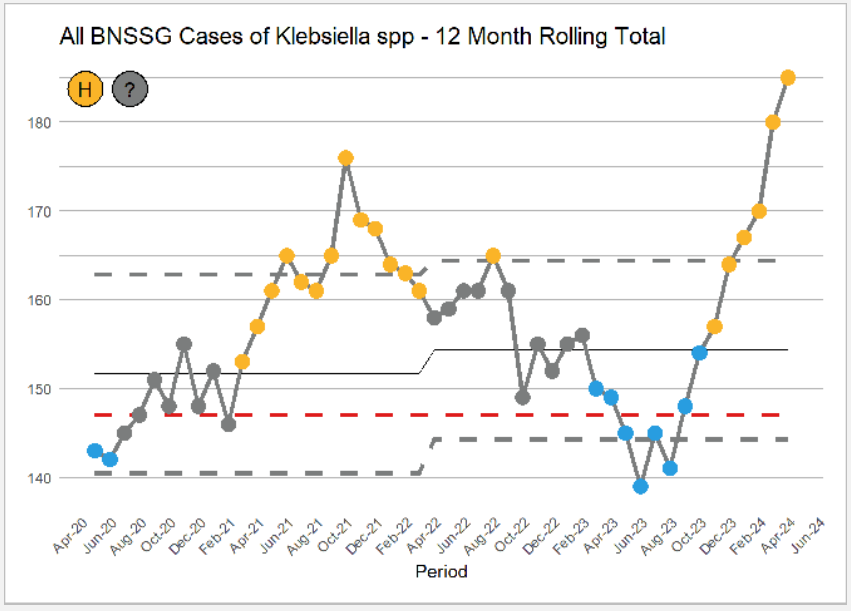
Klebsiella spp	15
HOHA	6 (NBT - 3, UHBW – 3)
COCA	6
COHA	3
COIA	0
Unknown	0



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

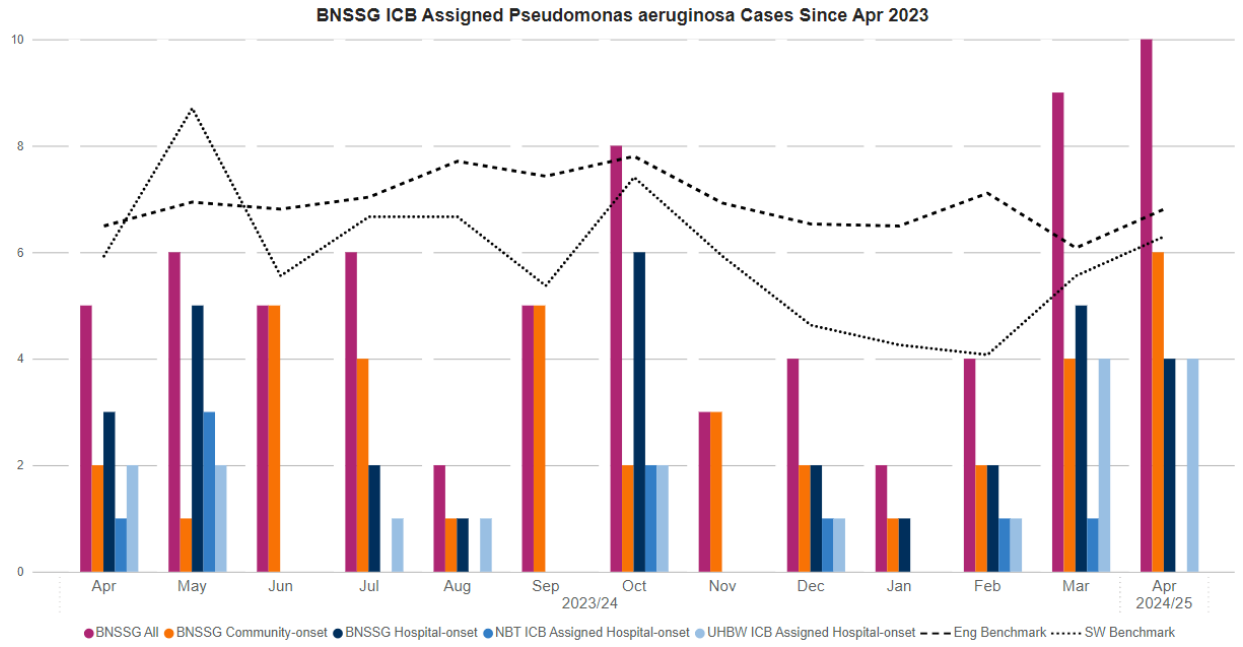


All BNSSG Klebsiella spp: Common cause variation indicating no significant change, however inconsistently passing and missing target.

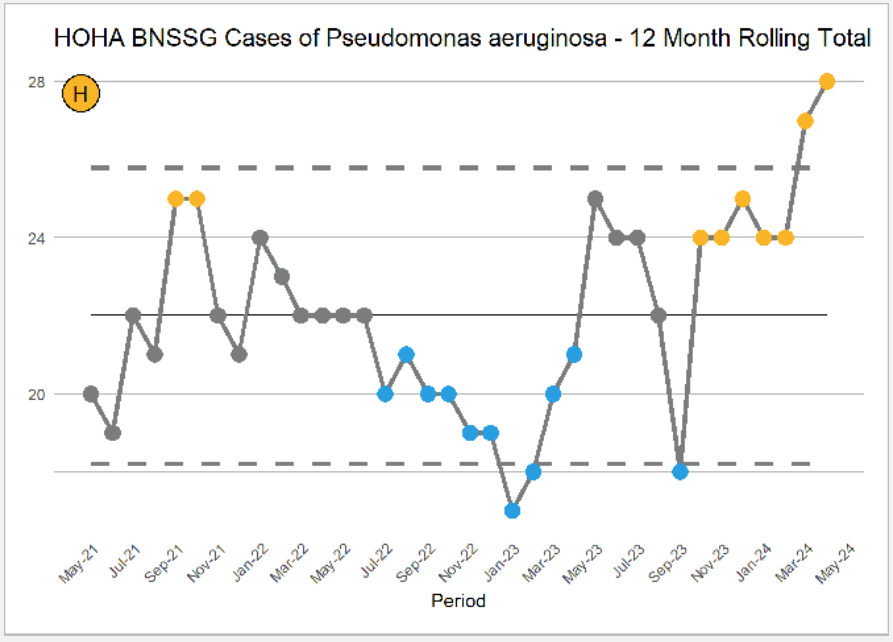


Quality Report – Healthcare Acquired Infections - Supporting Analysis

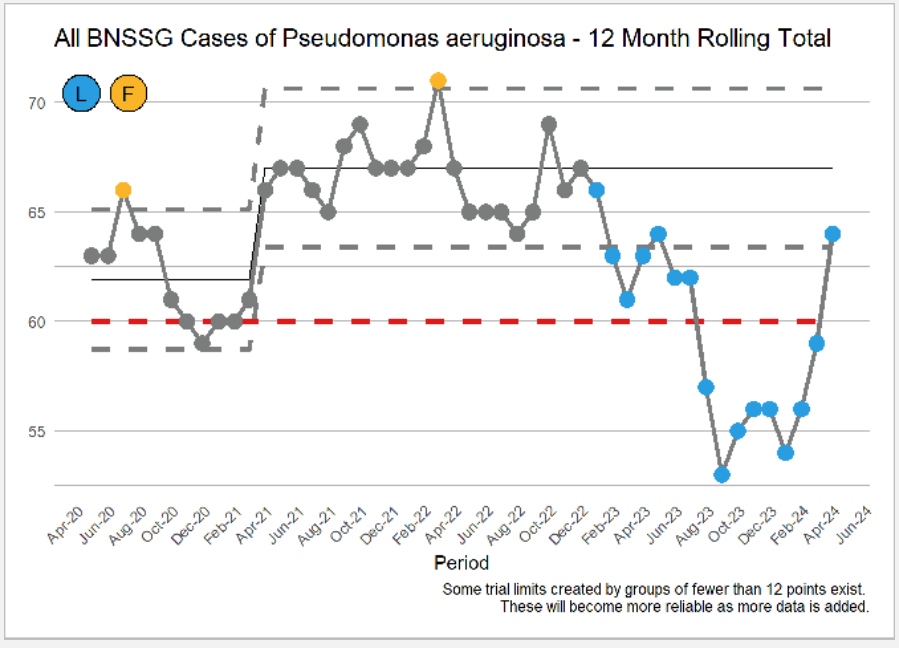
Pseudomonas aeruginosa	10
HOHA	4 (NBT - 0, UHBW – 4)
COCA	5
COHA	1
COIA	0
Unknown	0



