NHS
Surrey Downs
Clinical Commissioning Group

**Clinical Governance, Clinical Quality and patient Safety Committee Minutes**

**DATE: 23rd April 2013 TIME: 09.00 – 12.00 VENUE: Crick & Watson, Pascal Place**

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| Karen Parsons (KP) | √ | Eileen Clark (EC) | A | Denise Crone (DC) | √ |
| Liz Clark (LC) | √ | Helen Blunden (HB) | √ | Suzanne Moore (SM) | √ |
| Mark Hamilton (MH) | A | Philip Gavins (PG) | A | | |

**In Attendance: Justin Dix – minutes (JD); Georgette Welch – PALS (GW)**

| Item | Actions | Action owner | |
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| **1.** | **Welcome and introductions**<br><br>EC welcomed everyone to the meeting. She apologised for the lateness of the papers; this was due to the start-up arrangements for the CCG. Proper administrative arrangements were being put in place for future meetings. | | |
| **2.** | **Declarations**<br><br>No outside interests were noted additional to the register, which had been bought up to date for the next Governing Body meeting on the 26th April. | | |

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| **3.** | **Minutes of the last meeting and matters arising**<br><br>Matters of Accuracy –<br><br>P3 Serious incidents – LC stated that she was not concerned about acute hospitals; in fact her concerns were about reporting in primary care.<br><br>P4 Information sharing within GP practices – LC said her concern was that information needed to be shared within the CCG not just within practices. SM said this was beginning to happen e.g. around referral rates. DC asked how this worked and SM said it was at practice level although the former Surrey PCT had had a procedure for significant events. At practice level there were logs for serious incidents.<br><br>Otherwise the minutes were agreed as an accurate record<br><br>**Matters arising -**<br><br>It was noted that the handover to NHS England and the Area Team meant that it was not yet clear how information would be shared going forward. KP said that there were discussions taking place with the primary care team within the Area Team to look at this. SM noted that part of the discussion would be about the switchover from QOFF to looking at quality markers.<br><br>It was agreed that a meeting would be arranged with Shelley Eugene in the Area Team to look at Quality Markers in the Primary Care Contract, and that the CCG could help to facilitate this.<br><br>SM said that there was a need to create a culture of improvement around significant events and system failures in primary care. Sharing significant events would be one way forward, drawing out key themes to see where the common concerns were.<br><br>DC said that patients would expect primary care to be the same as other areas of the NHS in terms of learning and improvement. SM noted there would be a range of views in primary care.<br><br>KP noted the future role of the CQC and the need to pre-empt this. Creating collaborative arrangements between practices could be part of the approach, aligned to the overall scheme of governance. She proposed that the governing body seminar in June should focus on this issue.<br><br>It was noted that the government's response to Francis would probably mean more scrutiny of primary care and this was another reason for looking ahead on this issue. GPs nationally were concerned about the pressure on them and their capacity to respond. There would be a need to support practices with evidence based prioritisation.<br><br>Actions from last meeting – | **KP**<br><br>**KP** | |

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| | Review of terms of reference for the Clinical Quality, Clinical Governance and Safety Committee – it was agreed that his should wait until the next meeting when the additional lay member would be present and then terms of reference signed off by September. | **EC** | |
| | Adult safeguarding workshop – HB reported that this was scheduled for 8th May in the morning, facilitated by Chris Maclean, Head of Adult Safeguarding at Surrey County Council. This workshop would be for all CCGs and it was expected to have about 25 people present. A venue was still being identified. HB talked to the agenda for this. It included Domestic Homicide, Serious Case Reviews, Domestic Homicide, Scenario reviews, Training plan, and "Prevent" (a scheme relating to anti terrorism and radicalisation of individuals for which there were two trained trainers in Surrey). | | |
| | Networks – There is a workshop on 1st May organised by the Area Team which KP, EC,SM and DC were attending on behalf of the CCG. This will cover clinical senates across Surrey and Sussex, and would be a good opportunity to shape the future. The morning session will be on information and the afternoon will be exploring configuration and how it will work in practice. It was clarified this was about the bigger formal networks such as Mental health (including dementia), End of Life Care, Urgent Care and Children's and Families rather than the local networks. They would be co-ordinated by NHS England and be supportive rather than directive in approach. Attendees would feed back to next meeting. | **EC/SM** | |
| | Clinical Audit Plan - EC had met with MH for a discussion about how to progress this. The plan will be prioritised against agreed areas. Discharge procedures / summaries at Epsom would be one area of focus, working with Sutton as lead CCG and integrating with other local CCGs. SM said this was a good area to focus on and would link to the out of hospital strategy and work on virtual wards. Visits on day of discharge were felt to be crucial. To come back to next meeting. | **EC** | |
| | LC noted that prescribing audits were also being co-ordinated, she would give details of these to EC for inclusion in the plan. | | |
| | Locality liaison – EC has been going around the localities and developing the relationship, looking at issues such as Francis. This was a developing dialogue. | | |
| | Summary of minutes from meetings with providers – a summary of key points would be provided for each meeting by EC. | **EC** | |
| | EC reported that there had been a recent SABP meeting arranged but it had not been possible to attend due to short notice and clashes with other meetings. This had been discussed with NEH&F CCG to ensure better arrangements in future. | | |

