

**MINUTES OF WILTSHIRE CLINICAL COMMISSIONING GROUP (CCG)
 QUALITY & CLINICAL GOVERNANCE COMMITTEE MEETING
 HELD ON TUESDAY 7 MARCH 2017, 9.30HRS AT SOUTHGATE HOUSE, DEVIZES**

Present:		
Jill Crook (Chair)	JC	Registered Nurse Member, Wiltshire CCG
Dr Mark Smithies (Vice Chair)	MS	Secondary Care Doctor, Wiltshire CCG
Christine Reid	CR	Lay Member, Wiltshire CCG
Dina McAlpine	DMcA	Director of Quality , Wiltshire CCG
Susannah Long	SL	Governance & Risk Manager, Wiltshire CCG
Dr Helen Osborn	HO	Medical Advisor, Wiltshire CCG
In Attendance:		
Alison West	AW	Associate Director of Quality, Wiltshire CCG
Jo Easton	JE	Interim CHC Operational Lead, Wiltshire CCG
Emily Shepherd	ES	Quality Lead, Wiltshire CCG
Emma Higgins	EH	Quality Lead, Wiltshire CCG
Fiona Barnard	FB	Quality Lead, Wiltshire CCG
James Dunne	JD	Designated Nurse, Safeguarding Children, Wiltshire CCG
Nadine Fox	NC	Head of Medicines Management, Wiltshire CCG
Laura Gold	LG	Quality Manager Wiltshire CCG
Helen Edwards	HE	Quality Administrator, Wiltshire CCG (minute taker)
Debbie Haynes	DH	Senior Consultant Public Health, Wiltshire Council
Apologies:		
Dr Fiona Finlay	FF	Designated Doctor, Safeguarding Children, Wiltshire CCG
Dr Richard Sandford-Hill	RSH	GP and Chair for West Wiltshire CCG

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QCG/17/03/01	Welcome and apologies for absence JC welcomed everyone to the meeting and noted apologies as above.	
QCG/17/03/02	Declarations of Interests Members were reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the Wiltshire Clinical Commissioning Group (CCG). (This included any relevant interests previously declared upon the Register of Interests). There were none. The meeting was quorate.	
QCG/17/03/03	Minutes of the meeting held on 31 January 2017 The minutes of the meeting held on 31 January 2017 were approved as an accurate record.	
QCG/17/03/04	Matters Arising CR queried if there was any further news regarding the suggested attendance of GP representatives at the meeting as detailed in the Committee Terms of Reference. DMcA confirmed this has been discussed by the Executive Management Team; once reviewed, consideration can be given to further representation by the GPs. The Exec meetings often conflict	

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	<p>with other meetings, which makes attendance by the GPs difficult, however going forward, the QCG meetings will be held during the afternoon to try to accommodate this.</p> <p>a) Emergency Department at GWH WCCG met with Swindon CCG, NHS England and NHS Improvement to complete a risk tool, using the hard data and soft intelligence provided. This had now been completed. Along with other concerns regarding safety in ED, GWH were reporting high numbers of trolley breaches, with a lack of evidence of assurance processes in place, or data to demonstrate these with no clear process of escalation.</p> <p>GWH had reported another 30 trolley breaches over the past month, however WCCG had received RCAs from GWH which report 'no harm' despite one patient not receiving the stroke pathway element.</p> <p>GWH had requested not to report individual cases of trolley breaches, but would prefer instead to use an aggregated report, as other trusts (NBT use an aggregated reporting system). WCCG are considering this with NHS England/NHS Improvement and Swindon CCG, (it was acknowledge at the meeting that the 12 hour reports currently provided had limited value). The Committee agreed it may be advisable to change the process over a time period, in order to establish numbers and isolate any harm. WCCG will need to be assured that GWH will identify harm rather than cutting and pasting "no harm occurred". In addition they need to be really clear about their barometer for no harm, particularly if a patient was missing the stroke pathway. It was agreed last year at the single item QSG that GWH should follow patient's pathway to the ward in order to better assess harm. If GWH provide an aggregated report they must still follow each pathway through.</p> <p>MS asked if it was feasible to agree that GWH should carry out variance reporting, rather than formal in terms of a particular pathway using a list of agreed variances.</p> <p>MH suggested a conversation with GWH about moving to a composite report expanding the scope to include all trolley waits not just the reportable 12 hour breaches and address good practice.</p> <p>DMcA reported the ED had a lack of identification of rapidly deteriorating patients and application of the NEWS. GWH needed to be clear about SI reporting thresholds, RCAs and escalation processes if ED is under pressure. CCG had no assurance that there was a clear view of what's not happening and what should be happening in ED; there appeared to be a 'disconnect' between front line staff and senior leaders; (this was a theme in the warning notice from CQC), the Trust needed to improve information sharing and provide internal and external assurance.</p> <p>DMcA suggested sharing good practice around the STP, at a meeting NHS England/NHS Improvement and SCCG, to establish how we can learn from each other.</p> <p>CR questioned the status of the current relationship between all involved, given the current situation in ED. DMcA confirmed the relationship was improving, WCCG are currently working with SCCG Quality team to establish more synergy.</p>	

