Putting good health into practice

Nottingham North and East Clinical Commissioning Group

Clinical Cabinet Minutes
Nottingham North & East Clinical Commissioning Group Clinical Cabinet
Meeting Held 20th June 2018 1:30 – 4.30pm
Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU

Present

Dr James Hopkinson (JH)	Clinical Chair and Calverton Practice Representative (Chair)
Ian Livsey (IL)	Deputy Chief Finance Officer
Jeff Burgoyne (JBu)	Patient and Public Representative
Ian Campbell (IC)	GP Representative, Park House Medical Centre
Dr Smita Jobling (SJ)	GP Representative, Highcroft Surgery
Dr Paramjit Panesar (PP)	Assistant Clinical Chair and Ivy Medical Practice Representative
Dr Caitriona Kennedy	GP Representative, Trentside Medical Practice
Dr Ann Cockburn (AB)	GP Representative, Stenhouse Medical Centre
Dr Sarah Bamford (SB)	GP Representative, Newthorpe Medical Centre
GP Representative	West Oak Surgery
Dr Akila Malik	GP Representative Westdale Lane Surgery
Dr Suman Mohindra (SM)	GP Representative, Om Surgery
Mandy Moth	Practice Manager
Michael Orozco	Practice Manager
Dr Amelia Ndirika (AN)	GP Representative, Whyburn Medical Practice
Sharon Pickett (SP)	NNE Locality Director
Dr Chic Pillai (CP)	GP Representative, Plains View Surgery
Dr Ben Teasdale (BT)	Secondary Care Consultant
GP Representative	Oakenhall Medical Centre

In Attendance

Louisa Hall (LH)	Corporate Administration Officer *(minute taker)*
Simon Castle (SC)	Deputy Director - Cancer
Kirsten Owen (KO)	Programme Manager (Interim) - Planned Care
PICS representative	

Apologies

Dr Jonathan Gribbin (JG)	Consultant in Public Health, Nottinghamshire County Council
Sam Walters	Accountable Chief Officer
GP Representative	Apple Tree Practice
GP Representative	Daybrook Medical Practice
GP Representative	Unity Surgery
GP Representative	Jubilee Practice
GP Representative	Torkard Hill Medical Centre
GP Representative	Peacock Medical Practice
GP Representative	Giltbrook Surgery
Practice Nurse	
Kathryn Sanderson	Patient and Public Representative

		Actions
CC 18/034	**Welcome and Apologies** Dr James Hopkinson (JH) welcomed the members to the meeting. Apologies were noted as above. The meeting was declared quorate.	
CC 18/035	**Declaration of Interest** The Chair reminded cabinet members of their obligation to declare any interest they may have on any issues arising at cabinet 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/ A declared interested was raised from Highcroft Surgery for agenda item CC 18/042 (Federation working) as the Practice is a members of PICS.	
CC 18/036	**Minutes of the meeting held on 16th May 2018** The minutes of the meeting held on the 16th May 2018 were approved as accurate with 2 minor typological amendments.	
CC 18/037	**Matters arising and actions from the meeting held on 16th May 2018** The Chair confirmed that there were no formal matters arising or actions from the meeting held in May. Cabinet members raised the following: Jeff Burgoyne (JBu) further queried the shortage of Head and neck surgeons and if the equipment is good enough to attract the specialty needed. Simon Castle (SC) confirmed that it is up to date and that the main issue is that East Midlands does not deliver the fellowship needed to get expertise therefore clinicians go internationally. SC added that this would not impact on FRP as wouldn't cost more out of area. JBu also queried the new GN structure. Sharon Pickett (SP) confirmed that the final structure is being finalised and will be sent out when possible.	

CC 18/038	**Accountable Officer and Chair's Report June 2018** No report available	
CC 18/039	**Finance Update** Ian Livsey (IL) provided an update on the financial position and highlighted the following points. **a) Finance Report** As the CCG is currently in M1, the data is not available as this gets processed one month behind. Acute data from NUH and Circle are however, both showing a pressure in month 1. This combined is around £200-300k so there is a risk of potential pressure. Continuing Care is below budget for 2 months; circa £170k below plan. Fast track data shows that the CCG is showing an acceptable position. Lower A & E attendance, showing a similarity with outpatient attendance. **b) Financial recovery plan** IL gave an overview of the Financial Recovery plan to the cabinet: Main headlines were that there would be significant risk on acute side. NNE requires £13.5m for QIPP to balance budget. Higher than last year. NNE did achieve full plan last year therefore needed support from the other GN CCGs. £51m QIPP identified but still pipeline needed to get the total of £52.5m. Risks have been identified through these. Planned care has got around £28m which will be a challenge along with prescribing. NHSE have provided CCGs with BRAG ratings which the CCG is required to follow. Dr Mohindra (SM) queried if we were at fair shared. JH commented that the CCG would not achieve there as we also get a reduced % every year. The Cabinet **acknowledged** the reports.	
CC 18/040	**Cancer profiles** Simon Castle (SC) introduced the Workstream in terms of clinical leads and finance leads. It was explained that the delivery programme plan is to mirror what is nationally required. SC outlined the work stream objectives and presented these to the members, identifying that a new target will be 28 days from	

