NHS
Wandsworth
Clinical Commissioning Group

Notes of a meeting of the Integrated Governance Committee held on 10th September 2013

Present:	Nicola Jones (NJ)	CCG Clinical Lead (Chair)
	Stephen Hickey (SH)	Lay Member Governance
	Graham Mackenzie (GM)	Chief Officer
	Rod Ewen (RE)	Battersea LCG Clinical Lead
	Mike Lane (ML)	Wandle Joint LCG Clinical Lead
	Andrew Neil (AN)	Secondary Care Doctor
	Di Caulfeild-Stoker (DCS)	Registered Nurse
	Chris Savory (CS)	Associate Lay Member
	Andrew McMylor (AM)	Director of Development and Delivery
	James Olweny (JO)	Director of Corporate Affairs, Performance and Quality
	Evonne Harding (EH)	Head of Clinical Governance and Quality
In attendance:		
	Yarlini Roberts (YR)	Head of Finance
	Iain Rickard (IR)	Performance Manager
	Sandra Allingham (SA)	(Minutes)

13/081	**Apologies for Absence** Received from Lucie Waters and Hardev Virdee.	
13/082	**Declarations of Interest** Item 5.2 GP Outcome Standards – this would apply to all GPs.	
13/083	**Minutes from the previous meeting held on 13th August 2013** 13/073 Patient Group Directions – GPD to read **PGD**. 13/076 Safeguarding – penultimate paragraph – "… providing brief information on three current Serious Case Reviews (reference A1 and A2). Work would be done …." 13/079 111/OOH – Merton – "AM reported that **the providers** had withdrawn from providing …" Subject to the above amendments, the Minutes were agreed as being an accurate record.	
13/084	**Matters Arising** 13/070 Kingston Hospital Clinical Quality Reference Group – EH reported that the meetings were scheduled for the same day as the SGH CQRG meetings. EH would be sighted on the papers and feed back comments as appropriate. NJ requested that an alternative attendee be considered – JO to follow-up. 13/073 Patient Group Directions – It was reported that this issue was almost resolved and a positive outcome was expected to be achieved. No PGDs had been issued yet under the new arrangements. DCS reported that a Primary Care Nurse Adviser had now been appointed and DCS/EH would liaise with her on this issue.	**JO**

	13/077 Review Recommendations Update – Keogh Report – NJ/AM had discussed the possibility of undertaking GP surveys on a regular basis and the climate survey to test the assumptions on the action plans could be included as part of this. 13/079 111/OOH – Merton – It was noted that Merton would have to follow a Due Diligence process and were currently in discussion with Harmoni and other potential providers. If Harmoni was awarded the contract, Wandsworth would need to look at any potential impact on current service delivery.	
13/085	**Safeguarding Action Plan** The Action Plan outlined the recommendations from the Serious Case Review presented at the previous meeting, actions in place and how these would be taken forward. A further update would be presented at the next meeting. It was noted that the timescales for reviewing the perinatal service would probably need to be reviewed as this was a complex piece of work. Comments and questions on the action plan were noted: • Was consideration being given to providing a holistic approach for training as a recurring theme? AM reported that two GP Education Leads and two Workforce Leads were in post and work was being done to develop a combined training programme as part of the Out of Hospital five-year plan to provide a fully articulated workforce plan. • Work was being done to review Job Descriptions to make sure that roles are in line with new guidance. • Monitoring sample audits of Health Visitor/GP records – The practicality of how this would be done would be discussed at the Safeguarding Group. The Safeguarding Group would also discuss under what authority case records would be requested. • Implementation dates for actions – Actions from the review recommendations would need to be worked out in detail once the report was published in order to determine dates for implementation. • Separate actions for providers and commissioners would need to be defined. • Action plan should include reference to access to third party records. ML requested a copy of the recommendations from the Serious Case Review to be forwarded – JO to action. It was agreed that an update report would come back to IGC in November.	**JO** **JO/ DCS**
13/086	**Integrated Report** Finance highlights: • Still on target to achieve year end position. • Still some risks regarding data validation, Specialised Commissioning, adjustments, and reconciliations. • Specialised Commissioning – The final position was still to be resolved – the latest information indicated that the risk was minimised, however, this could still be subject to change. • High level of over-spend being reported in acute and Continuing Care. • Continuing Care had seen a 30% growth in the last three years, which had been met with an increased budget. A lot of work had been done by the Continuing Care team on the data but there remained a significant risk. Comments and questions on the finance information were noted:	

- There was strong agreement that the specification for the national system should not have been signed off given the identified limitations and that this would undermine confidence. This had previously been raised at the Board meeting and reflected in the Minutes of the meeting, and the auditors had been alerted to the current position, therefore the CCG was doing everything possible to state on record the current position.
- Potential counter-risk of generating significant under-spend across the CCG and plans should be developed to mitigate that potential counter-risk.

