Putting good health into practice

NHS
Nottingham North and East
Clinical Commissioning Group

Clinical Cabinet Minutes

Nottingham North & East Clinical Commissioning Group Clinical Cabinet Meeting Held 19th July 2017 at the Civic Centre, Arnot Hill Park, Arnold, Nottinghamshire, NG5 6LU

Present

Dr James Hopkinson (JH) (Chair)	Clinical Chair and Calverton Practice Representative
Dr Ashish Alurwar (AA)	GP Representative, Highcroft Surgery
Dr Sarah Bamford (SB)	GP Representative, Newthorpe Medical Centre
Jeff Burgoyne (JBu)	Patient and Public Representative
Dr Ian Campbell (IC)	GP Representative, Park House Medical Centre
Dr Prakash Kachhala (PK)	GP Representative, Torkard Hill Medical Centre
Dr Mana Karpha (MK)	GP Representative, West Oak Surgery
Dr Caitriona Kennedy (CK)	GP Representative, Trentside Medical Practice
Dr Azim Khan (AK)	GP Representative, Unity Surgery
Ian Livsey	Deputy Chief Finance Officer
Dr Amelia Ndirika (AM)	GP Representative, Whyburn Medical Practice
Stewart Newman	Director of Commissioning *(deputy for Deputy Chief Officer)*
Dr Elaine Maddock (EM)	GP Representative, Stenhouse Medical Centre
Dr Akila Malik (AM)	GP Representative, Westdale Lane Surgery
Dr Suman Mohindra (SM)	GP Representative, Om Surgery
Dr Paramjit Panesar (PP)	Assistant Clinical Chair and Ivy Medical Practice Representative
Kathryn Sanderson (KS)	Patient and Public Representative
Dr John Tomlinson	Consultant in Public Health, Nottinghamshire County Council
Dr Sarah Webster (SW)	GP Representative, Oakenhall Medical Centre

In Attendance

Emma Pearson (EP)	Governance Manager (note taker)
Sergio Pappalettera (SPa)	Contract and Information Manager

Apologies

GP Representative	Apple Tree Practice
GP Representative	Daybrook Medical Practice
GP Representative	Giltbrook Surgery
GP Representative	Jubilee Practice
GP Representative	Peacock Medical Practice
GP Representative	Plains View Surgery
Practice Manager Representative	
Practice Nurse	
Paul McKay	Service Director, Nottinghamshire County Council
Sharon Pickett	Deputy Chief Officer
Dr Ben Teasdale	Secondary Care Consultant
Sam Walters	Chief Officer

		Actions
CC 17/062	**Welcome and Apologies** Dr James Hopkinson (JH) welcomed all to the meeting. Apologies were noted as above.	
CC 17/063	**Declaration of Interest** JH reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NNE Clinical Commissioning Group. Declarations of the Clinical Cabinet were listed in the CCG's Register of Interests. JH noted that the Register was available either via the secretary to the Clinical Cabinet or the CCG website at the following link: http://www.nottinghamnortheastccg.nhs.uk/contact-us/freedom-of-information/conflicts-of-interest/ No additional conflicts of interest were declared above those already recorded on the CCG register of interests.	
CC 17/064	**Minutes of the meeting held on 20th June 2017** The minutes of the meeting held on 20th June 2017 were agreed as an accurate record subject to the following amendment: CC 17/058: It was agreed that Ruberfacients would not be prescribed due to the lack of evidence to support the use in acute or chronic musculoskeletal pain The Clinical Cabinet **Approved** the Minutes of the meeting held on 20th June 2017	
CC 17/065	**Matters arising and actions from the meeting held on 20th June 2017** CC 17/059: Sergio Pappalettera (SPa) confirmed that the data was not available. Jeff Burgoyne (JBu) noted that the performance indicator for the number of patients waiting longer than 18 weeks for an ENT appointment had not been met for a period of time and queried if the CCG knew why. JH confirmed that two surgeons had left the service however mitigations had been put in place and the CCG would continue to monitor.	

CC 17/066	**Chief Officer and Chair's Report** JH presented the Chief Officer and Chair's Report and highlighted the following points; **Updated Patient Decision Aids for CCGs Published** NHS RightCare has published updated versions of 28 patient decision aids. The aids were deigned to support patients and clinicians to have informed conversations about treatment for conditions. The aids were available on the NICE website. **The results of the latest survey of adults' experience of their hospital stay published** Nottingham University Hospital (NUH) had scored 'about the same' when compared with other Trusts. SP highlighted that the overall view of care and services was scored at 5.6/10 however respect and dignity and care from staff were highly scored. **New Chief Executive for Nottingham University Hospitals NHS Trust** Tracy Taylor has been appointed the new Chief Executive of NUH The Clinical Cabinet **Acknowledged** the Chief Officer and Chair's Report	
CC 17/067	**Finance Update** Ian Livsey (IL) presented the financial update and highlighted the following points; **Finance Report** The report was for the period that ended the 30th June 2017 and was based on two months of accurate data and one month of prescribing data. The CCG had reported to achieve the 'Control Total' however there were risks due high levels of activity and QIPP delivery being scheduled for the 3rd and 4th quarter of the year. The QIPP target for Nottingham North and East was £12 million. The CCG had reported a forecasted deficit of £2 million to NHS England. There was pressure in the acute and community sectors which had required the use of £575k reserve funding. IL noted that the CCG had £1.5 million of reserve spend for 2017/18. There was untransacted QIPP on acute, community and mental health contracts.	

