Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG CCG Quality Committee

Minutes of the telecon held on Thursday 23 April, 14.00 – 16.00

Minutes

Present		
Alison Moon	Independent Registered Nurse (Chair)	AM
Rosi Shepherd	Executive Director of Nursing & Quality	RS
Sarah Talbot-Williams	Independent Lay Member (Patient & Public Engagement)	STW
Nick Kennedy	Independent Secondary Care Doctor	NK
Peter Brindle	Medical Director, Clinical Effectiveness	PB
Apologies		
Lisa Manson	Director of Commissioning	LM
In attendance		
Lesley Le-Pine	Interim Quality lead Manager	LLP
Sarah Carr (item 5 only)	Corporate Secretary	SC
Freda Morgan (notes)	Executive PA	FM

	Item	**Action**
01	**Introduction** In recognition of the system impact of Covid-19, the meeting has been streamlined and focussed on the items in section 6. Any comments on items under section 7 are requested to be sent to Freda Morgan by close of play, Friday 1 May. **Minutes of last meeting** • The minutes were agreed as an accurate record with the following amendments: • Page 3 – Delete sentence on Critical Incident. • Page 5 – re-wording needed about service providers in the community **ACTION: RS/AM to review minutes to determine which sections should remain in Closed minutes, and which can be in Open minutes.** **ACTION: STW to provide re-wording for page 5**	**RS/AM** **STW**

	Item	Action
	It was noted the LeDeR Annual Report is going to Governing Body in May, and LLP has amended the report with the feedback provided by the QC members who reviewed the report. Action log updated as attached.	
02	**Apologies:** Lisa Manson, Director of Commissioning	
03	**Declarations of interest** None raised	
04	**Chair's Introduction** AM asked if there were additional concerns not already to be covered in today's meeting. None were identified. Included for information with papers for this meeting was a letter from NHSE/I with suggestions of what activities should be continued, and what paused during Covid. AM asked members to note which actions are being paused and carried on, as we go through the Quality & Performance Report.	
05	**Risks and Mitigations**	
05.1 05.2	**Corporate Risk Register** **Governing Body Assurance Framework (GBAF)** SC joined the meeting to present this item. Most of the risks on the Corporate Risk Register either have been, or are currently being, reviewed for relevance to 2020/21. Risks which are no longer relevant will be renewed, and new risks are being added. The Governing Body Assurance Framework (GBAF) presents the framework for 2019/20. A new or amended framework is to be put in place for 20/21, and it is planned to hold a seminar at Governing Body in June to discuss corporate objectives. The new Corporate Risk Register and GBAF are due to go to Governing Body at the end of Quarter 1. STW asked where the decision making lies in terms of things such as ADHD, Mental Health services and health assessments for Looked After Children, which could present an issue in the future if not continued during COVID 19,	

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	as there is already a significant risk around waiting lists. PB said these concerns had been registered both within the BNSSG system and nationally. There has been an efficient move to close things down to mitigate the risk to NHS capacity and reduce the risk of infection, however this process was necessarily a lot briefer than would otherwise be followed to make a substantial change to a service under normal circumstances. A process is being set up through a system-wide enabling group to ensure that all the cells working on Covid will assess the risks and benefits of the changes they have made to services. AM asked when the Governing Body would see the CCG's proposed approach, and if PB and RS were assured of the systems and processes that providers have in place during this period. PB will be bringing a short briefing to Governing Body in May. PB said the work programme is developing a proportionate way of gaining assurance. The Acute Trusts have a plan to prepare prioritisation schedules for surgery, but this needs to be consistent and visible at a system level. NK asked about the potential for litigation, as some of the decisions made during this period may be open to challenge, and asked if the CCG has Governance oversight and assurance to be able to quantify those decisions in a robust way? PB confirmed that the Healthier Together Clinical Cabinet is keeping a clear decision log with explanation of what decisions have been made and why. The CCG needs to take a full population view of this, to ensure consistency and address patients' needs and priorities. The CCG needs to understand the needs and priorities of the BNSSG population, bearing in mind this population is diverse, and recognising that different groups will be very differently affected by changes made. SC updated that NHS Resolution has written to all organisations, and confirmed that all staff are indemnified for their activities in response to Covid-19, and this extends across all trusts. A new indemnity scheme has been set up for this purpose. STW asked about concerns expressed by the Independent Mental Health Network, about few people being able to access Mental Health services, including IAPT, which could be continued with virtual services. This group of the population are likely to be significantly impacted and asked how this will be incorporated.	

