North West London
Collaboration of
Clinical Commissioning Groups

Item: 10

Meeting name:	NW London Collaboration of CCGs' Joint Committee
Date	Thursday, 07 March 2019

Title of paper	Report from the Chief Nurse and Director of Quality, including Shadow Quality and Performance Committee update

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Confidential	**Yes**	☐	**No**	☑	Items are only confidential if it is in the public interest for them to be so

The Committee is asked to:
Note the update from the Shadow Joint Quality & Performance (Q&P) Committee held 14 February 2019.

Strategic Objectives and Board Assurance Framework
Quality: for each one of our providers to achieve a good or better rating in the next CQC inspection.

Summary of purpose and scope of report
The Shadow Joint Q&P Committee is a committee of all eight CCGs in the North West (NW) London Collaboration of CCGs. It remains a shadow committee meeting until the Terms of Reference are signed off by all 8 CCGs. **Governance arrangements** The meeting has a reporting function to the Joint Committee where an overview of the discussions is shared and the Joint committee is asked to take assurance from the discussions held at the Q&P Committee. The Joint Q&P Committee also has a direct reporting line to each Local CCG Quality Committee, where each CCG QC chair is represented on the Q&P committee.

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Items considered at the 14 February Shadow Quality and Performance Committee:

Areas of focus:

- Quality structure and governance
- Serious Incidents (SI) and Never Events (NE)
- Cancer 28 days faster performance
- Winter performance (separate paper attached)

Quality and Safeguarding governance

The paper outlined the quality governance arrangements across NW London Clinical Commissioning Groups by addressing these key questions;

- What are we trying to achieve
- What is the role of different groups/ organisations/ individuals
- What happens at NW London level and locally
- What are the functions and rhythms of different meetings
- What do we do strategically and what do we do operationally

The purpose of the paper will help the committee to agree the draft terms of reference which will be approved by the CCG Governing Bodies.

Whilst the paper gave an overview of the quality structure, it failed to give a comprehensive overview of the Local Quality Committees and NW London Quality and Performance Committee remit in relation to the Clinical Quality Groups (CQG). The Committee agreed for a smaller group to convene and map out the governance around assurance from CQG to each committee.

The paper also outlined a proposed way forward for safeguarding reporting to reflect the coming together of safeguarding teams under a single directorate as of March 2019. Following discussion with the designated professionals, a revised reporting plan was outlined.

There wasn't a final decision on either area. The paper will be amended and presented to the next NW London Q&P Committee in March 2019.

Serious Incidents and Never Events

The patient safety function is part of the NW London CCGs' Quality Directorate and has oversight and management of the interface with commissioned providers with respect to the reporting of all Serious Incidents (Sis) and Never Events.

All commissioners and providers of NHS funded services are required to manage serious incidents in accordance with the National Serious Incidents Framework (National Serious Incidents Framework 2015, developed by NHS Improvement)

The paper presented data covering financial years 2017/18 and 2018/19 up to and including

December 2018.

- Treatment delay continues to be the most frequently reported SI, this includes mental health bed breaches in ED departments;
- Treatment delay, Sub-optimal care, and Diagnostic delay as incident type are used interchangeably dependent upon interpretation of the incident by the reporting organisation. Examples of sub-optimal care and diagnostic delay incidents are *failures to recognise and /or escalate patient deterioration* and *cancer treatment delays.*

Never Events are not necessarily the most serious type of serious incidents in terms of levels of harm to patients; however, they are defined as being *wholly preventable* where National level guidance or safety recommendations that provide strong systemic barriers are available. The expectation on Trusts is that these recommendations have been implemented locally in relevant clinical areas.

Never Events by reporting Trust since 01/04/2017 to December 2018.

	ChelWest	Imperial	Hillingdon Hospital	CNWL	LNWHT	Total
Retained foreign object post procedure	4	2	1		3	**10**
Wrong implant/prosthesis	1		2	2	1	**6**
Wrong site surgery		3	1		2	**6**
Unintentional connection of a patient requiring oxygen to an air flow meter	1				3	**4**
Wrong route administration of medication	1	2				**3**
Misplaced naso- or oro-gastric tubes					1	**1**
Transfusion or transplantation of ABO incompatible blood components or organs	1					**1**
Grand Total	**8**	**7**	**4**	**2**	**10**	**31**

By request of the Secretary of State for Health and Social Care, CQC were asked to work with NHS Improvement to look at issues within NHS trusts that contribute to Never Events occurring. The CQC stated *'they wanted to understand what makes it easier – or harder – for the people and organisations in the NHS to prevent Never Events and also wanted to see what could be learned from other industries and countries'*

National Patient Safety Publication of the CQC Report 'Opening the door to change'https://www.cqc.org.uk/sites/default/files/20181224_openingthedoor_report.pdf

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Cancer 28 days faster performance
The purpose of the paper was to inform the committee of a new waiting time standard '28 day faster diagnosis'. The CCG will be working with stakeholders to develop the operating plan to meet the requirement from 2020/21, although it will be required to run in shadow from 2019/20. The committee discussed the challenges in meeting this standard and where the areas that required focus. The work will be led by the alliance with a working group set up to develop the plan. There will be representation primary and secondary care providers, as well as business intelligence advisors.

Winter performance

See attached paper.

The Governing Body can be assured that there were robust discussions on each of the topics.

The full suite of papers have been circulated to members.

What are the benefits of this project?

The benefits of working in this way enables CCGs and its officers to be more efficient by sharing items for discussion once, rather than eight times, as long as they are done in a way that enables each legal entity to demonstrably discharge its statutory duties.

Patient, staff and stakeholder engagement

The Committee recognises the need to invite additional lay members to be part of the group, as well as a Health Watch representative.

The Terms of Reference has been shared with the Health Watch representative that sits on the Joint Committee, who will discuss with NW London colleagues.

It is felt that the Chair of the Committee should be the Joint Committee lay member, with an additional lay member as the Deputy Chair. Lay members will be invited to select themselves / or be nominated following completion of the lay member review.

Where a lay member chairs the local Quality Committee, they are members of the Q&P Committee.

Jargon buster

Abbreviations are explained in the text

Quality & Safety

Items for follow up / review are on the forward planner for the NW London Q&P Committee

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Equality analysis
None undertaken for this report

Finance and resources
Financial considerations feature in individual reports

Risk	**Mitigating actions**
The papers support the NW London Board Assurance Framework (BAF) in wanting all providers to achieve a rating of Good or better at the next CQC inspection	There are a range of controls to which are referred to by the BAF

Supporting documents
Papers previously circulated

Conflict of interests
The authors declare no conflicts of interest.

Governance, reporting and engagement

Provide a brief overview of where this paper – or work in developing it – has been discussed. Signpost to where in the paper more detail on this can be found.

Name	Date	Outcome and where in the report can you find out more
Shadow joint Quality & performance Committee	14 February 2019	This is a summary report of that meeting highlighting where the GBs can draw assurance.