HEALTHY PEOPLE
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Eastern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Eastern Locality Board
Meeting
24th September 2014

Boardroom, Newcourt House, Old Rydon Lane, Exeter, EX2 7JU

MINUTES

Present:	**Title:**
Dr David Jenner (DJ)*	Chair, Eastern Locality and Mid-Devon Sub-Locality
Dr Simon Kerr (SK)*	Vice Chair, Eastern Locality and Co-Chair Wakley Sub-locality
Dr Alex Degan (AD)*	Vice Chair, Mid-Devon Sub-Locality
Dr Mike Slot (MS)*	Co-Chair, Wakley Sub-locality
Dr Tom Debenham (TD)*	Chair, WEB Sub-Locality
Dr Richard Mejzner (RM)*	Vice Chair, WEB Sub-Locality
Dr Rob Turner (RT)*	Co-Chair, Exeter Sub-Locality
Gilly Champion	Co-Chair, Exeter Sub-Locality
John Finn (JF)*	Managing Director, Eastern Locality
In attendance	
John Dowell (JD)	Locality Chief Finance Officer
Barbara Jones (BJ)	Head of Locality Contracting
Dr Alison Round (AR)	Clinical Policy Committee Board member
Sue Moreton (SM)	Patient Safety & Quality Support Manager
Apologies	
Dr Joe Mays (JM)	Executive GP
Tamara Powderley (TP)	Head of Commissioning
Jemma Moore (JM)	Locality Business & Governance Manager
Simon Polak (SP)	Head of Patient Safety & Quality (North & East)
Richard Croker (RC)	Head of Medicines Optimisation
Lorna Collingwood- Burke (LCB)	Deputy Chief Nursing Offices
Christopher Roome (CR)	Head of Clinical Effectiveness

***Voting member**

PART A

Part A of this meeting was held in private and therefore there are no minutes to report or approve.

PART B

1. Attendance and Apologies

Noted as above

2. Register of Interests

Dr David Jenner requested that members review their entries and inform Hannah Tapp of any updates accordingly.

3. Minutes of the last meeting and Action Log

The minutes were agreed to be a true and accurate record of the meeting held on the 23rd July 2014.

The Board reviewed the actions from the previous meeting and the Action Log was reviewed and updated accordingly.

EL_02_14_025 – Delayed transfers of Care - JF confirmed that this has now been raised at Executive level and to be reviewed in December 2014.

EL_04_14_034 – Warning notice – Tiverton Hospital – AD confirmed that he has written to Graham Lockerbie who has replied to confirm that he will investigate the matter further before providing a full response to AD. A telephone conference call to discuss this has been arranged. AD to report to October's Board.

EL_04_14_036 – Stoma services – It was confirmed that a Business case will be brought back to the Board in October to review.

EL_04_14_038 – Breast care referrals – TD confirmed that he met with the lead for Breast services and confirmed that they are reviewing figures as to where people are coming in and working on pathways. It was confirmed that GPs are aware of the 2 week wait referral rules. It was queried where the local versions of these rules are stored. TD confirmed that this is accessed through DRSS via the CCG website. TD confirmed that he would send the link to member practices for the 2 week wait rules.

EL_07_14_042 – Winter Resilience Plans – JF confirmed that the sign off of these plans will be undertaken via the Strategic Resilience Group.

4. Integrated Performance Reports

John Finn presented the report to the Board (commencing on page 16 of 92 of the Board papers). JF outlined the processes for agreeing risk and the purpose of the reports to assure the Board that each of the identified risks are being managed and noted the following:-

4.1.1 Stroke – Risk Rating – RED – JF confirmed that this relates to patients who have not experienced 90% of their stay on the acute stroke pathway. There has been some joint

working between RD&E and commissioners to formulate an action plan to deliver the 90% target with regular meetings between the organisations to monitor progress. JF confirmed that there are challenges around community stroke services and there is a meeting of executives next week to conclude discussions. JF to update the Board next month.

4.1.2 Delayed Discharges – Risk Rating – RED – JF outlined the current resilience planning work undertaken by the Strategic Resilience Group (SRG) . To ensure safety and good flow the system requires between 24-27 bed equivalents heading into winter (this is based on the ratio that 1 acute bed needs to support 4 community beds). Therefore there are plans in place which equate to 20 bed equivalents being found in the system leaving a shortfall of between 4 and 7 bed equivalents and upon which the SRG membership continue to work.