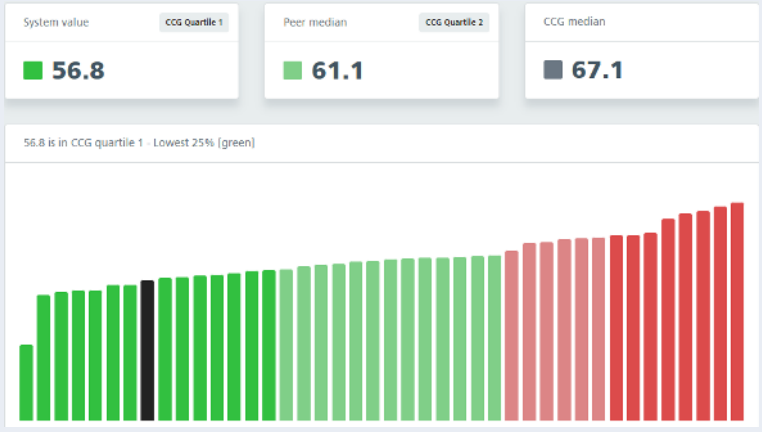
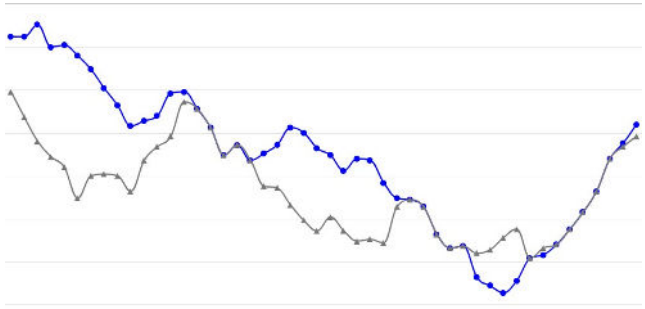
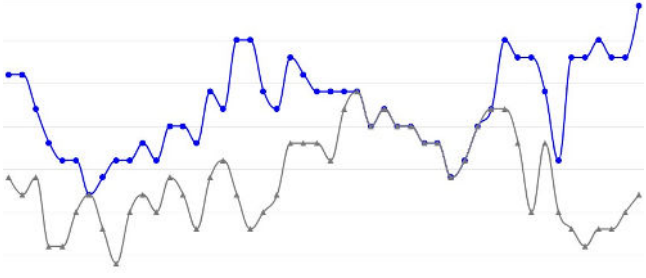
HOHA Pseudomonas aeruginosa: Common cause variation indicating no significant change.



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



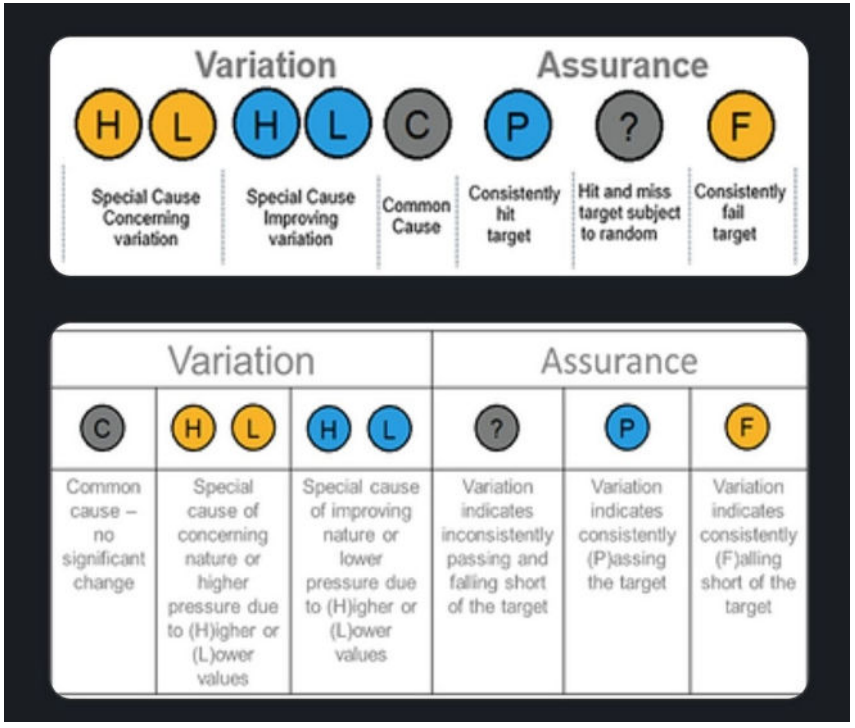
12 Months Rolling to Q4 2022/23 – All Systems

Infection	Onset / Sex	Age-sex standardised infection rates per 100k	Count of Infection (12 months rolling)	Comments
E. Coli	All/All		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		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.

Quality report – Healthcare Acquired Infections - SPC Grid

		Passing			
		Assurance			
		Passing the target	Hit & miss	Falls below the target	Total
Improving	Special Cause Improving	P1	H1	F1 Pseudomonas aeruginosa Cases BNSSG Wide	1
Variation	Common Cause	P2	H2	F2 MRSA Cases BNSSG Wide	1
	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.

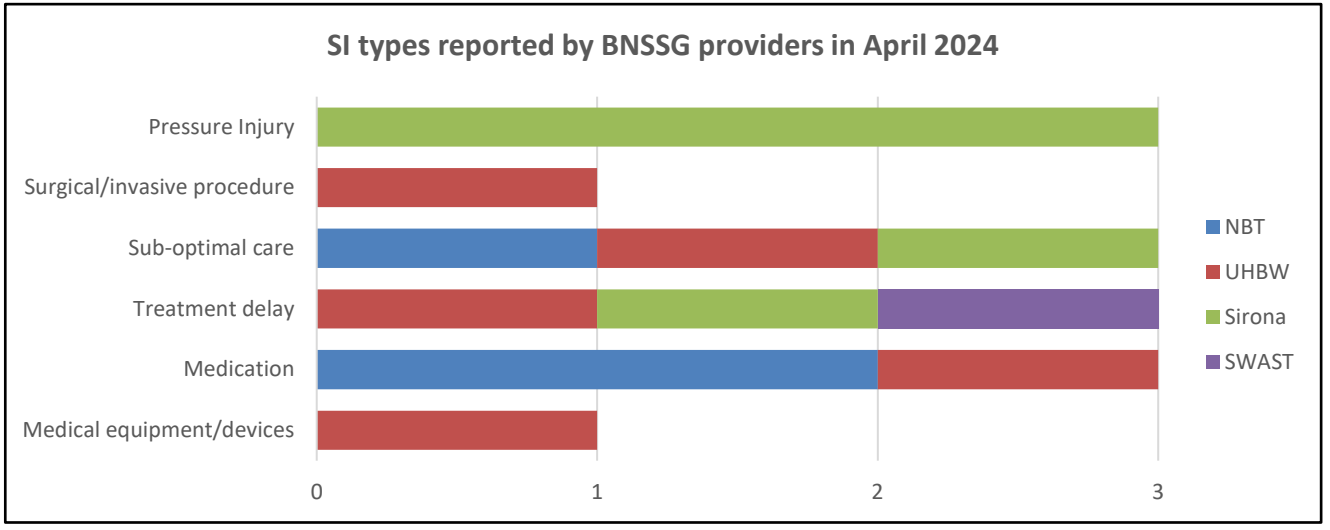
Nursing & Quality - Serious Incidents including Never Events
Reporting Period – Month 1 2024/25 – April data
Information Source and date of information – SI Tracker 14/06/2024

