Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Quality Committee

Minutes of the meeting held on 24 September, 1230-1600 on MS Teams

Minutes

Present		
Alison Moon (Chair)	Independent Registered Nurse	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
Niall Prosser	Deputy Director of Commissioning (Planning & Performance)	NP
Martin Jones	Medical Director, Commissioning & Primary Care	MJ
Apologies		
Lisa Manson	Director of Commissioning	LM
Ben Burrows	Clinical Lead GP	BB
Peter Brindle	Medical Director, Clinical Effectiveness	PB
Sheila Loveridge	IPC Lead	SL
Debbie Campbell	Deputy Director, Medicines Optimisation	DC
In attendance		
Lesley Le-Pine	Interim Quality Lead Manager	LLP
Michael Richardson	Deputy Director of Nursing & Quality	MR
Anne Fry (Item 6.3)	Head of Safeguarding Children (Designated Nurse)	AF
Angela Stephen (Item 6.3)	Designated LAC Nurse	AS
Katy Burton (Item 6.3)	Safeguarding & Quality Manager	KB
James Bayliss (Item 6.4)	Lead Quality and HCAI Manager	JB
Liz Jonas (Item 6.4)	Interface Pharmacist	LJ
Freda Morgan (notes)	Executive PA	FM

	Item	**Action**
01	**Welcome and Apologies** Apologies noted as above. Niall Prosser was welcomed to his first Quality Committee meeting.	
02	**Declarations of Interest** None declared	

	Item	Action
03.1	**Minutes of August 2020 meeting** The minutes were agreed as an accurate record, with the following amendments. Page 1: Ben Burrow's role is Clinical Lead GP Page 2: Removal of some shading on the amendments to minutes Page 7: Action on Serious Incident Compliance Report should lie with MR AM asked if there was further thinking on harm and waiting following discussions under item 6.1. RS said the system restoration slides under item 6.1 would provoke discussion on where risks lie in the system and what is being done to mitigate these risks.	
03.2	**Action Log** The action log was updated as attached.	
03.3	**Matters Arising** AM asked for a timeline for assurance on health inequalities and clinical prioritisation to be brought to this committee. It has been agreed that a health inequalities report will be presented to the System Delivery Oversight Group (SDOG) on a quarterly basis. LLP has written to UHBW and NBT, asking for details of plans around clinical harm and prioritisation. RS has spoken to acute colleagues who have confirmed that they are using the Royal College of Surgeons (RCS) guidance on harm reviews. National guidance has not yet been issued. MJ reported that Julia Ross (Chief Executive, BNSSG CG) had met with Rachel Pearce (Director of Commissioning, NHSE/I South West), and there may be national funding to help GPs review waiting lists, which would be an opportunity to look at health inequalities in primary care. AM asked if harm reviews include psychological harm, and whether this was considered to be equal to physical harm when waiting. She asked for a paper to be brought to the October Quality Committee to provide assurance as a system that patients on waiting lists are being reviewed and prioritised appropriately, and assessments are taking place to ensure that harm is minimised. **ACTION: NP to bring a paper to the October Quality Committee providing assurance on harm reviews for patients on waiting list.** NP advised that there is verbal assurance that each provider's waiting list is validated every two weeks, and every patient over a certain threshold also undergoes a clinical review. He offered to approach providers and	**NP**