Dr Simon Kerr queried how confident the SRG were that this is adequate social care provision in the form of packages of care. JF confirmed that the model will comprise of a combination of both health and social care which will include the following elements to include increased bed capacity, packages of care and rapid response.

4.1.3 Urgent care system resilience – Risk Rating – RED – JF confirmed that this risk relates to patients not being admitted to hospital in a timely fashion if there are unexpected peaks in demand. JF confirmed that as a result of the Prime Ministers Challenge Fund the CCG and Area Team has received a wide range of proposals for Primary Care providers to increase primary care capacity which it is anticipated will impact on Emergency Department attendances. In terms of process, it was confirmed that the Area Team are overseeing this and it hoped that JF will be in a position to being an update to the next Board as to what this increased capacity will look like.

4.1.4 Diagnostic Breaches – Risk Rating – RED – JF confirmed that data is currently awaited from the RD&E to confirm whether they have achieved the 6 week target for September. JF to update October board accordingly.

4.1.5 62 days urgent referral to first definitive cancer treat – RED – JF confirmed the reported position for breaches is deteriorating particularly in relation to urology where demand remains a concern. Therefore, RD&E performance will end in quarter 3 failure. It was however confirmed that the Integrated Provider Assurance meeting last week assurance was sought and given that patients who do not meet the RTT targets as a result of robotic surgery experience no clinical harm as a result. The Board discussed the recent increase in cancer pathways and the need to understand the reasons for the increase and queried whether there were inappropriate referrals into the service. GC queried the one stop appointment for assessment which may reduce the number of follow ups and increase capacity in the system. It was confirmed that there has been a review of patient flow in and out of urology in terms of the service offered for suspected prostate cancer and it has been noted that there is an increased element of patient choice. There has also been an increase in MRI scan alternatives and therefore patients are choosing to have a consultation rather than a one stop appointment to discuss investigative processes.

4.2 Quality, Patient Safety and Performance

Sue Moreton presented the report to the Board (commencing on page 33 of 92 of the Board papers) the contents of which were noted by the Board accordingly.

4.3 Finance

John Dowell presented the report to the Board (commencing on page 40 of 92 of the Board pack) and noted the following:-

4.3.1 It was confirmed that in terms of the overall position for the CCG, the CCG are reporting an in year deficit position of £14.700 million. JD confirmed that as well as this figure, repayment of 2013/14 deficit of £14.560 million must also be taken into account, which totals an overall deficit of £29,260 million. The CCG are working to achieve the planned deficit, but there are significant risks to delivery.

JD reported that for the Eastern Locality, the main focus must be on delivering the best possible outcome for the RD&E contract, where due to emergency activity levels and increased GP referral rates the forecast outturn stands at £4.4 million over contract. Actions to deliver savings through QIPP and further measures to control demand will be required to maintain this level.

The Board queried, in terms of unknowns, would there be any further payments to specialist commissioning? JD confirmed that there is now a more robust understanding of what falls within specialist commissioning so not material swings to the extent that they were felt last year are expected.

4.4 Contracting

Barbara Jones presented the report to the Board (commencing on page 45 of 92 of the Board pack) and noted the following:-

4.4.1 It was discussed that the RDE data was a retrospective analysis. BJ confirmed that as at month 4, the CCG has reported an overspend of £3.9 million. The Board reviewed month 4 activity and cost report summary (the table was incorrectly labelled as Month 3) and queried the context of the figures shown in the report (on page 45, para 6.1.1). BJ confirmed that the figures recited in the plan column are the numbers set within the contract before QIPP is applied; the volume is the activity before mitigation plans are applied. BJ confirmed that the activity plan was only affordable if the QIPP savings were realised in full. It was, therefore, requested that an additional column is added to this summary which recites the affordability budget to enable Board members to understand these figures for future reporting purposes.

ACTION:

EL_09_045 - Activity & Cost Report Summary – BJ to add an additional column to the Activity and Cost Report summary detailing affordability budget figures.

