

Meeting of the BNSSG ICB Board Open

Date: 5/3/2026

Time: 1230-1530

Location: Bristol Citadel Community Church and Family Centre, 6 Ashley Road, St Paul's, Bristol BS6 5NL

Agenda Number:	7.1	
Title:	Quality Report – cover 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	no
	Other (Please state)	No
Purpose: Discussion & Information		
Key Points for Discussion:		
<p>Updates from System Quality Group</p> <ul style="list-style-type: none"> Challenges on system urgent care flow continue, with pressures on no criteria to reside (NCTR), temporary escalation spaces and pressure in ED. The System Quality Group in December reviewed changes in urgent care flows, assessed current risk profiles, and ensured that system-wide mitigation strategies were in place ahead of winter and industrial action. Partners provided updates on actions taken to address key risks which are detailed in the main report. BNSSG plans to replace its current neurodiversity pathway with a jointly delivered, needs-led model that provides early support. BNSSG currently has no local Tier 4 CAMHS provision after the closure of Riverside and Wessex House, resulting in out-of-area placements. While the Trust explores long-term estate options there is a reliance on temporary placements and strengthened crisis/home treatment services <p>Infection Prevention and Management</p> <ul style="list-style-type: none"> The ICB is appointing some fixed term IPC/AMR leadership capacity to focus on MRSA and soft tissue infections. 		



- Influenza rates have declined to low background levels.
- Consequences of pressures in the urgent care pathway may be associated with some infection outbreaks such as C. difficile in in-patient settings due to 'boarding'. These have not been confirmed at the time of writing but are being monitored carefully.

Funded Care

- Continuing Healthcare (CHC) 28-day KPI for Q3 achieved 58% (Oct 62%, Nov 61%, Dec 50%) against the 80% standard. Performance reflects capacity issues within the team and a continued high number of referrals. A recovery action plan is in place and detailed in the main paper.
- Adult Continuing Healthcare (AACC) remained in recovery mode throughout Q3. Quarterly performance averaged 58%, with a monthly profile of 62% (Oct), 61% (Nov), 50% (Dec) against the 80% standard. The team continues to be impacted by increasing new CHC referrals for which in December 2025 were 22% higher than the previous year. A number of performance recovery actions are detailed in the report.
- The FNC caseload reduced to 2,219 at end December 2025, continuing the downward trajectory from 2024/25. Ongoing review work is removing ineligible cases and aligning practice.
- S.117 - ICB and LA colleagues are reviewing options around approaches to funding splits for S117 cases and opportunities to drive wider system efficiencies via a S117 programme of work.
- Joint working between the three LAs, ICB, the appointed care provider Agincare and the housing association Elim Housing is progressing with a view to the first two residents moving into the service from March/April 2026

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 ELT and 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 ICB Extended Leadership Meeting, Outcomes, Quality, & Performance Committee, and ICB Board for information and discussion.
Author(s):	Michael Richardson, Deputy Director of Nursing and Quality, BNSSG ICB <i>et al</i>
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd, Chief Nursing Officer, BNSSG ICB

BNSSG ICB Quality Report

February Report on Month 7/8/9 (October - December) 2025

1. System Quality Group (SQG) and National Quality Board (NQB) process updates from this reporting period

1.1 System Quality Group (SQG) December 2025

SQG reviewed the following areas:

Single item agenda meeting on Winter Pressures

The purpose was to review changes in urgent care flows, to assess current risk profiles, and to ensure that system-wide mitigation strategies were in place ahead of winter and upcoming industrial action, emphasising a collaborative approach to managing patient risk. Partners provided updates on actions taken to address key risks:

- Coordinate a system-wide refresh of the Dynamic Risk Assessment.
- Validated data to be shared on the reduction of harm by ICB footprint, following the implementation of the (Timely Handover Process) THP, to support workforce communication and address incivility concerns.
- Data on the impact on the Community Emergency Medicine Service (CEMS) to be provided, to inform system partners.
- Initiate a system-wide approach to identify and support the top ten to twenty high intensity users across organisations, sharing data and coordinating interventions through the Transfer of Care (TOC) Hub and linking with existing MDT work on challenging users.
- Review and enhance communications strategies to address vaccination inequalities.
- Commission modelling of current activity and projected frailty numbers for next winter under a “do nothing” scenario to inform planning and resource allocation.
- Plan a collaborative system-wide review to simplify urgent care pathways, reducing variability and complexity for staff accessing services, with input from commissioners and providers.
- Add audit of low intensity users/patients not seeking timely medical help to list of work for early 2026.

1.2 System Quality Group (SQG) January 2026

Neurodiversity Business Case

BNSSG’s diagnosis-led approach to supporting neurodivergent children is no longer sustainable due to rising autism/ADHD referrals, long waits, and unmet needs. A new needs-led model, focused on early support without requiring diagnosis and delivered jointly

across health, education, and social care, was proposed, and supported. The paper is going to ICB Board.

Impact of CAMHS Tier 4 closures on BNSSG Young People Admissions

The closure of Riverside and Wessex House means BNSSG currently has no local Tier 4 CAMHS provision, leading to 103 young people being placed across the region and nationally since January 2024. An independent review found Riverside unsuitable for future Tier 4 use, and NHSE is updating the service specification to support young people with more complex needs. The Trust is exploring alternative estate options, but significant capital requirements mean no reopening before 2027/28; in the meantime, temporary placements and strengthened crisis/home treatment services are being used to mitigate impact.

Learning from Patient Safety Events (LFPSE) platform update

The LFPSE service has received 5.4 million records and now has over 16,000 active users, with 14 vendors offering compliant systems. Although development slowed between January 2024 and September 2025 due to limited supplier support, progress has continued through data validation work and regular publication of official statistics. Since September 2025, new partner Kainos has begun planning the next phase, which will focus over the next 12–18 months on improved data access, integration with the Regional Data Dashboard, better feedback for reporters, enhanced tools for national reviewers, and redesigned online reporting forms. For BNSSG this will mean richer and more accurate availability of patient safety data later in 2026/27.

1.3 National Quality Board Escalation Process Updates

Avon & Wiltshire Mental Health Partnership NHS Trust

The plan remains for AWP to be stepped down from Enhanced Contractual Quality Oversight Meetings into routine surveillance by the end of March 2026. This is being delivered through a series of deep dives that have been presented to the oversight meetings. Please see separate paper (AWP SBAR paper).

Sirona Care & Health

Sirona confirmed to the CQC in July 2025 that all requirements contained within the CQC warning notices had been met, and a reinspection was carried out by the CQC earlier this month. The CQC Report following the reinspection is awaited. The provider remains in enhanced surveillance; please see separate paper (Sirona SBAR paper).

Community Learning Disability & Autism Services – quality improvement work

This is a system/multi-agency piece of work being led by the ICB, with AWP and Sirona being key players. The improvement work continues at pace, and a governance structure has been set up between Sirona & AWP, with oversight from the executive. A joint event is being planned, and it was agreed this work should be allowed to progress, and an update on the agreed proposals to improve the pathway be brought back to a future HCPE/SQG Meeting in Common.

2. Patient Safety

Purpose of this section: *To provide assurance that our partners and the system are applying patient safety governance commensurate with the NHSE Patient Safety Strategy. This section also highlights areas of patient safety concerns in the system and mitigations.*

NBT Stroke Performance

NBT continues to experience high bed occupancy, leading to increased outliers. Issues include limited community capacity, which has been escalated to the ICB's Organisational Delivery Group and Health Care Improvement Group for review against the original business case. Improvement actions include implementing an NBT "hot bed" Standard Operating Procedure (SOP) and working with the ICB to strengthen community provision. This work will be presented to the System Quality Group in Q1 2026/27.

UHBW Neck of Femur performance

Patients with a fractured neck of femur should receive surgery within 36 hours. UHBW achieved 46.6% in December against the 90% target, largely due to limited theatre capacity at both the Bristol Royal Infirmary and Weston General Hospital. To improve performance, additional theatre space is being created where possible, and at WGH elective lists are repurposed at short notice to support trauma activity.

Sevenside

Sevenside has adopted 'CLEO', a patient management system that streamlines patient journeys, improves clinical safety, and enhances operational efficiency. Integrated with EMIS and Connecting Care, CLEO gives clinicians timely access to key information, enabling quicker decisions and better outcomes.

Central Alerting System (CAS)

UHBW has one outstanding alert relating to an epidural bag supply issue; all actions are complete and closure confirmation is pending. Sirona still has an open bedrails alert due to non-compliant rails that pose entrapment or fall risks. They have met six of seven requirements, with the remaining action focused on completing a retrospective patient list. Sirona is using its active caseload list to complete this work and expects to close the alert by March 2026.

Primary Care Committee

The Southwest Collaborative Commissioning Hub (SW CCH) provides quarterly quality reports to the ICB. Although these reports summarise inspection outcomes, quality issues, risks, and concerns, the level of detail is limited. To mitigate this, the ICB's Medicines Optimisation, Patient Safety, and Customer Services teams are working collaboratively with SW CCH to ensure both organisations have the information required to meet their responsibilities effectively.

Mental Health Act (MHA) visit to Bradley Brook unit

15 of the 17 previously identified concerns by CQC have been fully resolved, with one partially resolved and one outstanding. The remaining actions relate to ensuring MHA Advocacy attendance at seclusion reviews and completing Estates work to replace a scratched window in a seclusion area.

AWP

- **Estates** - The installation of ligature-prevention doors on Cherry Ward was completed in October 2025. The work was managed through a reduced bed base, partitioned corridors, and increased observations, with no patient-harm incidents reported. All Trust-owned sites now have these doors installed.
- **Corporate Risk Register – Duty of Candour (Score 12)** The CNO has reviewed the risk, and actions are underway, including divisional audits of Duty of Candour decisions to strengthen assurance. Standardised processes are now embedded within Event Review Meetings.
- **Training Compliance** - Reducing Restrictive Intervention and Resuscitation training compliance fell below the 90% target in August 2025. By December, overall AWP BNSSG compliance reached 90%, though North Somerset remains below target. Full compliance is expected by March 2026.
- **Recording of Protected Characteristics** - Each locality has developed an action plan to improve low recording rates. From January 2026 (M10), a formalised improvement plan with clear trajectories will be implemented, aligned with the Trust-wide Patient and Carer Race Equality Framework (PCREF)."

Cygnets Kewstoke

A thematic review on Knightstone Ward identified that most ligature incidents occurred in patient bathrooms, with peak risk between 8pm and 10pm. All items used were standard patient-accessible items. In response, evening activities were increased, and a staff presence was ensured in the patient lounge.

Cygnets' annual culture review scored 90% (54/60), with improvement areas focused on care planning, and the service has achieved Triangulation of Care accreditation.

Kewstoke is strengthening its relationship with Weston General Hospital, particularly the Emergency Department, supported by reciprocal visits and planned joint training. Wider partnership work with the Police, SARI, and a local college continues, along with parish-council-led community initiatives such as litter picking. These activities support community integration and enhance service-user experience.

