NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Quality Committee – OPEN Minutes

Minutes of the meeting held on 19th September 2019, at 01:30 – 05:00, Board Room, South Plaza, Marlborough Street, Bristol BS1 3NX

Minutes

Present		
Alison Moon	Independent Registered Nurse (Chair)	AM
Dr Martin Jones	Medical Director (Primary Care and Commissioning)	MJ
Sarah Talbot-Williams	Independent Lay Member (Patient & Public Engagement)	STW
In attendance		
Paulette Nuttall	Head of Adult Safeguarding (Agenda 7.6 / 7.7 and 7.8)	PN
Bridget James	Associate Director Quality (Patient Safety) (Agenda item 7.11)	BJ
Angela Stevens	Looked After Children's Lead Nurse (Agenda item 7.10)	AS
Claire Thompson	Deputy Director of Commissioning (Agenda item 7.5	CT
Jackie Mathers	Head of Children's Safeguarding Designated Nurse (Agenda item 7.9)	JM
Ned Brown	Healthy Weston Project Manager (Agenda item 7.12)	
Lesley Le-Pine	Interim – Quality Lead Manager (Agenda item 7.1 & 7.2)	LLP
James Bayliss	(Agenda item 7.3)	JB
Elizabeth Jonas	(Agenda item 7.3)	EJ
Jenny Thompson	Lead Quality Manager	JT
Johanna Topps	Principle Medicines Optimisation Pharmacist	JTo
Helen Hanson	Senior BI Analyst Primary Care	HH
Sarah Carr	Corporate Secretary	SC
Gary Dawes	BI Performance Manager	GD
Apologies		
Cecily Cook	Deputy Director of Nursing and Quality	CC
Dr Peter Brindle	Medical Director – Clinical Effectiveness	PB
Dr Nick Kennedy	Independent Secondary Care Doctor (notes provided to chair)	NK
Dr Jeremy Maynard	Clinical Corporate Lead for Quality	JMa

	Item	Action
01	**Welcome and Apologies** Alison Moon (AM) welcomed members of the Committee to the meeting. Apologies were noted above.	
02	**Declarations of Interest** There were no new Declarations of Interests.	

	Item	Action
03	**3.1 Minutes of Meeting 22 August, 2019** The complete sets of minutes from the August meeting were reviewed. It was agreed that the closed set of minutes were accurate and suitable for the Closed Governing Body meeting, pending the agreed changes: It was explained by BJ that Freda Morgan is the new Exec PA for Quality and will take on the actions from the next meeting. **Action**: BJ to update the names for the Committee meeting. AM asked the Committee whether there were any items in the open set of minutes that should not be in public domain, none were identified. **3.2 Action Log** 21.03.19 Item 7.7– AM agreed to update the final sentence of the paragraph as follows: As there was still no assurance that there would be any improvement, it was agreed to escalate this to put on /CQPM agenda, and agreed to **close** the action. **Action:** 22/08/19 minutes to be amended as per above Action 23.05.19 Item 7.2, it was discussed that actions are being progressed and agreed that Claire would share the report with the Committee. Action 23.05.19 Item 7.7, it was agreed that BJ would check on the progress of this action because Cecily is leaving. AM commented that would be good to be closed by next meeting. Action 23.05.19 Item 7.8, Action agreed as ongoing to be discussed and agenda item for October's meeting. 20.06.19 Item 4.2 (2) – Action agreed as ongoing. AM questioned if this action should go back for Executive review in the first instance. Action to go back to Executive Review. 20.06.19 Item 5.1 – Action from the June meeting deferred to September QC meeting. On agenda, action closed 20.06.19 Item 6.3 – Action remained open as CC was not present, it was agreed to change the deadline to October. 20.06.19 Item 6.6 – Action remained open as CC was not present Cecily to discuss with Martin for a broader conversation 25.07.19 Item 6.1– Backlog reported in the Q1 report. It was noted that the Q1 report was easier to read. It was agreed for this action to be **closed.**	**BJ** **FM** **CT** **BJ** **BJ** **CC** **CC**

