WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

M

Minutes of the Quality and Performance Sub Group held on Tuesday 18 April 2017 at 9.00 am – 11.00 am in the Boardrooms, Woodgate, Loughborough

PRESENT:

Ms Gillian Adams	Lay Member (Chair)
Mrs Caroline Trevithick	Chief Nurse and Quality Lead
Dr Nil Sanganee	GP Locality Lead
Dr Chris Trzcinski	Deputy Chair
Dr Mike McHugh	Public Health Specialist
Mr Ian Potter	Deputy Chief Operating Officer (deputising for Mrs Bright)
Mr Andrew Roberts	Senior Finance Officer
Mr Ket Chudasama	Assistant Director Corporate Affairs

IN ATTENDANCE:

Mrs Kate Allardyce	Performance Manager (until item Q&P/17/061)
Miss Amy Linnett	Quality Lead
Mrs Fiona Barber	Healthwatch Officer (for item Q&P/17/059)
Mrs Karen Smith	Control of Infection Lead (for item Q&P/17/062)
Mrs Kay Bestall	Primary Care Contract Support Manager (for item Q&P/17/060)
Mrs Michele Morton	Senior Committee Clerk (Minutes)

Item	DISCUSSION	Action
Q&P/17/055	**Welcome and Apologies** The Chair welcomed all to the meeting and confirmed it was quorate. Apologies for absence were received from, Mrs Sue Venables and Dr Chris Barlow.	
Q&P/17/056	**Declarations of Interest on Agenda Topics** There were no declarations of interest.	
Q&P/17/057	**Minutes of Meeting held on 21 March 2017** The minutes of the meeting held on 21 March 2017 were approved and accepted as a correct record.	
Q&P/17/058	**Action Log and matters arising** Paper B, the action log, was updated. **Action:** The Quality and Performance Sub-group • **RECEIVED** the report.	
Q&P/17/059	**Hospital Discharge Report - Healthwatch** Mrs Barber introduced paper C that presented the findings and recommendations from Healthwatch Leicestershire's 'The Lived Experience of Hospital Discharge". The focus of the report had been to capture experiences from three key participant groups in the process of hospital discharge, namely patients, carers and staff with an aim to help inform and improve the hospital discharge process. Mrs Barber provided feedback on the recommendations and findings to the Q&P group.	

Healthwatch officers heard from 216 patients, 30 carers and 40 members of staff who were based across the hospital estates in Leicestershire where information was gathered. Subsequently Healthwatch Leicestershire made five recommendations as follows:

1. **Timely medication** - The issue of timings for medication to take out (TTOs) should be addressed with some urgency, including more immediate practical steps to examine how the overall discharge process could be speeded up and improved.
2. **Training** -The experience of hospital discharge should be the same whichever hospital setting the patient was coming from. There should be an improved schedule and a consistent approach to staff training relating to discharge. That training should have an element of multi-disciplinary and multi-agency focus.
3. **Cultural change** - There were many processes, people and procedures that were intertwined with hospital discharge. There needed to be a cultural shift that led to greater communication between staff teams, departments and partners working towards an effective pathway and process for discharge.
4. **Inclusive approach** - Carers and family members often felt on the margins and left out when it came to the care of the patient. Better information for carers and family members, in terms of processes, timings and care should be made accessible and explained.
5. **Feedback loop** – Hospital discharge affected people's lives in many different ways. There should be a timely follow up survey specifically around hospital discharge so that the system could continually be improved to benefit patient and carer's experiences.

The discharge report had been presented to the HOSC, H&WBB, UHL and LPT. A key element of discharge work was also being targeted through the Urgent Care Board, with Ms Tamsin Hooton as Director and that group would work towards improvements on a systemwide basis. If carried out successfully this would contribute significantly to the overall process of managing urgent care.

Dr Sanganee commended the report and said he would be interested to know what UHL's response had been, particularly with 75% of staff untrained and yet discharge elements should be a routine and integral part of staff responsibilities. Mrs Barber replied that the report had yet to be received at UHL's Board. The HOSC however intended to invite UHL's Chief Nurse to their next meeting to discuss discharge.