Rethink – Men's Crisis House

Previous management concerns have been addressed through the appointment of a new area manager and house manager. The service now offers an expanded and structured activity programme with strong resident participation. Residents report improved engagement with staff, contributing to more effective working relationships. Collaboration with AWP, as the referring and clinical support provider, has also strengthened.

BNSSG Wound Care Strategy Group

The 'Stop the Pressure' conference in November, was attended by around 100 staff from across the system. The event included speakers and interactive case studies focused on patient-centred pressure-ulcer prevention. Health Innovation (HIN) West is supporting a review of provider lower limb pathways, mapped against the National Pathway to identify gaps.

3. Infection Prevention and Management and Health Care

Acquired Infections (HCAI)

Invasive pneumococcal disease/Strep pneumonia – North Somerset care setting outbreak

A meeting on 16.12.25 reviewed two linked resident deaths in a 60-bed care home. Both symptomatic residents were admitted on 3/12/25 and 5/12/25, with the same strain identified. No other residents were symptomatic, though staff-to-resident transmission was suspected. Enhanced IPC measures were implemented, and the practice/pharmacy prescribed antibiotics for all residents and high-risk staff. UKHSA provided 60 doses of a novel vaccine under its compassionate use policy, and residents (including new admissions) and vulnerable staff were vaccinated over Christmas.

Healthcare Associated Infections

Table below shows position in November 2025 showing age/sex standardised rates of infection/s:

Rates per 100k	South West Position										
	BSW	BNSSG	Devon	Dorset	Glos	Kernow	Somerset	SW	England	BNSSG	BNSSG Age/Sex Standardised
C. diff	29.78	32.90	38.95	39.80	27.04	50.02	36.36	36.01	30.84	3	6
E. coli	59.15	62.30	83.95	81.91	35.31	80.43	88.47	70.42	70.97	3	6
Kleb spp	18.66	17.39	21.83	25.64	10.05	20.61	25.13	19.93	21.85	2	3
MRSA	1.02	4.06	2.04	3.05	1.03	0.33	1.34	2.01	1.73	7	7
MSSA	20.70	20.51	30.23	30.40	15.51	26.75	30.83	25.04	22.43	2	3
Pseud A	7.55	6.14	5.34	7.45	2.81	6.31	7.20	6.13	7.27	3	5

Table below shows position in November 2025 showing YTD cases against threshold:

Infection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Threshold to Date	Cases YTD	Threshold	23/24 FYTD	22/23 FYTD
C. difficile	22	29	25	25	41	37	28	29					195	236	292	208	196
E. coli	48	49	70	76	60	72	74	52					367	501	551	383	345
Klebsiella spp	18	22	17	10	11	15	15	23					111	131	167	122	115
MRSA	3	0	4	4	3	2	3	2					0	21	0	24	20
MSSA	16	18	12	22	18	22	16	18						142		142	126
Pseudomonas aeruginosa	9	6	3	8	6	6	10	4					37	52	56	40	45

MRSA – See separate SBAR paper

Clostridioides difficile (C. difficile) – Infection in BNSSG was reducing following a spike in September 2024 (44). Following an increase in August 2025 (41), November had a lower case-count. Community onset scrutiny reviews continue monthly in conjunction with the BNSSG CDI improvement plan. An outbreak in an acute setting of 8 cases determined that

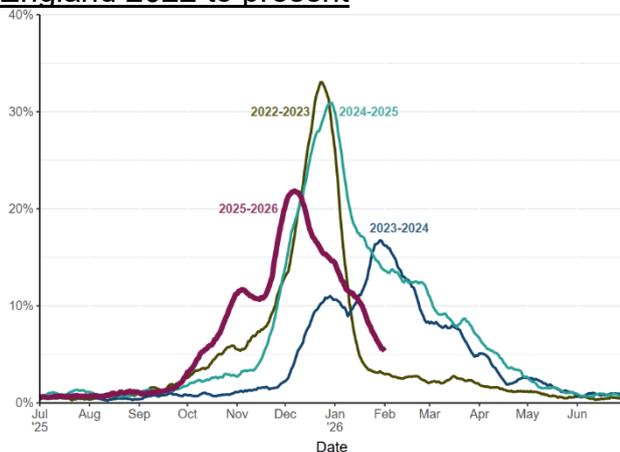
staff/patient transmission may have been possible and may have been linked (but not established) to boarding patients or cleaning.

E.coli - cases declined in November. Most infections remained Community Onset, Community Acquired. Acute and community microbiology teams are analysing recent peaks to determine whether cases were linked to urinary tract infections and whether this group may benefit from targeted risk-reduction interventions.

Other Infections

Influenza – The UK Health Security Agency (UKHSA) report from 5 February 2026 (week 6) shows that influenza activity has declined and is now at low levels. Emergency department attendances for influenza-like illness and confirmed acute respiratory infection incidents have also decreased. Among viruses subtyped, Influenza A (H3N2) remains the predominant strain. Influenza test positivity fell to 5.4% in week 5, down from 7.1% the previous week. Positivity rates were highest in children aged 5–14 years at 9.5%, a reduction from 11.9% the previous week.

Rolling 7-day positivity of tests positive for influenza among all reported influenza tests, England 2022 to present



Ref: [National flu and COVID-19 surveillance report: 5 February 2026 \(week 6\) - GOV.UK](https://www.gov.uk/government/news/national-flu-and-covid-19-surveillance-report-5-february-2026-week-6)

Influenza vaccination rates are as follows:

Cohort	BNSSG Percentage uptake 2025/26 (1/9/25 - 8/2/26)	BNSSG 2025/26 Ambition	BNSSG Percentage uptake 2024/25 Flu season
2 and 3 year olds	52.79%	57.78%	49.87%
65 yr and over	79.65%	81.00%	80.53%
Flu at risk	64.49%	n/a	61.28%
Under 65yr and at risk	50.43%	52.21%	45.08%
Pregnancy	57.29%	n/a	34.93%

**Data as per NHS Federated Data Platform (FDP) used for operational management*

Flu vaccinations continue to be available across BNSSG, with uptake rates remaining higher than the national average. Uptake has increased among pregnant people, clinically at-risk groups, and children aged 2–3 compared with the 2024/25 season. A slight slowdown is evident in the 65+ age group, which may require renewed engagement. Staff vaccination rates have also improved, with all local trust hospital hubs reporting higher uptake than last season.

Hospital Hub	2025/26 uptake to date (3/2/25)(%)	2024/25 uptake (%)
NBT	54.8%	47.9%
UHBW	56.1%	50.1%
AWP	51.3%	45.8%

COVID-19 activity remains at baseline levels, with emergency department attendances for COVID-19–like illness showing a slight increase. Reported SARS-CoV-2 acute respiratory infection incidents in week 5 were unchanged from the previous week.

The BNSSG COVID-19 vaccination programme achieved 67.66% uptake between 01/10/25 and 03/02/26, exceeding the national rate of 57.14%.

4. Funded Care

Executive Summary

Performance

- Continuing Healthcare (CHC) 28-day KPI for Q3 achieved 58% (Oct 62%, Nov 61%, Dec 50%) against the 80% standard. Performance reflects capacity issues within the team and a continued high number of referrals. Recovery action in place – see below.
- Fast Track caseload increased in December but overall remains below target levels for the year.
- Funded Nursing Care (FNC) caseload continues to reduce in line with planned trajectories.
- Learning Disabilities and Autism (LD&A) inpatient numbers are above trajectory due to an increase in mainstream mental health hospital admissions and long-stay cases.

Key challenges

- High CHC referral volumes, partner capacity for joint decisions, and an inexperienced workforce impacting throughput.
- LD&A trajectories missed (LD 25 vs target 21; Autism 15 vs target 11; total 40 vs target 32).

Actions

- Revised CHC assessment operational model introduced in December 2025 to recover 28-day performance by streamlining nurse assessor functions.
- Targeted outsourcing to create short-term surge capacity and address the increase in referrals
- Multi-agency support to mobilise of Oldland Common step-down LD&A unit (renamed Elizabeth Close), with first admissions in March/April 2026.

CHC Finance

- The All-Age Continuing Care (AACC) savings and efficiency programme is delivering ahead of profile and forecasting £6.8m savings for 2025/26. As a result, the AACC budget is forecasting a £1m underspend against a budget of £141m.

Adult Continuing Healthcare (CHC)

AACC remained in recovery mode throughout Q3. Quarterly performance averaged 58%, with a monthly profile of 62% (Oct), 61% (Nov), 50% (Dec) against the 80% standard.

The team continues to be impacted by increasing new CHC referrals for which in December 2025 were 22% higher than the previous year. Key drivers behind the increases are noted as:

- Care Home referrals 54% higher than average
- Local authority referrals 32% higher than average

The CHC caseload stood at 551 at end of December (-0.9% versus November).

Performance recovery actions

A number of actions are being taken forward to recover 28-day assessment performance:

- Revised CHC assessment operational model introduced in December 2025 to recover 28-day performance by streamlining nurse assessor functions.
- Temporarily diverting staff from 12-month reviews; pausing non-essential work.
- Outsource c.12 assessments/week to UB Healthcare, monitored against 28-day benchmark; daily capacity huddles with flexible allocation.
- Streamlined ratification processes to speed up decision making.
- Escalating issues around the timeliness of LA input into CHC assessments.
- Active wellbeing oversight: stress risk assessment and HR liaison on sickness trends; training to reduce poor quality referrals.

Funded Nursing Care (FNC)

The FNC caseload reduced to 2,219 at end December 2025, continuing the downward trajectory from 2024/25.

Ongoing review work is removing ineligible cases and aligning practice, with rolling audits continuing to show that approximately 30% of new FNC applications lack sufficient evidence of nursing oversight, guiding targeted feedback to referrers.

Fast Track (FT)

The Fast Track caseload ended December at 276 after averaging 257 throughout Q3. The percentage of case overdue a review reduced to 26%, with only 90 patients funded beyond 12 weeks (approximately 32% of caseload). December saw 255 FT referrals, which is a 13% increase from the previous month, and 10% above average.

UB Healthcare contract remains in place to support 3-month FT reviews, and we have strengthened contract oversight to drive further improvements in their processes and support with issues, such as LA related decision delays. Joint work with both acute trusts to refine the Fast Track process continues, plus in reach into the hospitals to expedite issues around discharge.

Mental Health - S117 after care

Case-by-case panels over the past 14 months have improved joint working and clinical input (including AWP presence), but the approach consumes significant time, lacks a codified methodology, and risks inconsistency and escalation. A locally-tested cost-apportionment tool showed potential but is too time-intensive in its current form. Benchmarking shows wide regional variation in approach (fixed splits, pooled budgets, matrices, case-by-case), reinforcing that a local solution must balance statutory compliance, equity, and deliverability. ICB and LA execs are reviewing options around approaches to funding splits for S117 cases and opportunities to drive wider system efficiencies via a S117 programme of work.

Learning Disability & Autism (LD&A)

Inpatient discharge performance

In line with NHSE directives, ICB reporting for this cohort is now split into distinct LD and autism groups. The ICB acts as a system leader to drive the reduction in people with LD and autism detained under the mental health act in hospital.

