NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 25 July 2019	**Paper No: 19/49**

Title of Paper: Annual Report of the Quality Committee

Paper is for:	**Discussion**		**Decision**		**Information**	✓

Conflicts of Interest (please delete tick as appropriate)	
No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:
The Quality Committee reviewed the draft annual report for 2018/19 at its 9 July meeting. The report presented here summarises the key activities undertaken by the Quality Committee over the last year, in order to discharge its duties under its approved terms of reference.

Engagement: clinical, stakeholder and public/patient:
Not Applicable

Financial Implications of Paper:
None

Action Required:
The report provides assurance that the Quality Committee is operating effectively and in accordance with the terms of reference.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Ensuring equality of both access and outcome is a key part of commissioning quality services. There are no specific equality implications of this report.

Link to Risk
The Quality Committee has oversight of the quality risks.

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Date of Paper: 15 July 2019

Annual Report from the Quality Committee 2018/19

As a formal sub-committee of the Board and in accordance with best practice, this is the Quality Committee's 2018/19 annual report to the Board.

This report was reviewed at the meeting of the Quality Committee on 9 July and is now submitted to the Board to provide assurance that the Committee has been operating effectively and in accordance with its terms of reference.

1. Introduction

The role of the Quality Committee is to provide assurance of the quality and performance of commissioned services and to promote a culture of continuous improvement in the safety, clinical effectiveness and patient experience of services. In partnership with the local authority, the Committee oversees the arrangements for safeguarding through the operation of the Safeguarding Children and Safeguarding Adults Boards.

The Quality Committee is chaired by the Governing Body lay member with responsibility for patient and public involvement. The Director of Quality is Deputy Chair. The Committee voting membership also includes: two locality clinical representatives, the CCG Chief Operating Officer, the Director of Governance, a Lay Member and a Specialist Medical Advisor.
Non-voting ex-officio attendees of the committee comprise Clinical Director of Quality (acute and community services), Assistant Clinical Director (Primary Care), Deputy Director of Quality, Deputy Director Joint Commissioning (OCC), Deputy Director Public Health (OCC) and a Patient and Public Representative.

2. Membership and Meetings

To be quorate, a minimum of five Quality Committee Members must attend, including:

- Quality Committee Chair or Quality Committee Vice Chair;
- Two Board members, ex-officio Board attendees or their deputies;
- At least one locality representative;
- At least one practicing clinician.

There were six meetings in the period covered by this report. All but the October Quality Committee were quorate.

Quality Committee								
Name	**Role**	**Apr 18**	**Jun 18**	**Aug 18**	**Nov 18**	**Dec 18**	**Feb 10**	**Total**
Voting Members								
Louise Wallace	**Lay member with a lead for Patient and Public involvement (Chair)**	✓	✓	✓	✓	✓	✓	**6/6**

Sula Wiltshire	**Director of Quality (Vice Chair)**	✓	✓	✓	✓	✓	✓	**6 /6**
Dr David Chapman	**OCCG Locality clinical representative(s)**	✓	✓	✓	✓	✓	✓	**5/6**
Catherine Mountford	**Director of Governance**	✓	✓	**X**	✓	✓	✓	**5 /6**
Diane Hedges	**Chief Operating Officer**	✓	✓	✓	✓	**X**	**X**	**4/6**
Dr Guy Rooney	**Specialist Medical Advisor**	✓	✓	**X**	**X**	**X**	**X**	**2 /6**
Non-Voting members								
Dr Andy Valentine	**Clinical Director of Quality/ Deputy locality Director (City)**	✓	✓	✓	✓	✓	✓	**6/6**
Dr Meenu Paul	**Assistant Clinical Director of Quality (Primary Care)**	✓	**X**	**X**	**X**	**X**	**X**	**1/6**
Helen Ward	**Deputy Director of Quality**	✓	✓	**X**	✓	✓	✓	**5 /6**
Andrew Colling or nominated deputy	**Deputy Director, Joint Commissioning, Oxfordshire County Council**	✓	✓	✓	**NLAM**	**NLAM**	**NLAM**	**3/3**
Benedict Leigh or nominated deputy	**Deputy Director, Joint Commissioning, Oxfordshire County Council**				✓	**X**	**X**	**1/3**
Val Messenger or nominated deputy	**Deputy Director Public Health**	✓	✓	✓	✓	✓	✓	**6/6**
Hilary Seal	**Patient & Public Representative**	✓	✓	✓	✓	✓	✓	**6/6**
Jane Bell	**Senior Quality Manager**	✓	✓	✓	✓	✓	✓	**6/6**
Alison Chapman	**Safeguarding Lead nurse**	**X**	✓	✓	✓	✓	**X**	**4/6**
Julie Dandridge (Deputy for DH)	**Deputy Director, Head of Primary Care and Localities**				✓	✓	✓	**3/6**
Sharon Barrington (Deputy for DH)	**Head of Planned Care and Long Term Conditions**				✓			**1/6**
Quorum		✓	✓	✓	✓	✓	✓	**6**