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	<p>SCCG have a different relationship with GWH; and appear to have a different perspective to Wiltshire's understanding of staff morale. Swindon CCG reported recently that GWH had a "feeling" the situation was better. Conversely front line staff were reporting they felt under pressure; the language they were employing did not demonstrate that there were any of the processes in place as described above; with staff feeling they had no control over what they do in their working environment.</p> <p>There are elements and questions around leadership in ED which had changed again recently. ED was currently employing 50% agency staff, alongside changes in the clinical leadership, so have been unable to sustain improvements made following their previous CQC inspection of patients as efficiently as the other acutes, who have a substantive workforce and don't use agency staff.</p> <p>EH commissioned reports from CSU Analytics to capture all the information and breaches to ensure that providers were reporting on every breach, in order to understand the harm to patients and identify any possible improvements and learning. The CCG currently relies on providers submitting breaches.</p> <p>MS suggested engaging with RUH/SFT in order to create a precedent to support front line clinical staff under pressure by reducing bureaucracy. AW, EH, FB are visiting RUH w/c 13/3/17 to look at the data collected in ED.</p> <p>ACTION: QCG/17/03/04.1: Ensure an update for GWH ED is included on the next Agenda</p>	AW
QCG/17/03/05	<p>Action Tracker The action tracker was reviewed and updated.</p> <p>05/11/2015-122 – Quality Team to liaise with Comms and RSS to review quality and safety information available to patients. AW to take this forward. ONGOING</p> <p>20/09/2016 –AWP to attend Q&CG Committee – The planned attendance by AWP had not materialised despite various conversations with them. A letter would be sent to raise concern formally with AWP re: AWP non-attendance at Q&CG Committee. MH to liaise with Tracey Cox.</p> <p>QCG/16/11/07.2 – Review of provider spending to achieve current activity – Action to be reworded to 'Review of potential costs relating to the Law Commission proposals once they have been published to ensure the CCG has an understanding of potential cost implications'. ONGOING</p> <p>QCG/16/11/07.4 – Appendix – Adult Safeguarding Dashboard – Adult safeguarding dashboard to be incorporated into the Integrated Performance Report. ONGOING</p> <p>QCG/17/01/09.0 – Adult Safeguarding Update – Case study to be discussed at the Wiltshire Adults Safeguarding Board. CLOSED</p> <p>QCG/17/01/13.0 – Risk Register – DoLs RAG rating report to be brought to the Quality and Clinical Governance Committee. ONGOING</p>	<p>AW</p> <p>MH</p> <p>LyF</p> <p>LyF</p> <p>LyF</p>