The target for the end of Q3 25/26 is 21 LD inpatients with the BNSSG at 25 at the date of this report. For autism the target is 11 inpatients and BNSSG is currently at 15. The overall target is 32 inpatients with BNSSG currently at 40.

Of note is that the increase in inpatients has been within commissioned in-area AWP beds, meaning that length of stay is expected to be shorter. There have been no new patients admitted into longer stay placements out of area.

Oldland Common/Elizabeth Close

Joint working between the three LAs, ICB, the appointed care provider Agincare and the housing association Elim Housing is progressing with a view to the first two residents moving into the service from March/April 2026.

The service will eventually support 6 residents, all of whom are currently inpatients in mental health hospitals. The service will play an important part in reducing inpatient numbers.

Meeting of BNSSG ICB Board

Date: Thursday 5th March 2026

Time: 12.30 – 15.15

Location: Bristol Citadel Community Church and Family Centre, 6 Ashley Road, St Paul's, Bristol, BS6 5NL

Agenda Number:	7.2	
Title:	Performance report Month 8 to 9 (November - December 2025/26)	
Confidential Papers	Commercially Sensitive	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: For Information		
Key Points for Discussion:		
This performance report provides an overview of November and/or December 2025 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 report includes any risks, mitigating actions and responsibilities as appropriate.	

Previously Considered By and feedback:	Existing levels of performance are built into the current planning submissions for February which will be discussed at SEG.
Management of Declared Interest:	None declared.
Risk and Assurance:	The report provides an update to Outcomes, Quality & Performance Committee in February 2026 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.
Patient and Public Involvement:	Not applicable to this paper which is reporting on performance metrics.
Financial / Resource Implications:	None referenced.
Legal, Procurement, Policy and Regulatory Requirements:	None referenced.
How does this impact on health inequalities, equality and diversity and population health?	All workstreams targeted at reducing health inequalities including examination of performance metrics by demographic where this is feasible.
ICS Green Plan and the Carbon Net Zero target?	Performance is defined within contracts held by the ICB with providers. The contracts include a section on the Carbon Net Zero Target and an expectation of providers to meet the standards set.
Communications and Engagement:	This report has been provided to Outcomes, Quality and Performance Committee for information and discussion.
Author(s):	Caroline Dawe – Deputy Director of Performance and Delivery, BNSSG ICB.
Sponsoring Director:	David Jarrett, Chief Delivery Officer, BNSSG ICB.

Agenda item: 7.2

Report title: Performance Update Background

The performance report for this month is based on November 2025 and/or December 2025 information.

Appendix 1 contains the operating plan metrics for reference.

1. Urgent Care

Mean Category 2 performance for the ICB in December 2025 was 29 minutes against a target of 30 minutes with lost hours to handover delays better than trajectory. Monthly type 1 performance for both acute trusts at ICB level in December was worse than plan at 63.92% against a target of 69.60%. All types performance at ICB level in December was 72.93% against a plan of 76.65%. Activity in terms of ED attendances and admissions increased in December at both acutes and there is a step change for NBT in terms of numbers of admissions. This created challenges in terms of managing flow. System Opel 4 was declared in late November and also December.

A&E waits over 12 hours from arrival at ICB level in December was 7.15% against a plan of 5.41%, a small improvement from previous months. A&E waits over 12 hours from decision to admit was still persistently high, again reflecting the higher levels of escalation experienced across the system.

111 performance remains good with 2.0% of calls abandoned in December 2025 compared to plan of 3%.

Virtual ward occupancy national standard of 80% was not achieved in December with an improvement plan in place. Urgent care response continues to perform well with the plan achieved in relation to number of 2 hour care contacts and response time.

No criteria to reside (NCTR) position in December was an improvement in terms of numbers compared to November but still above plan. Length of stay for P2 and P3 is still adrift from plan and causing concern. There is a separate SBAR within the OQPC pack which outlines the NCTR position up to January 2026.

POM continues to hold responsibility for system flow along with an oversight of the discharge improvement work related to securing improvement in the levels of NCTR to 15%. POM is trying to secure greater traction on takt times in relation to LA length of stay with demand and capacity work now taking place outlining what capacity there is within community services to try and move the system away from bed only solutions. GIRFT best practice is now available for community which will be weaved into the discharge improvement work. Modelling by Sirona on how to reduce the NCTR in the community has been undertaken and a delivery plan is being put together across the system to see how this can be enacted.

The UEC operational delivery group (ODG) has reviewed performance across the system, discussed mitigations in respect to the stroke pathway, trying to build additional flex into the system as per the business case, commenced updates on the immediate 5 year strategic

plan key workstreams e.g. care coordination, and updates from the interface group. Planning has been a key consideration including risks to delivery in 2026/27 onwards. These include NCTR with a new trajectory put forward with system oversight to base plans on in relation to UEC and elective care targets; ambulance handover trajectory to help achieve the Category 2 targets. ED performance for 2026/27 can still count MIU activity which will support the system in overall ED performance. Discussion has also taken place on the MH ED and capital monies secured by AWP to ensure links with the MH ODG in this area of planning.

2. Mental Health

Areas of key focus within mental health are discussed below.

Average length of stay for adults in acute beds is achieving above plan for BNSSG in November 2025 with an average length of stay of 63 days compared to plan of 64.10 days. Inappropriate out of area placements has remained consistent at 0 at ICB and AWP level against a plan of 0 at end November. Access to perinatal services continues to perform above plan in November 2025. The talking therapies measures were both above plan in November 2025. Reliable recovery rate achieved 52.42% against plan of 48% and reliable improvement rate achieved 67.72% against a plan of 67%. Activity levels (all types) for talking therapies is still below plan including completed courses of treatment. However, outcomes as shown above remain consistently above targets. Access to employment (IPS) support remains above plan.

The mental health ODG has received key updates from work programmes including:

- A workshop held to assess and determine the options of establishing a MHED at Callington Road. Overall agreement on developing at this site with working groups now being set up to determine a clinical model, impact on all parts of the system and links with other key areas of work including high intensity users. This work has been fed back to NHSE in line with the capital monies being secured by AWP for this purpose with some revenue funding within ICB baselines in future years.
- The crisis text procurement has now closed and bids are being evaluated.
- The crisis at night services will move into the integrated access partnership from April 2026.
- Increased national scrutiny around Staying Safe from Suicide with NHSE now requiring quarterly assurance.
- Updates on community mental health programme including MINT performance review which is very positive but with small teams can be fragile; the next step to integrate with primary care liaison service; and looking at ways to move to a holistic model for people with complex mental health needs as part of the accommodation work.
- Planning has been a key area for the ODG with compliance secured in all operating plan ambitions.

The ODG also received updates on performance and finance. Risks are reviewed at each ODG meeting including psychological therapies, finance pressures in relation to patient placements and assertive outreach review findings where the risks are decreasing.

3. Learning Disability and Autism (LD&A)

LD&A measures in 2025/26 focus on a reduction in inpatient care as well as a focus on annual health checks. Reliance on inpatient care for adults with a learning disability in December 2025 is at 25 against a plan of 21, reliance on inpatient care for autistic adults in December 2025 is at 15 against a plan of 11. Whilst this performance is disappointing we have made progress over the last couple of months and are assured that we will have 12 discharges in the next 6 months. These relate to 6 high cost relatively low complexity ICB newly commissioned beds and 6 which are long stay more complex provider collaborative beds and therefore have greater unpredictability. LD&A annual health checks are at 2339 against a plan of 2190 for November 2025.

Monitoring and management of indicative autism and ADHD activity plans is still ongoing with further overperformance against the plan set. This is still a major source of financial pressure for the ICB and the system. Work is ongoing in relation to a new adult ADHD pathway working closely with primary care leadership and with AWP with the aim to try and release a local enhanced service for April 2026. The business case and draft LES agreements are now going through governance routes to try and obtain sign off before April 2026.

Assurance in relation to LD&A performance is sought through the LDA ODG. The following areas have been reviewed at the ODG including performance, finance, learning from safeguarding and LeDeR reviews. An update on the Kingfisher Unit which is approved for opening with workforce risk now reducing due to successful recruitment. An options appraisal for implementation of the digital dynamic support register (DSR) seeking alignment with Gloucestershire ICB adult DSR process. The tender process for Oldland Common has now completed. The strategic commissioning plan has also been developed which helps inform the planning round. Planning for 2026/27 and onwards has also been a central theme with key priorities identified as well as risks including financial pressures driven by Section 117 and Right to Choose providers. Priorities for future years include shifting services from hospital to community with local work already in place on local facilities e.g. Oldland Common, digital priority relating to DSR, and prevention with annual health checks.

Items for Escalation:

1. Right To Choose and escalation of costs

Through new national guidance GPs and Patients have the right to choose any ADHD/ASD provider offering assessments and treatments when referred by their GP. These costs have escalated exponentially over the past two years. The only levers available to the ICB to manage activity within the financial envelope is through indicative activity plans, however, poor data flows and capacity within the ICB means this is a financial risk area as well as quality related to different pathways and standards with each provider. A steering Group has been set up within the ICB to bring finance, performance, contracting and transformation colleagues together and communications to GPs and system partners needs to be released.

4. Elective Care

Elective performance continues to hold a good position. Referral To Treatment (RTT) over 52 week waits continue to be ahead of plan at ICB and acute trust level. For the ICB at 525 against a plan of 634 at November 2025. This equates to 0.58% of waits greater than 52 weeks ahead of the 1% standard. RTT 18 week performance at acute trust level at end November 2025 is slightly below plan at 66.88% against target of 69.76% with clear

mitigations in place and discussed weekly with NHSE and ICB. Wait to first outpatient appointment in less than 18 weeks is at 70.29% against a target of 70.74% at acute trust level in November 2025.

The overall diagnostic position (percentage of diagnostic tests seen in less than 6 weeks) at ICB level is at 93.61% in November compared to a plan of 95% so below plan but in aggregate exceeding 26/27 national target. Overall the ICB is ranked first nationally and first in the South West. Performance is better than plan in CT and echocardiography. Activity is on plan in most modalities with DEXA and non-obstetric ultrasound below plan. NBT overall is performing well and with better performance the smaller number of breaches create a bigger impact on variance, however performance is around 92%. UHBW is on plan at this point in the year at 82%. UHBW has a greater number of nuanced tests e.g. MRI paediatrics, cardiac MRI which are impacting on performance levels. However, mitigation plans are explored and discussed at the Elective ODG and progress is being made in year.

FDS cancer standard is missed at ICB and acute trust level in November 2025. The ICB is at 78.17% compared to plan of 79.51%. The 31 Day combined standard is slightly behind plan at ICB and acute trust level in November, for the ICB at 92.16% compared to plan of 93.50%. The 62 Day standard is not being met at ICB or acute trust level. For the ICB 62 Day performance in November was 69.48% against a target of 72.53%. 28 day performance risks for UHBW relate to first appointment delays in head and neck and gynaecology, patient choice due to the impact of summer holidays and follow up outpatient delays in head and neck and skin. 62 Day performance risks relate to patient choice, hysteroscopy and lung surgery biopsy delays and surgical capacity especially in lower GI. Loss of beds from the wards closure at UHBW has made it more challenging for the Trust to manage all streams of activity although cancer activity is prioritised. At UHBW chemotherapy increasing demand still remains a risk with plans for additional capacity to come on line by Autumn 2026. For NBT, performance risks for 28 day relate to breast first outpatient appointment and urology (diagnostic); for 31 day performance is below plan due to skin and urology both first and subsequent treatments and for 62 day key issues are urology and breast. Additional funding through the Cancer Alliance is in place at NBT to support recovery to plan by year end with focussed remedial action plans for urology, breast and Lower GI.

