Meeting of BNSSG Outcomes, Quality and Performance Committee

Date: Thursday 28th November

Time: 1330-1600

Location: MST

Agenda Number:	6		
Title:	Performance report Month 5 to 6 (August - September 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 and Information			
Key Points for Discussion:			
This performance report provides an overview of August and September 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 21 November 2024. Key Points to note from SEG discussion: - NCTR backlog clearance. P1 surge has commenced but need to track progress and impact. Enable shift of resource if doesn't have required impact - NCTR ambition. Remains a stretch target for system. a) Enable reallocation of resources if required. Return on Investment review to help inform next steps b) CNO peer review of discharge process on-going c) Reinforcement of commitment to investment in admission avoidance initiatives. Enhance process for 25/26. - Vaccination Programme – Update requested with regard to progress and success for 25/26 - Integrated Care at Home: System working through procurement process. Conclusion of process required urgently to enable mobilisation for winter - On-going system conversations with regard to clarification for commissioning of clinical supervision for individuals who are subject to Section 37/41 of Mental Health Act (patients with Learning Disability) - General Practice Collaborative Action. No current evidence of impact being felt across UEC providers. Service and financial risk acknowledged of further action (patient monitoring)
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

Report title: Performance Update Background

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

The power business intelligence (BI) tool roll out is now complete within performance and delivery with a focus now on developing a level 2 suite of reports across all programme areas which provide a greater level of detail. 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

Urgent Care performance has deteriorated over September and October 2024. BNSSG went into system Opel 4 in September due to increased demand which impacted on performance.

Mean category 2 response time in September increased to 35 mins and in part is due to increasing ambulance handover delays with ambulance activity increasing by 6% year to date. Ambulance handover year to date performance is 30.18 mins at end of September and is still within our overall Operational Plan year-end target of 32mins. Ambulance handover time over 15 mins had been improving month on month through the year up until September.

ED 4-hour type 1 performance has deteriorated, however the ED 4-hour footprint performance-maintained performance at 72%. The overarching end of year goal for the system is to achieve ED 4-hour footprint performance of 78%. Type 1 attendances are within plan but admissions through ED have increased including at the children's hospital.

Additional pressure on the EDs has resulted in a marked increase in the number of patients waiting over 12 hours from arrival. This impacted on 6% of total attendances to the acute providers.

Following the system Opel 4 declaration in September a lessons learnt exercise was undertaken at the Performance Oversight Meeting (POM) which reported into Performance Escalation Meeting (PEM). These lessons learnt included:

- Set up of an operational taskforce group with senior limited membership to grip the situation
- Quicker system and partner identification of key metrics and de-escalation parameters as well as risk of harm indicators
- Support across the system when one partner is in a higher level of escalation
- Better early warning indicators and community escalation.

No criteria to reside (NCTR) has also increased across the BNSSG system. This is creating pressure across acute, community and mental health providers. Sirona have created

additional P1 surge capacity as per the D2A recovery plan, but this is currently not having the expected impact due to the higher demand from the front door.

A subgroup of the Performance Oversight Meeting (POM) has been created to look at creating additional discharge projects to support flow before/in winter. These projects range from community escalation processes to better usage of P1 slots by greater prioritisation of patients to social worker productivity. These projects will be presented to Performance Escalation Meeting (PEM) on 22 November. Constraints for these projects will potentially be funding sources.

Stroke pressure in NBT has decreased but is still higher than the original modelling through the business case anticipated with approximately an additional 20 patients within NBT. Further modelling work is being undertaken to understand why when demand hasn't increased why the flow is not working. Some key differences are understood between actual flow and the business case model as each SSARU is not able to flex its beds as required. POM is reviewing weekly the stroke position and when the P2 waiting list is at an appropriate level it is anticipated that with clinical approval some dynamic risk assessment may be necessary to ensure that a repeat of the stroke pressures does not happen.

The UEC operational delivery group (ODG) has concentrated on a number of areas including winter updates from NHSE. These include:

- a revised ambulance handover in extremis SOP for every system to use with early warning triggers and real time reporting,
- the new OPEL (Operational Pressure Escalation Levels) framework which includes acute, 111, community and mental health which will commence in January 2025,
- outputs from the CEO task and finish groups that met through the summer to respond to the pressure experienced on SWASFT as well as their cost improvement programme, reducing resources to systems. These outputs include a drop and go SOP for timely handovers, and a 12-week improvement to ED flow. It is not anticipated that these outputs will improve performance in BNSSG, but we recognise that there is potentially further work to do on same day emergency care to create a consistent offer for ambulance crews as well as more admission avoidance work.

Items for escalation:

1. System Opel 4

Earlier than anticipated winter pressures, building from September into November. Lessons learnt from Opel 4 to be noted.

2. No Criteria to Reside (NC2R)

NCTR still increasing despite additional capacity across all pathways, driven by increased admissions into the acute trusts. Further discharge priority projects being worked up and creative solutions in particular for funding will need to be realised. Focus on reducing community NCTR.

3.Revised Ambulance Handover SOP

All providers to note SOP and implementation.

4. Stroke Services

To note on-going pressure within stroke services.

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 in September 2024 is at 1315 against a target of 1042. Performance is expected to be maintained for the rest of the financial year.

Transformed community mental health access performance has been consistently achieved year to date and is forecast to remain above plan for the rest of this financial year. September 2024 performance is 10000 against a plan of 6141.

The dementia diagnosis rate has been consistently achieved year to date and is forecast to remain above plan for the rest of this financial year. September 2024 performance is 72% against a target of 68%.

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

Reliable recovery performance using September 2024 information shows a recovery rate of 48% against a plan of 50%. This is a slight decrease due to waiting list validation work but is expected to increase and meet the national stretch target of 50% so there is no concern at this point. Recovery activity is ahead of plan.

Reliable improvement performance using September 2024 information shows an improvement rate of 69% against a plan of 69%. The plan was exceeded in terms of activity as well as in terms of patient outcomes.

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. 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 inappropriate out of area placements are higher than plan and failing the operating plan metrics. In September 2024, there were 8 placements against a plan of 4. Occupancy in adult acute wards is above 95% and clinically ready for discharge levels have increased.

Assurance and mitigations 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 place of safety 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 went 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.
- Minimising delays in starting MH Act assessments for patients in the Place of Safety improving throughput and ensuring capacity for swift admission when needed.

The mental health ODG has concentrated on planning for 2025/26 as well as key projects including VCSE re-procurement and how the system approaches this as well as redesign of dementia pathways.

3. Learning Disability and Autism (LD&A)

LD&A annual health checks are on plan achieving 1426 against a plan of 1172 at end of September 2024.

Reliance on inpatient care for adults with LD and/or autism shows 35 patients (+2 patients) in September 2024 being cared for as inpatients against a plan of 28. This includes inpatient care commissioned by the ICB and specialist commissioning through NHSE. A service delivery unit has been set up to review LDA performance and pathways bringing together performance and delivery and nursing and quality teams to better align performance with actions being taken.

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. The ODG has also focussed time on planning for 2025/26 and prioritisation of proposals.

Items for Escalation:

1.Inpatient Admissions

The current number of inpatients is currently great than plan 35/28. The majority of these inpatients are not clinically ready for discharge. An ODG group is working closely to fast-track discharge for those patients who are ready for discharge.

4. Elective Care

Key metrics in relation to referral to treatment time (RTT) relate to waits over 65 week waits which are monitored weekly by regional and national teams. The October 2024 end of month position was 77 patients waiting over 65 weeks which is a significant improvement on the original forecast and also since the previous escalation last month taken to SEG and OQPC. Of the 77 patients waiting 15 were at NBT (7 plastics) and 60 at UHBW (25 corneal grafts, 33 oral surgery and orthodontics). Other patients were waiting at independent sector providers. Due to national tissue supply issues for corneal graft patients the system reported position can be reduced by 25 as agreed with the regional team. Performance against the 52 week wait plan and also non-admitted pathways were better than plan which is a good position to retain to support performance in 2025/26.

Cancer performance is mainly on target against plan. The FDS position for August 2024 was 78% across the ICB outperforming the plan target at year end of 77%. The 31-day standard has improved in August 2024 with NBT now at 82% and UHBW at 98% against a target of 96%; the ICB performance was just over 93%. The 62-day combined standard in august 2024 was met across both acutes and at ICB level (71%) surpassing the end of year target of 70% as well as exceeding the activity levels set in the plan.

Diagnostic performance based on increasing the percentage of patients that receive a diagnostic test within six seeks in line with the March 2025 ambition of 95% is good and on track against plan of 88% in August 2024. BNSSG benchmarks well across the Southwest and is currently ranked in first place in August 2024 and in fifth place nationally. There has been a deterioration in CT performance due to issues with cardiac CT. A plan is being finalised for additional provision to bring this back on track. General CT performance is on plan. Activity levels at ICB level exceeded plans for all modalities as of August 2024.

Activity levels as at end of September 2024 are on target against plan for outpatients and independent sector activity. There are variances of underperformance against plan in relation to day cases and inpatients. The main driver for this underperformance is at NBT due to an inaccurate setting of plan in relation to orthopaedic activity and consultant start dates coming into post. NBT are undertaking a revised forecast outturn position and have confirmed that there will be a level of catch-up but not a full recovery to year end. Independent sector activity is 1.9% above plan as at end of September and has increased again from last year, but 3.8% below plan from a financial plan perspective.

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. Over the last couple of months attention has turned to planning with the elective operational delivery group (ODG) holding

the ring on system discussions to prepare for the planning launch day in October and planning day one due to be held on 26 November. The elective ODG has established a set of system ambitions and is working through a refresh of the Joint Forward Plan with a steer towards the next 5 years and achievement of constitutional standards.

5. Children's Services

Children's ED performance is at 83% against a plan of 78% as at September 2024. A new children's outpatient department will open in November in UHBW Education Centre enabling an expansion of the Children's ED footprint reducing crowding risk.

The total community waiting list held by Sirona is currently 8257 at the end of September 2024 and demonstrates another decrease from the previous month (8794). 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 4158 against a plan of 4890 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 started in 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 September 2024 is not being achieved with access of 9410 contacts against a target of 10212. 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. This advice is being discussed with regional and national teams as different provider configurations in other systems is impacting positively and therefore BNSSG ought to be allowed to count data in the mental health dataset. Whilst these discussions are ongoing the outcome is looking more favourable.

Reliance on LD&A inpatient care for children in inpatient beds is currently on target with two young people with autism in general adolescent units across the Southwest as Riverside Unit is closed. The CETR team and the key worker service are both contributing to keeping the numbers of young people in mental health inpatient settings low and ensure all has been done to keep children and young people out of the hospital and their communities. The dynamic support register will further contribute to this admission avoidance work, when complete in May 2024. A service delivery unit has now been set up for LD&A which will create a greater connection between performance and delivery team and nursing and quality to ensure that performance and actions are more aligned.

Referral to treatment time waits over 52 weeks within acute services for the ICB is at 272 as at the end of September 2024 exceeding the plan of 649. Activity at provider level is currently below plan (-395 year to date) 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.:

- Accelerated neurodiversity model (neuroprofiling in 42 schools across BNSSG supported by neurodiversity health team) started in October – initial feedback has been positive and there is confidence that this approach aligns with national direction of travel and evidence base to identify and meet needs early. We do not know yet whether this approach will reduce demand for assessment (unlikely) and focus remains on how to reduce these long waits.

- New 4 week wait metric to improve access to mental health services is expected from April 2025. Assessment of ability to deliver this metric is underway looking at waiting times in each service and size of waiting list. Longest waits data (104/78/52 weeks) and improvement trajectories were submitted to NHSE on 8 November. For BNSSG ICB, 300 children and young people (CYP) were reported as waiting over 52 weeks. These are young people who were under 18 at the time of referral to adult Autism and ADHD services. These adult services are not in-scope of the new 4 week wait metric however NHSE have made the decision to count this older cohort within the CYP metric. Local data for this metric that focusses solely on the CYP 'in scope' services, shows zero waiters over 52 weeks (as at 30 November 2024). Implications of changing the data flow of autism and ADHD contacts from community data set to mental health data set on performance metrics needs to be fully understood and a decision reached re. compliance with this aspect of the national data service specification. Benefit would be performance improvement through ability to benchmark as well as an improvement in the CYP access rate.

- Planning process for 2025/26

6. Community

Adult community waits are less than 52 weeks; with zero patients waiting over 52 weeks.

Community waiting lists at September 2024 over 52 weeks is at 4158 against a target of 4890. Community beds occupied at end of September 2024 was 97% against a target of 98%.

Areas reviewed weekly within the discharge to assess pathways are cancellations, and P1, P2 and P3 performance. Collaborative system working has produced a protocol in relation to cancellations and to minimise these across the system. P1 surge plan as part of the discharge to assess recovery programme started at the end of October but impact has been minimal due to workforce issues as well as ongoing flow from Sirona.

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. Planning for 2025/26 is also a key feature of all the ODGs ensuring that interdependencies are articulated and shared.

Appendices

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

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Performance Summary

November 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	Sep 24	Count	63	✗ 81		-179	-68.85	NA	81	18	-	-
RTT waiting list	Acute Total	Sep 24	Count	107,589	✓ 102,169		-1821	-1.75	NA	102,169	-5,420	-	-
ERF Achievement %	ICB	Jul 24	%	101.5	✓ 111.29		0	0.13	-	111	9	-	-
Specific acute elective spells	Acute Total	Oct 24	Count	16,060	✗ 15,163		1442	10.51	NA	97,585	-5555	-	-
Consultant-led first outpatient attendances	Acute Total	Oct 24	Count	28,250	✗ 27,261		540	2.02	NA	188,095	6,052	-	-
Consultant-led follow-up outpatient attendances	Acute Total	Oct 24	Count	60,275	✓ 66,688		3062	4.81	NA	448,940	60,620	-	-
% outpatients follow-up without a procedure	ICB	Aug 24	%	52.13	✗ 58.31		0	-0.53	-6,115	58	6	-	-
Diagnostic tests % < 6 weeks	Acute Total	Sep 24	%	89	✓ 89.59		2	1.92	-	90	1	-	-
Cancer 28 day FDS	Acute Total	Sep 24	%	75.92	✓ 76.83		-1	-1.21	-	75	-1	-	-
Cancer 62 day combined	Acute Total	Sep 24	%	68.11	✗ 65.33		-7	-9.05	16	67	-1	-	-
Urgent and Emergency Care													
Urgent Community Reponse referrals	ICB	Oct 24	Count	1,394	✓ 2,959		214	7.80	NA	19,514	9,756	-	-
Mean Cat 2 Ambulance Response	ICB	Oct 24	Minutes	35	✗ 46	Worse	11	32.29	NA	32	-3	-	2 / 7
Average ambulance handover duration	ICB	Oct 24	Minutes	40	✗ 41		2	5.21	NA	32	-8	-	3 / 7
A&E 4 hour Performance (Footprint)	ICB	Oct 24	%	77.19	✗ 71.06	Worse	-1	-1.77	2,248	73	-4	28 / 42	5 / 7
% Beds occupied by NCTR patients	ICB	Oct 24	%	16.72	✗ 22.8	Worse	2	10.52	-105	22	5	41 / 42	7 / 7
% G&A beds occupied	ICB	Oct 24	%	99.11	✓ 94.1		-1	-0.74	-	95	-4	19 / 42	5 / 7
Virtual ward occupancy	ICB	Oct 24	%	80.56	✗ 66	Worse	11	19.31	21	66	-15	36 / 42	4 / 7

Better than previous period Worse than pervious period

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	Oct 24	%	97.83	✓ 98.85		2	1.69	-	97	-1	-	-
Community waiting list 52+ weeks	ICB	Sep 24	Count	4,890	✓ 4,158		-12	-0.29	NA	4,158	-732	-	-
Community waiting list	ICB	Sep 24	Count	NA	25,289		362	1.45	NA	25,289	-	-	-
Mental Health													
Access to Perinatal Services (Rolling 12)	ICB	Aug 24	Count	1,022	✓ 1,270		40	3.25	NA	1,270	248	-	-
Talking Therapies Reliable Improvement Rate	ICB	Sep 24	%	69	✓ 69		-1	-1.43	2	71	2	-	-
Talking Therapies Reliable Recovery Rate	ICB	Sep 24	%	50	✗ 47.31		-1	-2.63	23	51	1	-	-
Inappropriate OAP Placements (BNSSG)	ICB	Sep 24	Count	4	✗ 5		0	0.00	NA	5	1	-	-
Access to Transformed CMH Services for Adults and Older Adults	ICB	Sep 24	Count	6141	✓ 8,080		250	3.19	NA	8,080	1,939	-	-
Dementia Diagnosis Rate	ICB	Sep 24	%	68.39	✓ 71.7		1	1.70	-	72	3	May-42	1 / 7
Childrens													
CYPMH Access	ICB	Sep 24	Count	10,212	✗ 9,410		25	0.27	NA	9,410	-802	-	-
RTT waits 52+ weeks - Childrens	Acute Total	Oct 24	Count	800	✓ 364		-29	-7.38	NA	364	-436	-	-
Community waiting list - CYP	ICB	Sep 24	Count	NA	8,257		-81	-0.97	NA	8,257	-	-	-
Community waiting list 52+ weeks - CYP	ICB	Sep 24	Count	4,890	✓ 4,185		-12	-0.29	NA	4,158	-732	-	-
Specific acute elective spells - Childrens	Acute Total	Oct 24	Count	1,394	✗ 1,363		211	18.32	NA	8,393	-426	-	-

Better than previous period Worse than pervious period

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG ICB Outcomes, Quality & Performance Committee

Date: Thursday 28th November 2024
Time: 13:00-16:00
Location: Via MST

Agenda Number:	5.1		
Title:	Quality Report		
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:			

Key items to note in the Quality Report

Further details can be found in the slides in the main report. In summary:

- **General Practice Collective Action** – mitigations continue to be put in place across the system to address services that GPs are either considering or have commenced ceasing. This is being accompanied with a system quality impact assessment on the mitigations to ensure patient safety, patient outcomes and experience are impacted as little as possible.
- **System Experience Group** – A new formal System Experience Group has been established which has been formulated from a previous informal but very successful group, with representation from many partners across the system. A programme of work is currently being planned (with a current focus on experience across whole patient pathways), with new terms of reference to include stronger governance channels and widened membership.

Summary Reports from local System Quality Group (SQG)

The slides within the report refer in detail to the Quality Issues and developments reviewed in the system for the past 3 months. In summary these include:

SQG September 2024

- **Risk of Harm/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. , This project aims to improve this decision making by using evidence-based metrics based on person, population, service, organisation and system level perspectives, with plans to have a first generation tool in place to use by end of December 2024.
- **Winter planning –** Areas reviewed included, Discharge to Assess capacity and pathway planning, Transffer of Care hubs, expansion of NHS@Home services, Community Acute Respiratory Infection (ARI) Hubs, and Frailty services. A risk was explored concerning the reliance on a bedded model being the focus for recover capacity in P2 and P3 discharge pathways to mitigate the D2A backlog. A Quality/Inequality Health Impact assessment is currently being iterated for this initiative, and risks (financial and clinical) are being explored.

SQG October 2024

- **Quality focussed initiatives in response to the Winter Preparedness letter** from NHSE were explored with relevant partners and are detailed in slide 5.
- **NBT Surgery Waiting Lists; Healthwatch Survey –** A focus on the quality initiatives that can support patients' experience when waiting for surgery. Key areas included enhancing communication approaches, more information sharing and more pre-planning. The recommendations are being shared with partners of the system patient experience group, where further work is going to be undertaken to look at whole patient pathways.
- **SWAST; Frequent callers/High intensity users (HIUs)** – Current initiatives to manage and mitigate the pressure of HIUs was shared with the SQG, including current risks such as financial resources and capacity. An update on progress of this initiative will be brought back to the SQG in Spring 2025 with the anticipation of some system and regional learning ebing shared more widely.

Healthcare Acquired Infections

- Due to changes in data processes new HCAI data feeds are currently in the process of being accessed by the ICB's Intelligence Centre. HCAI data availability will resume for the next reporting period.

Patient Safety Events

- There is a reduction in the volume of system learning from patient safety events for this reporting period due to the transition across the system and nationally to a new patient safety reporting platform. Until recently the ICB had oversight of the previous platform known as the Strategic Executive Information System (StEIS). The new platform, Learning from Patient Safety Events (LfPSE) is now being used by most of our providers, however the analytical tools for ICBs to review, analyse, learn from and act on the data (being developed by NHSE)

have not been ready for this reporting period. We are liaising with NHSE and supporting partners to close their legacy cases on StEIS.

New Quality Report Format

- The ICB is working closely with our partners to be able to report across the system on progress against this years Quality Priorities of partners. This work is still underway, but the aim is for this to be in place by the next reporting period.

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

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Quality Report

November Report on Month 5/6 (August/September) 2024/25

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

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Current updates and any emerging issues identified since August 2024

Quality - Current updates and any emerging issues identified since August 2024

Primary Care – General Practice Collective Action
Mitigations continue to address the General Practice Collective Action. Risks to services and access may impact on patients and system partners with increased presentations in other settings. System mitigations include:

- A Quality Impact and Risk assessment is being completed against all proposed mitigations to address the GP Collective Action.
- LMC has surveyed practices and collated top 5 actions.
- An Urgent and Emergency 'Minors' mitigation plan
- Communications and engagement plan for public and professionals
- Working group in place to plan approach for physical monitoring for people with eating disorders

Note, there is a lack of national funding to support mitigations which is a risk to local financial position in addressing and implementing mitigations.

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

System Quality Group (SQG) and National Quality Board (NQB) process updates

Quality – System Quality Group (SQG) and National Quality Board (NQB) process updates

SQG and HCPE (Health & Care Professionals Executive) meeting in common - 19th September 2024. Joint meeting to discuss review of Winter Plans 2023/24, including Risk of Harm dashboard/Care Traffic Control progress and planned pathways for admission avoidance and rapid discharge.

Focused areas

Risk of Harm/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.

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 coupled 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

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.

Quality – System Quality Group (SQG) and National Quality Board (NQB) process updates

System Quality Group - 17th October 2024
Areas of focus

Trust responses to Temporary Escalation Spaces paper
Partners were asked to give an update on their Winter Planning position, following the NHSE letter sent in June 2024 to all partners, ICBs, Trusts and Regional Directors.
UHBW – Weekly Winter Planning Group is in place and sub-groups in place are IPC, Escalation Area SOPS and Risk/Quality assessments, Flow and Escalation policies/Transfer of Care Hubs/Winter Schemes (Mar 24 outcomes). Assessment and testing of all Temporary Escalation Spaces is underway. Every Minute Matters and proactive hospital focus. Flu and COVID Vaccination Hub in place, together with roving model. Dynamic risk assessments being conducted.
Sirona – Using the framework contained within the NHSE letter to both guide Winter Planning and to inform actions that need to be taken. Daily meeting to look at capacity and demand across both Adult and Children's Services with resources being reallocated as required. Capacity issues are being reviewed to identify any ongoing trends. "Integrated Neighbourhood Team Programme" – piece of work looking at where processes can be standardised. Executive visits taking place together with a programme of peer review visits using the CQC framework around fundamentals. Vaccination programme for staff up and running – roving model. Working with Acutes to conduct check and challenge around patient flow.
SWAST – Focusing efforts on Regional Ambulance Task & Finish Groups. Working hard to reduce ambulance handover delays. Staff flu vaccinations well underway.
St Peter's Hospice – No formal Winter Plan, but models built on resilience are in place. Daily meetings (involving Acutes) are held concerning Community and Inpatient Unit workload and resources. CNS's work with Sirona and GPs to try to ensure that needs are met. Hospice at Home teams are working 24/7, and there is a Hospice at Home 24hr helpline.
BrisDoc – Ongoing monitoring of flow, capacity, and outcomes. The expanded out-of-hours rota has now gone live, and extra bases will be opened to allow additional access for patients. Frailty ACE service – recent successful trial period with a SWAST Senior Paramedic with further testing to take place. Mental Health Option 2 behind 111 goes live on 1 Nov 2024. A huge amount of operational planning has gone into this, and it will be a new way of accessing support for urgent cases and crisis support for the BNSSG region. This should have a positive impact on ED attendance.
AWP – Urgent work on bed transfers to try to keep flow moving. Flu and COVID staff vaccination programme underway.
Bristol City Council – Social Care providers' events being held across BNSSG to promote vaccination.

Healthwatch BNSSG NBT Surgery Waiting Lists
NBT commissioned Healthwatch to carry out the survey due to their expertise in collecting feedback and their connections with the local community on patient experiences while on NBT waiting lists for elective surgery.
Findings:
Patients want more frequent communication during their wait for surgery
Patients felt that in addition to a medical-based pre-operative assessment, consideration should be given to personalised needs assessments of holistic factors (social, financial, housing) in advance of elective surgery
Patients want to be directed to evidence-based sources and would like to have links to these in one place
Patients used some online "waiting well" resources but also wanted help in their community, in-person support and Social Prescribing.

Quality – System Quality Group (SQG) and National Quality Board (NQB) process updates

Healthwatch BNSSG NBT Surgery Waiting List Report (continued)

Action plan:

- **Better / more frequent communication** with implementation of the five NHS England Elective Care 2023/24 core requirements. Text pilot running in Orthopaedics, to confirm if still require surgery. Plans to consolidate process and monitor mechanisms further within orthopaedics and then roll out to next speciality late 2024. Electronic screening tool being tested with all ortho DTAs for last 4 weeks, allocates risk rating, process for triage and onward referral being worked through.
- **Communication in a way people can understand:** An audit of how and where patients' preferred means of communication are flagged for practitioners - NHS Accessible Information Standard. AIS steering group, AIS alerts in place, working towards achievement, making progress but still some distance.
- **Information in one place:** Patients awaiting surgery would like to be directed to various evidence based, recommended sources with links to these in one place. It is hoped the new, integrated BNSSG webpages will be included. Website for all planned care pathways live, always improving, working with ICB comms team, posters in majority of outpatients, given to patients at DTA, next working on equivalent for those digitally excluded.
- **Local, community, in person support:** Online support should complement, but not replace, the role of community, in-person support, Social Prescribing and personalised needs assessment. Raising awareness of services that are available regardless of waiting list, information on new webpage of services available, need to include in communications to contact GP if deteriorating, both GPs and NBT have access to social prescribers, hosted services at recent collaborative peri op event to raise awareness.
- **ICB pre-rehabilitation approach** – consideration of personal needs: Patients would benefit from being referred to a comprehensive pre-rehabilitation / waiting well programme that crosses organisational boundaries. Screening questionnaire version one being piloted, will then be reviewed. Early supported discharge pathway embedded for hip and knee pathway which assesses post-operative community pathway requirements, and proactively engages with community providers pre-operatively, rather then at discharge. This process identifies patients with complex discharge requirements and pre-operatively plans discharge / support. Shared decision making.
- **Patient journey** – volunteers to follow a few patients on the journey from referral to surgery to sense check both the regularity and quality of contact, support available and other feedback. This would help us evaluate actions.
- **Support hubs** – to run a hub to provide information, answer questions, talk to people – volunteer or peer support, bring along physio, PALs, chaplaincy, fresh arts, carers support etc. UHBW & NBT deliver. AWP – Talking Therapies.

