NHS Wiltshire Clinical Commissioning Group

MINUTES OF WILTSHIRE CLINICAL COMMISSIONING GROUP (CCG) QUALITY & CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON TUESDAY 5 SEPTEMBER 2017, 13.30HRS AT SOUTHGATE HOUSE, DEVIZES

Voting Members Present:		
Dr Mark Smithies	MS	Chair, Secondary Care Doctor, Wiltshire CCG
Christine Reid	CR	Lay Member, Wiltshire CCG
Dina McAlpine	DMcA	Director of Quality, Wiltshire CCG
Linda Prosser	LP	Interim Chief Officer, Wiltshire CCG *(until 15.30hrs)*
Dr Richard Sandford-Hill	RSH	GP and Chair for West, Wiltshire CCG
In Attendance:		
Alison West	AW	Associate Director of Quality, Wiltshire CCG
Dr Helen Osborn	HO	Medical Advisor, Wiltshire CCG
Emma Higgins	EH	Quality Lead, Wiltshire CCG
Susannah Long	SL	Governance and Risk Manager, Wiltshire CCG
Nadine Fox	NF	Medicines Management Manager, Wiltshire CCG *(from 15.15 to 15.40hrs)*
Fiona Barnard	FB	Quality Lead, Wiltshire CCG
Emily Shepherd	ES	Quality Lead, Wiltshire CCG
James Dunne	JD	Designated Nurse, Safeguarding Children, Wiltshire CCG
Dr Fiona Finlay	FF	Designated Doctor, Safeguarding Children, Wiltshire CCG
Debbie Haynes	DH	Senior Consultant Public Health, Wiltshire Council
Sharon Woolley	SW	Board Administrator, Wiltshire CCG
Jagi Sawhney	JS	Quality Manager, Wiltshire CCG *(observer)*
Andrew Dean	AD	Deputy CEO & Director of Nursing & Quality, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) *(until 14.15hrs)*
Mark Tucker	MT	Joint Commissioner, Wiltshire Council *(from 14.30 to 15.00hrs)*
Karen Williams	KW	Quality Manager, Wiltshire CCG *(until 15.00hrs)*
Lena Pheby	LPh	Designated Nurse for Looked After Children, Wiltshire CCG *(from 14.45hrs)*
Connie Timmins	CT	Quality Manager, Wiltshire CCG
Apologies:		
Dr Toby Davies	TD	GP and Chair for Sarum, Wiltshire CCG
Mark Harris	MH	Chief Operating Officer, Wiltshire CCG

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QCG/17/09/01	**Welcome and apologies for absence** MS assumed the role as Chair of the meeting due to the Registered Nurse role currently being vacant. MS welcomed everyone to the meeting, particularly AD who joined the meeting to give an update on AWP. The above apologies were noted.	
QCG/17/09/06 ***(Item moved)***	**Presentation by Andrew Dean – Deputy CEO and Director of Nursing and Quality, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)** The anticipated PowerPoint presentation was not available for this item. AD instead gave a verbal update regarding the direction for the future of AWP and its plans as an organisation. AD updated the Committee that AWP intend to remain as a specialised mental health provider, this was a decision made by the Board. The organisation's strategy had however changed slightly, in that AWP will look at the potential opportunities within community services, which had not been	

