NHS West Essex Clinical Commissioning Group
Quality Committee

Date: **3rd *September 2019***
Time: ***1:30pm to 4pm***
Location: ***Boardroom, Spencer Close, SMH***

Attendees:

Name	Initials	Role
Peter Boylan	PB	CCG Board Lay Member (Chair)
Kamal Bishai	KB	GP Board Member
Jane Kinniburgh	JK	Director of Nursing & Quality, WECCG
Christine Moss	CMo	Clinical Director, WECCG
Theresa Smith	TS	Primary Care Quality Lead, WECCG

In attendance

Jenny Abel	JA	Head of Transfer of Care, PAH
Duncan Forsyth	DFo	Secondary Care Consultant, West Essex CCG (Vice Chair)
Andrew Geldard	AG	Accountable Officer, WECCG
Clodagh Hewins	CH	Clinical Quality Assurance Lead EWMHS, Children, Young People and Maternity Services, WECCG
Anurita Rohilla (from 3.17pm)	AR	Chief Pharmacist - WECCG
Gay Alford	GA	Executive Assistant to Director of Nursing & Quality (Minute Taker)

Item No	Agenda Item	Actions
1	**Chairs welcome and Apologies for absence** **Chair welcomed Jenny and everyone introduced themselves.** Apologies to be noted: David Wallace, Deputy Director of Nursing & Quality - WECCG Simon Surgenor, Head of Governance & Corporate Services – WECCG Stephen Fry, Performance Lead – WECCG Jen West, GP Board Member	
2	**Declarations of interest** PB reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of West Essex Clinical Commissioning Group. **None declared.**	
3	**Minutes of the last meeting 2nd July *2019 and matters arising***	

	Committee agreed the minutes were an accurate record of the meeting held on 2nd July 2019. There were no **Matters Arising**.	
3i	**Action Log from 2nd July 2019** Actions recommended for closure were agreed and will be removed from the action log.	
4	**Operational Risk Register Report** JK provided a verbal update on those risks assigned to the Nursing and Quality Directorate. **W242** - Fluctuating figures in relation to the capacity of discharge to asses. Have been working with Transformation team re additional HODs to be commissioned which it is hoped will impact that pathway. **W243** - EPUT have conducted a review around their admin function. Have identified a lead admin person for each locality. This went live in August 2019. Will report back to the September SPQRG. It is hoped it will have an impact on the 28 days. **W2** – Cases have been completed apart from a number still in the system going through an appeal process. Do not know what the final costs will be at the moment. Reliant on NHSE for the independent reviews; they are prioritising live patients rather than deceased patients. Have to wait for them to clear the backlog of appeals. CHC team to have oversight of complaints coming in. Gail Walker will follow this up. **W228** - Have got agreement on pilot for renal transport. Personal Health Budgets (PHB) for wheelchairs is in place. There is a Workshop scheduled for October with mental health colleagues to take forward the work relating to Section 117. Discussion at EPUT SPQRG yesterday; there has been an offer from NHSE that we have a targeted workshop here with contracting and finance to understand processes with the national lead. This risk will be reviewed due to the above measures in place. It was acknowledged that the target of 420 PHBs is challenging but if progress can be demonstrated to NHSE, it may be sufficient. **W251** – Now have agreement and an STP team is being mobilised. Want to put in place priorities for the work programme and will probably ask to close it next month once the integrated team is in place. **W252** – The CCG is very unhappy with the service from Purple but there are things going on at STP level that may mitigate this. Beginning to look for an alternative provision to reduce the risk. **W204** – Just had the report published following the CQC inspection. PAH is due to share the action plan with the CCG and then a discussion will be had about re-writing a list of priorities and how the CCG support implementation of the recommendations from CQC. **W256** – No change from last month as were waiting for the national practice guidance around how we implement this. Will have significant	

implications for the CCG moving forward but not entirely clear yet what they are.
W166 – PAH failed the 62 day target and have an improvement trajectory in several specialties. Mainly capacity/process issues. It is thought that it will resolve in November/December.
W221 - Mortality figures are not improving. Although some good work has been done, it is not delivering. It was acknowledged that when the PAH, Chief Medical Officer comes to Board, the CCG need to get an understanding of how the hospital proactively manages and monitors mortality across all specialties within the Trust so that they can demonstrate they have a true handle on it.
W237 – A urology consultant has been recruited. The risk will be closed once they are in post.