SWAST – Frequent Callers/High Intensity Users – SWAST presentation of action Plan. Progress to be reviewed again by SQG in Spring 2025

- A Frequent Callers/High Intensity User is a person aged 18+ who contacts the ambulance service enough to generate five or more episodes of care (incidents) in a month.
- The number of people calling SWAST frequently is increasing.

Support required

- Integrated HIU programs to support with the education and management of people that call SWASFT frequently.
- Enhanced HIU tracking and data integration.
- Input from Adult Social Care to address the large crossover with self-neglect.
- Escalation routes for complex cases for system-wide support.
- Pathways for HIU to access non-emergency care

High Risks

- Activity management of known high intensity users (both individual patients and care establishments) cannot be achieved with our current establishment, without external support.
- Current processes and capacity leads to a lack of equity across the cohort, not addressing all people's needs.
- Without action, calls from people calling SWAST frequently will continue to rise, using more emergency resources.
- High volumes of calls from this cohort may have an adverse impact on performance and patient experience for all SWAST patients.

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Patient Safety Events including Never Events

Transition to a new digital reporting and learning platform – interim reporting period for ICBs

There is a reduction in the volume of system learning from patient safety events for this reporting period due to the transition across the system and nationally to a new patient safety reporting platform. Until recently the ICB had oversight of the previous platform known as the Strategic Executive Information System (StEIS). The new platform, Learning from Patient Safety Events (LfPSE) is now being used by most of our providers, however the analytical tools for ICBs to review, analyse, learn from and act on the data (being developed by NHSE) have not been ready for this reporting period. We are liaising with NHSE and supporting partners to close their legacy cases on StEIS.

Closure of StEIS reported incidents is dependent on organisations being able to use Version 6 (V6) of the LFPSE taxonomy which includes fields for capturing insight from learning responses under the Patient Safety Incident Response Framework (PSIRF). A recent assessment determined that not all providers had adopted the new version, as a result, the decision has been made to maintain the StEIS platform until all providers have transferred.

We continue to monitor the completion of the very few new patient safety events that are being recorded and any legacy ones. To improve our governance, we have changed the ICB sign off process to be collaborative and working through completing legacy cases. Please see table below for an overview of STEIS open cases, including new and legacy ones.

Summary of remaining STEIS cases

Year	Number of open cases on STEIS
2018/2019	1
2019/2020	1
2020/2021	4
2021/2022	6
2022/2023	37
2023/2024	60
2024/2025	30

Provider	UHBW	NBT	Sirona	AWP	SWAST	Other	**Total**
Number of open cases on STEIS	48	18	31	26	8	8	**139**

The ICB is working closely with partners to close these cases (pending completion of investigations in some cases) by Q4 2024/25 prior to the decommissioning and closure of the STEIS system.

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Outcomes, Quality and Performance Committee

Draft Minutes of the meeting held on Thursday 26th September 14:00-16:30 on MST

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Paul May	Non-Executive Director, Sirona Care & Health	PM
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sue Balcombe	Non-Executive Director, UHBW	SB
Jonathon Hayes till 1600	Chair of General Practice Collaborative Board	JH
In attendance		
Greg Penglinton Agenda Item 6	Head of Urgent Care and System Flow, BNSSG ICB	GP
Michael Richardson	Deputy Chief Nursing Officer, BNSSG ICB	MR
Mark Hemmings Agenda Item 7.1	Senior Performance Manager (LD&A)	MH
Jodie Stephens (Minutes)	Executive PA, BNSSG ICB	JS
Laura Westaway Agenda Item 7.5	Head of Children's Services, BNSSG ICB	LW
Paul Roy 7.6	Associate Director for Research, BNSSG ICB	PR
Apologies		
Sue Geary	Healthwatch	SG
Aishah Farooq	Non-Executive Director BNSSG ICB	AF
Hugh Evans	Executive Director, Adults and Communities BCC	HE
Sarah Weld	Director of Public Health, SGC	SW
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Jeff Farrar	Chair, BNSSG ICB	JF

	Item	Action
1.	**Welcome and Apologies** ED welcomed attendees to the meeting and apologies were noted as above. ED introduced the agenda and highlighted current challenges in the system which has meant the running order of the agenda has been moved around. ED advised that an update regarding NCTR will be given to committee members as despite the efforts of the system the capacity target of 15% will not be achieved. ED will escalate this to ICB Board in October which will include writing to SD. ED asked committee members to input their views with regards to NCTR. RS gave an update to the committee on the system challenges and explained that NBT and UHBW have seen significant increase in demand at the front door and this resulted in an escalated situation by the most recent Sunday night/Monday morning. All temporary escalation spaces were open and occupied but NBT were reporting extremely high numbers of patients in ED and ambulances queuing, this then resulted in an ambulance divert from NBT to UHBW overnight. JH confirmed that the general practice collective action has not started, so this was not the reason numbers were high within A&E. Discussions took place regarding Sirona capacity and high levels of insulin demand, PM advised he had been linking in with Sirona to review P1 and P2 capacity. JM has stood up a Performance Escalation meeting on Friday 27th September which will have COOs and Medical Directors from providers, which may result in CEO escalation. Comms have been circulated to community's and patients. RS explained that the current situation is also causing CAT2 ambulance delays which are ranging between about 45 and 75 minutes. Discussions in the committee included the need for NCTR to be escalated to Board, there is also the need to reduce admissions to hospital via the 'front door.' Discussions need to include with Sirona whether they have the capacity to achieve the proposed NCTR surge plans, particularly in relation to P1. JM will also pick these issues up at the PEM meetings. SB questioned what lessons have been learned, how can the system act more effectively, was this a good example of escalation? **ACTION: Updated paper submission process to be implemented for November OQPC.**	
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 June 2024 committee** Committee approved minutes from June Committee. RS updated committee regarding LeDeR backlog reviews. RS explained that a contract has been awarded to a company called XYLA and they will be taken on	

	Item	Action
	the longest waiting LeDeR reviews immediately.RS will provide an update at November committee regarding trajectory for backlog LeDeR reviews. **ACTION: RS to update November committee regarding trajectory for backlog LeDeR reviews.**	
4.	**Committee Action Log** The action log was updated to be circulated with the minutes.	
5.	**Chief Medical and Chief Nursing Officer Update.** **CNO** RS explained that focussed discussions have taken place within the most recent System Quality Group (SQG) on the winter plans and pressures, in order that partners bring in their perspective on issues for shared learning and risk triangulation. Senior clinical and care leadership colleagues attended. Engagement from SWAST has improved which included a piece of work regarding treatment delays and quality information. Discussions took place regarding the safer nursing care tool and staffing levels. This is a large issue within NBT because the safer nursing care tool would suggest that NBT need to have higher numbers of staff because of the high numbers of side rooms in their estate. Reviews of NHS providers' safe nursing care tool modelling also took place. Quality Report – Graham Road CQ report published on Tuesday 24th September and practice awarded 'Good'. Healthcare Acquired Infection update – slight increase in C-diff which is also reflected nationally but ICB involved with region in a working group to address the issue, which includes system partners. Larger numbers of older people with more complex conditions and the increase in UTI prescribing in men are some of the factors cited for increase in incidence; this is a national, regional and system issue. Audit review – RS and MR met with the auditors today and have advised that the actions under CNO are on track. ED asked RS to review the last audit report which was viewed at BNSSG Audit and Risk committee for assurance, as ED under the impression timelines for actions had not been signed off. RS has advised auditors that specific delivery goals of the safeguarding transformation programme are collaborative goals with system partners and will not therefore be completely within the control of the ICB. RS will review timelines within audit report and feedback to ED.	

	Item	Action
	AM asked for updates regarding AWP (as not represented at system quality group) and also paediatric hearing delays. RS explained that paediatric hearing is commissioned by NHSE so is managed through them and JM added that there was a significant improvement expectation asked by UHBW based on a regional report. JM has contacted UHBW and will report back to committee members regarding position and the improvement trajectory. **CMO** HCPE – Items included NICE technology appraisals - The ICB must comply with these recommendations and has a statutory responsibility to make funding available within the published timeframe. BNSSG going against recommendations – JM has escalated regionally and nationally. Legal advice has also been sourced and system working group formed. Tier 3 weight management services at NBT have now been closed for over a year. Patients that need complex weight management services are not being seen and NBT want to continue their closure for another year- HCPE agreed to a further three months but want to understand the risks, benefits, solutions and mitigating actions as the current situation is impacting back into general practice. Women's Health - Two-year piece of work with limited funding but fantastic work has taken place. PCN's, GP's, practice nurses working with gynaecologists, reproductive sexual health and community services - a collaborative piece of work. The ask was for a women's health hub, which has not happened yet but there has been a significant improvement in services for women. This will finish in March due to funding coming to an end, but hope is for recurrent funding. Measles – Case numbers rising as high as they were in 2021. Outreach immunisation clinics are in place to immunise the most vulnerable of the population. BNSSG were not considered problematic enough to receive national funding. **ACTION: RS to review timelines within audit report and feedback to ED.** **ACTION: JM to contact UHBW regarding paediatric hearing delays and will report back to committee members regarding position and the improvement trajectory.** **ACTION: RS to escalate to SD and the AWP Improvement Board that Riverside independent review team has not been established.**	
6	**Chief Delivery Officer Update**	

	Item	Action
	GP joined committee on behalf of DJ due to annual leave. GP explained that a focused Winter clinical risk work session took place within system quality group and HCPE. Discussions within that group were how ICB want to move away from process, activity measures and how we manage the system, to how the metrics are looked at in real time every day and decisions made based on that. Work is taking place with regards to the system dashboard to include more information, so system is better interconnected in terms of visualising relative risks. GP highlighted that the work session also touched on initiatives, schemes and investment for Winter. Last Winter £40,000,000 of recurrent funding was invested into schemes to address and support system flow. This covered supporting discharge, complex discharge, admission, alternatives to admission and community front door. GP explained the following services to committee members - the frailty ace service, transfer of care hubs in hospitals and D2A. D2A - high quality detailed modelling has been done to address the long-standing issue of NCTR. Despite benchmarking well on metrics related to system flow, this is one metric where BNSSG ranked second lowest in the country. D2A recovery plan has been modelled to look at pathway 1, 2 and 3 to address a backlog. The model does bring more home-based pathway one, but it also brings more rehabilitation beds into the community to try and clear backlog in the acute trusts. RS highlighted conversations that took place within joint system meetings including risk and the modelling around purchasing additional P2 and P3 beds in care homes, nursing homes in the community. Evidence shows that a proportion of patients will decondition and end up staying in nursing and residential care homes and never go home. ED commented on the £40 million investment last year. Can GP assure committee that in the system, we are at least at that level in terms of processes, planning of workforce and implementation of that workforce? Also, assurance from conversation's taking place, that services added from last winter will be more effective and efficient. RS explained that two letters from NHSE have been received regarding winter planning. NHSE have asked for very specific Board assurance and bullet points from each ICP and provider organisations. DJ and his team will be producing a formal update and assurance piece at ICB Board. A letter was also received regarding temporary escalation spaces and the use of temporary escalation spaces, which is a high-risk patient safety issue. RS explained this letter will be taken through October's system quality group. GP highlighted that ICB are tracking investment very closely and have focused on the four areas which have been identified with a delayed delivery. Transfer of care hubs - a detailed evaluation has been done to give ICB assurance. There is	

	Item	Action
	a very clear improvement trend across all our key metrics (except for NCTR) over the last 18 months where money has been Invested. BNSSG are meeting national targets on response times and ambulance handovers. SB highlighted the concerns from UHBW Board regarding NCTR- Transfer of care hubs. Although there has been increased activity the NCTR situation has not reflected that. UHBW want assurance that changes are taking place to improve NCTR. What else can system do? AM highlighted that system is performing well in many metrics, but NCTR is a system issue and not an acute trust issue. Discussions in the committee took place regarding pathway one run rates, complex discharges and length of stay improvements in pathway three, being maintained with support from local authorities. RS added that system partners need to really challenge themselves about what they are doing, are the transfer of hubs really working as these have been a significant investment of money; there needs to be peer reviews of system processes. RS is having ongoing conversations with system CNO's regarding this. JM discussed management of flow variation - when the variation goes above the mean, the system does not then have a responsive flexible response to regulate pressures. ED thanked members for their input into conversations and ED will reflect on points raised: • Tracking and full details of the £1.4 Millon Investment • Winter surge sustainability. • Escalating Winter Planning to ICB Board.	
7	**Items for Discussion**	
7.1	**LD & Autism NHSE Segmentation Targets:** **• Out of area placement** MH explained to committee members the system issues regarding out of area placements: • The backlog in Autism and ADHD assessment means individuals are not getting the support they need. • Some individuals in this cohort do not want to engage with the system as there is still a stigma involved with Learning Disabilities and/or Autism. • Inpatient stays are becoming longer and there are significant delays in discharge due to: a) lack of appropriate accommodation b) lack of suitably skilled care providers c) reduced access to care coordination d) limited social care capacity. • Personalised care plans are essential especially for those transitioning into adult services, but they are not always in place.	

	Item	Action
	• The DSR will be operational in 2025/26 but currently there is no process for monitoring individuals within the community whose risk factors are increasing. MH explained the mitigation plans in place which included: A new model of care for inpatient units is being developed to explore ways to adapt the Learning Disability, Autism and Neurodiversity community offer to support the unit, including: • Length of stay • Increased culture of integration • Better use of multidisciplinary teams and Improved intensive therapeutic offer. BNSSG have a range of improvements underway as a system to support prevention and develop the right provision across the ICS which include: • BNSGG Learning Disability and Autism development team have several accommodation projects in progress which will help with discharge capacity. Ten additional community beds will become available in the summer 2025 to support community care. • Working with partners to provide a new model of community support pathways. Designed to support people who need short term interventions that can be linked and integrated with community-based support e.g. the development of the North Learning Disability and Autism treatment and assessment service. • An improved DSR providing a process where more proactive support can be planned and implemented. Our plan is to achieve a minimum of circa 10% reduction from current position in the next year, this equates to three people and is reflective of the high complexity of the current cohort of people. • A system wide plan to support and develop services which are local, inclusive and deliver safe, personalised and therapeutic care. ED reminded members that the subject matter is on the agenda because it contributes to BNSSG segmentation. As a system, BNSSG are in segment three as defined by NHSE and the reason BNSSG are partly in that position is because of out of area placements. ED asked, will targets be met within the next 6 to 9 months. RS explained to committee that constructive meetings have taken place with local authorities through the Children's HCIG regarding this subject matter and the specialist children's home. BNSSG ICB children's team are linking in with AWP, Sirona and with local authority colleagues regarding models of care. Specialist homes within Bristol will be available for residents from April/May 2025. Questions included when the model of care will be available online and whether set targets were correct and who sets the threshold? Clearer understanding of the data and what determines whether BNSSG are performing well is needed. Is	

	Item	Action
	there a correlation between the actual performance and the mitigating plans for improvement? Why aren't patients on the dynamic support register? MH could not confirm that targets would be met in six to nine months, but two projects are currently underway in Bristol. BNSSG have challenging targets, but and NHSE adjust the target as the year goes on. The dynamic support register is only populated by CAHMS colleagues, whereas the idea behind the register is that people can self-refer on to it or social care, but BNSSG do not have a digital solution to bring all that information together currently. Further discussions took place resulting in committee asking MH to ensure Children's ODG and HCIG treat this piece of work as a priority; to add onto children's risk register and then this committee will need assurance that the ODG/HCIG is working and acerating the issue as fast as possible. **ACTION: MH and RS to ensure that LD & Autism out of area placements are treated as priority at BNSSG Children's ODG and Children's HCIG.**	
7.2	**Customer Service & Complaints Quarterly Report to include Patient Experience.** **Due to time constraints, a decision was made for the committee to receive the report for information and feedback comments/queries to MR by email after the meeting**	
7.3	**Review of OQP Committee Terms of Reference.** ED asked committee members to review TOR and send any comments to ED and JS. JM and ED will meet to discuss and then add to OQPC in November. **ACTION: JM and ED to meet to discuss OQPC TOR and add to OQPC in November.**	
7.4	**BNSSG ICB Safeguarding Annual Report** RS explained that NHS England have a safeguarding assurance framework which is a set on performance indicators. BNSSG ICB is required to deliver against this, to demonstrate ICB is meeting statutory duties. This also requires the ICB to produce an annual report which focuses on the work of the ICB Safeguarding team. The report shows how the ICB team is delivering its statutory duties in terms of safeguarding and working with partners but gives an overview in terms of what is happening inside the partnerships. RS highlighted significant safeguarding issues within BNSSG system, and this has been reflected in the report. Transformation work is currently underway with local authorities and Avon & Somerset Police, to make sure that BNSSG get the best learning and assurance. The Safeguarding report has been to BNSSG ICB Executive and SD has reviewed the report in his capacity of Accountable Officer (Lead Safeguarding Partner) for the ICB.	

	Item	Action
	Questions and discussions from committee included acknowledging the challenges there had been within the partnerships in 2023/2024, and how data sharing is crucial for good safeguarding practice. Is BNSSG learning from other systems? SB advised how she had challenged her trust colleagues to reflect whether they were effectively sharing data and posed the challenge was everyone doing the same. RS explained that local authorities and all the safeguarding partnerships need to be clear on what health information is needed/required and how the information sharing governance arrangements is managed. RS stated that the Children's MASH is well established and staffed by Sirona who have direct access to the clinical records of the children. Adult MASH – RS updated that discussions have taken place today regarding a pilot for one year and using some resource from BNSSG ICB Safeguarding team. This matter has also been discussed at ICB Board and Children HCIG. . MR updated committee, the health metrics that local authorities and safeguarding partnerships require has been compiled and the final list and sign off should be by Christmas, when partners will be asked to provide the information directly to the partnerships. MR stated that the ICB today have also signed a wider system information sharing agreement across BNSSG. RS stated that the LGA review this year looked at safeguarding arrangements across BNSSG and highlighted areas which were performing differently and better. The transformation programme described in the report is for ICB to make sure that challenges reported are overcome. Regarding Adult and Children's as separate safeguarding bodies, the working together guidance, which was refreshed in 2023 gives specific statutory requirements for children safeguarding and how to operate. RS explained that it is up to local authorities to decide with the ICB and police, how they deliver these., Keeping Bristol Safe Partnership has an overall set of arrangements but sitting underneath is separate adults and children programmes. ED advised she would like to escalate the issue of safeguarding information sharing to BNSSG Board on Thursday 3rd October. MR supported by JM will provide written statement for ED. **ACTION: MR to provide statement regarding safeguarding information sharing for ED escalation to BNSSG Board in October.**	
7.5	**SEND Quarterly Report Q2** LW summarised the current position for each LA with regards to the latest send inspection, related outcomes and action plan. • Bristol area partnership has one outstanding area of significant weakness. • North Somerset had an improvement plan in place because of latest inspection but has been completed and signed off.	

	Item	Action
	• South Gloucestershire had an accelerated progress plan in place and that was signed off last April. The three local area partnerships are at various stages in terms of development and action plans. • Bristol's strategy and action plan is currently in development. • North Somerset is delivering the action plan, but the strategy is also being refreshed, they also have a self-evaluation framework. • South Gloucestershire have an approved strategy and action plan. The self-evaluation framework has been refreshed ahead of the imminent inspection. LW updated committee with regards to SEND performance. • Access to community paediatric services - 4000 children waiting over 52 weeks for community paediatrics or autism assessment. Recovery plan is bringing together the Neuro Diversity Transformation programme which is going to pilot in October. Within the recovery plan, is an efficiency and productivity programme in Sirona, which has resulted in a steady reduction in Sirona overall waiting lists - 30 children per month. Recovery plan is also reviewing where capacity can be built and looking at data and reporting to make sure opportunities are maximised to learn from other systems by having comparable data sets. • Access to children's therapies - an improving picture across BNSSG. Performance 92% target reached to see children under 18 weeks, 85.4% for physiotherapy, 82.5% for occupational therapy and 94.7% for speech and language therapy. Educational, health and care needs assessments are completed by Sirona and need to be completed within six weeks to meet system target of 20 weeks for an EHC plan, this has been sustained. Financial implications - Community Children's Health services - focus needs to be on making sure we have equitable provision across all 3 LA areas Neuro Diversity Transformation project has non recurrent funding and we are currently determining what will be required going forward. Questions and discussions focussed on the health inequalities lens regarding children on waiting lists. There is a new DFE funded post to review SEND in the Southwest region – PM to forward contact to LW. LW confirmed a health inequalities lens is applied with regards to the triage of children on waiting lists – Committee asked for assurances that health inequalities prioritisation is applied to children's waiting list and actions taken regarding risks highlighted in SEND report.	

	Item	Action
	ACTION: PM to forward DFE SEND officer for Southwest region details to LW so can make contact. **ACTION: LW to include in paper for OQPC - assurances that health inequalities prioritisation is applied to children's waiting list and actions taken regarding risks highlighted in SEND report.**	
7.6	**Research Bi-Annual Report** JM explained that the research bi-annual report was for OQPC to sign off and then as a subcommittee of ICB Board, the report will then be published on the BNSSG ICB website. The report has not been to BNSSG ICB Executive meeting – ED explained that committee would not be able to approve but will give constructive feedback/comments. PR explained that BNSSG ICB research team is the top team in the country in terms of research activity, received income but also in terms of patients who have been recruited into research projects. In terms of NHS organisations, BNSGG ICB are second and the only ICB in the top twenty. The success rate of the grant applications is 45% success rate. The ICB have high quality applications being developed and one hundred projects. Research team continue to support strategic priorities in the system and are proactive with under-served and under-heard communities within BNSSG communities. Research team link in with two networks - Research Engagement Network, who engage in key activities to increase local communities' participation in research and the GP Deep End Network, which is 17 GP practices across BNSSG who work with the 15% most deprived members of BNSSG population. Questions included outcomes from research projects, linking in with acute trusts engagement, process for prioritising research projects, collaborating with ICB priorities and core objectives. JM stated well engaged as proven by national ranking and across BNSSG system. Research criteria's link to objectives, health inequality and research framework has been developed and is used to allocate and prioritise the bids. Regarding ICB priorities, within the TOR it states bi-annual report which can be strengthen within the TOR. PR explained the research team is part of Bristol Health Partners which link in with acute trusts and also NIHR which is university-based units all funded through centralised funds. PR currently planning a research conference which brings all system partners together. JM highlighted committee members to review page 12 within the research report which highlights the GP Deep End network and recommend that they attend OQPC or Primary care Committee – It was agreed that GP Deep End Network to attend Primary Care Committee in the future. ED thanked PR for such a wonderful report and suggested that adding to BNSSG executive team, board and integrated care partnership agendas.	

	Item	Action
	ACTION: JM and PR to highlight Research Bi-annual report at BNSSG executive team, board and integrated care partnership meetings.	
8 8.1 8.2 8.3 8.4 8.5	**Items for Information** **EPRR Annual Report** **Healthcare Acquired Infection Group** **BNSSG System Quality Group March Minutes** **Health and Care Professional Executive March Minutes** **APMOC Minutes**	
9	**AOB** AM requested that an update regarding the letter that was addressed to Sirona Board, ICB board and ICB child safeguarding lead from Dr Alison Bolam GP regarding relocation of health visiting team at Horfield Health Centre is added to OQPC for November. **ACTION: JS to forward Dr Alison Bolam's letter to MR and add to OQPC agenda for November for DJ to update**	
	Meeting Dates 2024 • **Thursday 28th November 1400-1625 MST**	

Jodie Stephens Executive PA
September 2024

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Winter Planning 24/25

Greg Penlington, Head of Urgent & Emergency Care and System Flow

The national NHS context for winter

NHS winter letter:
Was published on 16th September setting out expectations of NHS England, Integrated Care Boards (ICBs) and NHS providers.

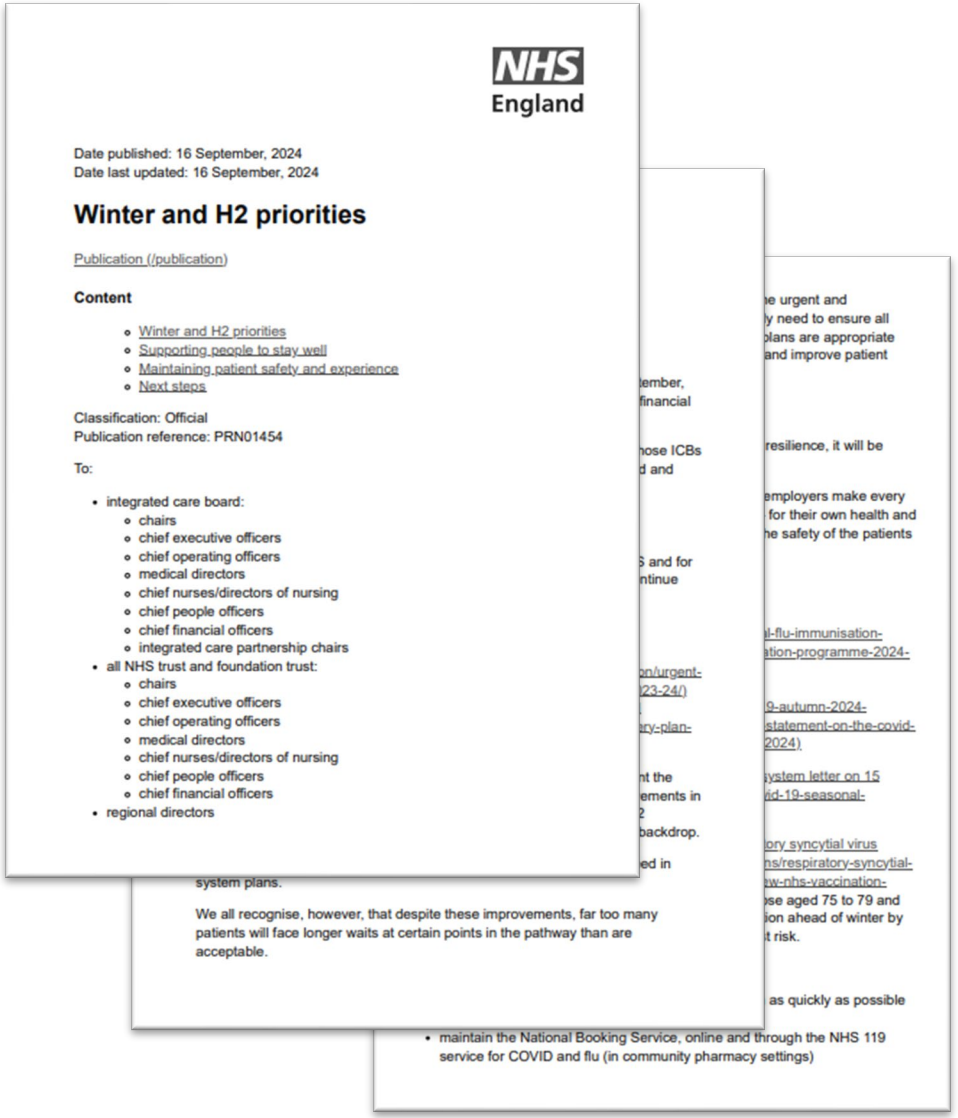
It clarified focus on maintaining delivery of the UEC Recovery Plan, whilst recognising challenges resulting from activity over the summer which was higher than planned.