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	ask for written assurance. RS suggested she and NP collaborate on this, so the letter can include questions on psychological impact and health inequalities. **ACTION: NP and RS to write to providers asking for assurance that waiting lists are being reviewed in line with national guidance, and whether psychological harm and health inequalities are being taken into account when reviewing these lists.** MJ suggested requesting a non-identifiable sample of some of the information documentation from these reviews, to provide assurance.	**NP/RS**
04	**Chairs Introduction** AM asked if there were any concerns which the committee needed to be aware of that were not on the agenda. No risks or concerns were raised.	
05	**Risks and Mitigations**	
05.1	**Corporate Risk Register** The Covid risk remains fluid and will require regular updating. AM asked if there was a role for the CCG to support encouraging uptake of Cancer screening. NP said we have received a letter from Public Health England requesting assurance that screening services will return to pre-Covid levels of activity, and plans are in place to achieve this. MJ advised that Geeta Iyer (Primary Care Provider Development Clinical Lead) has presented a paper on screening at the Primary Care cell and to Healthier Together Clinical Cabinet, and is working to include health inequalities in this. NP stated that challenges remain within Phase 3 planning in endoscopy and imaging/screening services. Plans are in place to get back to above pre-Covid capacity for endoscopy, but that assurance cannot yet be given that this is deliverable AM requested a timeline of mitigating actions being undertaken particularly for Commissioning. **ACTION: NP to provide a timeline of mitigating actions for Phase 3 planning being undertaken by Commissioning**	**NP**
05.2	**Governing Body Assurance Framework** There is more resilience in the Nursing & Quality Directorate, following the recruitment of MR and Denise Moorhouse (Interim Associate Director, Funded Healthcare) and BB as Clinical Lead GP.	

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	Inclusion of a wider range of nursing leaders into the regular System Directors of Nursing meeting will be considered as part of the Integrated Care System (ICS) planning. The current risk rating of 20 for AWP is a risk to achieving our strategic objective. AM asked if there was confidence that LD and Autism wards had continued to improve since March. RS said this is discussed at the provider assurance meeting, and at the trust's internal Quality& Governance Committee which the BNSSG Quality Team have attended. RS said while AWP have made significant improvement in some areas, there are areas that still need improvement. MJ said AWP have committed themselves to a 360 review on their strategy, and want to learn from other people's points of view. He has had a very positive interview with AWP. As we develop community mental health services jointly with them, this should mitigate against their capacity and patient experience. **ACTION: RS to feed back comments on AWP from the Quality Committee to Deborah El Sayed, as lead director.**	**RS**
06	**Items for Discussion**	
06.1	**Covid Update**	
6.1.1	**Current Position** There is a large regional variance, and the South West continues to have a low rate of infection. The rate of infection across BNSSG was close to the concern threshold but has decreased in the last week. Ongoing conversations are being held with regional and national teams about restarting a system management approach. The CCG continues to ensure resilience through business continuity plans, and will be carrying out an exercise in October to test resilience in the event of Covid concurrent with other infections such as a flu outbreak. Work is ongoing with providers to gain assurance that EPRR plans are in place, and partners are preparing to re-escalate plans if required. System focus is on planning for recovery and Phase 3 planning. STW asked what plans were in place for care homes. RS said the Care Provider Cell, chaired by Mary Lewis (Director of Nursing, Sirona) continues to provide a tactical response. The Clinical Reference Group is making sure education and training is available, and there is a system Care Home Transformation Board chaired by North Somerset Council. The CCG is working closely with system partners to ensure there is enough IPC capacity in the system to support the care provider sector, including domiciliary care and supported living. The current IPC Lead,	

