GOVERNING BODY REPORT

1. Date of Governing Body Meeting  
   16th March 2017

2. Title of Report:  
   Quality Improvement Report

3. Key Messages:

   • The Countess of Chester Hospital NHS Foundation Trust has published the findings of the report from the independent review undertaken in September 2016 of their neonatal service from the Royal College of Paediatrics & Child Health and The Royal College of Nursing. It is available on their website. It makes a number of recommendations and the Trust is developing an action plan that will address these.

   • The Countess of Chester Hospital NHS Foundation Trust has reported 5 Never Events between May 2016 and January 2017. These all relate to surgery and as targeted quality monitoring of safer surgery practice has not yet mitigated the risk of these incidents occurring the Trust will now be on an increased level of enhanced surveillance.

   • The Care Quality Commission has published the findings of their re-inspection of Cheshire and Wirral Partnership NHS Foundation Trust mental health services. Following the re-inspection five individual service reports have moved from “requires improvement” to “good”. Overall, the Trust remains rated as “good” with “outstanding” for care. The report recognises lots of excellent patient care and good practice within the Trust.

   • In December 2016 Cheshire and Wirral Partnership NHS Foundation Trust received 2 Regulation 28 Preventing Future Deaths notifications from both the Wirral and Cheshire Coroner offices. These notices mean that the coroner wants more assurance from the Trust that they will change practice as there is a risk that a further death could occur in similar circumstances. One related to the management of nicotine addiction for inpatients and the other related to discharge processes from Accident and Emergency departments for people who attend there with mental health problems. The Trust is preparing responses for the coroner detailing actions they will take to reduce the risk of future deaths.
• A portion of our population access services provided by Wirral University Teaching Hospital NHS Foundation Trust. This Trust has now reported 5 Never Events in the last twelve months in ophthalmology services. The Trust took immediate action to temporarily suspend a small number of operations so they could review the processes being followed to ensure safer surgery practice. Normal schedules have now resumed.

• Local GPs are making good progress in tackling the national issue of antibiotic resistance. They are on track to meet national targets set to reduce both the total number of antibiotics prescribed and the number of broad spectrum antibiotics prescribed.

• GPs play a vital role in safeguarding children and one of the ways they do this is by preparing reports for child protection case conferences. The local Safeguarding Children Board expects practices to do this for at least 75% of child protection case conferences. Local practices have achieved this standard for initial child protection case conferences but are consistently not achieving this for providing reports for review child protection case conferences.

4. Recommendations

The governing body is asked to:

a. Review the issues and concerns highlighted and identify any further actions for the quality improvement committee

b. Discuss the impact of the future quality premium targets in relation NHS continuing healthcare on the discharge to assess and intermediate care programme

c. Note the positive assurance provided about the quality premium targets for antibiotic prescribing

d. Note the update provided in relation to our equality and inclusion duties

e. Review the current position reported by the Designated Nurses for Safeguarding Children and Children in Care and identify any further assurances required against the actions taken to mitigate exceptions

f. Note assurance on the delivery of the requirements to support the national Learning Disabilities Mortality Review programme
5. **Report Prepared By:**  Paula Wedd  
Director of Quality and Safeguarding  
March 2017
<table>
<thead>
<tr>
<th>Corporate objectives</th>
<th>Alignment of this report to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire</td>
<td>This report highlights variations in practice that impact on patient safety and actions to mitigate risk</td>
</tr>
<tr>
<td>We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people</td>
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<tr>
<td>We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission</td>
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<tr>
<td>We will commission integrated health and social services to ensure improvements in primary and community care</td>
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<tr>
<td>We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets</td>
<td></td>
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<tr>
<td>We will develop our staff, systems and processes to more effectively commission health services</td>
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</tbody>
</table>
## Alignment of this report to the governing body assurance framework