Performance highlights:

- 52 week wait – This had now been cleared but there may be some further cases coming through the system for Assisted Conception.
- Cancer wait – Performance in July had improved.
- HAI – This area remained a challenge, cases attributed to Wandsworth patients were picked up through CWRG.
- Mixed Sex – The situation should improve as new national guidance had been published implementing a different method of reporting for Intensive Care – most of the SGH breaches were in critical care beds.
- Friends and Family Test – Since April the SGH rates were down month on month to currently 14% - the Quality Premium required the Trust to achieve 20% by the end of the year. The Trust was doing as much as possible with the responses received and fed information through to the CQRG.
- IAPT – Recovery rates had stalled. A review of the service was currently being done, which highlighted that more funding had been invested in high intensity rather than low intensity services.
- Information Governance – An application had been submitted for the CCG to become an Accredited Safe Haven (ASH), which will provide more flexibility to make contract challenges. Information Governance training would need to be 100% completed by the end of October to achieve Level 2 as required to become an ASH.

Comments and questions on the performance information were noted:

- Mixed Sex Breaches – The CCG was managing the situation closely with SGH to understand the issues and had agreed a reporting holiday with SGH to resolve the issues. With the change in reporting this would impact on the potential for resolving the issues resulting in the critical care breaches.
- Friends and Family Test – Other Trusts were reporting increased rates following an initial slow start. Why was the trend for SGH different?
- IAPT – How could this target be achieved? And are we providing the best service for patients?

Quality highlights:

- Serious Incidents – Number of reported incidents at SGH had reduced – some incident categories for Maternity and London Ambulance were now no longer required to be reported as SIs, however, the CCG would continue to monitor all incidents. A paper on the thematic analysis of SIs at SGH would come to IGC in October.
- Never Event – One incident was reported.
- Safeguarding Children – Three cases were on-going. A draft Female Mutilation Strategy had been drafted.
- Safeguarding Adults – Three Serious Case Alerts had been reported. One of the cases was rated as high risk – initial investigations indicated that there was no evidence to support the report.
- SGH Quality Walkabouts – Proposal to combine the Walkabout with

	Healthwatch Walkabout, with an agreed aim to feed into the governance process and back to the CCG. • Complaints – SGH had received 79 complaints in June – the themes of the complaints and responses had not been provided to the CCG. • Alerts – Alerts are received from a number of sources, such as Google Alerts, MAD button etc, for all providers. Comments and questions on the quality information were noted: • SGH Quality Walkabouts – Would these also provide opportunities to talk to patients on the spot? The structure for the walkabouts had not yet been structured – they were currently being undertaken by CSU but these would change. • SGH Interactive Map – Who would this be available for and how would this be advertised? The application was available for members of the public and had been actively promoted, with advertisements in local papers and in the hospital reception. • Alerts – Information on alerts could be made available to GPs via the newsletter. A question was asked about the SGH Cancer Survey – SGH had been asked to present the findings at the next CQRG.	
13/087	**GP Outcome Standards** IR presented the guidance available on the website including information on the identified groups of indicators – these indicators would be used as comparison benchmarking indicators to eliminate variation and were not performance indicators. The indicators would provide: • assessment according to the nature of the measure; • prevalence of conditions; • mean average for all practices. Information for indicators was provided from different timescales – data would be revised as updated information becomes available. Information was presented in detail for each of the indicators to enable comparison nationally, and across the CCG, highlighting best performance and areas requiring further emphasis/focus. Comments and questions on the information were noted: • Need for the CCG to be clear on how this information could be used, with a defined approach to support practices. A briefing would be drafted to be sent to practices prior to a dedicated session at the Joint Members Forum in October. • The high level indicators would sit alongside the Outcome Measures. • NHSE was looking at using these measures but it was not yet clear how they would translate information from the measures, however, it was anticipated that CCGs would be expected to drive this improvement work with practices. IR agreed to circulate the web link and organisation code to meeting members.	**IR**
13/088	**Board Assurance Framework** The Board Assurance Framework (BAF) had been in development for the past six months and a complete review had been done to identify all potential threats against the Corporate Objectives. The BAF would be presented to the Board the following day – it was noted that the identified gaps in the version presented to the IGC had been completed in the Board version of the paper.	