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| | Continuing Health Care Team input into this meeting – it was agreed the CHC team should attend routinely due to the number of quality issues relating to CHC.<br><br>KP noted that SASH had recently changed their policy on where CHC assessments were done and this meant patients would be discharged to an interim environment to await assessment. This was a quality issue which had not been fully thought through and needed to be picked up with the host CCG (East Surrey).<br><br>National Staff Survey – CSH have provided details of their own survey. Other providers surveys, particularly that of Epsom and St Helier had revealed that issues arising were around culture, appraisal and training in infection control. SM said that there needed to be a clear correlation between some of these clinical issues and issues in the staff survey and we needed to ensure that the provider was using the information and making the connections. It was noted that significant issues might need to be escalated to contract meetings or to the Executive Committee. This could also be part of the suite of Information for the governing body.<br><br>EC will summarise key points and circulate.<br><br>Diabetes –Mark Needham has picked up this work. The Diabetes Local Implementation Team was understood to be still running. The main issues were around follow up rates and the capacity of primary care to respond. It was noted that this work did not always fit with the work of the Diabetes network and there was a disconnect. KP said that the commissioning strategy for the CCG needed to make it clear what networks were needed and whether they were provider specific or wider. At the moment the CCG has not identified a diabetes lead and needed to feed this into a wider discussion about where the CCG wanted to put its capacity and how it wanted networks to be configured. There would be a clinical strategy paper going to the governing body that covered these issues.<br><br>LC said there was a diabetic specialist within the medicines management team and she would pass details to Mark Needham<br><br>Other items covered under matters arising were either covered above or on the agenda. | **EC**<br><br>**EC**<br><br>**LC** | |

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| **4.** | **Complaints and PALS**<br><br>GW attended for this item. Reporting in both areas was being developed. There had been six PALS enquiries and four complaints in the first few weeks. Some of these had fallen out of NHS Surrey as part of transition as they had passed work over to CCGs in the last month.<br><br>The service had not been advertised yet but this would now start with details on the web site and a dedicated page. KP said this needed to happen over the next three weeks.<br><br>Issues to date included:<br>• IVF eligibility<br>• Domestic abuse and GP engagement (this could be used as an example for discussion at the governing body as it involved mental health, social care and safeguarding and issues of confidentiality between patients and carers and the wider family). DC expressed concern about handling this carefully from a confidentiality perspective. This could be discussed as part of the quality seminar in June with breakout sessions to look at the case.<br>• Dental registration<br>• Dental charges. DC asked if these were followed up. KP said that this would be done by the Area Team who would visit the dentist. It was agreed that there should be a FAQs section on the website to cover regular questions from the public. NHS Surrey had had a good system for this and we needed to continue to support the public going forward.<br>• Treatment at Surrey and Borders and referral for crisis helplines. EC noted there had been some Surrey wide concerns about crisis support and relationship to suicide rates, and this was being fed back through the contracting route. There had been an incident recently with the computer based system going down. SM said the care pathway and the relationship between primary care and mental health were also key as well as timely access. She was concerned about IAPT and it was noted this was on the governing body agenda.<br>• Individual Funding Requests.<br><br>Complaints.<br><br>The following complaints had been received.<br><br>• Lost referral for surgery for ingrowing toenail. Still being reviewed.<br>• Surrey and Borders – complaint about poor treatment by both community and in-patient services. Detailed case involving other providers as well which does not seem to be | **GW** | |