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	Sheila Loveridge, will be leaving, but agencies have been approached for replacements. A proposal has been put to system partners through the IPC Strategic Group for the resource required to recruit additional capacity to be managed on behalf of the system by Sirona Health and Care. Longer term funding is also being sought for the Sirona Care Home Leads. Due to concern about care home outbreaks, the Wednesday Bronze Command Call is now IPC focussed, so all system partners can communicate their position in terms of outbreaks and community transmission. AM said powerful case studies were reported to this morning's LeDeR Steering Group, on community deaths of 15 people with Learning Disabilities in March and April. The recommendations from these would be relevant to any care setting. An action has arisen for LLP to speak to RS regarding these recommendations. LLP said the Sirona team produced a good, succinct presentation in terms of learning for primary and secondary care, with easy learning to implement before the second wave. This presentation will be seen by other groups, including the Care Home Provider Cell. **ACTION: LLP to ask Mary Lewis to include the presentation on LeDeR Covid deaths on the agenda for the Care Home Provider Cell** AM asked for outputs from this morning's LeDeR Steering Group to be presented to the October Quality Committee. **ACTION: LLP to ask Sirona to present the findings on LeDeR Covid Deaths at the October Quality Committee.** MR advised that mass Covid vaccination plans are being drawn up and NBT is the lead provider for the BNSSG system to co-ordinate this. It is anticipated that there may be a vaccine, for some parts of the population, by November. The Government's Social Care Winter Plan includes an IPC checklist, to be discussed at IPC Strategic Cell on 1 October.	**LLP** **LLP**
06.1.2	**System Restoration** NP shared the Phase 3 21/09 Submission Activity Summary. The second draft of this is to be signed off on Monday with the final submission at the beginning of October. There remain significant challenges within the Phase 3 plan including the restoration of services to pre-Covid levels. Challenges remain in restoring elective activity, particularly in areas such as the Dental Hospital which is open plan, so harder to impose social distancing. National planning includes potential for Priority 5, where a patient elects to	

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	remain on the waiting list but defers their intervention. This group would remain on the waiting list and be assessed as other patients, but would not be included for performance purposes. STW asked why some projections were fluctuating rather than showing steady growth. NP explained this is partly due to being a comparator to the previous month; in March services reduced to support the Covid response. Detailed planning this year will build a new understanding around the Did Not Attend (DNA) rate and winter planning, which was not included in as much detail last year. The predicted number of 52 week waits was high for the end of the year. BNSSG submissions are showing a reduction in the predicted number, however this remains a significant risk which is recognised nationally. The original predictions for the return of A&E activity and non-elective activity are broadly in line with the national average. Referrals are expected to be behind national average in Quarter 3, but in line by Quarter 4. The growth in the waiting list is higher than the national average, partly driven by a low level of activity BNSSG were a large user of the independent sector for elective activity, and although this is a main mitigation post-Covid, the system is heavily impacted by a lack of capacity. Discussions are ongoing with regional and national teams on how the independent sector can be used appropriately for planned care. The area causing most concern is endoscopy performance. Challenges within endoscopy are related to physical capacity and IPC regulations that are in place. There is a particular challenge at the BRI, where the endoscopy suite shares a recovery space with operating theatres, and it is proving difficult to meet IPC guidance. Diagnostics are close to returning to pre-Covid levels, and in some places are exceeding the national guidance. As part of the next phase submission, the Healthier Together finance team are working out what is achievable within available resources. A process is underway to prioritise and review mitigation schemes. The plan will be signed off by Healthier Together Chief Executives on Monday. There are a number of mitigations in the plan which do not necessarily improve performance against metrics, but are highlighted as key for the system. There is a business case to support and manage the future demands and challenges of Mental Health which is part of the process of highlighting clinical and quality urgency in performance improvement.	

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	AM said she has heard that fatigue is an issue for providers. She asked if NP was aware how this is recognised as a risk within the system, and what can be done to minimise the effect of widespread fatigue. NP said that each mitigation describes the workforce impact. The Healthier Together Executive Team have recently signed off a shared people plan, and there is work being carried out across the system to address workforce issues with a range of support options in place. RS added that there is recognition of the psychological impact of Covid on the workforce across Health and Social Care, and various national support programmes are being put in place.	
6.2	**Quality & Performance Reports**	
6.2.1	**Quality Report** The July reporting period had a significant focus on Covid. National CQUINS have been suspended, with the exception of flu. MR is working with Debbie Campbell (Deputy Director, Medicines Optimisation) to coordinate the system flu response. A Serious Incident was reported in August, where generators failed at UHBW, taking the system into Critical Incident. Power was quickly restored and an RCA is awaited from the trust. The investigation into the outbreak at Weston General Hospital was published this month. The Harm Review has identified it is likely that 18 patients died as a result of contracting Covid in hospital. The CCG will review these deaths as a group. Julia Ross met with Jonathan Webster on Monday, and RS is working with Carolyn Mills (Director of Nursing) and Bill Oldfield (Medical Director) at UHBW to ensure system learning is covered. Concern was raised last month over the time frame for LeDeR reviews. An agency worker has been recruited with experience in this field, and all but two reviews are now allocated giving strong confidence that all reviews will be completed within the required timeframe. The importance on completing these reviews in a timely way to ensure learning about deaths during Covid can be embedded back into the system. AM commended the executive summary, which described the main points of concern. AM asked if the RCA on the outage at the BRI would cover patient experience and outcomes. RS agreed that this should be the case. **ACTION: MR to ask Heidi Buck whether the RCA on the outage at the BRI will cover patient experience and outcomes**	**MR**