<table>
<thead>
<tr>
<th>Risk No</th>
<th>Risk Description</th>
<th>Assurance / mitigation provided by this report</th>
<th>Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)</th>
</tr>
</thead>
</table>
| 5       | Failure to commission safe, effective and harm free care from Providers | This identifies how:  
*risk to the delivery of neonatal services is being mitigated through changes in the delivery of critical care services to high risk babies  
*risk to the consistent performance against the national safer surgery practice guidelines is being managed by the Countess of Chester Hospital | No change |
| 6       | Failure to ensure robust arrangements are in place for the safeguarding of vulnerable children | This report identifies how escalation process across partners have delivered an improvement in the number of children in care with an up to date health assessment | No change |
| 7       | Failure to ensure robust arrangements are in place for the safeguarding of adults at risk | This report identifies how risk in care homes is being mitigated through closure to admissions and close surveillance | No change |
NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

QUALITY IMPROVEMENT REPORT

PURPOSE

1. To provide information to the governing body on the quality of services commissioned by NHS West Cheshire Clinical Commissioning Group by identifying areas where performance falls below expected standards.

2. To seek scrutiny of the assurance provided by the quality improvement committee in relation to the risks and concerns managed by the committee that may impact on patient safety, experience and outcomes in this health economy.

3. The quality improvement committee identified a number of issues to be brought to the attention of the governing body from its meeting on 9th February 2017.

INFECTION CONTROL

4. The committee noted the positive performance in West Cheshire in the delivery of the objective of no more than 78 cases of clostridium difficile in 2016/17. The year to date performance to the end of December is 36 cases.

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Neonatal Services

5. The Trust has published the findings of the report from the independent review undertaken in September 2016 of their neonatal service from the Royal College of Paediatrics & Child Health and The Royal College of Nursing. A link to the report can be found on the Trust’s website here.

6. The Trust is preparing an action plan in response to these recommendations and implementation will be overseen by NHS England’s North West Specialised Commissioning Hub, who are responsible for commissioning our neonatal services. However this is an important review that we need to take account of in our role as commissioners of high-quality care for the population of West Cheshire so we will be asking for updates through our monthly contract meetings with the Trust.

7. Paula Wedd, Director of Quality and Safeguarding has been working with our Designated Doctor Safeguarding Children, Dr Mittal, to identify what actions we need to take in respect of the references in the report to the Cheshire Child Death Overview Panel. Dr Mittal is our representative on the Cheshire Child Death Overview Panel.
Never Events

8. The committee received an update on the 5 Never Events that have occurred between May 2016 and January 2017 and were informed that the Trust will now move to the next phase of NHS England North’s enhanced surveillance process, as targeted quality monitoring of safer surgery practice has not mitigated the risk of ongoing quality concerns.

9. The next phase of NHS England North’s enhanced surveillance process involves the development of a Quality Risk Profile. This provides a comprehensive review of a number of quality and safety metrics and gives a global view of the Trust. A risk rating score is formulated for each metric, with the aim of forming a balanced view. The Trust’s regulators and commissioners have now completed this Quality Risk Profile. It is in draft for checking by commissioners and regulators prior to sharing it with the Trust.

10. The next steps involve NHS England facilitating a meeting with the Trust, the commissioners and the regulators. The provider is able to discuss their views in relation to the Quality Risk Profile. The aim of this meeting to gain overall agreement of the risk scores and any required actions.

11. If significant risks are identified and agreed, it would be routine for a provider to remain on enhanced surveillance for a period of time to allow for the agreed actions to be undertaken and for sustained improvement to be realised. In addition a further review of the Quality Risk Profile would be undertaken after an agreed time in order to establish if the identified risks have been resolved or reduced.

Falls

12. There has been a continued increase in the number of falls with harm reported over the preceding 8 months, this is not just a winter spike. Despite the overarching action plan developed in October 2016 by the Trust in response to their thematic review of falls the Director of Quality and Safeguarding has informed the Trust that there is a lack of assurance that this is delivering sustained changes. The committee received a brief at the last meeting on the action plan.

