WEST LEICESTERSHIRE CLINICAL COMISSIONING GROUP **O**

Minutes of the Quality and Performance Sub Group held on Tuesday 18 August 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
Dr Mike McHugh	Consultant in Public Health Medicine
Mr Ian Potter	Head of Delivery (deputising for Mrs Bright)
Mrs Liz Jones	Patient and Public Representative

IN ATTENDANCE:

Mrs Patricia Ford	Deputy Chief Nurse
Mrs Craigie Morrison	Quality Lead
Mrs Kate Allardyce	Performance Manager (for item Q&P/15/117)
Mrs Sue Venables	Communications and Engagement Manager
Mr Andrew Roberts	Senior Management Accountant, Localities
Mrs Julie Quincey	(for item Q&P/15/0)
Mrs Gill Stead	Head of Prescribing (for items Q&P/15/123 & 124)
Mrs Laura Rodman	Assistant Corporate Services Officer (for items Q&P/15/119 & 120)
Mrs Jennie Caukwell	Delivery Manager (for item Q&P/15/122)
Mrs Michele Morton	Senior Committee Clerk (minutes)

ITEM	DISCUSSION	Action
Q&P/15/113	**Welcome and Apologies** The Chairman welcomed all to the meeting and apologies were received from Mrs Caroline Trevithick and Mrs Angela Bright.	
Q&P/15/114	**Declarations of Interest on Agenda Topics** There were no declarations of interest.	
Q&P/15/115	**Minutes of Meeting held on Tuesday 21 July 2015** The minutes of the meeting held on Tuesday 21 July 2015 were approved and accepted as a correct record with the exception of **Q&P/15/096 Deep Dive – Ophthalmology** – where the last paragraph should be deleted.	
Q&P/15/116	**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** Mrs Allardyce presented paper C which provided an overview of performance assurance for WLCCG for May and June 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:	

CDifficile – some June/July data had been received which showed an increase in cases for West Leicestershire patients. If the rate continued there could be a possible 93 cases against a target of 77 at the year end, which would mean a breach in target. Mrs Allardyce would be seeking information from infection control on reasons for the increase, and members suggested having this as a future Q&P deep dive. No financial penalties were attached to non-achievement of the target but the situation would have an impact on patients. Dr Barlow said cases appeared to be sporadic, with no emerging pattern. A September PLT session would have a focus on infection control. **KA**

MRSA – to date there had been 3 cases in West Leicestershire, 2 of which were assigned to a third party and a third was awaiting a panel decision. Mr Rees sought clarification on what was mean by third party and Mrs Allardyce replied this meant the source of the infection was not identifiable. She agreed to seek further details for the September meeting. **KA**

IAPT – no national data had been received but local data showed an optimistic position, with July demonstrating 16% against a 15% access target. The service was now over-establishment and one challenge was to increase the number of referrals as no immediate wait times now existed and the backlog of patients had reduced significantly.

Dementia diagnosis – national data had still not been received – a bigger increase in West Leicestershire referrals had been experienced which demonstrated a raised awareness. As patients waited 3-6 months to be seen, this caused delays in receiving further information on increased referrals. Members noted this target was controversial as attitudes had gradually changed towards dementia. It was agreed to consider this in greater depth once further information had been received.

RTT – the national target was achieved in June.

Diagnostic Tests – problems were being experienced in endoscopy where UHL were organising some additional weekend lists to combat this.

Orthodontics – following a waiting list review, a major issue existed around 52 week orthodontic patients, a specialised commissioning service commissioned by NHSE. 85 patients on the list belonged to West Leicestershire and various remedial actions had been established. No immediate clinical need was apparent and the category of patients might be considered as low priority. Mrs Allardyce agreed to clarify which category of patients were affected. There was the possibility of a health inequality issue, with the majority of patients referred were usually from more affluent families and there was also a suggestion the treatment could be considered as cosmetic in some instances. The important thing would be to seek specific definition of the service to be delivered. Mr Rees agreed to speak with Mrs Trevithick and Mrs Ford outside the meeting on the best course of follow-up action. **KA** **ER**

A&E – performance was unpredictable but still remained higher than for the previous financial year. Mrs Allardyce agreed to circulate the national table. **KA**

Cancer – 62 day waits from screening referrals were no longer red and considerable actions were taking place on the remaining indicators. A brief discussion was held on delays occurring due to the need to hold constant MDT meetings to consider and reconsider cases. Mrs Ford suggested this should be raised with Dr Shah as part of his work with the Cancer Board. NICE had also recently revised the cancer guidance which was likely to create increased referrals. **CM**

