Meeting of BNSSG Outcomes, Quality and Performance Committee

Date: Thursday 26th September 2024

Time: 1400-1630

Location: MST

Agenda Number:	6.0		
Title:	Performance report Month 4 to 5 (July -August 2024/25)		
Confidential Papers Does this paper contain information that should not be in the public domain? (This box will be removed from Governing Body Open papers by the Corporate Team when the paper is received)	**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 and Information			
Key Points for Discussion:			
This performance report provides an overview of July and August 2024 performance. Where there are areas requiring mitigations to correct and bring performance back to plan, then assurance is provided of where those discussions are taking place within the system governance architecture.			

Recommendations:	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
Previously Considered By and feedback:	Review at System Executive Group on 19 September 2024. Key Points to note from SEG discussion: - SEG asked to consider POM escalation of fast-tracking of financial decision for additional community bed capacity to support NCTR reduction - Noted switching of capacity to facilitate additional SSARU beds at South Bristol hospital and improve stroke pathway flow - Heart Failure service - SBAR to be shared by Sirona - Agreed for system review of service. Leadership to be clarified - SEG requested deep dive into children's service performance at next meeting - GPCA action escalated and system risks and mitigations to be shared
Management of Declared Interest:	None declared.
Risk and Assurance:	The report provides an update to System Executive Group and Outcomes, Quality & Performance Committee in relation to key risks to performance within the system and highlights supporting mitigations including where those mitigations are being held in the system architecture.
Financial / Resource Implications:	None referenced.
Legal, Policy and Regulatory Requirements:	None referenced.
How does this reduce Health Inequalities:	All workstreams targeted at reducing health inequalities.
How does this impact on Equality & diversity	As above.
Patient and Public Involvement:	Not applicable.

Communications and Engagement:	This report is provided to System Executive Group and to Outcomes, Quality and Performance Committee for information and discussion.
Author(s):	Caroline Dawe – Deputy Director of Performance and Delivery, BNSSG ICB.
Sponsoring Director / Clinical Lead / Lay Member:	David Jarrett, Chief Delivery Officer, BNSSG ICB.

Agenda item: 6.0

Report title: Performance Update Background

The performance report for this month is based on July and August 2024 information.

The power business intelligence (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.

1. Urgent Care

Key measures within urgent care performance have been achieved. Based on August 2024 data Category 2 response time was at 25 mins with average handover performance at 24 mins, both measures meeting the ICB plan and performing well within the Southwest. A&E 4-hour performance (footprint) based on validated July 24 data was 76% which was just meeting plan of 76.07%. 111 calls abandoned performed exceptionally well meeting the national target of 3% and demonstrating best performance since 2019.

Virtual ward occupancy in July 2024 was 73% against target of 80% but is slowly improving with additional resourcing. A new virtual ward trajectory has been agreed which will result in the same target being achieved but profiled differently to reflect resourcing. Urgent community response within 2 hours achieved the target of 70% and continues to perform well.

The number of no criteria to reside (NCTR) patients within the acute trusts has decreased since mid-August 2024. However, some increase is being experienced at the time of writing this report. The reduction in August will reflect a small decrease in emergency department attendances and use of less escalation beds.

The urgent care operational delivery group (ODG) over the past 2 months has sought assurance in relation to key risks in the delivery of the urgent care. These include GP collective action of which there is a minor's plan which has been worked on across the system along with weekly updates into the performance oversight meeting as well as key pieces of work linked to winter preparation. These areas of work related to evaluation to understand impact of acute respiratory infection (ARI) hubs within primary care, update on workstreams relating to regional ambulance workstreams of which BNSSG is a key contributor in relation to integrated care coordination; feedback and actions from the OPEL (Operational Pressures Escalation Levels) workshop held in August and the work to date on reducing no criteria to reside (NCTR) to support delivery of the A&E target of 78% this financial year.

Items for escalation:

1. **NC2R position and financial affordability in relation to additional non-recurrent community bed capacity.**

Delivery of the reduction required in NCTR across the system to support delivery of the ED 4-hour target is still underway. On 15 August SEG approved commissioning of £1.4m additional community bed capacity to support delivery of the system ambition of reducing NCTR to 15%. System Chief Operating Officers (COOs) and Directors of Finance (DoFs) have been working to identify funds to support capacity within overall system financial position. To date £750k has been identified through slippage on UEC initiatives, leaving a residual gap of £650,000. The funds identified will support the continued commissioning of already open transitional beds but will not enable opening of further backlog clearance capacity. On 13 September 2024 COOs and DoFs met to try and close this residual gap. It was recognised that funding the backlog clearance capacity may have a positive impact on reducing costs of escalation capacity, and reducing the risk of elective recovery being impacted, as well as improving performance. It was agreed that NBT and UHBW would review their respective Year End Financial Forecasts against the scenarios of reduced NCTR as a result of the additional discharge to assess (D2A) backlog capacity, versus maintenance of the current D2A capacity. A further meeting of this group is now planned for 30 September 2024 when a final decision will be made with regard to the additional capacity.