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	<p>QCG/17/01/13.1 – Risk Register – Children’s CHC (Virgin Care) review paper to go to EMT, and then be brought to the Quality and Clinical Governance Committee.</p> <p>QCG/17/01/15.1 – Thematic Review – Safety in Emergency Departments – Wiltshire Local Delivery Board to receive the Safety in ED paper and its findings. CLOSED</p> <p>All other actions were marked as completed.</p>	DMcA
QCG/17/03/06	<p>Continuing Healthcare and Specialist Placement Briefing Paper. A presentation was given by DMcA (copy available).</p> <p>Questions from the Committee following the presentation:</p> <p><i>“Business Change Support – mainstream CHC into NHS England operations support to CCGs - what does this mean?”</i></p> <p>DMcA would check and clarify, but suggested it’s intended that the review panel process is supported by NHS England.</p> <p>DMcA confirmed the budget was fairly well controlled; 7 work streams currently in CHC working on a variety of projects to improve quality and timeliness. An update would be provided at the next committee.</p> <p>HO: <i>“Where does Wiltshire benchmark currently in terms of Right Care?”</i></p> <p>MH confirmed it is low in terms of referrals compared to other CCGs. Referral volume is an issue; if the clinician was adamant the patient needed a fast track referral, CHC carry out an assessment.</p> <p>DMcA suggested taking case studies to GP forums to use as a learning tool. The conversion rate fluctuates; the CCG would expect it to be around 25%-30%, however there are issues when too many inappropriate referrals are made. Community nurses appear to be consistently over-scoring on the CHC checklist; this stops the FNC process and raises expectations of families.</p> <p>To address this, DMcA confirmed there was a project working on preventing the wrong referral with lots of criteria training for the teams, which would mean the conversion rate would improve going forward.</p> <p>HO agreed that providing a learning tool for GPs would be useful in order to more easily understand the assessment process.</p> <p>DMcA explained it would be valuable to have a GP sponsor for CHC as this is high profile work but has never had an input from a GP. DMcA acknowledged that MS assists greatly but a GP involvement would be really helpful.</p>	
QCG/17/03/07	<p>Thematic Review – Adult Community Provider Wiltshire Health and Care (WHC) were invited to the meeting but were unable to attend; however they have confirmed they can attend the next meeting.</p> <p>WHC are a partnership formed by the three acute trusts; their contract is in</p>	

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	<p>place for at least the next 5 years and their success is reliant on key partners across different providers, agencies, Primary Care and GPs.</p> <p>SI Reporting: In April 2015 the SI framework changed to allow for multi incident reporting for incidents such as falls and pressure ulcers; previously an RCA would have been completed for each incident. The new guidance left room for interpretation and allowed providers to assess themselves when an SI should be reported. Since then, the CCG had seen a significant decrease in reporting in general, but particularly for incidents relating to pressure ulcers and falls.</p> <p>Pressure Ulcers – WHC consider that the pressure ulcer incident rate has improved and is currently at 0.9% against a national figure of between 4% and 7%. AW and ES attended a WHC internal Harm Free Care Focus Group (HFCFG). This is the forum where all incidents are discussed and agreement is reached as to whether an incident meets the threshold for reporting on to STEIS. The meeting included clinicians; safeguarding leads and IP&C leads. Professional challenge was evident and the group identified learning and actions that should be monitored and tracked. The CCG are however not seeing reporting or outcomes from the HRCFG.</p> <p>Data provided to the committee gave an indication of reported pressure ulcers from April 2014. The increase could be due to an improved reporting culture, rather than number of incidents of pressure ulcers. WHC has identified high reporting teams, and have produced a schedule of work to support teams in order to understand if this is a true increase in incidents, or improved reporting. The highest incident rate is currently being reported by the Marlborough Community Team; however this does change on a frequent basis.</p> <p>CR questioned if there was a correlation between the acute reporting and WHC reporting.</p> <p>ES responded that WHC track the number of patients discharged from an acute with a pressure ulcer, on a monthly basis.</p> <p>Falls WHC were triangulating falls data, with other information sources such as staff shortages and skill mix. Similarly to pressure ulcer reporting, the CCG has seen a decrease in the numbers of falls related incidents reported through STEIS. Where SI's have been received, the RCAs were reviewed and felt to not be robust in terms of the content of the investigations learning identified, associated actions and plans to embed the actions. As a result of this the CCG met with WHC to discuss the CCGs requirements. Both the CCG and WHC agreed that a RCA workshop will be organised to address what should be reported through STEIS, what should be included within a RCA investigation and how learning is embedded.</p> <p>WHC don't currently upload data onto the NHS benchmarking network, which means the CCG were unable to compare their data against other similar organisations nationally. From 2017/18 this would be a requirement of the Quality Schedule. WHC would load their data retrospectively for 16/17 to enable comparisons to be made.</p> <p>The CCG were planning quality assurance visits to areas where the reporting incidence rate is high.</p>	

