Paper N

WEST LEICESTERSHIRE CLINICAL COMISSIONING GROUP

Minutes of the Quality and Performance Sub Group held on Tuesday 15 September 2015 at 9.00 am in the Boardrooms Woodgate, Loughborough

PRESENT:

Mr Evan Rees	Lay Member (Chair)
Dr Chris Trzcinski	Deputy Chair
Dr Chris Barlow	Locality Lead, South Charnwood
Dr Nil Sanganee	GP, Ashby Health Centre
Mrs Caroline Trevithick	Chief Nurse and Quality Lead
Dr Mike McHugh	Consultant in Public Health Medicine
Mrs Angela Bright	Chief Operating Officer
Mrs Liz Jones	Patient and Public Representative

IN ATTENDANCE:

Mrs Craigie Morrison	Quality Lead
Mrs Kate Allardyce	Performance Manager (up until item Q&P/15/136)
Mr Andrew Roberts	Senior Management Accountant, Localities
Mrs Karen Smith	Head of Infection Control (for item Q&P/15/133)
Mrs Helen Cullinan	Quality Officer (for item Q&P/15/134)
Mrs Michele Morton	Senior Committee Clerk (minutes)

ITEM	DISCUSSION	Action
Q&P/15/129	**Welcome and Apologies** The Chairman welcomed all to the meeting and apologies were received from Mrs Sue Venables and Mrs Pat Ford.	
Q&P/15/130	**Declarations of Interest on Agenda Topics** There were no declarations of interest.	
Q&P/15/131	**Minutes of Meeting held on Tuesday 18 August 2015** The minutes of the meeting held on Tuesday 18 August 2015 were approved and accepted as a correct record.	
Q&P/15/132	**Action Log and matters arising** Paper B, the action log, was updated and would be circulated following the meeting. **Q&P/15/117 - Highlight Report, Contract Quality for Providers: City, East, LPT, Dashboards –** update provided from Infection control on third party MRSA instances: Third party was introduced this year. The purpose of the post infection review meeting was to identify if there had been any care lapses in the period prior to the MRSA which may have contributed to the infection. NHS England recognised that there are situations where there are no care lapses and therefore seemed unfair to penalise an organisation for something that was essentially unavoidable. Examples from a number of reviews across the 3 CCGs include: • Patient with previous MRSA bacteraemia who was non-compliant with decolonisation when MRSA was first isolated in a wound. He also lived in very poor environmental conditions at home. The patient had refused all offers of help and support and he was on the Zero Tolerance scheme due to his behaviour. He was non-compliant with medication and removed wound dressings when he allowed community nurses access to undertake wound management. It was	

inevitable that the patient would have another bacteraemia which was what happened so this patient's care had been investigated twice.

- Patient who was on immunosuppressant therapy, no previous history of MRSA, no wounds or devices. However, his daughter had been diagnosed with PVL-MRSA whilst a student in London. The patient was thought to have acquired MRSA via his daughter through normal social contact and in view of his immunocompromised status then developed pneumonia which was the source of the bacteraemia.

If a case is assigned as third party then an organisation was not performance managed on that case. The process meant that a review report was submitted to an arbitration panel with experts in the field who make the final decision on whether the case should be third party or not.

Q&P/15/133 **Infection Control**

Mrs Smith gave a presentation on Infection Control, with a particular focus on C-Difficile which included the following:

- **The National Position** - Public Health England (PHE) had reported a 6.0% increase in the number of CDI cases reported in England in 2013 to 2014 - the first increase in CDI cases since mandatory surveillance of CDI was initiated.
- **The Regional Position** - In July 2015 PHE report that the number of trust apportioned CDI cases had been declining since 2007/08. However, during 2013/14 and 2014/15 an increase in the number of trust apportioned cases was seen. For this time period the increase in the total number of CDI cases reported was seen to be greater in non-trust apportioned cases
- **The Local Position**:
  - Between April 2008 – March 2014 the number of CDI cases apportioned to University Hospitals of Leicester (UHL) reflected the national picture. UHL's reported cases were comparable to their equivalent trust within the East Midlands region
  - In UHL there had been a 26% increase in the January – March 2015 (19) quarter compared with the same quarter from January – March 2014 (14).
  - In West Leicestershire (WL) CCG there had been a 41% increase in the January – March 2015 (22) quarter compared with the same quarter from January – March 2014 (13).
  - In line with the national picture the highest CDI rates were seen in those aged ≥85 years for both males and females. The largest proportion of cases in WL CCG had been seen in females ≥85 years.
  - A review of WL CCG CDI cases between April and July 2015 had identified that:
    - 46% (13) had a specimen sent more than three days after admission to an acute hospital
    - 21% (6) had been discharged from an acute/community hospital within the previous 30 days
- **Significant co-morbidities and risk factors:**
  - 75% (44) had at least one co-morbidity linked to an increased risk of developing CDI i.e. long term conditions such as diabetes, COPD, renal failure, immunosuppressed.
  - 75% (44) had at least 3 or more risk factors associated with an increase risk of developing CDI i.e. over 65 years, hospital admission within the previous 3 months, antibiotic therapy within the previous 2 months, significant co-morbidities
  - There were no cases where the patient had no risk factors present
- **Cases by surgery during the period under review:**

- Two surgeries had four cases, Four surgeries had three cases, Twelve surgeries had two cases and Ten surgeries only had one case
- All the remaining surgeries didn't have any cases
- Following a review of individual CDI cases by the IPN with the GP, no IP&C or prescribing issues were identified in 44 of the 59 cases

- **Themes identified following case reviews:**
  - Of the remaining 15 cases the following themes were identified after review:
    - Antibiotics prescribed outside of LLR prescribing guidance (5 cases) with no rationale stated in the patient records to support the prescribing decision.
    - Incorrect CDI treatment prescribed (1 case). *Only 5 days of etronidazole prescribed instead of 10 days*
    - Poor IPC practice in a care home (4 cases)
    - PPI not reviewed after a positive CDI result (1 case)
    - Patient on prophylactic antibiotic (1 case) as prescribed by a Consultant with no discussion taking place for ongoing need
    - Inappropriate sampling (1 case) where the sample was sent on a patient's request
    - Inadequate communication to the GP relating to commencement of CDI treatment for oncology/renal day attendees (2 cases)

Members noted that following a steady decline in the overall position, there was now a slight increase in the number of C-Diff cases though it was difficult to interpret information with figures from only one quarter. Organisations were testing more thoroughly for C-Diff as they became more clinically aware. Mrs Smith briefly explained the procedure for testing and added automatic testing was carried out for all over 65's.

Dr Trzcinski raised the issue where many patients were provided with a Proton Pump Inhibitor (PPI) and it was unclear why. Sometimes people were prescribed high doses of anti-inflamatories and not reviewed regularly. Dr Sanganee added patients leaving hospital were often on a PPI and it would be useful to know what the rationale for this was, as GPs felt duty bound to adhere to the PPI until patients had a next review. An issue also existed around anti-biotics where patients might not necessarily be allergic, but might have had a bad reaction to a single dose. The Q&P agreed to add PPIs to the next PLT session and to also ask Mrs Ford to pick the issue up with the non-medical prescribers. **KS/PF**

Mr Rees queried the issue of poor IPC progress in care homes and Mrs Smith explained the local authorities had employed a team of infection control nurses from April 2015 and C-Diff cases would be kept under close review in future.

Mr Rees referred to the national increase in C-Diff cases and said it was important to be aware of this, but just as important to be aware of local increases and to identify any trends. Mrs Allardyce said the situation would continue to be monitored and it was agreed this item be revisited in the new year. **CM**

ACTION – The Q&P:

- **Received** a presentation on Infection Control

Q&P/15/134 **The Patient Experience**

Mrs Trevithick gave a presentation on the patient experience, that included the following:

- An aim to focus the patient engagement/insight, and to ensure the patient voice was evident in commissioning decisions.

- The strategic aim for quality, both statutorily and to encompass local values.
- Why gathering the patient experience was the right thing to do.
- Methodology used and the approach with patients, carers and stakeholders.
- The people powered objective and co-design approach to involvement, engagement and experience approach.
- Ongoing mechanisms for engagement and co-design/co-production examples.
- The desired governance relating to patient engagement.
- Whether opportunities to strengthen patient engagement might be introduced to help with decision making processes.