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| | progressing and the Ombudsman has had some involvement. This complaint had been sent to the CCG by the local MP who has since been communicated with. CSH had given a good response. There had also been issues with Ashford St Peter's although it was not clear if it was their staff who were at issue. DC noted that people could get stuck in the complaints system and this could be very frustrating for them. We needed to ensure the issues about the specific ward in question were acted on. It was agreed that HB and EC would review the case. SM asked about consent to discuss with other parties – GW said that a consent form was given to individuals to complete and sign.<br>• Primary care issue – referred to the Area Team but followed up for clarity to ensure the case is understood.<br>• IFR issue – resolved same day by the IFR team although raises communication concerns which will be discussed with the team and fed back to complainant.<br><br>KP asked how we would deal with a specific regular complainant who had been communicating with the PCT for several years. It was unclear if this had been genuinely concluded. KP asked that it figure in the reporting.<br><br>It was noted that this information was very useful feedback and had to be captured systematically via a database. KP also said that CHC complaints would be incorporated into the main CCG team as currently they were handled separately within CHC. It was confirmed it would still be dealt with discretely so as not to impact on main complaints and PALS. | **HB/EC**<br><br>**GW** | |
| **5.** | **Authorisation rectification Plan**<br><br>EC said that admin support was needed to progress this as there were formatting issues. This was being worked through with the corporate office.<br><br>Specific items:<br><br>Appointment of Quality and Safety Manager – now appointed - change to Green.<br><br>Guidance for public – ongoing, may turn to red due to deadlines. In future it will be done properly via the web site and also other routes as not everyone used the web.<br><br>DC said that she was concerned about the overlap between different agencies asking for feedback of the same groups and individuals. SM said there may be a way of co-ordinating this through primary care, particularly for people who did not use electronic methods. KP said that the key issue was the web site design and expected the CSU to support the Communications team to get this right. Going forward there were options of working with the local authority who had a number of ways of accessing | | |

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| | information from users in a more co-ordinated way. However it was noted that the rectification plan was not the same as the long term development of an integrated quality plan which was something for longer term consideration.<br><br>Case studies – These were in progress. To come back to next meeting to review before going to Area Team.<br><br>Process mapping – This was underway, due end of May. Move to Amber.<br><br>Anonymised examples. The examples in the PALS / complaints discussion were felt to be useful to address this section. These need to be specified and split into (a) Practice Participation Group feedback and (b) complaints, PALS and other sources.<br><br>SM said that there were developmental needs for Patient Participation Groups which would have to be put in place to ensure greater consistency. This needed to form part of the longer term plan. KP asked if DC and Cliff Bush could meet with herself and CF to undertake a more systematic mapping of this. It was agreed to pick up outside the meeting.<br><br>It was felt important to include reporting on developments with the NHS III service in the rectification plan.<br><br>Action Points from Quality Surveillance Group. EC reported that a number of issues were coming through this route but the information was often sensitive. KP said that the minutes should come to this meeting along with others that needed mapping in.<br><br>Quarterly Patient Story – as above, for June Seminar<br><br>Accountability and revised structure chart – now Green<br><br>Governing Body Lay Nurse Member – Advert is now out although Maggie Ioannou is covering on an interim basis. Change completion date to May.<br><br>Committee membership – LC now here but add Continuing Health Care due to the hosting arrangements.<br><br>Reporting of incidents and Serious Incidents Requiring Investigation by providers – this was felt to be on target. The new Patient Safety Assurance Review Group was meeting on a Surrey wide basis. KP said that this was another area that demonstrated that a clear quality structure was needed for the CCG and proposed that she and EC met to progress this.<br><br>Incidents and Trends – these could now be marked as green<br><br>Working with Area Team – this could now be marked as green<br><br>Case Studies – These had already been discussed as above | **EC**<br><br>**KP/DC**<br><br>**EC**<br><br>**KP/EC** | |

