NHS
Surrey Downs
Clinical Commissioning Group

*Quality Committee*
*10th March 2017*

# Minutes

**Committee members present:**
Dr Tony Kelly, Secondary Care Doctor
Dr Tim Powell, Governing Body GP
Dr Louise Keene, Governing Body GP
Steve Hams, Director of Clinical Performance and Delivery
Gill Edelman, Governing Body Lay Member - PPE
Jacky Oliver, Governing Body Lay Member - PPE

**Others in attendance:**
Jackie Moody, Head of Quality
Justin Dix, Governing Body Secretary
Dave Weaver, Head of Quality

**Chair:** Dr Tony Kelly

**Minute taker:** Justin Dix

**Meeting started:** 9.35

**Meeting finished:** 12.35



## 1. Meeting Matters

### 1.1 Welcome and introductions

Jane Lovatt, Peter Carvalho and Clare Stone were welcomed from NHS North West Surrey CCG in respect of item 4. Dr Fuller attended for item 3 and Shelley Eugene for item 7. QC100317/001

### 1.2 Apologies for absence

Debbie Stubberfield, Eileen Clark, Jennifer Smith QC100317/002

## 1.3 Quorum

The committee was noted as being quorate QC100317/003

## 1.4 Attendees interests relevant to the meeting

Committee members were reminded of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Surrey Downs Clinical Commissioning Group. QC100317/004

Declarations declared by members of the Committee are listed in the CCG's Register of Interests. The Register is available either via the secretary to the governing body or the CCG website at the following link:

http://www.surreydownsccg.nhs.uk/media/53186/01-register-of-interests.pdf

## 1.5 Minutes of the last meeting

These were agreed as an accurate record other than the following minor amendments: QC100317/005

- Tim Powell was not present QC100317/006
- Gill Edelman was present
- 007 – typo ("discussion")
- 027 – typo (Spelling of Jacky)
- 033 typo ("Hemorrhaging")
- 036 – The minutes should clarify that this related to the CQC report
- 067 – typo (Spelling of Jacky)
- 071– typo (Spelling of Root Cause Analysis)

## 1.6 Matters arising and action log amendments

## 1.6.i Action Log

QC041116/109 – forward planning. This was discussed in the context of the new meeting arrangements and the work of the committee for next year, where there would not be a distinction between seminars and business meetings but business meetings with a special focus. Dr Kelly emphasised understanding the nature of the topic to be covered in more depth at each meeting and signposting about specific issues that would come up during the year. The action would be kept open and Justin Dix and Eileen Clark were asked to bring a proposal to the next meeting under the existing action. QC100317/007

QC041116 /074 DOLS backlog. Steve Hams updated the committee. There were issues with shortages of social workers. This was a national issue for which local resolution was difficult. To be identified on the risk register as a risk to be tolerated on the basis that mitigation was outside the CCG's control. Close action. QC100317/008

QC060117/058 – organisations in special measures – given that the only organisation locally in this position was SECAmb, and given that the committee has a strong focus on the issue, it was agreed that this action could be closed. QC100317/009

QC060117/008 – PPE strategy – This has been raised with the Chief Officer and was on the agenda for today's meeting. Action can be closed. QC100317/010

QC060117/016 – Quality in contracts. Dave Weaver updated the committee on the progress with contract negotiations. There were a range of contracts and documentation varied but on balance it was felt this action could be closed. QC100317/011

QC060117/019 – Framework for assurance. Dave Weaver said this area was proving much bigger and more complex than originally envisaged. Dr Kelly emphasised the need for a framework or principles against which providers would report again. Steve Hams suggested this should focus initially on basics such as whether a contract was in place. Dave Weaver would progress this work with the contract team. This would give basic assurance to the committee and might highlight specific contracts at risk. Action to stay open. QC100317/012

QC060117/068 – Use the PPE strategy to inform risk management processes – it was agreed to keep this action open pending PPE discussions further on the agenda. QC100317/013

**1.6.ii Action transferred from Audit Committee**

Audit Committee had been reviewing Datix implementation and had agreed that the CCG should seek to roll the incident reporting module out to GP practices. It was felt that this sat better with the Quality Committee as it concerned incident reporting. There was not sufficient capacity to roll this out at the moment. QC100317/014

The Committee accepted the transfer of the action and agreed that it should continue to seek to roll Datix incident reporting out into primary care. QC100317/015

