WEST LEICESTERSHIRE CLINICAL COMISSIONING GROUP **O**

Minutes of the Quality and Performance Sub Group held on Tuesday 21 July 2015 at 9.00 am in the Boardrooms Woodgate, Loughborough

PRESENT:

Mr Evan Rees	Lay Member (Chair)
Mrs Caroline Trevithick	Chief Nurse and Quality Lead
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
Mrs Angela Bright	Chief Operating Officer

IN ATTENDANCE:

Mrs Patricia Ford	Deputy Chief Nurse
Mrs Craigie Morrison	Quality Lead
Mrs Kate Allardyce	Performance Manager (for item Q&P/15/097)
Mrs Sue Venables	Communications and Engagement Manager
Mr Andrew Roberts	Senior Management Accountant, Localities
Mr Adrian Ashe	Head of Planning
Mrs Janette Harrison	Designated Nurse, Safeguarding Children and Adults (for item Q&P/15/098)
Mrs Julie Quincey	(for item Q&P/15/098)
Mrs Pauline Williams	Head of Patient Safety, ELRCCG (for item Q&P/15/099)
Mrs Karen Smith	Head of Infection Prevention and Control, ELRCCG (for item (Q&P/15/098-099)
Mrs Gill Stead	Head of Prescribing (for items,
Mrs Michele Morton	Senior Committee Clerk (minutes)

ITEM	DISCUSSION	Action
Q&P/15/092	**Welcome and Apologies** No apologies had been received. The Chairman welcomed Mrs Liz Jones, the new patient representative to the meeting. He added Mrs Jones would bring a useful set of insights to the meeting as she had been a patient champion for some time.	
Q&P/15/093	**Declarations of Interest on Agenda Topics** There were no declarations of interest.	
Q&P/15/094	**Minutes of Meeting held on Tuesday 16 June 2015** The minutes of the meeting held on Tuesday 16 June 2015 were approved and accepted as a correct record.	
Q&P/15/095	**Action Log and matters arising** **Highlight Report, Contract Quality for Providers – Cancelled Operations –** Mrs Allardyce agreed to circulate the LCCCG deep dive report on cancelled operations. She reported the number of cancelled operations to date due to none clinical reasons was 79 in April and 56 in May for the current year. Last year the average had been approximately 90 per month so an improvement had been noted. Reasons for none clinical cancellations included holiday periods for both patients and teams of staff.	**KA**

	Extra non elective work also put pressure on elective appointments. As the urgent care system improved, then elective work would improve. Paper B, the action log, was updated and would be circulated following the meeting. Members noted an update on proposals to improve Cancer Services would be provided at the August meeting.	**CM**
Q&P/15/096	**Deep Dive - Ophthalmology** Mr Ashe presented paper C which provided an update on progress made following the request for a more detailed examination of the Ophthalmology pathway. The key issues initially put forward for scrutiny were waiting times, communication and the environment. A primary objective was to identify any key areas which were adversely affecting the key performance indicators, and also to look at patient experiences in Ophthalmology. Mr Ashe reported a project brief had been received for the Ophthalmology work and an initial meeting held to start to determine how patients could be treated in an improved way, which meant essentially better communication between patients and clinicians. He added at this stage it was not necessary for a total deep dive, however liaison would continue with the consultants. Mrs Trevithick explained Healthwatch had raised an issue with Ophthalmology at the recent H&WBB and this had been channelled through to the P&D where it had emerged the main issue was centred around communication. A brief discussion took place on the need for reshaping appointment times to stop people sitting for hours waiting, without knowing when they were going to be seen, or even that some people were unable to read the information screens in waiting areas. Members noted there was a lack of accredited Optometrists in the system who would be able to carry out simple pressure checks, and as a result reduce referrals to secondary care. Optometrists must be trained by Ophthalmologist which apparently was presenting as an issue in the Leicestershire area, and as a result full tariff was being paid for people waiting between 3 and 4 hours in secondary care settings, which Dr Sanganee felt was unacceptable. Mrs Bright referred to the table on page 4 documenting the RTT data and she pointed out an issue had existed for West earlier in the year. Mrs Allardyce replied this had been a back log situation which should now be resolved. With reference to waiting times Dr McHugh said there should be nil tolerance for people waiting for cataract operations.	
	Mrs Trevithick said the Ophthalmology issue would need to go back to the P&D and Mrs Morrison agreed to pick up with Mrs Bufton to clarify the action plan was being monitored by the acute contracting team **ACTION** – The Q&P: • **Received** an update on the work on the Ophthalmology deep dive request. • **Approved** the proposals to note the work already underway on the pathway.	**CTre** **CM**

