NHS
Kernow
Clinical Commissioning Group

GB2021/074

Meeting of the governing body
Summary sheet

Date of meeting: 1 December 2020
For: Public session (Part 1)
For: Information

Agenda item: Quality committee chair's report

Author(s): Lydia Harris, Nikki Thomas, Paul Cook
Presented by: Natalie Jones, chief nursing officer
Lead director/GP from CCG: Natalie Jones / Paul Cook
Clinical lead: Natalie Jones

Executive summary

The quality committee met on 24 November 2020 and the ratified minutes from the last meeting held on 29 September 2020 are attached below.

This report escalates information that the membership feel the Governing Body should be informed on prior to the minutes review.

- Learning from deaths review (LeDeR) – An independent review into Thomas Oliver McGowan's LeDeR process was instigated following grave concerns over the findings of an initial LeDeR review following his death. CCGs have been tasked with considering the recommendations from the report, which highlights local and national issues regarding the governance, quality and learning within the LeDeR process. The final recommendation in the report states, "Each CCG must formally undertake and document and review its own systems and processes against the learnings and recommendations arising from Oliver's re-review."

  NHS Kernow is asked to support the recommendations arising, to include:

  - All those who are new to the role of lead reviewer or local area contact (LAC), must be allocated a 'buddy' who is experienced in the LeDeR process.
  - Dedicated time and administrative support must be given to reviewers and LACs to undertake complex LeDeRs.
  - There must be a transparent process for LeDeR in each locality, with robust governance and appropriate resources to ensure that each review is properly monitored in terms of procedure and outcomes.

- Each CCG must identify an executive lead to be responsible for the LeDeR programme and for ensuring that the board has full sight of progress.
- The CCG executive lead for LeDeR will ensure that LeDeRs are completed in a timely and correct manner and will intervene where problems are escalated, such as the inability to obtain critical information from the relevant agencies.
- There should be an assurance process with regard to providing regular, appropriately documented supervision for individual LeDeR reviewers.
- Appropriate support should be available to reviewers, along with strong governance, to ensure that all LeDeR recommendations are robust and actioned in a timely manner, and that lessons learnt are shared nationally.
- Each CCG must formally undertake and document and review its own systems and processes against the learnings and recommendations arising from Oliver's re-review.

NHSE/I has requested an improved trajectory, and it is confirmed we are heading in the right direction. The quality committee will review this again in January 2021.

- Impact of vacancy of designated doctor for child safeguarding – clinical commissioning groups should employ, or have in place, a contractual agreement to secure the expertise of designated practitioners; such as dedicated designated doctors and nurses for safeguarding children and dedicated designated doctors and nurses for looked-after children (and designated doctor or paediatrician for unexpected deaths in childhood). The recruitment for this post is via RCHT and has now been vacant since March 2019.

  In the absence of a designated doctor for child safeguarding, a number of issues for the named GP for child safeguarding, the designated nurse for looked after children (LAC) (who is covering the safeguarding vacancy), and other health practitioners across the health economy have arisen, and presented to the quality committee.

  This is recorded on the organisation's risk register, ID: 10736 and 10751.

- Peer Improvement Tips for Care and Health (PITCH) – PITCH was developed 12 months ago to provide general practice with a central reporting system where they can raise concerns, share learning and highlight excellence. Quality Committee have asked the quality team to review the current use of PITCH to ensure continued commissioner focus.

NHS
Kernow
Clinical Commissioning Group

Recommendations and specific action the quality committee needs to take at the meeting

The committee is asked to:

1. Receive the report and request further information, where necessary.

Additional required information

Cross reference to strategic objectives
☒ Improve health and wellbeing and reduce inequalities
☒ Provide safe, high quality, timely and compassionate care
☐ Work efficiently so health and care funding give maximum benefits
☐ Make Cornwall and the Isles of Scilly a great place to work
☐ Create the underpinning infrastructure and capabilities critical to delivery

Evidence in support of arguments: Update to Governing Body.

Engagement and involvement: Finance and Performance Committee, Workforce Committee.

Communication and/or consultation requirements: Update to Governing Body.