13. The Trust Director of Nursing has advised that falls with harm is high on the agenda at their Trust Board and numbers of falls is being challenged by the Non-Executive Directors. The Director of Quality and Safeguarding has requested a written update from the Trust to the March Quality and Performance meeting giving an update on the actions required to reduce falls with harm.
Friends and family test

14. The governing body have previously been advised that the Trust has a consistently low response rate for this national survey. The November 2016 results for the Trust show a response rate of 2.2% which is an improvement on September’s rate of 1.5%. This is an encouraging increase on last month, but still remains below the national average of 2.6%. The committee have asked that this continues to be raised at the Quality and Performance meeting with the Trust with the expectation that it should be, as a minimum, in-line with the national average.

National Community Mental Health Services Survey

15. The annual Community Mental Health Services Survey results were published by the Care Quality Commission in November 2016. The Trust response rate was 29%, which is 1% higher than the national average. This is in contrast to the Family and Friends response rate.

16. The Trust maintained a high rating this year. 33% of those surveyed have been in contact with Cheshire and Wirral Partnership NHS Foundation Trust services for over ten years, and 44% of respondents had been seen by Trust services in the preceding month.

17. The Trust performed better than average over the majority of questions, and the overall experience that respondents reported placed them as one of the top scoring Trusts surveyed by the Care Quality Commission.

18. There are areas where the Trust performed less well and they have committed to actions over the next few months to ensure improvement in the areas below:

- Further improve knowledge of who the care co-ordinator or lead professional supporting the care package is, and how they can be accessed
- Review arrangements for ensuring people who access Trust services know who to contact out of office hours.

Care Quality Commission

19. In October 2016 the Care Quality Commission re-inspected the Trust’s mental health and substance misuse services, following on from the Trust-wide comprehensive inspection in June 2015. The re-inspection report was published on 3rd February 2017.

20. Following the re-inspection five individual service reports have moved from “requires improvement” to “good”. Overall, the result has not changed from “good” with “outstanding” for care. The individual reports recognise lots of excellent patient care and good practice within the Trust. The report can be seen [here](#).
21. The Trust is awaiting a similar re-inspection of community services.

**Regulation 28 reports**

22. In December 2016 the Trust received a Regulation 28 Preventing Future Deaths notification from the coroner. Following the death of an inpatient the coroner wanted assurance that the Trust would take action to ensure that when staff enforced the hospital smoking ban they had the knowledge and training to support patients with managing their nicotine addiction. The Trust will be responding to the coroner to address the training deficit concern raised within the Regulation 28.

23. In the same month the Trust also received a joint Regulation 28 Preventing Future Deaths notification from the coroner in relation to the death of a Wirral resident. The Trust is working with Wirral University Hospital Teaching Hospital, the Police and the Highways department to produce a response to the concerns raised by the coroner.

24. The concerns raised were in relation to the Trust’s self-harm pathways, the coroner was not assured that there was sufficient governance and audit of these policies. There was also concern raised in relation to Cheshire and Wirral Partnership NHS Foundation Trust staff discharging patients from the emergency department at Wirral University Teaching Hospital, the Coroner believes that only emergency department staff should discharge patients.

25. The other concern relates the proximity of the bridge over the M53 to Arrowe Park Hospital and its emergency department is seen as a risk factor with a high degree of lethality which needs assessing in relation to its Health and Safety.

26. Although this incident took place on the Wirral and involved Arrowe Park Hospital, we will be seeking assurance from the Countess of Chester Accident and Emergency Department about their processes for discharge with Cheshire and Wirral Partnership NHS Trust.

**Nurse Associates**

27. Cheshire and Wirral is one of only 11 pilot sites across England to pioneer the new Nursing Associate role with trainees starting in six NHS organisations across this region. The Trust will host eight trainees and is also leading the project for the region.