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| | Clinical Quality and Safety Report – It was felt this should remain amber until the Governing Body had approved the format for the report.<br><br>Minutes of this committee being available – This remained green System in place for provider adverse quality trends – This could now be marked as green<br><br>Management of SIRIS signed off by governing body – should be green after Friday<br><br>3 SIRI Case Studies – This was working quite well locally. EC was developing a system for who does what between herself, Jackie Moody and the new quality manager, and would set out how provider visits are followed.<br><br>Patient Safety assurance review group – green<br><br>Evidence that lessons learned are being shared on a wider basis – this was now green, but links with London around Epsom will be strengthened.<br><br>Partnership working with Area team – as above. | | |
| **6.** | **Clinical Quality and Patient Safety Report**<br><br>EC stated that we need to get information flows right to support production of this report, and agree the format of reporting to the Governing Body. KP offered to discuss this with EC.<br><br>SM noted that there had also been a request for more detailed review of a specific topic. KP highlighted infection control as an example of how this could be used to illustrate in depth issues that were covered in the baseline document. From today's discussion, others could include discharge processes, clinical audit, and safeguarding.<br><br>KP noted that there had been press interest in the high number of conditions around quality attached to the CCG's authorisation and this would influence how we developed our reporting to give the public assurance that we had safe systems in place. However we also needed to be aware that this is about rising to the challenge of a previously complacent system and changes could only be made over time.<br><br>EC also noted the work that had been done on safeguarding in primary care – this was positive story and could be included in the report.<br><br>KP said that for Friday's Governing Body we should take the report and the information on progress that had been discussed at today's committee and ask what the governing body wants in future. A short report could be written using the new template to illustrate the actions that have been taken. | **KP/EC** | |

HB noted an omission at the bottom of page 5 where there was a missing word – it should read should read mandatory GUIDANCE.

*Safeguarding*

HB reported on safeguarding training. All practices needed an adult lead and training for staff. All CCGs needed training as well - this meant something like 150 people.

There were three levels of training - These were: Level 1 – Awareness. Level 2 – people in 1:1 contact i.e. GPs, nurses. Level 3 – for people in co-ordinating report writing and training roles.

The main room at Pascall Place had been booked fortnightly to do this training through to the end of March 2014 in a Level 1 / 1 / 2 weekly cycle. This should encompass the large numbers needed and satisfy the CQC that we have a plan. This approach will avoid the need to shut practices as staff can come over the course of the year as individuals or in small groups. DC asked about online training. HB said that we needed more assurance than could be provided through this route due to the need to ensure people are aware of learning. SM said a lot of practice staff benefited from an interactive approach. Once the backlog was cleared there could be a process over time for refresher training.

*Other issues*

EC said that as we were seeing more data it was easier to identify where the problems were and what the issues were with providers. DC noted that Central Surrey Health were taking part in patient led assessments of care environment. 50% of teams had to be patients. Local patient reps were going on these visits. This felt like a positive joint approach.

DC asked about infection control at Epsom and how this was being addressed. SM said that the chair of the internal committee at ESH had emphasised the need to look at the issues in detail e.g. use of side rooms and hand washing. They had done a comprehensive review of laundry arrangements which had checked out as positive. This would be a learning approach for the CCG to engage with this.
KP noted the need for public health leads to be engaged in quality work.

LC noted that she used to report on INR for enhanced services – there was still a need to look at this. It was not something the team could do at this stage.

*Serious Incidents Requiring Investigation (SIRIs)*

EC took the group through the terms of reference of the PSARG. All CCGs except NW, which had yet to take the terms of reference to their governing body, had agreed to delegate to this group. The