**Action Justin Dix**

**1.6.iii Other Matters Arising**

There were no other matters arising. QC100317/016

**2. Assurance on quality and safety**

**2.1 Quality and Performance Report**

This was NOTED rather than discussed in detail due to the time constraints. Key issues were: QC100317/017

- Key issues with providers were highlighted on Pages 6 – 9 of the report. QC100317/018
- Jackie Moody specifically highlighted the safeguarding update on P41 QC100317/019

- Carers were highlighted on P42 – specifically that we have used nearly 70% of our allocated carer's breaks as a CCG. Also to note that the number of carer prescriptions issued by CHC was low and there were opportunities for improvement. QC100317/020

Dave Weaver highlighted that Epsom PTS was an emerging risk (in the last fortnight) due to the lack of contractual control over an ESH sub-contract that was terminating. This was causing a number of patient safety concerns. It was agreed a risk should be added to Datix in this respect. QC100317/021

**Action Dave Weaver**

## 2.2 Quality Objectives 2017/18

Deferred to the next meeting. QC100317/022

## 3. Stroke improvement

Steve Hams gave an update on stroke and its clinical characteristics. Strokes were responsible for extensive mortality and morbidity, although the number of deaths had declined over the last twenty years as service responses had improved. QC100317/023

Interventions were based around goals for three key groups: QC100317/024

- People with a suspected acute stroke or transient ischaemic attack (TIA) and ongoing neurological symptoms and signs
- People who have recently had a suspected TIA
- People who have had a stroke or TIA

Optimal stroke pathways had been defined by NICE and each step had key quality standards. There were seven key quality standards: QC100317/025

- Admission to a specialist unit with 4 hours
- Stroke rehab in hospital
- Access to clinical psychology
- Early supported discharge
- Active management to return to work
- Regular review of rehabilitation goals
- Structured health and social care reviews

There were two key performance standards for ambulance services relating to FAST QC100317/026

- Face to face treatment
- Admission to a hyperacute stroke centre within 60 minutes

Access to services in terms of patients receiving thromboysis and time spent on stroke units were key indicators. Follow up was key and this was an area where Surrey Downs commissioned specialist support. Joint health and social care planning had improved but could be better. QC100317/027

SSNAP (Sentinel Stroke National Audit Programme) data was comprehensive and logtitudinally robust. Surrey Downs was overall positive, in Category B. Very few organisations were in Category A. There was however significant variation in local provider performance, with East Surrey being in Category D. QC100317/028

There were a number of issues with data capture which had to be taken into account. QC100317/029

A key lesson was from London where care was centralised down from 30 to 8 specialist units within a hub and spoke model. This had very significant positive impact on mortality and morbidity rates. Similar results were experienced in Manchester. QC100317/030

Dr Fuller explained the two and a half year history of the Surrey Stroke review. There was significant variation in the county and concerns about two tier services. The Stroke Association had been involved in this work and patient feedback had been particularly strong regarding what happened in the handover of patients between organisations. QC100317/031

Thrombolysis and specialist services, along with speech therapy support as part of rehabiliation, were the key indicators of a successful bundle of care. The most effective organisations were seeing around 600 – 900 strokes per year. This suggested that Surrey needed no more than two HASUs in the county. The conclusion was that ASPH, FPH and SASH were the preferred HASU sites with the other sites keeping their Acute Stroke Units. This was complicated by the national team saying there should not be any standalone acute units, and by the financial implications. It reopened the case for services to be located at Epsom. As a result the current projected position was as follows: QC100317/032

- Ashford St Peter's – Hyper Acute and Acute Stroke QC100317/033
- Epsom – Acute Stroke with Hyper Acute at St Helier
- Royal Surrey – No stroke services
- Frimley – Hyper Acute and Acute Stroke
- East Surrey – Hyper Acute and Acute Stroke but only 10 % of Surrey Downs patients would normally attend this site as it was mainly Sussex facing

Geography and ambulance flows would be the determining factor in deciding which site patients were taken to. QC100317/034

These discussions were still ongoing as some stakeholders had concerns about this. Epsom were however mobilising from April / May along these lines. QC100317/035

It was agreed to ask Epsom Health and Care to review this and to undertake an Equality and Quality Impact Assessment around the changes. QC100317/036

**Action Eileen Clark**

It was noted that two separate one hour targets had been joined to create a single two hour call to needle time target. This was felt to be beneficial for patients QC100317/037