28. Local trainees will work alongside registered nurses and other healthcare staff in hospital wards and community settings, whilst also receiving support and training from the University of Chester as part of a two-year course. Once they have finished their training and placements, the Nursing Associates will work in a range of clinical and community settings to bridge the gap between care assistants and registered nurses in a hands-on role that ensures patients receive compassionate, person-centred care. The Nursing and Midwifery Council agreed in January 2016 to regulate the new Nursing Associate role.
NUFFIELD GROSVENOR HOSPITAL

29. Nuffield Health Chester underwent a planned Care Quality Commission inspection on 27th July 2016 and an unannounced follow up visit took place on 4th August 2016. The final CQC report has now been published and the Hospital received an overall rating of Good and a rating of Good for all areas which were inspected. The full report can be accessed here.

30. The Hospital was noted to have outstanding practice for the introduction of health MOTs for patients attending for pre-operative assessments.

31. The Hospital is now working on an action plan to address the areas identified for improvement within the report.

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

32. West Cheshire Clinical Commissioning Group is an associate to Wirral Clinical Commissioning Group’s contract with Wirral University Teaching Hospital NHS Foundation Trust. The governing body had previously been informed that Wirral Clinical Commissioning Group had informed us that there had been four Never Events in the last twelve months in ophthalmology services.

33. Since our last meeting we have been advised that a further Never Event in the same specialty has occurred. The Trust took immediate action to temporarily suspend a small number of operations so they could review the processes being followed to ensure safer surgery practice. Normal schedules have now resumed.

CRAWFORDS WALK NURSING HOME

34. This is a large care home which is part of the BUPA care home group, with capacity to deliver care to over one hundred and thirty residents. The Care Quality Commission report that following their visits in September 2015, March and May 2016 that improvements have been made. However their inspectors are not yet assured that the improvements being undertaken are sustainable. The published report in July 2016 rated the care home as requires improvement across all 5 domains and is not meeting all of its regulated activities.

35. In June 2016 Cheshire West and Chester Council, supported by NHS West Cheshire Clinical Commissioning group applied a breach in contract resulting in suspension of admissions to Crawfords Walk. Over the last 6 months quality monitoring visits by Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group have observed sustained improvements and following a period of phased admissions the voluntary suspension has now been lifted.

36. There has been substantial investment in the home environment but there remains improvement notices in place relating to regulatory activity until the Care Quality Commission are satisfied on inspection that they meet the standard regulated activity.
AGENDA NO.: WCCGGB/17/03/111

ORCHARD MANOR

37. Orchard Manor is a care home owned by Fordent Properties Ltd. They are registered to provide both residential and nursing care for up to 90 residents, divided into six units. Three of the units provide general nursing care and three units for dementia care.

38. In May 2016 Cheshire West and Chester Council, supported by NHS West Cheshire Clinical Commissioning group applied a breach in contract resulting in suspension of placements for Orchard Manor. The local health and social care partners provided support and mentoring to the home manager and staff.

39. A phased lifting of the suspension was introduced in July 2016 and they are accepting a limited number of admissions per week. No concerns have been raised in relation to sustainability of continued improvements. The frequency of the quality monitoring visits undertaken by Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group has been extended between visits. This is to allow the manager time to concentrate on embedding the cultural changes and a period to focus on auditing the changes and the impact.

40. There remains improvement notices in place relating to regulatory activity until the Care Quality Commission are satisfied on inspection that they meet the standard regulated activity. The Care Quality Commission is currently conducting an inspection of the provider.

CHESTER LODGE

41. Chester Lodge is a care home owned by Heathbrock Ltd. The home provides residential and nursing care for up to 40 people. In July 2016 a safeguarding enquiry under section 42 of the Care Act 2014 commenced. This safeguarding enquiry has now been concluded as inconclusive and the learning for the provider identified during the enquiry have been formulated into further improvements relating to people who are at risk of falling and sustaining injury.

42. The Care Quality Commission has imposed restrictions on admissions to the care home. Prior to any admissions the care home has to demonstrate to the regulator they can meet the needs of any future residents. A number of new admissions have now been permitted.

43. Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group continue to visit the home to support sustained improvements in care.
TARVIN COURT

44. Tarvin Court is a care home owned by Tarvin Estates LLP. They are registered to provide residential and nursing care for up to 28 residents. In October 2016 Cheshire West and Chester Council imposed a contractual suspension on the provider for environmental breaches of their contract, which has resulted in them being closed to admissions.

45. The Care Quality Commission rated the provider Inadequate in September 2016. The provider has undertaken environmental improvements to the care home. Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group continue to visit the home to support staff to improve care delivery. NHS West Cheshire Clinical Commissioning Group has reviewed the patients who are in receipt of funded nursing care.

QUALITY IMPROVEMENT IN CARE HOMES

46. The clinical commissioning group Quality Improvement Manager briefed the committee on progress made in establishing best practice initiatives to support quality and patient safety within the 23 registered Nursing Homes.

47. The Falls Group initiated in October 2016 continues to meet monthly with regular attendance from 8-10 nursing homes. The group has expanded its remit to a quality and safety agenda and is now called the Clinical Forum for care homes. The Clinical Forum is an opportunity for the care homes to meet up and share best practice supported by our Quality Improvement Manager.

48. The Prevention and Management of Falls Policy for nursing homes is complete and undergoing final consultation with stakeholders. It is anticipated that this will be submitted to Quality Improvement Committee at the next meeting. Management and prevention of falls training for all home staff commissioned by West Cheshire Clinical Commissioning Group commenced in January 2017. There are 4 further sessions planned. Delegate feedback has been positive.

49. NHS England Cheshire and Merseyside are providing direct support for the roll out of the national React to Red Pressure Ulcer Prevention programme until April 2017. Six of our care homes, Upton Dene, Crawfords Walk, Pinetum, Vale Court, Oaklands and Thornton Manor, have commenced the React to Red programme supported by our Quality Improvement Manager. A progress report will be provided to the next committee meeting.

CONTINUING HEALTH CARE SERVICE

50. The Quality Premium for 2017/18 requires clinical commissioning groups to:

- ensure that more than 80% of cases with a positive NHS Continuing Health Care Checklist, have the eligibility decision made by the clinical commissioning group within 28 days from receipt of the Checklist
• ensure that less than 15% of all full NHS Continuing Health Care assessments take place in an acute hospital setting

51. Work is underway to establish accurate baselines across the shared Wirral and Cheshire Continuing Health Care Service. The delivery of these targets though is equally dependent on local discharge to assess and intermediate care models being fully operational.

MEDICINES MANAGEMENT

52. The antibiotic quality premium encourages clinical commissioning groups to tackle the issues of antibiotic resistance by reducing both the total number of antibiotics and the number of broad spectrum antibiotics prescribed.

53. West Cheshire is on target to achieve the 2016/2017 quality premium. The table below shows attainment. To achieve the quality premium we need to be below target for both indicators.

West Cheshire CCG’s attainment against Antibiotic Quality Premium Data - 12 months rolling 2015/16 Q3 - 2016/17 Q2

<table>
<thead>
<tr>
<th></th>
<th>Antibacterial items</th>
<th>Co-amoxiclav, Cephalosporins and Quinolones</th>
<th>Highlight position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movement in year</td>
<td>Value</td>
<td>Target</td>
<td>Movement in year</td>
</tr>
<tr>
<td>West Cheshire</td>
<td>Up</td>
<td>1.04</td>
<td>Down</td>
</tr>
</tbody>
</table>

EQUALITY AND INCLUSION

54. Good progress has been made against the 2016/17 equality and inclusion delivery plan. A 2017/18 delivery plan will be developed to incorporate continued areas of focus from the 2016/17 plan, feedback from the equalities grading event and the work required to meet the 2017/18 equality delivery system outcomes. The plan and equality delivery system outcomes will be presented for sign off at the quality improvement committee meeting in April.

