**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**QUALITY COMMITTEE MINUTES**

**Thursday 9th February 2017**

**9.30-12.00 midday**

**Seminar Room 1, The Roxton Practice, Immingham, DN40 1JW**

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| **PRESENT** | Juliette Cosgrove (JC) – Chair, Clinical Lay Member of the CCG Governing BodyDr Anne Spalding (AS) - Clinical Lead for Quality and Caldicott |
|  | Bruce Bradshaw (BB) – DoLs (Deprivation of Liberty safeguards) & MCA LeadMichelle Thompson (MT) – Assistant Director of Service Planning and Redesign |
|  | Lydia Golby – Nursing Lead for Quality |
|  | Philip Bond (PB) – Lay Member of Public and Patient Involvement |
|  | Gary Johnson (GJ) – Patient Safety Lead |
|  | Peter Hudson (PH) – Clinical Nurse for Quality |
|  | Bernard Henry (BH) – Lay Member |
|  | Julie Wilburn (JW) – Designated Professional – Safeguarding Adults (NL & NEL) |
| **IN ATTENDANCE** | Ann Spencer (AMS) – Quality and Nursing Administrative Assistant (Minute-taker) |
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| **APOLOGIES**  | Bev Compton (BC) – Acting as Assistant Director of Care and IndependenceJan Haxby (JH) – Director of Quality and Nursing Gemma Mazingham – Patient and Client Experience Manager Lisa Hilder (LH) – Assistant Director of Strategic PlanningApril Baker (AB) – Lay Member, Community ForumPaul Glazebrook (PG) – Lay Member, Representative from Healthwatch |
| **TEM** |  | **Action** |
| **1.** | **Apologies** |  |
|  | Apologies were received from members and attendee as above.  |  |
| **2.** | **Introductions and Declaration of Interest** |  |
|  | Introductions were made and the recent highlighting of Declaration of Interest was drawn to everyone’s attention. Discussion took place around the topic of declaration of interest and conflict of interest which could arise. The question was raised as to whether each person should declare their interest/s at every meeting and the Chair suggested that should any member have a conflict of interest which they identify prior to the meeting that this should be declared or if during the meeting such conflict could be seen as arising, this should be indicated to the Chair/committee at the appropriate time ie before or during the meeting.  |  |
| **3.** | **Minutes and Action Summary from the last meeting*** **Update on item 3**
* **Update on Item 6**
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|  | **Minutes****Page 2** – Review of Terms of ReferenceAnne Spalding asked for clarification to be made in the minutes that her reference to the meeting being quorate and her mention of a clinician being present should not be interpreted as being a limited to a GP; the term clinician to reflect a clinical member and include members of the nursing profession.**Page 5** – Change SLA to LSA (Local Supervising Authority).**Page 6** – Action GJ? – change to MT.**Action Summary****Update on Item 3 – Poor attendance at QC Meetings**Item has been raised by Jan Haxby. No further feedback available at present.**Item 4 – Review attendance at QC meeting for 2017**Carry forward (apart from “Clinician (non GP) to be invited ….” as this has been covered in amendment to minutes above).**Item 5 – Triangulation of Intelligence**Nothing further to update – carry forward.**Update on Item 6 – SI Reports**Michelle Thompson explained that at the hospital there were two separate areas at A&E. One area being the (paediatric) assessment area which was open in the day through to 8pm. When working properly a decrease in paediatric admissions would be evident as children would be seen via the assessment unit and treated accordingly and only those cases needing further care would be admitted onto a ward. However, due to high demand in A&E, assessment beds have been used by adults and as the unit closes at night, again due to high demand on A&E, these additional beds have been used by adults, including the elderly, which has meant that with using this facility as extra capacity, A&E has not had to close their doors to new admissions. There had been a rise in the number of admissions of more than 24 hours but less than 48 hours which indicated people were being admitted to hospital who may not have needed to be there. Michelle Thompson reported that obtaining data on this area was proving difficult. Thus, children who would normally be seen in the assessment unit were being seen on the ward, which in turn affected the paediatric admission figures.Anne Spalding suggested an unannounced visit to gain a true picture of the situation. Juliette Cosgrove raised questions around the loss of the assessment unit meaning that paediatrics being sent through the A&E route and was that the right environment and were staff available with the right qualifications? Also questions were raised around whether this resulted in quality service in the day but compromised at night?Further lengthy discussion took place around the topic with other points being made that if A&E were under extreme pressure, using the assessment unit and by-passing the normal system this could prevent blockage, providing there were enough staff available on the ward.