Dave Weaver would continue to be involved with the London stroke review. It was noted that East Elmbridge were already receiving a good service due to the links and access to St George's and Kingston. There would be a visit to Epsom but not until after the review had been concluded. QC100317/038

## 4. South East Coast Ambulance (SECAmb)

Dave Weaver introduced this and explained the role of the host commissioner. The team from NW Surrey then gave a presentation. QC100317/039

The SECAmb performance position was challenging, both for 999 and 111. Information sharing had improved but the history was of a poorly governed organisation with poor organisational cultures and behaviour. Turnover in leadership positions had been significant and a new CEO was starting in April. QC100317/040

There had been a number of iterations of a recovery plan but little capacity to deliver these. More recently there had been a risk summit around medicines management concerns. QC100317/041

In summary there is still a lack of assurance about performance and governance. QC100317/042

Gill Edelman asked about the history of the trust. It was noted that Surrey Ambulance had grown through mergers to become part of a South East Coast wide service and there were deep rooted issues of culture and hierarchy. QC100317/043

With regards to 111 - The contract structure was a regional one led from Kent and tied into 111 procurements. There were a number of historical issues around procurement but this service was less of an issue than 999. QC100317/044

PTS – The SECAmb service does not apply to Surrey Downs, who contract locally, but there are exit and mobilisation issues. QC100317/045

999 – The contract runs to end March 2019. There are a number of issues tied to this. There is a separate Surrey contract but a regional performance target. QC100317/046

The history of the serious incidents commencing in 2014 were outlined. This led to a risk summit and a contract performance notice, and eventually to a remedial action plan. By October 2015 this had led to a regulatory notice from Monitor and 3 external reviews commencing. QC100317/047

During 2016 the continued difficulties with improving performance led to the issuing of a wider contract performance notice, a unified action plan being developed, and eventually (in September 2016) the organisation being placed in special measures by Monitor and the CQC. The Chair and Chief Executive had both departed in March 2016 and a CQC warning notice had been issued in May 2016. QC100317/048

Following the introduction of special measures, a wide range of support mechanisms were put in place including a buddying arrangement with South Central Ambulance Service. QC100317/049

Commissioning organisations had become increasingly involved as the above events unfolded and commissioning oversight had been restructured. This included improvements in information from the host CCG in Kent (Swale). The Quality Surveillance Group had been reviewing the position on a monthly basis and a Single Oversight Group had been put in place. Revised trajectories for performance were now in place but these had been developed around realistic expectations and were not based on getting back to national performance expectations immediately. QC100317/050

The Single Unified Recovery Plan bought together provider, commissioner and regulator requirements in one place and set out expectations that change would be properly documented and subject to governance. This was still proving complex. The revised arrangements were presented as an organogram. QC100317/051

Dr Kelly asked if these arrangements properly incorporated local commissioner performance concerns. It was felt that they did now but this had not always been the case. There was a stronger presence, for instance, at A&E delivery boards. QC100317/052

Gill Edelman asked about regulator responsibilities and it was acknowledged that these sat between NHS Improvement and CQC and commissioners had had to work hard to get their concerns recognised. The changes in the wider regulatory environment, with Monitor and The Trust Development Authority joining to become NHS Improvement had also not been helpful during this period. QC100317/053

It was felt that governance had improved and there was a much better understanding of where the failings had taken place and what was needed to address them. The really significant improvements had only taken place in the last few weeks. QC100317/054

It was noted that staff survey outputs had already been incorporated into the latest action plan. QC100317/055

Dr Powell asked about the R3 pilot. It was clear this had not gone through the trust's internal clinical governance and as a result all new projects were now subject to proper scrutiny. There was a formal governance signoff process, linked to the new PMO. This gave proper checks for any proposals, although it was acknowledged that there was a risk of stifling innovation if this approach was too heavy handed. QC100317/056

There were now 3 Operational Monitoring and Assurance Groups: 999, 111 and Clinical Outcomes Development. The last of these tries to go beyond simple performance data to look at patient outcomes and patient experience. This was complex and focused on specific groups such as stroke patients. QC100317/057

Reporting from their information systems was problematic for historical reasons due to the system that had been purchased. A new system was being put in place this summer that gave consistent data in line with other ambulance trusts. It was also noted that the 8 minute target was the only one that attracted financial penalties and this had distorted the focus of the trust. Dr Kelly noted that the work with the trust needed to ensure a more balanced approach to quality and performance. QC100317/058