X = did not attend
NLAM = No Longer A Member

Table 1 Attendance at Quality Committee, April 2018 – February 2019

The Director of Delivery and Localities is also members of the Finance and Investment Committee. The Director of Governance also attends the Audit Committee to ensure a link between all committees.

3. Duties within the Terms of Reference

The key duties of the committee are to oversee:

- Quality and performance of service
- Patient safety
- Patient experience
- Clinical effectiveness
- Innovation

The work of the Committee in discharging its duties was as follows. The duty to oversee innovation is demonstrated throughout the report.

3.1 Duty 1 – Quality and Performance of services

Close links between the Directorate of Quality and the Directorate of Delivery and Localities have continued to develop in 2018/19. This ensures CCG commissioning intentions and operational planning include all relevant clinical standards and key performance indicators.

The CCG works with its major providers and some smaller independent providers to agree quality objectives for the year. These objectives are then included in their quality accounts, which are reported to the Committee. The CCG reviews and comments on the accounts and evaluates how successful organisations have been at meeting their objectives.

Healthcare Intelligence

Oxfordshire CCG purchased a licence for Dr Foster Healthcare Intelligence Software commencing 2018/19. The software has provided OCCG with timely information on the quality, safety and performance of providers. It also provides clinical effectiveness benchmarking information. Use of the system has become common throughout OCCG, improving access to and use of data by the workforce. The Quality team has established links with counterparts within Oxford University Hospitals to develop a process of sharing and understanding potential areas of concern, both proactively and in reaction to other intelligence. As a result of the improved working, OCCG has developed a better understanding of quality within, in particular, Oxford University Hospitals and has improved working relationships. The healthcare intelligence software has allowed detailed investigation into services and pathways to understand the effectiveness of the care delivered; this has translated into improvements in the clinical effectiveness process.

3.1.1 Quality premium

NHS England offers all CCGs a Quality Premium. This rewards CCGs for improvements in the quality of the services that they commission and for associated health outcomes and reduced inequalities. The Quality Premium consists of national targets related to the NHS Constitution and local targets agreed between the CCG

and NHS England. The CCG's quality premium is set nationally. Local elements are reviewed and agreed and scrutinised by the Quality Committee.

3.1.2 GP feedback

As a part of ensuring the quality of commissioned services, primary care staff in Oxfordshire provide feedback directly to the CCG using the Datix risk management system. Between April 2018 and March 2019, 1687 pieces of feedback were received by the CCG. This information is used alongside information from serious incidents, patient experience and performance data to identify where services could be improved.

A summary of the feedback received in 2018/19 is set out in table 2.

Top 5 by subject Apr 18-Mar 19	GPFBK
Delay / difficulty in obtaining clinical assistance	**179**
Request from secondary care for GP to follow up tests/scans/investigations initiated in secondary care	**129**
Delay in GP receiving clinical docs (i.e. OPD/discharge letters)	**79**
Consultant to consultant not completed correctly	**79**
Inappropriate prescribing request from secondary care	**76**

Table 2. GP feedback by topic

As a result of this feedback a number of changes have been implemented. These include:

- Consultant to consultant (C2C) policy has been updated to make it clearer. This will support appropriate use of C2C referrals.
- The process of antibiotic prescribing in ED has been altered to prevent patients being discharged with part courses of antibiotics. This means they no longer have to visit their GP to request a prescription for the remainder.
- A focus on the time clinical documentation takes to be sent. This is monitored through quality review meetings (QRMs).
- Healthshare has implemented a new phone line for professionals, which has improved access to clinical assistance. The 179 pieces of feedback in table 2 above were mainly about this issue. There has been a significant improvement following the phone line implementation.
- InHealth has access to ICE (radiology requesting system) to request CT scans and direct referral to MDTs.