55. The feedback from the equalities grading event will form part of the clinical commissioning group’s equality and inclusion annual report to NHS England, which will be presented to the quality improvement committee in April 2017 for review and ratification by the governing body in May 2017.

56. Following the clinical commissioning group’s first equalities grading event, further work will be completed to consolidate the working relationships with our partners representing protected characteristic groups and to identify further contacts to build our equality and inclusion network.
57. Follow up visits to all representatives who attended the grading event will be completed by the end of May 2017 and a protected characteristics ‘village’ will be created to identify who those communities are across West Cheshire.

CHILDREN’S SAFEGUARDING AND CHILDREN IN CARE

Commissioned Services Standards for Safeguarding Children and Adults at Risk 2017/18

58. The clinical commissioning group is responsible for promoting safeguarding in the services we commission. This is achieved through the contractual arrangements with our service providers. To ensure that the services we commission embed safeguarding standards in their practice the Commissioned Services Standards for Safeguarding Children and Adults at Risk document has been reviewed and updated for 2017. The committee approved the updated document and it will now be included in NHS contracts.

Safeguarding Children Training – Governing Body level training

59. Governing body member training compliance has reached the expected compliance rate of 80%.

Children in Care

60. The committee received an update on our statutory duties in relation to our children in care and wants to highlight the following information to the governing body.

61. The child in care population for Cheshire West and Chester steadily decreased during 2015/16 and was 8.3% less by December 2015 (463) compared to December 2014. This number has risen during the first 3 Quarters of 2016/17 to 494 at the end of December 2016.

62. It is a statutory requirement for all children who become Looked After to have a holistic health assessment on entering care. This initial health assessment should result in a health plan by the time of the first review of the child’s care plan, 20 working days after becoming looked after. During their time in care children who are under 5 years of age have a review health assessment every six months and children and young people over 5 years have annual review health assessments (Promoting the health and well-being of looked after children statutory guidance for local authorities, clinical commissioning groups and NHS England DoE / DoH 2015). The clinical commissioning group has a duty to cooperate with requests from the local authority to undertake health assessments.

63. Timescales and quality of all Health Assessments for Children in Care are monitored regularly and reported on the Countess of Chester Hospital NHS Foundation Trust and the Cheshire and Wirral Partnership NHS Foundation Trust Safeguarding Assurance Frameworks.
64. Table below shows the Health Assessment data recorded on the local authority monthly performance report for Quarter 2 2016/17 for all children in care for 12 consecutive months or more. In summary the percentage of children with an up to date Health Assessment for Quarter 3 was 80.8% in comparison to 78.0% for Quarter 2.

**Source: Cheshire West and Chester local authority**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>England (latest)</th>
<th>Statistical Neighbour (Latest)</th>
<th>North West (Latest)</th>
<th>CWAC 2015/16</th>
<th>CWAC Q3 2016/17</th>
<th>Direction of Travel (against previous Quarter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children looked after for at least 12 months with a recent health assessment</td>
<td>89.7%</td>
<td>85.5%</td>
<td>90.9%</td>
<td>77.3%</td>
<td><strong>80.0%</strong></td>
<td>↑</td>
</tr>
</tbody>
</table>

65. The committee receives regular updates on this position and whilst it is acknowledged that focussed partnership working to improve this performance has been delivered by the Designated Nurse and Doctor for Children in Care, Cheshire and Wirral Partnership NHS Foundation Trust and the local authority, this is still an inadequate performance against a statutory duty and we will continue to drive improvements.

66. The process of ensuring that a child in care has a health assessment relies on children’s social care initiating a timely request to health partners. The committee have previously been alerted to recurrent challenges in social care meeting that requirement and the impact this had on the timeliness of the completion of health assessments for West Cheshire children in care, placed both in and out of area. Consequently the escalation process for late health assessment requests from children’s social care was strengthened. This has resulted in a significant improvement in the timeliness of requests and the ability of Cheshire and Wirral Partnership NHS Foundation Trust to undertake the assessments.