4.4.2 Patient Transport Services – NSL – BJ confirmed that there has been an improvement in performance but which still falls below acceptable levels. There is, therefore, continued communications between CCG, the relevant Trusts and NSL to resolve issues. BJ confirmed that patient transport services across the country were experiencing similar difficulties. The CQC report published on the 28th August which set out a number of failings on the part of NSL in terms of providing care, treatment and support to meet patient needs. The Board queried what contingency plans the CCG have in place in the event of continued poor performance. BJ confirmed that the CCG is developing mitigation plans.

4.4.3 111 - SWASFT Contract – BJ confirmed that SWAST are meeting the majority of Key Performance Indicators included within their contract and are making progress where this is not the case. DJ, however, confirmed that there remains significant concerns as to the impact of 111 on the system although causation between any issues and the implementation of 111 has not been proven. The Board requested that a more detailed report on 111 be included in next month's Board report to include data on call backs and to address concerns regarding impact of service on the healthcare system and NHS pathways and finally , what targets are and are not being achieved.

ACTION:

EL_09_14_046 - 111-SWAST report – BJ to review details of reporting on 111 to include data on call backs and achievement of KPIs.

4.5 Clinical Effectiveness and Medicines Optimisation

Sam Smith presented the report to the Board (commencing on page 47 of 92 of the Board papers) and noted the following:-

4.5.1 Primary Care Prescribing – SS noted that in terms of a change in category M drug tariff, this will impact in year cost pressure in the region of £1million. This equates to an increase in average item value of around 12 p. There are plans in place to target 6 priority areas which focus on primary care prescribing. SS confirmed that the medicines optimisation team are ready to progress and book meetings with practices now to focus on opportunities for prescribing as well as looking at those practices who are over/under budget.

DECISION: The report was NOTED by the Board.

5. Update on Eastern Locality's financial position

JF presented a verbal update to the Board regarding the current financial position. It was confirmed that the main risks are posed by the CHC budget (which is being overseen by the Partnerships Directorate) and, with specific reference to the Easter Locality, the outturn position with the Royal Devon & Exeter Hospital contract. In summary, the baseline contract is £208million, based on capacity and demand which following recent growth in activity leaves the CCG with a financial risk of £9 million worth of activity being undertaken outside the financial framework. £ 5 million QIPP plan will contribute in terms of mitigation plans.

JF confirmed that the senior teams from the CCG and RD&E have met to discuss how this risk should be managed. It was agreed that the forecast outturn was approximately £8million. The following areas of growth were highlighted:-

10% increase in GP referrals

2% increase in consultant referrals

15% increase in Emergency Department attendances

10% increase in admissions

It was confirmed that built into the contract was a plan for 3 year growth and schemes such as ACE were implemented with a view to contributing to this.

JF stated that there is currently £2.9 million of emergency activity and there is currently work underway by the Emergency Department working group to review attendances, medical admissions and onward care activity. There is also work to understand how the implementation of 111 is impacting on ED attendances. Therefore, in this deteriorating financial position, other options need to be considered in terms "bridging" the gap. JF outlined to the Board a paper which will be presented to the Governing Body on the 1st October, further plans in relation to consultant to consultant referrals which will bring mitigation of £1 million but it may also be necessary to review those services which can be decommissioned.

SK stated that in terms of reviewing the deteriorating financial position, the Board are reviewing month 5 figures in month 7. In terms of QIPP plans in the sum of £5million, any emergency measures to mitigate the deteriorating position would need to be implemented in month 7 in order to have a 6 month impact.

RM confirmed that he required assurance from the Governing Body in terms of timelines and financial figures. He stated that he did not feel assured at the current time that the CCG had a plan to control this deteriorating position. JF outlined the proposals in terms of demand management in response to Area Team review and stated that key to this issue is understanding the increase in GP referrals. JF confirmed that during the private session of the Board, there was agreement to review GP referrals and to request a data set to enable the locality to review GP referrals in detail to include practice level data (age groups, levels per practice, types of admissions (ED, outpatients, Emergency admissions). DJ confirmed the much of what is spent is out of the CCG's direct control so there is a need to deal in terms of how CCG can have an influence on this growth and increase in activity. However, to stop elective activity would be a breach of the NHS constitution and any decision in terms of a cessation of elective activity would be undertaken in consultation with the Area Team. AR confirmed that there a review of policies currently being undertaken to include a more criteria based access system however agreement and implementation of these policies need to be expedited. It was queried how member practices will be engaged in terms of any changes in criteria and out the communications department will engage with members of the community to convey this and the need for a robust communications plan.