3.1.3 CQC Inspections

The CCG only holds contracts with organisations which are registered with the Care Quality Commission (CQC). The CQC is the national regulator and providers are required to adhere to CQC standards. The CQC has a programme of inspections. When an organisation falls below a required standard they must respond, usually with an action plan. The organisation is required to inform, and share their action plan with, the CCG. The action plans are monitored and reviewed by the CCG and discussed at every Quality Committee, at which the CQC is a standing item. The CQC has this year undertaken a consultation on their programme of inspections and

have changed their process slightly so that practices with a rating of ‘good’ or above may be visited less frequently and receive only focused visits in the future.

Primary care

Oxfordshire has 70 GP Practices. Following on from 2017/18, the four GP practices rated as ‘outstanding’ retain their ratings through 2018/19. Sixty-five practices are rated as
‘good’ with one practice rated as ‘requires improvement’; the practice rated as ‘requires improvement’ last year has now been rated as good in 2018/19. In total, eleven practices were visited by the CQC during 2018/19.

CQC Local System Review

The CQC undertook a follow-up Local System Review of Oxfordshire on 6 and 7 November 2018. The review was intended to establish the progress made against key findings since the initial visit in December 2017. As with the original visit, no rating was awarded for the review.

The progress report was published in January 2019. The report concluded that there had been significant improvements in relationships between organisations, how they worked together and the strategic vision that the organisations worked towards. The report also identified positive responses to the challenges in patient pathways and flow.

The report identified that additional work to manage the domiciliary care market was still required, as well as making better use of the voluntary care sector and support for people funding their own care. The Health and Wellbeing Board has been refreshed and now oversees the action plan for improvement.

3.2 Duty 2 - Patient safety

The Committee reviews patient safety including safeguarding, serious incidents, infection control and service reviews in a regular plan of reports throughout the year. Safeguarding is a standing item.

3.2.1 Clinical risks

Clinical risks are detailed on the CCG clinical risk register and at each meeting, the committee scrutinises the action taken by the CCG to mitigate these risks.

Exception reports are provided through the Integrated Performance Report (IPR), which is a standing item on the agenda. The report also includes updates on performance; the quality schedules and CQC inspections for NHS trusts, independent providers, GP services and nursing homes.

3.2.2 Serious Incidents

Serious incidents (SIs) are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to produce a comprehensive response. SIs may affect patients directly but also include incidents which may indirectly affect patient safety or an organisation’s ability to deliver

ongoing healthcare. The CCG reviews all serious incidents to ensure action is taken to prevent recurrence. Detailed reports were provided to the Committee in June 2018 and December 2018. 2018/19 saw a slightly higher number of SIs reported than in the previous year, with 172 reported compared with 145 in 2017/18.

3.2.3 Never Events

Never Events are a nationally specified set of serious incidents that are regarded as being preventable because of the existence of guidance or safety recommendations which provide strong systemic barriers. These measures should always be in place and hence incidents should not happen.

There were thirteen Never Events during 2018/2019. Ten of these were in the OUHFT, two in OHFT and one SCAS. This compares to nine in 2018/19.

The agreed approach for Never Events is that they are reviewed in line with the serious incident framework and the incident is not closed until all actions are completed. This is followed by an assurance visit from OCCG and NHSE.

Trust	Ref	Reported	Adverse Event
OUHFT	**2018/12676**	**21/05/2018**	**Positive Patient Identification - procedure**
OUHFT	**2018/13468**	**31/05/2018**	**Wrong site surgery - hip size**
OUHFT	**2018/13587**	**01/06/2018**	**Treatment/procedure - inappropriate/wrong (Botox injection instead of nerve block)**
OUHFT	**2018/15393**	**22/06/2018**	**Retained swab**
OUHFT	**2018/17669**	**18/07/2018**	**Positive Patient Identification - procedure**
OHFT	**2018/20436**	**21/08/2018**	**Treatment/procedure - inappropriate/wrong (tooth removal)**
OUHFT	**2018/20457**	**21/08/2018**	**Treatment/procedure - inappropriate/wrong (Nerve block)**
OHFT	**2018/21148**	**30/08/2018**	**Non- collapsible shower curtain**
OUHFT	**2018/22633**	**18/09/2018**	**Retained guide wire**
OUHFT	**2019/2552**	**04/02/2019**	**Retained swab**
OUHFT	**2019/2778**	**05/02/2019**	**Retained instrument**
SCAS	**2019/6584**	**25/03/2019**	**Incorrectly connected to air flow meter**
OUHFT	**2019/7070**	**28/03/2019**	**Treatment/procedure - inappropriate/wrong**

OCCG is working with OUHT to understand the causes of these events. The causes are complex and addressing them involves cultural as well as system approaches. Assurance visits are undertaken for Never Events once all actions are completed and evidenced. In some cases immediate assurance is sought. In January 2018 OCCG joined an OUH walkabout for theatres to look at wrong site nerve blocks.