2. **Stroke flow within the system impacting on quality of care provided**

A key issue for urgent care has been stroke flow within NBT. Whilst demand has appeared to remain steady and in line with the original business case to support the transformation of the pathway and establishment of a hyper acute stroke unit, acute stroke unit and stroke sub-acute rehabilitation units (SSARU) at South Bristol community hospital and Weston General Hospital, there has been a significant increase in numbers of stroke patients in NBT which creates severely escalated stroke flow issues. These issues impact on the quality of the stroke pathway as well as flow into the SSARUs and out of the SSARUs. A system diagnostic has been undertaken with options identified through the Performance Oversight Meeting. Immediate actions have included commissioning four additional beds in a brain injury rehabilitation unit and at the Performance Escalation Meeting on 13 September 2024 it was agreed that SSARU capacity at South Bristol community hospital would be increased for a temporary period by 7 beds whilst concurrently reviewing length of stay improvements at the SSARUs to align with the original business case assumptions to allow a return to steady state.

2. Mental Health

Operating plan metrics in relation to mental health are being achieved at this point in the year with the exception related to in appropriate out of area placements.

Perinatal access performance has improved steadily over the past 12 months and since the single point of entry for all referrals in January 2024. Performance is meeting plan in quarter one and is forecast to remain above plan for the rest of this financial year. Performance in June 2024 is an access rate of 1175 against a plan of 981.

Transformed community mental health access performance has been consistently achieved in quarter one and is forecast to remain above plan for the rest of this financial year. June 2024 performance is 7255 against a plan of 5963.

The dementia diagnosis rate has been consistently achieved in quarter one and is forecast to remain above plan for the rest of this financial year. July 2024 performance is 69.6% against a target of 68.4%.

Talking Therapies metrics for 2024/25 changed to become a composite metric composing of reliable recovery and reliable improvement.

Reliable recovery performance using June 2024 information shows a recovery rate of 54.42% against a plan of 50%. The plan was achieved in terms of activity as well as in terms of patient outcomes. In terms of activity performance has increased well above Operation Plan targets. In June 2024 activity was 804 versus plan of 794. In terms of percentage achieving outcome, the Operational Plan target is 50% (a stretch target above the national average of 48%) and has been exceeded in quarter one.

Reliable improvement performance using June 2024 information shows an improvement rate of 73% against a plan of 69%. The plan was exceeded in terms of activity as well as in terms of patient outcomes. In June 2024 activity was 814 against a plan of 794. In terms of percentage achieving outcome the Operational plan target is 69% (a stretch target above national target of 67%) which has been exceeded.

There are two quality improvement plans in place in relation to the talking therapy service. The first relates to reducing the waiting list and long waits in particular over 90 days. The service is on track with the agreed trajectory in quarter one. The other relates to checking of patient safety and wellbeing of those on the waiting list with a wait over 90 days without a clinical contact. The service is compliant with the agreed quality schedule and the plan is closely monitored by the ICB in quality oversight meetings with Performance and Delivery and Nursing and Quality managers.

Rates of in appropriate out of area placements are higher than plan. In July 2024, there were 9 placements against a plan of 4.

BNSSG has seen an improvement in its emergency readmission rates within the last 6 months and is now operating at levels below the national average (which reliably runs at circa 9%).

As per national guidance, BNSSG are reliably ensuring that 80% of discharged patients are followed up within 72 hours

Assurance and mitigations for which relate to a need for an improvement of flow within BNSSG are underway through service delivery unit meetings, urgent and crisis care programme board, Mental Health ODG, Health and Care Improvement Group (HCIG) for mental health and learning disability and autism and the AWP Improvement Board. Actions being considered within these groups are:

- Protected inpatient capacity – ring fenced beds on MH Adult Acute wards to facilitate timely transfer from POS and other settings (e.g. patients awaiting a bed in A&E). This went live mid-July 24.
- Home treatment capacity – the home treatment offer(s) are being discussed and agreed with intensive services and other stakeholders to provide a more comprehensive 'hospital at home' offer. This is due to go live in Oct 24.
- Transfer of Care hubs – MH transfer of care hub is being created to facilitate discharge for all within AWP beds.
- New BNSSG Housing offer.
- Multi Agency Crisis and Contingency Plan (MACCP) – focussed work with patients identified as 'frequent attenders' to reduce attendances across multiple services/agencies (e.g. GP, A&E or Police) offering more appropriate support for these patients.
- Section 140 policy – consistent policy for usage of Section 140 powers (re-launch planned Oct 24).
- Minimising delays in starting MH Act assessments for patients in the Place of Safety improving throughput and ensuring capacity for swift admission when needed.

3. Learning Disability and Autism (LD&A)

LD&A annual health checks are on plan achieving 609 against a plan of 553 at end of June 2024.

Reliance on inpatient care for adults with LD and/or autism shows 33 patients being cared for as inpatients against a plan of 28. This includes inpatient care commissioned by the ICB and specialist commissioning through NHSE. During the month of July there were 5 admissions and 4 discharges from ICB commissioned beds which constituted of 16, the remainder with specialist commissioning. Of those patients in beds commissioned by the ICB there are 6 individuals within AWP services and others are in specialist commissioned hospitals across the country. Patients in inpatient beds commissioned by NHSE are currently detained within secure services.