Q&P/15/097	**Highlight Report, Contract Quality for Providers: City, East, LPT, Dashboards** Mrs Allardyce presented paper D which provided an overview of performance assurance for the CCG for April and May where available. It 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 for Leicestershire. Key points to note: **RTT** – UHL had achieved all three indicators for May which was the first time in three years. **Mixed Sex Accommodation** – no breaches had occurred. **Avoidable Emergency Admissions** – no change in the position except for more of a CCG focus – to be discussed with the AT on 22.7.15 – the BCF would also be looking at this. **Dementia diagnosis** – data still awaited from the National team – to be raised again with the AT and Mrs Allardyce agreed to check out if payments were still made to GPs. **A&E waits** – sat at 92%, an improvement on the previous year. **Cancer 62 day** target – expected to be met by UHL in September. **EMAS** – quite close to the National target but significantly short of the target for local indicators. The contracting team were working with EMAS to develop an improved trajectory and a clinical view was being sought prior to holding a further meeting to formalise a final plan. Mrs Bright informed members a project was being piloted in the South around triage times (allowing 2 minutes for the triage to commence) which was proving successful and might be considered in the Leicestershire area. Mrs Allardyce added this approach could also change the technical guidance around response times. Mrs Allardyce reported she attended the recent H&WBB where a presentation was given on UHL/EMAS handovers. An improved system had been put in place and significant improvements were expected in July. **CPA** – some issues still existed around data quality. **IAPT** – a presentation was given at the July CCG Board which had not been pitched at the correct level. Mrs Bright agreed to find out what feedback Mr Bosworth had received from Board members and consideration needed to be given on how to address any issues with Nottinghamshire Healthcare. A CMT discussion would take place prior to a decision on the next steps. **Quality Premium 15/16** – a new indicator had been added regarding anti-biotic prescribing. Although the required reduction in prescribing had not been achieved the data was now being received on a quarterly basis. **BCF and DTOC position** – a big improvement had been achieved since last year with the numbers of patients at April last year standing at 6.5% and recorded in July this year at 3.8%. Mrs Morrison reported on quality issues. **UHL** **Orthodontics and restorative dentistry** – a SI had occurred around the waiting lists and UHL were working this through with NHSE. A review and actions would be investigated as part of a root cause analysis. **Transplant Laboratory** – an external visit had results in suspension of the laboratory accreditation for a twelve week period. A further update would be provided as soon as a report was available and Mr Rees requested this be a separate agenda item for the August Q&P meeting.	**KA** **AB** **MM**