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	considered previously. The AWP Board were keen to progress in this area across the current footprint (and outside only if there was a pathway to do so), focussing on community provision at a local level. AD reported that AWP had seen a significant increase in acuity and activity. DToC's in Wiltshire were at 12%. AD considered that in-patient provision had a reasonably small, regional footprint. Specialist Centres were more cost effective, providing a better staff capacity to support prevention of hospital admissions. The prevention of hospital admissions is also supported by the Section 136 provision, places of safety which should be used as a last resort, along with the implementation of preventative street triage. AD felt that there was evidence to show that street triage was reducing the usage of the places of safety. MS questioned AWP's workforce issues, particularly the current numbers of vacancies. There were currently 100 WTE vacancies for AWP within Wiltshire, which is a long standing issue. MS suggested that the perceived increase in acuity could relate to the lack of appropriate staffing levels to assist with preventative measures. AD confirmed there was a 30-40% vacancy rate for Wiltshire. Funds were being spent on expensive agency staff that are booked as 'long line' staffing which mitigates having to book staff on a shift by shift basis. Staff were in place, but were not employees of AWP and there is still the potential for staff to be unable to work at short notice. MS remarked that for the quality improvements to be made within the organisation and across the system, permanent staff recruitment was vital for AWP. AD agreed with this. MS reported that the recent Friends and Family survey had shown only 40% of AWP staff recommending AWP as an employer. The Committee had concerns over AWP's recruitment and retention issues, and the impact staff levels were having on service delivery and for patients across Wiltshire. AD felt that the 40% figure was misleading, and suggested that most staff would not recommend AWP as an employer as it was not recognised as the employing body. AD confirmed that questions had been changed in the survey as it was felt that the results highlighted an issue in terms of an understanding about AWP as an organisation, but thought that most staff would recommend their team as a place to work. AD felt it was fair to say AWP had a recruitment and retention issue across Wiltshire. Evidence showed that AWP did in fact recruit well, but staff attrition then outweighed these numbers. AD confirmed that he has agreed a retention premium to be used to retain staff. The premium will be in place for 2 years and will only apply to Wiltshire. AD is currently reviewing whether the premium will apply to new staff only, or all staff. AD acknowledged that something different needed to be in place to change the historical issues within Wiltshire. AD had been in discussion with a number of bordering Universities to look at offering jobs to students at the start of a training and mentoring scheme, to ensure they felt part of the team and organisation, with the aim to employ then once qualified and to ensure retention. To date 34, students had been put forward for this opportunity. These staff would be recruited to support services in Wiltshire RSH questioned the issue of job satisfaction at AWP and why there was a need to go out of county to source staff. AD recognised the staffing issues, but did not understand why. 45% of 'leavers' were moving to other AWP posts as promotion etc. which is positive, but 55% were retiring (there is an ageing workforce across Wiltshire), returning to practice or were dissatisfied with the role and had found a better position elsewhere.	

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	As a GP, RSH was aware that the service from AWP was not at the level required and that quality issues continued. Pressure on staff impacted upon the service they could provide. AD stated that AWP was on a journey and believed that the organisation was at a place now to start the quality improvement work. AWP had reached a minimum standard, which was now to be built upon. In his view routine visits should not take more than seven days from referral, and emergency appointments should be accessible within three hours. AD agreed that there was work to be done to progress services, but overall felt that there had been an improvement. RS-H felt that if that is the case, Commissioners, were not seeing the right data to support this view, as on the ground services appear to be challenged. The CCG agreed to work with AWP to better understand the service provision and support with staffing challenges where possible. CR asked AD about areas of work in Wiltshire over the last two years that he and AWP were proud of. AD mentioned the successful turnaround of the Imber Ward, which had renamed as Poppy Ward. Improvement in recruitment was also of note. AD felt, although the failure to improve retention was then impacting upon the overall workforce, especially across Wiltshire. HO had followed AWP's journey for some time, but felt that any significant improvement had not been apparent. The rise in the level of acuity could be due to the difficulty of accessing the service. Repeated meetings often led to referrals back to GP's, increasing the acuity of people in Primary Care, presenting a problem of thresholds of accessing care. Referrals were often also due to caseload issues, giving a lack of continuity of care for people. AD felt this was a failure of AWP to articulate the improvements that had already been made. AWP had received a poor CQC report in 2014, which stated that openness and transparency was not in place. CQC had since acknowledged the year on year improvements made by AWP. AD suggested that joint conversations were needed with commissioners to define the commissioned service; it was not just a provider issue. The STP had been seen as an platform to create these pathways, but it was not working sufficiently. AWP were open and keen to transform and integrate. AWP were not commissioned to provide preventative services, but the organisation felt it was a key area to progress alongside their services. LP agreed that the CCG should be working alongside AWP. LP noted that the three BSW CCG's should line up their commissioning strategies where possible. Hayley Richards (AWP Chief Executive) had been written to regarding the transformation work, as CCG's felt that this work was being progressed in in isolation, and not with CCG's. LP agreed that there was a need to work together to avoid Section 136. The CCG was committed to working with AWP to ensure a strategic commissioning approach was applied to make improvements to the service. LP noted the importance of understanding AWP's perception that acuity had increased; AD confirmed that evidence had been requested concerning the increase in acuity. MS reported that, following the Sutton report, mortality issues and the findings of the MAZAR report would be looked at locally. Recent data provided by AWP highlighted that only 12% of mortalities were reported on STEIS.AD noted that this had previously been discussed at the Quality Sub Group and that he had since agreed that all deaths would be reported on STEIS. AWP would then review and agree with commissioners what could be taken off the STEIS system. DMcA suggested that data from other mental health providers nationally should be reviewed to provide a benchmarking figure. MS thanked AD for attending the meeting to provide some reassurance to the Committee on issues arising at AWP. The CCG and AWP were to work together	