Assurance in relation to LD&A performance is sought through the LDA ODG which is supporting workstreams in relation to supporting people to move into their communities and thrive, best start in life for children and young people, improving healthcare, ADHD progress within AWP and development of LDA approaches, strategy and culture within acute trusts. The ADHD adult pilot with 7 GP practices was approved at the MHLDA HCIG on 9 September 2024. Construction work is now commencing on the LD&A new unit including culture and approach to a new care model which is being picked up through the implementation of the inpatient quality transformation plan.

4. Elective Care

Diagnostic tests (% of patients waiting less than 6 weeks) continues to perform well at a regional and national level. In June 2024 BNSSG ranked best in the South and fifth best nationally. BNSSG holds the best ranked performance in the Southwest for MRI,

Colonoscopy, Flexi Sigmoidoscopy and second best for audiology, CT and ECHO. BNNSG holds second best and fourth best ranked position nationally for MRI and Audiology, respectively. Overall, the diagnostic performance at end of June 2024 exceeded plan and activity levels also exceeded plan across all modalities.

Cancer Faster Diagnosis Standard (FDS) exceeded plan at both the ICB and acute trust levels achieving 78.14% and 78.26% respectively. This achievement is also better than the Cancer Wait Time Standard threshold. Activity volumes exceeded plan across both Trusts and at the ICB population level. 62-day combined plan was met across both acutes (68.18% against plan of 63.97%) and at the ICB population level (68.21% against plan of 63.96%) for both activity levels and performance targets as at end of June 2024.

Activity levels for July 2024 are showing that day case rates are above plan for UHBW but slightly below plan for NBT. Both Trusts have delivered more activity in July than June which is also true for the ICB population position. Elective inpatient activity plan has not been achieved at either Trust or at ICB population level and further work is ongoing to understand the reasons. Outpatient activity is exceeding plan levels at Trust and ICB levels.

Core metrics for productivity in particular theatre utilisation and day case rates are being monitored. Progress is being made in both areas.

Independent sector activity at end of July 2024 is 3% above plan but financially 2.3% below plan. Activity overperformance is driven by Spire and Somerset Surgical Services outpatient attendances and New Medica retinal tomography. Cost underperformance is driven by activity at PPG in general surgery, ophthalmology and gynaecology.

The elective ODG meets weekly on a programme theme basis e.g. cancer, diagnostics, productivity and reviews key metrics as well as discussing areas of concern and mitigations required. This can include developments of services, new initiatives from regional and national teams, links with cancer alliance work programme.

Items for escalation:

1. **Delivery of 65 week wait operating plan target**

   Referral to Treatment Times (RTT) for 65 week waits at end of June 2024 have demonstrated a greater variance from plan trajectory compared to performance at end of May 2024. Focussed plans are in place to deliver clearance of 65 week waits in 2024/25. It is expected that with the exception of known areas of challenge including corneal graft tissue supply (a national issue), complex DIEPs (Deep Inferior Epigastric Perforator), and a small number of orthodontic and oral surgery patients, all other specialties will achieve zero 65 week waits by end of September 2024. Weekly forecast outturn returns on the September 2024 position are sent each week into the regional and national teams and these are demonstrating a downward trend in numbers waiting but are not forecasting delivery of the BNSSG plan

2. **Heart Failure Service**

The elective ODG also oversees community waits which align to outpatient services, for example musculoskeletal interface services, heart failure. A community heart failure service is provided by Sirona, however, the ECHO diagnostic test required is provided through the acute trusts. At present waits for an urgent ECHO through the community heart failure service are long and not reflecting an urgent pathway. An integrated contract, quality and performance meeting has been stood up with Sirona to cover escalating issues which includes the community heart failure service. An internal briefing report on the service will be submitted to the Sirona executive team where an assessment of risk and support actions will be discussed and identified including escalation into the wider system.

6. Children's Services – serious attention to children

Children's ED performance is at 82% against a plan of 76% as at July 2024.

The total community waiting list held by Sirona is currently at 8794 at the end of June 2024 and demonstrates a significant decrease from the previous month (9420). This is due to ongoing data validation work. The community waiting list over 52 weeks has changed to now reflect the number of children waiting over 52 weeks rather than the waiting list size. Whilst the current numbers of children waiting are ahead of plan -actual of 4170 against a plan of 4608 this is not considered acceptable and significant effort continues with work to maximise resources available and transformation of services. Transformation work continues and a new neurodiversity pilot will be trialled from October 2024. The impact of this pilot is not currently known but it is anticipated that waits will not reduce at least for the next year. Community paediatrics, which constitutes a smaller part of the waiting list are taking actions to improve the efficiency of the service and continuing to validate the waiting list. This has proven successful, but the waiting list size still exceeds the capacity available to see children in an appropriate timeframe.

The Mental Health access rate for children and young people at end of June 2024 is not being achieved although current performance is above the local plan set. The system has developed an access improvement plan; however, this is now at risk due to advice from NHSE on not including some services within the data.

Reliance on LD&A inpatient care for children in inpatient beds increased to 5 against a plan of 3 across the month of July 2024. This is not totally unexpected as end of Summer and start of the new school year can be a difficult time in terms of the keyworker caseload. The situation is also compounded in relation to the two general adolescent units within the Southwest Provider Collaborative currently being closed which means that BNSSG children and young people are being cared for further from home.

