NHS
East Berkshire
Clinical Commissioning Group

Quality and Constitutional Standards Committee Meeting

Minutes

8th January 2019, 08:30 – 11:00

Boardroom, King Edward VII

ATTENDANCE	
Present	
Sarah Bellars, Director of Nursing and Quality, East Berkshire CCG (Chair)	**SB**
Jo Greengrass, Associate Director of Nursing – Quality and Safety, East Berkshire CCG	**JG**
Fiona Slevin-Brown, Director of Strategy and Commissioning, East Berkshire CCG	**FSB**
Jackie McGlynn, Clinical Director, East Berkshire CCG	**JM**
Huw Thomas, GP Clinical Lead, East Berkshire CCG	**HT**
Jo Jefferies, Consultant in Public Health, Berkshire Shared Public Health Team	**JJ**
Mark Sanders, Healthwatch (representing the 3 Healthwatches in East Berkshire)	**MS**
Nuzhet A-Ali, GP, Dedworth Medical Centre	**NAA**
In Attendance	
Paul Corcoran, Quality Improvement Manager, East Berkshire CCG	**PC**
Sarah Locke, Quality Improvement Support Manager, East Berkshire CCG	**SL**
Chris Sneller, Head of Performance, East Berkshire CCG	**CS**
Jo Barnett, Named Professional – Safeguarding Adults, Children and Children in Care, East Berkshire CCG *(partial attendance)*	**JB**
Anshu Varma, Head of Corporate Affairs, East Berkshire CCG *(partial attendance)*	**AV**
Tracey Burrows, Senior Information Governance Manager, SCWCSU *(partial attendance)*	**TB**
Tim Langran, CCG Lead Prescribing Support Pharmacist, East Berkshire CCG *(partial attendance)*	**TL**
Rose Elhamamy, Senior Quality and Safeguarding Administrator, East Berkshire CCG	**RE**
Apologies	
Catriona Khetyar, Head of Medicine Optimisation, East Berkshire CCG	**CK**
William Tong, GP Clinical Lead, Clinical Chair, East Berkshire CCG	**WT**
Jim O'Donnell, Clinical Chair, East Berkshire CCG	**JoD**
Katie Simpson, GP & Clinical Lead, East Berkshire CCG	**KS**
Adrian Hayter, GP Clinical Lead, East Berkshire CCG	**AH**
Lalitha Iyer, Medical Director, East Berkshire CCG	**LI**
Viki Wadd, Associate Director – Communications, Engagement & OD, East Berkshire CCG	**VW**
Alison Davies, Quality Support Manager, East Berkshire CCG	**AD**

Item No	Item	Action
	Introduction	
1	**Welcome and Apologies**	
	SB welcomed everyone and accepted apologies as above.	
2	**Conflicts of interest / Declarations of interest**	
	No new conflicts to note.	
3	**Notice of Any Other Business**	
	None noted.	
4	**Minutes of the Last Meeting**	
	The minutes of the last meeting were accepted as an accurate record for the discussion held.	
5	**Action Log**	
	The action log was reviewed and updated; please see Paper 5 – QCSC Action Log.	
	Quality & Safety	
6	**Information Governance**	
	<u>IG & GDPR Report</u> AV highlighted that progress has been made on the GDPR action plan however there is one area that needs further work which is the data flows and sharing agreement. This has been raised to the Executives to ask for additional resources to complete this piece of work. There is also progress on the IG toolkit. The IG training is being looked at to be a new annual occurrence rather than a roll over training requirement. At present we are at 27% compliant however we need to be 95% compliant by the end of February 2019 in order to reach Level 2. SB asked AV to provide a list to managers to inform them who is not compliant with the IG training. TB informed the Committee that in each department there is an asset administrator who should be monitoring their staff if they are IG compliant. SB asked TB to send the asset administrators list for information. TB informed the Committee that 4 incidents that have been reported since the previous committee, of which none were reportable to the Information Commissioner Office (ICO). The new IG Toolkit has just been audited by PwC (PricewaterhouseCoopers) and the GDPR Plan will be audited next. This will help to identify any gaps or areas that need to be focused on. **Action: AV to provide a list to managers to inform them who is compliant with the IG training.** **Action: TB to send the asset administrators list for information.** <u>IG Policies:</u> All the IG policies have had to be revised due to the change in law and to be compliant	**AV** **TB**