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	<p>Workforce</p> <p>Vacancies: WHC reported an 11.72% vacancy rate in January. Shifts were supported by agency staff. Ailesbury Ward at Savernake Hospital had a high vacancy rate at 10.72 WTE. However, WHC have recently recruited a new Ward Manager and WHC were pleased with the progress made with regards to the skill mix review that had been undertaken by the new Manager. WHC assured that the new manager's focus is on attracting new staff and retaining those currently in place. Sarah-Jane Peffers (Head of Quality, WHC) was completing a WHC workforce strategy which will take into account Ailesbury Ward and to include a skill mix review and how this impacts on patient acuity. This would be shared with the CCG in July 2017.</p> <p>The vacancy rate in the community team at Salisbury was high too and would be the focus of a quality assurance visit.</p> <p>Caseload management: the 2016/17 quality schedule did not include the requirement for WHC to report on admission/discharge to and from community caseloads, or how these were managed. The CCG have had conversations with WHC and questioned if they were assured that there is a robust criteria regarding the management of patients on the caseload.</p> <p>As a result of a number national publications including publications from the Kings Fund and the Queens Nursing Institute; a number of quality schedule reporting metrics had been included within the 2017/18 contract. This would enable the CCG to better understand not only community caseload size, but how WHC managed the caseload.</p> <p>DMcA reported that caseload management would be a significant piece of work with this provider, if they were to succeed. This would have an impact on the provider as a whole, but also on the newly appointed rehab support workers. WCCG need to better understand the criteria for assessing patients and how they continually assess, as the patients' needs change to ensure that the community team capacity is utilised appropriately. HO questioned if individual patient pressure ulcer information was shared with primary care. ES confirmed it was, through SystemOne. HO reported she has been unable to find some information on SystemOne.</p> <p>ACTION: QCG/17/03/07.0 - Test reviewing patient needs etc. via SystemOne</p> <p>Rehab Support Workers: WHC were in the process of recruiting Rehab Support Workers and were working with stakeholders to agree the thresholds and criteria to be applied by acute providers when discharging patients; this is another key piece of work. The CCG need to be assured that WHC was applying the same criteria to all patients, irrelevant of which acute provider they were being discharged from.</p> <p>Reporting: The CCG were currently receiving a monthly scorecard from WHC, but this did not provide narrative information. Performance colleagues have a good reporting system set up with WHC and from a Quality reporting perspective, this template would be mirrored and this style of reporting would be shared with the CCG for the 2017-18 contract year. The new reporting style would enable the CCG to drill down into specific teams and inpatient and provide clearer triangulation of data.</p>	ES

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	<p>The NHS Benchmarking Network would provide important information on how the CCG can compare WHC with other organisations. CR commented that it was difficult to get a picture of what's going well and an understanding of the risk. There was no real sense of how WHC were performing.</p> <p>DMcA confirmed that it was difficult to say at this point, however it is evident that the quality reporting has to improve. WHC are under increased scrutiny from a quality perspective - historically the adult community provider reporting has been performance focused and the CCG had increased the frequency of CQRMs to ensure there was a robust feedback channel and opportunity for discussion from a quality perspective. Previously, community related quality reported formed part of the end of the GWH acute contract meeting. Ted Wilson leads on the contract and was working on identifying outcomes; the Quality Team will work with Ted to establish what 'good' looks like and to better understand where WHC sit amongst other community providers. The Quality team had reviewed the quality reporting received by other CCGs who have been inspected by the CQC and have received 'Good' or 'Outstanding inspection outcomes.</p> <p>DMcA confirmed WHC don't have a Director of Nursing; there is a Head of Quality who reports to the Medical Director. The CCG needed to establish how much emphasis and value was placed on quality. Quality visits would be planned to get a better understanding of caseloads, care planning and assessing; there appears to be risk averseness to discharging patients from the caseload. The importance of caseload management should be at the centred of the WHC priority.</p> <p>CR questioned if there was any evidence of synergy with WHC and the three acute hospitals and if not how this could be improved. MH confirmed there were reported conversations going on between them but it's difficult to see tangible outputs from this relationship. A test of synergy will be the CQUIN this year, which relies on the providers working together to provide a plan for safe discharge; this has to be demonstrated within Q1.</p> <p>HO questioned the caseloads; and if WHC have to specify what has been done i.e. a task oriented approach. ES confirmed the CQUIN last year was based on motivational interviewing, rather than a task orientated approach. The care plans being seen were not holistic care plans; it would be beneficial to have input from a GP to work with the community nurses to assist them to draw up care plans for the individual patients. The Committee questioned whether not having a Director of Nursing in the organisation to influence and drive policy may have a negative impact on prioritising the provision of holistic care, and a move away from a task oriented approach.</p> <p>MS questioned how many of the 23 WTE Rehab Support Workers were new recruits rather than from the 'pool' of other providers and domiciliary care providers in the County. WHC have provided some information on this – a small number of new recruits have come from other providers. Workforce would be discussed with WHC at the next Committee meeting.</p> <p>ACTION: QCG/17/03/07.1 - Title and theme for WHC presentation - 'Vision for the Community'.</p>	ES
QCG/17/03/08	<p>Quality Report</p> <p>Overview: there had been issues with flu and bed closures but these had improved now. The main problem was pressures on ED which was testing the new framework. AW, EH and FB recently visited RUH to try to</p>	