Dr Trzcinski pointed out that little had changed over a number of years and he queried if doctors had to be responsible for discharge letters and discharge prescriptions when these could be handled by other members of staff to avoid delays. Mrs Barber referred to the pressure experienced by hospitals but said changes did not need to be major to be effective. Often staff just needed appropriate training or the use of clinical pharmacists on each ward. Further improvements could be made by simply talking to patients, staff and carers and this simple communication had no cost attached.

Mrs Trevithick said the CCB would be looking at the need for fast track discharges in association with the End of Life strategy and the LMSG was putting together a plan with a proposition to take responsibilities for medicines for patients TTOs.

With regard to any action the CCG could take prior to the admission of patients to support discharge, good care plans needed to be established and people should understand what their care needs were in the community. There was often heavy reliance on carers and family members, but if documentation was thorough it helped

	with the discharge planning process. The CCG should consider from a community perspective the development of care packages through integrated teams, especially for the over 75s. Dr Sanganee replied care plans often were not read or understood and prescriptions provided on discharge were not trusted by practices and were frequently inaccurate. He felt the biggest challenge was a cultural change. Q&P members acknowledged generally that discharge was not a priority for junior doctors and the situation was not unique to UHL. One of the biggest issues was lack of communication with patients. Mr Chudasama said the solutions were well known but what was important was how to ensure real change was made. Mrs Barber felt the answer lay in clear leadership. She added that the recommendations were uncomplicated and considerable work was being carried out around the whole cycle of patient care where discharge was a key element, but it needed to be driven. CCGs were a key element of providing leadership in the health system so any action the CCG was able to take to ensure good discharge was embedded and made systemwide was to be welcomed. Mrs Trevithick said the majority of the actions stayed clearly with UHL and it was the CCG's responsibility to make sure they responded appropriately. She agreed to talk to LCCCG and request a formal response via the contractual route, and to then feedback to a future Q&P meeting. The issue would also form part of a Board to Board session with UHL. Mrs Trevithick said a process had been established where she received information on delayed discharges and members of her quality team were then able to engage in unblocking issues in the system. Mr Roberts asked if any comparative data existed around good practice that might help UHL and Mrs Allardyce agreed to look at any existing national data. Mrs Barber agreed to check with Healthwatch England on any national initiatives that might help UHL. **Action:** Following full discussion, the Quality and Performance Sub-group • **RECEIVED** the Hospital Discharge Report – Healthwatch.	**CTre** **KA** **FB**
Q&P/17/060	**Learning Disabilities Healthchecks** Mrs Bestall presented paper D and explained that the proportion of people with learning disability on the GP register receiving an annual health check within WLCCG area dropped from 57% in 2014/15 to 31% in 2015/16. Members of the Q&P Sub Group had requested a narrative on why this might have happened and what was being done to support improved achievement in 2016/17 and 2017/18. The report outlined the requirements of the General Practice Directed Enhanced Service (DES), the support provided by the Learning Disability Primary Care Liaison Nursing Service and the CCG, and the proposed process for encouraging higher achievement in 2017/18. Mrs Bestall informed the Q&P that for practices to receive the health check payment they must have a validated list under the DES. Regular LLR meetings had been established with the primary care disability nursing team, however, the team had reduced from 3 to 1 due to staffing issues. Extracted information for quarter 4 showed considerable gaps. 305 checks had taken place out of over 1000 people on the register that equated to 23%. Mrs Bestall said this might be partly due to patients who started the process but then did not attend for some appointments. Closer working needed to take place with the LD nurses and practices on how to better support patients for 2017/18. It was noted LCCCG had a number of staff who	

concentrated solely on health checks which put them in a slightly better position.

Dr Sanganee said the best method was to have an even flow of patients throughout the year but that non-attendance was a major issue. Patients needed to attend appointments with a carer and if this was not possible some practices did not have the resource to visit patients' homes. His practice knew who the LD patients were (a LD lead had been appointed within the practice) and staff had been trained appropriately but the lack of a LD nurse did affect the situation.