5 **Performance Recovery Report**

The committee reviewed and discussed the report.

The Chair confirmed that this was the first time the committee have had numbers quoted on super stranded patients. He referred to the data on page 4 of the report (see excerpt below) and asked for clarification on the <25 patients quoted:

Stranded patients	June	The number of stranded patients was fairly static with 148 reported at June month end. There were 24 WECCG patients classed as "super stranded". This is an un-validated snap shot at month end of patients with a Length of Stay > 21 days. This is the first month we have reported this metric – it will be tracked moving forwards with issues escalated through the monthly SPQRG meeting with the Trust.
< 25 patients	148	

Action: SF to clarify: is the 24 quoted part of the 148 or is it two separate strands? **SF**

CM verbally reviewed the table on page 2 of the report

- A&E across all West Essex acute providers is broadly showing a slight improvement.
- Addenbrooke's Referral to Treatment (RTT) has deteriorated, as has Barts.
- Mid Essex 62 day standard is deteriorating. They have been doing a complete root and branch review of their process which was due to conclude in June so we may not see an improvement until September/October data.

The Chair made reference to the Addenbrookes data on page 6 (see excerpt below):

Addenbrookes		
Accident & Emergency	**June**	• The Trust is one of

	(A&E) 4 hour target – 95%	NO DATA	14 sites testing alternative A&E access measures as part of the National Clinical Review of NHS Access Standards. The Trust will not be publishing performance against the 4 hour standard during the pilot • Further national guidance on outcomes and next steps is expected in the Autumn

As there will be no published data available for this target during the pilot, the committee would like to know:

- How long is the pilot?
- How long will it be before the data is available?
- How is the lead commissioner for Addenbrookes getting assurance about this service?

Action: The above questions to be raised with SF. **SF**

LD health checks
It was noted that the national target for LD health checks 19/20 has increased from 70 to 75%. This raises the question, what are we doing to manage that message across to primary care as it will make that target even more challenging to meet this year. What actions are we going to put into place to ensure that we achieve in the same way as we did last year?

6	**Quality Assurance and Oversight Group Update** No report - deferred to November Quality Committee meeting.	
7	**Primary Care Quality Report** No report – deferred to November Quality Committee meeting.	
8	**PAH CQC Update** JK gave a verbal update of the tabled PAH CQC Report which has now been published following inspection in December. Whilst there have been some improvements, the overall rating remains unchanged as “Requires improvement”. **Key points from the summary:**	

	Maternity - has gone from Outstanding to Requires Improvement which is quite significant. The CCG needs to address this with the Trust and this will form part of assurance approach for the rest of 19/20. **Emergency Care –** was rated as Requires Improvement. It was noted that some of the breaches from 2017 had not been fully resolved at inspection. **Safety Incidents (SI)** - were not always managed in a timely manner; this is something that the CCG had recognised as there had been increasing requests from PAH to extend SI reporting deadlines. The CCG has recently written to the Trust to stipulate that there will be no extensions to SIs. **Children's Services** – the rating had gone from Requires Improvement to Outstanding which is a significant improvement. It was commented that the senior management team at PAH will take their response to the inspection to their own Board and then feedback at the CCG Board. There were no immediate actions to be taken. The enforcement actions were around: • Governance • Staffing • Safe Care and Treatment **Action: The CCG to invite PAH senior management to the Board to feedback their response to the CQC report.** **Action: PAH CQC report to go to Board as a paper in September.** *AR joined the meeting at 3.07pm*	
9	**Continuing Healthcare (CHC) Assurance meeting update** Covered under agenda item 16.	
10	**Stranded/Super Stranded Patients** JA gave a PowerPoint presentation detailing the work being undertaken at PAH to reduce the length of stay (LoS) for stranded patients and super stranded patients. There is a long stay patient review at PAH for every patient over 7 days which is carried out once a week by: • Head of transfer of care or discharge matron • Colleagues from social care • Therapy colleagues • Consultants on the ward A weekly, exec led, length of stay review is undertaken for every patient over 15 days. This is carried out by:	

- Chief Medical Officer
- Director of Nursing
- Head of transfer of care
- Head of therapies
- Ward managers
- Consultants

JA's team have been looking at the top constraints contributing to the delays in patient discharges:

- Patient medically unfit
- Waiting for diagnostics/specialist's opinions
- System partner delays i.e. care package not due to start until the next day/waiting on equipment to be installed in the patient's home

They are about to go live with some immediate care beds which will give additional capacity which will be managed by a care co-ordination centre. This is on a two year contract while a re-design of Pathway one is undertaken.