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	<p>understand their pressures in ED and associated safety challenges together with the Trust's method of internal assurance and escalation. SFT were visited in November; they have extra measures in place to help address the challenges in ED including using volunteers to support patients on trollies in corridors and GPs to assist with discharges etc. GWH ED was a major concern.</p> <p>Dashboard: The end of the year cut off was approaching for C.Diff thresholds. RUH were very likely to breach their threshold. SFT and GWH remained below threshold and do not appear likely to breach. As a CCG, it was unlikely we will breach our threshold and would therefore remain eligible for Quality Premium.</p> <p>Never Events: 1 medication error for SFT which was currently under review.</p> <p>Safety Thermometer Issues: RUH/SFT were developing work streams around reviewing their use of the safety thermometer. RUH would stop uploading to the safety thermometer from 1 April 2017. They felt there were better ways of assessing harm and have provided evidence of their alternative processes. It was anticipated that ceasing the Safety Thermometer will save 1 full time nurse salary per week by not having to collate this data. The decision to allow RUH to cease uploading was agreed by BaNES. NHS England and NHS Improvement have both acknowledged it's 'a blunt instrument' but haven't provided an alternative solution.</p> <p>DMcA concluded that if RUH don't provide the promised alternative data evidence by Q1 they should resume the Safety Thermometer.</p> <p>JC; should there be parity under the umbrella of STP?</p> <p>HO; asked if this change by RUH had been discussed at STP level?</p> <p>AW confirmed there was a national drive when the safety thermometer was first introduced, however it appeared there was no sense of pressure for this to be used.</p> <p>ACTION: QCG/17/03/08.0 - Contact RUH and confirm they have a contractual obligation to use the safety thermometer.</p> <p>Post meeting note: <i>The contract requires the use of the Safety Thermometer, but also allows the co-ordinating commissioner (in this case B&NES) to agree to the provider ceasing upload if assurances have been received regarding better alternative data capture and measurement systems in place.</i></p> <p>SSNAP: results reported; SFT level B; RUH level D; GWH level E. There was an STP conversation taking place to look at this across the STP. SNNAP indicators for stroke fluctuate. RSH was particularly engaged with this and had agreed to facilitate an STP wide discussion around stroke with stroke clinicians in the room. A scoping meeting to be arranged to include Quality and Performance. WHC think SSNAP is labour intensive and doesn't add value; they have requested not to report on it.</p> <p>ACTION: QCG/17/03/08.1 - Contact WHC to confirm SSNAP reporting is a national indicator of the audit requirements.</p>	<p>EH</p> <p>AW</p>

