NHS
Wiltshire
Clinical Commissioning Group

MINUTES OF WILTSHIRE CLINICAL COMMISSIONING GROUP (CCG) QUALITY & CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON TUESDAY 6 MARCH 2018, 13.30HRS AT SOUTHGATE HOUSE, DEVIZES

Voting Members Present:		
Dr Mark Smithies	MS	Chair, Secondary Care Doctor
Dr Richard Sandford-Hill	RSH	Vice Chair, Clinical Chair of the CCG
Linda Prosser	LP	Interim Chief Officer
Christine Reid	CR	Lay Member for Patient and Public Involvement
Dina McAlpine	DMcA	Director of Nursing and Quality / Registered Nurse
Dr Anna Collings	AC	GP, Vice Chair for NEW
Dr Catrinel Wright	CW	GP, Interim Chair for West
In Attendance:		
Alison West	AW	Associate Director of Quality
Dr Helen Osborn	HO	Medical Advisor
James Dunne	JD	Associate Director of Continuing Healthcare
Susannah Long	SL	Governance and Risk Manager
Nadine Fox	NF	Medicines Management Manager *(for item 7 only)*
Emily Shepherd	ES	Quality Lead
Connie Timmins	CT	Quality Manager, IP&C *(for item 8 only)*
Donna Bayliss	DB	Quality Manager
Carol Paget	CP	Quality Administrator (minutes)
Apologies:		
Dr Lindsay Kinlin	LK	GP, Interim Vice Chair of West
Dr Fiona Finlay	FF	Designated Doctor, Safeguarding Children
Mark Harris	MH	Chief Operating Officer
Emma Higgins	EH	Quality Lead
Dr Andrew Girdher	AG	GP, Chair of NEW
Debbie Haynes	DH	Senior Consultant Public Health, Wiltshire Council
Lynn Franklin	LF	Head of Safeguarding Adults

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PART 1 – ASSURANCE ITEMS		
QCG/18/03/01	**Welcome and apologies for absence** MS welcomed everyone to the meeting. The above apologies were noted.	
QCG/18/03/02	**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.	

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QCG/18/03/03	**Minutes of the meeting held on 16 January 2018** The minutes of the meeting held on 16 January 2018 were approved as an accurate record.	
QCG/18/03/04	**Matters Arising** **a) Clinical Advisory Group items for Approval** Once daily tadalafill – it had been suggested that consultation with Patient Participation Groups would be beneficial and CR advised NF to liaise with Tracy Torr in the communications team.	
QCG/18/03/05	**Action Tracker** The action tracker was reviewed and updated.	
	FOR DECISION	
QCG/18/03/06	**Policies and Strategies** **a) Serious Incident (SI) Reporting and Management Policy** AW presented the new policy, and confirmed that it has been updated to reflect the CCG's internal management of SIs, in line with the National Serious Incident Framework. It describes the overarching process for ensuring that serious incidents occurring within the CCG and in commissioned provider organisations are promptly reported and managed, and that assurances are received that lessons have been learned and actions put in place. AW explained that the major revision to this policy was that a section to outline the process of managing multiple provider incidents has now been included, as it is becoming a more regular occurrence that more than one organisation is involved in the care and service delivery, in which a serious incident has occurred. The updated policy also includes a section relating to the management of incidents reported by Primary Care. Following a question from SL regarding the frequency of SI reporting, AW confirmed that monitoring of number of SI's, as well as the associated themes and trends is on-going and reported monthly in the 'Quality' section of the CCG's Integrated Performance Report (IPR). MS asked that this be clarified in the policy. ACTION: QCG/18/03/06 – AW to add information regarding the frequency and evidencing of SI reporting to the Policy. Subject to this addition, the Policy was approved.	**AW**
QCG/18/03/07	**Clinical Advisory Group Items** **NF presented each of the policies;** **a) Clinical Policies** **For Approval:** **Hip Replacement and Knee Replacement**: These policies were agreed by the MSK board and subsequently by CAG to replace the current published policies. The main change is the removal of a specified BMI limit. From 1 July 2018 all patients being referred for a hip or knee replacement will be directed to the MSK hub electronically via the Referral Management Centre (RMC), at which point the patient will be triaged against the criteria within this new policy by physiotherapist prior to a subsequent secondary care referral where	