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*

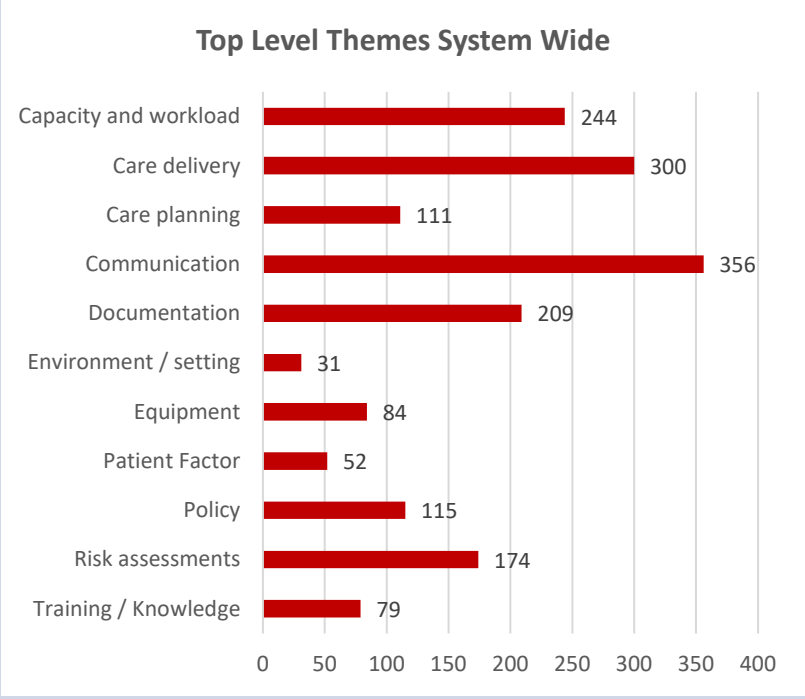


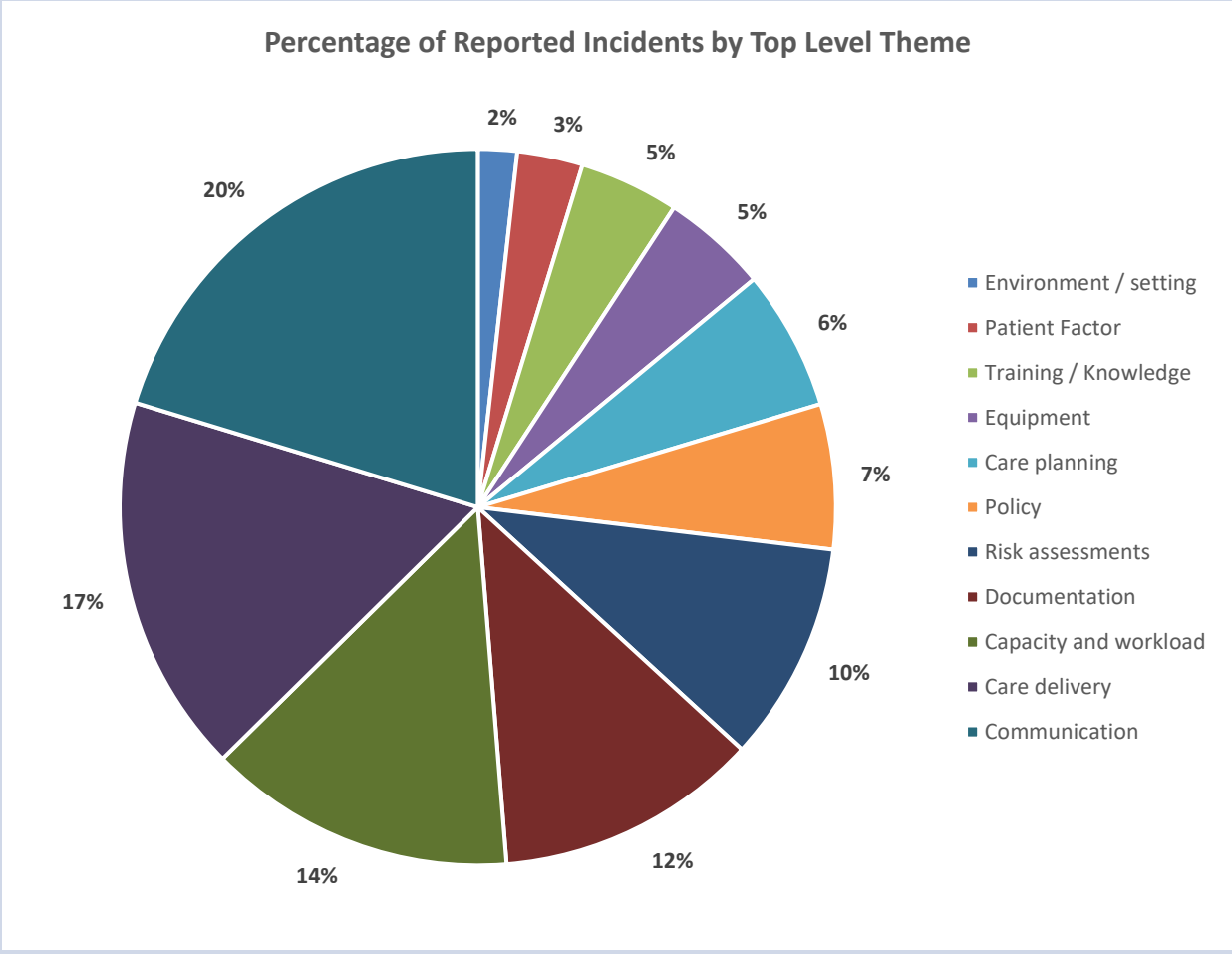
Year	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total SIs per Year
2023/2024	20	15	20	8	10	18 (2)	9 (1)	11 (1)	7	15	8	7	**148 (4)**
2024/2025	14 (1)												**14 (1)**

**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.

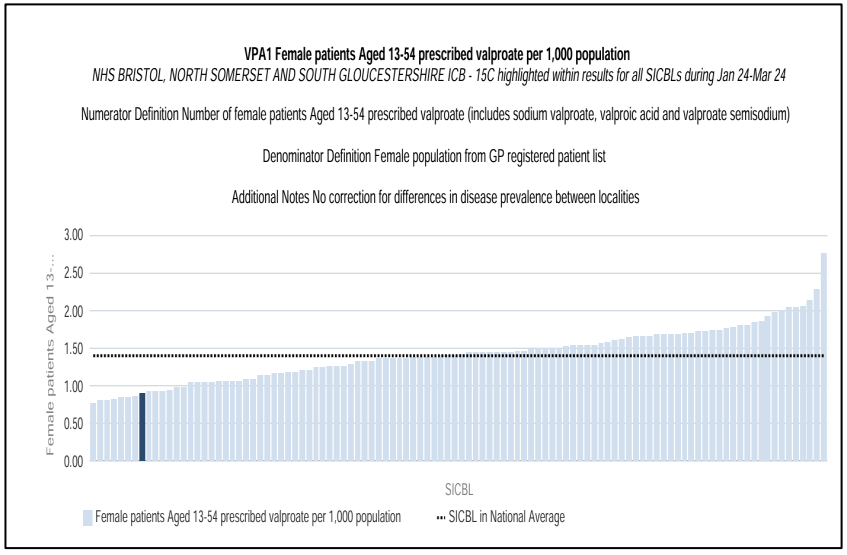
Overall, managing drug shortages takes increased resource, increased overall cost and potential impact on planned savings programmes.

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.