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. Focus over the past few months at the elective ODG has been on advice and guidance enhanced service specification and understanding the impact to the system at primary care and secondary care levels. Further guidance is still awaited on this major change programme which needs to demonstrate a single point of access in place across the system for 10 specialties by October 2026. A number of sprints are also in place within the elective programme overseen by NHSE using national non recurrent pots of money focussing on first outpatient activity, additional RTT delivery in NHS acute trusts as well as independent sector and also within cancer. All with an aim to improve upon quarter 4 plans, improving performance and supporting greater achievement in 2025/26 and 2026/27.

Further work has concentrated on the changes in contractual guidance in 2025/26 and the creation and sign off of indicative activity plans in particular with our independent sector

partners where there is a growth in activity in areas like weight management which requires a strategic approach to triangulate performance, quality and finances in the system as well as equity in approaches between providers. Currently at end of December 2025 the independent sector is showing an under plan performance of 2.3% on activity but 2.1% above financial plan, therefore indicative activity plans are being closely monitored with appropriate actions being taken where necessary.

Planning has also been a consistent theme within the elective ODG with a submission to NHSE in December and a subsequent one due mid February. Elective plans are starting from a good position but with current non compliance for 2026/27 in 62 day Cancer and some year on year issues in RTT and total RTT waiting list reduction driven by all providers but in particular growth in independent sector.

5. Children's Services

Children's ED performance in December 2025 is currently achieving 71.5% against the national target of 78%.

Over 52 week waits in children's community services is behind plan at end of November with 4350 children waiting compared to a plan of 3947.

RTT waits over 52 weeks in UHBW at end of December for children is currently at 370 against a plan of 173. Acute elective spells in December is ahead of plan which is reassuring.

Children and Young Peoples access is behind the recovery plan target of 11576 in November 2025 at 10140. This is despite a further recovery plan being developed including digital therapeutics being rolled out and increased investment. It is unlikely that the target will be met this financial year. Some improvement has been made in actuals but the variance has worsened. Improvement plans are aimed at reaching 92% of the target.

Reliance on LD&A inpatient care for children in inpatient beds is currently ahead of target with 2 young people against a plan of 3 in December. 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 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. Topics discussed include:

- Neurodiversity and development of a business case to review options for reducing waits and a future needs led model. The business case is focusing on system impact including outside of health, gaining local authority support and aiming to align decision making with the planning round.
- Expansion of MHST teams and expectation for the ICB to expand coverage this year.
- Neurodiversity waiting list task and finish group update.
- Risks including Riverside Tier 4 inpatient unit update.

The ICB Board made the decision in February 2026 to fund the proposed children's neurodiversity model and backlog reduction which will result in a trajectory to achieve 52 week waits for ADHD and autism assessments by March 2029. Clinically prioritised children's will be seen in 18 weeks.

Items for Escalation:

2. CYP Mental Health Access

Despite continued focus on this metric, the access target will not be met in 2025/26. Discussions are ongoing with all providers and picked up in contact meetings to ensure that all parties are being held to account and progress improves to provider greater assurance in 2026/27.

6. Community

The community waiting list for adults over 52 weeks remains at 0 as at November 2025. The overall size of the waiting list (which will be children) waiting over 52 weeks is above plan at 4350 against a plan of 3947. This will relate to ADHD and autism children waits and which will be reduced in line with ICB Board approval of funding for the children's neurodiversity business case (as per update in the children's section).

The P1 waiting list position has grown throughout December 2025, with a small dip mid December. Number of referrals received for P1 and ICSS has broadly been in line with 180 slots per week or more. The NCTR position for P1 is high at 40% demonstrating a flow block within Sirona which then impacts back into the acutes position. The P2 waiting list position over December was fairly consistent which was positive at around 45 but with growth just before Christmas. The number of referrals received was high in the last two weeks before Christmas. The NCTR position throughout December was around 45 which still needs to be lower to support overall system flow. The P3 waiting list position gradually increased in December and number of referrals was high the week before Christmas.

The Heart Failure business case has been supported in relation to the redesign of the urgent pathway which will now be led by the acutes and included in activity plans; the community element working with general practice is still progressing with further work underway to understand impact on general practice. The Health Based Intermediate Care (HBIC) work now has an SRO lead through the DASS in Bristol City Council which will allow a natural linkage with the Futures of Prevention Work. A resourcing programme of work has been completed and discussed at SEG to ensure that this vital piece of work is resourced appropriately in line with the discharge programme. It is anticipated that HBIC and the overall discharge programme, need to be kept as one programme as both are vital to the flow of the system and lowering of the NCTR position.

Appendices

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

Performance Summary

February 2026



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 52+ weeks	Acute Total	Dec 25	Count	943	✓ 726		-73	-9	NA	726	-217	-	-
RTT % waits 52+ weeks	Acute Total	Dec 25	%	1	✓ 0.78		0	-7.14	-	0.78	0		
RTT waiting list	Acute Total	Dec 25	Count	91,493	✗ 93,212		-2204	-2.31	NA	93,212	1,719	-	-
RTT 18 Week Performance	Acute Total	Dec 25	%	70.40	✗ 66.74		0	-0.21	NA	66.74	-3.26	-	-
Specific acute elective spells	Acute Total	Jan 26	Count	15,949	✗ 14,752		297	2.05	NA	148,056	-4,721	-	-
Diagnostic tests % < 6 weeks	Acute Total	Dec 25	%	95	✗ 93.28		0	-0.24	418	93	-2	-	-
Cancer 28 day FDS	Acute Total	Dec 25	%	79.42	✗ 75.03		-3	-3.71	198	77	-2	-	-
Cancer 31 day combined	Acute Total	Dec 25	%	93.53	✗ 93.24		2	2.44	NA	-		-	-
Cancer 62 day combined	Acute Total	Dec 25	%	73.29	✗ 70.27		0	-0.20	18	70	-3	-	-
Urgent and Emergency Care													
Urgent Community Reponse referrals	ICB	Jan 26	Count	1,395	✓ 2,923		203	7.46	NA	27,058	13,108	-	-
Mean Cat 2 Ambulance Response	ICB	Jan 26	Minutes	30	✗ 35	Same	7	23.00	NA	30	0	-	3 / 7
Ambulance Handover Delays 45+ minutes	ICB	Jan 26	Count	0	✗ 1,238		432	53.60	NA	11,535	11,535	-	-
Average ambulance handover duration	ICB	Jan 26	Minutes	42.47	✓ 30		6	25.31	NA	30	-12	-	4 / 7
A&E 4 hour Performance (Footprint)	ICB	Jan 26	%	77.57	✗ 72.03	Same	-1	-1.23	1,974	74	-4	23 / 42	3 / 7
% A&E waits >12 hours from Arrival	ICB	Jan 26	%	6.23	✗ 9.70		3	35.47	NA			-	-
% Beds occupied by NCTR patients	ICB	Jan 26	%	N/A	20.63	Worse	0	-0.82	NA	22	-	37 / 42	5 / 7
% G&A beds occupied	ICB	Jan 26	%	100	✓ 93.00		0	-0.11	-	94	-6	8 / 42	3 / 7
Virtual ward occupancy	ICB	Jan 26	%	86.06	✗ 68.40	Worse	6	9.27	30	68	-18	38 / 42	5 / 7

Same or Better than previous period
 Worse than previous 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 waiting list 52+ weeks	ICB	Dec 25	Count	3,912	✘ 4,399		49	1.13	NA	4,399	487	-	-
Community waiting list	ICB	Dec 25	Count	NA	24,338		-586	-2.35	NA	24,338	-	-	-
Mental Health													
Access to Perinatal Services (Rolling 12m)	ICB	Dec 25	Count	1,375	✔ 1,590		0	0.00	NA	1,590	215	-	-
Talking Therapies Reliable Improvement Rate	ICB	Dec 25	%	67	✔ 69.03		1	1.93	-	70	3	-	-
Talking Therapies Reliable Recovery Rate	ICB	Dec 25	%	48	✔ 51.35		-1	-2.04	-	50	2	-	-
Inappropriate OAP Placements (BNSSG)	ICB	Jan 26	Count	0	✔ 0		0	0	NA	0	0	-	-
IPS Count accessing services	ICB	Dec 25	Count	784	✔ 1,025		55	5.67	NA	8,890	2,338	-	-
Dementia Diagnosis Rate	ICB	Dec 25	%	66.7	✔ 71.51	Better	0	0.06	NA	71	-	5 / 42	1 / 7
Average length of stay for adult acute beds (BNSSG)	ICB	Dec 25	Days	63.75	✔ 59		-4	-6.35	NA	59	-5	-	-
Childrens													
CYPMH Access Rate (Rolling 12m)	ICB	Dec 25	Count	11,919	✘ 10,335		195	1.92	NA	10,335	-1,584	-	-
RTT waiting list - Childrens	Acute Total	Jan 26	Count	10,843	✘ 11,349		-78	-0.68	NA	11,349	506	-	-
RTT waits 52+ weeks - Childrens	Acute Total	Jan 26	Count	149	✘ 247		-123	-33.24	NA	247	98	-	-
Community waiting list - CYP	ICB	Dec 25	Count	NA	7,923		101	1.29	NA	7,923	-	-	-
Community waiting list 52+ weeks - CYP	ICB	Dec 25	Count	3,912	✘ 4,399		49	1.13	NA	4,399	487	-	-
Specific acute elective spells - Childrens	Acute Total	Jan 26	Count	1,340	✔ 1,349		89	7.06	NA	13,188	738	-	-

■ Same or Better than previous period
 ■ Worse than previous period



**Bristol, North Somerset
and South Gloucestershire**
Integrated Care Board

BNSSG Outcomes, Quality and Performance Committee- FINAL
Minutes of the meeting held on Wednesday 22 October 2025 1330-1600 on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Jeff Farrar	Chair, BNSSG ICB	JF
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Jacky Hayden	Non-Executive Director, Sirona Care & Health	JH
Dr Jacob Lee	Chair of General Practice Collaborative Board	JL
Michael Richardson (representing Rosi Shepherd CNO)	Deputy Chief Nursing Officer, BNSSG ICB	MR
In attendance		
Faye Kamara Agenda Item 3.0 & 3.1	Head of Safeguarding, BNSSG ICB	FK
Vicki Court Agenda Item 4.2	Patient Safety Specialist, BNSSG ICB	VC
Caroline Dawe Agenda Item 5.0-5.3	Deputy Director of Performance & Delivery, BNSSG ICB	CD
Neil Turney Agenda Item 5.3	Head of Performance, Mental Health, Learning Disability & Autism.	NT
Jodie Stephens (Minutes)	Executive PA, BNSSG ICB	JS
Apologies		
Shane Devlin	Chief Executive, BNSSG ICB	SD
Hugh Evans	Executive Director, Adults and Communities BCC	HE
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sue Balcombe	Non-Executive Director, UHBW	SB
Aishah Farooq	Non-Executive Director BNSSG ICB	AF
Sarah Weld	Director of Public Health, SGC	SW

	Item	Action
1.	Welcome and Apologies.	