EMAS – position was unchanged – members noted local urban areas were performing better than rural areas. It was noted EMAS attended a recent H&WBB where response times were discussed. A discussion was held on whether the target was practically achievable in the Leicestershire area. Members noted if general improvements were experienced at A&E in UHL, then this would have a positive impact on handover delays. Mr Rees agreed to raise the issue with Mr Harding for a possible PPAG discussion, to raise with the contract squares. **ER**

Cancelled Operations – UHL had a local matrix at 10 and 21 days and at the end of July 39 patients were rebooked within 10 days and 12 patients rebooked within 21

days. None were booked outside of the national 28 day target. Reasons given were lack of theatre time/staff, equipment failure and unavailability of beds.

GP Patient Survey Results – Mrs Allardyce was in the process of raising a couple of areas with the Ops and Delivery team:

- **Slight deterioration around GP and nurse consultation** – based on 5 specific questions.
- **Experience in making appointments** which had worsened from 74% to 73.5 %. Dr Trzcinski said it would be important to identify trends rather than individual comparative data, and Dr Barlow said he sat on a workforce group that had considered appointment times where it was noted problems occurred during holiday times and was often dependent on whether practices were heavily reliant on locums.

Mr Potter said it would be useful to present a high level summary of some of the trends from the survey and further detailed work would be picked up at the PCCC. Mrs Ford reported a dashboard was under development, arising from a national group and once approved by Chief nurses, should be available for sharing. **IP**

Local Priorities

Deaths in usual place of residence – achieved 48.1% of a 50% target. A decline in February/March 2015 had contributed towards none achievement. Dr Sanganee said the decline could be due to staffing issues and having insufficient resources to manage people's wishes. Members noted this target was part of the quality premium which had a financial element. Dr Trzcinski added the time of year and likelihood of deaths in acute settings possibly contributed to the decline.

Two Local Priorities for the current year

Deaths in usual places – a target had been set of 51%.

Satisfaction in access to primary care – data received so far was for 14/15. 15/16 data would be available in January 2016 and this would then start to be monitored.

Quality Issues – Mrs Morrison gave an update:

Women's and Children's sub group – a major review had taken place in maternity services following receipt of the Kirkup Report, and UHL appeared to be well placed on the majority of the recommendations. An action plan would be received at the Women's and Children's sub group and the CQRG sub group at LPT.

Community Teams Review – held last December where the majority of the issues were found to be in ELRCCG. Areas of concern included phlebotomy support, equipment delays, CHC issues, clinical supervision and high workloads. This had been a subject of discussion at the Quality summit held on 7th July.

Community Equipment – work continued to improve the co-ordination of services in relation to the assessment and follow up of equipment in the community.

ACTION – The Q&P:

- **Noted** the contents of the report and
- **Identified** any areas for in depth reviews at future Quality & Performance sub group meeting.

Q&P/15/118 **Review of Quality and Performance Sub-Group Terms of Reference**

The Q&P sub group received the terms of reference as part of an annual review. Amendments had been made that reflected the group's responsibilities in primary care, but otherwise no significant changes had been made.

It was agreed a non-Board GP should be recruited to the Q&P Sub-Group as soon as possible. **CM**

ACTION – The Q&P:

- **Approved** the amendments to the Quality and Performance Sub-Group Terms of Reference

Q&P/15/119 **Complaints Report Quarter 1**

Mrs Rodman presented paper E which summarised the complaints that had been dealt with by WLCCG between 1 April 2015 and 30 June 2015. The report aimed to provide assurance that complaints were comprehensively reported, investigated and that lessons learned were implemented via the quality and contract review processes. Key points to note:

- During the quarter 1 period WLCCG received six complaints, with a further complaint submitted via a local MP's office.
- During quarter 1 WLCCG resolved a total of six complaints.
- A graph in the report illustrated a quarterly comparison of the number of complaints received and resolved during 2014/15 and 2015/16.
- The report included an update on the Datix system.
- The 'contact us' tab on the CCG website had been updated to make the complaints process more visible for members of the public.

Mr Rees highlighted the high proportion of CHC complaints and Mrs Rodman replied she was working with Mrs Trevithick and Mrs Ford on these, most of which were due to communication issues and providing clarity around the 100% CHC funding arrangements.