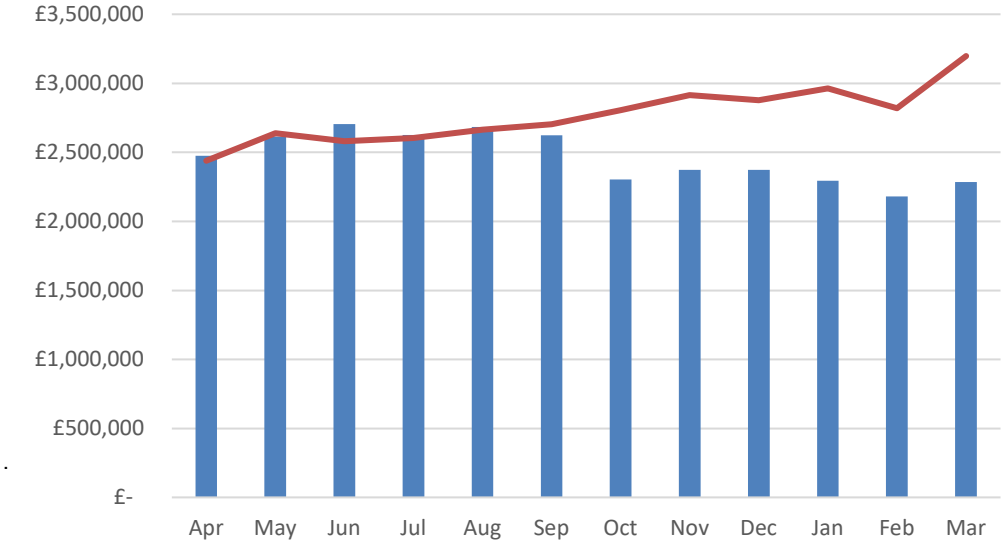
BNSSG OPQ is asked to note the work that has been undertaken and acknowledge that providers may need additional support should more extensive recommendations be published in relation to male patients taking valproate.

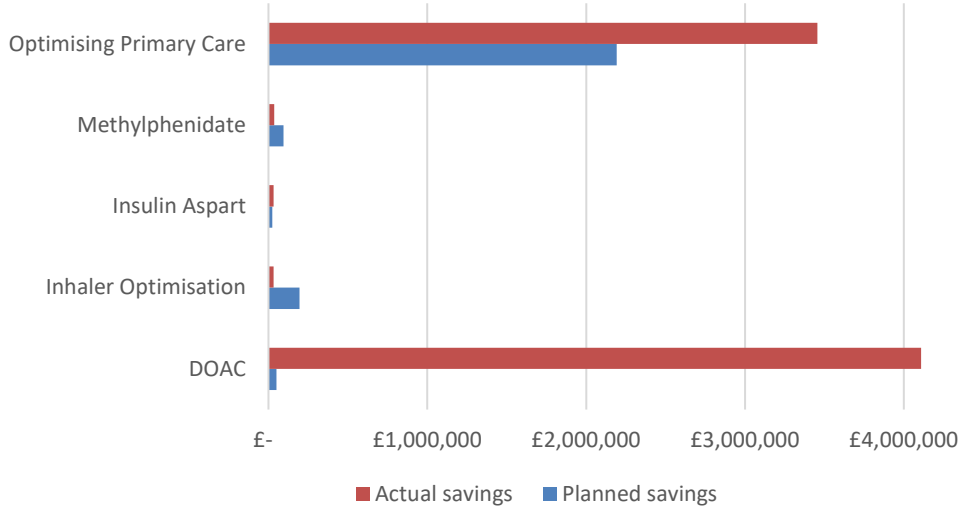
Medicines Optimisation Finance update

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.





Antimicrobial stewardship

Primary Care Prescribing

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

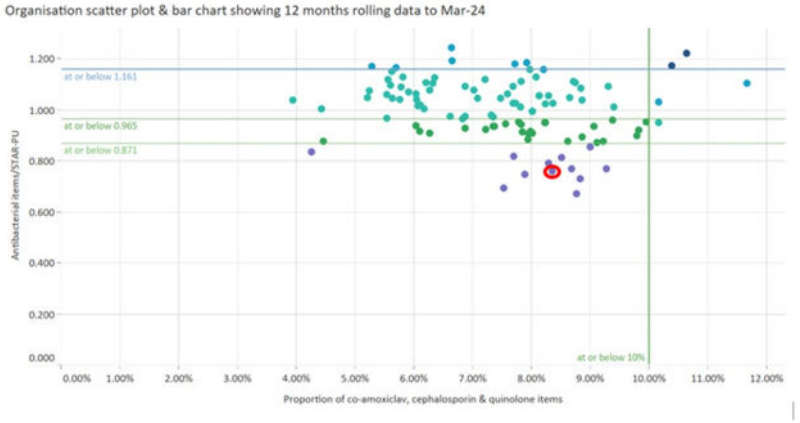
- Antibiotics/Star-PU (a measure of overall prescribing) being less than 0.871.

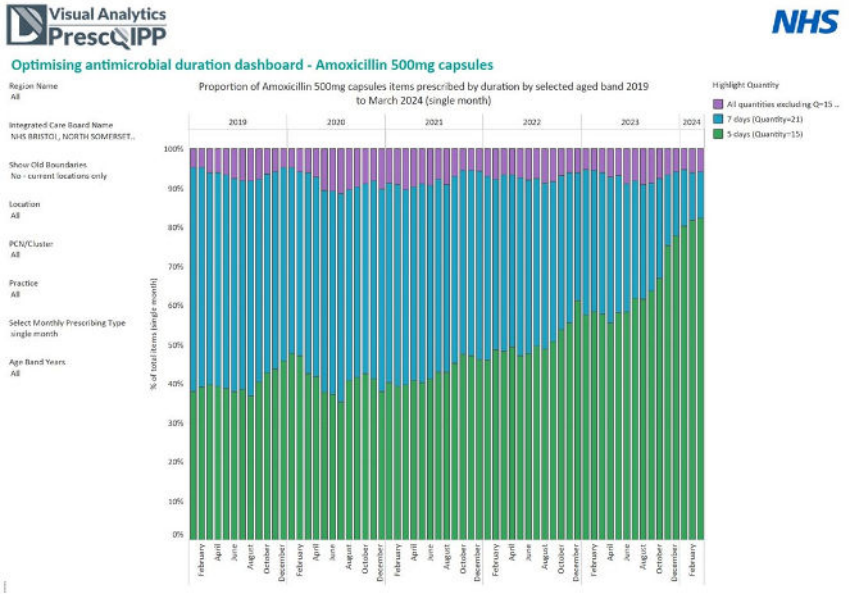
BNSSG was at 0.79

- 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.

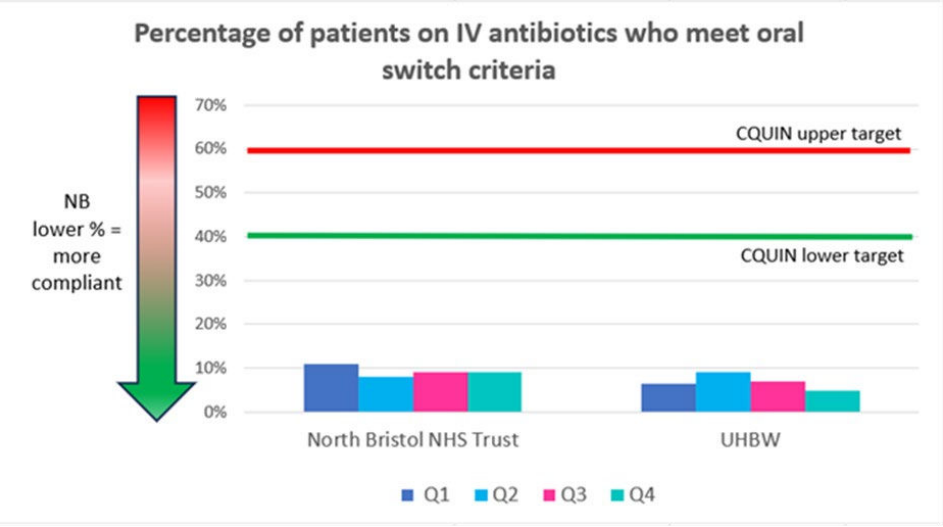
BNSSG ICB remains the lowest prescribers of antibiotics to children nationally. This highlights the continued stewardship for infections that do not routinely require antibiotics for example otitis media and sore throats. Antibacterial items prescribed per 1,000 children aged 0-9, 12 months to March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

Antimicrobial stewardship - continued

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.

