HEALTHY PEOPLE
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Eastern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Eastern Locality Board
Meeting
26th November 2014
Board Room, Newcourt House

MINUTES

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

***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 October.

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

EL_04_14_034 – **Warning Notices – Tiverton Hospital** – AD to chase Graham Lockerbie to clarify whether GPs require training on the Mental Capacity Act or just the Treatment Escalation Plan (TEP) completion. SM to clarify how many GPs attended the recent education session on TEPs.

EL_04_14_042 – **Winter Resilience Plan** – JF confirmed that that this is being overseen by the Strategic Resilience Group chaired by Dr David Jenner. The ambition is to have an equivalent of 24-30 beds in place in the form of a non-bed based model of care. The RD&E have received Tranche 2 monies in the sum of £1.2 million to support an additional 13 beds. There is therefore in place bed equivalents of 27 but the SRG continue to seek assurance that planning is sufficient in terms of maintaining patient safety during the winter period. JF confirmed that there is also a need to maintain domiciliary care at the same level as last year. Finally, JF reiterated that until such time as the appropriate assurance is obtained there will be no change in bed numbers until assurance in terms of mitigation is received.

EL_09_14_045 – **Activity & Cost Reporting Summary** – JD confirmed that affordability will be reflected in the central plan within the contractual approach for 15/16 and future reports will include what affordability looks like.

EL_09_14_046 – **111 SWAST Report** – it was confirmed that this is contained within the contracting report.

EL_10_14_047 – RD&E Contract – Reconciliation of low priority procedures - JF confirmed that the patient identifiable issue remains a challenge. The Information Governance Officers are now permitted to share patient identifiable information with a number of individuals. The BluTEQ programme is now in place and as a result this issue has been resolved.

EL_10_14_048 – **GP Referrals – Locum Education** - SK confirmed that he is working with Dr Tom Debenham and Erika Kittow to run some protected learning events on a quarterly

basis to review referrals and to explore how locums can be given the opportunity to join these meetings.

4. Integrated Performance Report

John Finn presented the report to the Board (commencing on page 19 of 67 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 Assurance summaries

4.1.1 **RD&E contract – Risk Rating RED –** JF confirmed that as of Month 7 the outturn position is reporting no deterioration in the position but the risk remains. There is further scrutiny around planning and proposals to bring contractual outturn to within affordable levels. Further financial opportunities were detailed at both the Governing Body meeting and a meeting between the Directors of Finance and CCG contract leads to reassess the outturn position and agree impact of urgent and necessary measures and decide how to progress with potential opportunities. JF stated that in terms of work streams being considered, this will include working with GP practices with a focussed programme of referral review to bring referrals into a manageable position. SK queried that following conversations with the RD&E, clarification needs to be given as to what will the outcomes of work will be and how will referrals on hips and knees be impacted and what can be done to make a difference. It was confirmed that a combination of medicines management, maximising the use of RTT has minimised risk but has only materialised £2000k to £3000k

4.1.2 **Stroke – Risk Rating RED –** JF confirmed to the Board that summary relates to the risk of harm to patients who have had a stroke and who have not experienced 90% of their stay on an acute stroke unit. JF confirmed that a key indicator of meeting the 90% stay on the Stroke Unit is the number of patients who are admitted to a stroke unit within 4 hours of their hospital arrival. It was stated that there is work underway between the stroke team and emergency department colleagues at the RD&E to review and identify those patients who require admission to the stroke unit but increased activity and associated pressures within the Emergency Department together with a lack of bed availability in the Acute Stroke Unit has contributed to the delays in appropriate transfers. JF confirmed the temporary consolidation of 15 stroke beds at Ottery St Mary with work underway to plan how the expansion of the early supported discharge team confirmation of which is anticipated in the new year.

4.1.3 **62 days Urgent referral to first definitive cancer treatment – Risk Rating RED** – JF confirmed that for the last 9 months the CCG have sought assurance around the trajectory. As part of their Action Plan to support the return to sustainable delivery of the cancer waiting times target, the RD&E have put in extra capacity to meet service demand requirements and there has been assurance that no harm has been caused to individuals as a result of the failure to achieve targets. However, it was confirmed that the position has now changed with an increase of referrals into the system reflecting the popularity and patient need for robotic surgery resulting in the RD&E failing in the last quarter of the year and furthermore, can no longer provide the necessary assurance to the locality going into the next financial year. JF stated that there is further scrutiny of these targets by the Local

area team with specific focus around patient safety and on that basis a meeting has been arranged between Dr David Jenner and the Medical Director of the RD&E to undertake a qualitative review of breaches over the last 9 months to review and to gain assurance that those patients referred to the service, were made aware of the choices open to them and the potential to breach the 62 day target. It was queried by MS, how many breaches relate specifically to robotic surgery. DJ confirmed that this was 50% but update on positon with allocation to responsible commissions. The majority relate to cancers commissioned by NHS England but as the locality are responsible for the RD&E contract, DJ will take the lead on this review.