Operational Plan targets remain unchanged:

- **Average Category 2 ambulance response times <30 minutes**
- **> 78% of emergency department waits <4 hours**

No additional funding is made available for this winter, but systems should work to optimise gains made from significant recurrent investments made last year.

NHS trusts have responded to the priorities letter through their own winter board reports.



NHS England

Date published: 16 September, 2024
Date last updated: 16 September, 2024

Winter and H2 priorities

Publication (/publication)

Content

- Winter and H2 priorities
- Supporting people to stay well
- Maintaining patient safety and experience
- Next steps

Classification: Official
Publication reference: PRN01454

To:

- integrated care board:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
  - integrated care partnership chairs
- all NHS trust and foundation trust:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- regional directors

system plans.

We all recognise, however, that despite these improvements, far too many patients will face longer waits at certain points in the pathway than are acceptable.

- maintain the National Booking Service, online and through the NHS 119 service for COVID and flu (in community pharmacy settings)

Specific ICB H2 priorities:

	ICBs are asked to:	
1	Ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter: primary care and community services should be working with these patients to actively avoid hospital admissions	
2	Provide alternatives to hospital attendance and admission: especially for people with complex needs, frail older people, children and young people and patients with mental health issues. This should include ensuring all mental health response vehicles available for use are staffed and, on the road, ahead of winter	
3	Work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow	
4	Assure at board level that a robust winter plan is in place: including surge plans, and co-ordinated system actions in real time, both in and out of hours. It should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers	
5	Make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system	
6	Review the 10 high-impact interventions for UEC published last year to ensure progress has been made	
7	Work with primary care providers to ensure good levels of access to vaccinations, ensure that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised	
8	Work with local partners to promote population vaccination uptake with a focus on underserved communities and pregnant women	
9	Work with primary care and other providers, including social care, to maximise vaccination uptake in eligible health and care staff	

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

Winter risks and mitigating initiatives

	ICBs are asked to:
1	Ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter: primary care and community services should be working with these patients to actively avoid hospital admissions
2	Provide alternatives to hospital attendance and admission: especially for people with complex needs, frail older people, children and young people and patients with mental health issues. This should include ensuring all mental health response vehicles available for use are staffed and, on the road, ahead of winter
3	Work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow

	ICBs are asked to:
1	Ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter: primary care and community services should be working with these patients to actively avoid hospital admissions
2	Provide alternatives to hospital attendance and admission: especially for people with complex needs, frail older people, children and young people and patients with mental health issues. This should include ensuring all mental health response vehicles available for use are staffed and, on the road, ahead of winter
3	Work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
5	Make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
6	Review the 10 high-impact interventions for UEC published last year to ensure progress has been made
7	Work with primary care providers to ensure good levels of access to vaccinations, ensure that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
8	Work with local partners to promote population vaccination uptake with a focus on underserved communities and pregnant women
9	Work with primary care and other providers, including social care, to maximise vaccination uptake in eligible health and care staff

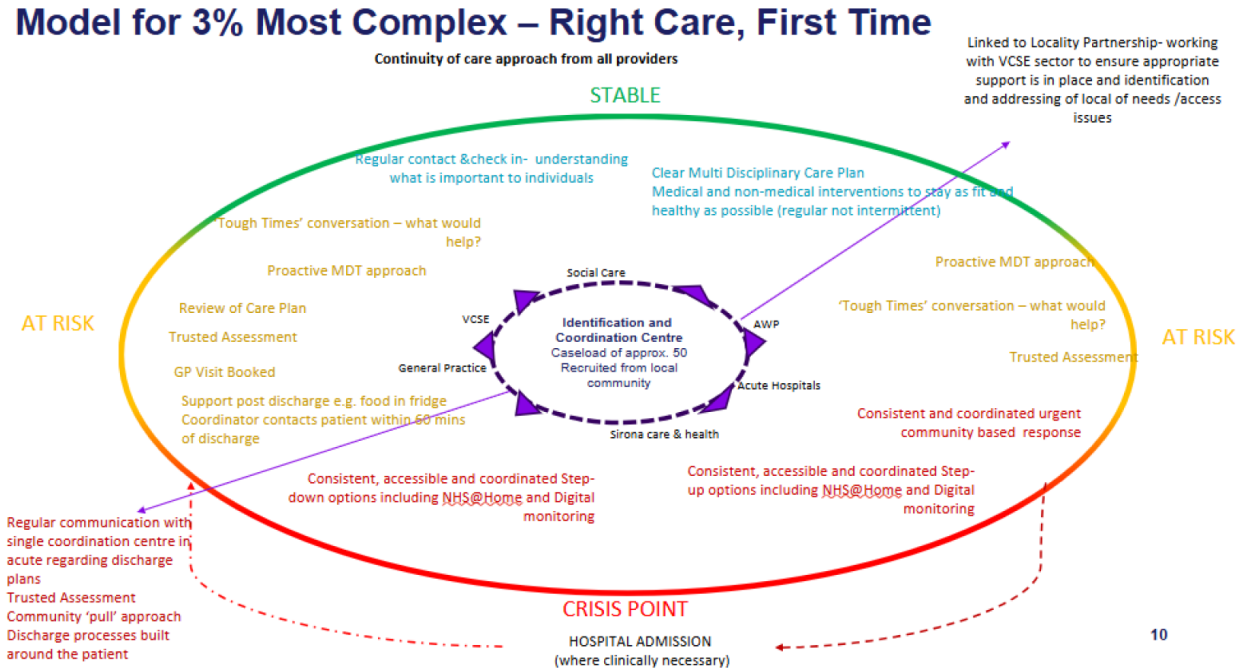
Care Coordinators Delivering Anticipatory Care in Primary Care

- This winter, new general practice-based care coordination teams will be employed to work across a Primary Care Network (PCN) and geographic area. They will take a proactive approach to identify and support people for whom care coordination will help with the aim of avoiding admissions and keeping people well for longer at home, using population health management information.

- There will be 20 in phase 1, attributed to PCNs depending on the number of people with complex conditions. They will be supported by 10 shared administrators. Recruited staff will be sought from within the local communities, so they reflect and understand the communities they are serving and what effective support is available.

- Care coordinators will receive supervision for a session a week of GP or ANP clinical time in their practice/PCN based MDT. Funding has been allocated to support practices to adapt and embed the transformational change consequences for them. Clinical governance will sit with the GP.

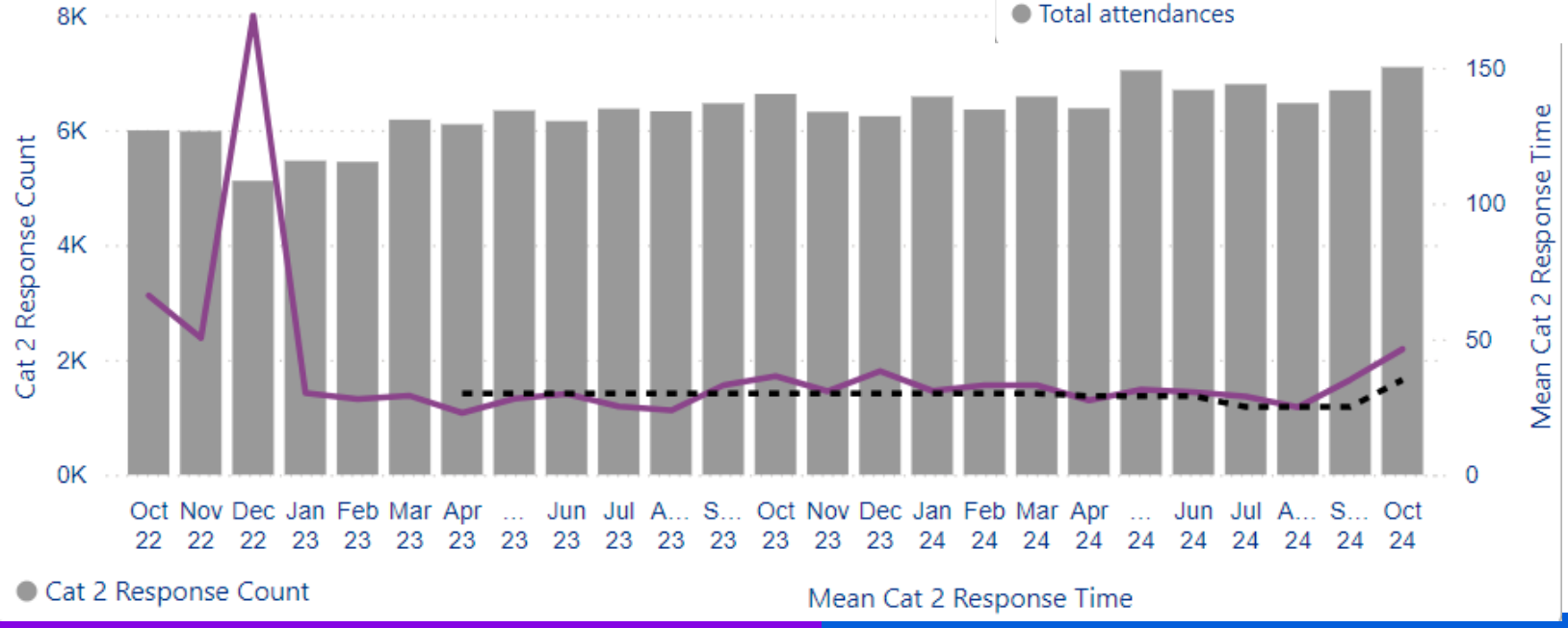
- The roles have been prioritised based on service user feedback, that patients would value coordination of the various medical support offers the receive. The model pushes this further to activate interventions to prevent crisis.



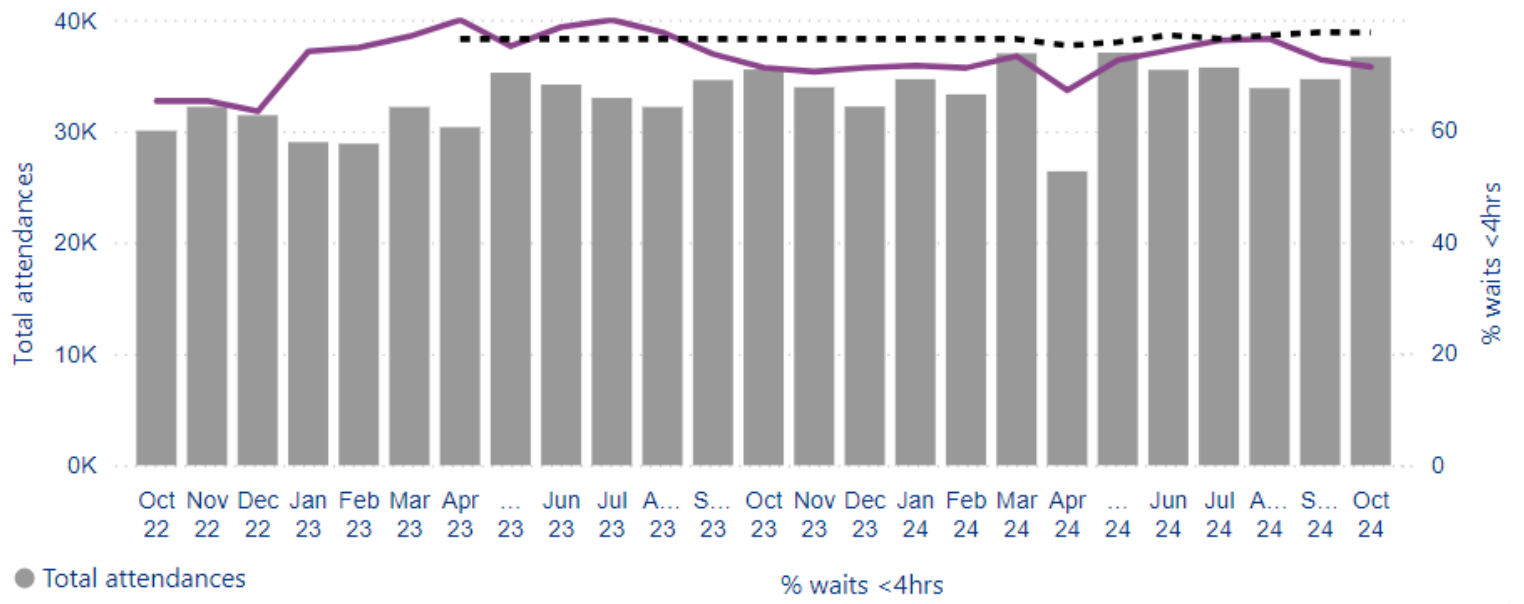
Segment	Cambridge Score	Proportion of population	Mean annual spend per person	Segment proportion of total spend
1	< 0.09	52.2%	£301	16.4%
2	[0.09, 0.69)	24.4%	£721	18.3%
3	[0.69, 1.58)	13.1%	£1568	21.4%
4	[1.58, 2.96)	6.8%	£3123	22.1%
5	≥ 2.96	3.4%	£6185	21.8%

BNSSG has maintained improvement in Op Plan core metrics following significant recurrent investment from 23/24, but the system remains fragile to shocks in demand as seen in September & October

BNSSG Cat. 2 ambulance incidents & average response time

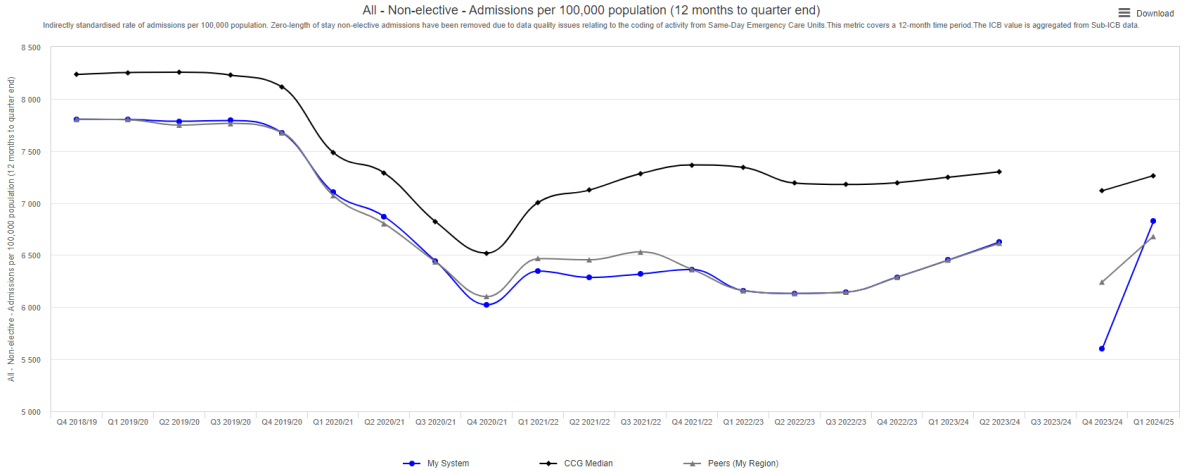


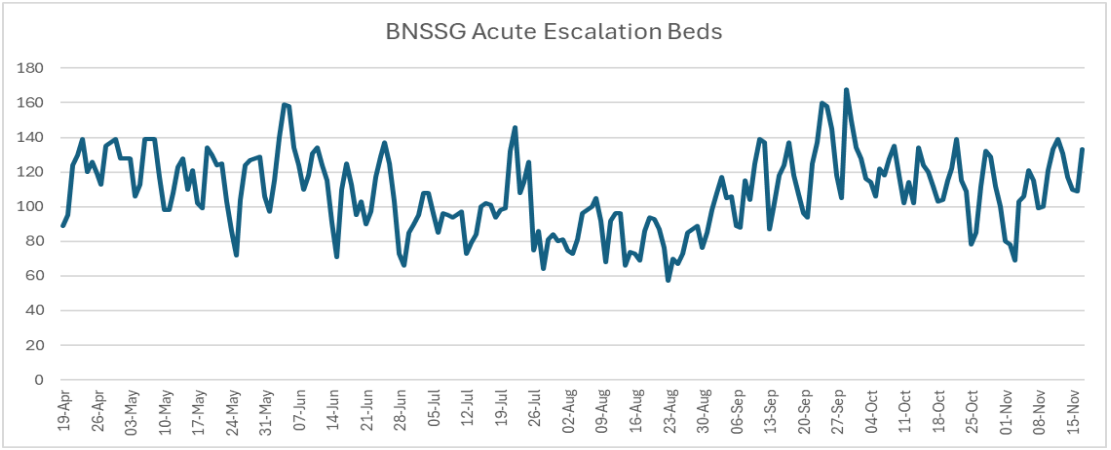
BNSSG all-types ED attendances and % seen within 4 hours

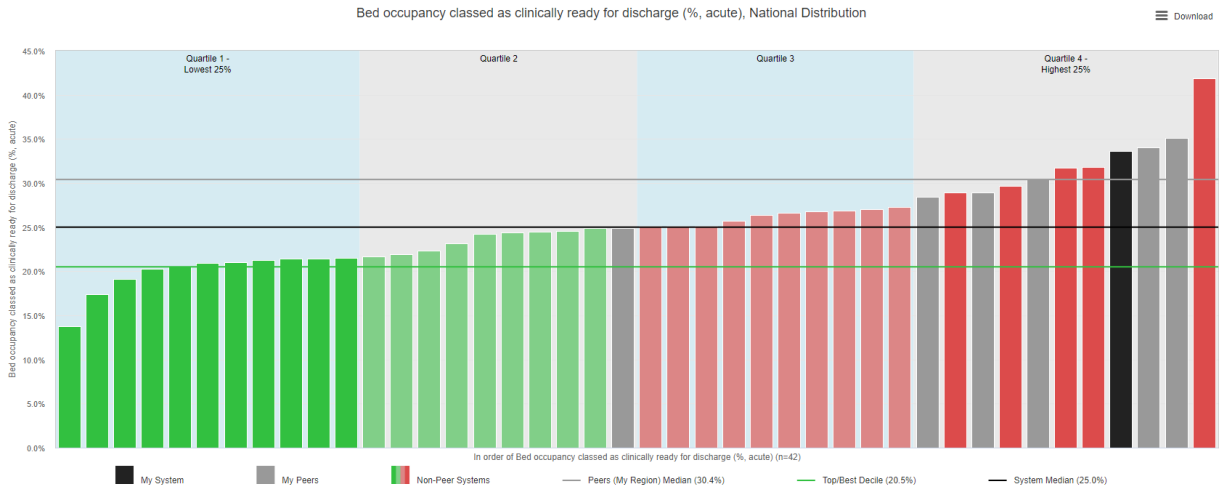


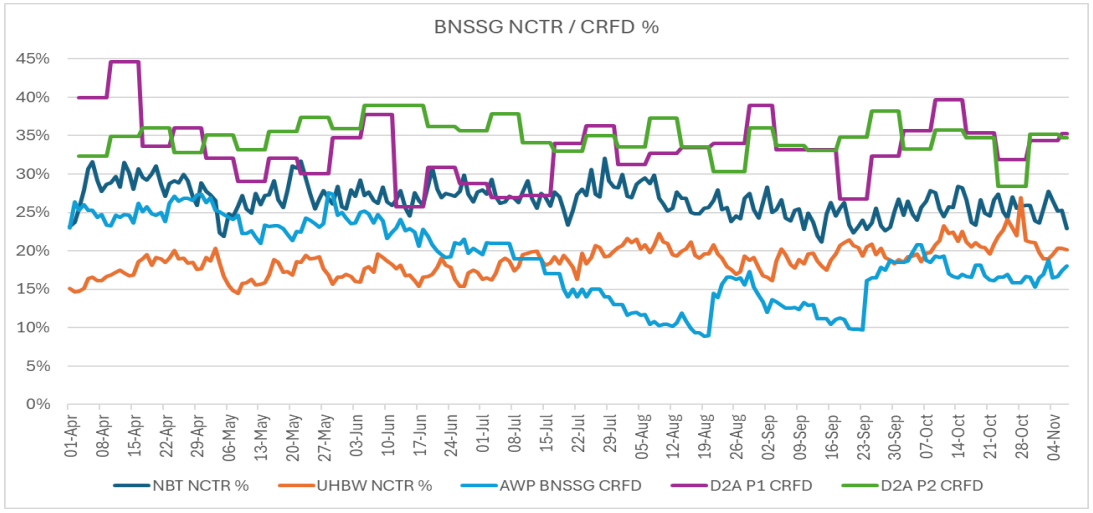
Winter risks to UEC performance

BNSSG winter mitigations focus on risks related to maintaining system flow within a pressurised system, driven in part by high levels of NCTR in acute and community settings and persistently very high levels of acute occupancy, which contribute to system flow fragility. Rates of admission are relatively low and in line with peer ICSs.









System service developments for winter

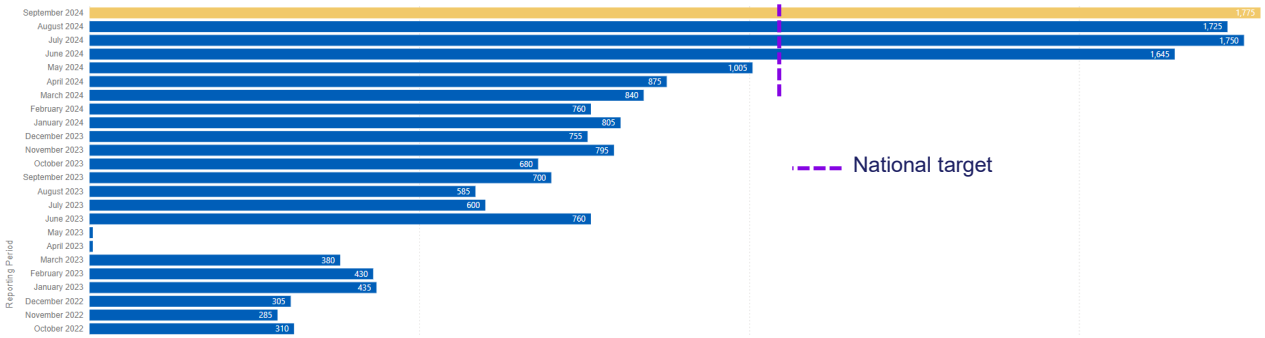
- BNSSG ICS committed record new, recurrent investment into urgent and emergency care (UEC) and 'Home First' services through the 23/24 planning round which have supported the performance improvements to date. These are well-aligned to the national 'High Impact Initiatives' which are known to support system flow. A stocktake at the end of last year identified four schemes which had not fully mobilised and where further impacts would be seen in 24/25:

Description		Lead Provider	FYE (£k)	Peak bed impact (plan)	Winter actions
Discharge to Assess (D2A)	Increasing community rehabilitation capacity in line with demand, with a focus on shifting towards home-based pathways (following a peer review of other ICS').	Sirona	-5,562	150	End of September go-live of quantified D2A Recovery Plan – extra home-based and community bed capacity to address backlog of people waiting in hospitals awaiting discharge with rehabilitation. Expansion of focus on non-D2A related delays (see next slide)
NBT Transfer of care hub	Increasing multi-agency capacity for discharge planning from hospitals including therapists, social workers etc.	NBT	-2,884	25	Both now fully staffed, focussed on continuing improvements in hospital length of stay of non-complex and non-D2A discharges.
UHBW TOC Hub		UHBW - Both	-2,900	25	
NHS @ Home expansion	Increasing 'virtual ward' capacity to support admission avoidance and earlier discharge using remote monitoring technology couple with community teams.	Sirona	-7,275	92	New NHS@Home 'step up' offer, via integration with Urgent Community Response teams to support next day and onward sub-acute care at home.
Community Acute Respiratory Infection (ARI) Hubs	Introduction of dedicated community capacity via Primary Care Networks for managing patients with acute respiratory conditions away from general practices.	General practice	-600	-	Seasonal delivery of circa 18,000 extra GP appointments between November and February.
***NEW* Frailty – ACE (ICC)**	Clinician-accessible remote MDT for assessment and coordination of frail individuals where conveyance or admission is being considered.	Severnside		32	Embedding specialist paramedic from SWAST to allow proactive identification of 999 cases where F-ACE could support a home-based alternative to conveyance. Creating new links with NHS@Home step-up pathway. Adding a new paediatric specialist to create P-ACE service.

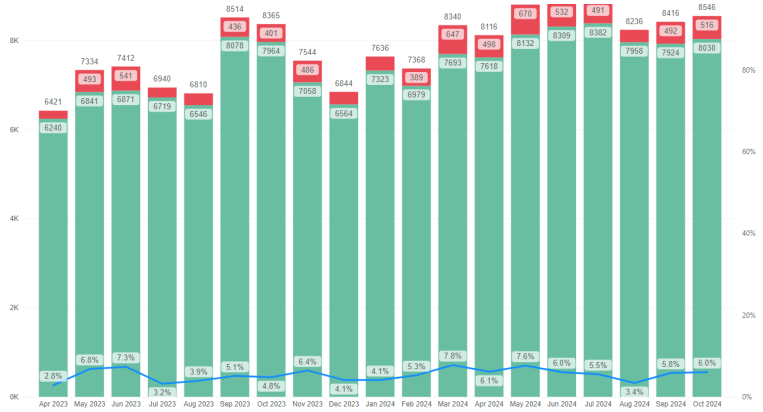
Community gains and opportunities

Community alternatives to hospital have been expanded to mitigate acute pressures, but further gains are expected from certain services.