Referral to treatment time waits over 52 weeks within acute services is at 427 as at the end of July 2024 exceeding the plan of 698. Activity at provider level is currently below plan with discussions underway with the provider to understand further and for mitigations to be put in place.

The Children's ODG discusses performance (by exception) with each provider and also has more focused discussions on areas of challenge which may not be included within the overall operating plan e.g.:

- Mental health access and mental health support teams in schools' improvement plans.
- Children's community services recovery plan (including neurodiversity transformation).
- Children's therapies access – closer monitoring due to longer waits, now improved.
- Children's dental and cleft access.
- Children in care – decision to set up system task and finish group to resolve cross-system issues.

Most of these areas have a task and finish group that reports to the contract review meeting and escalates to Children's ODG.

7. Community

A review of community operating plan targets including children took place in July 2024 as per the operating plan instructions. This review was to focus on long waits which in the main are concentrated in children's services and detailed in the section above.

Adult community waits are less than 52 weeks; with zero patients waiting over 52 weeks (one data quality issue).

Community beds occupied at end of July 2024 was 95% against a target of 98%.

Areas reviewed weekly within the discharge to assess pathways are cancellations, and P1, P2 and P3 performance. This information relates to the first week of September where cancellations were lower than anticipated and so less slots lost, although this has been highest in South Gloucestershire where there has been a very small waiting list. Demand has increased in P1 in particular for Bristol but NCTR has also decreased which has supported flow. P2 demand is still high but flow has been good and NC2R is at 35% of bed base. The waiting list for P2 and stroke SSARU has decreased (noting the flow issues described above in relation to stroke) and the SSARU waiting list has decreased from 25 to 15. P3 demand is down for the second week in a row so should support greater flow as well as a reduced waiting list.

Assurance for community services is much wider than operating plan metrics. There are multiple ODGs reporting into the Community HCIG focussing on a range of initiatives from return on investment in relation to the discharge to assess (D2A) return on investment, development of a long-term condition ODG to focus on specific conditions like diabetes and CVD, an integrated care at home board which is developing the strategic model for integrated care at home.

Appendices

A summary of the operating plan metrics and targets with comparison to Southwest ranking is attached as appendix 1.

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Performance Summary

August 2024

Performance Summary 1

Performance Summary		Latest Period	Unit	Target	Month Value (RAG vs Target)		Vs Nat Avg	Month Value Change	Month % Change	Distance From Target	Value YTD	YTD vs Target	National Rank	South West Rank
Planned Care														
RTT waits 65+ weeks	Acute Total	Jun 24	Count	249	✗	455		-4	-0.87	NA	455	206	-	-
RTT waiting list	Acute Total	Jun 24	Count	108,069	✓	105,931		-130	-0.12	NA	105931	-2,138	-	-
ERF Achievement %	ICB	Feb 24	%	100	✓	107.07		-1	-0.50	-	107	7	-	-
Specific acute elective spells	Acute Total	Jul 24	Count	15,458	✗	14,570		1465	11.18	NA	55050	-3107	-	-
Consultant-led first outpatient attendances	Acute Total	Jul 24	Count	27,463	✓	28,027		1628	6.17	NA	106620	3,210	-	-
Consultant-led follow-up outpatient attendances	Acute Total	Jul 24	Count	57,496	✓	65,733		5060	8.34	NA	253563	33,174	-	-
% outpatients follow-up without a procedure	ICB	Jun 24	%	52.47	✓	57.72		-1	-1.80	-5,188	58	6	-	-
Diagnostic tests % < 6 weeks	Acute Total	Jun 24	%	86	✓	86.24		0	0.52	-	86	0	-	-
Cancer 28 day FDS	Acute Total	Jun 24	%	75.13	✓	78.26		6	8.68	-	72	-3	-	-
Cancer 62 day combined	Acute Total	Jun 24	%	63.97	✓	68.18		3	4.35	-	66	2	-	-
Urgent and Emergency Care														
Urgent Community Reponse referrals	ICB	Jul 24	Count	1,394	✓	2,785		61	2.24	NA	11116	5,540	-	-
Mean Cat 2 Ambulance Response	ICB	Jul 24	Minutes	25	✗	29	Better	-2	-6.15	NA	30	5	-	2 / 7
Average ambulance handover duration	ICB	Jul 24	Minutes	40	✓	27		-2	-8.42	NA	30	-10	-	2 / 7
A&E 4 hour Performance (Footprint)	ICB	Jul 24	%	76.07	✗	75.75	Better	2	2.38	114	74	-2	18 / 43	4 / 7
% Beds occupied by NCTR patients	ICB	Jul 24	%	18.52	✗	21.81	Worse	1	3.17	-57	22	3	38 / 42	6 / 7
% G&A beds occupied	ICB	Jul 24	%	94.95	✗	95.1	Worse	-1	-0.63	-3	95	0	37 / 42	6 / 7
Virtual ward occupancy	ICB	Jul 24	%	80	✗	72.97	Worse	1.07	1.49	8	72.97	-7.03	25 / 42	4 / 7