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	PB agreed there is a sense that mental health will be affected more than any other at present; not just by access to services, but also the implications of lockdown and the anxiety-inducing nature of a pandemic. There can be a general reluctance with people with mental health difficulties to access care for various reasons. Impact on quality of life as well as length of life will be included in the criteria being brought to Clinical Cabinet, so the overall value of all interventions and care for people can be discussed. PB confirmed that the local IAPT provider, Vita Health, has moved to a total remote service, and the NHS is still open in this regard. PB added that there are concerns around the impact of a reduction in preventative pre-emptive social care work to reduce the risk of crisis. The work being undertaken around Mental Health is a system-wide piece of work, recognising that much of this care may be in the social care sector not health. HF said there is a balance between ensuring the capacity to deal with patients in the current situation, and the ability to align available capacity once we come out of lockdown. When system discussions are happening around plans and interventions to improve performance, new trajectories will need to be drawn up around what services are going to be reinstated; there will be less capacity as some will remain aligned to Covid-19. PB said there is a need to work together both nationally and regionally on this, taking every 2-3 days at a time and using the data and information we have today to think about the needs of next week, while trying to have a view of what the world may look like in a month's time. AM said these are the sorts of discussions and decision making that Governing Body should be making, which will be transparent to the public. RS spoke to the system Chief Nurses last week about the complexity of going back to business as usual; not only prioritisation and risk management, but the risk to non-COVID patients coming into hospitals for treatment while we are still in Covid-19. This will play into decisions being made on which patients are most appropriate to come into hospital, and is a debate which needs to be had both at Clinical Cabinet and at Governing Body. AM noted that our responsibility around supply chain of for example PPE or medications, is not mentioned in the Corporate Risk Register, and the Nightingale Hospital is not mentioned in regard to capacity; she queried these aspects as risks in our system and if so whether they should be explicit and mitigations included.	

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	AM noted there is a significant drop in people presenting with cancer symptoms, heart attacks and strokes, and asked what is being done to encourage people to still seek appropriate medical attention. PB said he had heard that there are some plans for a national communications campaign to share the message that the NHS is open. This needs to be backed up with messaging from the CCG. HF said this messaging was mentioned in Matt Hancock's update yesterday evening. STW said the Strategic Communications Cell are sending out messages to ask people to present if there is a need. AM thanked SC for her reports, and thanked the Committee for their contributions to this discussion.	
06	**Discussion Items**	
06.1.1 06.1.2	**COVID-19 Oversight and Response** **COVID-19 Provider Assurance and Governance** Rosi Shepherd updated the current position on Covid-19. **Risks** PPE remains a potential significant risk in light of supply issues and the regularly changing guidance. AM said this reiterates that the risk register is not up to date on the specifics of some risks and needs review and updating. *PB and SC left the meeting* RS said Sarah Truelove has a proposed risk template in place which has gone to all cells. There is a lot of positive work with a range of care providers, especially in collaboration with Sirona and our Local Authorities. There is a risk that care providers, both care homes and domiciliary care, will struggle to cope with Covid-19. There is a huge impact emotionally as well as the risk to physical health and wellbeing. CHC staff are being deployed to the integrated SPAs in Sirona along with social care colleagues, to provide a wraparound first point of contact for care providers regarding PPE and	

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	infection control. Linked into that are hospices, End of Life Cell and Frailty GPs. A range of support is available for those care providers to get targeted advice and support based on need, including an online resource library which includes YouTube clips on donning and doffing PPE. This is all being co-ordinated through the Care Provider Cell. This is part of the rapid transformation piece, and may form new ways of working for the future as multi-agency community working, and is part of coordinating the system response to align with local authorities and delivering a place based response. The LeDeR reviews will be continuing, and the CCG has chosen not to stand down this service and is recruiting additional reviewers to ensure that we are able to continue doing our reviews. **Mitigation Actions** Command and Control structure has changed, and a risk register piece of work is being undertaken. Normal CHC processes have been stood down, and work is being undertaken to assess how well this is working, what improvements have been made, and what the financial impact has been for the CCG. A huge opportunity has been made for complex care teams, who are focusing on a risk-based approach to case management. RS has had an online meeting with fellow Chief Nurses about governance within Trusts. There was a brief period where some core committees were stood down, but these have been stood up again so all Trusts in the system, and Sirona, are having normal (virtual) board meetings, quality and risk committees. A revised approach to Serious Incidents is being agreed, focusing only on detailed investigations for those which are high risk, or where new learning needs to be gained. There is a meeting with Chief Nurses on a fortnightly basis to discuss governance and risk,–SI closure updates, and the CCG's Quality Team are producing a weekly SI report, to identify if there is a pattern of reported incidents. AM noted the level of provider assurance. Trusts need to produce a regular learning from deaths report in a steady state, and she asked if there was confirmation that this would continue, and in what format as this would support wider learning. **ACTION: RS to find out if Trusts are continuing to produce a learning from deaths report, and in what format.** AM asked if monthly LeDeR Steering Group meetings should be reinstated, to keep a regular focus. RS agreed; as the number of deaths are rising, it is not appropriate to slow this down.	**RS**