	LPT **Community Nursing Services** – category 2 and 3 pressure ulcers had reduced in the East of the County, although it was noted category 4 had increased by 1 in the same reporting period. **OOH Cover on Elderly psychiatric wards** – problems were being experienced where the Royal College of Psychiatrists were indicating medical posts were insufficiently challenging at the Evington Centre. This was creating problems with providing cover. Mrs Trevithick agreed to request an update.	**CTre**
	Mrs Trevithick referred to the recent publication of the CQC visiting report into LPT, where a number of places had been identified as inadequate in terms of safety. As a result some actions had been completed, and the Oversight Group had been re-established. It was agreed to circulate the relevant Board paper to non Board members of the Q&P. Much of the focus of the visits was on mental health and community nursing which related significantly to staffing issues, recruitment and retention.	**MM**
	Staffing levels inpatient dashboards – quality dashboards for clinical service areas were now being produced and would be reviewed on a monthly basis by the contract quality teams.	
	In relation to the performance report Mrs Bright queried whether targets should be either red or green, with no amber ratings. Mrs Allardyce said she had not been formally notified of the change, but would do this in future.	**KA**
	ACTION – The Q&P: • **Noted** the content of the report and • **Identified** any areas for in depth reviews at future Quality and Performance sub-group meetings.	
Q&P/15/098	**Clinical Commissioning Group Safeguarding Report and Performance Report** Mrs Harrison, accompanied by Mrs Quincey presented paper E which provided assurance on the performance monitoring of local arrangements to safeguard vulnerable people, during quarter 4 (January to March 2015), and to inform the Q and P of the implementation of local and national safeguarding issues. Key issues to note: • **Deprivation of Liberty Safeguards** and the anticipated risk and challenges relating to the changes in thresholds. Mr Rees asked if there was any indication about the numbers of people who would need reviews in West Leicestershire and Mrs Harrison replied it was approximately 300 people across the three CCGs and 90 for West. • **Improving quality of safeguarding practice in primary care** – action following the results of GP post training evaluation. • **Female Genital Mutilation** - the production of the LSCB FGM procedures had slipped due to the March 2015 FGM guidance from the DoH and the endorsement of the Serious Crime Act 2015. • **LSCB Information Sharing Agreement** - production of the document had slipped pending additions required by the police. This would be circulated to all practices as soon as possible. • **Initial Health Assessments for Looked After Children** and the actions undertaken to improve the timely delivery of assessments. A backlog situation had occurred in February /March 2015 when local authorities and social care departments were working together and referring outstanding cases. LPT had received 60 requests and as a result had increased capacity to carry out additional clinics. Mrs Harrison felt this would be sufficient to handle the situation	

and she clarified the children concerned were children in the care of local authorities within Leicestershire and a handful of children from out of area (approximately 10).

Dr McHugh asked how the assessments linked to general practice and Mrs Harrison explained firstly when a child registered with a GP the safeguarding team issued a checklist for the practice where it would be determined who would be the main carer. Secondly when initial assessments were undertaken the healthcare plan was always sent to GP practices. A considerable amount of training had also occurred with GP practices to reinforce the main messages. Dr Sanganee said reports were received on children but it was not always made clear by the HV that they were 'looked after'. Mrs Harrison agreed to ensure all HVs were briefed on making sure LAC formed part of discussion with GPs about vulnerable children on their caseloads. **JH**

- **The Annual Review 2014/15 of CCG Safeguarding** contained within the highlighted section following each item in the quarter 4 report.

Mrs Harrison was thanked for her report.

ACTION – The Q&P:

- **Received** the key issues highlighted in the report.

Q&P/15/099 **Patient Safety Report for quarter 4 of 2015/15**

Mrs Williams presented paper F which informed and provided assurance about the safety of service provision commissioned by the LLR CCGs. It also provided an analysis of patient safety information, learning and actions, and how this information was used to inform the contracting process. Of specific note Section 3.7 of the report; Benchmarking, should read:

> The newly published NHSE SI Framework (March 2015) stipulates that frequently occurring incidents such as fractures, pressure ulcers and infection prevention and control incidents, should continue to be investigated and learning identified through common problems, factors and root causes.

Instead of:

> The newly published NHSE SI Framework (March 2015) stipulates that frequently occurring incidents such as fractures, pressure ulcers and infection prevention and control incidents, should continue to be investigated and learning identified through common problems, factors and root causes, but not reported as SIs.