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| | first meeting of the group had been held last week and all CSUs had attended. There was now a process in place for for notifying EC of never events immediately they happened. These processes seem to be working. Performance seems to be quite good with local providers but detailed information will be provided to give assurance on this.<br><br>CSH currently have two cases open. EC asked about Serious Case Reviews and whether you had to stop the clock. Guidelines on stopping the clock seem to have changed. It was agreed that this should be for discussion at the next meeting. Part of the issue was that coroners cases can take a long time to conclude, which was a particular issue for mental health. It was noted that Surrey's new coroner was taking a more detailed approach and this meant longer timescales.<br><br>It was noted that CSH had no overdue incidents and reported on incidents in detail at their own review meetings. With regards to Epsom St Helier, information was coming through. Two new Sis (pressure ulcers) had been reported; there were no overdue incidents and no never events. The trust had five open cases.<br><br>One area of concern was Cobham Day Surgery and a case relating to anaesthetic gases. No patient harm was involved and the provider have conducted an investigation, EC has gone through the case and how it was dealt with the provider. There had been some delays in the issue getting picked up and reported through STEIS by the CSU.<br>It was clarified that CHC cases would come to this meeting. We need to make sure they are communicated surrey wide as with the safeguarding ones.<br><br>The terms of reference will go to governing body as part of EC's report. | | |
| **7.** | **111**<br><br>EC reported on the difficulties following the launch of this service. East Surrey are lead commissioner. IT and staffing issues had led to a number of performance problems and concerns about patient safety. Backup plans did not work out and had impacted on delivery.<br><br>The CCG has worked closely with area team and has been doing daily sitreps. CB had raised concerns about Serious Incidents – in fact there were none in Surrey – but reporting was not giving an accurate picture of complaints. Peter Stott had met the CCG collaborative last week and reported that technical issues had been resolved and there was a plan for staffing improvements. A rectification plan was now in place. A lot of complaints had been reported by Peter Stott. There was some concern from the Area Team who feel that the plan is over ambitious. As yet the CCG had not received a copy of this. Despite the concerns Surrey is better than other parts of the country. Weekends are problematic | | |

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| | particularly Sunday although the last weekend had been better. It was noted that the service was not being promoted actively during the soft launch to avoid putting it under too much pressure.<br><br>It was noted that there had been complaints locally and it has been agreed this should in fact be an SI.<br><br>There had been issues with practice phones – SM said this was partly due to the delays in going live and the uncertainty involved - was that it was not clear until the last minute whether service was going live. This was beginning to work well now.<br><br>It was noted that one performance area was that the service was supposed to answer phones within 60 seconds – statistics for this have showed that compliance has dipped as low as 27%.<br><br>It was agreed that this needed a discussion at the governing body. There would be a paper for Steve Loveless to report on on Friday.<br><br>Practice comms – all practices have the information they need on 111, plus there is a feedback form on the SECAMB system for people to give feedback. | | |
| **8.** | **Future meetings**<br><br>It was agreed to keep monthly for time being. MH can't do Tuesdays. JD and EC will review corporate calendar and look at bespoke dates.<br><br>Need to invite Robin Gupta to this meeting.<br><br>Next meet 28th May – needs to be re-arranged as half term. | **JD/EC**<br><br>**EC**<br><br>**JD** | |
| **9.** | **Any Other Business**<br><br>There was no other business | | |

**Quality Committtee Actions**

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| 1. | Arrange meeting with Shelley Eugene to look at Quality Makers in the Primary Care Contract | KP |
| 2. | June seminar to focus on collabrative arrangements for quality | KP |
| 3. | Terms of reference to be brought back to meeting and signed off by September | EC |
| 4. | Feedback on networks workshop on 1st May | EC/SM |
| 5. | Clinical Audit Plan on next agenda | EC |
| 6. | Prescribing audit data included in clinical audit plan | LC |

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| 7. | Summary of meeting with providers to come to the committee | EC |
| 8. | Ensure CHC team attendance at Committee meeting | EC |
| 9. | CHC staff survey to be summarised for committee members | EC |
| 10. | LC to give details of diabetic specialist Mark Needham | LC |
| 11. | Ensure PALS and Complaints services properly highlighted | GW |
| 12. | Review specific Surrey and Borders complaint | EC/HB |
| 13. | Include long running complaints from PALS/Complaints team | GW |
| 14. | Rectification plan: Case studies to come back to next meeting | EC |
| 15. | Systematic mapping of paitent engagement | KP/DC |
| 16. | Include reporitng on III in rectification plan | EC |
| 17. | Develop a quality structure for the CCG | KP/EC |
| 18. | Develop clinical quality and patient safety report format and information flows | KP/EC |
| 19. | Re-arragne dates for future meetings | EC/JD |
| 20. | Re-arrange 28th May meeting | EC/JD |

Next meeting: Date to be confirmed