Mrs Trevithick reported a discussion had been held on the patient experience at the September Board meeting, where Board members were reminded of the statutory requirements.

Mr Rees said he was particularly interested in the roles of Federations and how they intended to take forward the patient experience. It was noted North Charnwood had been involved in piloting some work and he would be interested to know how the Federations might be supported in this area of work and also how data collated might better inform the commissioning strategies.

Mrs Bright said in respect of North Charnwood, the PPGs had demonstrated a commitment to working together across the locality, together with support provided from the CCG communications team. Local councillors had also been involved in their meetings. Dr McHugh added social prescribing had commenced in North Charnwood which was an extremely innovative initiative and they also had voluntary sector involvement.

Mr Rees asked how links were made with PPGs and Mrs Bright replied wider PPG network meetings were held on a quarterly basis, facilitated by the CCG communications team. As part of this it would be important to link with individual Federations, managers and clinical leads, and work together to consider a roll out approach similar to that of North Charnwood.

Mrs Jones felt there was currently an imbalance in patient voice. Attempts had been made to recruit young mums but if they were receiving a good service then it was often more difficult to secure commitment. Members noted virtual PPGs worked well where people were not required to attend meetings but could still contribute their views.

Mrs Trevithick said it would be important for the patient experience team to work with the Federation Leads around their patient experience aims and how they could be supported in taking this forward.

Dr McHugh felt there were insufficient examples of good practice and positive feedback and the CCG should invite more patients in to talk about their experiences. He felt patients with a mixture of experiences were able to provide a better insight than other forms of communication. Mr Rees agreed with this but said the right patients needed to be identified, and not just those with limited experience or their own agenda. It would be useful to align the patient voice with a specific deep dive, using video equipment if appropriate. **CM**

ACTION – The Q&P:

- **Received** a presentation on the Patient Experience.

Q&P/15/135	**Highlight Report, Contract Quality for Providers: City, East, LPT, Dashboards** Mrs Allardyce presented paper C which provided an overview of performance assurance for WLCCG for June and July where available. The report included an overview of the high risk indicators and remedial actions in place. A quality dashboard was also included which focused primarily on UHL quality indicators, along with the latest position on the Quality Premiums 15/16 and 14/15, and the Better Care Fund. Key points to note: In respect of the rag ratings the following had moved from red to green: o RTT o 61 day cancer waits – screening referrals o CPA **IAPT** – June data showed an increase from 12.8% towards the 15% target and early indications for July/August were showing approximately 16%. National data only generally was used, but local data was also collated. The service was now fully established and £71,000 additional funding had been secured for backlog and waiting time issues. **Diagnostics** – issue existed around endoscopies – reduction of backlog and recovery was expected in September – one of the causes was a lack of diagnostic resources. **4 hour waits** – a steady improvement had been apparent since April 2015 and UHL now ranked approximately middle in the national table, although the situation fluctuated regularly. Dr Trzcinski commented the bed bureau had started to advise that people be sent to A&E again instead of other admission routes. However it was noted DTOC had improved enormously. **Cancer waits** – 31 day surgery had now turned green. Formal guidance was still awaited on the 4 weeks waiting times. **EMAS** – all three targets were at red and contract performance notices had been served. Mrs Trevithick reported this would be debated at the next Regional contact meeting. Also no improvement in handovers between EMAS and A&E. **Mixed sex accommodation breach (Derby)** – a hoist was situated in a male ward and women had used the area when required. **Primary Care Patient Survey** – slight decline was showing in access to primary care across the whole West area. Members noted the decline was minimal and not statistically significant. A report on the survey trends was anticipated at the October Q&P. **<u>Local Priorities</u>** **Outcomes Framework** – a considerable amount of data still had not been published nationally, due mainly to its annual output. **Infant Mortality** - the position had deteriorated in Charnwood and North West Leicestershire. **Unplanned hospitalisation** for chronic ambulatory care sensitive conditions. **Employment of staff with mental illness** – improvement shown from June to March but no improvement from July to September 2015 – this County level only indicator would continue to be monitored. **Quality Premium** – achievement of RTT target had meant additional funding for the CCG in excess of £70,000. **Quality** – Mrs Morrison reported on the following: **<u>UHL</u>** **Fractured neck of femur** – improvements were indicated in the 36 hour time to theatre standard – a further report to the CQRG in August showed ongoing capacity issues, though better than the national average. **Nutrition and Hydration** – Education programme implemented by UHL to reduce avoidable weight loss and increase staff knowledge. Thresholds were not met,

however a number of improvement initiatives were being introduced.

