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Northern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Northern Locality Board Meeting

Wednesday, 22nd October 2014, 09:15 – 11:00
Crown Yealm House, South Molton

DRAFT MINUTES

Present: Dr John Womersley (JWom), Caroline Dawe (CD), Dr Stephen Miller (SM), Carol McCormack-Hole (CMcCH), Mark Elster (ME), Tracey Polak (TP), Ruth Carter (RCa), Kevin Wheller (KW), Dr Annabelle Tree (AT), Paul Hopkins (PHo), James Wright (JWr), Dr Tim Chesworth (TC), Dr James Szymankievicz (JSz), Tony Layton (TLa)

Apologies: Hannah Nicholas (HN), Richard Croker (RCro), Dr Darunee Whiting (DW), Lorna Collingwood-Burke, Dr Annabelle Tree (AT), Barbara Jones (BJ)

In Attendance: Sara Wright (SWr) for her agenda item and 6 members of the public.

1. Welcome and Apologies

JWom welcomed everyone to the meeting. Apologies were noted as above. Housekeeping procedures regarding emergency exits were explained and it was noted that no fire drills were planned.

2. Declarations of interest

A sign in sheet requesting any new declarations was circulated, the register will be updated post meeting and a copy of the register will be circulated with all future agendas.

No new declarations were made in relation to today's agenda.

3. Patient Story

Carol McCormack-Hole, Lay member to the board, verbally recited a patient story that had been brought to her attention. This story involved a patient who did not speak good English and had to translate through her child who was still of primary school age. Due to the language difficulties the outcomes were nearly not those intended by the patient. The question of translation and use of family members for translation however was raised.

Members of the board said that GPs can use 'LanguageLine' a national translation system via the telephone which can be pre-booked when a professional identifies a language barrier, e.g. when the receptionist books appointments.

4. Previous minutes

The previous minutes were signed as an accurate record.
Previous actions were updated as per below;

- JWr Breast cancer 2 week waits - Back on track following the set recovery trajectory and meeting targets – achievements commended to Northern Devon Healthcare Trust.

- JWr - 21 practices have been visited out of 22 regarding referral rates and commissioning pressures, these have been positive and the referral rates have slowed down and are currently just under 5%.
- PH to talk to RC 'What a waste' posters have been sent to pharmacies and discussed at the Public Stakeholder Network.
- RCarter - Teledermatology to be put on the agenda for the September GP Forum - Done.

5. Locality Board Report

This report highlights areas of concern, it details the actions being undertaken to provide the board with assurance around the operation and delivery of healthcare within the locality. Specific concerns, highlights, questions and actions in relation to these reports are reported below:-

Assurance reports
Only red risks are raised in the current assurance report template however amber risks of concern are shown as a watching brief.

Transforming Community Services and Care Closer to Home- Public and Patient Engagement
We are currently in the middle of the engagement process, having completed the three large group meetings and now part way through the town based meetings. These have changed their focus to consider the local community and the impact. Attendance has been mixed in size and responses; this will run until mid-December and has been well received so far, it is felt that the rating of this risk could reduce to amber.

Delay in approval of TCS strategy (community urgent care)
A case for change document will be presented to the Governing Body on the 5th November. In relation to urgent care there are a number of companies looking to provide services and we are likely therefore to be looking at a competitive tender process. The milestones for this work-stream and care closer to home engagement have now been more aligned than previously although discussions at Governing Body on the 5th November will impact on timelines and work-streams.

Patients Transport Systems
This is a risk on both the Northern and the Eastern locality board's registers as we share the same service provider – NSL. The CCG continues to have performance issues mainly in terms of timeliness. The CCG is actively trying to work with NSL for them to achieve Key Performance Indicators and is using contractual levers. There is still further work to be done by all parties including healthcare providers, NSL and the CCG, however small improvements have already been seen. There are a number of actions in progress including recruitment of staff and new vehicles. A number of new keys posts are hoped to make a difference including floor walkers at both of the acute Trusts, there have however been some difficulties in recruiting. The risk scoring has increased from 16 to 20 which demonstrates that we are aware of the issues, taking them seriously and are actioning improvements with our PTS provider in order to meet the contract.
At this point it was agreed to answer a question submitted by a member of the public in relation to patient transport for renal patients as follows:

Question "Is the board aware of the sorry state of patient transport as operated by NSL in Devon and if so, what steps have been taken to assist in improvements."

Answer; Non-Emergency Patient Transport Service – NSL. The CCG tendered the Patient Transport Service and Voluntary Car Service in 2013. The contract was awarded to NSL for 5 years which started in October 2013. It is true to say that the CCG has experienced many problems with the contract in terms of:

- Patient experience
- Timeliness
- Communication

There are clear performance targets for the contract (below) with contractual fines for performance failures, and the CCG has both worked with NSL constructively and brought into play penalties to effect improvement in the contract over the last year.