SK queried what actions were being undertaken operationally to mitigate the problem. He stated that clearly the demand is there but the responsibility for the commissioning of cancer services sits with the Area Team. It was discussed that there is a demand for surgery in Plymouth and indeed Cornwall and failure to achieve targets are driven by the lack of capacity. The Board discussed that there was not a shortage of robots but a shortage of robotic surgery (and specialist surgeons)and there was a suggestion that NHS England should be brought in to review and maximise the use of robots in the South West.

ACTION:-

EL_11_14_049 – 62 day Urgent referral to first definitive cancer treatment – DJ meet with RD&E to undertake review of those patients referred to cancer services to gain assurance that those patients referred to the service, were made aware of the choices open to them and the potential to breach the 62 day target and to report to January Board.

4.1.4 **Watching Brief –** JF confirmed to the Board that the following areas are under a Watching Brief:-

- Diagnostic Breaches
- Consolidation of inpatient beds
- Delayed transfers of care
- Urgent Care system resilience

4.2 Quality Patient safety & Performance

Sue Moreton presented the report to the Board (commencing on page 37 of 67 of the Board papers) and noted the following :-

4.2.1 **C.Difficile infections –** SM confirmed that the RD&E's C.Diff target was low. Last month saw 5 reported cases which have been reviewed by the Health Acquired Infections team. It was confirmed that each case was deemed "unavoidable". SM reassured the Board that eash reported case is review thoroughly by the team.

4.3 Finance Report

John Dowell presented the report to the Board (commencing on page 36 of 67 of the Board papers) and noted that the report should recite that the data relates to month 7 and not month 5 and asked the Board to note this correction.

JD confirmed that the overall forecast deficit should read £43.7 million which consists of three elements:-

- £14.6 million deficit for 13/14
- £14.7 million planned deficit for 15/16
- Current forecast exceeding deficit of £14.4 million

The response has been the continued control and contract management together with a series of additional urgent and necessary measures.

4.4 Contract Report

JD presented the Contract report to the Board (commencing on page 41 of 67 of the Board papers) and noted the following:-

JD discussed the RD&E Contract position with the Board. It was confirmed that there is no overall movement in forecast outturn of £8.5 million over plan. JD confirmed that the underlying, unadjusted activity position has increased from £11.5 million to £11.7 million over plan. This is then reduced by work that continues in terms of completing the actions targeted at the £1.453 million impact of planned QIPP schemes which have yet to be delivered and a number of contract queries raised and which are subject to a risk assessment each month. Referral growth to the RD&E continues to cause concerns and locality chairs are undertaking a piece of work with members practices to gain a better understanding in terms of reasons for a growth in referrals and to identify opportunities to impact on this.

A breakdown of the £8.5 million overspend by service category was discussed. Elective Care is over plan, forecast to be £900k after taking into account impact of planned QIPP. The remainder relates to emergency activity and accident and emergency attendances and £4.5 million of other QIPP in the plan which would need to be filled by urgent and necessary measures plans.

4.5 Independent Sector

It was confirmed that the forecast has increased to £415k over budget. There has been a steep rise in cardiology activity which relates partly to capacity restrictions at the RD&E due to building works. Following an analysis of the data it was confirmed that there has been some changes in certain activities within the cardiology speciality which may represent uncommissioned service development. DJ requested that this issue be raised at the next Cardiology C2C.

ACTION:

EL_11_14_050 - Increased Cardiology Activity – Christy Thurlow and Dr Joe Mays to review at the next scheduled Cardiology C2C meeting.

The Board reviewed the table for the Royal Devon & Exeter NHS Healthcare Trust on page 43 of the Board papers. There was considerable discussion about the lack of clear linkage between referral and activity information, and the resulting financial numbers.

For example, referrals are up year on year, but outpatient activity appears to be below plan. In order to most effectively brief member Practices on what action is required of them it is important to have a clear picture on where activity is truly above plan.

JD explained that this was partly due to the outpatient activity plan being shown gross of the anticipated impact of the elective QIPP programme, but agreed that a clearer presentation was required.

Other observations made included that out-patient procedures were significantly above plan with no clear indication of where this increase has occurred.

ACTION

EL_11_14_051 – Independent Sector - JD to work with Contracts & Business Intelligence team to improve presentation in future Board reports to address this issue.