Financial implications: As noted.

Review arrangements: Forms part of the in-depth monthly review of quality information.

Risk management: Corporate risks are discussed at each meeting.

National policy/ legislation: Covers constitutional, national and locally determined quality and performance metrics.

Public health implications: Consideration given to public health implications, particularly with respect to inequalities.

Equality and diversity: Equality and diversity is considered through all of NHS Kernow's work.

Climate change implications: Meetings are now being held virtually, papers are no longer printed and travel no longer required.

Other external assessment: A considerable amount of the information is nationally submitted and informs discussions with regulators.

Relevant conflicts of interest: None known other than those recorded within the declaration of interest register.

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FOI consideration – exemption*: None - item may be published

Qualified/absolute*: None - item may be published

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NHS
Kernow
Clinical Commissioning Group

Minutes of the Quality Committee meeting (part 1)

Tuesday 29 September 2020
9.30am to 12.30pm
Microsoft Teams

Attendees

- Dr Paul Cook (PC), chair and Governing Body GP, NHS Kernow
- Dr Katja Adie (KA), stroke and eldercare consultant, Royal Cornwall Hospitals Trust
- Liz Cahill (LC), head of commissioning for maternity, children and young people, NHS Kernow
- Tim Francis (TF), head of adult mental health and learning disabilities, NHS Kernow
- Lydia Harris (LH), minute secretary and quality business and governance manager, NHS Kernow
- Jessica James (JJ), head of corporate governance, NHS Kernow
- Lisa Johnson (LJ), nurse consultant director of infection prevention and control, NHS Kernow
- Natalie Jones (NJ), chief nursing officer, NHS Kernow
- Lorraine Long (LL), programme manager for long term conditions, NHS Kernow
- Georgina Praed (GP), head of prescribing and medicines optimisation, NHS Kernow
- Nikki Thomas (NT), deputy director of nursing and quality, NHS Kernow

Apologies

- Helen Charlesworth-May (HCM), accountable officer, NHS Kernow and director adult social care, Cornwall Council
- Melissa Mead (MM), Governing Body lay member, NHS Kernow
- Dr Rob White (RW), Governing Body GP, NHS Kernow

Minutes from the meeting

Item number	Minutes
QC2020/44	**Introductions and apologies**
	PC chaired today's committee and welcomed all to the meeting. Apologies noted as above.
QC2020/45	**Conflicts of interest**
	No new conflicts were declared. PC referred to the agenda items around flu planning and mental health for awareness, as this has links to his role.
QC2020/46	**Approve the minutes of the quality committee meeting held**

Item number	Minutes
	on 28 July 2020
	The minutes of the quality committee meeting held on Tuesday 28 July 2020 were approved.
QC2020/47	**Update action tracker**
	The action grid from the meeting held on Tuesday 28 July 2020 was updated, and is distributed with these minutes.
QC2020/48	**Risk register** discussed by Jessica James
	JJ informed the group that most teams' business as usual has begun to return to normal following Covid, although this may change as we head into a new surge. On the whole, all teams are continuing to regularly check and update their risks and add new ones. Appendix 2 reports the 10 corporate red risks owned by the quality committee. Some new red risks are included as a consequence of Covid, namely: • Delays to in-hospital treatment (10775) • Diagnostics (10777) • Community based services (10778) JJ discussed the risk relating to 52 week waits and RTT; this currently sits under finance and performance and may come across to quality committee as there are quality impacts. The group discussed the future of risk reporting and whether risks belong to finance and performance or quality committee. A suggestion is to add a further appendix that offers oversight of other committee risks that may impact on quality. This will be introduced to the next committee report. Appendix 3 reports the five high amber risks owned by the quality committee. Not much change from previous to report other than an increase from a score of 8 to 12 to the children and young people (CYP) crisis risk (4916). Appendix 4 reports one draft risk linked to quality team capacity. Appendix 5 reports two risks flagged for closure: • Liberty Protection Safeguards (10748) • GPs with Extended Roles (10684) The committee agreed to the closure of both risks. PC asked about cancer and 104 days. JJ said there is a separate