Practices also had no specific target to reach and were not penalised for non-achievement.

Mrs Bestall said the CCG needed to decide on the level of resources to help practices. The remaining LD nurse was willing to speak at PLT sessions but her resources were stretched. It was also important for the CCG to help practices to revalidate their lists.

Mrs Trevithick agreed to:

- Discuss the lack of LD nurse cover with the other 2 CCG lead nurses prior to discussions with LPT.
- Within the context of existing data collection issues, work with Mr Potter's team on how to demonstrate that work on LD health checks had been completed which might show the percentage as higher than 23%.
- Take the promotion of health checks through the Transforming Care Board. That group had a key role in ensuring people were appropriately supported and monitored in the community and Mrs Trevithick would ensure the social workers worked with carers to help get patients to appointments. Mrs Allardyce added that similar issues existed in LCCCG. **CTre**

A brief discussion was held on the importance of correct data recording at practice level and the need for sufficient resource to support that. Mr Potter added there were a number of practical steps that could be taken to help the situation, one of which would be to ensure the leadership aspects were covered at practice appraisals. There was also a national on-line resource available for promoting the service to patients. Mrs Allardyce agreed to link in with the team and provide a quarterly update. **KA**

Dr Trzcinski questioned the actual value of the checks as practices tended to know their patients well, however it was acknowledged that evidence showed patients who had regular checks had a tendency to avoid crisis situations.

Action: The Quality and Performance Sub-group:

- **RECEIVED** the Learning Disabilities Healthchecks report.

Q&P/17/061 **Highlight Report, Contract Quality for Providers: City, East, LPT, Dashboards**

Mrs Allardyce presented paper E that provided an overview of performance assurance for WLCCG for February 2017 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 Premium and the Better Care Fund for Leicestershire. A section identifying quality issues & actions was also reported.

A&E UHL position – the previous three months had seen an improved position from last year and the new unit was due to open at the end of April 2017.
Better Health Dashboard – no rag rating changes from the previous month:

anti-biotic resistance was at close achievement.
Cancer data – no data received for February at time of writing report, however verbal update that 31 day target for radiotherapy treatment was now being achieved.
IAPT – problems being experienced receiving national data.
Dementia – the national target had been achieved with an increase of 68 patients in March to 67.7% and the prevalence figure had dropped for 2017/18
A&E – the STF target was received in December – reduced targets had been agreed but this could change, and there are expected to be reduced STF targets on A&E, RTT and 62 day cancer and diagnostics – expected to be agreed in June 2017
EMAS – ambulance wait times improving slightly in February but not expected to achieve in 16/17.
Cancelled Ops – higher number due to the impact of the RTT position – out of 260 breaches 164 were LLR patients.
C-Difficle – not achieved this year and target for 17/18 remained the same.
Mixed sex accommodation – further breaches at UHL in February around intensive care and the stroke unit.
RTT – February position below the national target but still achieved YTD.

Dr McHugh referred to the six people waiting for orthodontics and asked for clarification. Mrs Allardyce explained this had been the previous high number of patients awaiting treatment which had since reduced to six. UHL had served notice on that (orthodontic) service to NHS England and so new patients would be sent to different providers in the future.

Dr McHugh referred to the quality performance for local priorities and noted that no savings had been made and he asked what the process was for next year. Mrs Allardyce replied that for 2017/18 the Commissioning for Value packs had been scrutinised and the paper taken through F&P to determine local priorities (approximately 80 suggestions on the list).

In respect of quality issues Mrs Trevithick said it would be important to monitor how the new urgent care pathway was progressing. Ms Adams added that herself and Professor Lakhani had attended the recent UHL Quality Summit and had fed back to the April Board meeting.

Action: The Quality and Performance Sub-Group:

- **NOTED** the contents of the report &
- **IDENTIFIED** areas for in depth reviews at future Quality & Performance Sub-group meetings.