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	deemed necessary. MS reported that this had been discussed at length at the CAG meeting and advised that it should be emphasised that the CCG are not restricting access to this surgery on the basis of BMI; the statements regarding BMI within the policy relate to risks involved with the procedure and not qualification for the procedure itself. The Panel approved the Hip and Knee replacement policy **For Approval:** **Freestyle Libre (FSL) for use in Type 1 diabetics:** FSL is a device which measures interstitial fluid glucose in people with diabetes. It helps reduce the burden of finger pricking blood tests, but there is currently no evidence as to whether it reduces complications or improves long-term outcomes for diabetic patients. There is no NICE directive for CCGs to support this technology. NB: Although FSL can be used in type 2 patients, this is not supported locally due to lack of evidence of cost-effectiveness. The sensors cost £910 per patient per year. After much consultation across the STP footprint, it was proposed that FSL be made available for the following groups under a 12 month pilot accessed as a RED drug via secondary care for which the CCG holds the financial risk; currently estimated to be £300k STP wide. NF confirmed that there is significant pressure regarding this issue and the CCG need to ensure that this is available for the right patient cohort. The Panel approved the Freestyle Libre policy. **For Approval:** **Co-proxamol guidance**: Following on from the discussions at the last meeting regarding the overarching NHSE Low Value Medicines consultation, the CCG has produced a statement on Co-proxamol to be published on the medicines management web site and be distributed via medicines management newsletter. The aim is to support GPs in reviewing and stopping any prescribing of co-proxamol which remains, following the withdrawal of its license for safety reasons in 2007 and subsequent NHSE consultation stating co-proxamol be formally considered for the Drug Tariff blacklist. All patients will be reviewed by their GP and medication ceased. CR suggested that this would also be useful to share with Patient Participation Groups and advised NF to liaise with Tracy Torr in the Communications Team. The Panel approved the Co-proxamol guidance policy. **For Approval:** **Funding for Post Clinical Trials:** This paper aims to provide clarity to those GP practices carrying out clinical trials, where the responsibility for any on-going post trial costs associated with that trial, will not be picked up by the CCG. That responsibility will lie with the individual or parties that have sponsored the treatment, until such time as WCCG may agree to fund via the formulary process or the annual commissioning round and the patient conforms to any specified criteria. A number of patients are provided with treatments or devices through clinical trials which are not routinely commissioned by Wiltshire CCG. This includes drugs, devices and treatments which are either still in development or are	

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	established as a treatment, but WCCG has been unable to secure resources to fund the treatments. Commonly the timing of requests for funding for patients who have been in clinical trials is around the time that a license for the drug/indication is granted. There is an assumption by some clinicians conducting clinical trials that once the drug is licensed then WCCG should assume responsibility for funding the drug. NF confirmed that this is incorrect, WCCG has a responsibility to consider and prioritise new treatments being made available, but this in no way places any obligation on the commissioner to fund patients already on treatment funded through industry. MS highlighted concern that the policy could be ratified but the implementation would be difficult as GP surgeries gain income from trialling new medications. NF explained that the data would be tracked by the medicines management team and trials would be challenged to ensure there is clinical justification for the choice of medication/treatment. NF confirmed that it will be made clear that medications/treatments will not be continued post trial and that this should be relayed to patients. Following a question from JD, RSH confirmed that patients are not paid for undertaking drug trials. The Panel approved the Post Clinical Trials policy.	
	FOR INFORMATION AND NOTING	
QCG/18/03/08	**2017/18 Influenza Season Overview** CT presented the report. In order to be robustly prepared as possible, Wiltshire CCG implemented Winter and Influenza Plans for the 2017/18 season. The plans' aims were to assist in the prevention and management of flu cases and outbreaks and contribute to the resilience of services commissioned by Wiltshire CCG. The paper submitted to the Committee gives a broad overview of 2017/18 influenza season and its impact on Wiltshire commissioned services. It also includes associated learning to inform the 2018/19 planning round. Nationally, we saw little influenza activity during October, November and December and activity during the initial start of the season was lower than predicted and lower than the same time period in previous seasons. Activity began to circulate at higher levels towards the final week of December and peaked in the first two weeks in January which coincided with the drop in temperatures and followed the predicted flu pattern, based on the southern hemisphere. The south west experienced a higher rate of influenza activity than national levels. The age group most affected nationally was the 45-65 age group; however locally across the south west it appears it is the 20-45 age group, with no associated co-morbidities, who were the most affected. This was reflected in acute hospital admissions seen across the south west. All three acute providers across the STP experienced larger volumes of admissions due to influenza and influenza like illness compared to previous seasons. There have been a total of 20 care homes temporarily closed due to influenza and influenza like illness during 2017/2018. These were dealt with efficiently and within the required timeframes by the GP practices and show good collaborative working between care homes, GPs and PHE. Care home temporary closures were less than the same time period last seasons and CT noted the improvement in vaccination rates compared with 2016/17, which is partly as a result of the CCGs robust flu planning.	