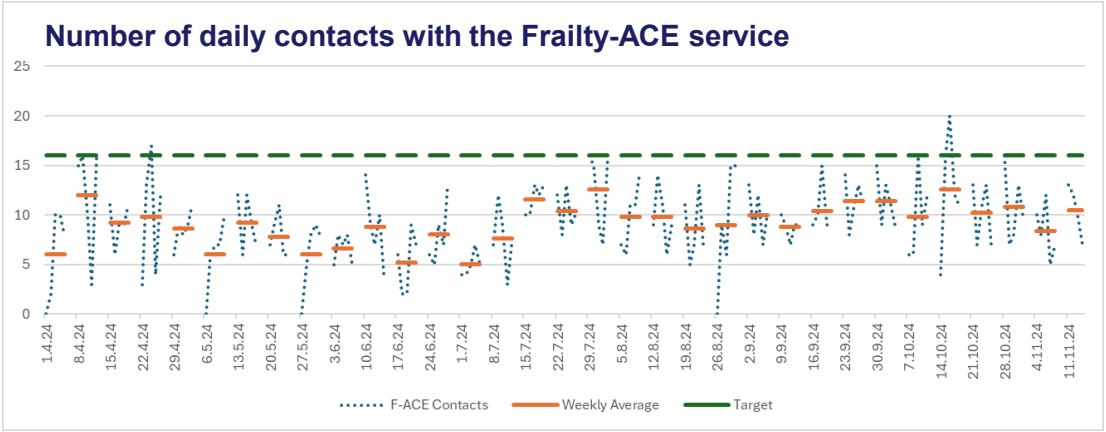
Number of 2-hour referrals to urgent community response team



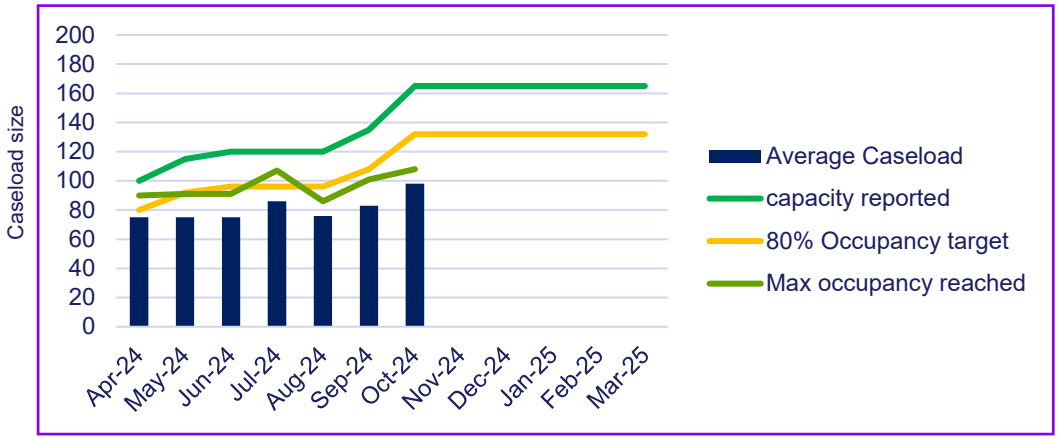
MIU & UTC activity and 4 hour breach rate



Number of daily contacts with the Frailty-ACE service



Snapshot of NHS@Home (virtual wards) caseload size



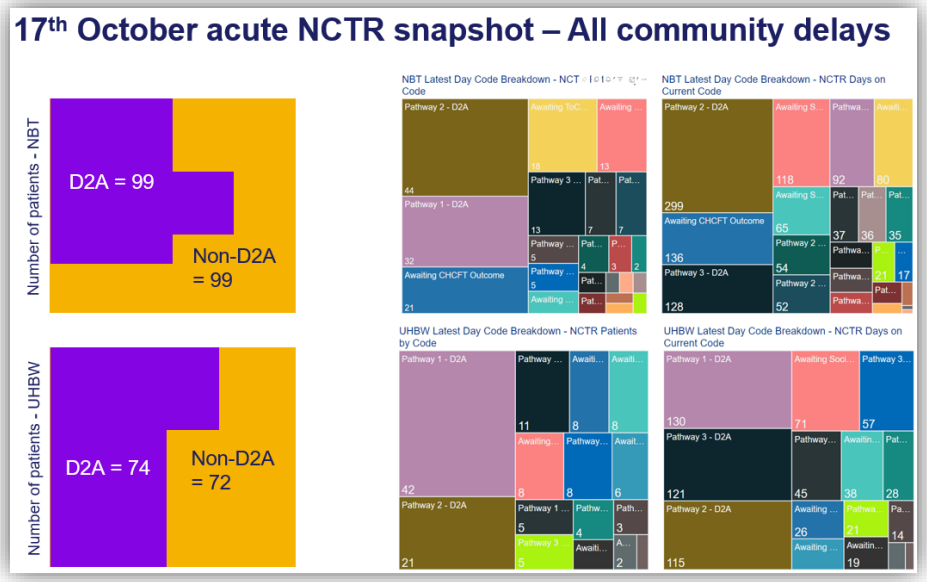
Acute respiratory infection (ARI) capacity:
seasonal delivery of extra GP appointments between November and February each year. Circa **18,000** delivered in 23/24.

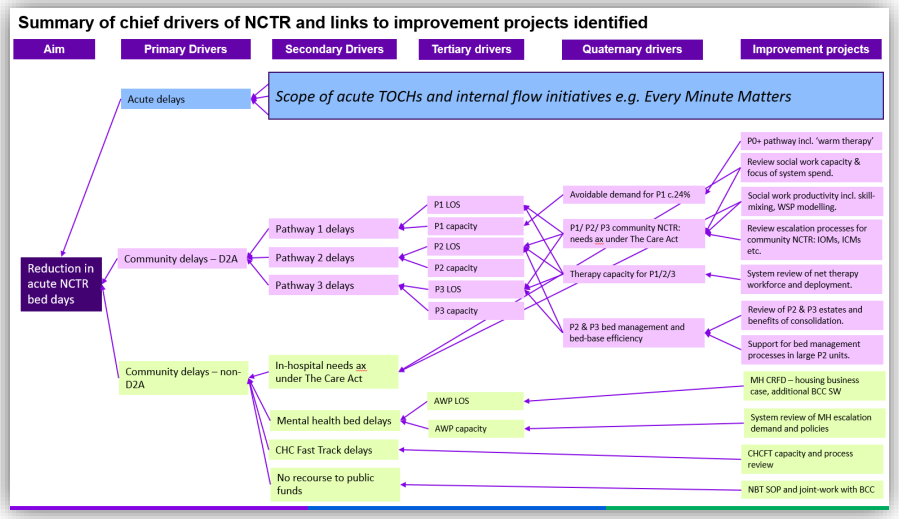
Discharge: gains and opportunities

The Discharge to Assess programme and acute Transfer of Care Hubs (TOCHs) have helped to mitigate acute pressures, but further gains are expected from addressing community LOS.

Area of Improvement	23/24 Performance targets	Impact	RAG	August 2024 YTD performance	Forecast RAG March 25
Acute spell LOS reduction to address 50:50 Process & capacity delays Supported by 'backlog clearance' temporary capacity	25% Acute LOS reduction > P0	200 acute beds saved		37 Beds P0	200 acute beds
	25% Acute LOS reduction > P1			137 Beds P1-P3	
	25% Acute LOS reduction > P2				P0-P3 combined total
	25% Acute LOS reduction > P3				
40% non-ideal Pathway shift	P1 > P0	350 less P1 starts per annum		P1 > P0	72 fewer community beds vs March 23, but 40% P2 pathway shift not completed in full. 5% P1 to P0 shift planned for Q3
	P2 > P1 or P0	660 more P1 starts per annum & 72 fewer combined P2 and P3 beds		P2 > P1 or P0	
	P3 > P2, P1, or P0			P3 > P2, P1, or P0	
P2 Community bed LOS Reduction	BCC target LOS 32.9 days	20 fewer P2/P3 beds		38.6 days	£0.2m funding gap for Sirona therapy support - NSC beds only
	NSC target LOS 27.1 days			31 days	
	SGC target LOS 23.7 days			38 days	
P3 Community bed LOS Reduction	BCC target LOS 45.5 days			74.1 days	£3m cost pressure, (£1.4 demand led and £1.6m on occupancy assumptions)
	NSC target LOS 27.9 days			33.3 days	
	SGC target LOS 28.1 days			44 days	

Fresh root cause analysis of NCTR has identified winter flow priorities





New priority projects for resourcing	Owner
1a. Social work productivity in acutes	Laura Saint, BCC
1b. Social work capacity in the community	Laura Saint, BCC TBC – Fiona Shergold, NSC
3. P0+ / 'Warm' P1	Nicki Carr, Sirona & TOCHs
5a. Pathway 2 bed management	Nicki Carr, Sirona & Emilie Perry, UHBW

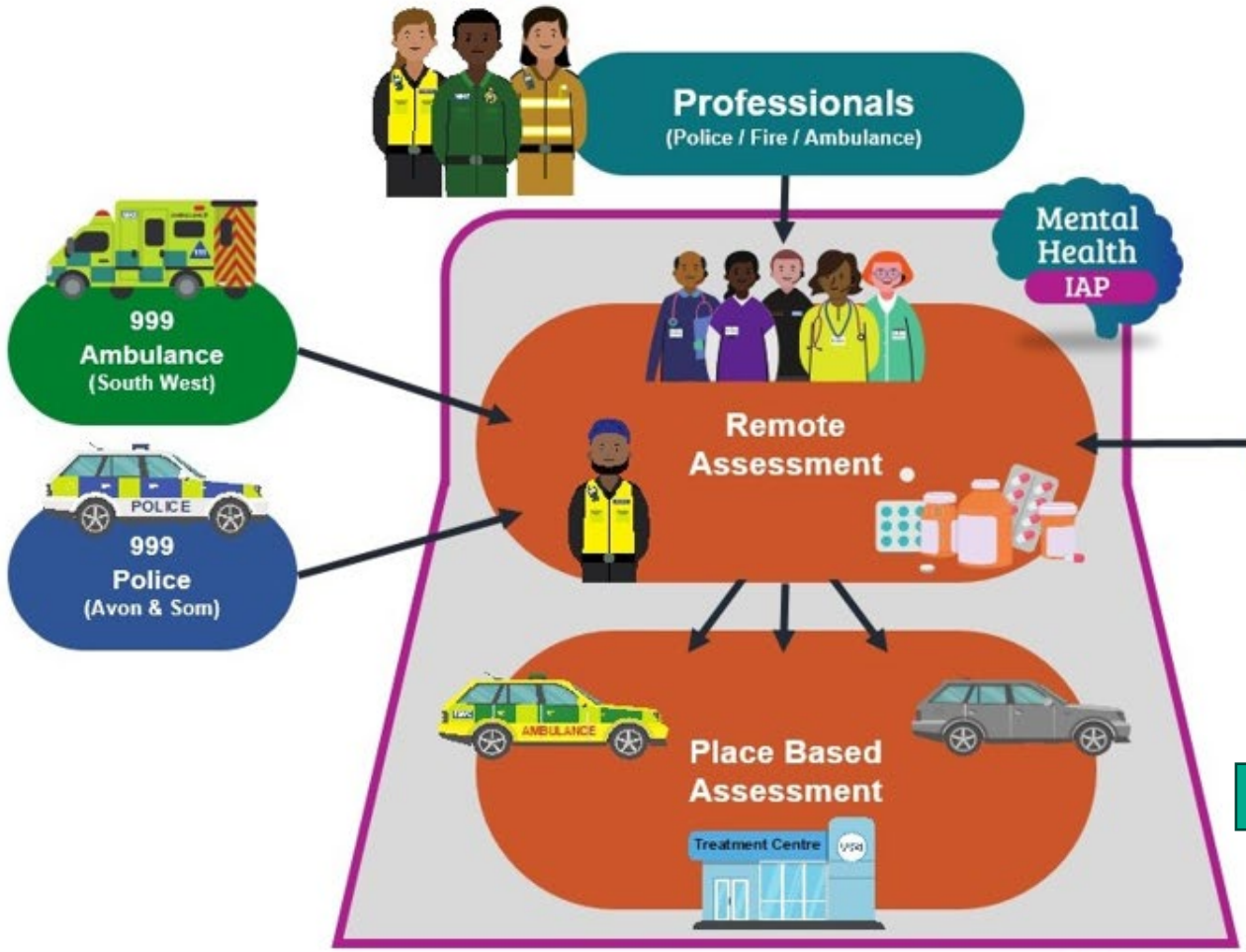
Priority projects near completion	Owner
2. Community escalation processes	Nina Wareham, Sirona
6. CHCFT efficiency	ICB CHC & Lucy Parsons, NBT
4. MH escalation processes and CFRD re-set	Neil Turney (ICB) & AWP

Medium term projects	Owner
10. Funding group / SDU refresh	Caroline Dawe, ICB
7. System therapies approach	D2A Programme Manager
5b. Community bed consolidation	D2A Programme Manager
5c. P3 case management incl. MH	D2A Programme Manager
10. Weekend discharges	D2A Programme Manager

Mental Health
Integrated Access Partnership
Intelligent Mental Health System Response

Further integration of physical, mental health and care services is in place for winter

The Model - Simple



Integration of separate remote MH services into 111 ‘press 2’ option live since November, with significant increase in MH professionals within Severnside service. Allows for enhanced triage and direct referrals to other services where necessary.

New AWP Transfer of Care Hub to address discharge delays from acute MH settings

BrisDoc
Patient care by people who care

NHS South Western Ambulance Service NHS Foundation Trust

NHS Avon and Wiltshire Mental Health Partnership NHS Trust

GP Collective Action will also impact over winter

GO LIVE	AVON LMC RECOMMENDATIONS	SPECIFIC SUPPORT TO FOLLOW
Now	CAP CONTACTS TO 25/DAY PER CLINICIAN - Practices can start making plans to move to the approach outlined in BMA Safe Working Guidance	Brief LMC summary will be shared
04/11/24	SINGLE GENERIC REFERRAL FORM TO ALL PROVIDERS (including managed referrals and AQP)	ICB BNSSG Standard Referral Template
04/11/24	PUSHBACK OF WORK FROM SECONDARY/COMMUNITY CARE - Fit Notes - Onward Referrals for same condition - Prescribing: initiation/28-day script/SCP stabilisation - Investigations: chasing/communicating/actioning/phlebotomy - Patient queries	Template letter Template letter Template letter Template letter Provider contacts
06/01/25	NO NEW INITIATION SHARED CARE PRESCRIBING IF NO LES Covers adults and children	Properly costed LES
06/01/25	NO NEW BARIATRIC SURGERY MONITORING IF NO LES	Properly costed LES
06/01/25	NO NEW PHYSICAL MONITORING FOR AWP/CAMHS	ICE licenses
Now	NEW DATA SHARING AGREEMENTS	Liaise with LMC/ One Care

LOCAL
AL COMMITTEE

GPCA: Modelling scenarios for non-elective impact

Methodology: NHS Confed table approach, informed by GP Survey results 2024 for BNSSG to apportion demand to different organisations.

High Level Summary of Potential Additional Daily Activity Use of NHS services:

(Figures based on August 2023 activity with 10% contingency – see modelling spreadsheet for full details)

Service	% Patients	10% of practices	30% of practices	50% of practices	Approx. current weekday demand
Pharmacy	6.83%	85	134	183	(160 pharmacies in BNSSG)
NHS 111	6.83%	85	134	183	111 = 900 SPA= 600-700
111 Online	2.01%	25	39	54	
A+E	4.35%	54	86	117	900
UTC	2.75%	34	54	74	280 (all PBUC)
Different NHS Service	1.94%	24	38	52	

NB A higher than proportional impact is expected on BRHC

It is assumed that the majority of displaced demand for UEC will be for minor injuries, given that minor injuries are traditionally seen in PBUC units, not general practice.

It is unknown however what the precise casemix of displaced demand will be**. Separate workstreams will address the impact of reduced routine appointments, and the long term impacts on LTCs and cumulative disease burden.**

Minor illness: proposed mitigations

Remote services

F2F services

999 call

Sirona SPA

111 call

In-hours general practice

Directory of Services

Community Pharmacy

PBUC

Type 1 ED

Unmet minor illness demand / triaged away

Unmet minor illness demand / triaged away

1 **Action**: Consider potential derogation to speed to answer and abandonment rate targets in 111.

2 **Action**: Explore additional clinical navigator roles on weekdays to ensure safety of queue.

3 **Action**: Establish Pharmacy First referral route from GPOOH/ CAS.

4 **Action**: Plan to promote call handler selection of Pharmacy when it returns first on the DoS. Option to suppress other options.

5 **Action**: Check demand and capacity for Pharmacy First including opening hours to 11pm+.

6 **Action**: Address risk to PharmacyFirst from practices moving away from referring patients formally.

7 **Action**: Agree route to practices for frail / complex demand where f2f required. Ringfence 111 GP slots?

8 **Action**: Consider more frequent, or adapted, use of 'triage only' protocol to redirect lowest acuity, self-limiting conditions to self-care.

9 **Action**: Consider ability to recommence primary care DoS profile for UTC, possible use of appt slots.

10 **Action**: Refresh and strengthen streaming and redirection protocols, including use of booths.

11 **Action**: Consider redirection of patients with illness to MIUs and to UTC.

12 **Action**: Consider potential derogation to 4 hour performance targets for lower acuity demand.

13 **Action**: Consider suppression of minor illness on type 1 ED DoS. NB requires PBUC to remain Green/Amber on DoS.

14 **Action**: Generate BRHC surge plan based on risk demand will be disproportionately higher for children.

15 **Action**: Influence national 111 calls comms – desire to promote self-care and not to promote NHS online.

16 **Action**: Public comms on repeat prescriptions: lead-in time, straight to pharmacy OOH, use of NHS App.

17 **Action**: Clarify route to practices for OOH 'handbacks' in case of 111 overwhelm. Ringfence 111 GP slots?

Action: Influence national 111 calls comms – desire to promote self-care and not to promote NHS online.

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

Managing the system over winter

	ICBs are asked to:
4	Assure at board level that a robust winter plan is in place: including surge plans, and co-ordinated system actions in real time, both in and out of hours. It should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
5	Make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
6	Review the 10 high-impact interventions for UEC published last year to ensure progress has been made

	ICBs are asked to:
1	Ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter: primary care and community services should be working with these patients to actively avoid hospital admissions
2	Provide alternatives to hospital attendance and admission: especially for people with complex needs, frail older people, children and young people and patients with mental health issues. This should include ensuring all mental health response vehicles available for use are staffed and, on the road, ahead of winter
3	Work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely
4	Assure at board level that a robust winter plan is in place: including surge plans, and co-ordinated system actions in real time, both in and out of hours. It should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
5	Make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
6	Review the 10 high-impact interventions for UEC published last year to ensure progress has been made
7	Work with primary care providers to ensure good levels of access to vaccinations, ensure that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
8	Work with local partners to promote population vaccination uptake with a focus on underserved communities and pregnant women
9	Work with primary care and other providers, including social care, to maximise vaccination uptake in eligible health and care staff

BNSSG service developments are delivering the system requirements:

High Impact Interventions	ICB	Mature Sites
Acute Respiratory Injury Hubs (ARI)		
Frailty		
Same Day Emergency Care (SDEC)		BSW, Glos
Virtual Wards (VW)		
Community Beds		
Inpatient Flow		
Intermediate Care		
Single Point of Access (SPoA)		
Urgent Community Response (UCR)		
Care Transfer Hubs		

System Co-ordination Centres	ICB	Mature ICBs
Digital		
OPEL		
Communication		
Standard Operating Protocol		
System Interface		
Benefits		BSW, CIOS, Devon
Ongoing Improvements		
Workforce		Cornwall, Devon

Integrated Care Co-ordination	ICB	Mature ICBs
Operating Model		BSW, CIOS, Dorset, Glos, Somerset
Core multi-disciplinary team		
Connected teams (physical/virtual/hybrid)		
System Collaboration		
System Integration/Technology		Alternative model in place
Established Referral Pathways		
Senior Clinical Decision Makers		

UCR	ICB	
08:00 – 20:00 operating hours		
9 clinical conditions		
National target 70% patients seen within 2 hours		
System wide planned vs actual activity (July 24)	Plan 1394	Actual 1830
Standardised rate of referrals July 2024 (national ambition 157 per 100k population)	252	
Variance	+95	

Indicates lower maturity based on self-assessment score

Indicates average maturity based on self-assessment score

Indicates high maturity based on self-assessment score

System Quality Group Oversight

The System Quality Group and Health and Care Professions Executive have been engaged, including via a meeting in common to review Winter Plans for 2024/25, incorporating:

- **Planned pathways for admission avoidance and rapid discharge**.
  - Feedback that initiatives were bed-based rather than an integrated care at home programme.
  - Programme to enhance on looking after people in their own homes, with better access to clinicians, domiciliary care, reablement and other services to prevent admissions
  - Acknowledged that over time the suite of system initiatives and overlaps may have overcomplicated pathways leading to gaps
  - Quality/Inequality Health Impact assessment is currently being iterated for this initiative, and risks (financial and clinical) are being explored

- **Risk of Harm/CTCC dashboard**
  - Digital platform to support 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
  - Programme will enable decision making by using evidence-based metrics based on person, population, service, organisation and system level perspectives.

Robust oversight and management of system performance

Tackling performance issues as they arise in BNSSG is managed by the nationally-defined System Coordination Centre, including a daily System Flow Meeting 7 days a week.

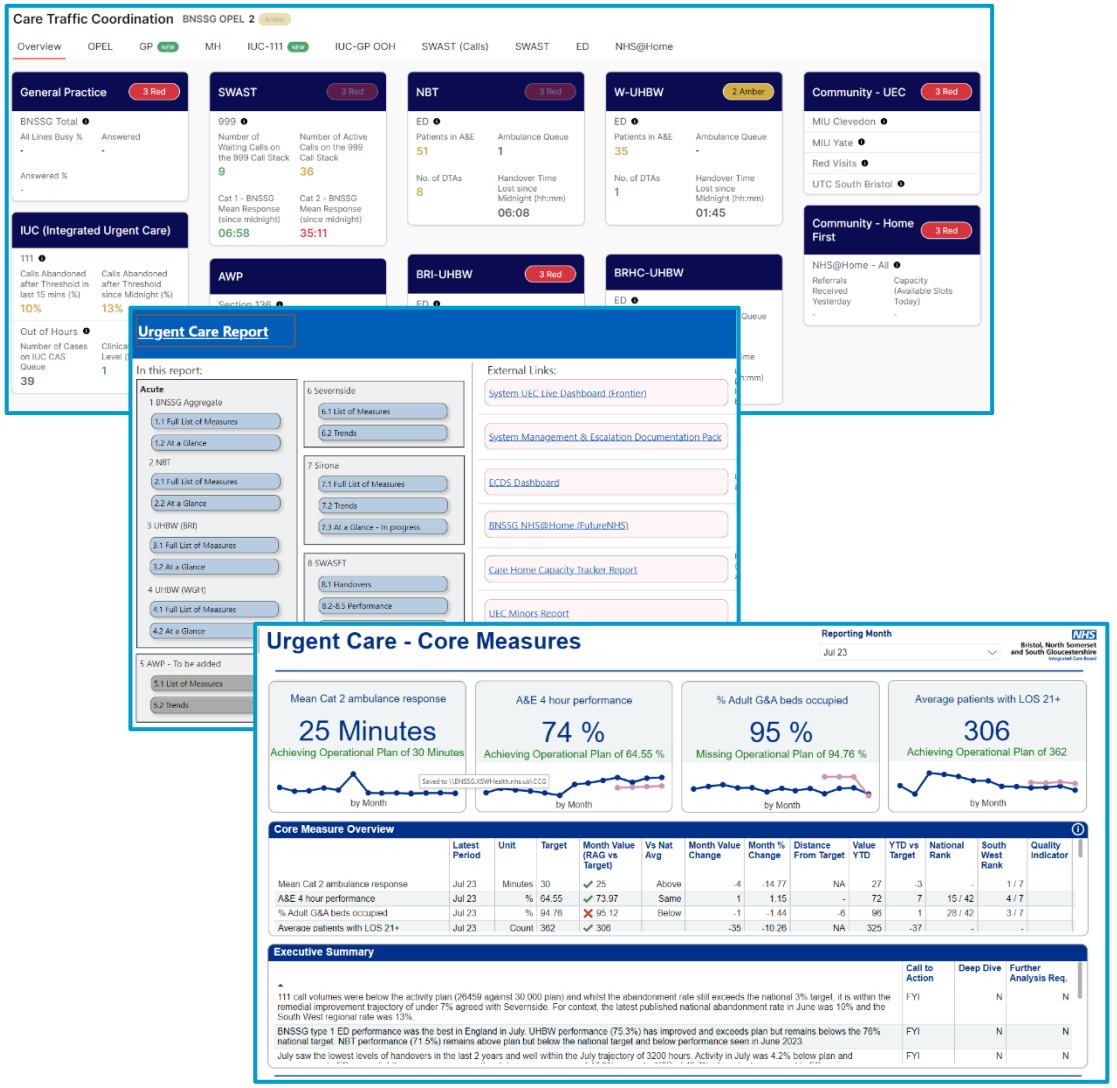
System tools available include:

- Real-time 111, 999, community, mental health (s136) & hospital metrics plus forecasts – within Frontier platform; this includes a live view of temporary escalation spaces in use. Live ambulance handover information is also shared via SWAST.
- Daily data across all providers available to understand trends and root causes – within ICS PowerBI
- Refreshed processes to align monthly validated reporting with the NHS Operating Plan – in formal ICS reporting

New national NHS Operating Pressure Escalation Level (OPEL) frameworks are being released for winter 2024/25 and rollout in BNSSG in underway. The frameworks standardise metrics and expected actions across mental health, 111, and community providers, with the existing acute framework also being refreshed. BNSSG already has in place sophisticated OPEL frameworks across all organisations which informed the national review and provide a foundation for undertaking this standardisation work to national deadlines:

16 December 2024:
Community and Mental Health OPEL dashboards implemented

- **27 January 2025**
NHS111 and Acute implementation completed



Refreshing our system response to escalation

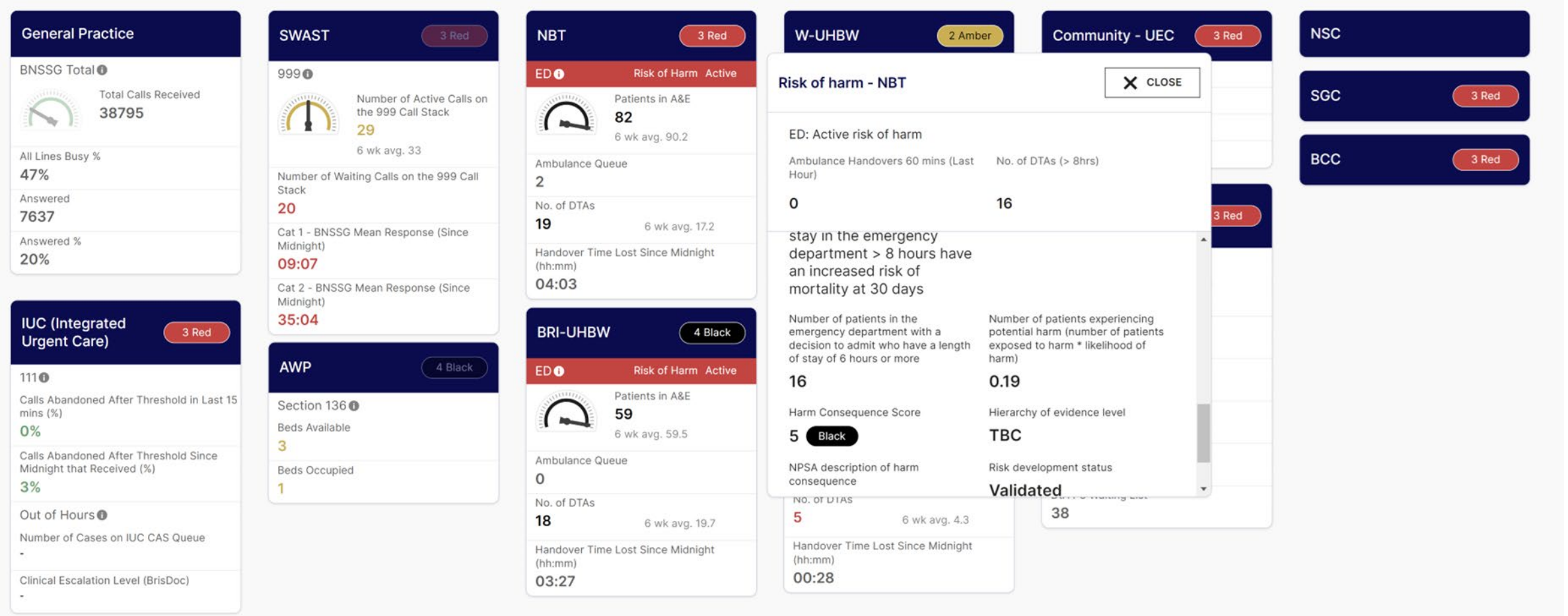
A system OPEL actions workshop took place in July to refresh our system OPEL action cards and ensure response to pressures is optimised between organisations and reflect scenarios from the previous year.