Work being under taken by OUH to address the causes of Never Events includes:

- The right patient every time. This has been one of OUHFT's priorities for 2018/19. This project has demonstrated significant improvements in positive patient identification and has reduced incidents**.**
- Support/advice obtained from the Healthcare Safety Investigation Branch (HSIB) and from other trusts.
- Refreshed and re-launched the 'Stop before you block' standard operating procedure.
- Focus on training/cultural change with the support of the 'human factors' practitioners
- Development of LocSSIPs (local safety standards for invasive procedures) and refresh of specific WHO checklists.

3.2.5 Safeguarding

Regular reports are presented to the Quality Committee on safeguarding. The report updates the Committee on adults and children's safeguarding, including actions, and themes and developments.

Providers and commissioners complete an annual safeguarding self-assessment against the statutory duties of the Children Act (1989) and the Care Act (2014). For 2018/19 good compliance levels were demonstrated by both providers and commissioners in Oxfordshire. This was scrutinised and validated at a peer review event facilitated by the Adults and Children's Safeguarding Boards.

During 2018-2019 health teams actively participated in a number of multi-agency reviews. These reviews involve the partners in the Safeguarding Boards: health commissioners and providers, the local authority, the Police, education, probation and other relevant parties. Learning from these reviews has contributed to service redesign and practice developments. One development this year has been a guidance document for primary care on coding patients' needs and vulnerabilities to promote consistency across the local area.

A focus for 2018-2019 was promoting effective information sharing processes. This builds on the template developments in 2017-2018. The use of chronologies as a part of care assessments and referrals has been effective in providing professionals with a clearer understanding of concerns and issues.

Mortality reviews within NHS services have been a priority for NHS England in since 2017. Provider trusts are now reporting regularly and have clear internal processes in place that link to the multi-agency processes facilitated by the CCG. Lessons from Child Death reviews and Learning Disability Mortality Reviews have been collated along with examples of excellent personalised end of life care. This is being used to promote a culture of proactive advanced care planning and the use of end of life care plans.

3.2.6 Maternity Services

During 208-19 the Committee continued to receive regular reports on maternity services following the emergency closure of consultant led obstetric services at the Horton Hospital in October 2016. The reports describe the enhanced level of monitoring by OCCG to ensure the quality and safety of the alternative service provision, a stand-alone midwifery unit (MLU). All incidents are scrutinised and followed up with the Trust.

3.2.7 Gosport and Mortality

In June 2018 the report into the inquiry into deaths between 1980 and 2001 at Gosport War Memorial was published. Following the publication of the report and the Government's response Oxfordshire CCG sought assurance that the events of Gosport could not occur in the services it commissions. The CCG and providers were required to submit a number of responses and assurances, demonstrating how measures are in place to prevent a recurrence of the events in Gosport. There were a number of immediate actions such as providing assurance on the use of particular syringe drivers and the management of controlled drugs.

As a system Oxfordshire wanted to have a more detailed discussion about the findings of the Gosport inquiry in order establish whether there were any gaps in current systems and to understand how different organisations' mortality processes work. In February 2019 Oxfordshire CCG hosted a workshop to explore the issues raised by Gosport. The workshop was attended by Oxford University Hospitals NHSFT, Oxford Health NHSFT, the Oxford Coroner's office, the Oxfordshire AHSN and Oxfordshire CCG. A report of the workshop was presented to the April Quality Committee.

The purpose of the workshop was not to repeat existing assurance exercises but to explore more widely the issues raised by Gosport in the context of Oxfordshire systems and processes. There were a number of overlapping themes emerging from the discussion at the workshop:

- Culture. The events at Gosport were the product of a poor organisational culture.
- Isolation. Gosport was both geographically and organisationally isolated.
- Raising concerns. When concerns were raised in Gosport they were not responded to
- Mortality and learning from deaths. The systems of clinical governance and mortality review have been put in place since the events in Gosport.
- Life and end of life. Attitude towards end of life have changed significantly since this time. An understanding of what constitutes good end of life care is crucial.