with GDPR Regulations. These policies are either a complete re-write or there are multiple amendments made to them. TB confirmed that all these policies have been through the proper procedures to ensure that they are all compliant. These IG policies are sent to all the asset owners who should direct them to their team. There is also an IG intranet page which gives access to these policies one they have been published. SB asked for training for the asset owners to understand the changes in these policies. TB confirmed that she has completed 12 face-to-face training sessions with departments.

All of the following IG policies were approved by the Committee:

Confidentiality & Safe Haven

This is a brand new policy brought about by new Data Protection Legislation and supersedes the Data Protection and Confidentiality Policy embedded with the IG Policy Handbook V4.0.

This policy details how the CCG will meet its legal obligations and NHS requirements concerning confidential information, information security standards and operate such procedures ensuring that confidential information sent to or from the CCG is handled in such a way as to minimise the risk of inappropriate access or disclosure.

IG & Cyber Incident management & Reporting

This is a brand new policy brought about by new Data Protection Legislation which introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. This policy has been re-written in line with national guidance and supersedes the incident Management Policy which was embedded within the IG Handbook V4.0.

The policy is to ensure that the organisation is managing and reporting incidents in line with new legislation and national guidance.

IG Management Framework & Strategy

This is an updated policy which has been completely re-written to bring in line with Data Protection Legislation, National Guidance and the Data Security and Protection Toolkit. This document supersedes the Information Governance Framework embedded within the IG Policy Handbook V4.0.

The policy is to ensure that the organisation has a robust information governance management framework to provide the clarity and context for its information governance activities.

JG asked about section 6 of this policy and how would the Quality Committee ensure compliance. TB confirmed that assurance is part of the departmental data flows which are required by the IG Toolkit. There are only 2 departments that are outstanding at the moment.

	IG Staff Handbook This is an updated policy which has been completely re-written to bring in line with the new Data Protection Legislation, National Guidance and the Data Security and Protection Toolkit. This document supersedes the IG Policy Handbook V4.0. To ensure Information Governance is the practice used by the organisation to ensure that information is effectively managed and that appropriate policies, system processes and effective management accountability provides a robust governance framework for safeguarding information. Individual Rights This is an updated policy which has been completely re-written to bring in line with new data Protection Legislation which has brought in new and updated rights for individuals in relation to their personal data. The document supersedes the Subject Access Request Policy embedded within the IG Policy Handbook V4.0. To ensure the organisation adheres with legal duty to comply with 'individual's rights' under the new Data Protection Legislation in relation to personal information it holds. Individual's Rights SOP This is a new Standard Operating Procedure to accompany the Individual Rights Policy. This documents sets out the approach the CCG will take in responding to requests made by individuals along with useful guidance and steps to follow when requests are received anywhere within the CCG. Information Governance This is a new policy completely re-written to bring in line with new Data Protection Legislation, National Guidance and the Data Security and Protection Toolkit. This policy supersedes the IG Policy embedded within the Information Governance Policy Handbook V4.0. This policy looks at the way the NHS handles information about patients, staff, contractors and the healthcare provided, with particular consideration of personal and confidential information ensuring it is handled in line with new legislation and national guidance. Training Needs Analysis This is an updated document completely re-written to reflect mandatory and recommend training for staff to ensure compliance with Data Protection Legislation, National Guidance and the Data Security and Protection Toolkit. This supersedes the IG Training Matrix – Appendix L embedded within the IG Policy Handbook V4.0. To ensure staff are aware of mandatory recommended training is required to ensure the organisation is compliant with legislation and national guidance.	