LPT

Pressure Ulcers – Challenges existed across the whole of LLR around the prevention of pressure relieving equipment, particularly in care homes. Performance on inpatient pressure ulcers remained good. East Leicestershire continued to have a disproportionate number of pressure ulcers and the patient safety collaborative were investigating this.

Workforce Recruitment – Staffing levels at the Bradgate Unit had deteriorated slightly. Issues were also being experienced at the Agnes Unit and St Luke's Hospital. Mr Rees asked at what point staffing levels became unsafe and Mrs Trevithick explained closure of beds would be one option if staffing was considered to be unsafe. However LPT were maximising all their opportunities for attracting staff, such as return to work programmes. She added this was a national problem. Dr Barlow said this was a complex issue, not helped by the suspension of the NICE guidelines on staffing levels.

Dr McHugh alluded to the overall left shift plans and asked if capacity existed to make the transformation a reality. Mrs Trevithick replied a workforce plan had been put in place which included details on doing things differently, encouraging student nurses to carry on in nursing after training, utilising skill mix and using an appropriate delegation of skills.

ACTION – The Q&P:

- **Received** the content of the report.

Q&P/15/136 **Out of County Dashboard**

Mrs Allardyce presented paper D, dashboard that had been developed to provide the Q&P with an overview of national Key Performance Indicators for the out of County providers to West Leicestershire. Delivery narrative was included where key performance indicators were at risk. The narrative had been taken from individual contract meeting papers or publically available Board reports. Of particular note were:

62 day cancer – Upgrade (Burton) – due to one patient with a complex diagnosis and took longer to diagnose due to the condition presented.
Mixed Sex Breach (Burton) – occurred in the high dependency unit due to capacity issues.
A&E 4 hour wait (Derby) – attendances were high in June, with 6 days with well over 400 attendances.
RTT – UHC&W were not achieving any of their RTT metrics currently – in particular trauma and orthopaedic specialties were the most affected.

Mrs Allardyce reported that one key message in relation to cancer was around the recruitment of Oncology Consultants at both Burton and UHC&W.

Mr Rees noted Burton and Derby had a situation with regard to pressure ulcers and Mrs Allardyce said members should be mindful of the way this had been reported as numbers only related to a proportion of pressure ulcers. She agreed to ask the appropriate contract officer for clarification on how the information was presented. **KA**

ACTION – The Q&P:

- **Received** the Out of County Dashboard.

Q&P/15/138	**Risk Register** The Q&P Risk Register was received for information. Mrs Trevithick suggested a reduction in the Burton risk and asked that the risk in respect of LPT be added. Paper E, the Risk Register was received for information.	**CM**
Q&P/15/139	**Items for escalation to:** **Board** • Bradgate Unit staffing issues • CNCS • EMAS **LMSG** • PPIs • Anti-biotic prescribing	
Q&P/15/140 **140a**	**Any Other Business** **CNCS – OOH Service** Mrs Trevithick reported that CNCS had received a poor CQC report in March 2015. Since then the CCG had been working with them to improve their position in respect of performance and governance. In terms of performance the KPIs were green, however the CCG had since been alerted to concerns surrounding the reporting of incidents and complaints. Following a review it became apparent CNCS's oversight of governance was very poor, and as a consequence an oversight meeting had been brought forward to look at this and to better understand the situation. **ACTION:** The Q&P **NOTED** the above.	
DATE OF NEXT MEETING		
Q&P/15/141	The next meeting of the Quality & Performance Sub Group would be held on Tuesday 20 October 2015, Boardrooms, Woodgate, Loughborough.	