	Comments and questions were noted: • Risk 39 Corporate Social Responsibility – Was the score for this risk higher than others on the Risk Register? The BAF reflected the principal risks to achieving the Corporate Objectives and was not based on risk ratings. • Risk 29 BSBV – Did this risk include the bigger overall risk that the programme may stall? The title of the risk had been amended to reflect the BSBV programme, however, it was agreed that the risk around the potential delay would be reflected. • BSBV/Out of Hospital strategy should reflect the potential impact for the different localities. The development of the BAF was acknowledged as providing a clear framework. It was noted that, as part of the development, the BAF had been subject to Internal Audit review.	**JO**
13/089	**Quality Strategy** EH presented the first draft of the document, which looks at what quality means and how this affected the CCG. The Executive Summary stated that quality was systematic, which ran through everything. The IGC was asked to comment on the aims and objectives and identify challenges against the additional objective. Comments and questions were noted: • Aspirations were important as well as challenges. • If the CCG was serious about quality, some difficult choices may be required. • Was there a training strategy behind this to embed this through the organisation and make this a reality? • Wording of section 10.1 to be amended – EH to liaise with GM. • Aims and objectives need to be strong, clearly stating what success looks like, with structures and systems in place, and performance management to reflect the aims and objectives. • Section 7.6 required additional wording to link into the NHS Outcomes Framework. • Which quality measures would apply that would add value? • Quality Assurance Framework – stage 4 could include BSBV and other programmes. • Potential to ask staff how their approach to work addresses patient safety/experiences? • Need to describe the specific CCG role to promote and challenge quality. • Objectives should be reflected through staff objectives. • Recognition that we deliver quality in partnership with others, eg community services, and that it is not just patients who are looked after but includes schools etc. • Vision Statement of the CCG was not described in the document. • Measurable aspirations should be explicit to include primary care quality and commissioned services. • Primary Care – Not sure if there was a common understanding of what was required in primary care, and resource implications had not been included in Commissioning Plans for next year. • Look at level of learning required across Wandsworth. • Potential to start with something more generic to be followed up with an action plan.	

	• Need to be clear regarding roles and responsibilities regarding quality of the whole health economy. • The CCG would have a more holistic role to develop primary care quality and encourage practices to improve in certain areas. • Stronger summary on what actions the CCG would take if poor quality was identified. It was noted that the final strategy would be presented to the Board for approval with the understanding that this would require a set of processes. Any further comments on the draft strategy to be forwarded to EH. AM left the meeting.	
13/090	**SGH Duty of Candour** Sal Maughan (SM), Corporate Risk and Assurance Manager, SGH, attended the meeting to present the paper, which had been discussed at the CQRG meeting on 21st August – feedback from that meeting had been incorporate into the updated version. The proposal takes into account the requirements of the Francis Report, DH response, and Berwick Report, with timelines set out against identified actions to allow the Trust in order to understand what was required and to put appropriate infrastructure and training into place for staff. The first audit would be completed in September. The proposal would ensure that debriefs for staff would be held at the earlier opportunity, policy updates being available, and monitoring systems to be implemented. On-going training is in place and this would be rolled out across the Trust to capture as many staff as possible. The following comments were noted: • Exceptions – Notification of all incidents would be embedded across the organisation and reflected the importance of having early discussions. Incidents that had been handled following the agreed process and were therefore unavoidable would be included as exceptions. These would be included in the debrief meetings. • With the phased programme of implementation, how would the Trust know if the policy had been adopted? SM stated that conversations would be followed-up in writing, with information leaflets and appointed main point of contact provided. This should provide more robust information to patients and relatives. • Were there plans to advertise this in the hospital to indicate that Duty of Candour had been adopted? • Testing of the system would be important, how would success be measured? SM stated that a six-month thematic exercise would be done as part of evaluation. This would be an open process with initial and on-going contacts, and sharing of decisions. It was agreed that the final version of the document would be made available.	
13/091	**Any Other Business** None.	
Date of next meeting: 8th October 2013		