	An IG update, including any new or amended policies, will be provided at each of the Quality Committee meetings and would need to be added to the Quality Committee Business Plan. **Action: AV & JG to work together to understand when IG updates will come to the Committee and for it to be placed in the Quality Committee Business Plan.** <u>Subject Access Request (SAR) Q2 Report</u> JG provided the Committee with an overview of the SAR Q2 report. We are fully compliant as requests are being responded to within the timescale. There were no SAR requests last quarter. SB provided the Committee with an update on the court case that the CCG were summoned to attend. It was decided that the CCG had provided all the information that was available which was very positive. <u>Freedom of Information Q2 Report</u> JG provided the Committee with an overview of the FOI Q2 report. In this quarter the number of FOI requests has been higher than in 2017/18 and 2016/17. There are still breaches to the FOI deadline in some areas which is being monitored and an escalation process is being used to follow up on delayed departmental responses.	**AV/JG**
7	**Equality, Diversity & Inclusion (EDI)**	
	<u>EDI Forward Plan</u> SB provided the Committee with a verbal update to the EDI Forward Plan. Formal reporting is only required every four years rather than annually as previously thought. The requirements are now understood and there will be a new EDI plan going forward with staged objectives. By the end of January there needs to be an EDI annual report published on the website.	
8	**Clinical Concerns Q2 Report**	
	JG provided the Committee with an update to clinical concerns in quarter 2. The numbers have been much lower in this quarter compared to previous. There has been a good response from Bracknell & Ascot practices and we have been attending members meeting. Slough numbers have been low. Practices have been reminded of the importance in raising clinical concerns. The number of clinical concerns against Heatherwood and Wexham Park Hospital is 18 and Frimley Park Hospital is 15. Some of the issues raised are with appointments; care and treatment; and discharge. There are some key actions and learning around the clinical concerns; therefore GPs can see that clinical concerns are making a difference. SB was worried about the clinical concern regarding the twins born at Wexham Park Hospital (WPH) that were assigned NHS numbers that had been mixed up. This was flagged to NHSE. JM was also worried about patients being referred out of area for Physio by ASPH	

	(Ashford and St Peter's NHS Foundation Trust) when it should be covered under the care plan bundle. JG stated that she will confirm if this is part of the contract with Ian Murdock (Associate Director of Contracting & Performance). **Action: JG to confirm if ASPH physio out of area referrals should be covered by ASPH under the care plan bundle in the contract.** JM picked up on a general theme from providers regarding clinical concerns and that the responses have not been of a satisfactory standard. JG clarified that all clinical concern responses are discussed in the Quality team meeting every Monday and if the responses are not of a satisfactory standard then we would go back to the provider for further assurances. They will also go back to the provider if a GP is not happy with the standard of response to a concern. JG and PC assured SB that this process would continue so that unsatisfactory responses are challenged.	**JG**
9	**Quality Report, Performance Report and Scorecard**	
	Quality Report FHFT (Frimley Health NHS Foundation Trust) PC provided the Committee with an overview of FHFT (Frimley Health NHS Foundation Trust) who have had an announced CQC (Care Quality Commission) inspection that focused on maternity, Surgery and Community Services. The report has yet to be published. Echocardiogram Results is an issue with the electronic notification from HWPH to GPs. The latest update is that a technical fix involving ICE does not appear to be possible, but an alternative reporting route via DocMan is being explored. There have been a number of clinical concerns regarding Cardiology - problems with appointment bookings and long waits for diagnostics; also an SI (Serious Incident) involving a missed echocardiogram follow-up. PC is meeting with the Chief of Service and Head of Quality to discuss. There have also been clinical concerns raised by Slough Extended Hours GP Service regarding Pathology and patients not receiving the results of cervical screening (smear) tests. This has been raised with PCSE (Primary Care Support England) and Public Health England for investigation as it is part of the national screening programme commissioned centrally. GPs have raised concerns with Gastroenterology about the efficiency and effectiveness of the service. The Trust has confirmed that a consultant from the FPH (Frimley Park Hospital) site is working across into HWPH (Heatherwood and Wexham Park Hospitals) to ensure alignment of governance and best practice. There have been issues with follow up and the diagnosis pathway has been revised. NAA stated that she is having problems with referring patients to a Gastroenterologist Consultant for an opinion where the patient has just been given a treatment appointment. PC confirmed that this	