The Board discussed the impact of 111 on ED and medical admissions. DJ confirmed that the rise in ED attendances looks similar across Devon part from North Devon where there

was earlier implementation of 111. It was confirmed that more GP resource has been put into 111 to assist with call backs and clinical advice but unfortunately a reduction in activity has not been seen. DJ confirmed that a more radical option to be considered may be putting DDOC in to answer out of hours calls as an alternative to 111 but this has not met with support from across the localities. It was stated that this could be done for the Eastern Locality in terms of putting a different message on out of hours answering machines but this would inevitably have cost implications.

RM was of the view that triage for ED should be undertaken in Urgent Care Centres and keep the 111 system as it is.

The Board discussed whether consideration has been given to population increases in Exeter and surrounds given the recent housing developments. JD confirmed that this would not change the funding as budget planning is influenced by historical rates rather than by changes in the population. There is however an awareness that there are patients who are not registered with GPs and who turn up at ED. The board discussed the impact of 111 and MS stated that there is a need for clearer evidence if attendances at ED have come via the 111 route. DJ confirmed that not all are directly referred from 111 however, 111 are not meeting targets in terms of clinical call backs and it may be that patients who are referred to a specific option “vote with their feet” and opt to go to ED.

JF confirmed that the Prime Ministers Challenge fund will put more money into emergency primary care and therefore over the next 6 months there will be an increase in primary care availability much of which will be provided by DDOC.

SK confirmed that he would support putting clinical triage back into the system and himself has notice a step change since the implementation of 111. He confirmed that in terms of his work with DDOC there has been a decrease in the number of visits and calls to DDOC have fallen since the implementation of 111.

In summary, the following actions were agreed by the Board.

- To devise an engagement strategy around delivering plan
- To produce a data set at practice level
- A clear financial plan to achieve breakeven position
- A plan around GP referrals to bring down to flat growth
- A plan for attendances/111
- Review/Call on clinical triage.

A plan is to be formatted and brought back to the Board in 7 days.

DJ sought consensus from the Board in terms of implementing clinical triage into DDOC and taking this proposal forward to the Area Team and Governing Body and subject to approval that this be a test of change. It was noted that both Dr Mike Slot and Dr Simon Kerr declared their interest in DDOC.

Dr Rob Turner, Gilly Champion, Dr Alex Degan and Dr Tom Debenham indicated their agreement to this course of action.

Dr Mike Slot and Dr Simon Kerr declared an interest in DDOC and therefore abstained.

Dr Rick Mejzner did not support with a caveat that this be a temporary measure.

DECISIONS: The verbal updated was NOTED by the Board and AGREED the following actions:-

- **To devise an engagement strategy around delivering plan**
- **To produce a data set at practice level**
- **A clear financial plan to achieve breakeven position**
- **A plan around GP referrals to bring down to flat growth**
- **A plan for attendances/111**
- **Review/Call on clinical triage.**

A plan is to be formatted and brought back to the Board in 7 days.

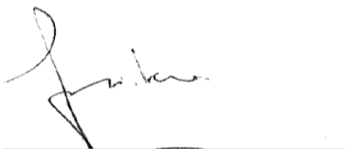
The Board SUPPORTED the implementation of clinical triage into DDOC and to take this proposal forward to the Area Team and Governing Body and subject to approval that this is a test of change.

6. Locality 360 Survey Results

JG presented the survey results to the Board (commencing on page 55 of 92 of the Board packs). The Board reviewed the Action Plan and the contents contained therein and accepted the action plan as a working document.

DECISION: The board ACCEPTED the Action Plan as a working document.

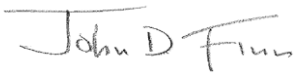
END OF MEETING



Signed

Dr Simon Kerr, Eastern Locality Vice- Chair

Dated 22nd October 2014



Signed

John Finn, Managing Director, Eastern Locality

Dated 22nd October 2014