Q&P/17/062

Draft Antimicrobial resistance (AMR) and infection prevention and control (IP&C) plan, Leicester, Leicestershire and Rutland 2017-2021

Mrs Smith presented paper F and explained that the scale of the threat of AMR and the case for action was set out in the 'Annual Report of the Chief Medical Officer, 2011' published in March 2013. In September 2013 the Department of Health published a five year AMR strategy outlining the actions needed to address the key challenges associated with antimicrobial resistance outlined in the Chief Medical Officers report. The LLR AMR plan outlined how health and social care organisations across LLR aimed to adopt a system wide approach to build on the good practice and wide range of local work currently being undertaken to tackle AMR and to prevent infections. The joint plan aimed to prioritise the work across LLR and focussed on four key areas:

1. Reducing inappropriate prescribing
2. Reviewing IP&C and AMR workforce planning and development
3. Continuing to raise public awareness of AMR

4. Strengthening data collection and surveillance

Overall responsibility for delivery of the joint plan would lie with the LLR Health and Social Care Infection Prevention group where Directors of Infection Prevention and Control would actively monitor and support the implementation of the plan within their respective organisations.

Ms Adams referred to a previous Q&P discussion where it had been felt UCCs and A&E had a tendency to be higher prescribers of anti-biotics and she asked if this would be monitored as part of the strategy. Mrs Smith replied the plan looked at a whole system approach on how to tackle AMR across health and social care. Valuable pieces of work were taking place but this was often fragmented. UHL's audit system would be an effective way of monitoring AM prescribing and the CCG's pharmacies would also be looking at AM prescribing in non NHS premises. Audits would also provide the target areas for education and training. Some pilot schemes were underway and due to finish at the end of the quarter and these would be followed up by an evaluation process.

Mrs Trevithick reported that from a national perspective NHS Improvement and NHS England were working on a toolkit to consider E-Coli that captured AM prescribing and would be launched once Gateway approval had been received.

Dr Sanganee asked how the new medical providers and OOH providers were audited and Mrs Trevithick said these organisations would carry out their own audits and would be integral to the strategy.

Mrs Trevithick announced that Mrs Smith would be retiring at the end of April. She thanked her for all the work she had carried out with infection control and wished her well for the future.

Action: The Quality and Performance Sub-group:

- **APPROVED** the Draft Antimicrobial resistance and infection prevention and control plan, Leicester, Leicestershire and Rutland 2017-2021

Q&P/17/063 **Risk Register Review**

Mrs Trevithick presented paper H, the risk register. The register had been reviewed by members of the quality team and it was now up to date with the exception of the learning lessons risk where a plan was being constructed for a second audit. The risk would then be updated.

Q&P/RR/03 - C Diff target – rating overall 8 - even though the impact was low (2) and likelihood high (4).
Q&P/RR/05 - CIP schemes – quality monitoring ongoing.
Q&P/RR/06 - avoidable attendances at A&E from care homes – all still moderate risks (12)
Q&P/RR/07 - Cheshire West – on the register because of the CW ruling in 2014 – still did not have a particularly robust process but progress was expected with the new provider. A CCG assessment of patients been undertaken to ensure DOLs were established for when patients had respite care and to also determine if they needed a Court of Protection process.

Ms Adams asked if the discharge report had highlighted any risks that needed adding to the register and Mrs Trevithick replied these would be reflected on the A&E Delivery Board risk register. She agreed to check that the correct detail had been captured. **AL**

Mrs Trevithick explained that the collaborative risks were considered by PPAG and the remaining risks were what emerged from Q&P discussion of the management of projects and contract management.

Dr McHugh said all risks would impact on quality and have the potential for harm and Mr Chudasama reminded the group a number of other risk registers would capture risks such as the corporate risk register.

Collaborative risks:

Q&P/RR/EMAS 02: WLCCG was responsible for EMAS and it would be important to see if improvements in the A&E handover times had made a difference to performance.
Q&P/RR/ARRIVA 02: the service would remain until handed over to the new provider in October 2017. Ms Adams pointed out that transfer to the new provider and the potential ineffectiveness in mobilisation of that provider could be a risk. Mr Chudasama explained that mobilisation would be on the corporate risk.
Q&P/RR/ARRIVA 01 - Dialysis times remained an issue
Q&P/RR/DHU 111 01: DHU: To be reviewed by the Quality Lead

Action: The Quality and Performance Sub Group

- **RECEIVED** and **REVIEWED** the Q&P Risk Register

Q&P/17/064 **Sub Group Effectiveness Review**

Ms Adams presented paper I and she explained that in accordance with the CCG's constitutional governance review arrangements, Q&P members had been invited at the March 2017 Q&P meeting to submit comments to the Chair on what had worked well in 2016/17 and what had worked less well.