	has been raised at the Planned Care Board. SB asked PC to inform the Planned Care Board that the Quality Committee are worried about the Gastroenterology service. **Action: PC to inform the Planned Care Board that the Quality Committee are worried about the Gastroenterology service.** There has been a deterioration of elective operations cancelled on the day and PC is awaiting further information from the Trust following on from the exception report previously provided. Mixed Sex Accommodation (MSA) has a large number of breaches involving the DSUs (Day Surgery Units) at Heatherwood and Frimley Park. The Trust has undertaken estates work to remedy and we are expecting the Trust to be back on trajectory in the December 2018 figures. Sepsis identification and treatment - overall the performance is improving. The Trust is prioritising staff education and has put in place a cross-site sepsis committee and a new clinical lead role. The Trust carried out a study of site-level data that shows the areas requiring most improvement continue to be screening in FPH inpatient wards and treatment in WPH (Wexham Park Hospital) ED (Emergency Department). For VTE (Venous Thrombosis) performance has met target on aggregate in the year to date however HWPH is fluctuating just above and below the target periodically. The Trusts has taken actions to focus on VTE assessment on wards during e-prescribing rollout to ensure compliance is maintained to a high standard. The Stroke service at FPH continues to fall below target on admission to the unit within 4 hours. The action plan has not resulted in consistent improvement in performance to date. The service has started to review patients on the day and a revised improvement plan is in place with a defined trajectory. <u>ASPHFT (Ashford and St Peter's Hospitals NHS Foundation Trust</u> The Trust has continued to underperform on admission of patients to the stroke unit within 4 hours. The lead commissioners are concerned about performance and the CQRM (Contract Quality Review Meeting) has escalated the issue for a CCG / Trust executive level meeting. JM was worried as this issue has impacted on the care of patients and suggested that the ambulance service is informed not to take patients to ASPHFT. FSB stated that we would need to find out how many patients are being affected by this issue. **Action: FSB to find out how many patients are being sent to ASPHFT and are being affected by the underperformance of patient admission to the Stroke Unit within 4 hours.**	**PC** **FSB**

RBFT (Royal Berkshire NHS Foundation Trust

The Ophthalmology deep dive report has been deferred to the February ICS (Integrated Care System) West Quality Meeting. The reason was that the consultant needed more time to collate the evidence and review. SB wants to increase the EBCCG presence at this meeting in February to ensure close scrutiny.

There have been two SIs in which a patient has been given haemodialysis on a machine isolated for another patient. The action plan involves ensuring sign-off of staff competencies, reinforcement of training and the Trust is looking into the procurement of covers for isolated machines to aid identification.

Also the Trust has reported 5 Never Events so far this year. Three of which involved accidental administration of medical air instead of oxygen via flow meters. The Trust has now capped off piped medical air from all units except for its respiratory wards, where the relevant Patient Safety Alert measures (clear signage and covering flaps on air flow meters) are in place.

RBFT and Berkshire West CCG recently sent out a letter to neighbouring CCGs notifying the immediate suspension of non-urgent dermatology services; except for two-week wait cases which will continue to be seen. There appears to have been a lack of prior consultation and there are concerns about the impact on Frimley Health dermatology services. SB has requested a copy of the Trust's Quality Impact Assessment and discussions with Berkshire West have been initiated.

BHFT (Berkshire Healthcare NHS Foundation Trust)

SL informed the Committee that BHFT have been issued with a Regulation 28 which is Part 7 of The Coroners (Investigations) Regulations 2013. This was following the choking incident on Bluebell ward. The regulation requires NHSP (NHS Professionals) and regular agency staff to complete specific training with regards to the increased risk of choking in patients with mental health disorders and no mechanical dysphagia. The deadline to comply with the regulation was 12th December which was met by the Trust.

The LD (Learning Disability) Care Plans and the DAAT (Drug & Alcohol Action Team) Service targets have not been achieved in the Windsor, Ascot & Maidenhead locality.