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	LLP recalled a similar incident at NBT, which revealed the need to ensure back up generators are tested for longer, random periods of time, not just 10 minutes. **ACTION: MR to speak to UHBW about testing periods for back-up generators** AM queried the Acute Providers report from UHBW which refers to "our" Bristol hospitals. The report needs to be clear it is from the CCG. AM asked if any themes had arisen from the complaints at NBT. **ACTION: RS to identify any themes from the complaints at NBT, and amend this slide before presenting to Governing Body.** AM asked if the section on providers should include hospices and the independent sector. AM noted reference to a potential Covid peak affecting the vaccination schedule and workforce. She asked what mitigations were in place should 10-20% of staff be absent. MR advised that system flu meetings are being held and an outbreak response being prepared through business continuity. Many assurance and SI meetings had been stood down during Phase 1. AM asked if there will be a different approach in any subsequent surge. RS said ICQPMs have been stood back up and that these will continue. Quality Assurance meetings with AWP were not stood down due to the risks being managed by this provider. A significant impact of Covid was that a significant number of the Quality Team was redeployed during the first COVID surge. The plan is to source additional staff to carry out IPC work, and allow the team to carry on with core quality work. NK queried the SI reported by a Mental Health provider; he said there appear to be pending reviews going back some months, and asked if this was a concern. RS said AWP have improved timing of reporting, and there is a plan to carry out a thematic review next month. Some delays were due to the deployment of the Quality Team. Melanie Ingham has carried out a clearance of SI reports, including a review of BNSSG process issues. NBT have been chosen as an early adopter for the Patient Safety Incident Reporting Framework (PSIRF). MR is working with them on this, and they are keen to disseminate across the whole BNSSG system.	**MR** **RS**
06.2.2	**Performance Report** A&E performance significantly improved during Covid, due to low rates of attendance and admission. Activity is increased and performance is now	

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	back below the national target. Work is ongoing to improve this position, and a business case is being put forward to change discharge pathways with the ambition of de-escalating a lot of challenges in hospitals. The national 111 First programme goes live in the next few months which will also aid improvement. As previously discussed, 52ww are increasing, and the position remains challenged. Cancer treatments continued during Covid although the numbers of people receiving treatment has decreased. Performance across the system remains pressured, although some areas are performing better than the national average. AM observed that it is positive that there are areas where BNSSG is leading the way, and asked if there is any merit in terms of cancer performance in looking at other systems who are performing better. NP said that pre-Covid we had a detailed understanding of pressure points. In P3 Planning, teams are sharing what they think best practices are, and these are being validated to see if they are in the Phase 3 plan for cancer. AM said it was good to see the summary in STPs, and noted it had changed a lot since the previous report. She asked if it would be worth having trend arrows on the slide, and asked about the number of long waiters on slide 13. NP said system performance has been challenged in RTT for some time, and this is likely to continue, due to both access to support and theatre access. The system is exploring a new model of delivery for orthopaedics, and starting to describe orthopaedics as a single service, so there is a large change agenda which will help in the long term. In the short term, assurance will need to come from conversations about waiting list management and the continued use of the independent sector.	
06.3	**Safeguarding**	
06.3.1	**Safeguarding Adults & Children Q1 Report** AF highlighted the following points: • The main issues during Covid were concerns around outbreaks in care settings. The team worked hard to ensure safety and are taking learning forward • Potential issues of organisational safeguarding concerns • Domestic Abuse risks: MARAC meetings continued. • LPS is delayed and will not come into place until April 2022. The CCG will need to make sure people are as aware and up to date as possible on the current Mental Capacity Act. • Training compliance in the CCG is at 85%. The team have spoken to all providers, recognising there may be a drop in compliance, and	