**ACTION:****Michelle Thompson agreed to take forward the points raised, particularly around appropriate staffing and formulate a list of questions to take back to the hospital and that the contracting levers for attaining the information required would be explored if information required is withheld.****Update on Item 6 – What has made a difference to the decrease in the overall demand within NEL and what could be implemented within NEL to make improvements**Carry forward.**Update on Item 6 – Strengthen SI process with NHS Hardwick regarding EMAS**Lydia Golby reported on having recently attended a meeting with Gary Johnson and Chloe Nicholson with the EMAS Co-ordinating Clinical Commissioner. Gary Johnson reported that the SI process has been strengthened following this week. Relationships with the co-ordinating commissioner had identified a local EMAS contact to strengthen this process. This meeting also facilitated a discussion and the sharing of information about risk in the provider. The Quality Risk Profile was explored and the sharing of information enabled a lot of areas of concern to be moved to an area of less risk. |  |
| **4.**  | **Safeguarding Update** |  |
|  | Julie Wilburn had presented reports in advance of the meeting and requested the reports to be taken as read.Julie Wilburn updated that the new nurse recruited, commencing employment from 13th March, would cover both adults and children.The new JTAI (Joint Targeted Area Inspections) theme would be around neglect and inspections would commence from March.The Serious Case Review which had been on-going was finally published and concluded on 9th January. The outcome for health was not as negative as portrayed in the media.Julie Wilburn apprised the Committee of the Multi-stakeholder SI logged by the CCG.Joint safe sleeping guidance was ratified following the Child Death Overview Process (CDOP) meeting held on 2nd February.A meeting was planned for 23rd February with the Head of Safeguarding at NLaG to discuss their safeguarding performance information.JW reported that the Primary Care Safeguarding Leads Forum would be meeting on the 14th February and would focus on the subject around mental capacity and DoLS, with a particular focus on covert medication, to be led by Bruce Bradshaw. Anne Spalding welcomed the news of a safeguarding resource pack for Primary care being finalised and available, hopefully in March.At the recent Keeping Children Safe LSCB (Local Safeguarding Children Board) sub group, the difficulties surrounding use of interpreters when communicating with unaccompanied asylum seeking children were identified. There were issues across the board relating to complex backgrounds, traumatic stories, and lack of clarity on who funds the translator services. Potential conflict of interest around cultural issues had been identified; this was particularly around sensitive subjects such as FGM (Female Genital Mutilation). This topic was also discussed within the LSCB health forum with a plan to raise this at the LSCB for further discussion.The Safeguarding Children Annual Report had been presented for information and would go to the Partnership Board.Anne Spalding queried the period where staffing level fell below recommendation however Julie Wilburn assured that the post was bolstered by the Specialist Nurse and NHS England approved this arrangement.Juliette Cosgrove commented that the report sets out the responsibilities but does not demonstrate how well they are met. In an instance where there was a shortfall, assurance should be given on what was being done about it. It was suggested that Julie Wilburn take the report back to Sarah Glossop and go through the document and rag rate it on levels of assurance. It would be useful to set a plan going forward. Anne Spalding suggested to ask practices how many staff have completed Prevent training – this should be noted on staff records/appraisals and ultimately this data would prove useful for CQC inspection as it would serve as positive evidence they would look at. |  |
| **5.** | **Quarter 3 Incident Report** |  |