Performance Summary 2

Performance Summary		Latest Period	Unit	Target	Month Value (RAG vs Target)		Vs Nat Avg	Month Value Change	Month % Change	Distance From Target	Value YTD	YTD vs Target	National Rank	South West Rank
Community														
% Community Beds Occupied	ICB	Jul 24	%	98	✗	95.16		0	0.00	5	96	-2	-	-
Community waiting list 52+ weeks	ICB	Jun 24	Count	4,608	✓	4,171		0	0.00	NA	4171	-437	-	-
Community waiting list	ICB	Jun 24	Count	NA		24,107		0	0.00	NA	24107	-	-	-
Mental Health														
Access to Perinatal Services (Rolling 12)	ICB	Jun 24	Count	981	✓	1,175		10	0.86	NA	0	-981	-	-
Talking Therapies Reliable Improvement Rate	ICB	Jun 24	%	69	✓	73.00		0	0.00	-	74	5	-	-
Talking Therapies Reliable Recovery Rate	ICB	Jun 24	%	50	✓	53.42		-2	-4.33	-	54	4	-	-
Inappropriate OAP Placements (BNSSG)	ICB	Jul 24	Count	4	✗	8		2	33.33	NA	8	4	-	-
Access to Transformed CMH Services for Adults and Older Adults	ICB	Jun 24	Count	5,963	✓	7,255		280	4.01	NA	7255	1,292	-	-
Dementia Diagnosis Rate	ICB	Jul 24	%	68.40	✓	69.60		0	0.58	-	69	1	7 / 42	1 / 7
Childrens														
CYPMH Access	ICB	Jun 24	Count	9,315	✓	9,455		95	1.01	NA	9455	140	-	-
RTT waits 52+ weeks - Childrens	Acute Total	Jul 24	Count	895	✓	610		10	1.67	NA	610	-285	-	-
Community waiting list - CYP	ICB	Jun 24	Count	NA		8,794		0	0.00	NA	8794	-	-	-
Community waiting list 52+ weeks - CYP	ICB	Jun 24	Count	4,608	✓	4,170		0	0.00	NA	4170	-438	-	-
Specific acute elective spells - Childrens	Acute Total	Jul 24	Count	1,291	✗	1,194		68	6.04	NA	4665	-302	-	-

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Meeting of BNSSG ICB Outcomes, Quality & Performance Committee

Date: Thursday 26th September 2024
Time: 14:00 – 16:25
Location: Via MST

Agenda Number:	5.0	
Title:	Quality Report – September Report on Month 4 (July data) 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:		

This report aims to be the last of the current format, with subsequent reports focussing more on progress against quality priorities of system partners. The report will continue to include Patient Safety Incidents (and the learning), Healthcare Acquired Infections, and Antimicrobial Stewardship information, but with a focus on progress of plans to improve quality and safety, a more comprehensive system perspective on quality should be able to be seen.

It is anticipated that this information will also align with the risk of harm work that is also currently underway in the system. The aim is to reduce the potential for healthcare-associated patient harm by ensuring we can understand, anticipate, prevent and mitigate risk across patient pathways by developing the capability to visualise dynamic, quantified, risks of harm associated with unintended healthcare service performance as part of an integrated system-wide view of demand and capacity. A system-wide clinical workshop was held on 22 August 2024 and plans are in place to develop a methodology and tool to visualise this data to aid effective risk-based decision making.

Key items to note in the Quality Report:
Healthcare Acquired Infections

- C.difficile (CDI) infections continue to rise (within the context of rising cases regionally, nationally and globally), and while our rate of increase over the past 2 years compares

relatively less worse to other areas of the region (slide 6), the current rise continues to be a concern. The report details the work currently underway in collaboration with NHSE SW and other regional partners on determining the cause of this rise.

Patient Safety Events

- In July 2024, 7 Significant/Serious Incidents (SIs) were reported across BNSSG partners, all being investigated either through the PSIRF framework or through mortality reviews.

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):	Michael Richardson, Deputy Director of Nursing and Quality, BNSSG ICB
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd, Chief Nursing Officer, BNSSG ICB

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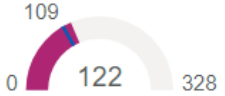
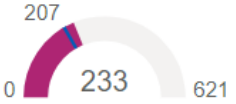
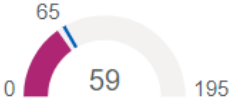
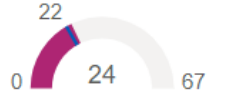
BNSSG Quality Report

September Report on Month 4
(July data) 2024/25

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

Quality Report – Health Care Acquired Infections (HCAI) Summary
Reporting Period – Month 4 2024/25 – July 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 4	2022/23 Position Month 4
C. difficile			122	112	97
E. coli			233	184	173
MRSA			10	13	8
MSSA			52	79	55
Klebsiella spp			59	52	57
Pseudomonas aeruginosa			24	22	21

Rates per 100k	South West Position									
	BSW	BNSSG	Devon	Dorset	Glos	Kernow	Somerset	SW	England	BNSSG
C. diff	29.88	28.64	31.33	33.08	31.17	40.71	29.99	31.65	27.03	1
E. coli	58.44	54.83	84.50	87.16	37.08	79.93	83.61	69.49	68.67	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	20.73	25.88	16.55	23.76	25.30	20.46	21.28	2