Other main points to note:

- Themes that had been identified as a result of reported serious incidents were being addressed locally. Learning and assurance was being monitored through organisational quality meetings. Work continued on the policies and both UHL and LPT had unique themes, with some inconsistencies over how different providers had been reporting and categorising incidents. Efforts were being made to reduce the inconsistencies.
- No Never events were reported for the quarter 4 period 2014/15.
- There had been an improvement in the number of reports submitted within timescales.
- Providers were sometimes inconsistent in the way patient harm was graded. The new NHS England Serious Incident (SI) Framework 2015/16 published in March 2015 aimed to provide a consistent approach to grading patient harm. It also

promoted thematic analysis and the development of organisational action plans for frequently reported incidents, for example falls and pressure ulcers that did not meet the SI criteria. The draft LLR CCG had now completed its consultation and the finalised LLR CCG SI policy was due for discussion at the CCG Quality group meetings scheduled for August 2015.

- GP concerns were ongoing around the issue of discharge.
- GP membership of the serious review group had increased during the year, with new GP membership from West and ELRCCG, and membership had been consistent throughout 2014/15. Mr Rees asked how the duty of candour was monitored and Mrs Williams replied there was a compliance section in each SI report.

Dr McHugh referred to the difference in pressure ulcer prevalence between the East and West CCGs and Mrs Trevithick explained this was due to capacity within community nursing teams in the East at present.

In respect of Infection control Mrs Smith gave an update on cases of MRSA – locally and nationally. She reported that nationally there had been a 7.1% reduction in the number of MRSA BSI reported. During 2014/15 West Leicestershire CCG reported 5 MRSA BSI cases – 3 gained third party alignment, 1 was aligned to Derby Royal Infirmary and 1 was aligned to Birmingham hospitals. During Q1 2015/16 West Leicestershire CCG had reported two MRSA BSI cases to date. One had gained 'third party alignment' again and the second one was still under investigation.

In relation to C difficile cases, West Leicestershire CCG had met their 2014/15 trajectory however for Q1 2015/16 the CCG was 3 cases over Year to Date trajectory and was currently recording 7 cases against a monthly trajectory of 6 cases for July 2015. Nationally there had been a 6% increase in the number of CDI cases on the 2013/14 cases which was the first increase in case numbers since the mandatory surveillance of CDI was initiated.

ACTION – The Q&P:

- **Received** the report and considered areas where further assurance was required.

Q&P/15/100 **Antimicrobial Resistance – response to Quality Premium**

Mrs Stead presented paper G which outlined the importance of having to make significant improvements across the CCG in terms of the reduction of antibiotic prescribing. The DoH UK Five Year Antimicrobial Resistance Strategy 2013 to 2018 outlined the fundamental need to address antimicrobial resistance, and in line with this the Quality Premium for 2015 – 2016 included the reduction of antibiotic prescribing in primary and secondary care as one of its targets. The two areas to be targeted were:

- Antibacterial items/STAR-PU.
- Co-amoxicalv, cephalosporin and quinolone items as a percentage of all antibacterial items.

In response to this the CCG had established a task and finish group which would focus on key areas in primary care outlined in Appendix C of the report. A separate plan would be drawn up for secondary care and other providers such as the urgent care centres and patient group direction driven health services.

Practice level data had been available since the beginning of June which made it possible to identify outliers. Dr Sanganee asked if this was part of the prescribing incentive scheme and Mrs Stead replied the issue had been raised too late to be