The review was conducted in a less formal way than previous years, in order to reduce workload whilst still being able to gain a perspective and guidance in the event that the terms of reference might need to be changed.

7 responses had been received (4 clinical and 3 managerial) and the results presented in the report were split into 5 categories:

- Deep dives
- Duplication with other meetings
- Sub-group effectiveness
- Frequency
- Papers

Comments had been reviewed by Ms Adams and Mrs Trevithick and summarised into relevant sections. Ms Adams gave brief feedback on the responses received from each of the sections.

The following actions were agreed with respect to improving the sub group's effectiveness:

1. Continue to include Deep Dives on the Agenda and include DHU in the forward plan.
2. Provide clarity on the overlap and differences between PPAG and Q&P.
3. Performance report to be re-ordered to reflect WLCCG only commissioning responsibility, WLCCG (on behalf of LLR) commissioning responsibility, services

	commissioned by ELCCG, LCCCG for West Leicestershire patients. 4. Subgroup to agree one of the following actions following discussions; a. Feed into PPAG b. Deep Dive c. Take direct action 5. CMT explore joint meeting with LCCCG for joint items 6. Ruth Brutnall to work with WLCCG authors on producing exemplar, concise papers 7. Review whether papers could be included 'For Information Only' 8. Improve the action log and follow up of actions Dr Sanganee felt in respect of the deep dive items it would be useful to ensure external speakers were more thoroughly prepared on what the Q&P sub group expected and Mrs Trevithick said it would be possible to develop key lines of enquiry for that purpose. **Action:** The Quality and Performance Sub Group considered areas for improvement and suggested actions to address those areas, and; • **RECEIVED** the comments made by Q&P members • **AGREED** to implement the above actions	**GA/ CTrev**
Q&P/17/065	**Review of Quality and Performance Terms of Reference** Mrs Trevithick presented the Q&P terms of reference for review and comments on suggested changes. These were. **Membership** • Deputy Chair should read Clinical Vice Chair • Locality Lead should read Locality Lead and two doctors • Take out – 2 doctors (non-Board members) • Take out – Communications, Engagement and Involvement Lead • Add – Assistant Director Corporate Affairs/Equality and Diversity **Attendance - Include** • Finance lead • Head of Patient Safety • Head of Medicines Management • Infection Control Lead • Safeguarding Lead • Communications, Engagement and Involvement Lead • Senior Performance Manager, Midlands and Lancs CSU **Meetings** Change first sentence to '10 meetings established, held annually' **Action:** The Quality and Performance Sub Group • **REVIEWED** and amended the Q&P terms of reference and, • **AGREED** to submit the proposed changes to a future Board meeting for approval	
Q&P/17/066	**Equality and Diversity (E&D) Annual Report** Mr Chudasama apologised that the E&D annual report had not been circulated and he explained it was currently in the final stages. He gave a verbal update and said the CCG had a corporate responsibility as a public sector organisation to comply with the Equality Act. In terms of due regard the CCG must demonstrate consideration	

had been given to the views of the local population, stakeholders and providers to ensure that services were delivered with the least possible impact.

Some analysis had been carried out on staffing numbers in the CCG building in respect of gender information, numbers of males and females and BME staff, and whether this correlated appropriately with the local population. The position appeared to be similar to last year with no cause for concern with the current staff portfolio. The following had been identified:

- 70 female to 30 male
- Senior roles – 74% held by women and 26% by men
- Percentage of BME staff – 23% last year compared with 16% in the current year that equated to a headcount of 3 fewer. Some BME leavers had moved across to other CCGs which were seen as a natural flow.
- A small number of staff had other protected characteristics but the number was small it was not possible to report on without identifying those staff.