	Item	Action
	25.07.19 Item 7.5 – Report on the agenda. It was agreed for this action to be **closed**. 25.07.19 Item 7.7 – Action was not discussed as the agreed timescale was October. (Lucy Jones) 25.07.19 Item 7.11 – Action was not discussed as the agreed timescale was December. It was discussed that Cecily (CC) needs to progress that.	**LJ** **CC**
04 4.1	**Risk and Mitigations** **4.1 Corporate Risk Register** Sarah Carr provided an overview of the current position in regard to high level risks which are being monitored via the Corporate Risk Register and the Governing Body Assurance Framework. Changes to the register are indicated in blue. Red indicates new risks added to the register. Work is underway to review directorate registers to ensure any high scoring risks are appropriately escalated to the corporate register. **4.2 Governing Body Assurance Framework (GBAF)** SC presented the GBAF and explained how the review identifies where there are risks to the CCG's principal objectives, the controls in place, mitigating actions and assurance sources provided to Governing Body. Each risk on the GBAF is reported to a specific committee. PO1 Quality and Governance systems relates to lack of capacity and the impact on effectiveness of the Quality Committee. AM commented that this is picked up for review with the new interim director. The committee noted the corporate risk register and assurance framework	
05	**Regulatory Updates** **5.1 Quality Surveillance Group** There had not been a QSG since the last quality committee.	

	Item	Action
06	**Items for Approval** **6.1 Quality and Performance Report** GD presented the draft activity report. CT commented on the provider performance drawing the committee's attention to key issues and mitigations for urgent care, planned care, diagnostics, cancer 31 & 62 days and mental health, as follows: • Overall, BNSSG Trusts' 4hr A&E performance was maintained at 77.7% in July, but was worse than the national average for Type 1 EDs of 78.9%. Demand to EDs and difficulties staffing to the required levels is impacting negatively on performance. A single BNSSG high impact performance recovery plan has been developed to address this and August performance will show recovery towards trajectory. • For planned admissions, the total waiting list size for BNSSG increased again in July, with performance for the BNSSG trajectory worse than trajectory for the first time. BNSSG is ranked 67th out of 191 CCGs nationally (up from 78th in June). • Patients waiting over 52 weeks for planned treatment improved in July, decreasing from 22 to 17, but failed the trajectory of 7. This continues to be mainly driven by waits at NBT (11 breaches). BNSSG's commitment to eliminate these long waits has been compromised by late inter-provider transfers and patient choice. A revised trajectory has been produced to achieve our trajectory of zero by Q4 19/20. This is being well monitored weekly to ensure progress is secured. • 62 day referral to treatment time for BNSSG cancer patients improved in July but continues to fail the 85% national standard and the monthly trajectory. Performance improved at WAHT but continues to worsen at NBT – both failed the national standard and their monthly trajectory. UHB improved, achieving the national standard and their monthly trajectory. • 2 week wait performance continued to worsen for the BNSSG population, failing the 93% national standard and monthly trajectory. This is driven by underperformance at NBT with the main breaches in the specialty of skin, where there has been significant growth in demand, in common with other health communities regionally, and underperformance at Weston or lower GI specialty. • For the year to date at June, both outpatient activity and planned admissions are above plan and above the same period last year. Non-elective activity is below plan, but above the same period last	

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	year. A&E attendances are above plan and above the same period last year. AM noted NK had asked a specific question about assurance on Severnside performance. CT noted that a recovery trajectory has been drawn up and staffing plans to support this but that call abandonment rates (which is a key indicator of knock-on to the rest of the urgent care system) were not increasing. The Committee had quality concerns regarding the lack of assurance from AWP related to the CPN and the CQC rating of requires improvement. It was discussed what the Committee would like to see in assurance terms **Action** - It was agreed for BJ to provide assurance information for the meeting in December. **6.2 Improvement Assessment Framework Q1** HH presented the IAF highlighting that framework reflects the CCG's fitness to operate successfully. Of the 58 measures for Better Health, Better Care, Sustainability & Leadership, the CCG rating 2018/19 is **Good**. The report covered the fourth quarter and the first full year as BNSSG. KLOEs – two indicators where there has been improvement; • Personal Health Budgets • Primary care workforce KLOEs – three indicators where there has been deterioration; • Inequality in unplanned admissions for chronic ambulatory care & urgent care sensitive conditions • Emergency admissions for urgent care sensitive admissions • Mental health out of area placements There are 13 indicators where we have achieved the best quartile performance compared to all England and achieved targets where they have been set. There were 15 indicators where we either failed target or were in the worst quartile in England. The report detailed the actions being taken to improve each indicator. It also included the assessments against all indicators. AM commented that the committee acknowledged the previous respective positions of the three CCGs and noted the progress of the first full year of BNSSG. CT commented that it was perhaps too early to predict overall	**BJ**