A particular focus is on upskilling HCAs and newly-qualified nurses and AHPs to a common skillset which would allow staff mobility between acute, community and care settings to address 'bottlenecks' in the system. Various system workforce groups are addressing this, including the Preceptorship Group.

A number of new actions were identified and will be embedded following approval by the System Quality Group in November.

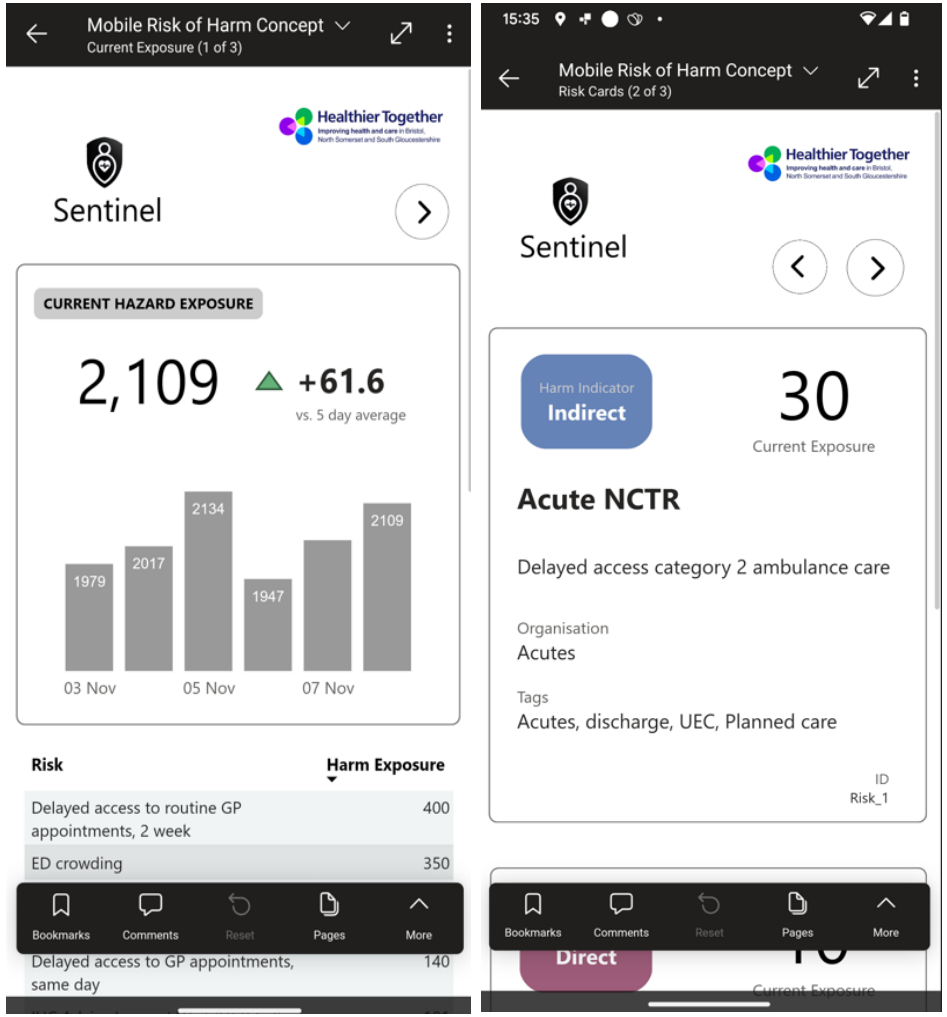
Ref	Action	Org	Impact
1	Review flex of capacity in HB place of safety, explore boarding in MH inpatient settings	AWP	Med
4	Explore hosting of patient waiting lists and ensure shareable with system partners.	AWP/ICB	Med
5	Progression of staff bank approach to allow mobility across providers of Band 4/5 staff to support a pressured organisation. re-ablement, Sirona district nursing, UTC/ MIU.	POM	High
8	Consider primary care DOS profile triggers for MIU, for turning on and off when Severn side experiencing surge	Sirona	High
10	Explore NHS@Home and possible NCHIP support to P3 beds to improve LOS	Sirona	Med
11	Review visibility and primary care protocols for directing to MIU UTCs.	Primary Care	Med
13	Explore enabling further slots for primary care in hours handovers from OOH. GP Connect slots/ensure they are open/visible by 8am to enable smooth handover	Onecare/ICB	Med
14	Agree process for responding to SWAST EOC58 requests relating to extending holding time for Cat3/4 cases in IUC, and to maximise 999 validation rates	Severnside	Med
16	Establish Sirona boarding (additional patients) at SBCH.	UHBW	Med
18	Consider utilising general P2 capacity to increase Stroke SSARU capacity at South Bristol Community Hospital	Acute	Med
20	Reinforcement of 24 hour mechanical thrombectomy repatriation and repatriation time frames outside of BNSSG	Acute	Med

Embedding a ‘risk of harm’ approach to our live management processes



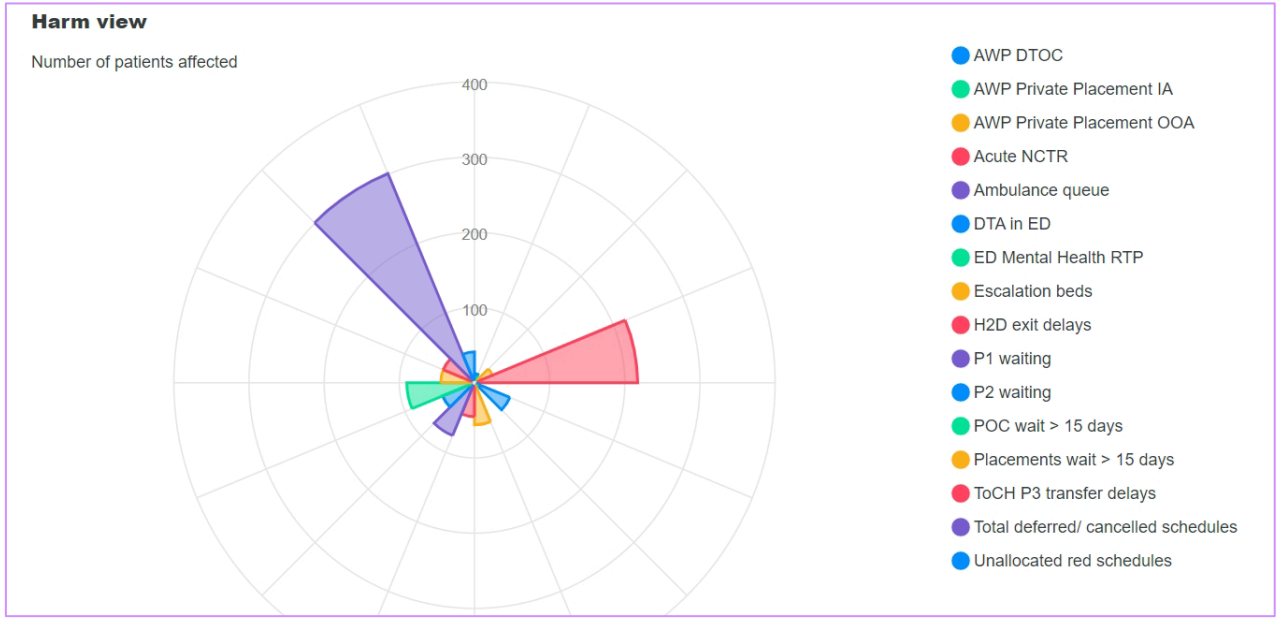
https://bnssg.my.faculty.ai/uec-dashboard

Risk of Harm (Sentinel) Prototype Dashboard



Working prototype of the mobile app in Power BI.

- Rollout **December 2024 :** System wide data visualisation of demand, capacity, risk and harm to complement system decisions
- Better information = better decisions = better outcomes
- “End to end” clinical pathway ownership
- Clinical outcomes, avoidance of harm and best use of resource at the heart of decision making
- Drive system working by defining and illustrating inter-dependencies across healthcare services



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

Supporting our population

	ICBs are asked to:
1	Ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter: primary care and community services should be working with these patients to actively avoid hospital admissions
2	Provide alternatives to hospital attendance and admission: especially for people with complex needs, frail older people, children and young people and patients with mental health issues. This should include ensuring all mental health response vehicles available for use are staffed and, on the road, ahead of winter
3	Work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
4	Assure at board level that a robust winter plan is in place: including surge plans, and co-ordinated system actions in real time, both in and out of hours. It should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
5	Make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
6	Review the 10 high-impact interventions for UEC published last year to ensure progress has been made
7	Work with primary care providers to ensure good levels of access to vaccinations, ensure that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
8	Work with local partners to promote population vaccination uptake with a focus on underserved communities and pregnant women
9	Work with primary care and other providers, including social care, to maximise vaccination uptake in eligible health and care staff

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Winter Vaccination Programme Highlights 24/25

Key Highlights

- Start date of Autumn/Winter Covid and Flu vaccination campaigns confirmed. Increased number of community pharmacies delivering covid vaccinations this autumn. PCN & Community vaccination clinics provide good coverage across BNSSG.
- New respiratory syncytial virus (RSV) vaccination programmes have been introduced nationally from 1st September 2024 for older adults aged 75 to 79years and pregnant women and people.
- Vaccination Clinical Delivery Group meetings continue for winter 24 discussing and ensuring oversight of Flu and Covid vaccinations, with the BNSSG Immunisation Strategic Oversight Board (ISOB) providing system strategic oversight.

National Guidance

- Following the national Flu letter publication on 12th March 2024, and the later statement of amendment on 18th June 2024, the recommended vaccines for the 2024/25 flu season as well as the eligible cohorts for the vaccinations, have been confirmed.
- Following the initial information regarding the covid vaccination programme, clarification was needed, the system letter Flu and COVID-19 Seasonal Vaccination Programme: autumn/winter 2024/25 published on 15 August 2024 has confirmed that frontline healthcare workers (FHCWs) (including social care and care home staff) are authorised and announced as a public cohort by the Commissioner. Employers of FHCWs should offer vaccinations to their staff or signpost them to a convenient COVID-19 vaccination site.
- In relation to the flu and covid campaign timings, it has been confirmed that flu vaccinations for pregnant women, and all children's flu cohorts, will commence from Sunday 1 September 2024. The main Flu and COVID-19 vaccination campaign will then commence on Thursday 3 October 2024. Vaccination of all COVID-19 cohorts will start on 3 October at the same time as all other adult flu cohorts, as set out in the flu letter.
- An October start date reflects JCVI advice that the flu vaccine's effectiveness can wane over time in adults and so a later start date is preferable. The advice differs for children, because Flu circulates in this age group earlier and protection lasts longer. Both FDA and EMA have advised that COVID-19 vaccines for the 2024-5 season should be updated to monovalent JN.1 versions and so this is reflected in the covid vaccines available this year.
- The national protocol and Patient Group Direction (PGD) for inactivated influenza vaccine and PGD for the intranasal vaccine have now been published. The Covid vaccination PGD and national protocol has also now been published. These will help to facilitate the delivery of these vaccinations.
- UKHSA have published resources and information for health care professionals to support the campaigns.
- A National letter to introduce the new Respiratory Syncytial Virus (RSV) campaign was published 24th June 2024, with the campaign starting for older adults and pregnant women& people on 1st September 2024. This is supported by national patient information materials and a national PGD to aid delivery. The vaccine is available via the national Immform vaccine ordering system.
- Over the last year NHS England has been building their own vaccination Point of Care (POC) system, the Record a Vaccination Service (RAVS). Overtime, this will be replacing NIVS and will allow hospital settings using RAVS will be able to record covid, flu, RSV and pertussis vaccinations and for this to be input onto the GP record.

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Governance

- BNSSG Immunisation Strategic Oversight Board (ISOB) continues to have oversight of the vaccination programme finance, operations, workforce and quality governance, this is supported by the Vaccination Clinical Delivery Group which continues to have operational oversight of the winter vaccination programmes in BNSSG.

Quality & Safety

- Programme reviewing quality & governance pathway ahead of new campaign
- Reinstating of the weekly regional clinical and operational incident reporting and assurance process with NHS England

Vaccination principles for BNSSG for the 24/25 season

The winter vaccination programme for 24/25 will have the following principles:

- Maximise opportunities for coadministration of Flu vaccination with Covid vaccination
- Ensure that identifying and addressing inequalities is central to approach
- Partnership working with community leaders/VCSE
- Outreach
- Alignment and partnership working across healthcare providers
- Provide forum/network for shared learning

Vaccination plans for the 24/25 season

- All PCNs and 77 Community Pharmacies awarded the contract for delivery of the covid vaccine Autumn /Winter campaign, with 28 of the Community Pharmacies being new. All PCNs and most pharmacies in BNSSG are offering the Flu vaccine.
- All local trusts and community providers have plans in place and plan to vaccinate their staff early in the season, with vaccinations ordered. Plans also in place for them to monitor vaccine uptake across all departments and proactively review demographic data.
- NBT awarded the Covid outreach contract (although co-administration of vaccinations is encouraged) until March 25. This contract will allow a focus on populations in BNSSG which need more support/alternative offers of vaccination.
- The delivery of the RSV vaccine for older adults will be via GP practices, with those adults turning 75 years old on or after 1 September 2024 being offered a single dose of the RSV vaccine on or after their 75th birthday as part of the routine programme and those already aged 75 to 79 years old on 1 September 2024 being offered vaccination via a catch-up campaign. Maternity services are offering the vaccine to pregnant women and people, supported by GP practices.
- Data will be reviewed to monitor uptake and will inform plans on an ongoing basis.

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Vaccination plans for the 24/25 season continued

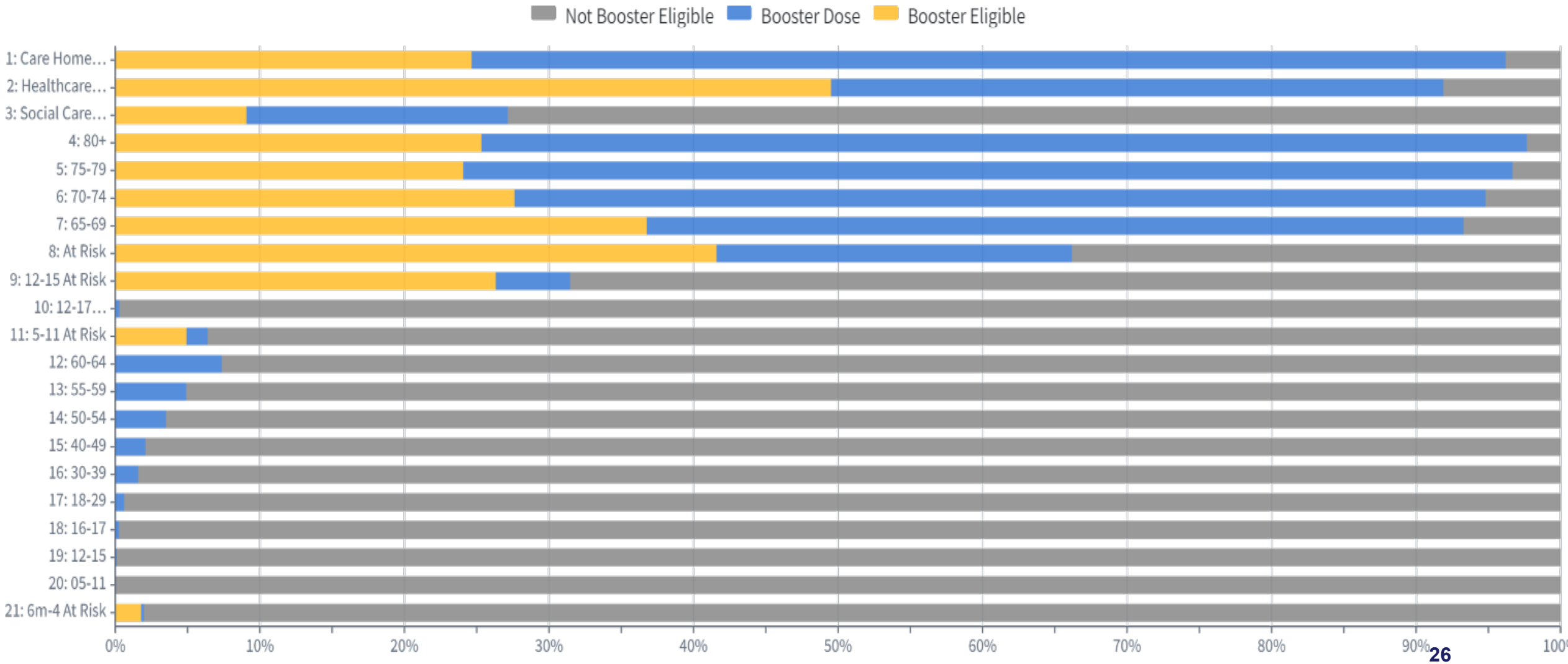
Lessons learnt from previous campaigns will support us to encourage good uptake of vaccination in the eligible group. These include but are not limited to:

- **Pregnant women and people –** Flu and Covid vaccination will be offered via a variety of sources including GP practices, community pharmacies and maternity services. Both trusts offer will include maternity COVID and Flu clinics. The local maternity app includes vaccination messages and multilingual resources available. Plans to enhance our communications include utilising local clinicians such as midwives, maternity consultants and community pharmacies to help promote vaccination and a 'Vaccines in Pregnancy' leaflet will be used to normalise, which has been translated into 6 commonly used languages in BNSSG and shared with all relevant parties. Maternity services will also support the offer of RSV vaccination to all women who are at least 28 weeks pregnant (the eligible cohort) and who remain eligible up to birth in line with national guidance.

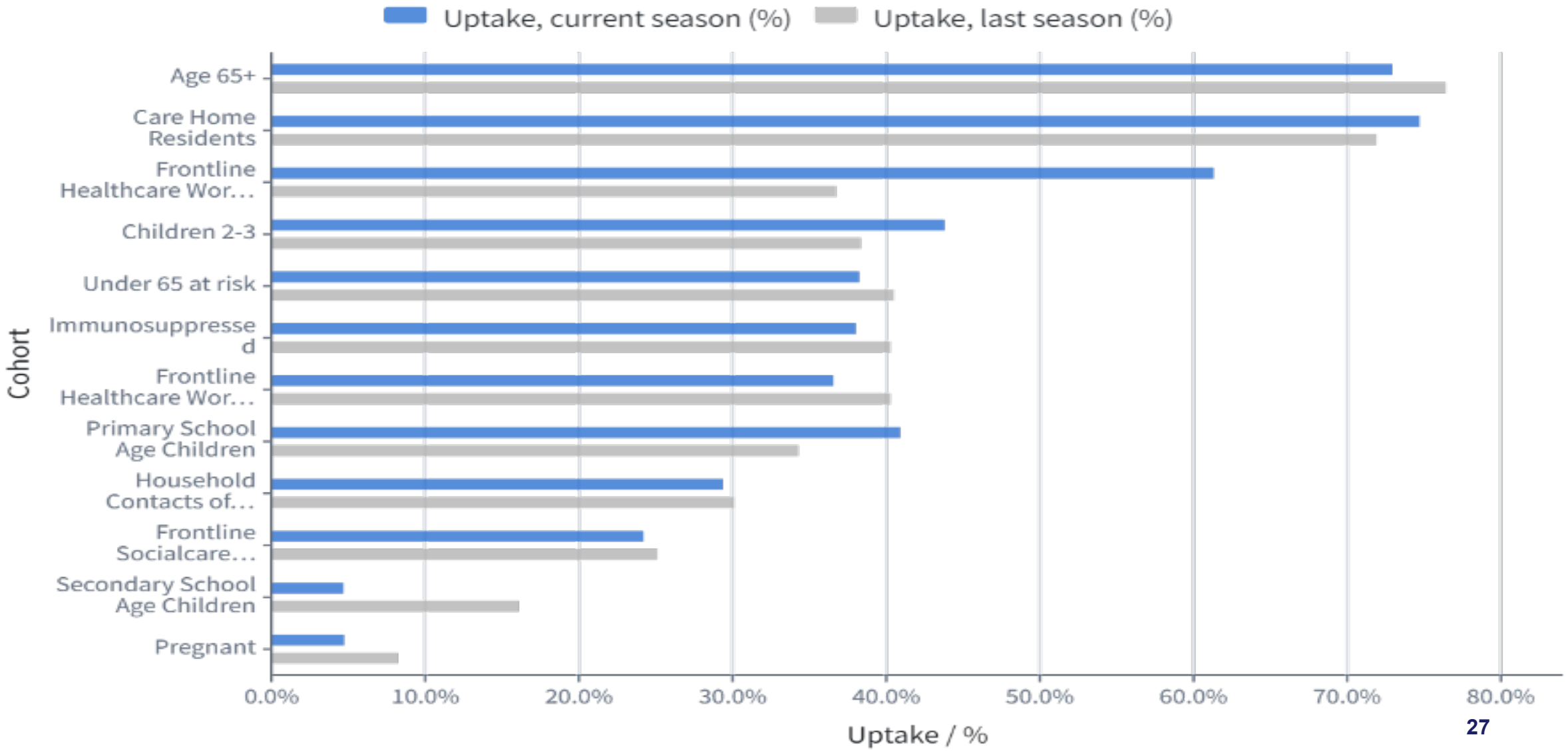
- **Clinically at – risk groups** - GP practices/PCNs will utilise EMIS searches to identify eligible patients supported by local dashboards. Active call and recall mechanisms in place. The use of personal invites and using 'accessible' invitation letters and information has been promoted. Community pharmacies will also proactively target these groups for example when collecting medication that might indicate they are eligible for vaccination. Plan to work with secondary care to target patients in at risk groups especially those who are less likely to access primary care such as liver patients when in-patients or at out-patient appointments and aim for vaccination messages to be embedded in relevant service messaging. Links have been made in previous years with different at-risk patient support groups and so these links will be used this season to share targeted messaging to support vaccination and ease any patient worries.

- **2 and 3 year old children and the offer of flu vaccination** - Practices have been reminded to order vaccine early in the season, with vaccinations in this age group already commencing in the BNSSG area. System communications have been sent to practices to support promotion of the vaccination to this age group and dispel any myths. Template invite letters and text messages were also shared. Communications also highlight that the injectable flu vaccine can be accessed, if parents decline to have the intranasal vaccine due to its porcine gelatine content. One PCN in Weston Super Mare is planning on providing flu vaccinations to its patients via a nursery setting using the collaboration agreement. This is a continuation from the positive feedback received from the pilot undertaken last season. The school aged immunisation team will be able to opportunistically vaccinate 2 and 3 year old siblings who present in their pre-planned catch-up clinics for school aged children.

Covid vaccination uptake by JCVI Group (%) to 12th Nov 24



Flu vaccination uptake Year to Date Progress at 12th Nov 24



RSV Vaccinations Up to and inclusive 12th Nov 2024

Total Vaccination Uptake = 16,421 (Up from 15,907)

Older Adults Catch Up
- 14,814

(Eligible Population: 39,463 = 37.53%)

Older Adults Routine
- 36

(Eligible Population= 1,265 = 2.85%)

Maternity under 55's
- 1,302

Over 79's
- 235

Other
- 34

- **1/9/24 to 12/11/24 inclusive.** Data from FDP (NHS Federated Data Platform (FDP))

Winter Communications 2024/25

Aim	Support **system resilience** and better **health outcomes** by helping people to stay well and access the right services for their needs.

Via three core areas of comms activity:

Prevention: Stay well this winter

- Local campaign promoting simple actions to stay well.
- NHS, local authorities, VCSE
- Aligned to national vaccs campaign

Self-care: Minor ailments/illness

- HANDi paediatric app (young children)
- Home medicines
- Online self-care advice
- Orcha library of trusted apps

Choosewell: Get the right care. first time

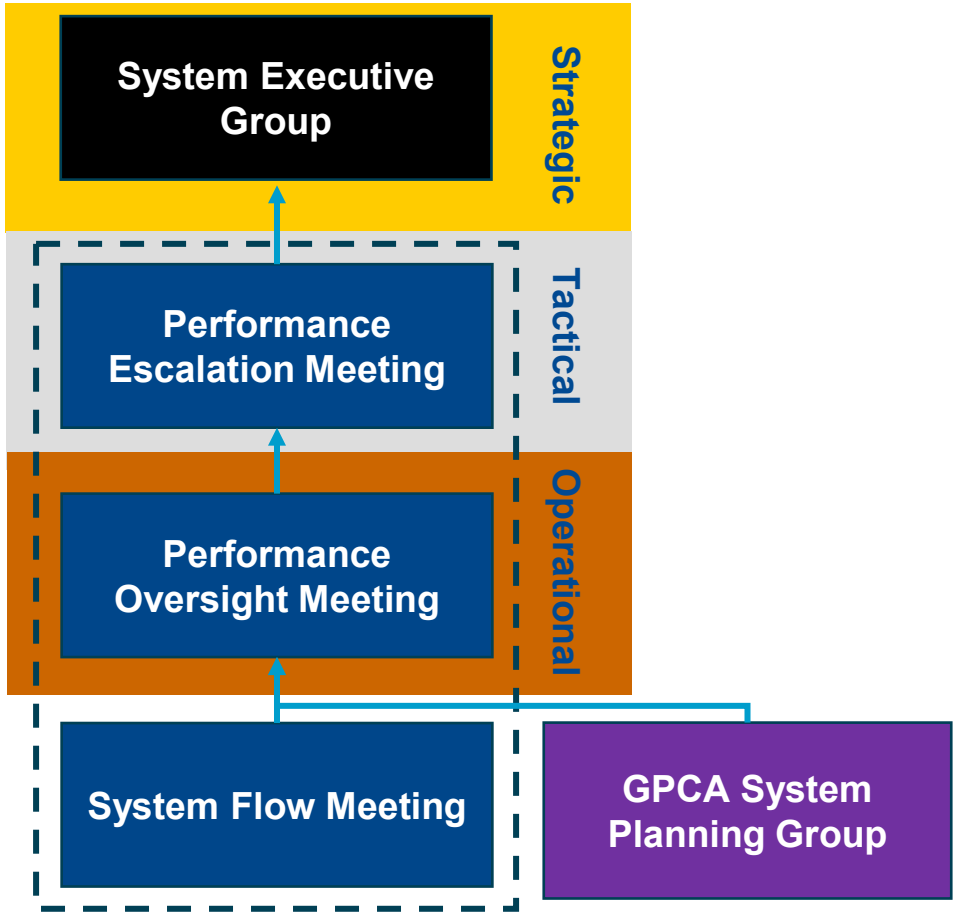
- Pharmacy First
- NHS 111
- NHS App
- Mental health 111

Supported by **PR moments** that raise awareness of services and campaigns and reassure public / stakeholders of steps we are taking to prepare our system for winter.

Summary and managing the plans

- The BNSSG plans address all of the H2 priorities for ICBs as set out by NHSE ahead of this winter, however the risks to delivery are recognised and are subject to further mitigating initiatives.

- Delivery of winter initiatives and the dynamic management of system pressures will continue through system governance: daily System Flow Calls, weekly Performance Oversight Meetings, fortnightly Performance Escalation Meetings and the System Executive Group.