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	asking for mitigations on how this will be increased. NBT are already back at 80% compliance. • A new named GP for Safeguarding Children (Farzana Hakim) has been appointed, to work across the BNSSG area with Helen Mutch. • Training is being provided virtually on Zoom KB presented Adult A Review. This Safeguarding Adults Review was published at the end of July and a learning brief produced. Paulette Nuttall is putting together an action plan for the Local Authority, working extensively with BrisDoc, Public Health and NBT, particularly around drugs and alcohol. She is looking for someone to take the lead on commissioning a proposed seven-day service for drugs and alcohol. RS has raised this at Keeping Bristol Safe Partnership (KBSP). RS has attended Safeguarding Executive meetings covering both children and adult services in all three localities, as well as the Avon & Somerset Strategic Safeguarding Partnership (ASSSP). There has been good discussion on the challenges currently being experienced in safeguarding. Harm to children including non-accidental injury to small babies has been discussed, and it has been agreed to do a system learning piece on this, arising from the Safeguarding Children Review being presented at today's meeting. This will be discussed further at an ASSSP meeting on Monday. There are different levels of contributions and funding across all three local authority areas, and some are struggling with capacity. Further work is needed to ensure consistency of resource across the safeguarding partnerships to ensure that their work programmes are supported. STW asked what learning arose during the Covid period, particularly around children's safeguarding. AF said issues related to the reduction in direct contact with children or families resulting in concerns that there would be a rise in hidden harm. To date this rise has not been evidenced. RS advised that this is being discussed at all the safeguarding executive partnership meetings.. Concern has been expressed at all partnerships about the impact of the national requirement for Health Visitors to be deployed into other roles during Covid. Feedback from learning recommends this not to happen again. STW asked what a "Channel Panel" is. AF explained this is a panel which decides what interventions to put in place to divert someone from a potential terrorist pathway. STW did not recall care home safeguarding being included in previous reports, and asked if this was a new issue. AF explained that some of the instructions around care home visiting had been perceived as safeguarding, and reports were received by safeguarding adult services. STW queried the use of the phrase "grab guide" to describe training on domestic abuse.	

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	AM said that at LeDeR Steering group this morning, when asked for assurance on adult review process assurance from adults was received, but anecdotally there was less confidence noted in the CDOP process. She asked if assurance could be provided at some point about the consistency of the CDOP process. **ACTION: MR to provide feedback to Quality Committee from the next CDOP meeting** AM complimented the safeguarding team on a good paper. She requested the next quarterly report include a risk section that discusses immediate risks, one of the largest of which is the lack of a single/integrated electronic patient record.	**MR**
06.3.2	**LAC Action Plan Update** Work is ongoing with the transformation team to produce the "Map of The World". They are helping to engage with providers to coordinate across the CCG and involve children's nurses. A Children's Operational Board Sub-Group has been developed. Local Authority and Police partners are involved, and Public Health are to be approached. A Corporate Parent Board dedicated to Health will meet in November. More detail is being received from Local Authorities on what LAC Health teams can contribute to above and beyond a health assessment. A Mental Health Pathway Working Group is in development, involving the Police, Health and Local Authorities. Concerns have arisen through Rapid Reviews of young people at risk of exploitation and self-harm. Resources are being pulled together for access by anyone coordinating work for children in care. AM noted the progress made.	
06.4	**C.Diff Deep Dive** A deep dive has been undertaken into the he increased rate of C.Diff in the system and further information will be presented to the October Quality Committee. C.Diff cases have remained stable for three years. BNSSG are often below the benchmark, and fare well against other CCGs in the South West. However during Quarter 1 this year, an increase was observed nationally.. This was discussed at the NHSE/I South West Infection Control Committee and at the CCG's AMR Strategy Board in August. The factors driving the increase have not yet been fully identified In the BNSSG deep dive a cohort of patients who were reported as having C diff in June were reviewed. A data tool was developed, using national guidance and taking advice from the regional AMR stewardship lead. C.Diff	