SCAS (South Central Ambulance Service NHS Foundation Trust)

The Trust was CQC inspected across the 999 and 111 sites where they received an overall rating of Good. There was an issue with a Private Provider that SCAS were using which received a rating of Inadequate from the CQC. The service with SCAS was suspended whilst a further investigation was carried out. SCAS put together an action plan and once all immediate actions were completed, the service recommenced. The CQC will be completing a follow up inspection with this private provider and should any further concerns rise at this inspection then the service will be suspended immediately.

Primary Care

There was an incident that was identified at a Slough practice where an individual member of staff was found to have entered false information on to patients' records. Processes are being followed and patients have been contacted and asked to attend their general practice. There has been no patient harm noted to date. This member of staff had also worked at another practice previously and it was found that this incident has gone back to 2007. The Committee discussed auditing of this data in patient records which will need to be monitored more regularly. The audit report will be looked at once it has been completed. This individual has been dismissed. FSB informed the Committee that there will be a review of the QOF (Quality and Outcomes Framework) data that has been agreed with the General Practitioners Committee of the BMA (British Medical Association) next year. There needs to be a close review of the performance of Practice Managers and looking at working differently with vulnerable practices.

There is a risk summit to discuss Health Hill Surgery; this is due to issues in the practice with a backlog of referrals and DocMan. The surgery had a deadline to complete the CQC action plan which they failed to meet. MS informed the Committee that there has been a formal complaint made against this surgery from a patient who was refused to be seen by primary care as she was waiting to see a consultant. However there was no referral made to the consultant. This patient is being supported.

Performance Report

CS highlighted the CHC performance data in quarter 2 has stayed the same; we are failing to achieve the threshold. Provisional Quarter 3 data show that this has not changed.

For Mental Health / Dementia the performance threshold is being achieved for the CCG however Slough data has not improved. There has been a push to appoint a Dementia lead for the Slough locality. A Dementia workshop scheduled for January has been postponed until the lead has been appointed.

For urgent care there are still challenges in A&E and with DToC (Delayed Transfer of Care). The MSA (Mixed Sex Accommodation) is still breaching - see quality section above.

Ambulance performance has been meeting the threshold however there are on-going issues with long waits which are linked to handover delays.

Planned care 18 Weeks RTT (Referral To Treatment) data is at threshold. The 52 Weeks cases are both out of area providers. The Diagnostic Wait 6 Weeks performance has not achieved the target.

Cancer performance is getting better; FHFT (Frimley Health) are in second position in the country. 62 Day Waits performance is good. However RBFT (Royal Berkshire NHS Foundation Trust) has not achieved the threshold which is due to changes in the pathway.

	MS queried the WAM (Windsor, Ascot & Maidenhead) performance for DToC and that the local authority figures are different. CS explained that there are different reporting criteria for the local authority. The delays reported here are due to health reasons and not social care. JM queried ASPFT performance on A&E. CS responded stating that the Trust are struggling compared to other Acute Trusts however they achieved 88% on aggregated for the 4hr admissions target. **CHC Turnaround Programme** PC provided the Committee with an update on the CHC (Continuing HealthCare) Turnaround Programme which is looking at different work streams, to understand the figures and making sure there is no oversight of cases. There are fortnightly turnaround programme meetings with a good representation for oversight and scrutiny of the work programme. This group is monitoring risk areas and remedial actions. The risk areas that have been highlighted are data validation; staffing and Children's Continuing Healthcare. There is on-going data cleansing and case identification work which has identified further cases for review. This includes the High Risk Reviews where the financial threshold has been lowered which has added to the figures. The Children's Continuing Care cases with BHFT which has also identified additional cases which have also been added into the figures. The other risk is staffing where they have a high level of vacancies. Recruitment is underway with shortlisting and interviews being scheduled. Also the Children's Continuing Healthcare is another risk where BHFT have told the Interim Head of Service that their children's CHC assessment function does not fit with their longer term strategy and that they wish to cease this function on 1st April 2019. FSB has written to BHFT regarding this as the team within BHFT also support children with long term life conditions who are not covered under CHC and she wanted assurance from the Trust that this support will continue. Also the cessation of the service will not be agreed until there is a robust transition plan in place. The contract states that BHFT would need to give 6 months' notice. In terms of CHC numbers (new cases, assessments within 28 days, reviews due and overdue), there will still need to be work on the assurance on the validity of the data. All cases are now coming in electronically where they will be allocated to a specific member of staff for assessment and for review. The Committee decided that once systems are embedded in the service then an audit will be carried out. Also with the level of interim support being used, JB suggested that she will offer to carry out safeguarding supervision for clinicians.	
10	**Performance against CQUINs Quarter 2 Report**	
	JG provided the Committee with an overview of the CQUINs (Commissioning for Quality and Innovation). Exceptions are summarised below:	