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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

ICB Board

Date: 16th January 2024

Time: TBC

Location: MS Teams

Agenda Number:	TBC	
Title:	**Commissioning Policy for All Age Continuing Care**	
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	No
	Other (Please state)	No
Purpose: Approval		
Key Points for Discussion:		
This paper accompanies an updated version of the ICB's Commissioning Policy for All Age Continuing Care. The policy was presented to the Outcomes, Quality and Performance Committee on 28th November for discussion, and OQP Committee recommended the policy for approval by ICB Board in line with the Scheme of Reservation and Delegation.		
Recommendations:	That ICB board ratify the revised Commissioning Policy for All-Age Continuing Care	
Previously Considered By and feedback :	Corporate Policy Review Group – 5 November 2024 ICB Executive Team Meeting – 6 November 2024 Outcomes, Quality and Performance Committee - 28th November 2024	

Management of Declared Interest:	No conflicts of interest.
Risk and Assurance:	The main risk associated with the policy remains the potential for challenge from service users who disagree with care option(s) presented by the Funded Care Team. Risk score: 3 (Possible) x 3 (Moderate) = 9
Financial / Resource Implications:	There are no direct financial implications from implementing this reviewed version of the commissioning policy. However, there are financial implications where the policy is not followed, potentially resulting in higher costs to the ICB, which makes effective implementation of the policy by the Funded Care Team essential.
Legal, Policy and Regulatory Requirements:	The policy notes the revised National Framework for CHC and FNC published in 2022. Input from Bevan Brittan in reviewing the policy has ensured that it remains legally and framework compliant, noting that decisions made by the ICB around the location, type and nature of care packages and placements for NHS-Funded Care can be contentious and potentially subject to legal challenge. The Funded Care Team has reviewed similar policies from other ICBs including Devon, Sussex, Hampshire & Isle of Wight, Northamptonshire, Cambridgeshire & Peterborough.
How does this reduce Health Inequalities:	Read in conjunction with the ICB's Personal Health Budgets policy, this policy has the potential to reduce health inequalities. The policy supports the Funded Care Team to commission personalised care that be innovative in addressing potential cultural and demographic challenges.
How does this impact on Equality & diversity	Eligibility for NHS Funded Care is assessed on the basis on an individual's needs only, regardless of age, disability gender or race etc. and is not influenced by a diagnosis alone. This commissioning policy supports the delivery of the National Frameworks for adult and children's CHC, aiming to ensure that the ICB effectively commissions care and support in a person-centred way, with a high degree of personalisation.
Patient and Public Involvement:	The policy has been informed by: -Direct feedback provided by individuals in receipt of Funded Care and their families since the previous version of the policy was published. -Information gathered from Brokerage Team patient engagement process – which is an ongoing process the involves contacting all people in receipt of a domiciliary package of care within 2 weeks of the package commencing.

	-Outcome of investigations into complaints received by the Funded Care Team -Analysis of care provider-related incidents reported on Datix.
Communications and Engagement:	Explain what activities have been undertaken and what will be required in future to inform stakeholders about the decision/ development
Author(s):	Denise Moorhouse, Deputy Chief Nurse
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd – Chief Nursing Officer

Keep these front pages to a maximum of two

Agenda item: TBC

Report title: Commissioning Policy for All Age Continuing Care

1. Background

This paper accompanies an updated version of the ICB's Commissioning Policy for All Age Continuing Care.

The policy has been presented to the Outcomes, Quality and Performance Committee on 28th November 2024 where it was recommended that it is ratified at ICB Executive Board in line with the Scheme of Reservation and Delegation.

This is the third revision of the policy since its initial publication in May 2017.

- May 2017 – first version published as part of efforts to align CHC process across the three CCGs ahead of the formal merger in 2018.
- May 2019 – updated version published
- April 2022 – updated version published

The commissioning policy outlines the process by which the ICB will commission and provide equitable, safe and effective care, for individuals who have been assessed as eligible for NHS-funded care.

NHS-funded care includes the following:

- Packages of care arranged by the ICB under NHS Continuing Healthcare for adults ("CHC");
- Packages of care arranged by the ICB under Children and Young People's Continuing Care ("CYPCC") (which in most cases with be jointly funded with the Local Authority who have separate responsibilities under the Children Act 1989); and
- Joint packages of care where an adult has an identified assessed health need that is beyond the power of the local authority to provide ("Joint Packages of Care").

2. Summary of changes

The policy has not required substantial changes and does not change decision thresholds for eligibility for NHS funded care. However, there are areas that have been revised to clarify the ICB's position, bring decision making in line with revised SFI thresholds, Improve governance to ensure a consistent approach is adopted when considering how care and support needs are met, and several new sections have been added to address areas that were identified as missing from previous iterations of the policy. A high-level summary of the changes is included in table 1.

Table 1. Summary of changes within the revised commissioning policy

Policy area	Changes / additions
Title	Changed from "Commissioning Policy for Individual Funded Care" to be more explicitly focused on All Age Continuing Care. The use of "All Age Continuing Care" acknowledges the emergence of this term, and the national move to more closely align adults and children's Continuing Healthcare.
Section 2. Purpose and scope	Further clarity provided around the scope of the policy and the exclusion of MH/LDA Section 117 aftercare.
Section 3. Duties	Notes the revised National Framework for CHC and FNC in 2022. Adds a reference to the ICB All Age Continuing Care Operational Policy.
Section 4. Responsibilities and Accountabilities	Updated to include the role of the Chief Nursing Officer. Clarity around the differences between nurse assessors and care coordinators. Added detail around the responsibility on individuals found eligible for NHS-Funded Care.
Section 5. Definitions	Reflects the change from CCG to ICB. Added definitions for Children in Care, Care Leavers, and Special Educational Need and/or Disability (SEND).
Section 7. Consent	Expanded to detail the approach to children and young people.
Section 9. PHBs	Reduced duplication with PHB Policy.
Section 11. Developing options for care	Final paragraph changed from; *"BNSSG CCG **will generally** only support a clinically safe and sustainable package of care within an individual's own home where the costs of doing so are in line with this policy."* to; *"The ICB **can only** support a clinically safe and sustainable package of care within an individual's own home where the costs of doing so are in line with this policy."*
Section 13. ICB Authorisation	Revision to this section. Upper limits for levels 1 and 2 lowered to move more cases into Complex Care Panel and High Cost Panel for additional scrutiny. **Level 1**

	Now differentiates between care home and domiciliary care package costs to enable standard, lower value placements and packages to be authorised outside of the panel process. Anything above those standard levels will move into the Complex Care Panel. Seniority of authorisers at Level 1 has been increased to require band 7 and band 8a sign off, which in the previous policy was band 7 only. **Level 2** Dom care upper limit lowered from £5k to £3.5k per week, to ensure that the more complex dom care packages move up to High Cost Panel for authorisation. **Levels 5 &6** Added into the policy to match the current ICB SFIs.
Section 17. Individuals with existing care arrangements	Expanded to address scenarios where newly eligible cases have existing care packages with carers employed on excessive pay rates.
Section 20. Respite	New section in the policy, setting out a case-by-case approach. Also includes detail on joint funding requests for children and young people eligible for CYP Continuing Care.
Section 21. Transport	New section in the policy.
Section 22. Funding requests for interventions not routinely commissioned	New section in the policy detailing the ICB's Exceptional Funding Request process. Added to the policy in response to an increase in therapy requests received by the Funded Care Team for people eligible for NHS-Funded care, which need to be assessed via the EFR route where they are not routinely commissioned by the ICB.
Section 26. Information Governance, Confidentiality and Data Security	New section in the policy.
Section 28. Counter Fraud	Updated wording from the new ICB policy template.

3. Financial resource implications

There are no direct financial implications from implementing this reviewed version of the commissioning policy. However, there are financial implications where the policy is not followed, potentially resulting in higher costs to the ICB, making effective implementation by the Funded Care Team essential.

4. Legal implications

There are no immediate legal implications from publishing the revised policy. Input from Bevan Brittan in reviewing the policy has ensured that it remains legally sound, noting that decisions made by the ICB around the location, type and nature of care packages and placements for NHS-Funded Care can be contentious and potentially subject to legal challenge.

The policy acknowledges and reflects the revised National Framework for CHC and FNC published in 2022.

Key legislation set out in section 3 of the policy remains unchanged from the previous policy review in 2022.

5. Risk implications

5.1 Risk of legal challenge

The main risk associated with the policy remains the potential for challenge from individuals who disagree with care option(s) presented by the Funded Care Team.

Risk score: 3 (Possible) x 3 (Moderate) = 9

Mitigating actions:

Effective communication by Funded Care nurse assessors and care coordinators can help to manage expectations of individuals, their families and representatives at an early stage.

When identifying suitable options for eligible individuals the Funded Care Team will consider a broad range of issues. These are set out in full in section 11 of the policy (p.13-14), and include:

- The safety, quality, sustainability (including care capacity and financial sustainability) and feasibility of proposed care options;
- The overall cost of proposed care options and any concerns about value for money or affordability for the ICB;
- The individual's preference about where care is delivered, e.g. at home, or in a care home;
- The effectiveness of proposed care options in meeting the individual's assessed health and social care needs;
- The potential impact on the individual's human rights;
- Whether the individual has a protected characteristic under the Equality Act 2010 and whether there are any steps that could reasonably be taken to promote equality of opportunity for that individual;
- Presence of informal carers to provide care. There is no obligation for family members to provide care for an adult, but where an offer is made, the Funded Care Team may take this into account as an integral part of the care package. In such

circumstances the Funded Care Team will consider a referral to the local authority so that a carer's assessment can be considered and offered in line with the Care Act 2014;
- Parent's role as informal carers; and
- Any concerns about contingency plans in terms of the support that may be required if a care option fails.

The process for considering alternative requests where a person declines all of the options initially proposed by the Funded Care Team is included in section 14 of the policy, and individuals have a right of appeal, which is set out in section 15.

6. How does this reduce health inequalities

Read in conjunction with the ICB's Personal Health Budgets policy, this policy has the potential to reduce health inequalities. The policy supports the Funded Care Team to commission personalised care that be innovative in addressing potential cultural and demographic challenges.

7. How does this impact on Equality and Diversity?

The key policy rationale for the National Frameworks for adult and children's NHS funded care (CHC and CCC) is to ensure that there is a consistent method to undertake the assessment for NHS funded care throughout the NHS. The purpose of the assessment process is to assess an individual's needs across a range of domains to establish whether they have a "primary health need".

Eligibility for NHS funded care is not based on condition, or diagnosis. The core purpose of the National Frameworks is based on eligibility by needs only regardless of someone's age, disability gender or race etc. and the frameworks are therefore inclusive in its principles with no individual being treated differently on the basis of any specific protected characteristic.

This commissioning policy supports the delivery of the National Frameworks for adult and children's funded care, aiming to ensure that the ICB effectively commissions care and support in a person-centred way, with a high degree of personalisation.

By the nature of the healthcare provided, there is a tendency for recipients of NHS Funded Care to be older and/or disabled in some way. The core values and principles of this policy are aimed at providing consistency and so improving access to funded care for these groups.

Effective commissioning of care and support has a positive impact on equality and diversity across most protective characteristics. By commissioning care in a person-centred way, with a high degree of personalisation, the ICB can support people to live fulfilled lives within their communities.

8. Consultation and Communication including Public Involvement

The policy has been informed by:

- Direct feedback provided by individuals in receipt of Funded Care and their families since the previous version of the policy was published.
- Information gathered from Brokerage Team patient engagement process – which is an ongoing process the involves contacting all people in receipt of a domiciliary package of care within 2 weeks of the package commencing.
- Outcome of investigations into complaints received by the Funded Care Team
- Analysis of care provider-related incidents reported on Datix.

Appendices

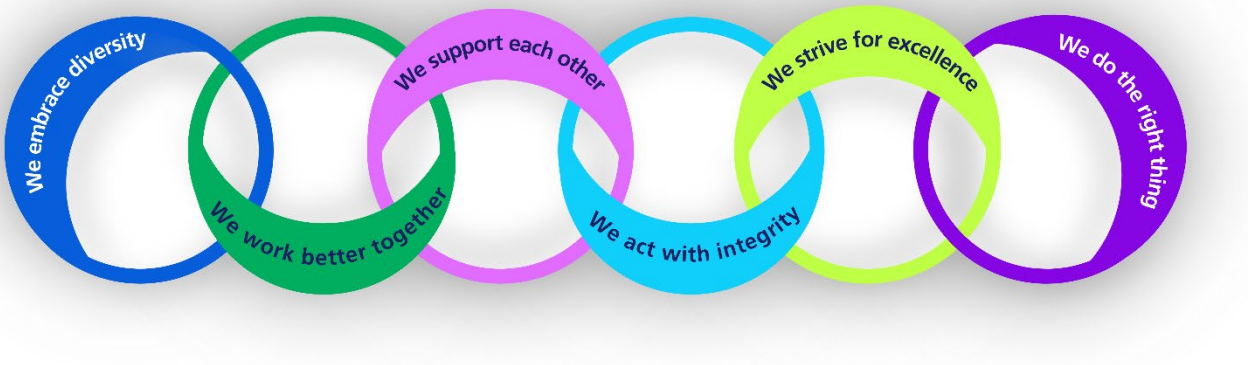
Glossary of terms and abbreviations

Continuing Health Care	Continuing health care describes a situation where, following a thorough assessment of needs, a person's overall health needs are judged to be so great that the NHS will manage and pay for all the care they need. An NHS professional will supervise the agreed care plan and care can be provided in any setting, for example the person's own home, a hospice, a care home or a hospital. In this situation, no charges are made for care services that are arranged as part of a care plan
Children and Young People's Continuing Care	CYPCC will be required when a child or young person (aged 17 or under) has needs which have arisen as a result of a disability, accident or illness that cannot be met from existing universal or specialist health services alone. For children and young people who are eligible for CYPCC, the ICB works collaboratively with the local authority to ensure a holistic approach is adopted to meet the health and care needs of the child or young person. These cases are usually subject to joint funding arrangements with the local authorities.
NHS-funded Nursing Care	For individuals in care homes with nursing, registered nurses are usually directly employed by the care home. To fund the provision of such nursing care by a registered nurse, the NHS makes a payment direct to the care home in respect of individuals who have an assessed need for nursing. This is called 'NHS-funded Nursing Care' ("FNC") and is a standard rate contribution towards the cost of providing registered nursing care for those individuals who are eligible.

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Commissioning Policy for All Age Continuing Care



Together we are BNSSG

Complete the blank cells in the table below. The rest will be added by the corporate team once the policy approved and before it is added to the website.	
Policy ref no:	To be filled in by Corporate Services
Responsible Executive Director:	
Author and Job Title:	
Date Approved:	To be filled in by Corporate Services
Approved by:	To be filled in by Corporate Services
Date of next review:	January 2026

Policy Review Checklist

	Yes/No/NA	Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	Included with supporting docs
Has the review taken account of latest Guidance/Legislation?	Yes	No significant legislative changes impacting on Funded Care since the previous version was published.
Has legal advice been sought?	Yes	Policy has been reviewed by Bevan Brittan
Has HR been consulted?	Yes	HR input through CPRG though no impact on staff
Have training issues been addressed?	Yes	Internal staff training requirement is addressed in the policy.
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	N/A	
Are there financial issues and have they been addressed?	No	There are no immediate financial implications from publishing this revised policy.
What engagement has there been with patients/members of the public in preparing this policy?		The policy has been informed by: -Direct feedback provided by individuals in receipt of Funded Care and their families since the previous version of the policy was published. -Information gathered from Brokerage Team patient engagement process – which is an ongoing process the involves contacting all people in receipt of a domiciliary package of care within 2 weeks of the package commencing. -Outcome of investigations into complaints received by the Funded Care Team -Analysis of care provider-related incidents reported on Datix.
Are there linked policies and procedures?	Yes	These are listed in the policy

	Yes/No/NA	Supporting information
Has the lead Executive Director approved the policy?	Yes	Chief Nurse approved
Which Committees have assured the policy?	Yes	Quality, Outcomes and Performance Committee
Has an implementation plan been provided?	Yes	Included in this policy
How will the policy be shared with staff	Yes	Included in this policy
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	N/A	
Has a DPIA been considered in regards to this policy?	N/A	
Have Data Protection implications have been considered?	Yes	Through input at the CPRG

Version	Date	Consultation

Table of contents

Table of contents 3

1 Introduction 5

2 Purpose and scope 5

3 Duties – legal framework for this policy 6

4 Responsibilities and Accountabilities 6

5 Definitions/explanations of terms used 8

6 Core principles for decision making 10

7 Consent and capacity to make decisions 11

8 Safeguarding 11

9 Personal Health Budgets 12

10 Overview of the commissioning process 12

11 Developing options for care 13

12 Agreeing a preferred care option 15

13 ICB Authorisation 15
14 Considering alternative requests for care....17
15 Appealing the ICB's decision....17
16 Refusing care 18
17 Individuals with existing care arrangements....18
18 Enhanced care 18
19 Additional private care....19
20 Respite 19
21 Transport....20
22 Funding requests for interventions not routinely commissioned....21
23 Review 22
24 Training requirements 22
25 Equality Impact Assessment 22
26 Information Governance, Confidentiality and Data Security 23
27 Implementation and Monitoring Compliance and Effectiveness 23
28 Countering Fraud, Bribery and Corruption 24
29 References, acknowledgements and associated documents....24
30 Appendices 25

Commissioning Policy for All Age Continuing Care

1 Introduction

This policy outlines the process by which NHS Bristol, North Somerset and South Gloucestershire ("**BNSSG**") Integrated Care Board ("**the ICB**") will commission and provide equitable, safe and effective care, for individuals who have been assessed as eligible for NHS-funded care. NHS-funded care includes the following:

- Packages of care arranged by the ICB under NHS Continuing Healthcare for adults ("**CHC**");
- Packages of care arranged by the ICB under Children and Young People's Continuing Care ("**CYPCC**") (which in most cases with be jointly funded with the Local Authority who have separate responsibilities under the Children Act 1989); and
- Joint packages of care where an adult has an identified assessed health need that is beyond the power of the local authority to provide ("**Joint Packages of Care**").

CHC, CYPCC and Joint Packages of Care are together referred to as **"NHS-Funded Care"**.

The NHS is committed to giving people more choice and control over their healthcare, but must balance this with its financial obligations to the whole population for whom it is responsible. ICBs also must consider the wider effect of its decisions and its financial responsibilities when making decisions about whether they will pay for specific care or treatment.

The ICB will commission healthcare for eligible individuals in a manner that reflects choice and preferences, whilst ensuring a balance between choice, safety and the effective use of finite NHS resources.

1.1 BNSSG ICB Values

This policy contributes to the values of the organisation by ensuring that the ICB meets its responsibilities to those individuals found to be eligible for NHS-Funded Care. The policy will support the ICB to act with integrity, strive for excellence, and ensure we do the right thing in commissioning care and support for the people of Bristol, North Somerset and South Gloucestershire.

2 Purpose and scope

The purpose of this policy is to set out the ICB's process for commissioning individual care, ensuring that it is person centred, balances equity, equality and risk, and allows the ICB to facilitate the effective use of finite NHS resources.

This policy is applicable to individuals deemed to be eligible for CHC and CYPCC under the NHS National Frameworks for Adult Continuing Heathcare and Children and Young People

Continuing Care. The process to determine eligibility for NHS Funded Care is not within the scope of this document. Links to the policy documents that set out the relevant processes are included in section 28 of this policy.

This policy is also applicable to adults who are eligible for a Joint Package of Care. For adults who may be eligible for a Joint Package of Care, the Joint Funding Protocol will be followed. The ICB will apply the core principles outlined in section 6 of this policy when making decisions around joint funded care packages.

For the avoidance of doubt, commissioning arrangements for people eligible for aftercare mental health services under Section 117 of the Mental Health Act 1983 fall outside the scope of this policy, save as to the extent the individual is also eligible for NHS-Funded Care.

For individuals who are to receive services outside the local ICB area, but where the ICB is the responsible commissioner, the principles outlined in this policy will apply.

3 Duties – legal framework for this policy

This policy should be read in conjunction with:

- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care 2022 (Revised)
- National Framework for Children and Young People's Continuing Care 2016
- The National Health Service Act 2006
- The Health and Social Care Act 2012
- The Care Act 2014
- Mental Capacity Act 2005
- The Human Rights Act 1998
- The Equality Act 2010
- BNSSG ICB Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- BNSSG ICB All Age Continuing Care Operational Policy
- BNSSG ICB Personal Health Budgets Policy

4 Responsibilities and Accountabilities

4.1 BNSSG ICB

The ICB holds system leadership accountability for arranging care under statutory frameworks like CHC and CYPCC, encompassing strategic and individual commissioning arrangements. It is also responsible for ensuring that all commissioned services are safe, equitable, and that any identified risks are appropriately and reasonably managed.

The ICB has an ongoing responsibility to fund the care for individuals outside of hospital settings, where the individual has been assessed as eligible for NHS-Funded Care. This care can be provided in a variety of settings and in a manner that reflects the choice and preference of individuals, however there is no legal obligation for the ICB to provide a

package of care greater than the individuals assessed health need (and in the case of CHC, associated social care needs).

4.2 Chief Nursing Officer

The ICB Chief Nursing Officer is responsible for establishing and maintaining governance arrangements NHS-Funded Care and ensuring that the Funded Care Team delivers in accordance with this policy and the supporting national guidance and legislation. They are also tasked with ensuring the provision of sufficient resources to meet policy requirements.

4.3 The Funded Care Team

The Funded Care Team is responsible for the assessment, case management, review and arranging care and support for individuals in receipt of NHS-Funded Care support and packages of care.

The Funded Care Team is also responsible for managing the appeals process where the individual or their family/carer/representative disagrees with (a) the care options that the ICB has identified; or (b) the decision made by the relevant panel to decline an alternative care option suggested by the individual, or their family/carer/representative.

4.4 CHC and CYPCC Assessors

Assessors work within the Funded Care Team and have a primary responsibility for assessing eligibility for CHC and CYPCC.

4.5 Care Coordinator / Case Managers

The Care Coordinator/Case Managers' roles are in some cases separate from the assessment role performed by the CHC and CYPCC Assessors. These roles, not exclusive to nursing professionals, may include registered or allied health professionals.

4.6 Funding Authorisation Panels

Individuals who meet eligibility for NHS-Funded Care have care needs that vary in the level of complexity and associated risks. There is a process for approval and authorisation of all care packages based on complexity. Where there is a high level of complexity, risk, and/or cost it will be necessary to seek authorisation via the appropriate funding panel (see section 13). Funding panels are responsible for ensuring that the ICB duly considers the balance between individual choice, complexity, risk, and equitable distribution of NHS resources in potentially intricate care arrangements.

4.7 Brokerage Team

The ICB utilises two brokerage teams; an internal team servicing the Bristol and South Gloucestershire population, and the other within North Somerset Council serving the North Somerset population. Brokers within these teams work closely with CHC and CYPCC Assessors, care coordinators, individuals eligible for NHS-Funded Care and, where appropriate, their family/carer/representative, and care providers, to identify care packages and placements that can meet assessed needs.

4.8 Individuals eligible for NHS-Funded Care

An individual found eligible for NHS-Funded Care is encouraged to play an integral role in shaping a personalised approach to meeting their care needs, working with an Assessor or care coordinator to explore how care could be provided to meet the individual's assessed needs, and identifying the outcomes that the person wants to achieve.

Further detail on how the ICB will work with people assessed as lacking capacity is included in section 7 of this policy.

5 Definitions/explanations of terms used

5.1 Integrated Care Board

ICBs replaced Clinical Commissioning Groups ("**CCGs**") in England with effect from 1 July 2022. ICBs are statutory NHS organisations that are responsible for planning health services to meet the needs of their local population. ICBs also, manage the local NHS budget. ICBs are part of Integrated Care Systems ("**ICSs**"), which are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They are formed by NHS organisations and upper-tier local authorities and also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing.

5.2 NHS Continuing Healthcare

NHS CHC means a package of ongoing care that is arranged and funded solely by the National Health Service ("**NHS**") specifically for those individuals in England aged 18 or over who are found to have a 'primary health need'. Such care is provided to meet health and associated social are needs that have arisen as a result of disability, accident or illness. Further information on the Primary Health need test is to be found in the National Framework for CHC[1].

5.3 Children and Young People's Continuing Care

CYPCC will be required when a child or young person (aged 17 or under) has needs which have arisen as a result of a disability, accident or illness that cannot be met from existing universal or specialist health services alone.

For children and young people who are eligible for CYPCC, the ICB works collaboratively with the local authority to ensure a holistic approach is adopted to meet the health and care needs of the child or young person. These cases are usually subject to joint funding arrangements with the local authorities.

5.4 Joint Funding

For adults, a Joint Package of Care may be agreed where an individual has a particular identified health need which cannot be met through existing commissioned care (for example if they are not eligible for CHC but they have an assessed health need that is beyond the power of the local authority to meet on its own). In such cases the Joint Funding

[1] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - July 2022 (Revised) - corrected May 2023 (publishing.service.gov.uk)

Protocol will be followed, which is available on the ICB's website. Care needs will be identified within an assessment and be part of an individual's care plan. It may also be applicable to those who are found to be no longer eligible for CHC or CYPCC.

5.5 Multidisciplinary Team

In the context of assessing eligibility for CHC a Multidisciplinary Team ("**MDT**") is a team of at least:

- two professionals who are from different healthcare professions; or
- One professional who is from a healthcare profession and one person who is responsible for assessing an adult's needs for care and support under section 9 of the Care Act 2014.

5.6 Decision Support Tool

The Decision Support Tool ("**DST**") is a national tool used as part of the process to determine eligibility for adults who are being assessed for CHC and children and young people being assessed for CYPCC. It has been developed by the Department of Health and Social Care to aid consistent decision making. The DST supports practitioners in identifying the individual's needs. This, combined with the practitioners' skills, knowledge and professional judgement, should enable them to apply the primary health need test in practice (for CHC) and make decisions in respect of eligibility for CYPCC.

5.7 Fast Track Pathway Tool

Adults with a rapidly deteriorating condition that may be entering a terminal phase, may require 'fast tracking' for immediate provision of CHC. A Fast Track Pathway Tool (completed by the appropriate clinician), with clear reasons why the individual fulfils the criteria, and which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is sufficient to establish eligibility with no requirement to complete a DST. If approved the individual will then be on the fast track for the immediate provision of CHC (the **"Fast Track"**).

5.8 NHS-funded Nursing Care

For individuals in care homes with nursing, registered nurses are usually directly employed by the care home. To fund the provision of such nursing care by a registered nurse, the NHS makes a payment direct to the care home in respect of individuals who have an assessed need for nursing. This is called 'NHS-funded Nursing Care' ("**FNC**") and is a standard rate contribution towards the cost of providing registered nursing care for those individuals who are eligible.

5.9 Children in Care

A child who has been in the care of their local authority for more than 24 hours is known as a child in care ("**CIC**"). Children in care are likely to be living with foster parents, in a residential children's home, or in residential settings like schools or secure units.

5.10 Care Leavers

A care leaver is a young adult between the ages of 18-25 who has previously been a child in the care of their local authority.

5.11 Special Educational Need and/or Disability (SEND)

A child or young person who has a special educational need and/or disability ("**SEND"**) may have an education, health and care ("**EHC**") plan that identities specific unmet health needs requiring ICB funding to address.

6 Core principles for decision making

In an effort to balance safety, sustainability, and value for money, the ICB has developed this policy to facilitate consistent, transparent decision-making and to assist with equitable distribution of NHS resources.