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	Vaccination uptake rates: As an STP, BSW are currently second in the country for the highest uptake amongst children age 2 and 3 and fourth in the country for the vaccination of the over 65s, having vaccinated just under 74% of all eligible people in this cohort. Further learning from the 2017/18 season will be identified at the end of the season (mid-March) and recommendations for future planning will be included in a 2017/18 'overview and learning meeting.' The meeting will discuss early planning and actions be to be taken forward in preparation for the 2018/19 seasons. CR asked how Wiltshire compares to other counties and CT confirmed that in the last week Wiltshire had 8 confirmed cases in comparison to 131 in Somerset, 66 in South Gloucestershire, 19 in BaNES and 115 in Bristol. CW said this is a very positive story for Wiltshire and should be highlighted across the county as a good news story on the CCG website and through GP surgeries. CT explained that this figure is as a result of thorough robust planning and the dedication of front line staff in primary care, community and acute services who carry out the immunisations in addition to their daily clinical duties. CT confirmed that this information will be disseminated through the Practice Nurse Forum. DMcA confirmed that influenza information is shared at EMT weekly during the season and discussed at the A&E Delivery Board.	
QCG/18/03/09	**Quality Report** AW presented the Quality Report. **C difficile:** The last three months have recorded an increase in reported cases of C difficile; these are attributable to GWH and RUH. Wiltshire currently remains under trajectory with a total of 72 cases year to date, and increase of 1 case in comparison to same time last year. WCCG Quality team continue to seek assurance and provide support to reduce cases and to ensure mitigating action is aligned across Wiltshire Services. A risk still remains that Wiltshire may breach the CCG threshold of 103 cases; the CCG are monitoring this closely. **Mortality Ratios:** SFT has confirmed that, despite being above expected level, HSMR continues to decline and the absolute rate and numbers are stable. SFT are reviewing themes relating to end of life patients being admitted, patients being admitted on a Friday and not receiving a full medical review until Monday and in some cases where Early Warning Scores (EWS) triggered, these were not appropriately escalated. CR expressed concern that patients were not being reviewed in a timely fashion and ES confirmed that this forms part of the SFT Action Plan produced which is reviewed by the Trusts' Mortality Group. In response to the RUH Mortality Assurance Report, the CCG has requested further levels of assurance regarding actions to address both coding process improvements and targeted work to review specialities and diagnosis groups, which have a higher than expected recorded mortality ratio. Progress will be reviewed at the next contract meeting later in March. In response to a question from CR in relation to WHC, ES confirmed that the 7.33% average agency staffing spend for November is a percentage of the total staffing spend.	