	Item	Action
	performance as the new guidance has only just been released. MJ commented on the diabetes indicator and all the significant work that had been undertaken to make improvements, commending the report and that it was easy to read. The committee noted the update of the Improvement Assessment Framework	
07	**Items for Discussion** **7.1 Annual Serious Incident Report 2018/19** LLP presented the report. There were 391 serious incidents across all providers, 181 from acute trusts – a reduction of 36 on the previous year. Top three categories of incidents from acute providers were; • Falls • Pressure injuries • Treatment delays Themes identified as contributory factors in acute SIs were; • lack of escalation for medical review • poor documentation • dispensing errors for medication (usually agency staff) • training/competency of agency staff Top incident category for community providers is pressure injuries. Themes identified as contributory factors in community SIs were; • delays to assessment • communication between teams • non-compliance with equipment use Incident management for AWP was taken in-house to the CCG part way through the year. 70 SIs were reported with the highest category of incident being self-inflicted harm. Themes identified as contributory factors in AWP SIs were; • lack of escalation • poor handover • poor risk assessment • not including family • poor discharge plans LLP reported on CCG responsive actions and the following system assurances; • robust SI panel • in depth scrutiny with multidisciplinary team	**LLP**

	Item	Action
	• documented provider feedback requiring assurance for closure • assurance visits for themes or aspects of concern • contract performance notices • strong organisational scrutiny AM commented on the improved content and presentation in the report. AM queried a figure on page 11 and asked for clarification on the figure. LLP confirmed it was 3, not 300. **Action** - to correct the figure on page 11 The committee noted the annual report **7.2 Serious Incident Q1 report** LLP presented the report. There were 101 new SIs in Quarter 1; • 44 acute • 20 community • 31 AWP Incident reporting is at a similar level to the same period last year. The report included NRLS data and compared incidents to bed days. The majority of incidents are no harm or low harm. In Quarter 1 acute top three categories of serious incident are; • falls • suboptimal care of deteriorating patient • medication errors A local CQUIN is in place for pressure injuries, a 'Stop the Pressure' conference for providers and a task and finish group led by the Quality Team. A suicide summit is planned in December to explore themes and best practice learning with AWP and the network has signed up to the Zero Suicide Alliance. SI backlog – In May 2019, 220 SIs were open on the system. That was reduced to 95 cases in August. Plan in place for backlog to be cleared by year end. AM commented that the report was well written and it was good to note the achievements on clearing the backlog. The committee noted the Q1 report	

	Item	Action
	7.3 Healthcare Associated Infection Q1 Report JB and JTo presented the report outlining the programme of work to review and reduce HCAI. The CCG did not achieve zero tolerance to MRSA BSI with 14 cases reported in Q1. Review of cases identified a change in assignment from hospital acquired to community onset in comparison to the same period last year. Comparison of the same period for E.coli shows a reduction of 165 to 156 cases. The local CQUIN to optimise catheter passport use is in place and working well. The CCG is focussing on improving hydration and this will be a focus for assurance during the year via quality sub groups and assurance visits. A review of anti-microbial prescribing in Q1 has demonstrated continued improvement and all localities are meeting the proportion of the broad-spectrum antibiotic prescribing target. MJ asked about assurance of primary care engagement and what are the blockers? JTo responded the ICP lead is at PCN level in the practice and there is a need to ensure this is added to the Primary Care Strategy. The committee commented on the antibiotic work that this was a positive overall position and a good piece of work. JB stated MRSA work was focusing on wound management and groin use. AM commented on the deep dive review of 6 cases and stated that there needed to be a focus on identifying issues for the 50% who were not drug users. JB commented that CDiff was improving position with new thresholds and the two CQUINs for catheter care. E coli is a challenge but under threshold currently. AM commented to add TB section for future reports and local data on e-coli **Action** - it was agreed for JB to provide this information in the next quarterly reports **7.4 Out of Area Performance Action Plan** CT presented the report in regard to the MH diagnostic review and Out of Area Placement recovery plan. The analysis was about getting to a single diagnosis for OAP in Bristol and developing an agreed action plan. • Headlines - Overall there is an increasing number of referrals into BNSSG community teams which accounts for 50% of community referrals. • Since June 2018 there has been a 26% increase on 72 hr referrals to triage.	**JB/CC** **JB**