3.2.8 Infection Prevention and Control

The 2017/18 Infection Prevention and Control annual report was presented in August 2018. There is a zero tolerance ambition for MRSA bacteraemias. In 2018/19 there were four cases, two fewer than 2017/18. All bacteraemia cases undergo a full case review by the health economy wide group. All were found to be unavoidable. OCCG was within *C.difficile* set parameters in 2018/19 with a total of 126 cases against a limit of 144 cases. All cases underwent a thorough multi-disciplinary investigation

and 92% were found to be unavoidable. There is a national ambition to reduce gram negative blood stream infections (GNBSI), focusing primarily on E.coli BSI. OCCG has achieved a 6.5% reduction from 497 cases in 2017/18 to 465 in 2018/19. Multi-organisational discussions to reduce GNBSI have been held during 2018/19.

Flu prevention

During the 2018/19 influenza season, the OCCG Infection Prevention and Control Lead monitored vaccination uptake weekly and supported GP practices with improving uptake. There were challenges around the introduction of tri-valent vaccine for the over 65 year age group, particularly around the staggered supply over a three month period. Oxfordshire achieved target vaccination rates in all patient groups apart from at-risk groups and pregnant women. Although targets were no met for these patients, both of these groups were vaccinated at above the national average rate.

Latent Tuberculosis (TB)

The project manager for latent TB screening completed her 0.2 WTE 12 month contract in March 2018. She was successful in engaging the local East Timorese community leaders in raising awareness in this hard to reach high risk group. With their collaboration she produced an information leaflet for LTBI in three alternative languages. This has been made available to other CCGs via Public Health England.

3.3 Duty 3 – Patient Experience

Delivering person centred quality care is a key OCCG value. Good patient experience, along with clinical effectiveness and patient safety is a key component of high quality care. OCCG receives patient experience information through complaints, PALs, Datix reports and serious incident reports. It also views complaints/PALS activity from provider reports. National and local patient and staff surveys are analysed, along with reports from patient groups such as Healthwatch. A patient experience report is presented to each Quality Committee.

The Friends and Family Test (FFT) is the nationally mandated test established in order to have a single comparable score for patient experience. FFT updates are included in the Integrated Performance Report presented at all Quality Committee meetings. Oxfordshire providers consistently score well when compared with national average scores. This means that, for example, a large majority of patients (above 95% for inpatients and 85% for A&E) would recommend the services they use to a friend or family member with a similar need.

Providers have focused on improving methods of capturing patient experience information to improve the patient's journey. Both OUHT and OHFT have strategies for addressing the feedback received from patients and carers.

The patient experience report summarises patient experience data for commissioned services and highlights issues. Examples of changes in practice and service delivery models as a result of patient feedback are included in provider reports and are shared through the report presented to Quality Committee.

3.3.1. Quality Assurance Visit process

The OCCG quality team works in an integrated way to ensure all data and intelligence about services is used to inform the quality team programme of clinical visits and where best to focus attention.

The team has implemented an enhanced quality assurance visit process which includes planned proactive visits. In the past visits have tended to be undertaken in response to a concern or incident.

The aim of the visits is:

- To gain a understanding of the services
- To develop effective working relationships between staff in provider and commissioner organisations
- To facilitate triangulation and exploration of indicators of service delivery and enhance intelligent interpretation and analysis
- To identify actions taken by providers in relation to key areas of concern
- To enable staff and service users to share their perspective
- To gain assurance that any issues are being addressed
- To identify good practice which can then be shared

The number of assurance visits significantly increased in 2018/19 when 25 visits were carried out compared with eight visits in 2017/18. A summary of visits is set out in table 3.