BNSSG Outcomes, Quality and Performance Committee

Draft Minutes of the meeting held on Wednesday 26th June 14:00-16:25 on MST

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Jeff Farrar	Chair, BNSSG ICB	JF
Paul May (arrived 1545)	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
Jonathon Hayes	Chair of General Practice Collaborative Board	JH
Sue Balcombe	Non-Executive Director, UHBW	SB
Shane Devlin	Chief Executive, BNSSG ICB	SD
Michael Richardson	Deputy Chief Nursing Officer, BNSSG ICB	MR
In attendance		
Nicholas Smith – Item 7.1	Deputy Chief Operating Officer, NBT	NS
Philip Kiely – Item 7.1	Deputy Chief Operating Officer, UHBW	PK
Alistair Johnstone – Item 7.1	Associate Medical Director, UHBW	AJ
Deborah El-Sayed – Item 7.4	Chief Transformation and Digital information Officer, BNSSG ICB	DES
Laura Westaway -Item 7.4	Head of Children's Services, BNSSG ICB	LW
Anna Clarke – Item 7.4	Senior Performance Improvement Manager (Children's Services), BNSSG ICB	AC
Vicki Cooper – Item 7.5	LeDeR Local Area Coordinator and Patient Safety and Quality Lead, BNSSG ICB	VC
Jodie Stephens (Minutes)	Executive PA, BNSSG ICB	JST
Apologies		
Sue Geary	Healthwatch	SG
Aishah Farooq	Non-Executive Director BNSSG ICB	AF
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS

	Item	Action
1.	**Welcome and Apologies** ED welcomed attendees to the meeting and apologies were noted as above. ED informed committee members that Audit Committee took place on Tuesday 25th June and the three areas that affect this committee are. • Safeguarding -lack of scrutiny of safeguarding reports and of evidence at OQPC. • Improving efficiency and effectiveness under the external audit report- more detail on actions against underperformance. • BNSSG Risk register – which ED has already discussed with DJ and item already added to forward planner for September OQPC. **ACTION: ED and RS to review the audit recommendations related to scrutiny of safeguarding reports within OQPC.** **ACTION: ED and DJ to review the audit recommendations related to improving efficiency and effectiveness with regards to underperformance.**	
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 April 2024 committee** AM noted that on page 13 just before agenda item 7.2 the following action should be added to minutes: Report regarding mortality of individuals associated with long waits in A&E to be listed at future OQP Committee. **N/B- Committee minutes from April 2024 have been amended and approved by ED.**	
4.	**Committee Action Log** The action log was updated to be circulated with the minutes.	
5.	**Chief Delivery Officer Update** • **Performance Report** DJ explained the new performance report highlights all the core operational standards for planned, urgent care, community mental health and children's services and further areas of development will include trend analysis.	

	Item	Action
	DJ gave the following summary: • BNSSG ambulance handover delays – second best performer in Southwest in terms of handover delays. • Junior Doctor Industrial action commences from Thursday 27th June 0700 to Tuesday 2nd July 0700 – Providers are prepared, and mitigating actions are in place. DJ noted that those actions will have a further impact on elective and cancer position over the coming weeks. Community partners are working to reduce occupancy and make the best use of Community capacity. • General practice is now out to ballot and expecting collective action from the 1st of August. This could have a significant impact on BNSSG health and care system. Will be discussed at ICB Board in July – system working to plan on mitigating actions. • Elective care - in terms of the submitted operational plan, there is an improving position in terms of waiting lists particularly at NBT. Zero 65 week waits at NBT by the end of March 2025. • Diagnostics, although slightly below the national standard, BNSSG do remain best in the West in terms of diagnostic performance and do expect to be at the national benchmark of 80% by the end of this year. • Community Diagnostic Centres, the sites are now open both at Weston and NBT, predominantly mobile units at the moment. • Dip in Cancer FDS performance over April and May. This is due to several reasons but the backlog waiting list is being drawn down and when you treat breach patients that has a negative impact on your performance. Bank holidays and JD strikes have affected performance. • BNSSG still retain delivery of 62 week wait in terms of mental health targets. • Continued improvement in access to perinatal services. • Improved performance regarding talking therapy and dementia. • National outlier in terms of the numbers of children waiting for assessment over 52 weeks to be discussed in committee today. JH asked regarding the Children's mental health waiting list does it incorporate CAMHS or just ADHD and autism referrals? DJ replied to JH, ADHD and autism. DJ also noted that segmentation is included within the performance report and committee members will see the segment quarter for segmentation for ICB/UHBW and NBT. DJ explained the new oversight and assurance framework for 24/25 is being consulted on currently which will be slightly amended with potentially different implications in the ways of ICB working. SD explained ICB will be assessed as an organisation as to whether fit to oversight and then	

	Item	Action
	depending on what score is awarded- one/two is brilliant/good and three/four is poor/very poor will then determine the role ICB plays in oversight. Therefore, if three and four, it is likely that the oversight of providers will be in partnership with NHSE England, if one or two, then ICB will be a good oversight organisation. SD stated it will have an implication for our oversight at OQPC because if the ICB is awarded three or four, the ICB is jointly responsible for oversight of our providers with NHSE. ED thanked SD for the update and asked DJ for the following clarification: Are BNSSG 65 week waits on target or not and if not when do we expect to be? DJ confirm that System is ahead of the 65-week plan and are on track for delivering this target for this year. ED explained that the report is not showing BNSSG on track so further understanding would be helpful to assure targets are being made. AM commented, how do we as an assurance committee understand when BNSSG achieve, and what milestones should the committee look for to make sure we are on or off track. System is very close to achieving some targets but also not in other areas, so further reporting regarding milestones, trajectories and timeline for achievements needs to be included. In terms of the potential GP collective action ballot AM asked how far the ICB can go in terms of system partners for them to understand the potential impact on them and anything else that ICB need to do to minimise the impact. DJ explained he would pick up AM points within Delivering Our System Ambition - No Criteria to Reside item. SD is reviewing how live data can be presented to committees instead of a static report which will show targets in real time, as a static report will never give you full assurances. ED asked DJ for more details regarding CDC recruitment – ED raised at People Committee and Jo Hicks, CPO, BNSSG ICB was not aware of any workforce issue with Virtual Wards and CDC. DJ to pick up recruitment issue outside of committee and report back to future committee. DJ answered AM questions regarding: • GP collective action- This will be a system response. Jenny Bowker, Deputy Director of Primary Care is meeting with community mental health, acute sector colleagues along with primary care colleagues to look	

	Item	Action
	to work through the different actions that can be taken and the potential impact. This will enable system partners to start thinking about mitigating actions in response to that. This will be a full wrap around EPRR response and will be tracked and logged similar to previous industrial actions. DJ has also flagged at regional level and has also been discussed within ICB executive team. • Perinatal – improving position on access to perinatal services particularly during implementation of a single point of access. JH explained presentation at GPCB this morning and pathway is active on remedy. **Delivering Our System Ambition - No Criteria to Reside** DJ explained that the D2A programme has a home first ethos and focus, which has been captured by the programme and by wider system ambition work and the best bed is your own bed and that ethos is being driven through that team. DJ explained that an a NCTR working group had now been establish with system Chief Operating Officers this will ensure that work is embedded. Connections have been made over the past month with different systems- Coventry, Warwickshire, Worchester and Dorset which had enabled learning from key areas of development. DJ explained that through BNSSG Integrated Care@Home Board we have now got enhanced primary care input into the programme. DJ shared slides and provided summary to committee members: **Current position:** • Although the NCTR position is improved compared to last year, we have not maintained the low levels attained over the summer months, despite successful implementation of improvement schemes for admission avoidance and D2A. **Priority areas for the next 6 months:** • Admission avoidance – continued delivery of current schemes plus F-ACE (Frailty assm.t & co-ordination) • D2A Transfer of Care Hubs (ToCHs) and Technology Enabled Care (TEC) to achieve further pathway shift and improvements to acute LOS across P0 – P3 • Reductions in community LOS, esp. P2 and P3 **Overall:** • System prioritisation and focus on achieving NCTR ambition < 15% by end of Q2; in support of year-end target to reach 78% on 4hr performance and 92% acute bed occupancy. • New NC2R National coding system launched in May 2024. NBT live, awaiting implementation date for UHBW. Greater granularity of coding will aid system understanding of blockages (esp. those outside D2A pathways)	