	included in the scheme. Mrs Trevithick emphasised the importance of dealing with this public health issue, particularly with the increase in C Difficile cases in the community, with no specific emerging pattern. Practice data would help to provide a picture of prescribing patterns, however a separate piece of work would need to be carried out with trusts and UCCs. Mrs Trevithick reported she was the CCG representative on a national working party that had been looking at the impact of 7 day working, where people might not have had access to GPs previously and were being prescribed anti-biotics. She added the situation would need careful monitoring. **ACTION** – The Q&P: • **Received** the content of the report. • **Commented** on the content of the report.	
Q&P/15/101	**CDI/Anti-Microbial Resistance (AMR) Challenge** Mrs Smith presented paper Gi which outlined details of the Antimicrobial and Clostridium Difficile infection challenge. She explained AMR was one of the biggest threats facing the population today. In response to the threat the DoH had published the UK Five Year AMR Strategy 2013-2018, and one of the recommendations from the strategy identified the need for increased public and professional awareness about antibiotic use, through encouraging the general public in the UK and healthcare professionals to become Antibiotic Guardians. By agreeing to become an Antibiotic Guardian people would pledge their commitment to promoting the appropriate use of antibiotics in their daily personal and professional lives. The pledge would not be monitored by organisations, however it was hoped that national awareness would be raised. All employees, families, friends, healthcare professionals, patients and their carers signing up would make a significant difference. Dr Sanganee said it would also be important to include pharmacists in the scheme and Mrs Trevithick added she would like to include patients by taking the issue out to the PPG groups and patient leaders. Mrs Jones said the campaign could be taken on the health bus in September and also raised at the PPG Network due to meet on 2nd September. In relation to nurse prescribers Dr Sanganee suggested there might be a lower tolerance to uncertainty and risk and therefore a higher rate of anti-biotic prescribing. Mrs Ford replied this had previously been reviewed and anti-biotic prescribing by nurses had proved to be very low. Mrs Trevithick said robust communication between all partners would be essential in order to make the necessary changes. Dr Sanganee agreed it would be a time consuming exercise but concentrated effort usually provided a focus. Mrs Stead said NHSE had produced a number of publications, leaflets and protocols for outliers which outlined some simple steps to be taken. Mr Rees acknowledged anti-microbial resistance as an issue and asked for a further update at the most appropriate time. It was agreed on the importance of linking in with the LPC and to also build in data from OOHs services, UCCs and nurse prescribers. Mrs Trevithick also agreed to look at the possibility of holding a PLT session for September.	**CT**

	Mrs Venables agreed to work with Mrs Smith to promote the concept of the Anti-biotic Guardians throughout the community. **ACTION** – The Q&P: • **Approved** the content of the report and supported the Antibiotic Guardian campaign.	**SV/KS**
Q&P/15/102	**GP/OOH CQC Themes** Mrs Trevithick presented paper H which identified themes gathered following CQC reviews and inspections into the LLR Out of hours Service and Primary Medical Care settings The findings in the two settings were similar and CNCS and some local practices had to implement urgent actions to address the findings. The information would be shared with localities to ensure that all practices were aware of the issues identified so that they could review their own local circumstances. Individual issues would be taken up with providers through the contractual route, however it was the role of the Q&P to consider any identified common themes. In terms of supporting providers as part of the process Mrs Trevithick said the CCG would be able to support practices in terms of signposting, providing advice on policies and how to access the standard framework, but otherwise the CCG was insufficiently resourced to carry out the pro-active work. Mrs Bright said the identified themes were standard practice issues and normally part of contractual obligations such as regular systems and processes around clinical governance, and having up to date policies and procedures. Sessions had previously been carried out with all practice managers and key messages given through appraisal meetings. Dr Trzcinski said he found the CQC review process frustrating and unhelpful. Mrs Bright replied these were a requirement for all providers and an important control in terms of ensuring patient safety and a reflection of good clinical leadership. Dr Trzcinski agreed on the need for the process but felt an issue existed around proportionality and would welcome a more collective approach. **ACTION** – The Q&P: • **Received** the content of the report.	
Q&P/15/103	**The LLR General Practice Workforce Delivery Group** Mrs Bright presented paper H which provided the Q&P with information regarding a new LLR General Practice Workforce Delivery Group; a sub-group of the Better Care Together Workforce Implementation Group/LLR Local Education and Training Committee that aimed to support primary medical care with workforce development in order to provide high quality out of hospital care. The group was chaired by Mrs Bright and membership from the three CCGs included GP clinical leads, deputy Chief Nurses, LMC representation, LETC lead, BCT leads and the LLR General Practice training manager. The action plan which detailed the actions of the group would be circulated immediately following the meeting. **ACTION** – The Q&P • **Received** the contents of the report.	**MM**