Quality Report – Health Care Acquired Infections (HCAI) ICB Overview
Reporting Period – Month 4 2024/25 – July data
Information Source and date of information – UK Health Security Agency (UKHSA), ICS HCAI Lead

Performance for July 2024

- **CDI = 31, HOHA = 9 (NBT - 4, UHBW – 4, RUH - 1), COCA = 9, COHA = 8, COIA = 5**
- **E. coli = 64, HOHA = 13 (NBT - 5, UHBW – 7, Other - 1), COCA = 44, COHA = 7**
- **MRSA = 2, HOHA = 1 (NBT - 1, UHBW - 0), COCA = 1, COHA = 0**
- **MSSA = 9, HOHA = 4 (NBT - 3, UHBW - 1), COCA = 4, COHA = 1**
- **Klebsiella spp = 20, HOHA = 6 (NBT - 3, UHBW - 3), COCA = 12, COHA = 2**
- **Pseudomonas aeruginosa = 5, HOHA = 1 (NBT - 0, UHBW - 1), COCA = 1, COHA = 3**

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

BNSSG Annual Standard

- Both ICB and secondary care threshold levels are 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 Community Onset HCAI this month.

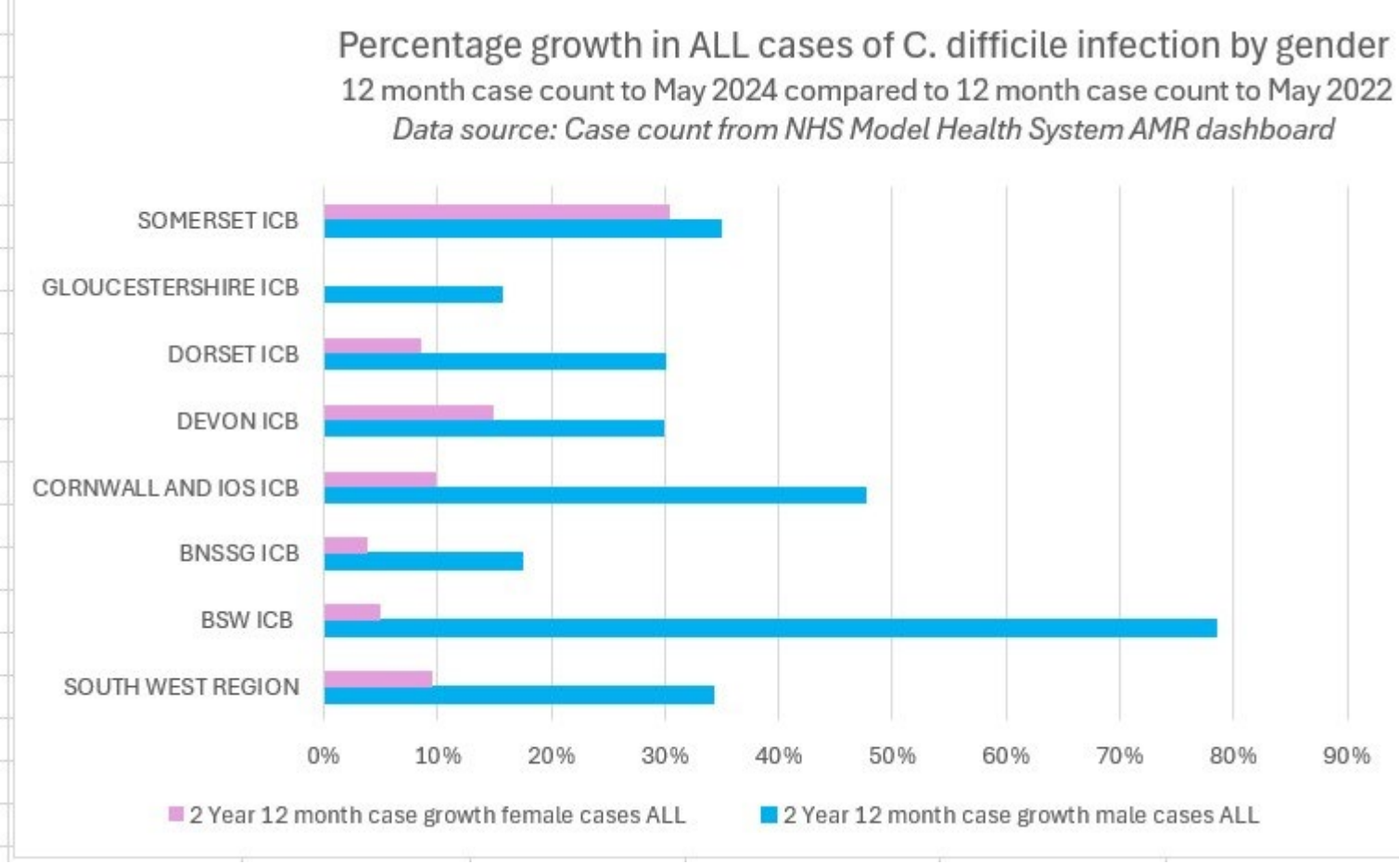
Infection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Threshold to Date	Cases YTD		Threshold	23/24 FYTD	22/23 FYTD
C. difficile	34	26	31	31									109	122		328	112	97
E. coli	53	55	61	64									207	233		621	184	173
Klebsiella spp	15	12	12	20									65	59		195	52	57
MRSA	3	3	2	2									0	10		0	13	8
MSSA	10	18	15	9										52			79	55
Pseudomonas aeruginosa	10	3	6	5									22	24		67	22	21

Commentary

- MRSA- Zero tolerance has not been achieved. There were 2 cases in May (1 COCA, 1 HOHA).
- CDI - The 31 cases are currently categorised as follows: Continuing Infection (5), New infection (25), Repeat/Relapse (1).
- E.coli- the majority of the 64 cases continue to be Community Onset (51).