Within the contract with NSL there are specific quality and timeliness targets that NSL are performance managed against on a monthly basis such as:

- 95% of renal patients should arrive for their dialysis appointment on time or not more than 30 minutes early. (NSL are currently reporting 82%).
- 95% of renal patients should be picked up at the agreed collection time or not more than 30 minutes after. (NSL are currently reporting 86% with a further 10% within 15 minutes of the standard i.e. 96% within 45 minutes).
- The provider will ensure that no renal patients spend more than 60 minutes on the vehicle either on the outward or return journey (target of 90% of patients). (NSL are currently reporting 90%).

There are a number of issues that the CCG require NSL to urgently resolve, these are:

- Renal patients being dropped off outside the renal units before the unit is open
- Renal patients being dropped off too early for their appointment
- Renal patients being picked up too late and then late for dialysis – knock on effect for the next patient
- Renal patients being late picked up as waiting for other patients
- Renal patients on journey with other patients and then having a longer journey home. One patient complained recently that since NSL took over that his journey from home to home is taking an extra 2 hours (3 times a week). Instead of 5 hours in total, it is now a 7 hour regular journey.
- Incorrect mobility
- NSL Staff attitude (because of patients running late).
- Communication issues

Actions to resolve:
NSL have recently employed a dedicated Operational Support Manager (OSM) to resolve the issues that the renal departments are experiencing. This person started 1 week ago. The OSM is there to work with all renal departments on a daily basis. They have started in Wonford and are present early morning (just before the unit opens) and monitors patients arrivals to ensure they are at the unit on time. If the patient is not on time, the OSM communicates with the drivers (taxi/VACS/PTS) to understand the issues and also to convey the message of what is expected from this service (patients are conveyed on time). The OSM liaises with the renal department throughout. I am informed by NSL that patients are also contacted if a driver is going to be late to pick them up. Where an incorrect mobility has been booked this is reported to the control room to change.

NSL have recently re-structured the Control Room, and put in place an OSM to have lead responsibilities for each area (Devon, Somerset and Cornwall). This will enable process, escalation and communication to improve between the units and NSL. I am informed by RDE

that they have seen an improvement in staff attitude and communication since the introduction of this new structure, which is still in a trial period. NSL are actively looking to recruit new VACS drivers, but they have also started to employ drivers to drive their own cars to convey patients to increase their capacity to resolve timeliness issues and multiple patients pick up.
Finally, I hope I have given you a flavour of some of the work that has been implemented to resolve, in particular, the renal patient issues. I can only re-iterate that the CCG is still committed to working with all stakeholders to resolve the non- emergency patient transport issues until the CCG is satisfied with the service NSL is providing.

We are also working with hospitals regarding patient appointment times to link up with patient transport availability. The member of the public who is involved with the South Molton kidney Dialysis Centre has also met with NSL and issues are around short notice on-the-day requests for transport due to a lack of flexibility in the system which is deemed to be due to a loss of voluntary drivers from around 30 to 8. The loss of voluntary drivers is thought to be due to restricted mileage and expenses put in place.

CD responded that there are work streams within these areas which are recognised as key factors and that NSL is closely governed by HMRC in relation to voluntary drivers. It is recognised that the voluntary car drivers built good relationships with patients which impacted positively on patients. This issue does however need to be resolved in the near future.

Financial position including management of 14/15 NDHT community contract and CIP
Financial position including management of 14/15 NDHT acute contract and QIPP
Finance will be covered in the main finance section on the agenda however – regarding CIP, the position stated in the locality report is unlikely to change between now and the end of the financial year. Regarding the acute contract – referrals and QIPP contribute to the overall financial position and emergency measures have been put in place - to be covered later.

Patient Safety and Quality
There was no further information than that contained within the report. One page of data related to Royal Devon and Exeter Hospital, it was requested to have Northern Devon healthcare Trusts data next month and this was to be fed back to the Business intelligence Team (RC – completed).

Finance and contracting
The financial position has worsened. Reasons for this include over-performance at the acute Trust, Continuing HealthCare funding, complex care and prescribing financial issues. The figures are within the report. There is work occurring to improve this including the practice visits for referrals. The main priority is to manage the contract with Northern Devon Healthcare Trust back to plan.

It was queried if population increase has been factored into referral increase and TP offered to audit GP practice registration increases against referrals per practice.

The impact of the 'Be Clear on Cancer' campaign is also starting to be seen within practices. The increase in referrals does not appear to be turning into an increase in day-case or in-patient procedures although this could yet be the case due to time-lags within the system.

Contracts
Page 31 of the report, underperforming against plan in terms of activity however costs still high due to a number of high-cost complex patients within the first quarter. CQUIN meetings are continuing.

Medicines Optimisation
The figures for the early part of the year indicate a break even although this could yet change due to changes in drug tariffs due to a national pricing change.