Item number	Minutes
	risk around cancer waits which likely sits with finance and performance. This will be reviewed at their committee meeting this afternoon. Patient safety incidents received re: cancer are discussed/ shared with both public health and cancer alliance for shared learning. JJ said UHP's cancer risk is scored as a red, whilst RCHT's is amber. Lorraine Long is due to present a cancer update later in this meeting and the committee will ask for an update. JJ referred to the SWAST call stacking risk (10680). SWAST has increased their risk back up to 25. Devon has not maintained the agreement to follow SWAST's scoring. The committee asked if there is a need to accept one risk for the south west, this had been agreed by all CCGs at a previous single item quality surveillance group. PC asked if we have any control over the risk level and mitigations. The risk level is set by SWAST; we do agree/hold SWAST to account for mitigation actions. NT suggested we ask Julie Green/Samantha Jacobs for an update at the next meeting in November. This has been raised in the directors' briefing, and will also be flagged in the chair's report. JJ referred to other risks to be aware of with actions in place: • Community based access to treatment (10778) has a small number of actions in place to manage this; no actions are completed. • NT has not received an update re: neurosurgery at UHP. • NT is satisfied with the mitigations and actions against the long waits risk. • The designated doctor for children post remains vacant and an update will be brought to November's meeting around the potential impact on children of this post not being filled. NJ commented that the responsibility for filling this post sits with the CCG.
Action	1. SWAST call stacking risk to be added to the chair's report. 2. SWAST update to be brought to the next committee meeting in November. 3. The vacant designated doctor for children post and its impact on children to be reviewed at the next committee meeting in November.
QC2020/49	**Flu planning** discussed by Lisa Johnson
	LJ brought the flu plan 2020/21 to the committee today. NJ said this will be going to the urgent flu board in October.

Item number	Minutes
	NJ said there has been a lot of noise in the system about there not being enough vaccines. LJ said the primary care orders were put in last year with further ordering now closed. The national order is received. GP surgeries do not have baseline figures, e.g. the number of healthcare workers, shielded cohorts, etc. A risk to the system is that we do not know these numbers and may not have enough vaccines. The biggest challenge seen has been the drip feed of information and mitigating against low stocks. As the season moves on we can facilitate reallocation of stores in the system. LJ is trying to target pockets of misunderstanding across the patch, and has reported to the primary care committee. PC asked if there was a crib sheet about flu jab criteria that could be used by his receptionists to advise patients who call in with queries. LJ is working with the communications team and can pull this together. NJ also suggested sending this out via the GP bulletin. NJ said a Covid vaccine is not available at the moment. It is anticipated that once available there will be six or so different ones, for different groups. PC asked how RCHT and CFT will vaccinate their staff appropriately and LJ referred to drive through opportunities. Care home providers are struggling – many use pharmacies, and stocks are declining. Onsite pop up clinics will be allowed (not previously allowed). LJ said this has certainly been a challenging flu season, and PC thanked LJ for all her hard work.
Action	1. LJ to create a crib sheet for GP surgery receptionists.
QC2020/50	**Safeguarding update** discussed by Nikki Thomas
	NT gave the current safeguarding position. • The vacancy for the adult safeguarding lead was advertised for a second time and again no-one shortlisted. NT will go back to the drawing board and consider what to do differently. • The vacancy for the designated nurse for safeguarding children has been shortlisted with interviews to be held on Thursday. • The first safeguarding assurance meeting (SAM) took place on 1 September and this will provide assurance that NHS Kernow has a robust and rigorous safeguarding monitoring function to meet its statutory responsibilities. • The quality and safeguarding team are working closely with the