	Item	Action
	<p>ED opened the meeting, acknowledging the busy schedules of attendees and expressing gratitude for the contributions of the executive and support teams, including those presenting and those who supported papers. Apologies were noted as above.</p> <p>ICB Organisation Changes JF explained that updates have been delivered to staff by ICB executive team and noted a delay around reorganisation. JF mentioned an upcoming consultation, no update on finances, and ongoing conversations about Treasury funding, expressing doubt about receiving additional funds. JF committed to keeping colleagues informed via the transition committee, written updates, and video updates.</p> <p>Declarations of Interest ED asked if there were any declarations of interest.</p> <p>No declarations were made.</p>	
2.	<p>Minutes of the Previous Outcomes, Quality and Performance Committee July 2025 ED asked if there were any matters of accuracy or matters arising from July's committee minutes.</p> <p>No issues were raised and the minutes were agreed.</p>	
3.	<p>BNSSG ICB Prevent Policy ED introduced the agenda item and thanked FK for joining, ED made a statement clarifying the governance route for the policy, noting ED had checked with Rob Hayday, Chief of Staff at BNSSG ICB about whether the policy should come to OQPC. RH confirmed all policies must go through a board or committee for review before ICB board or CEO sign-off, and the committee's role is to review, not approve.</p> <p>JF reinforced the value of committee review for governance, stating that routing policies through committees allows for deeper discussion before board consideration and is essential for good governance. JF noted that some policies may go directly to ICB board, but most benefit from committee scrutiny.</p> <p>ED agreed, explaining the concern was about the level of detail and the sign-off process, but Rob Hayday clarified the correct procedure. ED confirmed that OQP committee's role is assurance and review, not approval, and wording in the policy should reflect this.</p> <p>FK confirmed the policy should be reviewed for recommendation, not approval. FK presented the ICB Prevent Policy, explaining it is a review of the previous policy, required under the Counter Terrorism Act and the contest strategy. The policy is based on a national NHS England template, ensuring consistency and expert input. FK assured the committee the policy had been scrutinized by the Corporate Policy Review Group with Rob Hayday, fraud, HR, and the Safeguarding Governance Group (chaired by MR as deputy CNO). The policy is</p>	

	Item	Action
3.1	<p>standalone, as required, and the Designated Safeguarding Nurse for Adults is the Prevent Lead, supported by RK and RS as executive lead.</p> <p>FK highlighted the importance of prevent training for all staff, with current compliance at 90% (target 95%). Targeted outreach is underway to increase compliance, working with Colin Burlinson Learning and Talent Manager for ICB for reminders. The e-learning module is one hour every three years.</p> <p>AM asked for assurance that the national template incorporates learning from high-profile failings since the previous policy expired in 2021. FK confirmed this. AM expressed concerns about the gap between policy and practice, asking if targeted training is sufficient to minimise risk, and whether there are other measures. AM also asked about assurance that other clinical policies are not similarly out of date, referencing the risk noted in the paper.</p> <p>FK responded that the most important staff to target are patient-facing especially Continued Health Care. FK proposed safeguarding supervision and quarterly Prevent Board learning for Continued Health Care staff, including learning from live channel panel cases. Targeted training and specific input for patient-facing staff should bridge the gap between policy and practice.</p> <p>ED asked JM to respond on the risk of out-of-date policies. JM, as chair of the Clinical Policy Review Group, assured the committee there is a detailed tracker for clinical policies, with stratified sign-off processes. JM offered to bring tracker evidence if needed. JM expressed less assurance about corporate policies and suggested an action to check with Rob Hayday about corporate policy tracking.</p> <p>ED confirmed an action for JM to review risks of out-of-date policies and assess escalation processes. AM clarified she did not need to see the tracker but wanted assurance that risks are escalated appropriately. ED asked JM and DJ to discuss the corporate policy gap with SD and follow up.</p> <p>FK added that Rob Hayday manages corporate policy tracking and the Corporate Policy Review Group meets monthly.</p> <p>Decision: OQPC agreed the Prevent Policy should go to board for approval, with the committee’s role as review and assurance.</p> <p>BNSSG ICB Safeguarding Q2 Report.FK presented the report in three sections: children including children in care and care leavers, adults, and thematic issues.</p> <p>Children: Serious Youth Violence and Reviews</p> <p>FK noted the complexity of language across local authorities e.g. Risk outside the home” vs. “harm outside the home and described the establishment of Multi Agency Child Exploitation (MACE) panels in Bristol with similar panels in South Gloucestershire and North Somerset.</p>	

	Item	Action
	<p>FK informed the committee about an upcoming ICB Board session on Thursday 6th November on learning from statutory safeguarding reviews, focusing on cultural humility which emphasizes openness to learning from individuals lived experiences.</p> <p>Children in Care and Care Leavers. BNSSG ICB's Designated Nurse for Children in Care is working with all three local authorities to establish a notification system, aiming to better understand and record care leaver deaths. FK described this as a live risk, primarily for local authorities but shared by BNSSG ICB.</p> <p>Adults FK explained that the adult safeguarding section focused on domestic abuse. FK stated that a new report on learning from domestic abuse death-related reviews (including suicides) recommends stand-alone domestic abuse training. BNSSG ICB and health providers currently embed domestic abuse in safeguarding training but do not offer stand-alone training. Such training is available through safeguarding partnerships, and the focus should be on signposting and encouraging uptake.</p> <p>FK explained that MAPPA (Multi-Agency Public Protection Arrangements) now includes offenders convicted of coercive or controlling behaviour under the Domestic Abuse Act. Few such convictions locally, but the system could do more to use MAPPA for offender management and breaking cycles of abuse.</p> <p>JL asked about the strategic leadership role regarding stand-alone domestic abuse training, questioning whether it should be mandatory for providers. JL shared positive experience with IRIS-accredited training and suggested BNSSG ICB should go beyond signposting.</p> <p>AM asked How does BNSSG ICB use predictors (e.g., deprivation, ethnicity, domestic violence) from the Child Death Overview Panel (CDOP) report to inform strategic commissioning and target support?</p> <p>AM asked regarding care leaver deaths, what can be learned from the “pre-death” phase and sought reassurance that the system is not just reactive. JH referenced work in Cardiff where health and police mapped violence episodes to target interventions and asked if BNSSG ICB could do similar predictive work with partners.</p> <p>JF described his experience establishing the Cardiff programme, emphasizing the value of multi-agency intelligence for targeting resources and suggested BNSSG ICB should ensure such conversations are happening locally.</p> <p>MR added that the system has a Serious Violence Partnership chaired by the Police and Crime Commissioner, with a cross-system action plan and quarterly meetings.</p> <p>FK agreed that stand-alone domestic abuse training should be a “must do” and committed to working with providers to add it to the quality schedule for next</p>	

	Item	Action
	<p>year and explained that safeguarding data is fed into system delivery units and operational delivery groups, and specifically into the Health System Improvement Group (HSIG). FK committed to reflecting on how to further use predictors for commissioning.</p> <p>FK acknowledged a commissioning gap for 18–25-year-olds and described previous attempts to fund a care leaver nurse but is in live discussions with Sirona care & health to address this.</p> <p>FK described the use of needs assessments, the Violence Reduction Partnership, and the role of acute providers in sharing data for hotspot mapping.</p> <p>ED asked FK to reflect further on whether BNSSG system is doing enough on predictive safeguarding and to report back especially regarding care leaver deaths and the sufficiency of current links for action.</p> <p>MR provided assurance that the CDOP annual report and conference had identified deprivation as a key theme, and deep dives are planned for the coming year.</p> <p>ACTION: FK to change the wording in the Prevent Policy cover sheet from approve to review for recommendation.</p> <p>ACTION: JM to check with Rob Hayday on corporate policy tracking and bring assurance to OQPC.</p> <p>ACTION: DJ, JM, and MR to discuss corporate policy governance gap with SD</p> <p>ACTION: MR and FK to consider further socialisation of the ICB Prevent Policy flowchart through internal conferences. MR/FK and BNSSG ICB Safeguarding team to deliver targeted safeguarding supervision and Prevent training for patient-facing staff.</p>	
4.	<p>Chief Medical Officer and Chief Nursing Officer Update.</p> <p>JM reported a £1 million underspend on medicines, helping to mitigate system financial pressures. BNSSG is compliant with the rollout of weight management injectables (e.g., GLP-1 agonists) and has implemented these through primary care. JM explained that there are significant pressures due to increased demand, drug impact, and financial implications (an additional £700,000 allocated to the Oviva contract to meet waiting time targets). JM is chairing a group to review and integrate local authority and health elements of weight management, including Tier 3/4 and bariatric surgery pathways, to address demand, capacity, and policy/process changes. JM explained ongoing issues with national medicines shortages and interface challenges between primary and secondary care (the “28-day challenge”).</p>	
4.1	<p>Quality Report – Focus on MRSA HCAI data and systems with high MRSA rates.</p>	

	Item	Action
	<p>MR reported that MRSA rates in BNSSG remain high and are a persistent concern. Several workstreams are in place, and the system is collaborating with regional colleagues to address the issue. Benchmarking was conducted with comparator systems; however, no fresh solutions were identified, and in some cases, other systems learned from BNSSG’s practices.</p> <p>The system has secured regional funding for an IPC/AMR leadership project, focusing on soft tissue infections, which includes most MRSA cases. This will add capacity and leadership to the MRSA agenda. MR emphasized that MRSA is not considered “tolerated” within the system, and there is ongoing frustration at all levels regarding the lack of improvement. The new leadership project is expected to drive further progress.</p> <p>ED asked for clarification on the benchmarking data, noting a discrepancy between the reported current rate (5.06 per thousand) and the benchmarking figure (2.2), and pressed for lessons learned from the benchmarking exercise. ED expressed concern about the MRSA benchmarking data and the lack of learning from systems nationwide. ED emphasized the need to examine not just the actions but also the scale, quality of implementation and to continue seeking solutions.</p> <p>AM also raised concerns about the persistent high MRSA rates, questioning whether the system is now “tolerant” of the issue and emphasizing the need for continued focus and improvement.</p> <p>MR responded that all actions being taken by comparator systems are also being implemented in BNSSG, and in some cases, BNSSG is ahead. The regional leadership project will provide additional resource and focus. MR reiterated that MRSA is not tolerated and that the system is escalating the issue for further action.</p> <p>Vaccination Programme Processes and Governance Update</p> <p>JM clarified that system vaccine uptake data is available in the report, with mechanisms in place to monitor flu campaign progress. It is early in the season, so meaningful comparison to last year is not yet possible, but systems are in place to identify and address problems. MR reported an early increase in respiratory illness cases, with concern that the COVID vaccine is not being offered to NHS staff this year. This is being closely monitored. JM noted that vaccine uptake and outcomes are monitored through national reporting systems and local clinical groups.</p> <p>ED asked for clarity on progress versus 2024 and whether the system is on track or ahead of plan.</p> <p>AM highlighted the link between low vaccine uptake and child deaths, referencing the Child Death Overview Panel report. AM asked about the use of virtual wards for respiratory viruses, outcomes on pathways (especially lower limb amputations), and whether there are other outlier pathways. AM expressed concern about the persistent MRSA issue and whether the system is now “tolerant” of high rates.</p>	