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	to ensure the service was right for the patients of Wiltshire. *(AD left the meeting)*	
QCG/17/09/02	**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.	
QCG/17/09/03	**Minutes of the meeting held on 4 July 2017** The minutes of the meeting held on 4 July 2017 were approved as an accurate record, with the following correction: • Item 9 – page 7 – correction to fourth paragraph – 'royal assent'	
QCG/17/09/04	**Matters Arising** • Page 7 – Safeguarding Adults – CR queried if Wiltshire Council had now implemented the DoLS complex cases process to ensure these were a priority. DMcA reported that there was still a significant backlog of cases @ 1700. The Council had employed additional Best Interest Assessors. This was to on the agenda for discussion at the Adult Safeguarding Board on Thursday 14 September 2017.	
QCG/17/09/05	**Action Tracker** The action tracker was reviewed and updated. **QCG/17/05/06.0 -** DMcA reported that Chris Weiner had left Wiltshire Health and Care, a new Medical Director had been appointed. DMcA was to meet with the Chief Operating Officer, Lisa Hodgson, to review the lessons learnt from the Swindon CCG report following the transfer of community services from SEQOL GWH Community. **ONGOING** **QCG/17/05/07** – RSH confirmed that an email had been circulated to West practices to seek examples of requests made by hospitals to GP's. **CLOSED** **QCG/17/05/08 – ONGOING** **QCG/17/07/06.1 –** LP and DMcA would follow this up. LP reported that North East Sessional GPS (NESG) had undertaken significant work across Emergency Departments (ED) to ensure processes and systems were in place. **ONGOING** All other actions were marked as closed or completed.	**DMcA** **MH** **LP/DMcA**
QCG/17/09/07	**Quality Report** AW presented the new format Quality Report. The dashboards flag any issues arising with indicators and commentary and assurance is provided within the body of the report. AW summarised improvements across some indicators since the last report. The urgent care audit requirements were reporting a recovered position with no backlog of calls to be reviewed. SWAST were progressing well against their CQC recommendations with most actions completed and taking effect. Wiltshire Health	