During discussions, DF suggested that stranded/super stranded reviews should be underpinned with physicians/clinicians asking the same question twice:

- Why are you here?
  and
- Why are you still here?

Questions raised during discussions:

Q. Why are the stranded patient figures high, yet the delayed transfer of care figures are low?

A. The top groups of patients in this cohort are medically unfit or not medically optimised to be discharged. The delayed transfers of care figures are low because social services try to work ahead and anticipate patients' needs in order to get the capacity aligned.

Q. How mature would you describe the services available to PAH to prevent admission in the first place?

A. There is a lot of change happening at the moment. The Community Assessment Rapid Service (CARS) which runs seven days a week and consists of a small group of nurses who provide the admission avoidance function at the front door, will have additional capacity when it is combined with the Acute Frailty service, due to go live shortly.

It was challenged that there could be a number of opportunities that could prevent people arriving at the hospital in the first place, an example given was ambulance paramedics being employed by GP surgeries to do home visits and make decisions about where to signpost people to.

Q. Are there community services that would make a difference?

A. The Care Co-ordination centre will give patients one number to call and JA's team will make decisions about what services will be required.

Q. Are any of the stranded/super stranded patients transfers in from other hospitals?

	A. There are some that fall into this category but they are West Essex patients that have been re-patriated. Their length of stay count starts from the day they are admitted to PAH. **Q. What specialties have been covered in reviews undertaken?** **A.** gastroenterology, medicine for the elderly, acute physician, diabetic endocrinology. During discussions, there was a challenge to a statement quoted in the PowerPoint presentation: ***"A stay in hospital over 10 days leads to 10 years of muscle ageing for some people who are most at risk"*** DF shared with the committee that there is no evidence that this statement is true and asked colleagues to read the BGS blog in the link below: https://britishgeriatricssociety.wordpress.com/2018/07/25/10-days-in-a-hospital-bed-leads-to-10-years-worth-of-lost-muscle-mass-in-people-over-age-80/ **Q. What is the model for MDT support?** • There is going to be a wrap-around service covering mental health, OT/physio and access to the other therapies. • The Provider is going to be required to provide enabling care. • There will be a MDT review to make sure patients enter the right pathway and then MDTs weekly. • Finally, discharge from service back to the Primary Care Networks (PCNs). • If a patient has a long term condition they will plug into long term condition management. **Q. Is there some strategic document that pulls all the initiatives together to give us a sense of direction about what we are trying to achieve and how we are trying to achieve it?** **A.** There is the Urgent Care system wide programme plan which will have all of this in it. CM added that they will be re-looking at some of the assumptions at PLG on Thursday 5th September. *JA left the meeting at 14.17pm.* The Chair asked colleagues if they found the presentation helpful? It was acknowledged that whilst it was re-assuring to hear what PAH are doing, there is a concern that we haven't understood what triggers the admissions in the first place for this group of people and understood what community offer might make a difference to that?	
11	**Transforming Care Report** JK reported on the update paper from Phil Brown. It gives a profile of our transforming of care cohort of patients, detailing where they are in the system and what the plans are for them. It also highlights the issues around large numbers of children in Tier 4 beds. These are mainly children with ASD who end up in mental health beds as	