	IL drew attention to the table on page 6 on the Finance Report and highlighted that year to date NUH was overspent by £458k, Circle was overspent by £235k and CHC was overspent by £53k. IL noted that CHC was a QIPP scheme and savings were expected and any overspend was a significant risk. The pace of the delivery of the QIPP programme would need to increase to ensure that it was delivered. Year to date the QIPP delivery was £1.68 million against a plan of £1.81 million. Dr Paramjit Panesar (PP) noted that the QIPP programme was a challenge and the NNE GPs were able to impact the referrals that were made into the acute sector and investigate clinical variation across Primary Care. PP queried if clinical variation was being investigated in secondary care, IL confirmed that the Financial Recovery Group were focused on clinical variation including unwarranted variation in relation to follow up appointments. PP queried if the QIPP programme would change once the Greater Nottingham CCGs align. JH confirmed that the CCG would remain a statutory body and the QIPP requirements would remain the same. IL noted that the four Greater Nottingham CCGs would be working collectively in the delivery of the Financial Recovery Plan however the statutory duties would remain with individual CCGs. Dr Sarah Bamford (SB) queried if areas where concerns were already identified in relation to patient discharges were being investigated? JH confirmed that Elective Care was an area that was being investigated. Katheryn Sanderson (KS) noted that there may be pressure from patients to maintain follow up appointments because to restart the process of referral for an appointment can be lengthy. JH highlighted the importance of soft intelligence and explained that a recent practice visit highlighted that follow up referrals to circle were being coded as new appointment in error. Dr John Tomlinson (JT) explained that the CCG should ensure that there was a criteria for discharge and a criteria for follow up patients in place. **Activity Report** Sergio Pappalettera (SPa) presented the Activity Report for April – May 2017 Cost pressures were recognised in the health system and Emergency Department admissions from GPs were 4.7% higher than 2016/17.	

	Circle had overspent in elective care which was predominately in T&O by £130k. The GP e-referrals had seen a reduction in April and May however there had been a rise in June. Stewart Newman (SN) confirmed that a Contract Query Notice had been issued to NUH as the elective growth didn't reflect the referrals made by GPs or via A&E attendance. Dr Elaine Maddock (EM) queried if the Community Gynaecology initiative in Rushcliffe CCG had demonstrated savings. JH confirmed that the saving made were not at the level anticipated. Dr Caitriona Kennedy (CK) queried why all NNE practices were not performing ring pessaries. AN explained that training was required. CK noted that she had received requests from patients for a referral for knee injections and noted that the service would not provide the injections without a referral, JH confirmed that this had been resolved and no further request should be received. The Clinical Cabinet **Acknowledged** the Financial Update	
	Atrial Fibrillation Quality Improvement Proposal PP presented the Atrial Fibrillation (AF) Quality Improvement Proposal and the following points were highlighted; The East Midlands Clinical Network (EMCN) reported that the current management of AF against the QOF data in 2015/16 had prevented an estimated 44 strokes and 15 deaths. PP drew the attention of the Clinical Cabinet members to Table 5 in the report which outlined the optimum management targets that the CCG should strive to achieve. The EMCN had offered to support the CCG. The AF QIP would consist of each practice identifying an AF champion. Rushcliffe CCG had implemented targeted screening during flu clinics which had positive results with an estimated 16 saved strokes. PP explained a pulse check was taken using Alivecor devices. SB queried the cost of the device; PP confirmed that cost of the device was £93. PP directed the Clinical Cabinet members to the YouTube link which provided support to practices. The Clinical Cabinet;	