Trust	Date of visit	Area	Reason for visit	Outcome
OUHFT	**10/05/2018**	**Maternity**	**Serious incident**	**Good**
BSPS	**11/06/2018**	**Labs**	**Concerns raised by GPs**	**Satisfactory**
SCAS	**12/06/2018**	**Oxford station PTS/999**	**Planned**	**Good**
OUHFT	**26/06/2018**	**NOC – Oxford centre for Enablement**	**Post CQC follow up**	**Good**
OUHFT	**24/09/2018**	**Horton theatres**	**Serious incident**	**Satisfactory**
OUHFT	**25/09/2018**	**Urology**	**Serious incident**	**Good**
Ramsay	**19/10/2018**	**Horton Ramsay**	**Planned**	**Good**
OUHFT	**06/11/2018**	**Stroke Ward, OUH**	**Planned**	**Good**
SCAS	**08/11/2018**	**Wokingham IUC**	**Planned**	**Good**
TVIUC (Thames Valley integrated Urgent Care)	**08/11/2018**	**TVIUC – GP Clinical assessment Service (CAS)**	**Planned**	**Good**
SCAS	**15/11/2018**	**Bicester IUC**	**Planned**	**Good**
TVIUC	**15/11/2018**	**TVIUC - Northern House**	**Planned**	**Good**
OHFT	**16/11/2018**	**Stroke ward, OHFT**	**Planned**	**Satisfactory**
OUHFT	**21/11/2018**	**Maternity, JR**	**Never Events**	**Unsatisfactory**
OUHFT	**21/11/2018**	**Gynaecology, JR**	**Never Events**	**Unsatisfactory**
Foscote	**17/12/2018**	**Foscote**	**Planned**	**Good**
Nuffield	**08/01/2019**	**Manor**	**Planned**	**Good**
OUHFT	**15/01/2019**	**BIU ward**	**Serious incident**	**Good**
OHFT	**16/01/2019**	**Abingdon MIU**	**Serious incident**	**Good**

InHealth - echo	**29/01/2019**	**InHealth - echo**	**Concerns**	**Good**
InHealth - endo	**30/01/2019**	**InHealth - endoscopy**	**Concerns**	**Good**
OUHFT	**12/02/2019**	**Sobell and oncology, Churchill**	**Serious incident**	**Good**
OUHFT	**12/03/2019**	**Thematic assurance visits multiple areas. theatre OUH - NOC site**	**Never Events**	**Good**
OUHFT	**25/03/2019**	**Thematic assurance visit multiple areas. Outpatient PPID- JR site**	**Never Events**	**Good**
Healthshare	**25/03/2019**	**East Oxford Health Centre & Wallingford Community Hospital**	**Planned**	**Good**

The outcomes are assessed using:
Unsatisfactory: no evidence of the actions underway or completed or a significant area of concern highlighted

Satisfactory: limited documented evidence of the actions and recommendations underway but staff responses provide assurance of implementation. Moderate areas of improvement highlighted

Good: evidence of the actions and recommendations completed and improvements documented or demonstrated in practice.Good practice demonstrated and minor or no no areas of improvement required.

When the outcome is unsatisfactory a repeat visit is undertaken following corrective action.

3.4 Duty 4 - Clinical effectiveness

Clinical effectiveness is defined by the NHSE National Quality Board as ‘people’s care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence’.

Since 2017, regular Clinical Effectiveness Papers have been reported to Quality Committee. These seek to understand the effectiveness of the care of four broad patient groups: children, maternity, adults and older adults. This continued into 2018/19, with the core aim of reviewing and understanding national clinical audits, clinical outcome reports, public health data, patient reported outcome measures, relevant committee minutes and reports of providers and relevant national reports. During 2018/19 NHS Oxfordshire CCG incorporated the use of healthcare intelligence software (Dr. Foster) into the Clinical Effectiveness portfolio. The current approach to clinical effectiveness covers a wide breadth of pathways from prevention, effectiveness and patient experience. This use of all the available information allows assessment of whole pathways, for example the outcomes of circulatory disorders such as stroke and infarctions can be linked to preventative measures such as smoking cessation and treatment of obesity and to treatment within national guidance. A more complete picture of patient care is drawn and this can point to gaps or anomalies.

3.4.1 NICE, Individual Funding Requests and prior approvals.

The Quality Committee received the NICE annual report in June 2018. NICE produces national guidance on clinical and cost-effective treatments and service design. The report set out compliance with NICE guidance throughout Oxfordshire. The Committee was assured that major providers in Oxfordshire complied with NICE quality standards where appropriate.

The Clinical Ratification Group (CRG) receives the recommendations and actions arising from the Area Prescribing Committee (APCO), Thames Valley Priorities Committee (TVPC) and NICE. The Quality Committee receives the minutes of the CRG. The CRG approves commissioning policies recommended by the Thames Valley Priorities Committee which define local funding of procedures of limited clinical value. The commissioning policies are publically available on the CCG website. This is in line with best practice and the NHS Constitution.

The Individual Funding Request (IFR) and Prior Approvals annual report was presented to the Committee in June 2018.