Item number	Minutes
	director of planned and integrated care to establish a robust system around domestic homicide reviews (DHR), to ensure reporting deadlines are met and recommendations captured for CCG oversight. • NJ informed the group of three child deaths in the last two weeks; there is an ongoing piece of work with the Our Safeguarding Children Partnership (OSCP).
QC2020/51	**Stroke mortality** discussed by Dr Katja Adie
	KA introduced herself and explained she has been in her stroke and eldercare role since 2008. KA presented a stroke mortality update today. It was noted that stroke mortality was rising in March this year and an investigation was carried out. This rise was also seen nationally. Three patient deaths were related to Covid. Nearly 50 per cent of patients died after discharge from the stroke unit; many had palliative plans and were expected to die in the community. Last autumn, Getting It Right First Time (GIRFT) asked for two audits around readmissions to identify trends. Nothing was noted other than slightly older patients; all patients were followed up. It was noted that a higher risk of people with stroke went on to have a fracture neck of femur (NOF) – this cohort were older and frailer, and already at a higher risk of falling. There is work ongoing to review patients' bone assessments on admission. PC asked in terms of improvement that could be made to outcomes and quality of life, and should we be focussing elsewhere. KA said we are looking at the national data collection (having the right scan, being looked after by the right therapist/doctor, etc.). One issue noted is around therapy and there is a business plan focussing on this. Stroke Association reported that patients are not getting enough therapy/ access to therapy, and patient feedback and complaints have been received to this end. A patient focussed group around this would be helpful. We do have a very white population and not enough BAME (black, Asian, and minority ethnic) involvement. The TIA (transient ischaemic attack) clinic returned to a face to face setting very early on and a lot of preventative work is seen around this outside of the hospital. The aim is to see patients within 24 hours of referral. This is not always possible mainly due to capacity, and this is a current focus. There is a monthly stroke governance meeting and stroke mortality meeting where data is heavily scrutinised. There is now a new manager in post, which should help to improve the service further.

Item number	Minutes
	PC thanked KA for her assurance and hard work leading stroke services.
QC2020/52	**Children's services** discussed by Liz Cahill
	LC took a paper to the health and adult social care overview and scrutiny committee around increasing access to children and young people's mental health support. Young people are very engaged and their voices are being heard, and we have received positive feedback. There is some challenge around understanding that this is a mental health based intervention, and around pathways and skill sets. It is agreed that there is a need for comms around referrals, and a cultural change about what is actually needed, not what is thought to be needed. LC said this message needs to be put across clearly. A Care Quality Commission (CQC) inspection showed a high percentage of people are being accepted into a service and receiving an initial appointment within 28 days. In June this year we started to see an improvement of satisfactory wait times. We are expecting more referrals during the Covid surge and there is capacity to manage the wait time. Wait times for treatment have improved also and a measure has been put in place to main this. The RTT over 18 weeks has gone down due to the work carried out, and this is a significant improvement. Positive feedback has been received around people being contacted whilst waiting to be seen and there is now a better system in place which has helped to reduce DNA (did not attend) rates. It is noted that cases are not closed if a DNA occurs, and there is an improved system for scrutiny and following up of DNAs.
QC2020/53	**Medicines management** discussed by Georgina Praed
	GP provided an update on the work that has been going on behind the scenes, particularly in response to the Covid pandemic. • Provision of EOL (end of life) symptom packs have been delivered and are held within each primary care network (PCN). • Nutritional advice has been prepared and provided to care homes and GPs to manage patients discharged with Covid. • Medicines information support around stock shortages in the

Item number	Minutes

	early stages of Covid when demand on stocks resulted in shortages. The medicines optimisation team used countywide networks and resources to provide timely and clear information for GP practices and pharmacies.
	• The four Medicines Optimisation in Care Home (MOCH) pharmacists have returned to their roles following redeployment.
	• A number of medicine safety issues have arisen to include the increased use of direct oral anticoagulants (DOACs).
	• In response to an overuse of Oromorph, Sevredol 10mg tablets are an alternative for immediate relief pain relief and can be easily reduced to 5mg.
	• The 2020/21 work plan is approved and the team are in the throes of communicating this to PCNs and practices.
	• A project initiated document (PID) has been drafted and key areas of focus include:
	  ○ National target to support the GP directed enhanced service (DES) around greener inhalers.
	  ○ Diabetes and self care.
	  ○ Patient safety elements to include the use of antibiotics.
	• The Cornwall and Isles of Scilly formulary has improvements with the old version containing obsolete information has been taken down.
	• A joint piece of work around antimicrobial resistance has taken place between NHS Kernow and RCHT, and this was presented at the Longitude Prize and received national recognition.
	• Quarterly meetings with GP leads continue to take place virtually. The next one is tomorrow around sepsis, penicillin allergy, and a microbiologist will be in attendance to discuss testing.