It was noted that Chair recruitment was still taking place. QC100317/059

Gill Edelman asked about communication with the public. It was noted that there had been a dialogue with Healthwatch on the key issues but there was a responsibility on the part of SECAmb to communicate directly with the public and provide re-assurance. Work on this was still ongoing. QC100317/060

Surrey Performance drops had been worse than those in Kent and Sussex partly due to rurality but also vacancy rates associated with cost of living, and operational arrangements. Concern was expressed that performance could not improve unless the workforce issues were addressed. This related to historical issues with paramedic training and reinforced the view that performance improvement would take several years. QC100317/061

Jacky Oliver asked about 999 skill mix. This was a factor – the target had been about getting a presence and not necessarily the right professional to the patient. QC100317/062

Steve Hams noted that improvements in the local system e.g. urgent care could support the trust with issues such as handover delays. SECAmb were themselves prioritising "hotspots" for practical reasons. However it was also noted that risk averse behaviours were impacting on call cycle times, e.g. crews were not leaving an incident unless they had sign off from a GP or other clinician that it was safe to do so. QC100317/063

Handover delays were covered and it was noted these were increasing across the patch. There was however concern about the interdependence between ambulance handover delays and trust A&E targets, and the incentives and penalties for both. There were often highly operational issues involved such as the physical availability of trollies. This was the subject of a number of pieces of work involving ECIS (Emergency Care Intervention Service) and reviews of procedures. QC100317/064

It was highlighted that associate commissioners had a strong role in feeding back concerns, attending commissioners meetings, escalating risks and concerns, and engaging with local A&E Delivery Boards to minimise handover delays. QC100317/065

Dr Fuller emphasised the need to bring quality committees together to take a Surrey Heartlands wide approach. It was agreed that this should be taken forward by quality leads. QC100317/066

**Action Eileen Clark**

Gill Edelman highlighted the need for engagement with the public on what they can do to help and it was acknowledged this was important and fitted with wider urgent care work, including choice and personalised care. There was a need for better communications. QC100317/067

It was noted that the re-inspection in May by the CQC would in fact be effectively a fresh inspection. Dr Kelly asked that patient safety collaboratives and Academic Health Science Networks to be invited to feedback as well as commissioners. QC100317/068

Next steps were as follows: QC100317/069

- Improving reporting and assurance:
  - On-going updates to Quality Surveillance Groups
  - AO and collaborative Briefing papers
  - AO Commissioner Forum
- SPG and SOG attendance
- URP and specific measurable action monitoring
- Development of the 2017-19 schedule 4 (Financial review) in line with quality improvement methodologies and clinical outcomes
- Financial Review provider procurement underway (PID).
- Re-procurement of NHS 111 contract currently underway
- Tail end review working group
- Escalation to NHSE/NHSI of on-going concerns
- Follow up Risk Summit for Medicines Management

Dr Kelly thanked the team for attending. It was felt that it would be useful to see what lessons commissioners could learn from being engaged with this process over the last two years. This could be done jointly with regulators to see how they could mutually provide better outcomes for patients. QC100317/070

## 5. Governance, Planning and Engagement

QC100317/071

### 5.1 Right Care Update

There had been no significant developments since the last meeting. The CCG continued to use the Right Care packs to inform its transformation of specific care pathways.

QC100317/072

### 5.2 Patient and Public Engagement

QC100317/073

This had not been progressed as the planned meeting had not happened. The situation was complex in that this was not a revision but largely a new strategy. It was also complicated by the STP and the potential for an STP wide engagement strategy.

A draft strategy was being written for presentation at the next Governing Body. This was not felt to be appropriate as it did not give time for the Quality Committee to have any input. It was requested that the draft should be circulated for discussion and go to the May Governing Body.

QC100317/074

**Action Eileen Clark to discuss with Suzi Shettle**

### 5.3 Annual Reporting issues

The template for the annual report issued by the Department of Health was NOTED. This set out the CCG's statutory duties in respect of quality and how it was expected to account for them in its narrative report.

## 6. Other Matters

### 6.1 Any other urgent business

Jackie Moody noted that a Serious Incident report would come to the next meeting.

### 6.2 Items to highlight to the Governing Body

It was agreed to highlight the following:

- Contract performance
- SECAmb
- Stroke

### 6.3 Date of next meeting

This was noted. It was also noted that this was the last meeting for Steve Hams and Dr Powell, both of whom were leaving. On behalf of the committee they were both thanked for their significant contribution to the organisation and to developing the quality agenda.

QC100317/075