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QCG/18/03/10	**Draft CAG Minutes from the meeting held on 20 February 2018** MS suggested that these minutes are not bought to this meeting as an agenda item for decision but rather an item to note. The draft minutes from the CAG meeting held on 20 February 2018 were noted.	
QCG/18/03/11	**Continuing Healthcare and Specialist Placement Update** MS explained that there are multiple and complex elements to this Agenda item and it would be advisable to defer at this time. This was supported by the Committee.	
QCG/18/03/12	**Primary Care Quality** AW presented the Primary Care Quality report and talked through the Quality in Primary Care presentation. **Arrangements following delegation:** • **Performers List, GP appraisal and revalidation**; - this remains with NHS England • **Supporting Vulnerable Practices** - The team also leads on engagement with CQC and the Quality Surveillance of Practices. • **Supporting the development of a patient safety culture in primary care;** Increasing incident reporting rates and learning within primary care. Supporting the development of a patient safety culture. GPs are increasingly sharing SIs at the Clinical Governance meeting. • **Primary care quality reporting**; Sits with Quality Team and has been developed over the last year with continual improvement as necessary. • **Safeguarding**; CCGs already have systems in place to monitor compliance with the contractual standards. These arrangements did not change post 1 April 2017. • **Complaints**; NHS England remain responsible – however the CCG register, track and monitor these complaints and highlight trends for reporting purposes • **Patient Experience**; Quality Team leads in developing and sharing best practice in improving patient experience, and monitors and responds to national experience capture mechanisms. **Incident Reporting and Learning:** Medication incidents are the highest NRLS incidents reported. CW noted that Clinical Assessment including failure to diagnose, fall outside the remit of a GP and she gave an example of the RUH ultrasound and MRI guidelines which have impacted on their workload. AW confirmed that as a result of this reporting, incidents such as this are discussed with commissioners at regular provider quality meetings. **Infection Control:** • Offering increased support to practices in particular around following up cases within the community • Focus of IP&C strategy • C.Diff cases – links to prescribing by primary care • 2 MRSA cases • Antivirals assessment and prescription • Immunisation rates RSH asked how many C.Diff cases there are currently within primary care. AW confirmed that an individual GP may only see one case a year and C.Diff cases relate to the whole patient pathway involving a number of organisations. MS confirmed that anti-microbial stewardship is imperative in reducing cases of C.Diff.	

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	DMcA reported that RUH have reported a higher rate than other acute Trusts and NHSI have been involved in developing action plans with the Trust. Three cases of legionella's disease have also been reported by the RUH. DMcA will be meeting with the RUH Director of Nursing to share learning from other Trusts such as SFT who have developed effective IP&C working practices. **Patient Safety Collaborative** This is facilitated by the Academic Health Science Network and is currently working with three practices based in Trowbridge. Throughout the year, workshops and events were held to discuss: • Learning from Excellence; route cause analysis when things go well • Creating a Culture which recognises and values the importance of reporting near misses – lessons from the Nuclear Industry • Quality Improvement tools and techniques in primary care • ThinkSAFE; Staff and patients working together to improve patient safety • Managing Patient Safety – learning from a Medical Barrister • Managing and reducing Demand It is hoped to roll this programme out across Wiltshire and engage more practices in this initiative. **PALS and Complaints** The CCG has recorded 62 concerns or enquiries regarding GP practices for the year to date. Most calls related to patients' concern regarding ability to obtain an appointment, or to obtain an appointment within what they consider to be a reasonable time frame. Other notable trends are concerns relating to care and treatment (9). The committee noted the challenges with obtaining robust, timely and meaningful data relating to complaints from NHSE. **Friends and Family Test** There is an expectation from DOH & NHSE that the response rates for FFT will improve; however some practices are providing responses consistently. AW explained that some practices make it easier than others for patients to provide their feedback through good signage, leaflets and easy access to feedback forms. LP asked how practices respond to FFT feedback and CW confirmed that within her practice, comments, compliments and criticisms from FFT are discussed at monthly team meetings and circulated to all staff where appropriate. RSH also stated that within his practice all comments are circulated to staff on a regular basis. **GP Patient Survey** The overall reported experience of a GP surgery in Wiltshire has not changed from 2016. Practices whose survey results indicate patients may not be satisfied with their experience of their surgery across the key indicators have been identified a Patient Experience Action Plan has been put in place to provide support. **CQC Inspection Results** The CQC Inspection results were very good across Wiltshire with only 2 practices identified as requiring improvement in the effective domain. **Workforce Survey** The Primary Care team had requested that further questions be added to the Survey and the response rate had dropped slightly in this reporting period. LP asked if the CCG has access to staffing data to show how many GPs or healthcare professionals there are per head of population. DMcA confirmed that	