	Item	Action
	• Whole system review of what is working well and review / reset investment to achieve ambition. • System support through NHSE/ADASS Discharge Support and Oversight Group • Extra out of hospital Capacity and Demand Modelling completed May 2024 to support D2A programme. • Further seventy-two acute bed saving impact in 24/25 from D2A programme. On track in April, deterioration of position in May driven by longer waits for P3 beds. **Discharge to Assess:** Out of Hospital Demand and Capacity analysis • Mapping resource requirements from hospital discharge, through Discharge to Assess (D2A) Pathways 1-3 and into social care services, prior to long term package and/or placement decision. • The model provides options to reduce external reasons for no criteria to reside (NC2R) associated with D2A activity through adjusting capacity "stock" and/or transforming services to reduce process delays "flow". • Shows impact of planned transformation activities and one off "recovery" period & backlog reduction vs. steady state. Two scenarios modelled: average NC2R of 15% and stretch acute site-specific rates. • Series of D2A partner workshops June/ Early July to plan coordinated efforts to manage the "recovery" period (between July to Sept). Progress reported to PEM and ICB Performance committee. • Due to the greater emphasis on Homefirst vs. bedded intermediate care, under all scenarios extra P1 and Reablement will be required to achieve the system NC2R ambition. Extra P3 required under stretch scenario. Next Steps: Q2 Delivery: **UEC front door** – POM and ODG review and prioritisation of themes: • Intermediary care offer around frailty and delirium • Evolution of F-ACE to full Integrated Care Coordination model • Recovery of NHS@Home trajectory in light of ongoing workforce challenges. **D2A:** • D2A Board session on confidence of Homefirst recovery delivery 26th June i.e. Sirona slots, Reablement & Bridging capacity, with any unmanageable cost pressures to be surfaced. • IOMs to generate timeline of improvements in next fortnight e.g. SG develop daily huddle to determine whether a non-linear pathway is in patients' best interest (triage between P1 and reablement) • WSP modelling outputs provide guide to capacity requirements; operational teams to provide week to week monitoring against targets into POM and PEM	

	Item	Action
	• Focus on mobilisation from start Q2 for Scenario 1 (i.e. 15% acute NCTR system average). • Risk being escalated to D2A board around delivery of P3 LOS changes required to reduce bed base further down to 230 beds come October 24. Mitigations to be explored in dedicated session (4th July) based on learning from Bristol P3 LOS reductions achieved. Partners committed to the principle of not opening additional beds if LOS gains can offset the need. ED asked HE to clarify a press release regarding £4,000,000 funding in Bristol to free up beds. HE explained that was BCC ratifying the commitment of the discharge fund which BCC are required to do via political system. HE added that system working is the strongest it has been – extra domiciliary care which has provided an extra three thousand hours which is a 15% increase. HE also stated that the words bed blockers are being used in system reports and in conversations. We should not encourage the use of this pejorative terminology where possible as it has an insinuation of blame to the people residing in the beds. ED thanked HE for his comments and to confirm where £4,000,000 funding was from. HE stated that it is funding which comes into the system from the Department of Homes and Communities. ED asked the following questions to DJ: • How confident is the ICB, that there is buy-in across the system from those that really can make have the impact? • When will the ICB know that this is working? The next OQPC is 26th of September so will you have update and progress by then? DJ explained the level of input, had over sixty system colleagues in the room at a recent system D2A workshop to look at admission avoidance and conveyance. There is also clear governance and buy-in through System Executive Group, Performance recovery Board and Chief Operating Officers. DJ expects by September 2024 a steep reduction on the graph. SW highlighted huge buy in and support from South Gloucestershire council, but all adults focus and questioned support for children. SW also mentioned that public health nursing colleagues must also be part of the discussion/working group. DJ replied children's space was discussed at recent admission avoidance session but not a NCTR issue. Discussions were regarding what support can system give to children in urgent care pathways. A workstream is embedded and representatives from Bristol Children's Hospital are part of working group. DJ believes public health nursing colleagues are included within work group but will review and confirm. Should this be an action? AM highlighted regarding NCTR, BNSSG are 42nd out of forty-three systems and asked if ICB had linked in with the top four systems to take any learning from them. SB agreed with AM question regarding learning from the top systems and thanked DJ for update and commented that plans were very ambitious and to	

	Item	Action
	see turnaround in only two months will need the whole system to pull together. SB asked is funding was for the whole system not just Bristol. DJ stated ICB have confirmed focus through partners. ICB are part of a discharge support and oversight group and that group is continually linking in with different systems, all local authorities and teams are involved not just Bristol. In terms of NCTR, ICB need to link in with acute community reside, mental health community and children to make sure all captured. JM just highlighted to committee members the GP collective action will have a knock-on effect to predictions and trajectory. ED thanked DJ for all the work which is taking place across the ICB/system and expressed her hope that we will be in a better position by September. **ACTION: DJ to meet with Jo Hicks regarding CDC workforce issues and report back to future committee.** **ACTION: ED asked committee members to review new performance report and feedback to DJ.**	
6	**Chief Medical Officer & Chief Nursing Officer Update** **Emerging Risk / Quality Report** **CNO** - MR explained the significant events information from the quality report and the key themes which remain as care delivery, capacity, access and workload. Four significant events recently in ophthalmology, and currently waiting for the learning. Improvement work across different programmes is positive. LMNS is currently on target with all key objectives for this year. The current priority is recruiting to the Maternity and Neonatal Voice Partnership (MNVP) to ensure the service user voice is central to all we do. Current progress towards the Three-Year Delivery Plan, Saving Babies Lives Version 3 and the Maternity Incentive Scheme Year 6 is all on track with no risks to escalate. There is ongoing work supported by the Acute Provider Collaborative to create a system wide Maternity & Neonatology Dashboard to clearly identify inequity and where improvements can be made. Safeguarding Transformation Programme is underway including a paper which was discussed at System Executive Group last week and was supported by all system partners, local authorities, and health partners at CEO level.	

	Item	Action
	CHC performance remains positive – all key KPI's being achieved. BNSSG seeing an increase in admission to specialist hospital placements. A discussion with the Southwest provider Collaborative has highlighted the different model of care that is available to BNSSG when compared to other ICB areas. There is a view that a gap is in service provision results in a potential avoidable admission. The keyworker team have had conformation of recurring funding to recruit an additional keyworker to the team which is a key component when working with young people to avoid a hospital admission. The Funded Care team have identified a suite of schemes to deliver the savings plan. Some of these are internal actions whilst some require a wider system plan. At this point there are some unmitigated risks to being able to deliver the service within plan. ED asked MR to confirm the emerging issue regarding BEH and patient records being lost. MR clarified that is it not patient's records being lost but seven hundred patients possibly *lost to follow up* appointments. BEH are currently working on this and will provide updates. **CMO** JM updated committee regarding: **HCPE-** • Data Story on cardiovascular disease – paper giving background of Greater Manchester work and introduction on how this may inform BNSSG work. • Swap to stop and vaping hesitancy – BNSSG ICS Nicotine Vaping Position Statement and supporting HCPE members to understand the evidence on nicotine vaping. • Introduction to the work of the BNSSG VCSE Alliance – Mark Hubbard VCSE Lead (Voluntary, Community & Social Enterprise sector). • Trauma informed care - Explanation on work to date and invitation to BNSSG conference. Junior Doctor Industrial Action starts 0700 Thursday 27/6 to 0700 Tuesday 2nd July. BNSSG System Activity includes: • Emerging Risks and Mitigations meetings have been put in place by ICB on affected days. • Jo Medhurst on strategic call for strike period. • Glastonbury Festival – impact • Hot weather warning. **Womens Health:** • Seeking expressions of interest from 6 PCNs for Phase 1 of our 'Women's Health PCN' work to improve access to and quality of care for	