Quality Report – % growth in ALL cases of C.difficile infection by gender
Reporting Period – May 2022 to May 2024

Meeting to discuss South West region rising C. difficile infection case count trend particularly in males held by NHSE/UKHSA on 6/9/24

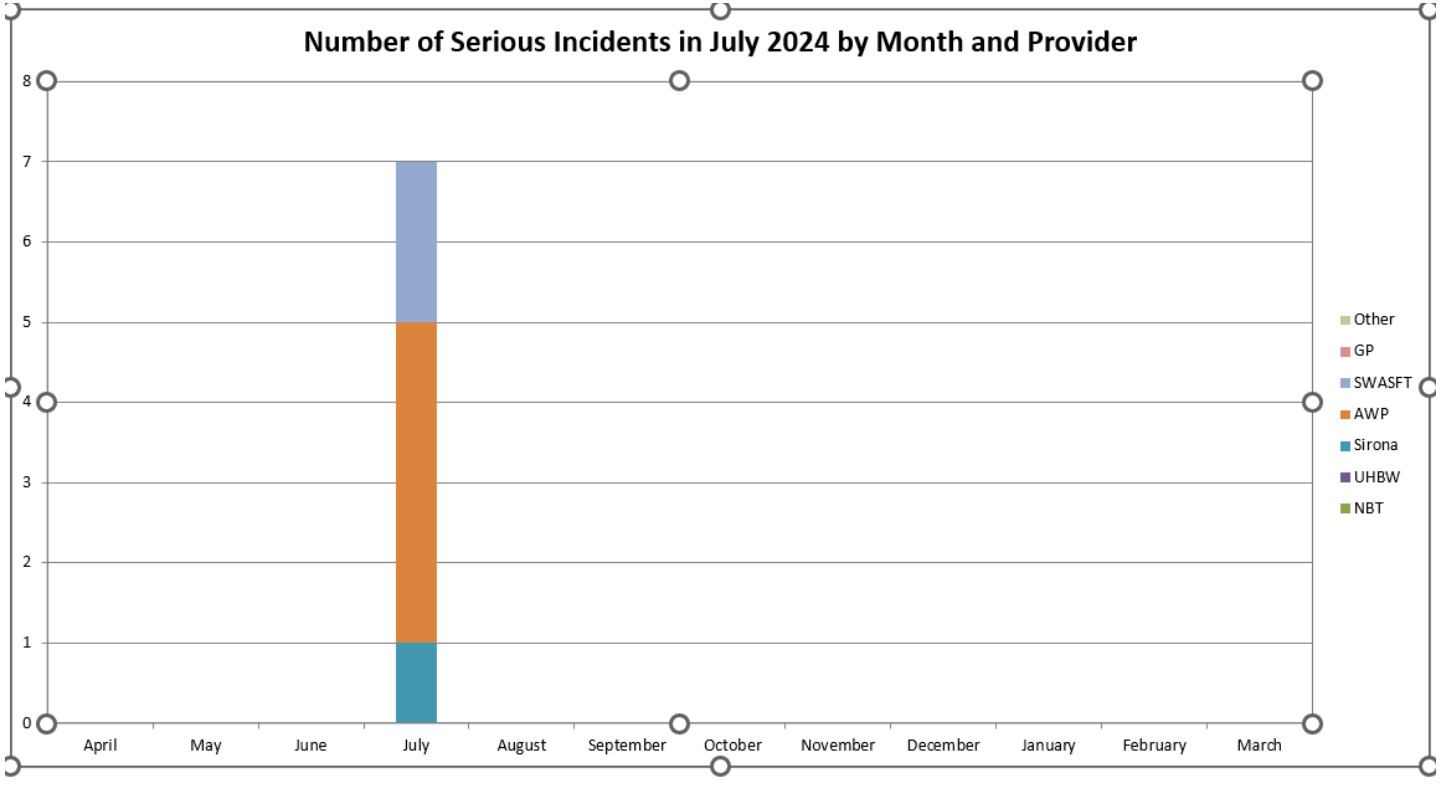


BNSSG has had a percentage growth of CDI of 17.4% in males and 3.8% in females in the past 2 years. The chart above shows our comparison in growth to the other regional providers; this is against a backdrop of rising CDI cases nationally and globally. A meeting was held by NHSE/UKHSA to discuss the rising case counts of C.difficile within the South West region on 6 September 2024 with strong representation by BNSSG. We are currently undertaking monthly end to end reviews for both male and female community onset cases of C.difficile (all age), and for hospital onset cases our partner organisations are doing the same. This information will be fed into the regional work together with that from other regions. The cases within BNSSG are rising with YTD cases in July 2024 for this year at 122 cases compared to 112 and 97 cases in previous years respectively.