	Item	Action
	<p>JM explained the limitations of outcome data infrastructure and described ongoing work to improve outcome-based commissioning, including a focus on diabetes and lower limb amputations as mainly diabetes causing amputations. JM suggested the long-term conditions group report and the BNSSG health inequalities annual report to be added to agenda for future OQPC meetings.</p> <p>JM and MR confirmed that vaccine uptake is a key focus, with ongoing monitoring and escalation as needed. JM clarified vaccine uptake data and mechanisms for monitoring flu campaign progress; noted it is too early in the season for meaningful comparison, but mechanisms are in place to identify problems.</p> <p>Perinatal and Maternity MR reported a spike in perinatal losses at the end of Q4. All cases were scrutinized, with no trends or themes identified. Monitoring continues with the LMNS and partners.</p> <p>MR reported positive response to the national rapid investigation of maternity services. Some staff morale issues remain, but the national team was assured by the system's response.</p> <p>Infection Prevention and Control (IPC) MR reported a small but increasing number of TB outbreaks, mainly linked to asylum seekers. MR explained that a new TB strategy group is in place, and the system is working with the national Getting It Right First Time (GIRFT) team. MR highlighted a small spike in E. coli cases but too early to determine if this is a trend, MR stated that C diff rates were improving.</p> <p>Quality Oversight MR stated that AWP has exited enhanced surveillance, but enhanced quality oversight meetings would continue until the end of the financial year, then would step down to elevated oversight. MR reported a year long delay with new anti-ligature doors being fitting at Callington Road premise due to builders pulling out. MR explained that Sirona care & health would remain in enhanced surveillance for several issues. MR reported system-wide working on red card individuals to ensure consistent policies and 28-day performance in all-age funded care has decreased but remains within regional benchmarks but mitigation in place.</p> <p>AM questioned the delay in anti-ligature doors at AWP which was disappointing and whether a year's delay is acceptable.</p> <p>JH emphasized the need for a whole-person approach to diabetes and amputation risk and raised concerns about insulin management in the community.</p> <p>JF clarified the difference between type 1 and type 2 diabetes and raised ethical concerns about prioritising those with poor control for advanced treatments.</p>	

	Item	Action
4.2	<p>MR provided assurance that the Health Innovation Network is reviewing the wound pathway and formulary as many MRSA cases are linked to lower limb wounds. MR clarified that the anti-ligature door delay at AWP is specific to Cannington Road, which is not currently open.</p> <p>LeDeR Annual Report</p> <p>VC presented the LeDeR annual report, noting benchmarking challenges due to delayed national reporting. The ICB board delegated sign-off to OQPC, aiming for publication by month-end. VC highlighted improvements in performance: increased number and timeliness of completed reviews, attributed to a new reviewer workforce and Sirona’s support in clearing backlogs. VC explained focus can now shift to quality improvement.</p> <p>VC reported that social care colleagues’ involvement has increased knowledge around hoarding and executive functioning, leading to more safeguarding referrals. Collaboration with the fire service and updates to primary care resources were noted. VC explained that a new health passport is now widely used, supporting consistent documentation and information sharing for people with learning disabilities.</p> <p>VC explained that annual health check initiatives include quarterly webinars, a new toolkit, a “was not brought” policy to prompt professional curiosity, and support for people from global majority backgrounds via health navigators. VC reported performance data which BNSSG is second from bottom among statistical neighbours for annual health checks but highest in the Southwest. The goal is to exceed 80% coverage.</p> <p>VC reported that top causes of death were pneumonia, aspiration pneumonia, sepsis and that 51% of deaths were preventable or treatable. Workstreams are focusing on increasing pneumococcal vaccine uptake and reducing aspiration pneumonia. VC highlighted the priorities for 25/26 which were to raise annual health check coverage above 80%, continue joint work with social care and maintain focus on quality-of-life improvements.</p> <p>JH expressed concern about the 51% preventable death rate and requested more precise metrics in future reports e.g., actual numbers rather than “many/some/few to track year-on-year improvement, especially for health passport completion.</p> <p>AM praised performance improvements but advocated for a higher ambition than 80% for annual health checks and a shift from quantity to quality, especially focusing on health action plans and the 51% preventable death rate. AM emphasized the importance of personalized care and setting a high bar for BNSSG.</p> <p>ED endorsed AM comments and thanked VC for benchmarking outside the Southwest and reiterated the committee’s ambition to be a national leader.</p> <p>VC agreed on the need for more granular data and is working with social care colleagues to incorporate housing data which may impact pneumonia/aspiration</p>	

	Item	Action
4.3	<p>pneumonia rates. VC explained with three years of data; future reports will provide more detail.</p> <p>JM supported a targeted, campaign-based approach to quality improvement (e.g., focusing on aspiration pneumonia), rather than spreading resources too thinly. Suggested two campaigns per year on key conditions, with committee support for this prioritisation.</p> <p>MR noted that Somerset is using a similar thematic deep-dive approach and supported the prioritisation strategy.</p> <p>Decision: OQPC approved the LeDeR annual report for publication on behalf of BNSSG ICB Board.</p> <p>ACTION: BNSSG IPC Team/MR to monitor MRSA rates and JS will add to forward planner as a standing item for assurance and escalation until improvement is demonstrated.</p> <p>ACTION: BNSSG IPC Team/MR to implement the regional IPC/AMR leadership project focused on soft tissue infections and report on its impact.</p> <p>ACTION: JM and MR to monitor vaccine uptake and report any issues or trends at future OQPC meetings. JM and MR to ensure robust governance and escalation processes are maintained for the vaccination programme.</p> <p>ACTION: JM to bring Long-term conditions group report on diabetes and lower limb amputation work and JM to bring the BNSSG health inequalities annual report to OQPC in December.</p> <p>Committee Action Log</p> <p>The action log was updated with committee members and to be circulated with the minutes.</p>	
5	<p>System Performance Update</p> <p>DJ provided a comprehensive update on system performance, focusing on assurance and oversight as reviewed by the System Executive Group (SEG). DJ reported on the recent mid-year review meeting with NHS England, noting that BNSSG ICB is considered a low-risk system for both performance and finance. The committee was not required to resubmit any performance trajectories, as all targets are being met or are on track.</p> <p>ED congratulated DJ and the team for the positive assurance outcome, confirming the review covered both finance and performance.</p>	

	Item	Action
5.1	<p>Mental Health: Out of Area Placements: As of August, the system was off plan, but AWP implemented an improvement plan, halving the number of placements since the report was published. This remains a focus for further improvement.</p> <p>Children and Young People’s Access (CAMHS): The system is marginally off trajectory for the type one access target. A revised trajectory has been submitted, with new triage and digital tools being implemented to improve performance.</p> <p>Right to Choose (ADHD/Autism): There are significant challenges due to high demand for private provider pathways, resulting in financial and activity pressures. Contractual measures and legal advice have been sought to manage risk, and a business case for further transformation and waiting list clearance will be presented to the ICB board in December.</p> <p>ED asked about the financial and legal risks associated with the right to choose pathway, and whether controls were in place. DJ explained that formal contract measures were only implemented this year due to escalating demand, and legal advice has been sought. The issue is under scrutiny and will be reported to the board.</p> <p>JM added that accreditation of providers is not limited to the local ICB, making market control difficult. Significant informatics resources have been allocated to monitor activity and manage contracts. AM praised the encouraging performance and asked about the sustainability of improvements in out of area placements and the effectiveness of digital triage tools for CAMHS. DJ responded that AWP’s improvement appears sustainable, but digital tool effectiveness will require ongoing monitoring.</p> <p>JM noted that high levels of “no criteria to reside” in mental health beds, linked to local authority placements and housing stock, continue to restrict flow and require ongoing attention.</p> <p>Elective, Cancer, and Diagnostic Standards – DJ reported that elective, cancer, and diagnostic standards are well on track, with only marginal deviation in 62-week waits. Recovery trajectories are in place, and providers have assured full achievement of standards by year-end. There is potential to exceed targets, supported by the elective centre.</p> <p>Winter Planning Feedback – update from Check & Challenge session. DJ provided an update on the winter planning process, focusing on the feedback from the recent Check & Challenge session attended by ED and AM, as well as the subsequent assurance process with the hospital group and System Executive Group (SEG). DJ summarized that the ICB winter plan was</p>	

	Item	Action
5.2	<p>considered robust, evidence-based, and underpinned by high-quality data. The Check & Challenge session concluded that the plan could be approved, but highlighted risks to delivery due to variation in performance across the system, particularly in P3 (community bed) length of stay across the three local authority areas. DJ reported that these risks were escalated to the SEG, and the ICB and providers have now submitted their assurance statements. The hospital group's assurance statement is caveated regarding delivery of the no criteria to reside plan, and both the ICB and providers agreed to rigorously monitor progress through system governance.</p> <p>DJ outlined three main areas of focus for ongoing monitoring:</p> <ul style="list-style-type: none"> • P3 length of stay (community beds) • Standard operating procedures and expectations for pathway elements • Clarity of locality community escalation and KPIs <p>ED and AM expressed concern about the ability of local authorities to deliver on the plan, emphasising that a robust plan is only effective if all partners can implement it. They indicated that their main concern was whether local authorities were up for delivering it.</p> <p>DJ acknowledged these concerns and explained that the winter planning process had shone a light on local authority variance, which was now being escalated to a higher level than previously, including direct correspondence from Shane Devlin to each local authority Chief Executive to seek a different level of response.</p> <p>DJ confirmed that the committee's feedback and concerns were being addressed through escalation and ongoing monitoring, and that the winter plan and associated risks would remain a standing item for SEG and the Performance and Recovery Board.</p> <p>NCTR P0 to P3 progress update</p> <p>DJ presented a detailed update on progress against the 15% reduction ambition for "no criteria to reside" (NCTR) patients, tracked monthly across D2A pathways (P0–P3) and community bed capacity. DJ explained that the monitoring tool provides clear trajectories for each pathway and tracks reductions in numbers of NCTR patients within acute trusts.</p> <p>For September, overall progress was improved compared to last year, but there was variance from plan, especially in P3 (community beds). P3 length of stay remains the largest area of concern, with Bristol averaging 60 days, North Somerset 42 days, and South Gloucestershire 34 days (below target).</p>	