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	<p>Patient Safety: Falls were increasing across all providers, this had been identified as a key piece of work for next year. DMcA requested an invitation to the next meeting of the falls group in Wiltshire, chaired by Ted Wilson, to establish a consistent quality presence.</p> <p>Facedown Restraint: CR asked for clarification of AWP's practice on facedown restraint, currently being reported in the media as being used in acute units. DMcA confirmed that this method was used for some incidents and had featured in the 1363 and on the wards. AWP were required to record the incidents.</p> <p>ACTION: QCG/17/03/08.2 - Review NICE facedown restraint guidance and liaise with AWP to see where they benchmark against guidance.</p> <p>AWP staff vacancies concerns were mostly based in Wiltshire; this had been raised again with AWP and was being addressed through the Performance.</p> <p>111(Care UK): Were currently reporting 32% vacancies; this was an improved position, there had previously been up to 50% clinical vacancies. The CCG had assurances that 111 were using temporary, agency and bank staff and taking up additional capacity in national overflow centres in London etc.</p> <p>Dashboard Reporting: MS raised concerns around the 'gaps' in the dashboard and the assurance for the board of scrutiny in the reporting.</p> <p>EH clarified that the dashboards sit in front of more information; this was currently evolving and in future will present consolidated CCG indicators in a more meaningful way; this would provide assurance with further information provided by exception. The challenge was demonstrating assurance when there was a huge range of reporting variances by the providers. The new version was currently in draft form; it will be circulated once agreed.</p> <p>DMcA confirmed the monthly report feeds the quality element of the IPR; other CCGs provide a quarterly IPR which allows more time to analyse data and highlights trends in more potentially more meaningful way. MS commented that it may be more useful to have quarterly reports if they include a significant amount of the data. MH explained that he thought the time might be appropriate to review the frequency and depth of reporting by the CCG.</p> <p>Norovirus: MS asked what was being done by Public Health to advise the public to stay at home in the event of a reported case of Norovirus within the acute hospitals.</p> <p>DH confirmed that every year Public Health publishes a programme of support messages, to alleviate impact of Norovirus; advice is given to clinicians and workers within care homes to carry out initial assessments etc. over the phone rather than visiting.</p> <p>Primary Care CQC GP practices have scored well, however no practices were awarded 'outstanding' for safety. The CCG were currently working with three practices in Trowbridge to support them in becoming 'Beacons of Excellence in the Safety domain'.</p>	DMcA/ES

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QCG/17/03/09	<p>Serious Incidents – Review of Themes and Trends</p> <p>SI Reporting. AW set out oversights, responsibilities and trends. The CCG was responsible for reviewing serious incident investigations for all Wiltshire patients, at any provider. Providers report the incident to STEIS (or to the CCG to log on their behalf if they do not have access to STEIS) and complete a 72 hour report and submit RCAs within 60 days; these were reviewed by the CCG SI Closure Panel who meet every two weeks. These processes had been strengthened since the new SI framework was published in 2015 to ensure they were robust and that providers were evidencing that learning was taking place as a result of the incident.</p> <p>Section 5: On review of the 3 acute providers, SFT appeared to have robust SI reporting processes embedded. The numbers of SI's raised in 2016-17 (YTD) was 37 compared to 26 in 2015/16. RUH reported 26 SI's in 2016/17 (YTD) compared with 24 in 2015/16 and GWH reported 7 SI's (YTD) compared to 15 in 2015/16. GWH's reporting to the NRLS system had also declined (currently 17th from the bottom out of 136 providers), which was a concern.</p> <p>JC questioned the sanction for lack of reporting? In line with the NHS Standard Contract, providers can be issued with a Contract Penalty Notice (CPN) and are then required to complete a remedial action plan.</p> <p>DMcA – confirmed she has been invited to a meeting with SCCG and NHSE, regarding GWH. NHSE have requested that both Wiltshire and Swindon CCGs complete a risk trigger tool. GWH will be given the same tool to assess themselves Dependent on the outcome of this meeting; a risk summit with GWH could be called.</p> <p>Never Events: During 2016/17 three Never Events have been reported. Two were reported at SFT (a wrong site surgical procedure and an overdose of insulin due to incorrect device incident) and one for BPAS (a wrong implant surgical procedure).</p> <p>Slips trips and falls: There had been an increased number of SI's reported in 2016/17 relating to slips/trips/falls. Some of the incidents reported relate to patients who were ready for discharge and are mobilised.</p> <p>Self-Harm: This was related to AWP and was the subject of deep dive into the suicide rate trust wide, with benchmarking against national figures. AWP had benchmarked themselves against two other providers; however the CCG had concerns about rates of attempted suicide. The CCG were working with AWP; a meeting had been planned to review RCAs and the learning achieved from them; however these varied in quality. The AWP community was another area of concern and RCAs have demonstrated lack of appropriate risk assessment and care plans not being updated appropriately or not being completed. Caseloads would be the subject of a further deep dive.</p> <p>Pressure Ulcers: Pressure ulcers account for more than one third of the SIs currently reported. However, there had been fewer reported in 2016/17, due in part to differing interpretations following Framework in 2015.</p> <p>The report outlined that none of the AWP SI's have been closed in 2016/17. MS asked whether this was an accurate picture. This would be checked and confirmation provided at the May Committee meeting.</p>	