QC2020/54	**Mental health and learning disabilities** discussed by Tim Francis
	TF gave an update on what has been going on in the last six months and ongoing projects. Business as usual has continued as much as possible alongside deliverables against Covid, and recovery objectives are still in the response phase. Activity across the board has returned to normal across all service lines. There is more acuity of people becoming unwell. There were three out of area placements in August. We are committed to zero OOA placements and there were none this month. An expression of interest (EOI) co-produced with CFT resulted in a successful bit to host a First episode Rapid Early intervention for

Item number	Minutes
	Eating Disorders (FREED) champion role in the eating disorders service for the 16 to 25 age group. An EOI has also been put together by NHS Kernow, CFT and the Cornwall voluntary sector forum to become a trailblazer site for peer support worker education. This requires formal NHS Kernow approval. A bid for transformation funding to support the development of an all-age pathway for suicide bereavement support in Cornwall and the Isles of Scilly has been successful. The Dementia Partnership Board has agreed objectives for the next 12 months consisting of 13 priorities. The July diagnosis rate for Cornwall and Isles of Scilly remains static at 54.8 per cent, although the overall number of people diagnosed increased this month and this fits the current national picture. Physical health checks in severe mental illness (PHSMI) Q1 performance has dropped reflecting a national trend. Stuart Cohen, dementia programme manager, is leading a project with St Austell Healthcare. Two successful discharges from out of area hospitals have taken place under the Transforming Care Programme (TCP) in the last two months. Further discharges are planned across Q3 and Q4 to bring us in line with our planned end of year position. A local area coordinator has been appointed who will lead the LeDeR programme. TF will bring a LeDeR update to the November committee. We are an outlier currently by a margin, and learning is being driven. The five year strategic framework for mental health is almost complete. This will take all strategic objectives locally and match against the long term plan, and describes what to look at in terms of impact. TF gave an update on the Regulation 28 report to prevent future deaths. A positive discussion was had recently with the interim coroner, around the dual diagnosis strategy. The interim coroner is very engaged and is keen to be kept up to date. TF has agreed to invite him to the dual diagnosis implementation group, and he will provide quarterly updates on progress. NT asked if we could use EIA (equality impact assessment) phase 3 recovery plan to benefit the dual diagnosis work.

Item number	Minutes
Action	1. TF to bring a LeDeR update to the next committee meeting in November.
QC2020/55	**Cancer and diabetes** discussed by Lorraine Long
	Diabetes: LN gave an update on the national diabetes prevention programme. Diabetes is a co-morbidity in terms of Covid risks, and there is a need to reduce type 2 diabetes. Improvements are required in terms of uptake to the programme this year and the team are engaging with practice nurses through 'lunch and learns' etc. Dr John Garman featured on Radio Cornwall to publicise the benefits of the programme and the self-referral 'know your risk' tool. Data shows that the average weight loss in Cornwall for those that have joined the programme is five kilos. There is an opportunity for a bid for funding, and the outcome is expected mid-October. Proposed projects include foot care, reduction in complications, structured education around type 2 diabetes and inpatient nursing. NT asked if we have communicated with diabetic/pre-diabetic patients to ask them what they need. LL said that people broadly felt that face to face services were more helpful. The top three self-management options are individual care plans, physical activity exercise and referral for lifestyle support to manage low mood. There is no specific focused work with people with diabetes but there is learning. NT asked about diabetes and people with learning difficulties and whether there was focussed work linked to this. LL said this has been updated since this paper was written incorporating annual health checks and retinal screening service approx. There is an issue around access to support for insulin administration in students with a learning disability (i.e. timings of nurses to do this before they go to college); can college staff receive training to administer the insulin? LL said there is a small cohort of such patients. NT referred to patient safety incidents recorded. Louisa Forbes, enhanced health in care homes programme manager, has noted the need for training in care homes. NT is interviewing next week for a practice lead nurse which could help link in here. **Cancer:** Assurance is received that providers have confirmed they can meet the ambitions of the phase 3 recovery plan supported by the Cancer Alliance.