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	and Care's Serious Incident reporting and their safety culture was being reviewed through the CQRM's and a collaborative piece of work between the community and CCG Quality teams had been very positive. The new CCG Long Waits ED report had highlighted cases of patient waits in ED of over 16 hours, and some un-reported breaches of the 12 hour trolley wait target. Providers had fed back that these reports do not align with their own data. The provider and CSU analytics team were to meet to jointly review the data and identify whether there was an error in reporting at either point, or if the data was accurate. CR questioned if assurance had been received from Circle regarding the five unplanned transfers reported. FB confirmed that the incident details had now been received and the learning was to be shared. MS questioned what initial assessments had been carried out to ensure that it was appropriate for those patients to attend a private/independent provider for an operation, and what interventions were available. FB would bring a summary paper to the November meeting. ACTION: QCG/17/09/07.0 – Summary paper concerning Circle Bath, initial assessments and unplanned transfers to acutes to be brought to the November Committee meeting. MS questioned the Midwife to Birth Ratio indicator and the causes for the 'red' performance. AW explained that this was an ongoing issue. Each acute Trust was actively recruiting and SFT had held successful open days but midwifery recruitment remained a challenge across all three providers. LP reported that a Birth Centre consultation was underway led by RUH. Wider community input was required alongside commissioners and providers to ensure alignment with the developing Local Maternity System. It was noted that there was inconsistent data for the Fractured Neck of Femur indicator. SFT had experienced data issues. This had been addressed through their CQRM meeting and assurance was given that they were getting back on track. An update against this would be provided. ACTION: QCG/17/09/07.1 – Update on validity of Fractured Neck of Femur data to be provided. On reviewing the new report format, it was noted that the indicators needed to link clearer with the charts and commentary. ACTION: QCG/17/09/07.2 – Quality Report format to be adjusted to ensure indicators linked more seamlessly with the charts and commentary. *(MT joined the meeting)*	**FB** **FB** **EH**
QCG/17/09/08	**Care Homes Project** EH explained that the draft 'CATHEDRAL' project scoping paper was brought to Committee for comment and approval. EH went through her presentation. The CCG had reviewed extensive data, reports and guidance to identify the project aim, objectives and work streams. The full details are available in the project scoping paper which was presented. From review of the information and research evidenced, the following project aims	

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	and objectives have been identified:-
	
	Aim: To enable care homes to adopt a continuous improvement culture and using this, to build on successful local and national initiatives in order to promote and enable safe and effective care for care home residents through a person centred approach.
	
	To support delivery of this aim, the project will focus on the following objectives:-
	
	• Standardising processes and reducing unwarranted variation in comprehensive assessment of the needs of care home residents.
	  o This will improve person centred care planning and risk management
	• Reducing the numbers of avoidable emergency hospital attendances from care homes
	• Reducing the numbers of avoidable admissions to hospital from care homes
	• Reducing the length of stay in hospital for care home patients following an admission
	• Reducing the incidents of acquired infection in care homes and improving management of infections when they occur.
	• To increase the connectivity and participation of care homes with the wider healthcare system.
	• Enhancing staff capability and competence in care homes to deliver:-
	  o Improved capacity for quality improvement
	  o A more consistent and sustainable workforce
	  o A workforce capable of meeting the increasingly complex needs of patients
	RSH questioned the use of Treatment Escalation Plans for residents within Nursing and Care Homes. He felt this should be included within the project, with an aim of 100% being in place. This would help reduce admissions to hospital. EH explained that this project was being developed with support from the GP Clinical Governance Group. A stakeholder group would be formed to also take the project forward, it was hoped this would include GP representation which will include discussion around TEPs. In addition, TEPs will be part of the standard documentation implemented in work stream 1 (Hospital Transfer Pathway).
	
	LP suggested that there needed to be incentives to ensure care homes engaged with the project, and that links should be formed with Local Authority commissioners. AW hoped that the offer of training and support would be the encouragement needed for care homes to become involved. The CCG already has good buy-in from the Council and from care home and practice managers.
	
	CR reminded the Committee of her conflict of interest as a Trustee of charity Warrington Homes. The Chair agreed to continue the meeting discussion with CR present. CR felt that the project needed to minimise paperwork and the sense of extra work additional to existing duties and responsibilities.
	
	EH explained that those care homes engaged with the project in Sutton had expressed that they would be willing to share their experiences and learning with other care homes to encourage wider involvement. The project would start small, but expand as it developed and refined. It was hoped that care homes would see the project as positive and practical, and would enable them to feel part of the health provider landscape.	