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	ACTION: QCG/17/03/09 - Check Serious Incidents for 2016/17 for AWP, as none had been reported as closed.	ES
QCG/17/03/10	<p>Independent Providers Safety Overview</p> <p>Laura Gold presented an overview to the meeting. The Committee agreed that this was a helpful report. (A copy of the report available)</p>	
QCG/17/03/11	<p>For Decision – Quality and Clinical Governance Committee Terms of Reference</p> <p>JC thanked SL and Sharon Woolley for their work on the Terms of Reference.</p> <p>CR commented on the core voting members and expectation of attendance. CR suggested the quorate of 4 was too low a number when there are 13 on the committee. MS suggested reviewing the voting quorum in 6 months' time, when the time of the meeting had been change to p.m.</p> <p>ACTION: QCG/17/03/11 - Committee to review voting quorum in 6 months' time</p>	DMcA
QCG/17/03/12	<p>For Decision – Risk Register</p> <p>SL provided a copy of the risk register for the Committee.</p> <p>Key issues:</p> <p>031 closed – warning notice had been lifted</p> <p>035 open – GWH ED.</p> <p>117 - this was being managed through a robust panel process.</p> <p>DoLS - needed to be updated.</p> <p>SFT warning notice has been lifted.</p> <p>Local Authority still not accepted 6 cases</p> <p>GWH ED – the risk scoring for this should be reviewed in light of concerns and increased as appropriate.</p> <p>ACTION: QCG/17/03/12 - Review ED risk register</p>	DMcA/AW
QCG/17/03/13	<p>Clinical Advisory Group Update</p> <p>Policies:</p> <p>MS asked that the Minutes reflect that the CCG had a useful CAG group which functioned well, but needs more responsibility. The scrutiny of polices takes place at the CAG meeting; he further commented that previously, though some policies have been through several processes, the Committee were being asked to scrutinise them again.</p> <p>DMcA suggested that policies should go to CAG for scrutiny, following this NF/EH would produce an overarching brief, including recommendations and the decisions made by the CAG. The brief should then be circulated to the Quality & Clinical Governance Committee members (with the policies) to review and ratify.</p> <p>ACTION: QCG/17/03/13.0 - CAG Clinical Policies overarching paper to be submitted with policies to be approved at Quality and Clinical Governance Committee.</p> <p>NF reported the key issues with the following three policies:</p>	EH/NF

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	<p>Breast surgery: WCCG were clear that they would not fund cosmetic breast surgery. Exceptional funding is required.</p> <p>JD suggested the title of the policy was changed to “Breast Reconstructive Surgery” as the current layout of the policy was confusing. NF agreed to amend the policy.</p> <p>ACTION: QCG/17/03/13.1 – Breast surgery policy title to be changed to “Breast Reconstructive Surgery”.</p> <p>Tattoo Removal: WCCG do not fund tattoo removal.</p> <p>Wigs: The ‘Choices’ website provides information for patients; they can ‘top up’ funding to get a natural hair wig if required. NF reported that lots of requests had been received for Interlaced systems for hair pullers, which was costly. WCCG are very clear that this was exceptional funding; however the IFR route was available for patients.</p> <p>Ectropion/Entropion: There have been discussions with some consultants about the thresholds for funding; CCG need to be clear about what can and cannot be funded.</p>	NF
QCG/17/03/14	<p>Any Other Business</p> <p>a) Glenside (Neurological Rehabilitation Hospital) Quality Issues</p> <p>DMcA reported that there are some Quality issues with Glenside (Neurological Rehabilitation Hospital) which the CCG were currently investigating with the Local Authority. A Quality visit was planned to establish assurance around training and competencies of staff caring for complex patients in a resus situation. The investigation was in the early stages; the CCG needed to carry out triangulation and mapping of other intelligence received in order to formulate an action plan.</p> <p>ACTION: QCG/17/03/14.0 - Provide an update on the Glenside (Neurological Rehabilitation Hospital) Quality issues at the next Committee meeting</p> <p>HO queried the best forum for better health presence in respect of child safeguarding. DMcA confirmed this was the Safeguarding Committee; JD should be discussing next steps if there was a gap.</p> <p>ACTION: QCG/17/03/14.1 - Assess the key issues regarding better health presence in respect of child safeguarding in order for these to be agreed through Exec Committee.</p>	DMcA HO/JD/DMcA
	The meeting concluded at 12.20 hrs	

**Date of next Quality & Clinical Governance Committee Meeting:
Tuesday 4 July 2017 - 13.30–15.30hrs - Southgate House, Devizes**