Item number	Minutes
	The Peninsula Cancer Alliance has reported that no-one from a black, Asian or minority ethnic background had participated in the national cancer patient experience survey for Cornwall and the Isles of Scilly. As a result, a working group has been set up to address this issue, to be led by the Alliance's patient and public engagement lead. There is a new DES for supporting early cancer diagnosis in primary care. The LMC will be asked if they agree with the plans. PC asked if there was a neurosurgery update from UHP and NT highlighted the risk entry on the corporate register. LL had no update to provide and this will be picked up outside of this meeting.
Action	1. LL to provide committee with a position re: neurosurgery in November
QC2020/56	**Quality report** discussed by Nikki Thomas
	Key issues from the quality report were presented. Work continues on the new patient safety incident review framework (PSIRF) and there is a plan to submit the plans to the respective boards in October/November. It was agreed with the national team to submit three separate plans – NHS Kernow, CFT and RCHT – with one overarching governance structure. Prosecution of UHP by CQC re: duty of candour noted. This is the first prosecution in England, with some media interest. Further system understanding of quality improvement is required after PSKQI (Patient Safety Kernow Quality Improvement) was stood down.
QC2020/57	**Clinical audit** discussed by Lydia Harris
	LH gave an update on healthcare system clinical audit programmes, which was presented to the audit committee this month. NHS England suspended the national audit programme in response to the Covid pandemic, which affected activity at both CFT and RCHT. RCHT currently has 19 audit projects recorded on their register directly related to Covid, three of which are completed. A large number of audits (mostly priority 3 and 4 projects) are past their anticipated end date and it is thought Covid is largely responsible for this. An internal audit on clinical audit at RCHT was carried out and

Item number	Minutes
	returned a limited assurance conclusion. In response to this, a robust action plan has been put into place, and this will include strengthening oversight of actions against priority 1 and 2 audits. NJ referred to two queries arising from NHS Kernow audit committee: • Who is the internal auditor for RCHT clinical audits • There are a large number of priority 3 and 4 audits on RCHT's register in comparison to the number of national and must do audits – do we have assurance that the priority 1 and 2 audits are being monitored effectively and actions completed. LH sits on RCHT's clinical effectiveness group (CEG) which takes place bimonthly, and can provide an update to these queries.
Action	1. LH to provide feedback to NJ and Chris Blong, chair of the audit committee, in relation to the queries arising from audit committee.
QC2020/58	**Quality Surveillance Group: update from the meeting 26 August 2020** discussed by Natalie Jones
	The thematic review for August's meeting was around potential harm to patients whilst waiting to access services. A conversation took place at QSG around the decision to lower RCHT's surveillance from enhanced to routine. It has since been agreed to keep them under enhanced surveillance. The next QSG meeting is in October and the themed review will focus on mental health in all ages. NJ extended the invite to PC.
Action	1. NJ to extend the QSG October invite to PC.
QC2020/59	**Quality Assurance Meeting: minutes from the meeting 18 September 2020** discussed by Nikki Thomas
	The minutes from the last quality assurance meeting (QAM) in September were reviewed with no comment from the group.
QC2020/60	**Key issues discussed at the Committee and recommendations for resolution for GB**
	The group agreed that the following topics need to be escalated for Governing Body oversight: • LeDeR (learning disability mortality review) 2019 annual report • SWAST call stacking risk • Acknowledging the positive reports received today that highlights robust CCG oversight during Covid • RCHT assurance around harm reviews

Item number	Minutes
	• University Hospitals Plymouth Trust (UHP) Duty of Candour
Action	1. The above issues to be pulled together into the chair's report for Governing Body.
QC2020/61	**Any other business**
	No other business declared.

Final copy for ratification
Signed by the chair:
Date: Ratified at the quality committee 24 November 2020