Q&P/15/104	**Update report for the WLCCG Quality Assurance Framework and actions resulting from the Francis Review recommendations** Mrs Ford presented paper I which provided the Q&P with an update of the key activities of the CCG for quality and safety that were within the Quality Assurance Framework and that incorporated the learning and recommendations following the Francis review. Key points to note: • A number of deep dives had taken place at: o George Eliot Hospital October 2014. o EMAS November 2014 o Burton Hospital and IAPT December 2014. o Dementia Pathway February 2015. o Cancer March 2015. • Significant changes had taken place with regard to the development of the 2015/16 CQUINs. • A number of announced and unannounced quality visits to provider organisations had taken place such as UHL, LPT, EMAS, Arriva and CNCS. • A number of key insights had been gathered through patient experience and engagement, particularly in care homes. • A primary care safety incidents and serious incident reporting system via Datix had been developed. • Practice nurses, practice managers and GPs had been informed of the proposed new model of nurse re-validation due to commence in April 2016. Members noted a separate report on Equality and Diversity would be presented to Q&P. **ACTION** – The Q&P • **Received** the contents of the report.	
Q&P/15/105	**Controlled Drugs Report** Mrs Stead presented paper J which related to the prescribing of oral oxycodone. A review across West Leicestershire was undertaken to look at concerns mainly around more than 30 days prescribing. Where more than 30 days had been prescribed prescriptions had been reviewed and quantities reduced in line with DoH guidelines. The practices concerned had also been sent an email reminding them of the DoH guidelines on CD prescribing. **ACTION** – The Q&P: • **Noted** there were no outstanding concerns with the prescribing of oral oxycodone prescribing as measured by NHS England audit data.	
Q&P/15/106	**Authorisation of the PGD for Adrenaline (Epinephrine) 1:1000 (1mg in 1ml) injection for the emergency treatment of acute anaphylactic reaction** Mrs Stead presented paper K which outlined the PGDs for the administration of Adrenaline (Epinepherine) Injection 1 for ratification in line with the policy and process for PGD development, tentatively approved by the Quality and Governance sub group in 2014. **ACTION** – The Q&P: • **Approved** the Adrenaline PGD.	

Q&P/15/107	**Approval for LLR Medicines Optimisation Policies (no corporate) to be archived on the new LMSG website** Mrs Stead sought approval for the new LLR Medicines Optimisation Polices to be placed on the new LMSG website. She added the host for the website was LCCCG and appropriate links would be added to give access to relevant staff access. **ACTION** – The Q&P: • **Approved** the placing of the above policies on the new LMSG website.	
Q&P/15/108	**Risk Register** Paper M, the Risk Register was received for information. Members noted a new LPT risk would be added following receipt of the next iteration of the PPAG risk register.	
Q&P/15/109	**Caldicott Log** Paper L, the "Caldicott Log" of incidents was received for information.	
Q&P/15/110	**Item for escalation to:** **Board** • CQC themes. • Initial health assessments for looked after children. • Anti-microbial Resistance. **P&D** • Ophthalmology Feedback. **Localities** • CQC themes. • Initial health assessments for looked after children. • Anti-microbial Resistance.	
Q&P/15/111	**Any Other Business** No other business.	
DATE OF NEXT MEETING		
Q&P/15/112	The next meeting of the Quality & Performance Sub Group would be held on Tuesday 18 August 2015, Boardrooms, Woodgate, Loughborough.	