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	infection is associated with an increase in fatalities, and the aim of the review was to capture whether patients are dying due to infection. From the 21 community cases in the June cohort, 20 have been reviewed. Three key elements have stood out: • Half of these patients did not have C.Diff documented in GP summaries. This is to be taken forward with practices. • Seven of the patients were prescribed clindamycin, an antibiotic associated with C.Diff. This drug is in guidelines for patients with cellulitis, but for five of these patients, the prescription was outside of guidance. An audit is being carried out into clindamycin prescription within the CCG, asking each practice to review five patients. • Five patients had repeat infections, four of these following the end of treatment for a recent earlier C.Diff diagnosis. Local guidelines are to be drawn up on C.Diff treatment. AM commended a good thorough approach, with clear early findings. NK asked if the repeat infection was the same strain of C.Diff. LJ said ribotyping is not currently being carried out. JB said this is not currently routine for hospital onset cases, but he understands this may possible. NK noted the spike in infections arose at the same time as the Covid pandemic, and asked whether these might be related. LJ said it had been considered whether antibiotic prescribing had affected the rise in infections, but antibiotic prescribing had decreased during the pandemic. One patient in this cohort had Covid, and was prescribed antibiotics, but these were not high risk antibiotics for C.Diff. AM noted BNSSG have the second highest clindamycin prescribing rate in the country, and asked what visibility there is for areas around medicines management at PCCC. JB said Elizabeth had reported that there is a CCG with a higher rate of clindamycin prescribing, which also has a high incidence of C.Diff. RS suggested this paper go to Primary Care Cell. This would be the best place to have a quick impact on prescribing, and if there is a prescribing issue it would need resolving quickly. She also suggested checking with regional colleagues whether they have had similar learning. **ACTION: RS to request JB and LJ present the C.Diff review to the Primary Care Cell, and to speak to regional colleagues to see if they have identified similar learning**	**RS**
07	**Items for Information**	
07.1	**Minutes: LeDeR Steering Group** The minutes were noted for information.	

	Item	Action
07.1	**Minutes: Safeguarding Governance Group** The minutes were noted for information.	
07.1	**Meeting Forward Planner** Noted for information.	
08	**New Risks Identified**	
09	**Any Other Business** LLP reported that £35k has been awarded to BNSSG as an exemplar site for Annual Health Checks for people with learning disabilities.. RS said BNSSG have been nominated to be a national pilot site for PSIRF, and she has been invited to join the national working group on influencing future Quality Surveillance Groups.	

10	**Review of Committee Effectiveness**
	
	• Did the meeting run to time? YES
	• Did the right people attend? YES
	• Were action items assigned where appropriate to the right people? YES
	• Were all items given sufficient time to discuss? YES
	• Were all members able to contribute? YES
	• Has the meetings business contributed to the organisation's aims and objectives in terms of:
	  ○ Strategy
	  ○ Planning
	  ○ Governance
	• Were any of the items inappropriate for this committee? NO
	• Did the meeting receive the administrative support that it needed? YES
	
	AM added that from a quality point of view there is an improvement in papers. RS reported a business meeting is now held monthly to discuss the slides.	

	Date of next meeting: Thursday 22 October	

Freda Morgan
Executive PA
24 September 2020