Public Engagement
Engagement with Patient Participation Groups (PPGs) remains a key focus and engagement continues through the public stakeholder network and other meetings run with our lay member through the communications team. A reminder will also go into the practice manager's weekly email requesting that practice managers forward information regarding care closer to home events on to their PPG members to ensure they receive this important opportunity to engage with us at an event.

Assessment of Assurance reports
Pages 41 and 42, there have been a noticeable improvement in the assurance ratings between September and October.

6. Quality Committee Quarterly Report

The quality of serious incident reviews has improved with recognition for the hard work of Dr Stephen Miller and Dr Tim Chesworth who have undertaken this work, Sara Wright commissioning Manager for the locality is also going to be involved. It is recognised that the northern locality have provided a high level of support to this process.

7. Operational Resilience Capacity Plan

New guidelines from NHS England to CCGs stipulate that system resilience needs to incorporate whole year planning including elective system planning as well as emergency; the previously entitled 'winter plan' is therefore now called the Operational Resilience and Capacity Plan and is contained within the papers for the meeting. This new approach enables greater inclusiveness of other networks and providers within demand and capacity management throughout the year. Urgent care working groups have changed to System Resilience Groups and are focused around the Northern Locality urgent care system including, Northern Devon healthcare Trust, South Western Ambulance Service Foundation Trust (SWASFT) and Devon Doctors on Call (DDOC) as well as others like local authorities. There is a requirement to widen this to include the voluntary sector and other networks over the next 6 months.

There is a sum of money available towards mitigating system risks which need to be evaluated to ensure the most beneficial usage. The board were made aware that since submission of the papers, a table on page 67 has been updated regarding allocations. Through the Transforming Community Services process, concerns have been raised about community staff being able to reach rurally isolated patients in the community due to snow and / or ice. There is some allocation for increasing community capacity support although the details of the business continuity plan for extreme weather will be for the provider to specify. The board were asked to vote to sign off the plan.

Vote 5/ 5 voting members approved the plan.

8. Financial Position of the CCG and Urgent and Necessary Measures

Following the financial section of the locality report outlining the position of the CCG, emergency measures were discussed, some of these are already approved and others are still under consideration. These include requiring patients with high BMI or who smoke to lose

weight or stop smoking prior to surgery as the health benefits and outcomes of surgery are known to be improved for the patient and can also make savings financially. These are preventative measures and have been evidenced by Public Health to have quality improved outcomes. Patients who are unable to meet the criteria for surgery will be assessed through the exceptional treatments panel. Discussions and decisions around emergency measures are difficult however it is important to have these openly and honestly in regards to the financial position.

Approved - Current Urgent and Necessary Measures:

- Weight loss for morbid obesity prior to routine surgery
- Weight loss for obesity prior to routine surgery
- Avoided Consultant to Consultant referrals and related activity
- 6 weeks smoking cessation prior to routine surgery, separate to BMI
- Restrictions on Out of Area referrals
- Establish appropriate Watchful Waiting / Active Monitoring on 18 week pathways, commissioning to the natural history of presenting conditions
- Account more clearly for the impact on follow-ups of QIPP schemes which target first outpatients
- Criteria based prior approvals: hernia, cataracts, anal fissures, anal skin tags, botulinum toxin outpatient procedures
- Suspension of treatments with poor evidence of outcomes, pending commissioning review
- Revaluation of QALY threshold on existing commissioning decisions.

9. Care Closer to Home Update

Sara Wright attended to speak to the update report enclosed.

The third round of meetings has not yet had the content planned as this will come from the feedback being received from the first two rounds of meetings which is currently being collated and reviewed. Items arising to be looked into seem to be availability of joint health and social care provision and also quantity and quality of nursing home beds for spot purchasing. These will be evaluated and included in the final document. There has been a varied response to the closure of community hospital beds in relation to having enhanced community services and health and social care hubs. A number of people have seen the need to commission less units with more beds due to the need for sufficient staffing and avoidance of lone working, although equality of access across the area is also very important. There has been lots of interest regarding minor injury units including the need to look at cross boundary service possibilities with Cornwall.

10. Written question from the public

One question was submitted this was answered above under Patient Transport Systems.

11. Closing Business

Date and time of next meeting: Wednesday, 26th November 2014 at 9.15am
Amory Centre, Oak Room, 125 East Street, South Molton, EX36 3BU

12. Summary of Actions for this meeting

1. ME to identify LanguageLine PACT information for the next executive team meeting.

2. RCa to ensure the Friday email to practice managers includes LanguageLine contact details to raise awareness amongst GPs locally, also to send to contacts within the other localities for onward transmission.

3. RCro - Report for next board please - More detail was requested on the recovery work-streams listed in the report for the next board meeting. The board were interested to know what the spend is on medicines in the northern locality and what effect an enforced limited formulary might have on the financial over-spend. They also requested figures around secondary care compliance with the formulary.

4. TP to audit GP practice registration increases against referral increases per practice. To see if it is population increase that has had an effect on the referral increase.

Signed;

Date;

Name; Dr John Womersley

Job Title; Chair