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	The Committee approved the implementation of the 'CATHEDRAL' Care Home project and associated action plan.	
QCG/17/09/09	**LeDeR (Learning Disabilities Mortality Review) Programme** The paper briefed the Committee on the National LeDeR Programme. KW explained that locally the programme was launched in April 2017, with a soft launch planned for September, and a full launch planned for December. The CCG were keeping on target with the national timescales of the project. A more detailed update would be brought to the Committee when appropriate. ACTION: QCG/17/09/09 – A detailed update on the LeDeR Programme to be brought to the Committee when appropriate. MS was keen that the learning and reviews were shared. KW advised that a steering group was being set up to drive forward the actions and recommendations and a mechanism would be established to enable the sharing of learning. A tracker would be kept to ensure progress of actions was monitored across the STP. *(KW left the meeting)*	**KW**
QCG/17/09/10	**Policies and Strategies** **a) Learning Disability and or Autism – At Risk of Admission Register Policy (Adults)** MT explained that the paper was a resubmission of the Risk of Admission Register Policy as seen at the July Committee meeting. Amendments as suggested by the Committee had been made. **The Committee approved the Learning Disability and or Autism – At Risk of Admission Register Policy (Adults)** *(MT left the meeting)* *(LPh joined the meeting)* **b) Infection Prevention and Control Strategy and Work Programme 2017-18** CT presented the Strategy and Work Programme for 2017-18. The team had worked collaboratively with stakeholders across the patch to define the Strategy outcomes. Engagement with the general public would be key to raise awareness. Together these documents would be vital during the winter pressures, setting out the CCG's responsibilities and objectives for infection prevention and control. The Quality Team would be working with the Medicines Management Team to establish a Medicine Optimisation Strategy. A mapping exercise of the pressure patterns had been undertaken by BaNES CCG. The resistant patterns were being looked at. **The Committee approved the Infection Prevention and Control Strategy and Work Programme for 2017-18.**	
QCG/17/09/11	**Serious Incidents April to July 2017** FB presented the NRLS comparative report, which looked at the safety culture across the acute NHS organisations. Page 3 Table 2 indicated that SFT had the highest reporting rate to NRLS at	

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	47.68% per 1,000 bed days within 89.4% rated as no harm, demonstrating a good reporting culture. SFT were being proactive in trying to reduce incidents before they caused harm to patients. MS stated that the reporting culture of AWP was known to be poor, but felt that this was not reflected in the report. FB explained that the data was retrospective, but AWP had improved. MS suggested it would be useful to have reports compared to another mental health trust to benchmark against to help improve the quality element. A better understanding of what the information was showing was needed. ACTION: QCG/17/09/11.0 – Serious Incident reports to include a comparison to another mental health trust to benchmark against. HO queried the 20 Provider Serious Incidents captured against WCCG. FB explained that this was due to the CCG logging serious incidents for Primary Care private and independent providers through STEIS, as they were unable to do so. This would be amended to reflect this in future reports. MS suggested that each report have a theme, with the next focussing on AWP. FB will work with the Lead Commissioners in each area to ensure AWP's approach to review all patient deaths and report to STEIS was being taken forward. ACTION: QCG/17/09/11.1 – Future Serious Incident reports to have a theme. The next report to focus on AWP. *(NF joined the meeting)*	**FB** **FB**
QCG/17/09/12	**Safeguarding Children Annual Report** JD talked to the Annual Report, which outlined the responsibilities of the CCG, provided an update of the work undertaken and outlined areas for development over the coming year. The Joint Targeted Area Inspection undertaken in the Autumn of 2016 was broadly positive, but recommended some key areas for improvement which were being actioned. The CCG was fully meeting its statutory responsibility. During 2016-17, the CCG set up the Wiltshire Children Safeguarding Committee, chaired by the CCG's Registered Nurse. This role would be reviewed following the departure of Jill Crook at the end of August to ensure this remained the appropriate role to Chair the Committee. There was good compliance from providers against Level 1 and 2 training. Virgin Care had shown a significant improvement. AWP recorded the lowest compliance; an action plan was being developed. AWP had recently appointed a Children Safeguarding Nurse, shared with Swindon and BaNES – it was hoped this role would drive forward improvements. Wiltshire Health and Care had also appointed an Children Safeguarding lead. CR raised the issue of the vacant Named Doctor role at Virgin Care. FF updated the Committee that Mark Bagoett had been appointed as the safeguarding lead for Virgin Care for Wiltshire. FF reported that the Serious Case Review Panel had reviewed five cases over the reporting year. A final report would be brought to the Committee when available.	