Dr Barlow referred to the on line directions for the Loughborough UCC and said these were incorrect. Mrs Rodman explained this had been changed though unfortunately many people still referred to the Loughborough UCC as the Loughborough Walk-in-Centre. The communications team were aware of the problem and had asked for the details to be amended.

Mr Rees asked about the status of GP complaints and Mrs Rodman replied at present these remained the responsibility of NHSE and national guidance was awaited.

ACTION – The Q&P:

- **Received** the content of the report.
- **Received** assurances that the CCG had robust systems and process in place to ensure that complaints were being managed effectively in accordance with both the CCG and regulatory expectations.

Q&P/15/120 **Complaints Policy 2015**

Mrs Rodman presented paper F which presented the revised policy for dealing with complaints. She explained the CCG initially adopted the policy originally developed by the PCT, a predecessor organisation. The policy had since been updated and the main changes were:

- Removal of the role of 'Directorate Complaint Leads' and further clarification on the role of the Chief Nurse and Quality Lead and the Corporate Affairs Team.
- Removal of the section that related to 'Complaints Screening Panel' as this did not take place within the CCG.

An earlier iteration had been circulated to CMT members for comment and these had been added to the revised version. Once approved the document would be placed

	on the CCG website. **ACTION** – The Q&P: • **Approved** the revised iteration of the policy for dealing with complaints. The policy once approved would be uploaded to the CCG's complaints webpage.	
Q&P/15/121	**CCG: Mental Capacity Act (MCA) 2005 including Deprivation of Liberty Safeguards (DoLS) policy** Mrs Quincey presented paper G which outlined how the CCG would discharge its statutory obligations within its commissioning duties, of the MCA. The MCA was intended to assist and support people aged 16yrs and over who may lack capacity. It also aimed to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lacked the capacity to make decisions to protect themselves. Mrs Quincey explained that the CCG was statutorily responsible for ensuring that the organisations from which it commissions services provided a safe system which safeguards vulnerable children and adults. It would, therefore, ensure that it commissioned MCA compliant care and would ensure that providers met their statutory responsibilities to the people who were without capacity to consent to care and treatment. Mr Rees asked who needed to be aware of the policy and what methods were used for circulation and implementation. Mrs Quincey replied the policy would be for the attention of all clinicians. She agreed to produce an executive summary which would act as a reference guide and she added the MCA checklist was gradually being sent to all providers, where a slightly longer period of time would be spent disseminating the guidance to smaller providers. Once produced an executive summary could then be disseminated via GP networks, the care homes newsletter, placed on PRISM and raised at the practice nurse conference to be held in November 2015. Mrs Quincey also pointed out some useful guidelines to the MCA were available on line. **ACTION** – The Q&P: • **Approved** the CCG: Mental Capacity Act 2005 including Deprivation of Liberty Safeguards DoLS) policy, July 2015.	**JQ**
Q&P/15/122	**Anti-coagulation Oral Operating Guidance** Mrs Caukwell presented paper H which provided the Q&P with an update on the Oral Anticoagulation Operational Guidance which was due for review in July 2015. She explained that no changes had been made for 2015/16 and further work was underway to review the guidance for 2017/17. Dr Trzcinski said when the guidance was reviewed it would be important to include the new anti-coagulation drugs NOACS. **ACTION** – The Q&P: • **Approved** the content of the report and supported the Antibiotic Guardian campaign.	
Q&P/15/123	**Homely Remedies Policy** Mrs Stead presented paper I, the Homely Remedies Guidelines for the Management of Minor, Self-limiting Conditions. The policy had been received at the June Q&P	

meeting where it had been agreed changes should be made to ensure pharmacists were more involved as part of the process. Mrs Stead confirmed the relevant changes had been made and was being re-presented to all three CCGs for agreement.

A lengthy discussion took place on who should be the first point of contact, either the GP or pharmacist. Discussion points included:

- In the case of care homes, paracetamol could be bought by the home instead of prescribed by GPs. People who felt ill and lived at home would purchase their own paracetamol.
- There needed to be the potential for the reduction in workload of GPs.
- There could be the possibility of extending the number of hours a person was unwell before contacting a GP (from 48 to 72 hours).
- A distinct danger existed of over-medicalising minor conditions when advice and guidance could be provided by pharmacists.
- Pharmacists did not have access to patient records, but might have access to a MARS chart.
- It would be useful to clarify if care homes were able to keep a stock of homely remedies without individual patient names on.
- One fundamental issue would be to ensure the necessary authorisation forms were signed.
- Professionals should be appropriately trained to ensure homely remedies were being handled by the appropriate service.