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	this data is available but is not presented against these figures. RSH suggested it would be more appropriate to look at how many clinical sessions have been undertaken within each practice. ACTION: QCG/18/03/12 – AW to include the number of clinical sessions undertaken within each practice to future Practice Workforce Survey **Assurance and Contracting** AW reported that the first meeting of the Primary Care Quality Surveillance Group will take place this week, and the Quality Team has initiated a review of the Primary Care Dashboard system, with a view to move to an integrated, dynamic system of data review. The information is available at individual practice level and will be reviewed at the regular Quality Surveillance Group meetings. The Quality Team is developing a Primary Care Quality Framework which will set out the parameters of the Quality Team role within primary care services and the priorities for improvement and development over the coming 12 to18 months. Once completed, the framework will be shared widely with practices. MS explained that the key to enthuse practices to engage in this work will be to evidence clinical outcomes. LP suggested that it would be useful to produce a snapshot of this report for circulation to practices. The GPs noted that having a 'league table' of practices with different quality indicators would be helpful. **Quality Improvement Priorities** AW reported that 3 practice nurses are being recruited into the Quality Team for 1 day per week each, initially on a three month basis, to look at supporting the practice nurse network and developing content for an IT platform. Work will also be undertaken to look at job descriptions and map against the Health Education framework to support primary care with recruitment RSH stated that all practices across Wiltshire need good standardised policies to ensure parity across practices. HO suggested it would be useful to set up a specific website for all practices to gain access to all information regarding this on-going work	**AW**
QCG/18/03/13	**Risk Register** SL reported that there are 5 risks currently on the register and there has been little change since the previous meeting. AWP are not consistently providing completed RCAs for Serious Incidents in line with Serious Incident Framework timeframes. A Contract performance Notice in relation to this has been served. ES confirmed that the commissioners to the contract cannot support the proposed compliance trajectory, who have confirmed in their remedial action plan (RAP) that they will not be in a position to meet their contractual obligation until April 2019. The CCG have challenged this proposal and asked for evidence of short and medium term actions to mitigate risk. LP asked how many incidents are being reported and is this comparable with other Trusts. DMcA confirmed that AWP are not over-reporting and the issues that are reported are serious in nature and would meet the serious incident threshold, she added there are rarely reports of slips, trips or falls. There is a sense that there is a cumbersome internal ratification process within AWP that delays	

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	timeline submission of RCAs. ES confirmed that there is work underway within AWP to set up a central patient safety team consisting of eight band six clinicians who will lead on individual RCAs. Currently, each incident that occurs within the Trust is reviewed at a bi-weekly executive meeting to establish whether this needs to be reported as an SI, as well as this group 'ratifying' all RCAs, which is also adding to delays. AW clarified that the central patient safety team approach may not be a long term option because ideally these skills should be embedded throughout the organisation. DMcA confirmed that a succinct incident review and summary is what is required in her view and training workshops have taken place in the past between the provider and commissioner to discuss the management of serious incidents. MS felt that the previous Quality & Clinical Governance meeting at which Paddy McKee, Clinical Lead at AWP had attended, was very productive and it is hoped with his appointment to see improvements across the board. The Committee approved the Quality Risk Register.	
QCG/18/03/14	**Any Other Business** There was none.	
	The meeting concluded at 15.14hrs	

Date of next Quality & Clinical Governance Committee Meeting:
Tuesday 1 May 2018 - 13.30–15.30hrs - Southgate House, Devizes