Healthy Future

NHS Hammersmith and Fulham Clinical Commissioning Group

Item A0(iii)

QUALITY, PATIENT SAFETY & RISK COMMITTEE MEETING

Tuesday 27 September 2016
St Paul's Church, Hammersmith

Governing Body Members Present:		
Vanessa Andreae	H&F Clinical Commissioning Group Vice Chair (Chair)	VA
Peter Fermie	H&F Clinical Commissioning Group - GP	PF
Jonathan Webster	Director of Quality, Nursing & Patient Safety, CWHHE	JW
Trish Longdon	H&F Clinical Commissioning Group - Lay member	TL
Jane Wilmot	H&F Clinical Commissioning Group - Lay member	JaW
Sena Shah	H&F Clinical Commissioning Group – Practice Manager	SS

Officers in attendance:		
Mark Jarvis	Head of Governance and Engagement- H&F Clinical Commissioning Group	MJ
Beverley Mukandi	Designated Adult Safeguarding & Clinical Quality Manager, CWHHE	BM
Judy Durrant	Assistant Director of Safeguarding CWHHE	JD
Kathryn Hodgson	Planned Care and Mental Health Manager	KH
Jenny Platt	Head of Joint Commissioning	JP
Chakshu Sharma	Senior Business Development Manager, IFR Team	CS
Lizzie Walman	Assistant Director of Quality Improvement and Clinical Assurance, CWHHE	LW

Apologies:	
James Cavanagh	H&F Clinical Commissioning Group Vice Chair
Amy Wilson	H&F Clinical Commissioning Group - GP

Item	Agenda Item /Discussion	Action Owner
1.	**Welcome & Apologies**	
1.1	VA welcomed everyone to the meeting.	
2.	**Conflicts of Interest**	
2.1	The general conflict of GPs as commissioners and providers was noted. PF noted a conflict in relation to item 6 as his practice provides services to one of the local nursing homes.	
3.	**Minutes of the last meeting**	
3.1	The minutes of the previous meeting were approved.	
4.	**Matters Arising/Action Log**	
4.1	**492 Safeguarding Training** – Noted that a comprehensive review of systems and processes had been undertaken with Chelsea and Westminster Trust in September. Safeguarding team assured that systems and processes were in place and were robust and that staff were being trained, despite what the data was reporting. An assessment had been undertaken in relation to the recent merger with and evidence had been triangulated as part of a deep dive style review. BM advised the committee that Imperial College Healthcare Trust had increased the numbers in its safeguarding team and processes were now more robust. CLOSE **493 Healthcare Support Workers in General Practice –** Noted that requested email had been sent. CLOSE	
5.	**Maris Stopes International**	
5.1	KH introduced the report. She advised the committee that the decision to suspend services provided by Marie Stopes International (MSI) had been taken by the Care Quality Committee (CQC) following concerns with regard to organisational governance and a lack of assurance in respect of training and SI management. KH reminded the committee that Hammersmith and Fulham CCG was the lead commissioner for termination of pregnancy services and as such had taken action locally to ensure that services remained available to women through other contracts in place for these services.	

	Communications had been sent to all GPs advising them of the situation and the actions they should take to ensure that referrals were made to appropriate alternative providers. She also advised that MSI had put information on their web site which was accessible to patients. In response to a question from TL, KH confirmed that NHS England had confirmed that any additional travel costs that women might incur accessing alternative providers would be reimbursed. It was agreed that information would be put on to the CCG website in respect of travel reimbursement. The committee raised a concern about the assurance in respect of the other providers within this specialty as it was likely that they were all using similar systems, processes and procedures. KH agreed to have a discussion with NHS England colleagues as they held national contracts. TL asked whether service user involvement had taken place to date in drawing up the specification for the re-procurement exercise that would be starting shortly. KH said that identifying service users for this re-procurement was difficult and clearly needed to be handled sensitively. TL offered to help in identifying people/organisations to approach. It was agreed that KH would link with TL to take this forward. BM asked whether there was any involvement from the local safeguarding team in the light of any potential safeguarding issues that might arise from the current situation or in any on-going work with the service providers in general. JW confirmed that there was on-going engagement in Ealing where there was a local service. However, he highlighted that there was some confusion in relation to the contractual and, therefore, accountability/responsibility arrangements for termination services in light of the various entities involved. He explained that as there was a facility in Ealing the quality committee for Ealing CCG had discussed the contract extension that had been agreed with all providers except Imperial and reviewed SI reports. However, the central contracting team also had a role to play as did Hammersmith and Fulham as the lead commissioner. KH confirmed that as far as assuring quality in relation to the overall contracts this was the responsibility of the central contracting team whilst Hammersmith and Fulham took the lead in procurement on behalf of the other CCGs. The committee **noted** the report.	**KH/MJ** **KH** **KH**
6.	**Audit of Deaths in Care Homes**	
6.1	JP reported that in early 2016, a number of cases were highlighted by the Tri-borough Continuing Healthcare Team, where patients who had been discharged from hospital sites to care homes within the Tri-borough area had died within a short period of time on arrival at the care home. She explained that the cases raised concern about the nature and timeliness of discharges from hospital for people at end of life stage, the pressures placed on the care homes and local GPs in supporting these discharges, and the quality of end of life provision and experience for these patients and their families. JP advised the committee that the audit was undertaken jointly between the CWHHE Quality team and the Joint Commissioning Team for Older People and Vulnerable Adults based on agreed objectives and scope of the areas to be investigated. She said that from the criteria identified the audit sample covered 8 cases. It was noted that a review of each case was undertaken by two members of the team (who were registered nurses) and involved case notes and files as well as interviews with care home staff where possible. ML reported that the clinical findings concluded that there were no overall immediate issues with the pathway; however one case resulted in an adult safeguarding concern being raised. She said that a partners workshop was held on 30th June to share the findings of the audit and to identify improvements that could be made in line with the findings. A particular focus of the was on improving documentation supporting the EOLC pathway and discharges; to enable further training around EOLC and difficult conversations; and to have clear escalation routes for when issues occur. A need for further joint work on the best interests process was also identified. ML advised the committee that it was proposed to take forward these areas through existing EOLC groups and programmes as well as the hospital discharge programme. TL sought clarification as to whether any carers were involved in the audit. ML confirmed that carers were not included. However she accepted that their perspective would have provided another dimension and would be taken into account for any future audits. JP confirmed that the findings of the report were being discussed with colleagues leading on last phase of life work.	