Nursing & Quality - Serious Incidents including Never Events
Reporting Period – Month 2 2024/25 – May data
Information Source and date of information – SI Tracker xx/09/2024

Current Month Overview

- In July 2024, 7 Serious Incidents (SIs) were reported across BNSSG partners
- There were no Never Events in July 2024



- **Status of incidents currently pending initial 72 hour report or full incident investigation.**

Main themes:

- **4 mortality reviews pending on community mental health caseload/support**
- **Pressure injury occurring on admission from community care provision**
- **1 death during pregnancy**

Summary report from local System Quality Group (SQG)

Report by	Local SQG Chair	Date of meetings reported
BNSSG ICB	**Rosi Shepherd ICB CNO**	**Joint meeting in common SQG and HCPE (Health & Care Professionals Executive) 19 September 2024**

	Summary to include actions taken by local SQG (including what is hoped to be achieved)	Are risks discussed considered to be suitably managed within providers/at system level? Do any risks require escalation?
	Joint meeting in common to discuss: Review of Winter Plans 2024/25, including Risk of Harm dashboard/Care Traffic Control progress and planned pathways for admission avoidance and rapid discharge.	
Care Traffic Coordination	Updates were provided on this ambitious piece of work which aims to produce a digital platform that will help colleagues in the system better understand, anticipate, prevent and mitigate risk across patient pathways when making decisions. Methodology for risk quantification, analysis, comparison, inter-dependency and forecasting is being developed, and a successful partners' clinical workshop in early September informed this piece of work. Provider partners and the ICB are collaboratively finalising risk metrics by the end of September ready for the design phase. The existing platform (care traffic coordination centre CTCC) provides some risk information; however, this project aims to improve decision making by using evidence-based metrics based on person, population, service, organisation and system level perspectives.	Risks to manage the current flow pressures include using the CTCC platform, Opel status and other Performance Escalation (PEM) governance processes. The timeline for this project is currently on schedule, with the first iterative development of the tool commencing in mid-October.
BNSSG Winter Initiatives 24/25	**Areas of discussion:** **Discharge to Assess -** Increasing community rehabilitation capacity in line with demand, with a focus on shifting towards home-based pathways (following a peer review of other ICS'). **Transfer of care hubs -** Increasing multi-agency capacity for discharge planning from hospitals including therapists, social workers etc. **NHS @ Home expansion** - Increasing 'virtual ward' capacity to support admission avoidance and earlier discharge using remote monitoring technology couple with community teams. **Community Acute Respiratory Infection (ARI) Hubs** - Introduction of dedicated community sites via Primary Care Networks for managing patients with acute respiratory conditions away from general practices. **Frailty – ACE** - Clinician-accessible remote MDT for assessment and coordination of frail individuals where conveyance or admission is being considered	See next page

	BNSSG (Continued) Summary to include actions taken by local SQG (including what is hoped to be achieved)	Are risks discussed considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Winter initiatives (continued)	**'Recovery' capacity in P2 & P3 to mitigate the D2A backlog this winter, reliant on a bedded model** Detailed Out of Hospital modelling and risks in achieving the original P2 & P3 D2A programme trajectory indicated a requirement to review the D2A bedded capacity, both to recover from the existing 'backlog' impacting Acute NCTR and System NC2R ambition of 15%. The modelling suggested that a recovery boost is required (i.e. more beds) in P2 and P3 capacity totalling a cost of **£1.37m**. On 15th August the System Executive Group approved in principle support to commission this capacity, subject to COOs/DOFs agreeing a source of funding from system initiatives. The SQG/HCPE meeting on 19 September heard and accepted the plans but colleagues were conscious that these short-term solutions was more bed based rather than an integrated care at home programme. The aim should be a much higher focus on looking after people in their own homes, with better access to clinicians, domiciliary care, reablement and other services to prevent admissions. i.e. more focus on front door rather than back door. It was also acknowledged that over time the suite of system initiatives and overlaps may have overcomplicated pathways leading to gaps, as a result this has compromised the integration of discharge services and admission avoidance pathways. Feedback particularly from Primary Care has centred on the difficulties in securing support for patients who then need to be admitted; If we had more robust services in place in the community there would be less of a need for P2/P3 beds. A Quality/Inequality Health Impact assessment is currently being iterated for this initiative, and risks (financial and clinical) are being explored (see right column).	A key clinical risk with this initiative (as of any bed-based model) is the risk of service users deconditioning the longer they are in a hospital or care home bed. Quality of care and patient safety could be compromised as the longer patients are in institutional beds, the less chance they have of being discharged home. Financial risks are also being considered: the £1.37m is only the cost of the beds and does not include services such as therapy. Also, the higher the number of service users in care home beds the higher the numbers of service users who will need (and be eligible for) funded nursing care/CHC. This would result in further financial pressures to the system. Note for 25/26 there are proposals for a programme of step-up social care capacity/wrap around dom care to support admission avoidance; this will be an opportunity to revisit the whole system model.

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. 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