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	AM asked if the slide deck will pick up the Covid-19 legislation. RS said this will be part of routine reporting.	
06.2	**Quality & Performance Report** HF presented the Performance Report, asking the committee to be mindful that the data is the same as the previous month's report due to the changes in reporting required during the initial period of COVID 19. There are some positive aspects; the number of patients medically fit for discharge has been reduced, and some of the interventions and initiatives in the Long Term Plan have been moved forward. Alamac is reporting A&E performance above 90%, and there is a balance between the capacity available for Covid-19 patients, and potential future impact. NK said that one of the issues around when we re-start surgical services is around PPE; most procedures demand a degree of PPE, so it is difficult to justify any non-Covid-19 related activity while PPE is so limited. AM asked what percentage of cancer operations are taking place and what the plan would be in recovery **ACTION: HF to get a clear view of what the percentage of cancer operations or treatment is being taken across the system.** HF said that staffing may be an issue as well as PPE, and there is a need to look at how to utilise additional staffing, once it has been prioritised what will be reinstated across the system. Planned Care will also be discussed through Governing Body. STW referred to the figures on page 8, and asked if there was an inaccuracy on 4 hour waits, which says "16th, down from 16th". She also queried page 29 which speaks of Mental Health performance improving slightly but then falling. AM said there appears to be some typos in these pieces. **ACTION: HF to check the figures on pages 8 and 29 of the Performance Report for accuracy.** RS presented the Quality Report. New format slides will be in use from May, to include LeDeR and CHC slides and more fully represent the work of the team. A risk-based approach conversation has been held with AWP, and a new approach is to be taken regarding quality assurance. RS has spoken to Julie Kerry and agreed top line risks going forward, to keep sight on their significant risk issues and how the CCG can best support. AWP have done a lot of work on internal governance which has been shared proactively.	**HF** **HF**

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	STW said that before taking over the IAPT contract, Vita Health spoke of developing their services with other organisations in the mental health sector, but this doesn't seem to have occurred. Her understanding was that Governing Body had reported that Vita Health's performance was poor due to a larger backlog than expected, but the slides do not appear to reflect this. HF confirmed the backlog was greater than expected. STW asked if statistics are being maintained on MRSA. RS said she will double-check this. A lot of MRSA is in relation to drug injecting homeless who are now in a different situation. She said she would also check with Public Health England where we are with the redesign work on this. **ACTION: RS to find out if statistics are being maintained on MRSA** **RS** **ACTION: RS to ask Public Health England about the status of redesign work on MRSA.** **RS** STW asked if each Serious Incident is investigated in depth. RS said investigations of Serious Incidents depend on the clarity of the initial reporting of the incident. If it is clear that causative factors are understood and have been dealt with, there will not necessarily be a full RCA during the COVID 19 period. However with factors such as sub-optimal care, a full RCA would be expected. There is an aim during the COVID 19 period, to pick out Serious Incidents with good learning, and focus on these to get a better understanding on the impact of patients, and on changing systems or human factor risks which led to the incident. AM noted the time delay in these reports. She said there were three things that would benefit from a higher profile in the Quality and Performance Report which then goes to Governing Body. 1) The CCG's leadership role in supporting care homes; what providers have been asked to do, and how care homes are being supported during Covid. 2) The role of the CCG in understanding the increased risk of domestic violence and child protection issues, and what is being expected of providers. 3) Awareness of childhood immunisations, whether these are on track and if there is a role for primary care or community services to support if there is a decreased rate of immunisations.	