	SS sought clarification on whether the findings from the report matched with findings in other care settings. JP confirmed that there were areas of commonality, in particular relating to communication and joint working. JW thought the report was very helpful in understanding the concerns that were raised about the high number of deaths. He also wanted assurance that this report would also link to the wider work that is being undertaken with regard to nursing home care. JP acknowledged there was a significant amount of data on nursing homes which needed to be better aligned. She felt that this would get resolved once a decision had been taken with regard to the AQP framework as there would be standardised reporting metrics. PF noted that there was a potential for variation of provision within nursing homes in relation to GP input because of the different agreements in place between nursing homes and GP practices. JW highlighted that there was a general point about engagement with nursing homes and the need to find ways of involving care home providers in on-going discussions. The committee **noted** the report.	
7.	**Recommendations For PDG**	
7.1	**1. Modification of the Policy Criteria for Abdominoplasty/Apronectomy** CS introduced the paper. She advised the committee noted that at its meeting on 26 July 2016 the Policy Development Group (PDG) noted the recommendations made by the Clinical workshop and approved the suggested modification of the current policy, i.e. to remove the threshold *"The patient has BMI of 18-27 kg/m2 and stable for at least two years".* She said that the rationale behind the recommendations to remove this criterion were to ensure that only patients with a significant abdominal pannus would be eligible for surgery, removing the threshold that allowed for patients with minor problems to be funded. The committee **approved** the recommendation. **2. Commissioning Options for Weight Management Service (Tier 3 & Tier 4)** CS introduced the paper. She advised the committee that the proposal was to adopt the NHSE criteria with the following changes: • Remove Tier 3 as a mandatory step. Consider disinvesting in Tier 3 service (intensive weight loss programs) and redirect resources to enhance Tier 2 and Tier 4 services • Remove the criteria suggesting "Obesity to be present for five years" It was noted that the recommendation was based on the following: • The commissioned Tier 3 service is poor value for money • The recommendation to redesign the pathway allowed commissioners to exploit current commissioned services (Tier 2) which already provide some Tier 3 services • The modification of Tier 4 access criteria allowed better access to bariatric surgery for those who need it clinically. JaW sought clarification as to how patients would be engaged with the changes proposed. CS confirmed that there would be engagement across a range of patient groups. The committee **approved** the proposed changes to criteria.	
8.	**Risk Profiling**	
8.1	JW introduced the item. He advised the committee that the risk profiling tool being developed by NHSE was being trialed at Imperial College Healthcare Trust. The committee raised concern about sustainability of methodology after the trial. JW acknowledged that this would be something to take into account. He emphasised that the outcome of the pilot was to ensure that the Trust and the CCG had the same level of understanding of the position and issues.	

	The committee **noted** the report.	
9.	**Assuring Transformation Quarter 1 2016/17 Progress Update**	
9.1	PB introduced the paper. He advised the committee that although the CCG was behind trajectory for discharges at this time it was anticipated that the CCG would hit trajectory by year end. He confirmed that there were currently five Hammersmith and Fulham residents with a learning disability in an inpatient setting. It was anticipated that this would reduce to four by the year end. He said that Care and Treatment Reviews (CTR) had recently been completed on two residents. Another two were in specialist residential services and there were on-going Court of Protection and Official Solicitor issues being resolved. JaW asked what type of service would someone who has lived in a group setting for a long while expect to receive once they had been placed back in the borough. PB explained that their placement would be determined on their individual needs. TL sought clarification on current progress given that the issues previously discussed about lack of progress with discharge dates had been escalated to the Governing Body. PB advised that the two CTRs recently completed were outstanding when this was referred to the Governing Body and with a planned discharge in early 2017 the year end trajectory would be reached. TL remained concerned about the level of assurance in respect of discharge dates and sought clarification on whether the CCG retained responsibility or whether this was vested with the joint TCP Board. PB confirmed that the CCG retained responsibility as the CCG commissioned and funded the services. The CCG was responsible for ensuring that people were provided with safe and appropriate care at the point of discharge. TL felt that, in the circumstances, the committee needed more information to ensure an appropriate level of assurance to the Governing Body. It was agreed that a matrix would be developed providing information for the committee to review and to consider the level of assurance. The committee **noted** the report.	**PB**
10.	**Clinical Quality Group Minutes**	
10.1	The minutes of the CQG meetings at Imperial, Chelsea and Westminster and West London Mental Health Trusts were noted	
11.	**Exception Reporting**	
11.1	There were no items agreed for escalation/exception reporting.	
12.	**Any Other Business**	
12.1	There were no items of any other business.	
Date of next meeting: Tuesday 24 October 2016, 12.30 – 3.00 pm, St Paul's Church, Hammersmith		