	CQUIN 4; improving services for people with mental health needs who present to A&E: There has been a reduction in A&E attendances and the CQUIN milestone has been fully achieved by BHFT and FHFT. CQUIN 9; which is preventing ill health by risky behaviours – alcohol and tobacco. This has been a challenge for the providers to achieve. FSB stated that this will be targeted in the 10 year NHS plan. Also JJ stated that capturing the data is very hard for providers. Local CQUIN for SCAS; which is an increase in the number of nursing/care homes with access to Live Link. SCAS have had difficulty in achieving their milestones and have revised this for quarter 4.	
11	**Update on ICS Quality**	
	SB provided the Committee with an update following the ICS Quality and Performance Committee meeting. PC was asked by that committee to pull together an initial quality report covering system providers which will be used as a starting point for an evolving system quality report. The operational plan from a quality perspective is being developed and will be coming to the next Committee meeting.	
	Patient Experience	
12	**Patient Story**	
	Lauren's story (https://vimeo.com/272759054/9266d3e5c4)	
13	**Healthwatch Update**	
	MS provided the Committee with a Healthwatch update. The x-ray department has closed at Fitzwilliam House in Bracknell. FSB stated that the x-ray department has moved to Heatherwood Hospital and that Bracknell GPs were written to in October informing them of this closure. MS stated however that the x-ray leaflet that GPs provide to patients still has the Fitzwilliam House location. FSB confirmed that GPs were notified of this change in October 2018 as the lease in Fitzwilliam House ends this year. The outpatient's element moved to Brants Bridge and the x-ray department to Heatherwood Hospital. Comms will need to go out again for GPs to change information provided to patients. FSB has asked FHFT for the quality impact assessment for this change in service. There has been no review of the chaperone policy in primary care. GPs have had issues with which patients are covered under the chaperone policy and when they should be reviewed. There has been an issue when a patient turned up for an appointment and they were told that there was no trained chaperone available.. SB stated that if a patient needs to be chaperoned then they should be provided with a chaperone under GMC (General Medical Council) conditions. There have been issues with prescribing controlled drugs to the homeless where they	

	have been told that they need to go to Maidenhead for the prescription. SB suggested that MS links in with JJ for the local authority involvement. **Action: MS to link in with JJ regarding prescribing controlled drugs to the homeless where they have been told that they need to go to Maidenhead for the prescription.**	**MS/JJ**
	Safeguarding	
14	**Cases of Concern**	
	JB provided the Committee with an update that there is one new Bracknell case regarding a man who killed himself and was known to services. The East Berkshire CCG Designated Nurse will be chairing the safeguarding adult review.	
15	**Health Strategic Safeguarding Group Chairs Report**	
	The Committee noted this report.	
	Policies	
16	**Policies**	
	<u>TVPC 17 Policy for the Preservation of Fertility (with reference to TVPC 2 Treatments for Gender Dysphoria)</u> TL informed the Committee that this policy was originally in place for patients who have suffered from cancer. The Thames Valley Priorities Committee have reviewed the policy and have now included patients who are not suffering from cancer and patients who are undergoing treatment for gender dysphoria. Also any patients who would likely have an impact on future fertility. SB asked if this change has an impact on our local CCGs and for the Frimley ICS. TL will check this and feedback to the Committee. **Subject to this feedback the Committee approved this policy.** **Action: TL to find out if TVPC 17 policy has been adopted by neighbouring CCGs and by the Frimley ICS.** <u>TVPC 79 Iron Chelation in Myelodysplastic Syndrome (MDS)</u> TL informed the Committee that this policy is to put in place priorities of which patients are able to undergo this treatment. This would include patients who suffer from minor Myelodysplastic Syndrome and patients who are having blood transfusions and as a result suffer from an iron overload. This would affect a small number of individuals. There is evidence that this treatment would have promote longer survival and reduce cases of cardiac arrest. **The Committee approved this policy.** <u>EPPG Policy 8 Prescribing of Gluten Free Foods</u> TL informed the Committee that this is an amended version of the policy that was already in place. The existing version covered patients who suffer from coeliac and were to be prescribed 8 units of carbohydrates per month. Also the use of flour, mixes, breads and pasta. However nationally pasta and flour has been removed from the drug tariff which is a national list of products that can be prescribed. So even if a prescription is written for those items a pharmacy will not be able to dispense them. This update to	**TL**