An Individual Funding Request (IFR) is the means by which an NHS clinician may advocate the use of an intervention for his/her patient which is not commissioned and is, therefore, not normally funded. In doing so they must seek to demonstrate in what way the clinical circumstances may be regarded as exceptional when compared with other patients for whom the requested intervention is not funded. The IFR and Prior Approvals team work closely with internal and external stakeholders to ensure consistent and robust decisions are made in line with the CCG IFR Policy and within the published timescales.

The CCG conforms to the NHS Constitution, which ‘gives patients the right to expect that decisions made at a local level on funding of drugs and treatments will be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment which a patient and their doctor feel would be right for the patient, that decision must be explained to the patient’.

The number of IFR request received by the CCG in 2018/19 (270) was similar to 2017/18 (277). However, the number of cases reviewed at Panel has reduced by around half as a result of the streamlining of the IFR and prior approvals process. IFR requests are now submitted on an IFR proforma. In addition, the requesting GP/Clinician has to ensure that evidence of clinical exceptionality and exceptional capacity to benefit has been demonstrated before the case can be considered by the IFR team.

The team has also worked with the secondary care providers to ensure they have a clear understanding of the prior approvals and IFR process and what is meant by clinical exceptionality. This work will be further extended in2019/20 via practice visits, the GP bulletin and GP locality events/workshops.

The percentage of cases approved at Panel has remained the same at 44% demonstrating a consistent and thorough approach to decision making.

There were no cases in 2018/19 which went to Decision Review Committee.

Prior Approvals (PAs) are the means by which a provider is required by the CCG to secure funding before specified criteria based interventions are carried out. They must provide the necessary level of clinical evidence in writing to demonstrate that an individual patient, who requires the intervention, meets the clinical criteria set out in the CCG Policy. The Prior Approval (PA) process is the method operated by the CCG to facilitate the submission and response to PAs in a systematic and efficient manner, minimising the possibility of a delay to an individual patient's treatment.

Bluteq is the software used by the CCG to manage the prior approvals system. An electronic version of the IFR form has been agreed will be implemented in primary care starting in July 2019, shortly followed by secondary care. This will significantly improve the management and reporting of IFRs and support the move to paperless files.

Providers have to evidence approval has been sought and given for low priority procedures. Procedures are not paid if compliance cannot be demonstrated. This process delivered savings and quality benefits by picking up specialist procedures being undertaken when patients did not meet criteria.

3.4.2 Medicines Optimisation

The CCG Medicines Optimisation supports appropriate prescribing in primary and secondary care. This is done in a variety of ways including the review and implementation of guidelines, collaborative work with providers (including care homes), the introduction of new pathways and the review of governance arrangements.

Locally medicines management is well established and use of medicines benchmarks well. The NHS England Medicines Optimisation Dashboard provides data and the NHS RightCare Programme is useful in identifying where the OCCG is different compared with other CCGs with similar populations.

In 2018-19, OCCG spent £79.774 million on medicines prescribed by family doctors for the population in Oxfordshire. The CCG Medicines Optimisation worked closely with GP practices and other clinicians to promote good quality, cost-effective prescribing across the county including minimising spend in areas where there is limited clinical value.

As in previous years, there was a Prescribing Incentive Scheme (PIS). The Prescribing Dashboard was updated monthly and made available via the CCG website in order to inform practices on all their prescribing targets and priorities. The software tool ScriptSwitch continued to be used in all practices to support appropriate prescribing.

Repeat prescriptions represent approximately 60-75% of all prescriptions written by GPs and approximately 80% of primary care prescribing costs. By adding repeat prescribing as an area of work to the PIS in 2018-19, the Medicines Optimisation team supported practices to review the processes involved with the aim of reducing unnecessary waste.

3.4.3 Primary Care

Accountability for monitoring the quality of primary medical services sits with the CCG through the Quality Committee. New processes for assuring the quality of

primary medical services and promoting improvement have been established. During 2018-19 the Quality team has made progress in implementing and testing these processes. There is a growing awareness in practices of the role of the Quality Team and the availability of support, advice and guidance from the CCG.

Quality Improvement Visits

In the last 6 months of 2018/19 the Quality Team made 24 visits to GP practices. The CCG team supported practices to prepare for CQC inspections, as well as helping them to develop action plans where areas for improvement had already been flagged up in inspections. Support was also proactively offered to practices with negative variation in Quality and Outcomes Framework (QOF), health checks or patient survey ratings. The majority took up this offer. Feedback on the visit programme from practices has been consistently positive.