|  | The Q3 Incident Report presented by Gary Johnson was taken as read.Gary Johnson was pleased to report that GPs were championing the SI App and continuing awareness and support for it was being gained countywide.Despite a decrease in the number of reported incidents over December, confidence remained in the value of the system; Practices were receiving quarterly reports; data used in MIFS, Primary Care Oversight meeting etc.There had been an increase in the reporting of medication incidents. Rachel Staniforth has joined the Incident and Serious Incident Group – providing Pharmaceutical advice and expertise to the process. The Incidents Group have considered that a deep dive into the medication incidents is required to analyse the intelligence and identify any themes and trends. Gary Johnson drew attention to P10 of the report and explained that although some GP practices appeared not to have reported any incidents, that in fact most were capturing these and putting through one practice if the overall practice was a multi-site practice. Going forward, it was suggested to clarify in the sub headings, to say that other practices were incorporated. Anne Spalding suggested that the App was a powerful tool and ‘get it on the App’ should be celebrated – a good news story.“So what, what’s changed” was discussed with explanation of how out of the 2-300 incidents received, that the most relevant ones were selected for this report; how the Quality Team worked on a 21-day turnaround; that incidents were reviewed clinically by Lydia Golby and fed back to the reporter and that theme and trend reports were compiled. Discussion took place around whether further distribution of this information could be affected. It was suggested that just the number of incidents that had occurred, rather than any detail, as difficulties in anonymising such information was acknowledged with such small providers. Also that the CQC advised that it was up to individual Practices to decide how and what to share. Philip Bond requested that Victoria McMillan add incidents to the next agenda of the Patient Participation Group. Philip Bond added that it would be useful for Gary Johnson to attend the Community Forum.The appendices on Incident Escalation Flow Chart and Risky Matters -Learning from Incidents, were presented to CCG staff at recent Time Out and will go out to Practices with the Q3 report next week.**ACTION:****Philip Bond requested that Victoria McMillan be asked to add Incidents to the next Community forum agenda.** |  |
| **6.** | **Exception Reporting** |  |
|  | Lydia Golby reported on current concerns on NELCCG commissioned services. Lydia Golby provided the Committee with an overview of the Quality Risk Profiles completed in response to the concerns being raised. Lydia Golby agreed to report back to the Committee following the February meeting with NHS England, Focus and the CQC.Lydia Golby provided the Committee with an overview of the Acute Care Provider, bringing the Committee up to date with the current concerns in the system.**ACTION:****Jan Haxby/Lydia Golby to report back to next meeting*** **Review and Risk Assessment Report**
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| **7.** | **MCA and DoLs** |  |
|  | Bruce Bradshaw explained that there were delays in producing reports due to the current system requiring all reports having to be manually pulled from SystmOne. However, from next month a more aligned scheme would be in place. Q2 and Q3 data should be available for the next meeting and it was hoped that TPP (SystmOne software provider) will be releasing the reporting functionality in March 2017.There had been success in gaining extra funding for Best Interest Assessors; however some of the posts were on hold due to cost pressures. Receiving 70-80 requests per month for authorisation and in the new financial year if capacity issues are not addressed will only able to assess four rota cases per week thus creating a further increase in the backlog. This had been noted on the Risk Register and taken to the Council of Members. Council budget-setting aware of huge risks and financial implications of this work.Court of Protection work; supported living could not use DoLS scheme, but must go to the Court of Protection. Four applications going forward; others will progress when ready. Bruce Bradshaw highlighted the need for awareness that not just those in supported living will need to be considered but also service users who may be deprived of liberty within their own home. This would be a gentle step to build up a case load as it is anticipated these will be identified at planned reviews and may then need to refer to Court of Protection which would add to the already heavy workload. Currently the original 200 cases have been whittled down to 117.Case law and legislation will impact on clinical decision-making.A recent case in Barnsley presided over by a circuit judge made explicit recommendations about use of covert medication and DoLS, although not a legally binding requirement, but could have a significant impact on use of medication for a person who lacked capacity to consent. Drafted guidance around covert medication had been circulated around Primary care and widely circulated around care homes.BB then reported on training, identifying needs and requirements.* Block of training around decision-making for people who do not have capacity.
* Identified across whole internal audit - mental capacity.
* Principles of legislation.
* FOCUS provides main training but this may need to be looked at differently to ensure impact

Training needs analysis:* Care homes are free to choose what training they want.
* Primary care – what are their needs?
* Discuss who pays for training.