	Item	Action
	women's health in general practice. We are initially focusing on PCNs in areas of high deprivation. • Working with UHBW to establish a 12-month Menopause Training Clinic to upskill 6 GPs in menopause care. • Planning a Women's Health training, education and service awareness programme. This will include sessions on inclusive care and clinical care and bring together professionals working in women's health from across the system. • Soon to embark on a grants process to improve access to and quality of care for women's health for (i) migrants in vulnerable circumstances and (ii) people experiencing multiple disadvantages. These two groups have been identified as experiencing significant health inequalities with need around women's health. • Dame Ruth May, Chief Nursing Office NHS England visiting Southmead Hospital on Thursday 27th June – presentation regarding Womens Health. **Medicine Optimisation**: • TA guidance being released which will have a significant financial impact due to huge amount of dementia medication- This is being worked through HCPE to understand ethical position but NICE guidance you are expected to implement within 90 days of publication. ED asked about the working relationship with ICB Finance team, JM explained strong relationship with Sarah Truelove involving weekly and monthly meetings. AM asked if the medicine shortages are short term especially the salbutamol replacement. JM replied that Debbie Campbell, Chief Pharmacist is working with system colleagues to keep information updated and producing a monthly update but to regards time frame we are not sure at this stage. ED highlighted discussions which took place at Audit Committee regarding internal/external audit reports referencing to health inequalities and reporting against KPIs, JM acknowledged.	
7	**Items for Discussion**	
7.1	**GIRFT (Getting It Right First Time)** **• Our approach to responding- NBT/UHBW** **NBT-** NS presented slides to committee which included the following GIRFT update: • Theatre Utilisation - Increase the pace of change to drive towards 85% utilisation across specialties. This includes the review of any data quality issues and sharing learning across the system. Maximise cases per list. • BADs day case rates - Overall, day case rates are good, but continue the drive towards 85% utilisation across all specialties. This includes the review of any data quality issues and sharing learning across the system.	

	Item	Action
	• Orthopaedics - Review of primary hip and knee day case pathways required at pace Ensure ALL list are running to the equivalent of four joints Robust protection for ringfenced beds. • Faster Diagnosis - Implementation of teledermatology model Progress with planned review of gynaecology services across BNSSG, including, incorporating new PMB guidance in development Continue focus to improve waiting times at the front end of the prostate pathway, including optimising use of new MRI scanner. • NBT Theatre Utilisation - Improvement from average of 71% to 79% submitted trajectory plan to reach 82% by April 2025. • Workstream: W2 Clinical, Operational and Workforce – Ortho Roadmap Delivery – ON TRACK. Recruitment of 5 x trauma consultants in May 2024 has projection of improved list uptake from September 2024. Challenged average cases per session – reviewing at local TEG drive improvement. Significant volume of complex revision work playing role in reduced cases per session and increased total average length of stay. Hip and knee replacement LOS remains on target. • New elective care centre opens April 2025 • Theatre governance and route of improvement highlighted to committee. • FDS – 28 day was on target but last-minute year-end capacity loss in skin clinics impacted end of year target. • 30% increase in skin, gynae and endoscopy referral is a significant driver. ED asked what time frame NS would be able to return to a future OQPC to talk about the improvements in productivity. NS replied to review the whole productivity in GIRFT would be three months. **UHBW-** PK presented slides to committee which included the following GIRFT update: • GIRFT governance -The UHBW GIRFT Programme Board oversees reviews of all aspects of patient care provided by the Trust. It supports the Trust, commissioners, and integrated care systems to deliver the improvements recommended. The group is chaired by the Trust's Associated Medical Director. • Theatre Utilisation - The Trust has a decentralised model of delivery with thirty-nine theatres across seven hospital sites. Clinical and operational management representatives are present from each hospital site. UHBW is currently reporting 75.6% capped utilisation (2 June 2024). There are differential rates of utilisation at each site, with the acute hospital sites reported the highest rates of utilisation, with community hospital or sites that can only perform less clinically complex, day case surgery reporting the lowest rates of utilisation. • Cataracts - Cataract capacity in BEH was very challenged from the advent of the pandemic until the winter of 2023. This was due to a combination of pandemic related factors, and multiple vacancies within BEH Theatres. Given this improvement in capacity, from March 2024 the BNSSG has reverted to offering BEH as a choice to patients alongside IS providers. Referrals to BEH have increased. BEH continues to foster	

	Item	Action
	close working relationships with community optometrists who have communicated the improved cataract capacity position out to the community. • Outpatient Productivity - The Trust's Outpatient Steering Group oversees the Trust's outpatient improvement programme. The group is led by the Trustwide Outpatient Clinical Director. Clinical and operational management representatives are present from each division. One of the areas of focus is on benefits realisation from the roll out of the DrDoctor patient portal. In particular, the scope to reduce DNAs. • DrDoctor – The trust has successfully migrated video services to DrDoctor. Since June 2022- 29,000 patients have used video consultation. Since July 2022 – four million appointments notification have been sent to patients. 256,000 patients can access their appointments digitally. ED thanked NS, PK and AJ for all the fantastic work which is taking place within acute trusts. ED would like the team to return to OQPC in September/December to update committee on governance, productivity and performance on focused areas and as may be leading nationally. **ACTION: Acute Trusts to return to OQPC September/December to give GIRFT – System response productivity progress.**	
7.2	**Safeguarding** • **All Age Safeguarding Report – Quarter 1.** MR explained to committee that the safeguarding report is highlighting issues from each of the five partnerships with BNSSG and the following items were highlighted: • Working with health partners to standardise heath data. • KBSP -Adult MASH is underway which includes appointing a health system navigator for one year to be the broker with local authority's, health and police agencies. • Expressions on interest from dental practices – interested in providing an enhanced service for system children in care and care leavers. • Preparation for joint targeting areas inspections with partnerships the theme is youth violence. • Sirona performance in terms of heath assessments continues to be an issue even though there has been some improvement- Team working very closely to ensure improvements over the next months. ED asked MR to confirm what is the oversight of receiving safeguarding reports from providers and what the current position is. Initial health assessments performance is disappointing. What is the escalation route for this? Is there an opportunity to write to the interim CEO of Sirona to request an improved position on that?	

	Item	Action
	AM asked MR to confirm the timeline for children to get improved access to dentistry and what, risks are there around partners in our health and care system, not sharing data, also regarding the safeguarding internal audit could ICB link in with transformation so not looking at two separate areas. MR replied that the ICB has a statutory safeguarding responsibility and that some colleagues within our system, had not appreciated that there is still a strong quality assurance element for safeguarding performance, which still has to be provided. Now this has been clarified reports are being received from providers regularly. In terms of dentistry deadline MR will link in with contracting team ICB and will report back. Data sharing, MR also agreed would be helpful but whilst different partnerships are asking for different information, we felt the best way forward and long-term aim is trying to work with all the partnerships and help partners to standardise health information. MR agreed in terms of the internal audit and in terms of the wider transformation programme, the team need to include that now in this report. PM explained that he would take an action and link in with Sirona to request a formal response regarding health review assessments backlog. ED stated that safeguarding assurance will be a standard agenda item at every OQPC going forward. **ACTION: Children's Dentistry deadline - MR will link in with contracting team to confirm the timeline within BNSSG ICB and will report back,** **ACTION: PM to request a formal response regarding health review assessment backlog.** **ACTION: Safeguarding assurance to be added to OQPC as a standard item.**	
7.3	**LD & Autism NHSE Segmentation Targets** **• Out of area placement** **Item deferred to future committee.**	
7.4	**ADHD & Autism (CYP) waiting lists.** **•Neurodiversity waiting list and delivery road mapping.** DES explained that the children's community services waiting list for autism and ADHD pathways is unacceptable and is resulting in over 4700 children waiting over 52 weeks. 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. This means that children are not seen within 52 weeks which is a focus of the NHSE operational plan and there is a risk of harm to	