Quality & Outcomes Framework (QOF)

QOF achievement for 2018-19 continued to improve and continues to compare favourably with the national average. Oxfordshire average achievement increased to 97.5%, which is above the England average of 96%. 11 Oxfordshire practices achieved the maximum score compared with ten last year. The average overall exception rate for Oxfordshire also dropped slightly and remains below the national average. Focused support was offered to practices with lower achievement or higher rates of exception reporting during Quarters 3 and 4.

Primary care quality dashboard

A dashboard has been developed to summarize quality in Oxfordshire GP practices. The Quality Team and the Primary Care Commissioning teams are now working with our commissioning support unit to implement a data management tool that will allow us to interrogate quality and performance data in depth, produce meaningful reports and to carry out trend analysis. This tool will be available to practices and PCNs as well as to commissioners.

Learning from incidents and complaints

During 2018-19 practices carried out 26 significant event analyses. These have been shared with the CCG. The majority of issues were raised by Oxford Health NHS FT and Oxford University Hospitals NHS FT and detail of type of issue is shown below. The current status is that 16 cases have been completed and closed, five are awaiting a response from the practice and five completed responses are awaiting review by clinical leads.

Reported by	*No.*
OHFT	8
OUHFT	8
Practice (self-referred)	5
Safeguarding	2
MP office	1
NHS England	1
Patient	1

Type	*No.*
Treatment & Care	16
Access	5
Medication management	4
Information governance	1

Key learning points from incident reporting over the past 18 months will be shared with practices via the GP Bulletin and the OCCG website during quarter 2.

4. Achievement of key Quality Committee priorities from 2018/19

4.1 The priorities for the Quality Committee in 2018/19 were to:

- Drive improvement in infection control through a system-wide approach to managing sepsis.
- Work towards a paperless NHS through the management of the Electronic Referral System (ERS)
- Support all GP practices to achieve 'good' or better in CQC inspections
- Support the work of the integration agenda through the use of quality improvement.
- Develop processes for multiagency incident analysis and sharing the learning across the system.
- Further develop the clinical effectiveness function to ensure patients always receive evidence-based healthcare.
- Work with providers to address the underlying causes of Never Events. Continue with the clinical visits following Never Events.
- Consider the implications for the management of quality in a changing NHS landscape.
- Undertake programme of clinical assurance visits.
- Develop an oversight of how the CCG uses evidence to support planning and decision making.

This report has demonstrated how these priorities have been met in 2018.19/ The ERS system was presented to the Committee in April. A multiagency incident investigation process has been developed, trialled and presented to the Committee. Clinical Effectiveness has developed further in the year and, supported by Dr. Foster intelligence, is a core part of the Committee's work. Despite significant work, never Events continue to take place. OCCG continues to work with providers, and other agencies to address the complex causes of these incidents. The programme of assurance visits is well embedded, and its usefulness is demonstrated throughout this report.

4.2 Priorities for 2019/20

- Develop quality framework for the new NHS landscape, including the Oxfordshire integrated care partnership (ICP)
- Support primary care networks to deliver the revised QOF requirements
- Support Oxfordshire consistently to deliver learning disability health checks
- Implement the National Early Warning System (NEWS2) for sepsis in primary care.
- Implement the new working requirements for safeguarding.
- Use clinical effectiveness information to support the development and redesign of pathways for long term and chronic conditions.
- The Quality Committee will develop its links with the National Institute for Health Research (NIHR), the Academic Health Sciences Network (AHSN) and Applied Research Collaborations (ARC) in order to support the ambition of innovation.

5. Conclusion

OCCG's Quality Committee is responsible for overseeing the quality and safety of services in Oxfordshire. The five duties of the Committee are: quality and performance of service; patient safety; patient experience; clinical effectiveness and innovation. The Quality Committee fulfilled its duties in 2018-19

In December the Committee received a presentation on the innovative multiagency model for Child and Adolescent mental Health Services (CAMHS).

A core part of the Committee's work for 2019/20 will be to support the development of quality within the new system landscape to support the NHS ten year plan.

The Committee will continue to build upon the improved knowledge and understanding it has developed through Dr. Foster and the programme of assurance visits to deliver quality improvements in safety, effectiveness and patient experience.

The Committee is informed by the views of many clinicians and managers in our commissioned services, and the views of patients. We would like to thank them for their contribution to our work to ensure the services provided in Oxfordshire are safe, accessible and clinically effective.