	Item	Action
5.3	<p>DJ emphasized the level of detail and transparency in the data, noting that variance is immediately escalated to SEG and leads to direct correspondence from Shane Devlin to local authority chief executives, seeking improved support for P3 length of stay reductions.</p> <p>ED highlighted the significant improvement in grip and transparency compared to previous years, commending the escalation to local authority chief executives and noting the importance of monitoring the journey over the coming weeks and months. JM asked about acute sector delays not linked to local authority placements, recalling that about 40% of delays were within the acute sector's control. JM emphasized the need for discipline in addressing these delays and asked if improvements were being pursued in parallel.</p> <p>DJ and CD confirmed that improvements are being pursued in parallel, including addressing CHC delays and integrating BNSSG ICB into area performance meetings. CD noted that each local authority does things slightly differently and that there are coding improvements to be made, especially in Bristol.</p> <p>AM praised the clarity of the data and the ability to focus on improvement rather than data accuracy debates. AM noted the significant difference between the three local authority areas in P3 and emphasized the importance of monitoring local authority commitment and delivery.</p> <p>JL provided an on-the-ground perspective, noting that P3 patients often require long-term nursing care and delays are due to assessment and placement challenges. JL supported escalation to the highest level.</p> <p>5.3 Intensive Assertive Outreach work – Update</p> <p>DJ introduced the agenda item and welcomed NT and CD to present the update on Intensive Assertive Outreach, referencing the requirement for a public update and the recent submission to NHS England. NT provided a structured update, referencing the new NHS England self-assessment tool covering nine domains for system assurance. NT explained that the BNSSG system is currently rated amber in six domains and green in three, with no reds. The Southwest regional team will visit all ICBs by the end of November to review progress.</p> <p>NT summarised progress and next steps for each domain:</p> <p>Domain 1 (Partnership Working): Remains amber.</p> <p>Domain 2 (Safer Staffing): Moved from red to amber due to improvements in AWP staffing and oversight.</p> <p>Domain 3 (Policies & Governance): Remains amber.</p> <p>Domain 4 (Key Worker Allocation): Moved from red to amber.</p> <p>Domain 5 (Out-of-Hours Support): Rated green.</p>	

	Item	Action
	<p>Domain 6 (Effective Care Planning): Moved from red to amber; improvements in engagement and medication guidance.</p> <p>Domain 7 (Information Sharing): Rated green.</p> <p>Domain 8 (Family Feedback): Moved from amber to green; engagement methods and lived experience representation are in place.</p> <p>Domain 9 (Service Effectiveness): Rated amber; work is ongoing to improve outcomes reporting and VCSE digital maturity.</p> <p>NT highlighted two key risks:</p> <p>Risk 1: Discharge under the current DNA policy—mitigated by a new non-engagement policy, MDT discharge processes, and upcoming training. Risk rating may be reduced after further audit and training.</p> <p>Risk 2: Absence of a case-finding tool—AWP is implementing a tool, with deployment scheduled for November. This will enable better tracking and management of the cohort.</p> <p>NT explained that next steps included ongoing prioritisation, regular highlight reports, awaiting NHS England’s visit and feedback, and a formal update to NHS England in January. Awaiting further service specifications and potential funding in future planning guidance.</p> <p>ED noted that the submission to NHS England had been circulated to members and invited questions and comments from OQPC.</p> <p>AM praised the structured approach and asked has the risk rating for the two key risks changed since May? And could committee members have a clear view of short, medium, and long-term actions, as some items are described as “in the coming months” or “will take time”?</p> <p>NT responded that the risk rating is currently 3x5 (likelihood x severity). An audit found no inappropriate discharges, supporting the current rating. The rating will be reduced after further evidence from audits and training.</p> <p>NT explained that the MDT approach and consultant approval for discharge provide safety checks. The case-finding tool will be key for future risk reduction. Some improvements (e.g., psychological therapies, caseload sizes) are longer-term and may require funding. The system is moving from phase one (risk mitigation) to phase two (quality improvement).</p> <p>ED clarified that the OQPC would like future updates to include a clear reporting format with timelines for actions and risk reduction.</p>	

	Item	Action
	<p>CD confirmed that a further report will be provided to OQPC committee and potentially BNSSG ICB Board in January, with a more structured format addressing AM questions.</p> <p>ED and NT agreed that keeping the work high on the agenda is helping to drive progress.</p> <p>ACTION: DJ - SEG and Performance and Recovery Board to continue rigorous monitoring of NCTR progress, with immediate escalation of any variance from plan, especially regarding P3 length of stay and local authority performance.</p> <p>ACTION: DJ to feedback to OQPC updates regarding SD direct engagement with local authority chief executives to secure improved support for P3 length of stay reductions.</p> <p>ACTION: NT to provide an intensive assertive outreach work update at OQPC in February with a structured reporting format including timelines for actions and risk reduction.</p> <p>ACTION: NT to prioritise intensive assertive outreach work, maintain regular highlight reports, and incorporate NHS England feedback after their visit.</p>	
6	Items for Information	
6.1	BNSSG Healthcare Acquired Infection Group - DRAFT	
6.2	BNSSG System Quality Group	
6.3	BNSSG Area Prescribing Medicines Optimisation Committee	
7	<p>AOB</p> <p>No items were brought forward.</p>	
8	<p>Review of Committee Effectiveness</p> <ul style="list-style-type: none"> • Did the meeting run to time? • Did the right people attend? • Were action items assigned where appropriate to the right people? • Were all items given sufficient time to discuss? • Were all members able to contribute? <p>Has the meetings business contributed to the organisation's aims and objectives in terms of:</p> <ul style="list-style-type: none"> • Strategy • Planning 	

	Item	Action
	<ul style="list-style-type: none"> • Governance • Were any of the items inappropriate for this committee? • Did the meeting receive the administrative support that it needed? 	
9	<p>Meeting Dates 2025/2026</p> <ul style="list-style-type: none"> • Thursday 11th December 2025 1330-1600 • Thursday 26th February 2026 1330-1600 • Thursday 30th April 2026 1330-1600 • Wednesday 24th June 2026 1330-1600 • Tuesday 22nd September 2026 1330-1600 • Thursday 19th November 2026 1330-1600 	

Jodie Stephens Executive PA
October 2025

BNSSG Outcomes, Quality and Performance Committee- FINAL

Draft Minutes of the meeting held on Thursday 11th December 2025 1330-1500 on MS Teams

Minutes

Present		
Ellen Donovan (Chair)	Non-Executive Member for Quality and Performance, BNSSG ICB	ED
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Jacky Hayden	Non-Executive Director, Sirona Care & Health	JH
In attendance		
Caroline Dawe Agenda Item 5.0-5.2	Deputy Director of Performance & Delivery, BNSSG ICB	CD
Greg Penlington Agenda Item 5.0-5.2	Head of Urgent and Emergency Care, BNSSG ICB	GP
Jodie Stephens (Minutes)	Executive PA, BNSSG ICB	JS
Apologies		
Shane Devlin	Chief Executive, BNSSG ICB	SD
Hugh Evans	Executive Director, Adults and Communities BCC	HE
Dr Jacob Lee	Chair of General Practice Collaborative Board	JL
Aishah Farooq	Non-Executive Director BNSSG ICB	AF
Sarah Weld	Director of Public Health, SGC	SW
Jeff Farrar	Chair, BNSSG ICB	JF

	Item	Action
1.	<p>Welcome and Apologies.</p> <p>ED opened the meeting by thanking the executive directors and their teams for their excellent papers and specifically acknowledged JS for her efforts in pulling everything together. ED noted that BNSSG ICB is in a challenging transformation period, with processes now underway, and reiterated appreciation for everyone’s contributions. ED explained that, following the announcement of changes to the ICB transformation, ED is working with RS, DJ and JM to determine what is needed for the committee to support the executive and teams while fulfilling statutory duties and NHSE responsibilities. ED highlighted today’s agenda focuses on quality, performance issues, winter delivery, stroke and planned resident doctor industrial action.</p>	

	Item	Action
	<p>Declarations of Interest ED asked if there were any declarations of interest.</p> <p>RS declared role as Non-Executive Director for Gloucestershire Health and Care NHS Foundation Trust.</p>	
2.	<p>Minutes of the Previous Outcomes, Quality and Performance Committee October 2025</p> <p>ED asked if there were any matters of accuracy or matters arising from Octobers committee minutes.</p> <p>AM asked JS to check that within page seven it should read Callington Road. JS acknowledged this request and October minutes were agreed.</p>	
3.	<p>Review of Committee Action Log.</p> <p>The action log was updated with committee members and to be circulated with the minutes.</p> <p>ED raised action 196 regarding MRSA, asking RS when it would be appropriate to bring the item back to OQPC. RS explained that the MRSA rate remains high despite various interventions. The team is recruiting additional clinical leadership to focus on soft tissue injury and will work with the regional team to understand the persistent high rates, particularly in populations who inject drugs and those experiencing homelessness. RS requested time to develop a meaningful update, estimating it would not be ready before quarter one. AM supported RS approach, suggesting a handover document for the new organisation outlining current actions, medium-term plans and ongoing work. AM recommended this be completed before quarter one to support transition.</p> <p>RS agreed to prepare an SBAR (Situation, Background, Assessment, Recommendation) for March 2026, summarising current work, plans and engagement, to serve as a handover for the new organisation. JM highlighted the need to consider future governance and accountability for MRSA improvement under the new strategic commissioning framework, suggesting the approach may need to change post-transition. RS added that MRSA is a population health issue, with the highest rates among people who inject drugs and those who are homeless and emphasised the need to align provider accountability and commissioning.</p> <p>AM stated that a legacy report from BNSSG ICB would be helpful for the new system, outlining what needs to happen and where responsibilities lie.</p> <p>JH suggested reviewing lab practices and ensuring the focus on homeless and drug-using populations is correct but supported the current approach. RS agreed to double-check all assumptions and interventions, acknowledging that previous efforts have not reduced rates.</p>	
4.	<p>Chief Medical Officer Update - Industrial Action and Winter Pressures</p>	

	Item	Action
	<p>JM reported another round of resident doctor industrial action is expected from 17th to 22nd December with mitigation plans underway and significant reporting required. The situation is complicated by increased flu rates, with over 2,500 people in hospital beds across England and the flu season arriving earlier and more severely than anticipated. This combined with annual leave and the Christmas period, is causing concerns about shift coverage. JM that national expectations for elective care continuation during strikes may be softened, as maintaining 90–95% elective activity is likely unachievable. The only way to keep patients safe may be to reduce elective care and redeploy workforce to urgent care. There is debate about banning annual leave for consultants over Christmas, which could have reputational impacts. If the situation worsens, a critical incident may be declared, leading to the cancellation of electives and potential harm from delayed care. JM stated there is little optimism that the government's new offer to resident doctors will be accepted, so strike action is likely.</p> <p>DJ added that the new offer does not include pay, which is a red line for the BMA, and the strike period may extend into late January, increasing disruption.</p> <p>ED noted the shift in public messaging to emphasise the impact on colleagues as well as patients. JH highlighted the need to work with the postgraduate dean to ensure locally employed posts are moved into training programs that meet local needs and to start this dialogue early to recruit ahead of other regions. JM reported that emergency legislative changes to medical recruitment are expected, which may cause controversy and have equality implications. There is a mismatch between increased medical school places and available junior doctor posts, creating further workforce challenges. JH offered her expertise as a former postgraduate medical dean to support the process.</p> <p>AM asked about risk register mitigations, especially regarding public messaging and local mitigations, and requested assurance on risks that cannot be mitigated. JM explained that risks are escalated through a clear derogation process and communications are ongoing about appropriate service use and flu. JM agreed to review the risk register to ensure it accurately reflects the current situation. AM emphasised that some risks to the population cannot be mitigated, and the committee should note this. JM agreed, noting that shifting resources to urgent care creates new risks, such as harm from delayed elective care and will review how this is described in the risk register.</p> <p>Medicines Optimisation: The team is forecasting a £3.3 million underspend, a significant achievement.</p> <p>Weight Management: The ICB is the top performer in England for delivery of weight management drugs in general practice.</p> <p>Seasonal Vaccines: Performance is generally good, with some areas for improvement, especially in children's vaccination. Weekly national reports are reviewed.</p>	