	there is no other commissioned service for them to go to. Following discussions with ECC, some funding has been agreed from the commissioning collaborative for mental health. Spot-funding packages will be available where there are gaps for these children following care and treatment reviews. There is also a piece of work for ECC as the lead commissioner to scope and develop a spec for a universal offer for these children. **Learning Disabilities Mortality Review (LeDeR) Update** The LeDeR review of deaths for people with a learning disability is a national programme that requires CCGs to: • Complete a review of all deaths within 6 months of notification • Participate in a LeDeR Steering Group to review the learning from these reviews • To implement actions arising from the learning and recommendations • Deliver an annual report. JK reported that there is a backlog of reviews still to be completed. NHSE has agreed additional funding to clear the backlog and has appointed a team to pick this up. It was noted that the responsibility sits with the local authority to lead on this work. During discussions it was commented that assurance is required that there is oversight of LD patients who are placed out of area and there is a process in place for when we do have to commission to a service, that we have a programme of assurance visits. **Action: Bring back to the Quality Committee in January for further scrutiny once a proposal for a process has been put together.**	**P. Brown**
12	**Medicines Safety Report** AR gave the following update: **Antibiotic prescribing** Improving antibiotic stewardship is a priority. There is a West Essex antimicrobial stewardship group being hosted by PAH which hasn't met yet. AR suggested that there is scope for looking at antibiotic prescribing as an ICP and to give it a system push. There is a concern around sepsis information influencing antibiotic prescribing both inside and outside of the hospital. Whilst sepsis is a national threat there needs to be a message of lets prescribe appropriately. It was suggested that Whipps Cross hospital could be included in this otherwise it could put the south facing PCNs at risk. It was countered that the Harlow locality is a higher priority for the meds management team at the moment. AR highlighted that the opiod work is a really good story – she has been asked to present at the NHSE Controlled Drugs Local Intelligence Network (CD LIN) on the work they have been doing and share their good practice.	

13	**Quality Premium update** JK reported that the paper shows the end of year achievement for Quality Premium 2018/19. We are impacted on as we have not met all the constitutional standards. Have not had any information on process or if there will be a Quality Premium from NHSE or NHSI for this year.	
14	**CQUIN Achievement update** JK explained that the report contains a summary by provider of what has been achieved for 2018/19. It was noted that the process is changing – the CQUINs are now nationally mandated with the CCGs having a lesser role. The Trusts have to upload their information directly to NHSE who then inform the CCG contracts team whether or not they have achieved.	
15	**Emotional Wellbeing and Mental Health Service (EWMHS) provided by North East London Foundation Trust (NELFT)** There was one update that CH wanted to share with the committee. There was a Quality visit to the Crisis Team in south yesterday. • They have been successful in recruiting another three members of staff to their team. • The new service model that is in process of being mobilised in the north has not started to be mobilised in the south yet due to staffing levels. It will be a wrap-around service that will be offering intensive interventions for a two week period after the child has been initially assessed when they are in crisis. • The idea behind it is to give the child skills and strategies to build resilience so it reduces attendance at A&E/Crisis team/Tier 4 admissions. • Will start implementing in November/December so should hopefully start seeing a reduction in the figures of the assessments being undertaken within the A&E department.	
16.	**Continuing Healthcare (CHC) Report** JK reported that that there is some work being done with Finance and Transformation around how we try and build capacity in placements and how we try and improve the rates we are paying for funded packages of care that links to what was not a very successful exercise for us in the Essex-wide IRN procurement. So doing some work locally to try and understand: • What is our profile going to look like? • What is our requirement for beds? • Having some engagement with the providers to see how we might be more attractive to them and how we can work more closely with them. Gathering data for modelling to see what that looks like moving forward. **CHC User Survey results (01/07/19)** There are two surveys in the report but the numbers are very small, only two patients for the PHB survey and eight for the patient experience survey. It will need to be put to a much larger cohort for it to be meaningful.	

	Action JK to have a conversation about patient surveys with Liz Hall.	**JK**
17	**Infection Prevention Control** JK gave a verbal update on the report on behalf of DW. The report shows our position at end of year. Benchmarks us nationally. It does show PAH as a good performer. It was noted that there is an agreement around an STP-wide Infection and Prevention Control team which will begin to go live imminently It was agreed that a condensed version of this report will go to the November Board. **Action: IPC report to go to November Board**.	**JK**
18	**Review of Risk Register** It was agreed that there was nothing new to add to the Risk Register.	
19	**Points to Board** 1. **Antibiotic prescribing** - There is a slight drop in the number of antibacterial items being prescribed, however West Essex is still higher than the national and STP average. This is a priority for West Essex and it is recommended a joint ICP strategy for tackling antibiotic prescribing is adopted across the system 2. **Opiods –** In West Essex the team identified 299 patients who were being prescribed opioids above the recommended dose in 2017. As at March 19, this number had reduced to 172. i.e. a 44 % reduction. The team has been asked to share this work with other organisations within the East of England region. 3. The CQC PAH inspection paper will go to Board in November.	
20	**AOB:** None. *The meeting closed at 3.49pm.*	
22	**Date and time of the next meeting** Tuesday 12th November – 1:30pm Boardroom, B4 Spencer Close	