**GPs and Child Protection Case Conferences**

67. The Cheshire West and Chester Local Safeguarding Children Board continue to monitor the initial and review child protection case conference information via the quarterly multi-agency dataset that is reported to the Board.
Table to show GP attendance at initial child protection case conferences and submission of reports to initial and review child protection case conferences

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% of Initial Child Protection Case Conferences with GP attending</th>
<th>% of Initial Child Protection Case Conferences with report submitted</th>
<th>% of Review Child Protection Case Conferences with report submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 4</td>
<td>31% 11 out of 35 conferences</td>
<td>80% 28 out of 35 conferences</td>
<td>55% 35 out of 64 conferences</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>11% 2 out of 18 conferences</td>
<td>72% 13 out of 18 conferences</td>
<td>59% 36 out of 61 conferences</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>6% 1 out of 18 conferences</td>
<td>78% 14 out of 18 conferences</td>
<td>54% 28 out of 52 conferences</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>24% 5 out of 21 conferences</td>
<td>76% 16 out of 21 conferences</td>
<td>71% 30 out of 42 conferences</td>
</tr>
</tbody>
</table>

Table above demonstrates activity over the last four quarters in West Cheshire. Attendance at initial child protection case conferences remains below 25% for the last three out of the four quarters and coincides with the discontinuation of funding for locum cover. Submission of reports for initial child protection case conferences has met the expected standard of 75% for the last two quarters. Submission of reports for review child protection case conferences has not met the required standard of 75% at any time during the last four quarters.

The child protection case conference data is included in the Primary Care Dashboard and the Quality Improvement Committee has requested that the Primary Care Committee respond to this performance level.

LEARNING DISABILITIES MORTALITY REVIEW

This national programme has been established as a result of one of the key recommendations of the Confidential Enquiry into the premature deaths of people with learning disabilities. Commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England.
71. It supports local reviews of deaths of people with learning disabilities aged 4 to 74 across England. Where there are concerns about the sequence of events leading to their death, or it is felt that further learning could be derived from a review of a death, then a full multi-agency review of the death is recommended. This is likely to be after discussion with other agencies (e.g. safeguarding boards, coroner’s officers, and child death review process). This is to ensure that a coordinated approach is being taken and in reviewing these deaths, circumstances leading to a death could be identified and potentially avoided in the future through improvements to health and care services. The programme also aims to capture best practice in the care and treatment of people with learning disabilities.

72. Following a wide consultation exercise NHS England have agreed the process for local reviews of deaths of people with learning disabilities and the core data to be collected. A secure, web based platform has been built to handle notifications of deaths and the local review process. All deaths of people with learning disabilities aged 4-74 will have an initial review of their death. It is important to stress that this review applies to all people with learning disabilities, not just those currently known to health and care services.

73. Work is also taking place with community organisations and family / carer forums to notify them of this Learning Disabilities Mortality Review Programme. This work forms part of the wider Transforming Care agenda and NHS England’s commitment to address health inequalities experienced by people with learning disabilities.

74. The programme requires clinical commissioning groups to take a number of actions and the committee has received an action plan from our commissioning manager which identifies next steps and timescales. It is imperative that we deliver this and the committee has asked for assurance at its next meeting on delivery against these commitments.

RECOMMENDATIONS

75. The governing body is asked to:

   a. Review the issues and concerns highlighted and identify any further actions for the quality improvement committee

   b. Discuss the impact of the future quality premium targets in relation NHS continuing healthcare on the discharge to assess and intermediate care programme

   c. Note the positive assurance provided about the quality premium targets for antibiotic prescribing

   d. Note the update provided in relation to our equality and inclusion duties
e. Review the current position reported by the Designated Nurses for Safeguarding Children and Children in Care and identify any further assurances required against the actions taken to mitigate exceptions

f. Note assurance on the delivery of the requirements to support the national Learning Disabilities Mortality Review programme

Paula Wedd
Director of Quality and Safeguarding
March 2017