Juliette Cosgrove commented that it was an absolute must to have good training otherwise could be caught out under legislation.BB reported that the latest court case suggested DoLS guidelines must be used in intensive care setting (Cheshire West ruling), but has been granted to appeal, so this may provide first real legal challenge to Cheshire West. Most recent local data showed a rise for Acute hospital applications. However for NL&G this showed a low transition rate for turning into an actual DoL. This was because the person was often discharged before an assessment could be arranged/carried out.Acute setting of big concern as impossible for that demand to be served.Law commission recommendations - Still talking up to two-year time gap before existing system could be changed.The Chair thanked BB for his comprehensive update. |  |
| **8.** | **Mortality** |  |
|  | Lydia Golby reported that the meeting held on 20th January had been positive. The Mortality Strategy was discussed, in draft, in partnership with NL&G and would be opened up wider and include Public Health.There would be two key elements to the strategy:**Case Note Reviews**By NL&G Representatives and Lydia Golby, Dr Anne Spalding and Lisa Revell. Next step to open up into care homes with the audit proposal to structure and link in to pre-admission to hospital.**8 Mortality Work streams**Respiratory; this having the highest incidence of mortality, Deteriorating Patient/ Sepsis, Cardiology, Gastroenterology, End of Life, Still Birth, Stroke and Clinical Process Group.The Mortality Group would have oversight of MACIC (Mortality Assurance and Clinical Improvement Committee).The Mortality Group would hone in on particular areas where mortality is high; share findings of Case Note reviews; link in to the Care Home project; explore around coding of SHMI (Summary Hospital Mortality Indicator); improvement in SHMI and look at data more closely.The Group were investigating production of a mortality dashboard and would bring to next meeting.Definitive areas of focus would be refined over time. |  |
| **9.** | **Reports on National Programmes****LeDeR** |  |
|  | Locally there had been one death reported (01.11.16).Julie Wilburn gave background to this programme, formulated by Bristol University, to improve outcomes for the learning disability cohort. There was a draft process in place to test out with this death. The death should have been reported on within four weeks. It proved time consuming to complete the report with four to five reviewers needed.When approved through CDOP meeting, a report would come to this meeting through the Safeguarding update. |  |
| **10.** | **R&D Status Report – Primary Care** |  |
|  | This was discussed at Clinical Leads meeting on 19th January.Under the Health & Social Care Act 2012 it is stated that CCGs to have regard to the need to promote research within the health service. This could be accessed through the AHSC (Academic Health Science Centre).This would be useful to share at Community Forum.Anne Spalding nominated to lead on Research and Development and to attend meeting presented by NIHR (National Institute for Health Research). Lydia Golby also attends this.There were financial incentives for practices to be involved in becoming research ready.Lydia Golby updated the group on the Questionnaire we will be asking the Service Leads to complete. The Questionnaire focuses on understanding Service Leads access to Research and Evidence for their role. Whether they have any specific learning needs in this area. The Questionnaire will contribute to complete the baseline assessment we are undertaking to assess compliance with Guidance. |  |
| **11.** | **Infection Control Strategy – Update on draft strategy** |  |
|  | This is in progress in draft. Due to achieving a draft ready for consultation by 7th March. |  |
| **12.** | **A Patient’s Journey** |  |
|  | The Patient’s Journey was a Community Cardiology positive story.This was a good report for Cardiology Project.Lydia Golby provided the Committee with a verbal update on the Cardiology Project and would like the Committee to note that the Provider needed to work on including more quality elements in their reports on the service; there was more work to do rather than just producing numbers. Although positive feedback, clinical indicators were needed to enable assessment of the clinical quality in the service through auditing clinical pathways. NICE guidance could be looked at; an audit carried out in an area identified as being useful.Philip Bond referred to the Cardiology pilot scheme and queried whether this could be extended. More time was needed to evaluate the current service. |  |
| **FOR INFORMATION**  |  |
|  | **Additional Reports/Information** |  |
|  | * **NICE**
* **LAC Annual Report 01.04.15-31.03.16**
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| **13.** | **Items to be escalated to the CCG Partnership Board** |  |
|  | * Mixed news on EMAS.
* Getting better access to incidents (Incident App).
* Safeguarding SI.
* Bradley Woodlands and Bradley Apartments.
* Mortality strategy developments.
* MCA and DoLs – risk identified.
* Patient journey as a good news story.
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| **14.** | **Any Other Business** |  |
|  | Juliette Cosgrove commented that reasonable time should be allowed to discuss Acute Provider CQC report when the report is available. |  |
|  | **Date And Time Of Next Meeting:****Thursday 9th March 2017 – WORKSHOP – 9.30-11.30 am****Thursday 13th April 2017 – 9.30-12.00 midday** |  |