Mr Rees said in respect of the above discussion it would not be possible for the Q&P to approve the homely remedies guidance.

Post meeting note: Mrs Stead to arrange a meeting with relevant officers including lead GPs for further discussion on next steps and feedback would be provided to the Q&P in September/October. **GS**

ACTION – The Q&P:

- **Received** the homely remedies policy but were unable to approve it due to the above discussion.

Q&P/15/124 **LLR Medicines Optimisation Committees**

Mrs Stead presented paper J which outlined the structure and work of the Leicestershire Medicines Strategy Group (LMSG). She explained that in common with other local health communities, the LMSG had a Leicestershire Health Community-wide strategy for the purpose of prescribing of specialist medicines and the managed entry of new drugs and related technologies. LMSG along with its subgroups and associated committees had well defined remits, terms of reference and reporting mechanisms.

GP representatives felt it was important for the Q&P to be involved in policy development at the consultative stage. Mr Rees supported this view and added there was almost always discussion to be held before policies were approved. Mr Potter said it might help to have a slightly wider consultation period prior to policies being submitted to Q&P for further scrutiny. Other comments included:

- Suggestion of a forward planner, produced by the LMSG which could be established at the start of the year.
- The importance of distinguishing between policy and guidance.
- Part of Q&P's earlier input would be to seek assurance developments were cost effective, safe and with a robust patient experience component.

	Mrs Stead stressed that it would be important the route was not made too unwieldy and she agreed to produce a flow chart to simplify the process. **ACTION** – The Q&P: • **Received** the content of the report.	**GS**
Q&P/15/125	**Risk Register** Paper K, the Risk Register was received for information.	
Q&P/15/126	**Item for escalation to:** **PPAG** • EMAS (discussion between Mr Rees and Mr Harding) **Board** • Q&P Deep Dives	
Q&P/15/127	**Any Other Business**	
127a	**Deep Dives** Mr Rees asked Q&P members how deep dives were appropriately identified for consideration by the group and felt it would be useful to develop a programme of items to help with planning. He was also interested to know how patient feedback could be integrated into deep dive sessions. Mrs Jones said there was currently a tremendous amount of work occurring on a number of consultations and patients were very aware of areas of concern such as general and cancer waiting times. She reminded the group of the importance of consulting with staff in addition to patients, particularly in new service developments. Consultation should also include staff working in the area of social care, the voluntary sector and community organisations. Dr McHugh added that junior staff members also often felt excluded from important consultation exercises. Mrs Jones felt that some patient stories might be presented as isolated episodes and not connected to current issues. Once deep dive subjects had been identified a sense could be gained from various patient groups on how the patient experience might be integrated. Mrs Venables added a recognised methodology now existed around patient experience, in the form of experience led commissioning, and it was no longer necessary to speak with huge numbers of people to gain a perspective. Pathways were used to find out what mattered most to people and only required between 5-10 patient voices per deep dive which was a reasonably simple process. Dr McHugh said patient stories were more informative than any reporting mechanisms. As well as talking to patients it would also be beneficial to include staff. Mr Rees asked the GPs specifically how areas of concern might be identified. Dr Sanganee replied some recurring themes existed in performance reports, with some obvious areas for scrutiny. Dr Barlow queried whether deep dives could be repeated and if so, he felt some areas were worth revisiting. Mr Roberts suggested individual sections of services could be scrutinised, for example EMAS handovers as part of the EMAS service. Other areas of concern for consideration were: • Dementia • C-difficile • Orthodontics	

	• CAMHs • EMAS • Workforce (a key theme running through all of the existing quality issues in relation to the excessive number of vacancies) Mr Rees agreed to raise the deep dive issue at Board level and to discuss the suggestions with Mrs Trevithick on how to programme and prioritise items, to include key speakers. **ACTION** – The Q&P: • **Noted** the above.	**ER**
127b	**Confidential Quality and Performance minutes from 21 July 2015** Members noted the above minutes had been approved by email circulation and would be submitted to the September Confidential Board meeting.	
DATE OF NEXT MEETING		
Q&P/15/128	The next meeting of the Quality & Performance Sub Group would be held on Tuesday 15 September 2015, Boardrooms, Woodgate, Loughborough.	