Some provider information had been received in the current year and all were declaring amber on their action plans which indicated some progress. Issues still existed around data capture and also protected characteristics, but this was insignificant.

Providers were actively engaging with the WRES (workforce report equality standard) that ensured providers had plans for career succession for BME staff, due to the low number in senior and leadership positions. This included schemes such as reverse mentorship programmes at UHL.

In respect of primary care nothing of significance came out of the practice appraisals and thought needed to be given to any other bodies of information that might exist to help form a view of the primary care position around the equality and access of services for people with protected characteristics. This could then be included in the delivery plan for next year.

With regard to internal processes LCCCG had one whole time equivalent for E&D and ELRCCG had their resource from MLCSU. For WLCCG in house support existed via Mr Chudasama but with limited capacity within the corporate services team. EIAs had been completed on some of the main service changes, the Vanguard and HR policies. Further staff training would improve the situation, however the risk based approach that had been developed minimised any challenges the CCG might face.

The E&D report would be submitted as part of the CCG's annual report and the CCG would score itself against 18 outcomes. Mr Chudasama confirmed to Ms Adams that the report would be submitted to the Q&P prior to its inclusion in the annual report.

One challenging area was the CCG's work with the voluntary sector. Investments had been made in social seeding and outcomes from projects would have been included as case studies, but funding no longer existed in 2017/18.

Significant work had been carried out by the Experienced Level Commissioning company on engagement with the population in general and the targeting of protected characteristic groups as part of the CCG's routine work.

Dr McHugh said the nature of the E&D challenge was significant; as an example he pointed out if people did not turn up for learning disability health checks then staff were obliged to chase up patients, and the CCG was obliged to act positively if people had problems with access. Mr Chudasama said the learning disability example was a good one which was not routinely raised through the contractual route

	and the need to consider those situations in a different way was imperative to instil a changed approach in each member of staff. Mrs Trevithick said she was pleased to see information had been received from providers and she asked if the CCG could learn anything from the WRES. Mr Chudasama replied that it offered some practical advice for next year such as using BME networks through the East Midlands Leadership Academy. Dr McHugh felt the real opportunity existed when new services were commissioned, particularly around the recording of demographic data, so that providers were asked to capture relevant data at the start of a contract. Ms Adams said from a contractual point of view she was keen to see that private providers were asked to provide the same information as the NHS providers, and this should be discussed with the contracts team to ensure complete understanding on what the CCG wanted from its providers. She suggested herself and Mr Chudasama hold a discussion to ensure the CCG was taking responsibility for addressing areas where groups were under-represented, and exploring actions to encourage and target specific under-represented groups, for example how WLCCG might encourage female GPs to apply for Board roles. Ms Adams suggested a conversation with Dr Anu Rao at the LMC might be useful to find out how they had achieved a balanced E&D position. **Action:** the Quality and Performance Sub Group • **RECEIVED** the update on the Equality and Diversity Annual Report	**GA/KC**
Q&P/17/067	**Safeguarding Minutes** The Quality and Performance Sub Group received the following minutes for information: • Leicestershire & Rutland Local Safeguarding Children and Safeguarding Adults Board held 27 January 2017 • Leicestershire & Rutland Local Safeguarding Children Board held 27 January 2017 • Leics & Rutland Local Safeguarding Adults Board held 27 January 2017 **Action:** The Quality and Performance Sub Group • **RECEIVED** paper K for information.	
Q&P/17/068	**Items for escalation to be agreed** For the Board: • Hospital Discharge • Learning Disability Healthchecks • Antimicrobial resistance and infection prevention and control plan • Q&P terms of reference • Equality and Diversity Annual Report **Action:** The Quality and Performance Sub Group • **NOTED** the items for escalation.	
Q&P/17/069	**Any other business**	

	No other business.	
Q&P/17/070	The next meeting of the Quality & Performance Sub Group will be held on Tuesday 16 May 2017, 9.00 – 11.00 am, Boardrooms, Woodgate, Loughborough, Leicestershire LE11 2TZ.	