	Item	Action
4.1	<p>Women's Health: Despite no additional funding, work continues with system partners. A gynaecology health needs assessment is underway to inform future service redesign.</p> <p>Chief Nursing Officer Update</p> <p>Maternity System Performance RS shared positive news that the BNSSG LMNS is currently the highest performing Local Maternity and Neonatal System in the country, based on 32 national metrics, with only one red outlier related to trainee midwife experience which NBT is addressing. RS emphasised the importance of communicating positive outcomes to the population, especially as public perception is often negative. Plans are underway to share women's voices and stories to improve public understanding of maternity care. RS highlighted progress in the Black Maternity Matters program and improved outcomes for women racialised as Black. Community feedback indicates women feel safer in care, though ongoing work is needed.</p> <p>ED congratulated RS and the team for their focus and performance in maternity, referencing previous system changes and challenges. ED asked how confident RS is that the positive trajectory will continue in the new organisational structure. RS expressed confidence that BNSSG will maintain and improve maternity outcomes due to strong connections between trusts and executive commitment, including a three-year contract for the MMVP to ensure women's voices are heard.</p> <p>Continuing Healthcare (CHC) and Community Services RS reported that the CHC team is overperforming on their savings target, forecasting £7 million in savings. However, performance has been affected by sickness, turnover, and bereavements, with agency support used to maintain service levels. RS noted the importance of maintaining clinical assessor capacity to avoid performance drops, especially as the organisation transitions.</p> <p>AWP enhanced contractual oversight meetings are planned to return the team to business as usual from April 2026.</p> <p>AM commended improvements in AWP and noted the extraordinary number of missing clinical hours in CHC (245 hours/week), highlighting the impact on performance and the need for agency support. RS explained the vacancies are due to a mix of sickness, bereavement, turnover and agency support is used to mitigate pressure.</p> <p>AM asked JM about 28-day prescribing, noting repeated updates and requesting clarity on the timeline for resolution. JM explained the issue is due to digital infrastructure challenges in hospitals, with national guidance expected to drive prioritisation. AM suggested the report wording be amended to clarify whether the work is short, medium or long term. JM agreed to ensure this is reflected in future reports.</p> <p>ED asked if the hyperacute stroke pathway issue discussed today is the same as in quality report; RS confirmed she would address later in this meeting. ED</p>	

	Item	Action
	<p>also referenced a SWAST incident involving a patient asking about the committee's role and actions taken. RS explained that Dorset is the lead commissioner for the ambulance service and will lead the investigation. RS advised against including individual events in system quality reports and emphasised the need to support staff involved in challenging incidents. RS suggested future committee reports focus on themes and trends rather than provider-specific incidents.</p> <p>ACTION: JM to ensure that the wording regarding 28-day prescribing report clarifies expected timelines.</p> <p>ACTION: JM to ensure the Research Strategy summary is included in the CMO report in February OQPC.</p>	
5	<p>System Performance Update: Assurance and oversight of system performance governance as reviewed by System Executive Group.</p> <p>DJ began by highlighting positive system performance, noting that BNSSG system is the best in the country for diagnostic performance. RTT (Referral to Treatment) remains on track and while there is some variance in cancer performance, providers are expected to meet year-end trajectories. DJ also noted significant improvement in AWP (Avon and Wiltshire Partnership) with a reduction in inpatient length of stay and the elimination of out-of-area placements as of last week.</p> <p>Key Challenges</p> <p>DJ flagged ongoing challenges with ADHD and autism assessments, particularly the financial impact of the "right to choose" initiative, which allows patients to access private providers. A business case is coming in February to address children's ADHD and autism, but adult services remain a concern. Children and Young People (CYP) mental health access targets are unlikely to be met due to recruitment, data quality and seasonal factors. DJ is awaiting further information on projected performance.</p> <p>AM noted that the report's section on CYP mental health access lacked detail and assurance and questioned the RTT for UHBW over 52 weeks, which affects 381 children. AM asked for a breakdown of these cases and noted the large community waiting list (over 4,000), likely related to autism and ADHD. DJ confirmed the 381 children are waiting for acute care at UHBW, with a significant portion in oral health but agreed to provide a detailed breakdown. DJ acknowledged the issue spans multiple subspecialties. AM observed that the distributed nature of the waiting list could allow for incremental improvements across services.</p> <p>ED echoed concerns about the children's waiting list and suggested that closedown reports be prepared for key areas (MRSA, AWP, Sirona, no criteria to</p>	

	Item	Action
5.1	<p>reside and children’s services) for handover to the new organisation. DJ agreed, provided the process is succinct and does not distract teams from operational work. DJ suggested that these closedown reports could align with executive planning submissions. JM proposed that HGIG’s prepare closedown or transitional risk registers for ongoing operational challenges, integrating this into the annual cycle. DJ and JM agreed that the planning submission process could be used to generate these reports efficiently.</p> <p>Urgent Care and Winter Pressures</p> <p>DJ reported that urgent care remains the most challenging area, with the system already under winter pressure and having experienced a period of critical incident and OPEL 4 escalation. GP explained that the timely handover process for ambulances has significantly improved handover times and reduced average CatA performance, making the Southwest the best-performing region. However, this has shifted risk into acute hospitals, increasing occupancy and corridor care. DJ noted the impact of a critical incident at the BRI, which led to the closure of 40 beds and the rapid commissioning of additional community placements, adding further pressure to the system.</p> <p>JM described the ethical and moral injury concerns for staff due to the shift in risk and outlined plans to review the process through the system’s ethical group-REAF. ED asked GP for specific examples of actions that improved handover times. GP explained the formalisation of the 45-minute handover rule, which requires ambulance crews to withdraw after 45 minutes, pushing responsibility to hospital staff and using corridor spaces as buffers. RS and JH cautioned that while handover metrics have improved, the risk has simply shifted and the pressure on emergency departments and staff has increased.</p> <p>RS and JH emphasised the need to focus on flow and to avoid celebrating metrics that do not reflect improved patient outcomes. ED summarised that system flow remains the core challenge and commended the system for achieving strong results despite these pressures.</p> <p>No Criteria to Reside (NCTR) and Discharge Pathways</p> <p>DJ reported that the system remains off track for NCTR reduction, despite some improvement. DJ noted that provider ownership and engagement with action plans is improving but not yet sufficient. SD has written to local authority chief executives regarding P3 length of stay, with a response from Bristol but not North Somerset or South Gloucestershire.</p> <p>GP outlined four key next steps:</p> <ul style="list-style-type: none"> • Peer review across the community bed base to identify bottlenecks and unwarranted variation, with an external chair and open-book workforce data sharing. 	

	Item	Action
5.2	<ul style="list-style-type: none"> • Exploring consolidation and rebalancing of the community bed base, including a potential shift of acute capacity to community hospitals. • Sustained change at North Bristol Trust in pathway 1 referral demand. • Improved escalation and data sharing for delayed patients, with weekly reporting of live caseloads <p>JH asked if data could be analysed by deprivation index and complexity (multimorbidity) to inform interventions. AM commended the effort but expressed concern that trend data does not show sustainable improvement and questioned whether the current actions are sufficient to improve performance this winter. AM also noted the high dependence on local authorities and the need for system-wide commitment. ED echoed AM concerns, noting that BNSSG has remained near the bottom of national rankings for NCTR despite significant effort. ED suggested writing to Shane Devlin to express disappointment at the lack of system response, particularly from North Somerset. DJ agreed that further diagnostics are not needed; the focus must be on delivering agreed actions at pace. DJ will take the committee's message to the System Executive Group.</p> <p>ED confirmed that Dave would deliver this message to System Executive Group and thanked GP for his work, encouraging GP to leverage Jo Beer's (Chief Executive of Sirona care & health) expertise in the peer review process.</p> <p>Stroke Pathway Performance and Outcomes</p> <p>DJ introduced the stroke outcomes update, noting the absence of NBT colleagues and referencing the report presented by Phil Clatworthy, Consultant Stroke Neurologist. The report reviewed the impact of the stroke business case and pathway implementation on patient outcomes. DJ highlighted the Sentinel Stroke National Audit Programme score which was at its lowest earlier in the year at NBT, improving slightly to level D since April. DJ noted that multiple factors, including capacity and patient flow through the Scale for the Assessment and Rating of Ataxia (SARA), contributed to these results. The report included recommendations and actions to improve flow and outcomes, such as commissioning further capacity and moving teams.</p> <p>ACTION: OQPC Executive team to prepare succinct closedown reports for key areas (MRSA, AWP, Sirona, no criteria to reside, children's services) for handover to the new organisation, aligning with planning submissions and HCIG annual cycles.</p> <p>ACTION: HCIG's to prepare transitional risk registers for ongoing operational challenges.</p>	

	Item	Action
	<p>ACTION: NCTR - Peer review of community bed base to be completed by February with findings to inform planning and resource allocation.</p> <p>ACTION: OQP Committee to receive a further update regarding stroke pathway after NBT's internal review and workshop, with a short report summarising the current position and next steps before committee closure/transition.</p>	
6	Items for Information	
6.1	BNSSG Safeguarding Governance Group	
6.2	BNSSG System Quality Group	
6.3	BNSSG Area Prescribing Medicines Optimisation Committee	
6.4	LeDeR Governance Group	
6.5	BNSSG Health and Care Professional Executive	
7	<p>AOB BNSSG ICB Outcome Letter 2025 Core Assurance</p> <p>ED raised the topic of the BNSSG ICB outcome letter 2025 core assurance. ED asked if any further information or action was required from DJ. DJ responded that the item was just for information and did not require any action, confirming it was a great result for BNSSG ICB. JS clarified that the letter was simply to be noted at OQPC committee with no further action needed.</p>	
8	<p>Review of Committee Effectiveness</p> <ul style="list-style-type: none"> • Did the meeting run to time? • Did the right people attend? • Were action items assigned where appropriate to the right people? • Were all items given sufficient time to discuss? • Were all members able to contribute? <p>Has the meetings business contributed to the organisation's aims and objectives in terms of:</p> <ul style="list-style-type: none"> • Strategy • Planning • Governance • Were any of the items inappropriate for this committee? • Did the meeting receive the administrative support that it needed? 	
9	<p>Meeting Dates 2025/2026</p> <ul style="list-style-type: none"> • Thursday 26th February 2026 1330-1600 • Thursday 30th April 2026 1330-1600 	

Jodie Stephens Executive PA
December 2025