	Item	Action
	• Currently 2,800 individuals on the Assessment & Recovery team's caseload. • Up to 25% of current Bristol bed capacity is being used for re-admissions within 30 days (target is 10%). • Out of Trust inpatient cost to AWP and BNSSG through risk share in 2018/19 was £3.4 million in direct cost. Does not include indirect cost to AWP or costs to families/friends. AM asked is it getting better. CT responded yes, but early days and not sure of meeting all targets by 2021 but we are recording all placements. We have seen an increase in out of hours placements. NHSE have developed a set of actions in regard to OAPs. MJ suggested taking these to Commissioning Exec. **Action:** CT to take NHSE actions to Commissioning Exec. **7.6 Domestic Abuse Policy** PN presented this new policy which sets out the procedure for the CCG to support employees who are victims of domestic abuse. The policy is based on best practice and supports developing a culture that acknowledges domestic abuse is unacceptable. This policy complements the CCG's duty of care for all employees and responsibilities for the health and safety of staff. It is an HR policy and a programme of training will be provided. AM welcomed the policy and stated it was an important piece of work to establish this in the workplace. STW asked if this was in place for the whole of NHS staff through providers. PN responded that NHSE undertook an audit recently and most providers already have their own policies in place. There is a recommendation that all NHS organisations have a policy. It was suggested that the policy could be shared with Primary Care and link to the domestic abuse website. **Agreed:** The Committee **agreed** to recommend the policy to the Governing Body for approval. **7.7 Mental Health Homicide Review and action plan KA & MX** PN presented the report and summarised the case focussing on the recommendations. A Safeguarding Adults Review (SAR) took place and there were five recommendations for health – four for AWP and one for Cygnet healthcare. An Independent Mental Health Homicide Review (IMHHR) was also undertaken and there were fourteen recommendations for	**CT**

	Item	Action
	AWP. AM commented that this is not the first murder in sheltered accommodation and asked if the safeguarding team is assured by the recommendations reducing the risks of further such incidents. PN responded that there is no national risk assessment regarding placements. This looks at the system but more important from an assurance perspective is that the recommendations are embedded. PN said there is an assurance visit to AWP tomorrow and to the two sites including Collingwood Road where the incident happened. This will be to review the transfer and discharge process. The CCG also has oversight for the provider response to the SAR and IMHHR **7.8 Safeguarding Adults Quarter 1 report** PN presented the report providing assurance to the committee on key areas of safeguarding. This included an overview of GP Level 3 training which will be evaluated during Q2. Safeguarding adults and prevent training target is set at 85% for CCG staff. Current compliance in Q1 is 86% for MCA, 70% for Prevent and 76% for Level 1 safeguarding. Work is underway to improve the monitoring system and data cleanse to improve accuracy on figures. Level 2 compliance for Level 2 training for acute and community providers is above the 85% target with the exception of AWP where performance is reported at 79% for Q1. MCA/DoLs training has good compliance at 85% from all providers with the exception of WAHT which is at 77% Multi Agency Risk Assessment Conferences (MARAC) were funded by the Home Office, however this ceased in April 2019. Each local authority has established different arrangements. Domestic Homicide Reviews – there are 13 open cases. Safeguarding Adult Reviews – there are 5 open cases. The Mental Capacity Act (amendment) Bill became law during Q1. This will replace DoLs with Liberty Protection Safeguards. Publication of regulations and a code of practice is awaited and expected implementation will be in 2020. The Safeguarding team will bring a briefing paper to Quality Committee in regard to the implications for the CCG when the regulations are published. AM noted the training compliance and asked for the AWP figures to be updated for the next meeting. AM asked for the briefing paper to come to Quality Committee as soon as the code of practice is published. **Actions:** PN to chase AWP figures for the next meeting and bring a paper about Liberty Protection Safeguards to a future meeting.	**PN**