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	JD reported that children exploitation in Wiltshire was becoming a concern, sexually and criminally, and was now high on the agenda for the Wiltshire Safeguarding Children Board (WSCB). The proposed changes to the WSCB would see the Board working towards a new multi-agency partnership. A number of meetings to progress this change have been held. This would give the CCG a more prominent role in safeguarding. ACTION: QCG/17/09/12 – Final Safeguarding Children Serious Case Review report to be brought to the Committee when available. The Team Objectives for 2017-18 were shown on page 16. Previously it had been recorded that minutes of the Wiltshire Child Protection meetings were no longer to be circulated. FF reported that this decision by Wiltshire Council had reversed following concerns raised by partners. Data and information sharing should be encouraged both ways. **a) Annual Report on the Health of Looked After Children (LAC) 2016-17** LPh explained that the report gave the Committee assurance that safeguarding children arrangements were in place across Wiltshire. Elena Morozova had been appointed to the Designated Doctors for Looked After Children role in January 2017. The LAC team provided a service which kept children at the centre and recognised them as unique individuals. Working with social care teams and the Independent Review Service, the team were proactive in assessing needs to enable those children and young people to reach their full potential. Page 7 presented the key findings from the National Profile of Looked After Children. The number of LAC per age range in Wiltshire indicated 10-15 being the highest band. The LAC rate per 10,000 in Wiltshire was 43, lower than the national rate of 10,000:60. LPh reported that there were currently 152 children out of county being supported. Page 12 illustrated the completion of Review Health Assessments (RHA's) completed in Wiltshire during 2016-17. Providers supporting those LAC placed out of county have refused to complete RHA's due to capacity. To ensure assessments were completed, the team brought back those children to Wiltshire. LPh noted that this was not a sustainable solution, but it ensured that assessments were completed. The timeliness of RHA's was a national issue and was being fed up through NHS England. Gloucestershire CCG had identified a GP Practice that was willing to complete RSA's, which was an avenue that Wiltshire could explore. Another alternative was to send someone out to those placed out of county to conduct the assessment. Kent was being overwhelmed by the number of RHA's required. WCCG had taken three on, and was expecting more. DMcA reported that GP's had fed back that they were not receiving LAC notifications. LPh explained that GP's were sent a copy of the RHA's, but on occasion there was a time delay. LPh reported that the number of asylum seekers and unaccompanied children was growing and impacting upon resources. There was no health	**FF**

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	funding allocated to this support area. This would be raised again with NHS England. ACTION: QCG/17/09/12a – Growing impact of asylum seeker and unaccompanied children, and the lack of health funding to be raised again with NHS England.	**JD**
QCG/17/09/13	**Clinical Advisory Group (CAG)** **a) Proposal for Re-Launch of the CAG** EH explained that the re-launch of CAG came recommended by CAG following approval of the plan at their recent meeting. **The Committee approved the plan to re-launch CAG.** **b) Clinical Policies** • **Home Oxygen (including Cluster Headaches)** The Policy pulled together the contact details, helpline contacts and links to information leaflets into one statement. • **Novel Obesity Drugs** A statement to advise GPs on the CCG's position on prescribing Saxenda ® and Mysimba ® to treat obesity. **STP Clinical Policy:** • **Zero Risk Schemes** A CCG statement for providers to clarify the use of drug treatments pre-NICE published guidance. NF explained that CAG recommended these three policies for approval by the Committee. **The Committee approved all policies.** **c) RightCare – Anticoagulation Summary** The paper was for information. NF stated that she would be working with Danielle Harris to sense check the data and the £1.1m against Deep Vein Thrombosis. **d) Clinical Advisory Group Minutes** The minutes from the Clinical Advisory Group meetings held on 20 June 2017 and 15 August 2017 (draft) were noted. *(NF left the meeting)*	
QCG/17/09/14	**Quality Premium 2017/18** The paper was for information. AW highlighted the need for the whole of the CCG to sign up to the Quality Premium, and for EMT's support. It was not just an area for the Quality Team. This would maximise the opportunity to achieve Quality Premium payment.	
QCG/17/09/15	**Quality and Clinical Governance Committee Annual Report** The paper was for information and would go to the September Governing Body for noting. ACTION: QCG/17/09/15 - Quality and Clinical Governance Committee Annual Report to go to the September Governing Body for noting.	**SW**