Application of this policy will help to make sure that care decisions:

- give due consideration to individuals' wishes around care and support;
- are person-centred;
- are robust, fair, consistent, and transparent;
- are based on an objective assessment of the individual's need(s), safety and best interests;
- consider the safety, sustainability, and appropriateness of care to the individual and those involved in care delivery;
- involve the individual and their appointed representative whenever possible and appropriate;
- account for the need for the ICB to allocate its financial resources in the most cost-effective and equitable way; and
- support individual choice to the greatest extent possible considering the above factors.

In instances where more than one suitable care option is available, the Funded Care Team will need to balance the individual's circumstances (taking into account all relevant factors) with the ICB's responsibility to provide care equitably across its entire population.

Many individuals prefer being cared for in their own homes rather than in a registered care home. Although the choice of care setting will be taken into account, there is no automatic right to a home-based care package.

It can, in some circumstances, be difficult to deliver care at home on a sustainable and safe basis. For example, it can often not be possible to replicate support services available within in-patient NHS settings and registered care facilities (e.g., 24-hour nursing care) at home. The Funded Care Team will consider individual circumstances and all relevant factors when considering whether a home care package is a feasible option.

The Funded Care Team will need to identify and assess each care option for cost-effectiveness and consider this alongside the psychological and social care needs of the individual and the impact on their home and family life as well as the individual's care

needs. In doing so, the Funded Care Team will take into account the ICB's Public Sector Equality Duty under the Equality Act, and obligations under the Human Rights Act and Article 8 of the European Convention on Human Rights.

Further guidance on how the Public Sector Equality Duty, Human Rights Act, and Article 8 of the European Convention on Human Rights apply to this policy is included in Appendix 1.

7 Consent and capacity to make decisions

The Funded Care Team will support individuals in playing an integral role in shaping a personalised approach to meeting their care needs. In situations where an individual has been formally assessed as lacking the mental capacity to make a decision and falls within the remit of the Mental Capacity Act 2005, the Funded Care Team will act in accordance with that individual's best interests. This will be in line with the Mental Capacity Act 2005 and the ICB'S Mental Capacity Act & Deprivation of Liberty Safeguards Policy, available on the ICB's website and is also included in the references section of this policy.

For CYPCC, the consent of the child or young person (or their parents where necessary) to be considered for continuing care should be sought. Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision not to give consent, the Funded Care Team should discuss with the local authority the implications of this.

Where the individual is under 16 and lacks the mental capacity to make a decision, someone with parental responsibility can give consent for them, provided that person has capacity to give consent. If one person with parental responsibility gives consent and the other does not, the Funded Care Team will consider whether it can accept the consent of one parent, based on the specific facts and circumstances.

If the individual has appointed someone to act on their behalf through a lasting power of attorney, or if a Court has appointed a deputy, the Funded Care Team will work with the appointed individual.

8 Safeguarding

The ICB will adhere to the statutory functions for safeguarding adults under the Care Act 2014 and safeguarding children under section 11 of the Children Act 2004.

An adult is defined as anyone over 18yrs; all adults have the potential to be at risk of abuse or neglect.

The safeguarding of individuals is integral to the commissioning, quality assurance, clinical governance, performance management and finance audit arrangements.

The ICB's Safeguarding Policy can be found on the ICB's website[2].

[2] https://bnssg.icb.nhs.uk/library/adults-and-childrens-safeguarding-policy/

9 Personal Health Budgets

All individuals in receipt of CHC and CYPCC who live at home will be offered a Personal Health Budget (**"PHB"**) to meet their assessed care needs.

PHBs can be managed in three ways, or a combination of these:

- **Notional budget**: the ICB is responsible for holding the budget and using it to arrange and secure the agreed care and support
- **Third party budget**: an organisation independent of both the individual and the ICB (for example an independent user trust or a voluntary organisation) is responsible for and manages the budget on the person's behalf and arranges support by purchasing services in line with the agreed care and support
- **Direct payment**: the PHB holder or their representative has the budget on a prepaid card or paid into a dedicated bank account and takes responsibility for purchasing the agreed care and support.

A notional PHB may be the most appropriate option for some individuals eligible for CHC/CYPCC should they wish to have a PHB, as this functions similarly to a traditional home care package, however this will depend on the circumstances of each case.

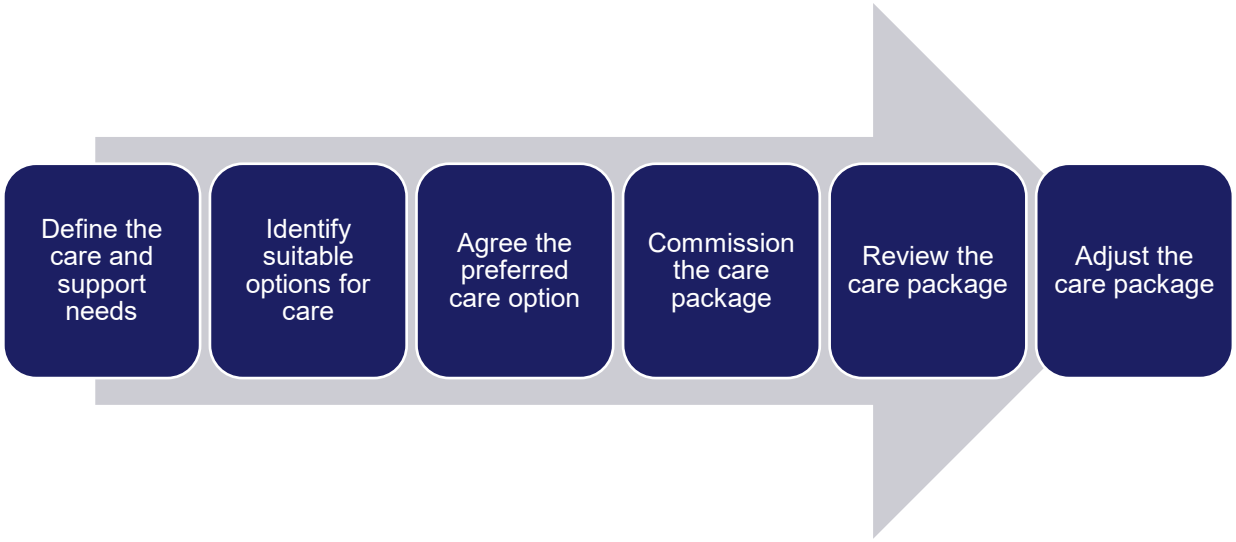
Individuals in receipt of a Joint Package of Care can also be offered a PHB although there is no automatic entitlement to one. The ICB will consider all facts and circumstances when deciding whether to offer a PHB for Joint Packages of Care.

Developing the PHB care plan will follow the steps outlined in the BNSSG PHB Policy and the following sections, however further information on the ICB's approach to PHBs is available in the BNSSG PHB Policy, which can be found on the ICB's website and is also included in the references section of this policy.

Individuals will not be forced to take on more control over their care than they feel comfortable in taking, and support will be provided to help individuals work through the options available to them.

10 Overview of the commissioning process

A high-level overview of the commissioning process is set out below. This is described below and is built into this policy.



11 Developing options for care

Once eligibility for NHS-Funded Care for an individual has been determined an Assessor or care coordinator will continue to work with the individual and / or family/carer/representative to explore how care could be provided to meet the individual's assessed needs. The discussions will help to clarify the individual's care needs and the outcomes that the person wants to achieve.

The outcome of these discussions will be captured in a care needs document, which will aid the relevant Brokerage Team in identifying available care options.

An individual who lacks the mental capacity to make decisions about their care will still be included in discussions as much as they are capable of participating. The assessor will also discuss care options with others involved in the individual's care, in accordance with the principles of the Mental Capacity Act 2005 and the ICB's Mental Capacity Act and Deprivation of Liberty Safeguards Policy.

There may be several suitable options to meet an individual's needs. These typically involve care at home or in a registered care setting such as a nursing home, residential home/school, or an independent hospital. In identifying appropriate options for individuals eligible for NHS-Funded Care, the Funded Care Team will consider factors such as:

- The safety, quality, sustainability (including care capacity and financial sustainability) and feasibility of proposed care options;
- The overall cost of proposed care options and any concerns about value for money or affordability for the ICB;
- The individual's preference about where care is delivered, e.g. at home, or in a care home;
- The effectiveness of proposed care options in meeting the individual's assessed health and social care needs;
- The potential impact on the individual's human rights;

- Whether the individual has a protected characteristic under the Equality Act 2010 and whether there are any steps that could reasonably be taken to promote equality of opportunity for that individual;
- Communication needs and requirements;
- The Care Quality Commission ("**CQC**") registration status of potential care providers and whether there are any open suspensions or enforcement actions by the ICB, local authority or CQC;
- Presence of informal carers to provide care. There is no obligation for family members to provide care for an adult, but where an offer is made, the Funded Care Team may take this into account as an integral part of the care package. In such circumstances the Funded Care Team will consider a referral to the local authority so that a carer's assessment can be considered and offered in line with the Care Act 2014;
- Parent's role as informal carers; and
- Any concerns about contingency plans in terms of the support that may be required if a care option fails.

Where the ICB funds care in an individual's home, it is important to understand that a time may come when it is no longer appropriate for care to continue within the home environment. The Funded Care Team will periodically review the arrangement to ensure it remains safe, sustainable, and affordable and continues to meet the individual's needs.

The ICB considers that in some circumstances an individual's needs may be more appropriately met within a registered care setting. The general principles are set out below; however the Funded Care Team will take into consideration all relevant circumstances to the individual to establish whether any of these principles can be displaced, or if any other factor is relevant:

- a package in excess of eight (8) hours a day would indicate a high level of need which may more appropriately be met by a registered care / nursing home placement;
- individuals who need waking night care would generally be more appropriately cared for in a care / nursing home. The need for waking night care indicates a high level of supervision at night; and
- individuals who may benefit from direct oversight by registered clinical professionals and 24-hour monitoring.

Certain conditions or interventions may not be suitable for home management. These may include, but are not limited to, the requirement for subcutaneous fluids, intravenous fluids, complex polypharmacy, enteral feeding, continual invasive or non-invasive ventilation, or the management of grade 4 pressure injury.

The ICB can only support a clinically safe and sustainable package of care within an individual's own home where the costs of doing so are in line with this policy. In assessing the comparative costs of different packages the Funded Care Team will use the costs of care in accordance with the personalised care needs of the individual and not a generalised cost of the type of care.

12 Agreeing a preferred care option

Care options identified by the Funded Care Team (taking into account the factors set out above) will be provided to the individual or family/carer/representative. The Funded Care Team will endeavour to offer a choice, although this may not be possible where there is limited availability of appropriate care provision.

Once the Funded Care Team has confirmed the available care options individuals or their family/carer/representative will be asked in most cases to make a decision on their first choice within 48 hours, however more time can be requested to make the decision if required. Depending on the availability of residential/nursing home support or a domiciliary package of care at home, it is not always possible to find a suite of options that can meet the need of the individual which are aligned to the responsibility of the ICB to make equitable decisions. The Funded Care Team will make the necessary arrangements with the individual and the care provider to confirm for a suitable start date.

The Fast Track pathway (for adult CHC) requires an adapted approach so that needs can be met in a timely way. For those at home and whose care needs have changed and can no longer be met safely or sustainably at home, the ICB may only be able to offer one option for the place of care if it is not able to locate any other options taking into account the general urgency of the Fast Track pathway. If this location of care is not the preferred place for the individual or the family, the ICB will endeavour, as soon as practical, to find a suitable alternative place of care.

The Funded Care Team may make additional time available for decisions to be reached by an individual or family/representatives where there are exceptional circumstances, but in such circumstances it may be necessary for the Funded Care Team to offer a temporary service to make sure that the individual is safe and their needs are met while they are making a decision.

Temporary arrangements may also be needed if the preferred option for care at home or the first choice of care home is unavailable, or in the event that an existing care arrangement breaks down. The temporary arrangement will always be one that meets the individual's assessed needs, but may not be the person's preferred choice. This may be necessary, for example, if an individual is medically ready to leave hospital but the preferred care provider is not immediately available.

13 ICB Authorisation

Authorisation to commission an agreed care package is granted in line with the ICB's Standing Financial Instructions ("**SFIs**")[3]. SFIs detail the financial responsibilities, policies and procedures adopted by the ICB.

The formal authorisation to procure packages of care is delegated as follows (values represent weekly costs of packages of care, inclusive of VAT where applicable) and will follow an escalation process:

[3] https://bnssg.icb.nhs.uk/about-us/governance-handbook/

Level 1

Care home placement up to £2,000 per week

Domiciliary care package up to £1,500 per week

- Care packages and placements being made at existing agreed rates can be authorised by:
  - CHC Clinical Lead and Lead for CHC Operations (for adults) or Lead for Complex Cases;
  - CYP Nurse and Head of CYP (CYP CC).
- Any care home placement requiring enhanced care will move to level 2 for authorisation.
- Where the proposed care agency or care home standard fees are different to those already agreed by the ICB, for example where a care home placement has been approved at under £2,000 per week but the provider later increases its core rates, the case will move to level 2 for authorisation.

Level 2 – Complex Care Panel

Care home (CH) placement between £2,001 and £5,000 per week

Dom care (DC) package between £1,501 and £3,500 per week

- Care packages and placements require authorisation by the ICB Complex Care Panel.
- Any care home placement requiring 24 hour enhanced care or greater will be referred to the ICB High-Cost Panel.

Level 3 – High Cost Panel

Care home (CH) placement between £5,001 and £10,000 per week

Dom care (DC) package between £3,501 and £10,000 per week

- Care packages and placements must be authorised by the ICB High-Cost Panel.

Level 4 – Extraordinary High Cost Panel

Any care package or placement between £10,001 and £15,000 per week

- Care packages and placements will require authorisation by an extraordinary High-Cost Panel including the members of High Cost panel plus the Director of Nursing.

Level 5

Any care package or placement between £15,001 and £20,000 per week

- Panel will include the Chief Nursing Officer, and Chief Finance Officer **or** Chief Executive Officer.

Level 6

Any care package or placement above £20,001 per week

- Care packages and placements will require authorisation by a specially convened panel including Chief Nursing Officer, Chief Finance Officer, Chief Executive and a Non-Executive member.

14 Considering alternative requests for care

Where a person declines all of the options initially proposed by the Funded Care Team they can suggest a different arrangement (including alternate temporary arrangements), as long as the care option meets the requirements and considerations outlined in section 11 above.

Where a care option is requested by an individual, the costs and risks will need to be considered by the Funded Care Team before a decision can be made to arrange the care. The request will be taken through the relevant authorisation process detailed in section 13.

This process will take into account the core principles for decision making set out in section 6, and the key considerations for developing care options listed in section 11. In addition the process will consider whether a decision not to pay for a more expensive option would be reasonable and proportionate given the potential effect on the individual and their family/carers/representative and their rights.

Individuals and their family/carers/representative will be fully informed of the process to be followed and given the opportunity to submit a rationale as to why a more expensive care option should be funded by the ICB. The decision will be clearly documented, shared with the individual or the representative/advocate acting on their behalf and details will be provided about how the person may appeal the decision.

Where an individual is eligible for CHC via the Fast Track pathway a streamlined process may be used to ensure that a prompt decision can be made and care arrangements progressed with minimal delay.

15 Appealing the ICB's decision

An individual, or carer/family/advocate acting on that individual's behalf, wishing to appeal the decision of the ICB will need to confirm this in writing to the Funded Care Team via either of the below addresses:

- Email address: bnssg.chc@nhs.net
- Post to: Funded Care Team, NHS Bristol, North Somerset & South Gloucestershire ICB, Floor 2, North Wing, 100 Temple Street, Bristol, BS1 6AG It will be important that an individual appealing provides a clear rationale as to why the decision should be reviewed.

In such cases the decision of the relevant authorising body will be reviewed by the next higher level of authorisation, as set out in section 13. For example, an appeal of a decision by the Complex Case Panel at level 3, would be considered by the ICB High Cost Panel at level 4.

The review of the decision will be clearly documented and shared with the individual or the representative/advocate acting on their behalf.

If an individual is dissatisfied with the decision they will have the opportunity to make a complaint, and details as to how to do so will be included within the decision response.

16 Refusing care

If an individual who has mental capacity to make decisions about their care refuses to accept any of the options offered by the Funded Care Team, the ICB will, taking all factors into account, usually consider that it has fulfilled its legal duty towards the person. If this is the case, the Funded Care Team will inform the individual in writing that they will need to make their own arrangements for ongoing care within 28 days of the date of the letter. The letter will explain the risks of refusing the care and advise who they can contact if they change their mind in the future. The risks will also be documented in the individual's care record.

If the Funded Care Team is worried about serious risk to the person because they have refused care, it will consider whether it would be appropriate to follow adult safeguarding procedures including consideration of a referral to the relevant local authority.

If the person lacks mental capacity to make decisions about their care and they or those involved in their care refuse to accept any options offered by the Funded Care Team, the process will continue according to the requirements of the Mental Capacity Act 2005 being mindful of the deprivation of liberty safeguards, where appropriate.

17 Individuals with existing care arrangements

Where an individual with an existing home care package, or care home placement, becomes eligible for NHS-Funded Care, the Funded Care Team will follow the process for identifying care options set out in section 11 of this policy. This will involve a comparison of the current care package or placement against alternative care options, to ensure that the care option meets the individual's reasonable assessed needs and correctly balances safety, quality, sustainability, risk and cost.

If an individual's existing care package is not identified by the Funded Care Team as a suitable care option, or is more expensive than the personalised options offered by the ICB, then the case will be presented to the relevant authorising body for a decision following the process set out above in section 14. As part of this process the ICB will consider if there are reasons in each specific case why it should meet the cost of the existing package.

In situations where this process identifies that carers are employed at rates of pay in excess of those deemed appropriate by the ICB for the tasks being undertaken, which may be in cases where an individual has either self-funded care arrangements, or used a social care Direct Payment, the ICB will expect pay rates to be brought in line with its guide price for personal assistants, which is broadly in line with Agenda for Change and set out in a Pay vs Task Tool. Any changes will be made in compliance with applicable employment legislation at the time of the change. The ICB will provide HR support as required to facilitate this.

18 Enhanced care

The ICB will exercise firm financial control, accountability and quality assurance in respect of requests for enhanced care, such as dedicated one to one support. Where an

enhancement to a care package or care placement is requested, the Funded Care Team will require clinical evidence to support the request, as well as all appropriate risk assessments, behaviour charts, evidence of communication with the individual/relative, a proposed step down plan and any other relevant evidence deemed helpful to support the request.

Requests for enhanced care will be considered at the relevant authorising level as set out at paragraph 13 and subject to review. This process applies where the request is made as part of the CHC or CYPCC annual review, or in response to a change in need. The Funded Care Team will operate a streamlined authorisation process where risk and safety concerns around a request for enhanced care require a prompt decision.

19 Additional private care

The ICB is obliged to provide services that meet the assessed needs and reasonable requirements of the individual eligible for NHS-Funded Care. These services, whether delivered within a registered care setting, or at home must be free of charge to the individual.

In the case of adult CHC, the package of care which the Funded Care Team has assessed as being reasonably required to meet the individual's assessed needs is known as the core package. The ICB is not able to allow personal top-up payments into the CHC package of healthcare services, where the additional payment relates to the core package. This is because top-up arrangements for CHC provision are unlawful.

If an individual or their carer want to make arrangements directly with a provider for additional services that are not within the ICB's core package, they should first notify the Funded Care Team (through the case manager). The Funded Care Team must make sure that the additional services do not replace or conflict with the care arranged by the NHS. Examples of permitted arrangements may include hairdressing, massage, reflexology, beauty therapies, and preference for a specific room or some sitting services that have not been identified as part of the care needs assessment.

Detailed guidance on this issue can be found in the National Framework for Continuing Healthcare and Funded Nursing Care.

20 Respite

Respite is an interim short-term arrangement for carers which provides relief from their caring duties. Respite requirements will be assessed on an individual case by case basis and included with the care and support plan.

In the event that the ICB receives a request from an individual (and/or his/her representative/s) to fund a period of respite (which is not already provided for within the care plan), the ICB will review the individual case with the aim of determining whether there are any circumstances which would warrant the approval of additional funding over and above the agreed package of care.

The amount of respite care that the ICB will fund will be considered on a case by case basis and will be based on individual circumstances. The panel decision as to whether to fund

additional respite care will be clearly documented, shared with the individual or the representative/advocate acting on their behalf and details will be provided about how the person may appeal the decision.

Where the individual package of care is joint funded with the local authority, requests for respite will be considered jointly between the ICB and the local authority. Responsibility to fund the respite will depend on the specific circumstances.

Please refer to the PHB Policy in respect of how respite care is commissioned when a PHB has been agreed.

Guidance around ICB contributions to respite for children who are eligible for CYPCC is set out in a Standard Operating Procedure, which is available on the ICB's website.

The ICB will consider a request for joint funding of a respite care package for a child where there is a clear health need and all other respite options have been explored. Respite care should deliver a mix of health care and social care where health needs can be met but also leisure and pleasure activities are provided or accessed.

Where the provision of emergency health care interventions is required to keep the child well and safe then the ICB will consider funding towards a short break. Cases will be considered on an individual basis depending on assessed needs and clinical interventions.

Consideration will be given to the following factors:

- the care requires the carers to be appropriately trained and competent in meeting the clinical need. i.e., a child that requires airway management via mechanical ventilation, effective suction or administration of medication.
- the purpose of the care or part of the care is to deal with continuing medical needs which if not met will give rise to urgent or immediate medical needs.
- In exceptional circumstances the care must be provided by a qualified nurse.

21 Transport

The ICB's general position is that transport for individuals to attend health appointments will be reimbursed only if specific circumstances are met. These circumstances are set out in the NHS (Travel Expenses and Remission of Charges) Regulations 2003 (as amended) ("**HTCS**"). Broadly and as per the HTCS, the ICB will reimburse travel expenses incurred in obtaining certain NHS services commissioned under the NHS Act 2006 for individuals who are in receipt of certain state benefits or who are on a low income. In line with the scheme, the ICB will also arrange for those same individuals to be exempt from the payment of certain NHS charges which would otherwise be payable.

Where the circumstances set out in the HTCS are not applicable, routine transport costs will not be funded as a part of a package of care apart from in exceptional circumstances and these will be considered on a case-by-case basis via the funding panel authorisation process.

The ICB recognises that travel may form part of a package of care as an assessed health and social care need and where this is the case, it is expected that this would be included in the individual's care plan and would therefore be agreed as part of the overall package.

The ICB is not therefore required to pay / reimburse the travel costs associated with the Respite Travel, Educational Travel or Family Travel, however it will consider each application on a case by case basis.

In relation to Educational Travel, the ICB will not usually fund travel to educational settings as it is noted that local authorities have a number of duties in this regard.

In relation to Family Travel (i.e. travel expenses incurred by family members to visit individuals placed out of area that are funded by CHC), the ICB will consider funding travel to facilitate family contact on a case-by-case basis where exceptional needs are identified. Visits out of the area will usually mean visits outside of the ICB's area, however this can also mean visits within the ICB's area if an individual is placed in a different part of the ICB area which is far away from their family. In order to review a request for funding to facilitate family contact, the ICB will expect to see evidence of a clear best interests need for the individual to be visited by family members (which includes clinical, emotional, psychological and wider needs).

22 Funding requests for interventions not routinely commissioned

Requests for funding for treatments, drugs and devices (collectively referred to as interventions) that the ICB does not routinely fund will be managed via the Exceptional Funding Request (**"EFR"**) process.

There are two situations where the ICB does not routinely commission an intervention. These are where:

- the ICB does not commission the intervention for anyone with this condition; and/or
- the patient does not meet the criteria set out in the commissioning policy for this intervention.

To be eligible for consideration as an EFR, a case needs to be made by an individual's referring clinician on medical grounds, being deemed either sufficiently rare, or clinically exceptional.

Clinical exceptionality is defined as being (a) an individual is significantly different in some clinical manner from the cohort of patients with the same condition at the same stage of progression for whom the ICB does not fund the intervention and (b) the individual is likely to gain significantly more clinical benefit from the intervention than that cohort.

Further information on EFRs is available on the ICB's website and the address is included in the references section of this policy.

23 Review

Care packages for individuals eligible for NHS-Funded Care will be subject to review, initially at 3 months and then annually, to ensure that care needs and personalised outcomes are being met and that the care package remains clinically safe, sustainable and within cost limits.

Care packages for individuals eligible for CHC via the Fast Track pathway may require more frequent review to ensure that the care remains effective in meeting the assessed needs and/or where an individual's care needs change.

It is important to recognise that the review may result in either an increase or decrease in support and will be based on the assessed needs of the individual at that time. If it is clear that an individual's needs have changed it may be necessary to re-consider the care options available, following the process set out in sections 11 and 12 of this policy.

Individuals and their carers/representatives must be aware that there may be times where it will no longer be appropriate to provide care in line with the individual's existing arrangements or preferred choice based on safety concerns, sustainability or cost. Any decision to provide care in a different way will take account of all relevant factors set out in section 11 of this policy.

A care review may indicate that a full assessment is required to confirm if the individual remains eligible for NHS Funded Care. The Funded Care Team will make any decision about reviewing eligibility in a Fast Track case with sensitivity. Where an individual is no longer eligible, the ICB will no longer be required to fund the identified care.

The Funded Care Team will give 28 days' written notice of cessation of funding to the individual or their representative and the relevant local authority. Any ongoing package of care may qualify for funding by social services, subject to any local authority assessment criteria. Alternatively the cost of any ongoing package of care may need to be met by the individual themselves. The transition of care should be seamless and will be coordinated by the Funded Care Team before transferring to a local authority representative. The individual and/or their representative will be notified of the proposed changes to funding and involved by the organisations as appropriate.

24 Training requirements

In order for this policy to operate effectively an understanding of its contents is required for ICB staff, specifically the staff members in roles included in section 4 of this policy. Refresher training will be delivered to all staff within the Funded Care Team within 1 month of publication.

25 Equality Impact Assessment

To ensure compliance with the ICB's public sector equality duty, an Equality Impact Assessment has been undertaken to support this policy development, and to identify any potential negative implications of the implementation on particular groups, and any mitigation required.

The key policy rationale for the National Frameworks for adult and children's CHC is to ensure that there is a consistent method to undertake the assessment for NHS CHC throughout the NHS. The purpose of the assessment process is to assess an individual's needs across a range of domains to establish whether they have a "primary health need".

Eligibility for NHS CHC is not based on condition, or diagnosis. The core purpose of the National Framework is based on eligibility by needs only regardless of someone's age, disability gender or race etc. and the framework is therefore inclusive in its principles with no individual being treated differently on the basis of any specific protected characteristic.

This commissioning policy supports the delivery of the National Frameworks for adult and children's CHC, aiming to ensure that the ICB effectively commissions care and support in a person-centred way, with a high degree of personalisation.

By the nature of the healthcare provided, there is a tendency for recipients of NHS Funded Care to be older and/or disabled in some way. The core values and principles of this policy are aimed at providing consistency and so improving access to funded care for these groups.

Effective commissioning of care and support has a positive impact on equality and diversity across most protective characteristics. By commissioning care in a person-centred way, with a high degree of personalisation, the ICB can support people to live fulfilled lives within their communities.