4.6 Clinical Effectiveness and medicines optimisation

JF presented the report to the Board (commencing page 47 of 67 of the Board papers) and noted the following:-

JF confirmed that the CEMO work is profiled as a result of the recently announced urgent and necessary measures.

4.6.1 Varicose veins – JF confirmed the options appraisal formulated by the Clinical Effectiveness Team to inform the making of a CCG service commissioning. A paper was subsequently taking to the CCG's executive group for decision making. JF confirmed that this was agreed by the Executive group, however, it was agreed that the CCG not in a position to commission sufficient capacity, however, it was further agreed for some of the aspects of the current policy to be looked at again. It is anticipated that those with severe symptoms will reach the acute trust quicker. Education will also be a key part of this pathway as well as a 6 month review. The Board discussed those presenting late who should have been referred earlier and the need to improve education amongst nurses, GPs, District Nurses around the current pathways.

4.7 Primary Care prescribing

JF presented the report to the Board (commencing on page 48 of 68 of the Board papers) and noted the following:-

4.7.1 Primary Care prescribing budget - It was confirmed that the prescribing budget remains volatile and in the last quarter of the year there is an increasing risk that this budget will overspend. It was confirmed that there is work currently underway between NHS England and the Royal Devon & Exeter Hospital to review, inter alia, prescribing systems, prescribing changes in GP practices and review of polypharmacy in frail elderly. However, it is anticipated that the level of risk will increase as each month goes by.

4.7.2 Medicines not reimbursed via national prices (MNRVNP) – JF confirmed that although the budget as of months 6 is underspent, the likelihood is that the by the end of the year over performance is possible. This is compounded by the fact that there are £700k of

unpaid invoices partly resulting from a change of invoicing process by homecare companies. However, it was discussed that this has been included within the overall financial plan and should not adversely affect the CCG.

DECISION: The report was NOTED by the Board accordingly.

5. DVT Specification

Dr David Jenner presented the specification to Board (commencing on page 55 of 67 of the Board papers).

DJ confirmed that the service is currently provided by NDHT through the Walk in Centre on the RD&E site. Following, a review of NICE guidance, quality standards for DVT service requires scans for suspected DVTs within 24 hours. The service is provided 5 days per week but there is a long waiting times for scans. DJ confirmed that the concept behind the specification is to procure a service that is fit for the future and meets with NICE standards. Furthermore, to ensure much of the NICE pathway can be implemented and set future direction with an aspiration to provide a 7 days service. Presently, the current service is 90% compliant with NICE guidance in terms of scans being offered to patients. DJ confirmed that the specification will be subject to amendment in the future with an ambition of to move from a Monday – Friday service next year with ambition to move to a Saturday to Sunday in the future.

The Board was therefore asked to consider specification in principle with the exception of 7 day working. Thereafter, this document would then be taken to the January Board to approve and thereafter circulated to member practices in the Eastern Locality with information to include choice of drug to be prescribed and with a recommendation to GP colleagues that DVT services are provided by Nproviders.

The options for consideration for the Board were confirmed as follows:-

1. To approve the policy in principle and share with member practices
2. Approve recommendation of the group that the decision regarding prescribed drugs should happen at the point of diagnosis and would initiate treatment which may have implications on the drug budget and therefore GPs might not want to follow policy
3. Agreement from Medicines Optimisation Team around anti-coagulants.

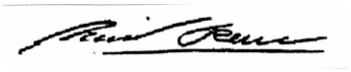
The Board discussed the above options. JM stated that there is a need to ensure what is recited in the specification is in line with Joint Formulary in terms of treatment in the first 24 hours. DJ confirmed that the Medicines Optimisation to need to give a view as to what doctors should be giving from a commissioning perspective in terms of choice of drugs prior to referral and to agree process for prescribing post procedure.

Following discussion, the Board agreed that the document should be circulated to member practices and therefore to bring to the January Board for approval and to prepare an information sheet to process to describe what happens in terms of compression and screening concerns.

DECISION: DJ summarised the Board decision as follows:-

1. **On the specific issues of DVT clinics to discuss the choice of treatment – this was SUPPORTED by the Board.**
2. **The Board SUPPORTED the specification.**
3. **The Board mandated the Medicines Optimisation Team to define which drug and choice drug from suspicion of diagnosis to scan and agreement of drug to be used. To agree formulary choices and to work with NDHT to discuss impact of costs.**

End of Meeting

Signed 

Dr David Jenner, Eastern Locality Chair

Dated 28th January 2015

Signed 

John Finn, Managing Director, Eastern Locality

Dated 28th January 2015