	Item	Action
	7.9 Safeguarding Children's Quarter 1 report JM presented the report. Sirona's compliance for Level 3 safeguarding presents a significant concern. During Q1 this was reported as 38% against a target of 85%. The Safeguarding team will attend the next contract monitoring meeting with Sirona to seek assurance and planned actions to address this. The Safeguarding team participated in an audit of referrals from NBT emergency department to Children's Social Care. An action plan has been developed to address concerns identified in the audit. An audit has been completed of referrals into Initial Child Protection Conferences. 116 cases were reviewed. Health professional engagement during the audit period was good but depended heavily on health visitors and school nurses. GP requested contribution to conferences was at an average of 52% across BNSSG and at 25% for South Gloucestershire. Since concerns were raised about CAMHS provision at Priory Hospital a review was held and a number of actions agreed. The CCG has agreed supervision arrangements for the Priory designated safeguarding leads. AM thanked JM for a detailed report. MJ asked if it was clear about what action was being taken when standards are not being met. JM responded that these issues have been raised with NHSE as they need a national dashboard on training. Helen Mutch (named GP) was working with GPs to work on this and a named GP for NS was advertised last week. There does need to be a detailed feed into PCCC and also included in the primary care strategy. AM said it was good to see Level 2 training going up but asked what the specific risks were for the CCG. JM responded; • Safeguarding arrangements for the Children and the Social Work Act being signed off • CDOP sign off – now being implemented • Financially at risk due to funding streams for the 3 areas being different • Clarity about the purpose of the Safeguarding Group and are we seeing the same information **Action** - it was agreed for BJ and JM to discuss how Safeguarding management becomes part of Primary Care functions and issues feed into relevant PC committees. **Action** - it was agreed for BJ to feedback to CC in regard to clarifying the purpose of the safeguarding Group	**BJ/JM/ CC** **BJ/CC**

	Item	Action
	7.10 Looked after Children Quarter 1 report Angela Stephen (AS) attended to present this item. Following the results of the Spring 2019 CQC inspection to Weston Area Health NHS Trust (WAHT) which indicated that the Children and Mental Health Services (CAMHS) were inadequate, the CCG carried out two critical friend visits to CAMHS to support the Trust with the implementation of an action plan. AS confirmed that the team raised similar observations during the first of the CCG visits in May. At the time of the CQC report, the main risks were around staffing issues. This related to a smaller team of staff which meant that there was a conflict in dealing with a large caseload resulting in increasing difficulty triaging and managing new referrals into the service. The CCG undertook a notes audit and found that some notes were difficult to find and difficult to read; risk assessments also required greater legibility– it was reflected that digitisation would be ideal to address this. The group discussed section 8 of the briefing paper entitled "Implications for Public Involvement". STW asked whether children and young people (not foster parents) were involved in representing the needs of Looked After Children at the Corporate Parent Board. AS confirmed that this was the case and agreed that the title was misleading. **Action**: AS to change the wording on this paragraph	**AS/CC**
	The Committee raised the following points: AM reported that Sirona are doing a capacity assessment on undertaking reviews and want to report this to a contractual meeting. Also noted that Sirona have offered to come and present to the committee. **Action:** It was agreed for CT to have a look at this with AS. Consideration will be given to Sirona being invited to present this report to a future Quality Committee meeting.	**CT**
	7.11 LVMR paper This paper was deferred to the October meeting	
	7.12 Healthy Weston Programme QIA NB presented an updated overview and commented on the document updates. AM noted a question from NK about the clinical cabinet 'taking responsibility' and was this correct? MJ responded that this was a wording issue and would be amended.	

	Item	Action
	The Committee commented that the QIA report was very good and appreciated the amount of work that had gone into the programme **Agreed:** It was agreed to recommend the report for publishing to the Governing Body.	
08	**Items for Information** **8.1 Healthcare Acquired Infection Group Minutes** Noted **8.2 LeDeR Steering Group Minutes** Noted There was concern around the lack of attendance at the LeDeR Steering Group. BJ confirmed LeDeR was included in the quality schedule, but this was not specific around attending every month. JBG had spoken to Director of Nursing who confirmed they were willing to take part. The Committee discussed the moral responsibility to attend even if this was not mandated in the contract. **Any Other Business** None	
09	**Committee Work Plan** Deferred due to lack of time.	

10	**Review of Committee Effectiveness**
	
	• Did the meeting run to time YES
	• Did the right people attend YES
	• Were action item 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 - YES
	  • Planning - YES
	  • Governance -YES
	• Were any of the items inappropriate for this committee NO
	• Did the meeting receive the administrative support that it needed NO	