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QCG/17/09/16	**Wiltshire Safeguarding Children Board (WSCB)** The documents from WSCB were for information. CR was surprised that there was no mention of asylum seekers in their report. JD reported that LAC was not well represented at the Safeguarding Children Board, but should be on their agenda. ACTION: QCG/17/09/16 – DMcA to raise Looked After Children representation upon the Wiltshire Safeguarding Children Board at the next Board meeting.	**DMcA**
QCG/17/09/17	**Risk Register** The format of the risk register had recently been revised to show one risk per page. SL and DMcA had fully reviewed the Quality risk register. DMcA went through each risk: • Q15/028 – This risk had reduced its score slightly. Cases were being agreed by the panel, but there was no joint process in place. A 50:50 split of funding cases had been agreed. Patients had not been affected by this, but there was a need for an agreed joint policy. • Q15/029 – The four disputed LD CHC cases with the Local Authority continued. Formal disputes were underway. The Local Authority did not agree with the existing dispute process. A draft dispute policy was being developed with Alison Elliott from Wiltshire Council. Once this was agreed, it would be presented to the dispute panel. The CCG would have to continue funding the cases until this was resolved, which over the last two years had been a cost pressure of £1m. • Q15/032 – Approximately 40 people were currently being funded by the CCG who required care in their own home through the Deprivation of Liberty scheme. Beechcroft legal team had conducted training for CCG staff and issued a toolkit. A process was being drafted. The team would be assessing CHC and s117 patients, and this would be conducted annually and would become business as usual to manage the risk. A Best Interest Assessor would be recruited to assist due to lack of capacity within the team. • Q15/034 – There were six cases that the Local Authority agreed (in 2015) not eligible for CHC, but have declined to transition over to Social Care funding. The CCG continued to fund the cases without prejudice. • Q16/035 – GWH ED had seen consistent issues and serious incidents, including regular 12 hour trolley breaches. But these issues were reducing. The SHINE checklist was now being used and an ED dashboard was in place. Further assurance was needed before the risk rating was amended. It was noted that AWP's workforce issue was recorded on Ted Wilson's risk register. DMcA would review this entry with Ted. The Committee agreed that written statements should be requested from Andrew Dean to evident the discussion and verbal update provided under item 6, to include: • All deaths would be reported through STEIS • Confirmation of number of students coming through from bordering Universities to train with AWP • Routine visits to not be more than a 7 day wait, and emergency appointments no longer than 3 hours. • Acuity increase evidence to be sought	

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	ACTION: QCG/17/09/17.0 - DMcA to review AWP workforce issue risk register entry with Ted Wilson. ACTION: QCG/17/09/17.1 – Andrew Dean to be requested to confirm in writing the statements from the discussion and verbal update from the September meeting. **The Committee approved the Quality Risk Register with the noted amendments.**	**DMcA** **DMcA**
QCG/17/09/18	**Proposed 2018/19 Committee Meeting Dates** The meeting dates were noted.	
QCG/17/09/19	**Any Other Business** There was none.	
	The meeting concluded at 16.05hrs	

Date of next Quality & Clinical Governance Committee Meeting:
Tuesday 7 November 2017 - 13.30–15.30hrs - Southgate House, Devizes