	Item	Action
	those children waiting on the waiting list. DES added that if clinicians could be found in the way that we currently operate it would cost £24,000.000 to address the backlog just for the ADHD waiting list. There have been significant system efforts to improve this situation through increasing capacity to meet this demand attempted via 'waiting list initiatives and sub-contracting with private providers, however, this approach is unworkable both from a staffing and finance perspective. The system prioritised neurodiversity to go through the transformation hub and an accelerated design of a new neurodiversity pilot will be trialled from October 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. DES explained an implementation approach paper will be heard at ICB Board on 4th July. The paper will include the approach that BNSSG want to adopt from Portsmouth in which a neuro profiling tool have reduced waiting lists by 70% where only 30% of children who had used the neuro profiling took were then required to go back on the waiting list and go forward for a diagnosis. If Board approved at ICB Board on 4th July, on the 6th of July, an update will be sent to the forty-two schools that have been identified and then this process will be in place ready for the new term in September 2024. JH asked if Portsmouth had data with regards to the neuro profiling tool reducing waiting list by 70% and regarding the children that are removed of the waiting list what support/wrap around care is there is place? AC replied that Portsmouth have been using the profiling tool for 18 months but ICB do not have the outcomes data currently. DES stated the waiting list continues to grow so we need to put a different approach in place as some children have been waiting 5 years. SW stated that schools really welcome this approach but so crucial to get evaluation piece right so very keen to see the evaluation piece and to make sure that education colleagues are reassured about the way in which tool will be monitored and then the impact reflected in terms of resource allocation going forward. DES agreed we have got to understand the impacts on all parts of the system and particularly on the children themselves and their longer-term outcomes. PM stated the system needs to make sure it is not just the wrap around support for 70%, but also the 30% that are in the system. Sirona must think about how we are dealing effectively with those moving forward. It is a major issue and one of the biggest risks that Sirona have now. PM stated that the recommendation from Sirona medical director was that to commence and Sirona will work with ICB colleagues regarding evaluation piece and report back. SW asked if can link in with DES to give assurance to evaluation plan from Public Health perspective. DES welcomed the opportunity and offer from SW.	

	Item	Action
7.5	**LeDeR Recovery and Annual Report** VC explained the ICB continue to have a backlog of LeDeR reviews which was contributed by having the highest number of notifications the team have ever received 23/24. The lead portal sustained some power and software outages, so there was a delay in the ICB receiving the notifications and insufficient LeDeR capacity. BNSSG ICB have received the most LeDeR reviews, but the number of unallocated reviews is very comparative within the southwest region. There is a strong system approach to driving improvements including: • Procurement to secure LeDeR reviewers as an interim basis. • Allocated reviews to an approved agency. • Reviews that were received in the financial year 22/23 are being prioritised. LeDeR data has been reviewed by BNSSG Mortality Group and Strategic Prevention Oversight groups to ensure that there is strong oversight, and these are aligned with ICB health inequality work programmes which the data is showing the following: • More deaths caused by diseases of the elderly. • More cardiac related deaths. VC stated the national LeDeR report published in November 2023 suggested that there were more excess deaths during heat wave periods, so ICB have collaborated with Sirona and people first colleagues to write an *easy read* for leaflet and video. ICB also collaborated with autism independent, this project is aimed at increasing the number of people who had an ethnic minority background to accessing the annual health check. Communication being distributed in various language not just English. The cost-of-living crisis, which is hardest in the most deprived areas, of which many ethnic minority groups reside is having a knock-on effect in regards population coming forward for annual health reviews. ED thanked VC for attending OQPC and commented how the key points and priorities are very clear in the LeDeR annual report.	
7.6	**Healthcare Acquired Infection Annual Report** MR explained that the Healthcare Associated Infections (HCAI) and Infection Prevention Control Management (IPCM) – Annual Report 2023/24 for BNSSG is to provide assurance to committee on the partnership working undertaken across the BNSSG ICS to reduce the risk to our population from Healthcare Associated Infections (HCAI) and the actions undertaken though our Infection Prevention Control Management (IPCM). Committee is advised that the rates of blood stream infections have been seen to increase at a regional and national level, the report shows that BNSSG have only met the national standard (“threshold”) for Pseudomonas Aeruginosa.	

	Item	Action
	However, the increases in blood stream infection rates have not increased as significantly in BNSSG when compared to the other six systems in the region, or nationally, for most infections (except MRSA); meaning that BNSSG's position in terms of benchmark ranking against the other six systems in the Southwest is favourable. However, despite this position infection rates have continued to rise and so we must not be complacent. **Antibiotics Prescribing**: BNSSG continues to benchmark well on antimicrobial stewardship. Both acute trusts and primary care are working collaboratively and both lower CQUIN target/ secondary care national prescribing target focuses on reducing broad spectrum antibiotic prescribing have been met. BNSSG continues to meet the primary care targets for overall antibiotic use of prescribing per STAR/PU and broad-spectrum prescribing. **MRSA** - 34 cases of Methicillin Resistant Staphylococcus Aureus (MRSA) were assigned to the ICB. The national threshold continues to be zero and has not been met during this period. BNSSG were ranked at the bottom (seventh) of the Southwest ICB position for cumulative rate per 100K population. Two initiatives are the Chlorhexidine programme and MRSA reduction programmes set up to focus on interventions to reduce the incidence of MRSA/MSSA. Work continues with NHSE and UKHSA colleagues to understand why BNNSG as a system is an outlier in this area. MR explained BNSSG remains highly respected for our IPCM governance arrangements, and we continue to work closely with our system partners including our Local Authorities. The Infection Prevention Control and Management (IPC&M) team continue to successfully focus on supporting infection management and improvement to adult social care providers (ASC), inclusion health settings and assist with any other community infection challenges identified. The IPCM System Governance Response Group matured during this year ensuring representation of community issues and overview, alongside other system providers, in addition to updating to the IPaMS group as required. SB highlighted that conversations are also taking place in UHBW board meetings and system partners continue to work closely together. AM commented that 2877 bed days have been lost to C-Diff in BNSSG, are teams looking at exemplars regions to compare data /cases? MR replied that BNSSG are seen as an exemplar region especially with regional colleagues. ED requested benchmark data and learning from the top regions regarding C-diff to be provided for members in future reports. **ACTION: MR- Regional C-diff benchmark data and learning to be reported at OQPC in future IPM reports.**	

	Item	Action
7.7	**Customer Service & Complaints Quarterly Report** **Item deferred to future committee.**	
8 8.1 8.2 8.3 8.4	**Items for Information** **Healthcare Acquired Infection Group** **Meeting in common BNSSG System Quality Group and Health and Care Professional Executive Minutes- April** **BNSSG APMOC Minutes - April** **LeDeR Governance Group Minutes**	
9	**AOB** HE highlighted to committee that all three BNSSG councils have received notification from CQC of intention to conduct adult social care assurance inspections. South Gloucester inspection was a few weeks ago and currently North Somerset and Bristol are pulling together data submission within three weeks to give CQC reading material. The ambition is that all three councils will be done within six months. HE highlighted that CQC are focusing on ICB patches. SD stated that CQC are focussing on areas but not completing ICS assessments yet as the assessment model has not been confirmed. ED thanked members for contributions to committee meeting.	
	Meeting Dates 2024/2025 • **Thursday 26th September 1400-1625 - Virtual** • **Thursday 28th November 1400-1625 - Virtual** • **Thursday 30th January 1300-1600 – Virtual** • **Thursday 27th March 1300-1600 – Virtual** • **Thursday 29th May 1300-1600 – Virtual** • **Wednesday 23rd July 1300-1600 - Virtual** • **Wednesday 22nd October 1300-1600 – Virtual** • **Thursday 11th December 1300-1600 – Virtual**	

Jodie Stephens
Executive PA June 2024