	the policy is removing those products and will only retain breads and mixes. This was following a national consultation as at the time when this was first introduced it was very expensive to buy gluten free products and they were not widely available. Now you can find gluten free products in all supermarkets and it is of similar price to ordinary products. From a quality point of view this makes it fair and equitable. SB asked if there is any documentation to support primary care in this change.TL stated that there are template letters and a small leaflet will be produced for GPs to give to patients. NAA asked why breads are still being prescribed. TL stated that the gluten free bread is more expensive than normal bread. Also gluten free pasta is at the same price as normal pasta. NAA also questioned whether there is assurance that the over the counter gluten free products are of the same quality as the gluten free prescribed products. TL confirmed that the gluten free products of the same quality as those previously prescribed can be obtained over the counter.. The Coeliac Society has supported this policy following the national consultation. **The Committee approved this policy.**	
17	**Other Policies**	
	Clinical Supervision Policy JG provided the Committee with an overview of this policy which has been introduced for non-medical clinicians. Also for nurses who have supervision via PLTs (Protected Learning Time). This process has already been piloted. **The Committee approved this policy.**	
	Quality Committee Governance	
18	**Items Expected At Following Committee**	
	As per the Business Plan.	
19	**Other Minutes**	
	Minutes from the following meetings were noted: • FHFT SI Panel Oct 18 • FHFT SI Panel Nov 18 • FHFT CQRM Sep 18 • ASPHFT CQRM Oct 18 • ASPHFT CQRM Nov 18 • ICS SI Panel Part A Oct 18 • ICS SI Panel Part B Oct 18 • ICS SI Panel Part C Oct 18 • ICS Quality Aug 18 • ICS Quality Oct 18 • BHFT CQRM Aug 18 • EBPC OOH CRM Sep 18 • SWiC CRM Sep 18 • SCAS PTS CQRM Aug 18 • SCAS 999 CQRM Aug 18 • SCAS 999 CQRM Oct 18 • BUCC CRM Sep 18	

	• LeDeR Steering Group Aug 18 • ICS+ Mortality Review Group Aug 18 • EDI Steering Group Nov 18	
20	**Risk Register**	
	JG proposed to the Committee the following changes to the risk register. Risk QC5 for the Urgent Care Contract (One Medicare Ltd) who has had a CQC inspection where they were rated as Good. The CCG has reduced the number of Quality meetings. JG proposed that this risk is reduced to 4 and closed. Risk QC6 for the SCAS contract has been on the risk register for a while and now overall their performance is good. JG proposed that this risk is closed. Health Hill will remain on the risk register at the highest risk which is reviewed weekly. **The Committee approved the proposed changes.**	
21	**AOB**	
	SB informed the Committee that it has been announced that there will be a joint inspection JTAI which is a joint targeted area inspection in Bracknell with CQC and OFSTED. This inspection was looking at the safeguarding of familiar sexual abuse of children based on the 2015 report.	

Next meeting:

05/03/2019 09:15 – 12:15
Boardroom, King Edward VII Hospital, Windsor