	Approved the Atrial Fibrillation Quality Improvement Proposal	
CC 17/069	**Healthy Families Programme** SN presented a paper on the Healthy Families Programme and highlighted the following points; The Healthy Families Programme commenced on the 1st April 2017 and it was acknowledged that the implementation had been challenging. SN requested that feedback was important and should be send to Kerrie Adams the Senior Public Health and Commissioning Manager. The funding available for the service was set to reduce over a number of years with an expectation that the same service and quality was provided. CK noted that there was a lot of extra activity in primary care and explained that the practice had seen 3 children that required an ADHD referral that hadn't been seen by a school nurse. CK suggested that there was a tier missing in the service in relation to assessment. It was noted that when a GP rings the service they are required to leave message which has hindered relationships. The Clinical Cabinet **Acknowledged** the Healthy Families Programme	
CC 17/070	**On Going Compression Bandaging** SN presented a paper on the provision for ongoing compression bandaging and the following points were highlighted; The responsibility for providing ongoing compression bandaging was not clear, SN explained that the leg ulcer clinic was provided by Local Partnerships and would see patients for up to 20 weeks. There was no contractual requirement for GP practices to provide compression bandaging however some GP practices were providing the service and as a result there was inconsistent provision across the CCG. Due to the inconsistent provision some patients are seen in the leg ulcer clinic for extended periods which impacted on waiting lists for new patients. Whilst patients were waiting for an appointment their ulcer were getting worse which made them more difficult to treat. SN proposed that there was an opportunity to reduce workload for practices if the waiting times for the leg ulcer clinics were reduced by consistently providing compression bandaging across the CCG.	

	Due to the long waits for the leg ulcer clinics, practice staff will be seeing patients to dress their legs. CK explained that her practice provided compression bandaging to patients twice a week and noted that the appointments were long. EM noted that at the end of 20 weeks treatment with the leg ulcer clinic, patients were discharged to primary care. JH confirmed that compression bandaging was not in the GP contract and there was an inequity of access. SN confirmed that the CCG was able to provide training to upskill Practice Nurses if practices agreed to routinely provided compression bandaging. SB explained that their practice had purchased a Doppler machine and noted that patients would need to sit for 30 minutes prior to the examination which took 20 minutes resulting in a room being required for an hour, SB highlighted that a room being available for an hour would have an impact on smaller practices. JT noted that in the long term it would be good to see the service tendered appropriately and noted that as the population gets older it was expected that the number of patients with a leg ulcer would increase. AN queried how long the average recovery from a leg ulcer was. It was confirmed that a 6 month recovery would be considered a fast recovery. JH queried if the design of the service had been reviewed to establish if the service should be acute or community based with appropriate funding available for GPs services in relation to compression bandaging. 14:45 : Dr Suman Mohindra left the room AN queried if there was funding available for preventative measures. EM queried if there was a potential QIPP programme in the redesign of the service and a focus on preventative measures. **ACTION:** SN confirmed that he would request the data and provide feedback. The Clinical Cabinet **Reviewed** the provision for ongoing compression bandaging.	**SN**

CC 17/071	**Reports** a) NNE Performance Report February 2017 JH presented the Performance Report for February 2017 and highlighted the following points The 4 Hour Standard had not been achieved and Nottingham University Hospitals declared black status on the 18th July. The cancer waiting times were not met with the 62 day urgent referral to treatment performance recorded at 81.63% for May 2017. JH drew the attention of the Clinical Cabinet members to the Improvement and Assessment Framework indicators and noted that the cancer indicators required improvement. AN queried why there was variation across the South CCGs in relation to cancer, SPa explained that the CCG tended to refer more patients to NUH instead of Circle. JH explained that the Cancer service backlog was affecting the data and the trajectory to hit the backlog target was November. JH confirmed that the backlog was reducing. The Clinical Cabinet **Acknowledged** the Performance Report.	
CC 17/072	**Minutes** a) A&E Delivery Board Action Log b) SIG Minutes 02/06/17 JH presented the minutes and requested any questions or comments from the members. The Clinical Cabinet **Acknowledged** the minutes.	
CC 17/062	**Any Other Business** CK noted that recent communication had highlighted that the CCG were performing poorly for splenectomy and immunisations. Jeff Burgoyne requested information on the Suicide Prevention Plan and noted that services were needed for the dependents of those that had committed suicide. EM confirmed that there was a charity called Bereavement for Suicide. Dr Azim Khan queried if GP practiced had used a template document to discuss with relatives the possibility of a Do Not Resuscitate being implemented. EM confirmed that her	

	practice had used a template and held a register that worked well. EM noted that the Ultra Sound Provider Health Harmony has not been returning scan details. JH advised to contact the Contract Team. JH confirmed that a risk based approach to the practice visits was being taken and NHS England had advised that the CCG focus attention on the top four overspent practices. JH confirmed that the visits had been positive and there had been shared learning. CK queried if the practices were comfortable with CK and EM viewing patient notes, it was confirmed that the notes could be viewed if the purpose for viewing the notes was justifiable and necessary. 15:30 Dr Suman Mohindra returned to the room JH proposed to cancel the August Clinical Cabinet due to the holiday season and a high number of apologies received, the Clinical Cabinet agreed to cancel the meeting.	
	Date, Time and Venue of Next Meeting 20th September 2017, Reception Room, Civic Centre, Arnot Hill Park, Nottingham, NG5 6LU **SIGNED: …… (Chair)** **DATE: ……..**	