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	RS thanked AM for her comments. **ACTION: RS/HF to collaborate to include the points highlighted by AM in the front sheet of the Quality & Performance Report to Governing Body.**	**RS**
06.3	**Independent Hospital Briefing Paper** RS presented this paper which will be going on to Governing Body. The issue regarding rectopexy and actions going forward will be supported by advice from NK, and the way the provider manages the sub-contracting process. There is a template in appendix 3 which is a draft proposal on a risk-based approach to quality assurance in the independent sector going forward and there will be specific frameworks for NHS providers and Sirona. These will support focussing on a risk based and quality improvement approach and aim to reduce the burden of additional reporting for the providers. This is the first draft and incorporates some of the existing Quality Surveillance Group escalation framework that was used by NHS England and Improvement; it aims to show what business as usual (BAU) should look like, and the thresholds for going into amber if risks are not being resolved through BAU, or if there are multiple high level risks creating a need for more enhanced support. This framework is intended to support a risk based approach to assurance, less additional reports being required of providers and a greater focus on quality improvement. STW commented that the Paterson report in the appendix cites the inaccessibility of patient information in private providers as a clear problem, such as with the rectopexy issue at Spire Bristol, but this doesn't appear as a core issue in this paper. RS said that page 7 speaks about a quality assurance visit to Spire Bristol in January, and bullet point 3 raises concerns around record keeping, but agreed this point could be reinforced. NK said that historically private hospitals owned the records and kept them, so these were not in public domain, which is not the case with NHS patients. He said he was not aware what oversight regulations are in place with private hospitals. RS said that, if carrying out NHS work, independent hospitals will be required	

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	to comply with NHS regulations. Part of the work to be done this year is to be clear that if an acute trust is sub-contracting to any other provider, they need to assure themselves of all aspects of compliance with the standard NHS contract including clinical record keeping. NK asked if private providers are mandated to attend the Quality Surveillance Group. RS said that, following discussions with colleagues, the position is that the Quality Surveillance Group is the ICS system governance forum and so independent providers will not be included. The QSG will be looking at system risks and not individual provider risks. Individual provider governance will be carried out through contractual oversight processes. NK said that the CQUINS for the private sector appear minimal, with no clinical content. RS said these will be picked up by the contracts teams going forward. NK suggested record keeping should be a CQUIN. RS said there is a need to see which are nationally mandated, and which can be negotiated locally, and what financial leverage can be attached to these. AM also commented that there could be a stronger focus on the responsibility around sub-contracting from acute providers. RS said that this paper focusses on assurance, and that Lisa Manson has delivered a paper on the sub-contracting issues. AM said the desired outcome is that when funded care is commissioned that there must be robust governance around clinical decision making including all aspects of record keeping. NK suggested there should be more emphasis on decision making being done as part of the commissioning trust's NHS MDT process, and not part of a separate process within the independent provider. He also said that the role of the medical advisory committee in private hospitals is important, and can have a lot of influence. **ACTION: RS and HF to meet to discuss clinical audits**	**RS/HF**
06.4	**Harm Reviews for Patients Experiencing Treatment Delays** RS updated that this is included in the future plans work that PB spoke about earlier. There is still work to be done on what a robust harm review process should look like.	

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07	**Items for Information** **7.1 Looked After Children Q3 Report & Action Plan** This report is in the new style format, and will be going to Governing Body. STW commented this was a useful paper, and praised the new format. She questioned whether care leavers are being allowed to leave at present, as there is a duty of care to safeguard them. She asked if there was assurance that the health and wellbeing of Looked After Children is being looked after. RS said she will talk to Jane Guvenir about this, as during Covid, LAC work is being embedded with Children's Complex Care. Case management is being undertaken more closely; initial health assessments had stopped, but there is a risk based approach to case management, which will give a better model going forward, and enable a better understanding of needs. RS clarified that the lack of figures or cases in North Somerset is due to data submission to us from the Local Authority. **ACTION: RS & LLP to chase figures from North Somerset, and ensure embedded documents are separated out, to make the document more readable for Governing Body** AM agreed that the new report format is very helpful. She noted the appreciative enquiry review, and asked what work can be done to improve assessments now, as the workshop with the provider had been deferred. RS said there are elements that are being carried on during the COVID 19 period, and will make sure this is articulated for Governing Body. **7.5 NHSE Safeguarding Q4 Return** STW commented there are a number of embedded documents in the safeguarding reports that can't be seen on Boardpacks, and she would be interested in seeing some of those to have a look at. AM asked if there were any recommendations in the Serious Case Reviews which are significant enough to include in the safeguarding quality schedule for next year. **ACTION: RS to check if there were any recommendations in the Serious Case Reviews which are significant enough to include in the Safeguarding Quality Schedule for next year.** **7.4 Quality Schedule for new contracts** AM asked if, in the light of COVID 19, this was still the right quality schedule for 2020/21. RS said discussions have been held with Chief Nurses on both CQUINS and the Quality Schedule, and once we start to enter recovery, their appropriateness will be reviewed.	**RS/LLP** **RS**

	Item	Action
08	**New Risks Identified** None identified	
09	**Any Other Business** None identified.	
15	**Review of committee effectiveness** The committee agreed there had been focus on appropriate subjects.	
	Date of next meeting: Thursday 21 May 2020	

Freda Morgan
Executive PA
23 April 2020