26 Information Governance, Confidentiality and Data Security

Accurate, timely and relevant information is essential to deliver the highest quality health care, and it is the responsibility of all ICB staff to ensure and promote the quality of information and to actively use information in decision making processes. The ICB's Information Governance Policy sets out how the ICB will ensure that information is held securely and confidentially, obtained fairly and efficiently, recorded accurately and reliably, used effectively and ethically, and shared appropriately and lawfully[4].

The BNSSG ICB Confidentiality and Security of Information Policy details how the ICB will meet its legal obligations and NHS requirements concerning confidentiality, information security standards, ensuring that confidential information sent to or from the organisation is handled in such a way as to minimise the risk of inappropriate access or disclosure[5].

27 Implementation and Monitoring Compliance and Effectiveness

This policy will be audited as part of the Funded Care Team audit programme to demonstrate that the ICB is being effective at ensuring equity in the delivery of care to individuals across Bristol, North Somerset and South Gloucestershire. Exceptional reports on delivery of equity and choice in Funded Care will be taken to Funded Care Delivery

[4] https://bnssg.icb.nhs.uk/library/information-governance-policy1/
[5] https://bnssg.icb.nhs.uk/library/confidentiality-and-security-information-policy/

Group, Funded Care Risk, Audit and Governance Group, Outcomes, Quality and Performance Committee, Finance Estates and Digital Committee.

28 Countering Fraud, Bribery and Corruption

The ICB is committed to reducing and preventing fraud, bribery and corruption in the NHS and ensuring that funds stolen by these means are put back into patient care. During the development of this policy document, we have given consideration to how fraud, bribery or corruption may occur in this area. We have ensured that our processes will assist in preventing, detecting and deterring fraud, bribery and corruption and considered what our responses to allegation of incidents of any such acts would be.

In the event that fraud, bribery or corruption is reasonably suspected, and in accordance with the Local Counter Fraud, Bribery and Corruption Policy, the Funded Care Team will refer the matter to the ICB's Local Counter Fraud Specialist for investigation and reserve the right to prosecute where fraud, bribery or corruption is suspected to have taken place. In cases involving any type of loss (financial or other), the ICB will take action to recover those losses by working with law enforcement agencies and investigators in both criminal and/or civil courts.

29 References, acknowledgements and associated documents

BNSSG ICB Mental Capacity Act & Deprivation of Liberty Safeguards Policy

https://bnssg.ICB.nhs.uk/library/mental-capacity-act-and-deprivation-liberty-safeguards-policy/

The BNSSG ICB Safeguarding Policy

https://bnssg.ICB.nhs.uk/library/adults-and-childrens-safeguarding-policy/

BNSSG Personal Health Budgets Policy

https://bnssg.icb.nhs.uk/library/personal-health-budgets-policy/

Policy on the management of Compliments, PALs enquiries and Complaints

https://media.bnssgICB.nhs.uk/attachments/bnssg_complaints_policy_c7Y4GQB.pdf

National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - October 2018 (Revised)

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

National Framework for Children and Young People's Continuing Care 2016

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499611/children_s_continuing_care_Fe_16.pdf

BNSSG ICB Exceptional Funding

https://bnssg.icb.nhs.uk/about-us/governance/interventions-not-normally-funded-innf/exceptional-funding/

BNSSG Information Governance Policy

https://bnssg.icb.nhs.uk/library/information-governance-policy1/

BNSSG ICB Confidentiality and Security of information Policy

https://bnssg.icb.nhs.uk/library/confidentiality-and-security-information-policy/

30 Appendices

Appendix 1 – Additional Guidance on the Human Rights Act and Public Sector Equality Duty

Human Rights Act

In adopting this policy the ICB has taken into account the issue of human rights, and specifically the right to respect for an individual's private and family life provided by Article 8 of the European Convention of Human Rights (ECHR).

There is an obligation under Article 8 to respect an individual's private and family life, home and correspondence. Family life should be interpreted widely and may include persons who are not related or married, depending on the circumstances.

When making decisions under this policy regarding an individual, the ICB will need to consider the individual's circumstances and the impact of any care package on the individual's Article 8 rights. Any impact identified should be documented.

The Human Rights Act requires that any interference with an individual's Article 8 rights must be necessary, reasonable and proportionate. Where a decision regarding a care option is likely to impact on an individual's right to private and family life, the ICB will consider whether any adverse impact on the individual is necessary, reasonable and proportionate given their circumstances; the clinical appropriateness, safety and sustainability of the proposed care package and other alternatives; and, also their obligations to their entire population.

Where an individual is already receiving care in their own home and a move to other accommodation is being considered, the ICB will need to assess the impact on the individual's needs (including physical, psychological and emotional needs) that a move to a different care setting may have.

Article 8 may also be engaged in the context of an ability to maintain family and social links. If the ICB proposed solution would be more remote from the individual's family, this will need to be taken into account in any decision making process. For example, if an individual is active within their local community and has many friends and family in the local area, a move to accommodation in a different geographical area is likely to have a material impact

on the individual's Article 8 rights. Given the impact on this individual's Article 8 rights, the ICB may consider it is appropriate to commission a more expensive care option closer to the individual's community to minimise the impact on the individual's Article 8 rights.

In contrast, if an individual has limited interaction within their community and has no friends or family locally, the ICB may take the view that the impact on the individual's Article 8 rights of a move to a different community area is proportionate, reasonable and necessary given the ICB/ICB's duty to provide resources for its entire population.

The above examples are provided for illustration purposes only. Each case will need to be decided upon its individual circumstances in line with this policy.

Public Sector Equality Duty

The Equality Act 2010 introduced the public sector equality duty. In relation to implementation of this policy, the ICB has a duty to have regard to the need to:

- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- remove or minimise disadvantages suffered by people due to their protected characteristics; and
- meet the needs of people with protected characteristics (e.g. where the needs of a disabled person may be different from those of non-disabled person).

Protected characteristics include age, disability, gender reassignment, pregnancy and maternity, race (including ethnic or national origins, colour or nationality, religion or belief (including lack of belief), sex, and sexual orientation

In making decisions regarding care options, the ICB must consider whether the person affected by the decision has any protected characteristics and if so, whether any reasonable adjustments should be made available, which are proportionate in the circumstances.

Decisions about proportionality of adjustments can take into account the ICB's obligations to its entire population; however, decisions must be taken on the individual circumstances of each situation considering whether it would be reasonable to make additional resources available in each case.

Appendix 2 – Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
Staff	Funded Care Team awareness and understanding of the revised policy	Refresher training to be delivered over a one-month period post publication of the policy.	DW	Jan 25	Feb 25	N/A

Public	Publication of the policy	Policy to be added to the ICB website.	LC	Jan 25	Jan 25	N/A

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG Outcomes, Quality and Performance Committee

Date: 28th November 2024

Time: 14:00-16:30

Location: Microsoft Teams

Agenda Number:	7.4	
Title:	BNSSG System Safeguarding Update	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	
	Time Sensitive – not for public release at this time	Yes
	Other (Please state)	No

Purpose: For information and discussion – Update paper on Safeguarding Partnership and Corporate Parenting Board activity

Key Points for Discussion:

The Systemwide Safeguarding Transformation Programme Project Group has produced an 'Aspirational Statement of Challenges and Opportunities' in addressing how the ICB, Local Authorities and Police could work closer together to support the safeguarding activity at system (1), place (3 local authorities) and 6 (localities). Further agreement is required at Executive Director level from Local Authorities, ICB and Police on next steps for Design phase.

As per the Working Together to Safeguarding Children Statutory Guidance, changes have been implemented within the Partnerships including the assignment of ICB personnel to support LSP (Lead Safeguarding Partner) and DSP (Delegated Safeguarding Partner) responsibilities.

Recommendations:	To note the report and updates in relation to safeguarding activity across the areas both- workstreams and geography.

Previously Considered By and feedback :	Previously considered by ICB Safeguarding Team
Management of Declared Interest:	None declared.
Risk and Assurance:	There is a risk that the Enhanced Dental Provision for Children in Care and the Free Prescriptions for Care Leavers will cease after 1 year if the funding from within the system is not secured for these two programme areas.
Financial / Resource Implications:	The financial implications are limited with now a fully recruited ICB safeguarding team- having received increased investment in 2022. However, it should be noted that there continues to be a high volume of statutory reviews which the ICB have a responsibility to financially contribute to. It should also be noted that there are financial implications in relation to the risk above, and contributions to Safeguarding Partnership and Adult Board arrangements which is also review and may require further NHS contributions.
Legal, Policy and Regulatory Requirements:	There are no legal requirements specific to this paper other than the ICB statutory duties for safeguarding.
How does this reduce Health Inequalities:	This report identifies the work of protecting children, young people and adults at risk of abuse and neglect. Safeguarding within BNSSG ICB is underpinned by a performance management culture, contracting systems and processes that aim to reduce the risk of harm, and to identify and quickly respond to any concerns universally and in at risk groups.
How does this impact on Equality & diversity	This paper considers equality and diversity, and the impact on our population by focusing on the individual cohorts of people; children, children in care and adults.
Patient and Public Involvement:	This is not applicable because the main function of the ICB Safeguarding team is at a strategic level not operationally with patients.
Communications and Engagement:	This is for system partners by way of an update on Safeguarding Partnership activity, not all of this information is available to the public
Author(s):	Faye Kamara (Head of Safeguarding All-Age)Toyah Carty-Moore (Designated Nurse for Safeguarding Children)Nicki Ayres (Designated Nurse Children in Care)Alex Morgan (Designated Professional Safeguarding Adults)
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd Chief Nursing Officer

All Age Safeguarding Report

The purpose of this report is to provide the Outcomes, Performance and Quality Committee with updates on:

- Themes and Trends relating to Safeguarding work programmes affecting the BNSSG population
- Identified risks and mitigations for current safeguarding issues
- Examples of transformational work being undertaken relating to safeguarding

The updates are based on information and work programmes undertaken in Quarter 2 (July-September 2024)

Safeguarding Children

Themes and trends in relation to Children Partnerships

Following the publication of the **Working Together to Safeguarding Children Statutory Guidance in December 2023**, all three local authority based Safeguarding Children Partnerships have been working collaboratively to implement changes and publish their new arrangements by December 2024. Below is a summary of the key changes in statutory guidance:

- Chief Executives/Officers of the Local Authority, ICB and Police are required to be the Lead Safeguarding Partner (LSP) for their agency- they should meet regularly, work in partnership, and sign off key decisions, budgets and an annual report in September.
- LSPs should each appoint a Delegated Safeguarding Parter (DSP) to oversee operational delivery, one or more of whom must act as Partnership Chair for safeguarding children
- Strengthen Education's role within Partnerships including at the highest level of decision-making. Also strengthen the role of the VCSE sector.
- Strengthens information- sharing, oversight, quality assurance and scrutiny.
- A broader range of practitioner can be lead practitioner for children and families receiving support under Section 17 of the Children Act 1989.

The following are the requirements expected of each Safeguarding Children Partnership by end of December 2024:

- Revise multi-agency safeguarding arrangement including role of LSPs, DSPs, Education, VCSE sector and arrangement for scrutiny and chairing
- Ensure practice is in line with principles and standards in WT2023 in respect of working with children and families, with partners and in line with child protection standards.
- Ensure that there is an effective early/family help offer in the partnership
- Ensure that policies, procedures and practice guidance are in line with WT23

- Ensure that training and development offers are in line with WT23
- Ensure that practitioners and agencies are aware of changes.

All 3 Partnerships are in the final stages of publishing their arrangements. The LSP from the ICB is Shane Devlin as Chief Executive Officer for the ICB, supported by Rosi Shepherd as Chief Nursing Officer. The DSPs from the ICB are Michael Richardson (North Somerset and Bristol) and Denise Moorhouse (South Gloucestershire) who are both Deputy Chief Nursing Officers.

Joint Targeted Area Inspection

The three local authorities are actively exploring how to work with system partners to best prepare for the potential selection of a Joint Targeted Area Inspection (JTAI). South Gloucestershire are currently piloting a dry run that includes participation from some health system partners. While this initiative is valuable, there is an opportunity to enhance its relevance for health system colleagues, as it primarily appears to focus on testing the Local Authority system.

To foster collaboration, all three Local Authorities have encouraged partners to complete the Annex A document which is a requirement of the JTAI. This will help ensure that everyone is aligned in considering how they work with children and families concerning domestic abuse, which is the new theme. We have proposed that all three Local Authorities consider ways to work together more efficiently in preparation for a potential inspection. By streamlining the support required from health system colleagues, we can reduce duplication of efforts and improve overall effectiveness. Furthermore, it has been proposed that the Heads of Safeguarding from across the health system meet to explore what a JTAI looks like for us as a Health System and to discuss how we can best prepare our teams for such an inspection. This collaborative approach will help us all be better equipped and serve our communities more effectively.

Update on Children's Safeguarding Partnership 'Health Data'

Work continues within the ICB as part of the Children's Programme under the Health and Care Improvement Group for Children to include safeguarding metrics within a Performance Report which can then in turn be shared with the Children's Partnerships. It is hoped that there will be a prototype before the end of December 2024 to share.

In addition, South Gloucestershire Children's Partnership invested in a Data Acceleration Programme which has produced a performance report including health data for their Partnership each quarter. Data has been obtained from Health Partners directly and therefore exploration is also underway by the other two local authority safeguarding children business managers to obtain the same.

Learning from statutory safeguarding reviews including Child Death Reviews (CDOP Panels)

There was one notification made to the National Panel in relation to Rapid Reviews between July-September 2024. This was in relation to a child's experience of quality and timeliness of safeguarding response in relation to injuries endured and the vulnerability of

both child's parents who were both care experienced. Please see Children in Care section for more information.

In addition, during October 2024 a Rapid Review was undertaken that related to an incident in August 2024 where a child died following a tragic car accident.

The learning points relating to this Rapid Review which was undertaken outside of the reporting period were the following:

- KBSP to request that Public Health partners review messages in relation to use of car seats and ensure that these messages are accessible to families whose first language is not English. Consideration should also be given to how and when these messages are shared with families arriving in the UK as refugees or seeking asylum including links with Sanctuary Services.

- KBSP to request that Safeguarding in Education team develop a communications plan for information to be shared with schools regarding specialist services available to support refugee and asylum-seeking families. This should include how to access training to support professional development of staff and the importance of understanding the whole family including history and the potential impact of trauma for these families.

- KBSP to undertake multi-agency quality assurance with a focus on trauma informed approaches to work with children and families and ensure that an action plan is put in place as required. This should take a particular focus on practitioners demonstrating professional curiosity to look beyond the presenting factors and consider what may be driving these. This should also include the importance of considering the potential impact of issues across the whole family.

- KBSP to oversee a partnership task and finish group to review translation and interpreting services and cultural competence and maintain oversight of individual agency plans to address identified areas for development.

- Learning from this review to be shared across the partnership and disseminated to all agencies, schools and primary health care settings as well as with neighbouring local authorities.

There are two CSPRs (Child Safeguarding Practice Reviews) underway. One is focussed on the Serious Youth Violence incidents that occurred in February and March 2024 and the other relates to the death of 3 young children by their parent. Further Panel meetings have taken place during this reporting period, and it is expected that the draft reports will be shared with Panel members by December 2024.

Learning briefings relating to these two CSPRs referred to above were published in September 2024 and can be viewed here- Welcome to the Keeping Bristol Safe Partnership website.

There were two CDOP meetings that took place between July-September 2024. Here are two practice points that were raised:

1. There was some learning identified for SWAST colleagues in relation to concerns around managing clinical pathways for children who have a shortness of breath and how this is escalated. A review and amended protocols have been put in place for SWAST colleagues.
2. There was some good practice identified in one case in how interpreters were used which was positive by the junior doctor and physiotherapy team in UHBW.

Current risks and mitigations relating to safeguarding work programmes

Current Risk/Issue	Actions underway to mitigate the risk	Deadline
There is an issue that all 3 local authority areas have a safeguarding work programme focus on managing 'Risk outside of the home', and that each area will have a different tool, strategy or approach to tackling this	Designated Nurse for Safeguarding Children to bring together the 3 strategic leads from across the 3 local authority areas to share ideas and information, with an aim of reaching a consensus on principles being the same to support health practitioners across the BNSSG footprint. Police colleagues would also benefit from a systemwide approach also.	January 2025
CP- IS (Child Protection Information Sharing) system – a national flagging system held by NHSE	Discussions to be had with all 3 local authorities in how children can be flagged on this system for concerns relating to ROTH when they are not on a Child Protection Plan.	January 2025

Children in Care and Care Leavers

A Care Leaver work experience group (led by the ICB) has been making good progress and local partners have already ring-fenced certain posts that will be open to care experienced applicants first. How the outcomes of the working group will be embedded when the programme ceases is still being worked through. Another gap which has been highlighted is how managers are supported to provide trauma-informed line management support to those postholders in understanding the additional needs that this cohort may have. This is work in progress by the working group. To support this the ICB Safeguarding team are ensuring that children in care and care experienced young adults are explicitly referenced in their Safeguarding policies.

The offer of free prescription exemption certificates for eligible care leavers is now available and received positively with applications being deemed as eligible.

The access to dental services pilot is also now live and is accessed via Sirona's children in care team. Anecdotal feedback from the carers and participating dental practices is positive, discussions regarding a formal evaluation are yet to be had. Data in relation to how well this has been accessed and the experience of care experienced children will be available for the next report.

Themes and trends in relation to Corporate Parenting Boards

All 3 Corporate Parenting Boards have seen a positive improvement in their Children in Care receiving timely Initial Health Assessments nd team managers across all 3 have worked with Sirona to promote continuous improvement. Where performance has dipped, the data now shows why, and Sirona and the Local authorities work in collaboration to seek improvement.

While there continues to be some children placed in unregistered/unregulated placements, all 3 local authorities are working with Ofsted and providers to reduce these numbers. For example, North Somerset at the time of writing only have one unregistered placement actively supporting a child in their care.

Bristol Corporate Parenting Board is having a development day in November 2024 to look at its strategic plan and agree priority setting for the Board and thus its corporate parenting partners. The ICB will be represented by the Deputy Designated Nurse for Children in Care and Care Leavers.

South Gloucestershire, led by their Head of Corporate Parenting, are working on a more formal and robust transitions pathway which should include all children with SEN (Special Educational Needs), Children in Care and Care Leavers. This work is ongoing and has been actively supported by agency partners including the ICB.

North Somerset have agreed a shared Care Leavers Housing Protocol which encourages collaborative working across essential services under their corporate parenting duty and aims to ensure that they have both suitable housing as well as the right support to live as independently as possible.

All 3 Corporate Parenting Boards remain concerned about the lack of focussed mental health support that these children and young people receive from all tiers/levels of support, but particularly from tier 2 as well as the formal CAMHS and AMHS offers. This is owing to the waiting lists, inequitable services in North Somerset and vulnerabilities of this cohort. The system Children's Operational Delivery Group which reports into the Health and Care Improvement Group are sighted on these concerns and specifically the inequitable service in North Somerset for Children in Care who require support from mental health services is one of the prioritised funding requests. Further exploration of this issue and how AWP can manage respond to these concerns will be tabled at the next Enhanced Contractual Oversight Meeting.

Learning from statutory safeguarding reviews specific to this cohort

As noted above, there was a Rapid Review undertaken in September 2024 relating to a young child who was found to have several injuries, although this level of injury did not meet the threshold for a safeguarding review- safeguarding partners all agreed to undertake one on the basis of quality and timeliness of safeguarding response to concerns raised by health agencies including maternity services.

The key learning points identified were the following.

- There was a lack of information gathering at the point of the safeguarding assessment to include information held about the care experienced young parents so that a subsequent service could be offered to the family.
- There was some complexity in relation to family members and arrangements which could confusion for professionals involved with the parents which flagged the importance of informative multi-generational family trees and establishing an agreed practice standard.
- There was some learning in relation to strategy meetings held; training offered to system partners, use of the non-mobile baby protocol etc.

Current risks and mitigations relating to Children in Care and Care Leavers work programmes

Current Risk/Issue	Actions underway to mitigate the risk	Deadline
Children in Care in Out of Area Placements - OOA funding and the CIF (Child Individual Funding) request process	Internally mapping of the ICB process is being finalised CIF requests continue to be quality assessed and overseen by Designated Nurse and Deputy. System workshop planned for 9th December to discuss process and rationale behind CIF form revisions and process.	December 2024
Possible future risk – loss of dental provision if pilot not carried forward	Awaiting figures from Sirona and to agree formal evaluation process	Evaluation through Q4 to support forward funding plans – March 2025
Ensure that the care leaver free prescription monies is ring-fenced moving forward	Share with CNO/CMO SMT to agree future plans for budget etc..	February 2025

Safeguarding Adults

Themes and trends in relation to Safeguarding Adult Boards and Community Safety Partnerships

Work in relation to the Adult Multi-Agency Safeguarding Hub (MASH) in Bristol has been progressing at pace. This has been developed as a result of learning from safeguarding reviews which have recommended the need for a MASH to provide early decision making and strategic input on complex cases with the potential to progress to Safeguarding Adults Reviews (SARs). The Adult MASH pilot started in September 2024 with 1 multi-agency meeting a week to look at new safeguarding concerns. Since then, work is ongoing to

extend and expand the pilot, so that more cases can be discussed. The ICB is supporting with this work and will provide an Adult MASH Nurse as a health representative for the MASH, this position will be supported by a secondment, and we hope to have the successful candidate in post by February 2025. This has been a key priority from the Keeping Bristol Safe Partnership and will need system funding from March 2026 if evaluation proves that the MASH is effective in reducing risk and multi-agency working.

North Somerset Community Safety Partnership have been developing their policies and processes around domestic abuse to further improve their system response. This has resulted in making the decision to trial increasing the frequency of the Multi-Agency Risk Assessment Conference (MARAC) to once a week. This decision has been made to try to make the meeting more accessible to partnership members, particularly the police, by making the MARAC shorter but more frequent. The evidence from the pilot so far is that this has been successful, meaning that domestic abuse cases brought to MARAC are able to have more holistic protection planning discussions with representatives from all agencies present. Further evaluation and impact assessment is required to better understand how this change would affect health partners specifically.

South Gloucestershire are continuing to conduct Quality Assurance Audit's into their safeguarding practice. Since July 2024 two audits have been conducted into Sexual Abuse and Safeguarding Enquiries impacting adults aged 18-25 years of age. Both of these audits have highlighted the importance of involving advocates at all stages of Safeguarding Adults. As this has been a consistent theme throughout all the Quality Assurance Audit's over the previous year, the SAB will decide whether advocacy will be listed as one of the SABs priorities moving forward.

Learning from statutory safeguarding reviews (SARs and DHRs)

During this period there has been a considerable amount of activity in relation to adult statutory reviews, with 2 new SARs and 1 new DHR being commissioned in Bristol; and 2 new SARs and 1 new DHR commissioned in South Gloucestershire. The 2 SARs in Bristol both related to self-neglect and have therefore been grouped together into a thematic SAR. Early learning from these indicates the importance of practitioners' awareness of fire risks, how to refer to Avon and Wiltshire Fire and Rescue and understanding around mental capacity assessments. The SARs in South Gloucestershire both relate to Neglect and Acts of Omission. Self-Neglect (45%) and Neglect and Acts of Omission (35%) are the two most common abuse types in SARs opened or published in the BNSSG area between Oct 2022 and Nov 2024. This is in keeping with national statistics.

Within DHRs currently, we are continuing to see connections between domestic abuse, mental health and suicide. This is prevalent in both male and female victims of domestic abuse. To address this, learning has been identified about the use of routine questioning to identify domestic abuse concerns, the promotion of training to promote the identification of domestic abuse and ensuring that multi-agency guidance into both domestic and suicide prevention include the interconnections between domestic abuse and suicide.

There have been three Domestic Homicide Reviews published within this period (July-Sept 2024). All of these DHRs were from Bristol. There was particular learning from DHR Julia (published 9th September 2024) for the health system, as this report provided evidence of

good practice, in relation to the involvement of interpreting services and provision of accessible information by both the GP and Avon and Wiltshire Partnership Trust (AWP). DHR Julia also highlighted the importance of GP registration as Julia had not registered with a GP at the time of her death, as she was deemed to be outside the catchment area. A recommendation was therefore put in place that "*New residents, particularly for those for who English is not their first language, to be supported to register with a GP practice*". To address this the ICB have shared guidance through a GP bulletin to remind staff to signpost other GP practices that are in the service users' catchment area. In addition, the ICB Primary Care Safeguarding Team are currently working on a supplementary safeguarding registration form for GP surgeries, to support GPs to be aware of any relevant safeguarding or domestic abuse concerns for new patients registering at the practice.

Please follow this link to read the DHR in full. Welcome to the Keeping Bristol Safe Partnership website.

Current risks and mitigations relating to safeguarding adult work programmes

Current Risk/Issue	Actions underway to mitigate the risk	Deadline
Weekly MARACs in North Somerset	These remain in the pilot phase and the ICB are continuing to support and monitor this change. If there are capacity issues with attendance, then the ICB will share these concerns as a member of the CSP where the decision was made the pilot this change.	January 2025
Bristol Adult MASH pressure to increase meetings to 3x weekly	The ICB have been clear that the team are unable to support attendance at 3 MASH meetings a week until an Adult MASH Nurse is in post. It is hoped this will be in place by February 2025.	February 2025
Outstanding Recommendations from Adult Statutory Reviews - currently there are considerable number of Actions outstanding from Adult Statutory Reviews. This is in relation to the number of Statutory Reviews that have been	A Stat Review Recommendation Tracker has been completed and the ICB are auditing the Tracker on a monthly basis to ensure the team remain on track to complete all the assigned actions. This has also involved meeting with different SAB managers to ensure that	March 2025

completed and published over the last year	recommendations / actions are achievable for the ICB. The ICB will also be alerted to any outstanding actions required from Health Partners.	

Systemwide Safeguarding Transformation Programme

As per previous reporting, a Systemwide Safeguarding Transformation Programme is being undertaken to explore what opportunities there are to create a safeguarding arrangement or set of arrangements that support the population of BNSSG and has a focus on prevention, de-escalation, protection of the whole family – adults and children and is assured NOT reassured that organisations are compliant with safeguarding statutory duties.

A Project Group was established in August 2024 consisting of strategic leaders from all 3 local authorities for safeguarding children and adults, police colleagues and the Head of Safeguarding from the ICB Safeguarding team. The Project Group has worked through a number of tasks assigned to them from the System Executive Group including.

- Writing a problem statement/aspirational statement
- Learning from other areas and their safeguarding arrangements
- Reviewing the 'as is' position of the 5 different parentship arrangements/safeguarding adult Boards
- Making recommendations for next steps.

A system workshop took place with Executive Sponsors on 5th November 2024 which is more recent than the reporting period for this paper but is important for awareness. At the workshop, feedback was ascertained from Executive Directors across local authorities, police and ICB in relation to the Aspirational Statement, early opportunities in relation to a 'Design Phase' were also explored and the Governance arrangements for this transformation programme was discussed.

Executive Directors from Bristol City Council were unable to attend the system workshop mentioned above, and there were concerns raised by South Gloucestershire colleagues in relation to the capacity to support this work given the limited resource in their Business Unit. Therefore, a 'Current position' paper is currently being worked up by the Project Group so that further steer can be ascertained from either Executive Directors or System Executive Group on the next steps.