	referral to diagnosis from the 14 days. Different metric indicators are being analysed which will warrant further review/investigation. SC highlighted key links to access information on cancer profiles within CCG specific areas. (See paper) A main aim is to achieve 75% one year survival rate by 2020. Forecast shows predictions as positive for NNE; however, there are variations with cancer types. The national average has been tracked and the following identified: Breast cancer laps with national average but colorectal is showing below average. Gap is closing and trajectory is reducing. Lung cancer is also below for NNE, not unique for the CCG but working go on to see what's behind this. Proxy measures such as stage at diagnosis are used. 55% circa for NNE and a 6% gap for hitting target. Emergency presentation shows similar pattern to national average. Demographics for NNE from NHS dashboards show higher for 2 week wait referrals, detection rates and more referrals within the CCG overall. SC presented the indicators for Practice specific data. This included referrals, detection, emergency presentations etc. (See paper) A summary was highlighted to the members for those who are similar, lower and higher. Outlier indicators will be looked into. City and Rushcliffe CCGs have used Cancer Research UK to look at referral patterns and how direct access diagnostics are used alongside all other metrics. Dr Ann Cockburn (AC) commented that tools are not integrated into system one and have not been able to download since cyber-attack. SC added that there is a national drive to get working with system one. SC also recommended Mind maps by Ben Nobler and added that this can be put onto F12 and template forms. National approach is to reduce the threshold of 3% detection rate. Reduction at NUH from around 60 to 30 which will make a difference. The Cabinet was invited to comment: Dr Caitriona Kennedy (CK) commented that it is sometimes difficult to keep track of locums who maybe not up to speed with all updates etc. Ben Teasdale (BT) commented that we then need a reaction to counteract that with there being a responsibility to get them using the things they need. Dr Parm Panesar (PP) commented on the system and that there	

	is a need for lessons learnt as currently complicated. It was added that pathways should have simpler tests and referrals. CK commented on prevention services which sit more with Local Authority and Public Health services. In terms of Practices to improve rates, there is an offer to support them and to use Simon as a contact point. Sharon Pickett to contact Unity.	**SP**
CC 18/041	**Prescribing budgets** IL presented the paper on the new year budget for prescribing. This has been based on the same basis as previous as Astro PU plus allocating to practice level. £19.5 million compared to last financial year. £261k less. Budget slightly less than last year's outturn. £800k around the NCSO issue. This shouldn't continue and have been told not to budget for. It was queried why have some had reduced budget or added more. IL added that this is relative to their last years outturn so would receive less compared to what was spent last year. A further query was raised around minor medications e.g. hay fever, gluten free etc. The Cabinet were informed that there is national consultation but at Nottingham level there are differences through stopping some prescriptions.	
CC 18/042	**Federation working** Ian Campbell (IC) covered the latest action points and confirmed all practices have now responded. Torkard and Oakenhall have decided not to participate with Giltbrook and Newthorpe now sitting under West Locality. IC emphasised the impact that this has on all other practices in the Federation. Bank holidays have changed to include Christmas and New year, however this has been challenged. Extra hours due to the non-participation of Torkard and Oakenhall will require splitting over the rest of the Federation. IC proposed having these as "floating" hours or rota'd on. It was confirmed that practices will receive payment. Non participants get the benefits but not the payments. A discussion took place around the higher number of GPs per population and how the work load is fair for all. Issue around bank holidays and Sundays was raised and it was suggested that numbers for BH and Sundays would be helpful	

	as this is a point of debate. Discussion around the workforce issue and having those discussions with staff. It was queried if 10 hours have to be provided by a clinician. IC confirmed that 1 in 4 would have to be a clinician. IC added that there has been an offer of one locum who can be employed for Saturdays around the patch. (as a pool to visit other practices) No obligation for those to have worked at the practice for 18 months. It was reiterated that the initial contract is for for 6 months and then a further 12 months with nothing confirmed after this timeframe. IC added that there could be a future possibility that this will be a clinical requirement without pay. A member queried what would happen if a practice decided to pull out in 3 months' time. IC informed them that this is not is a contract yet but maybe included in this. Mon-Fri is practice based. Sundays and Bank Holidays have agreement for 1 practice to be open for the whole Federation. There is also scope for collaboration with another practice. PICs can be flexible with this so it was advised to share issues with PICS. IC introduced Sally from PICS. Mandy M requested a model of the hours so they can visualise how this will look. It was added that hours have been worked out and it is the decision of the practice where they want the hours. The Practice then informs PICS. A discussion was held around normal service in the evenings with 15 minute appointments. It was added that some elements cannot be covered due to skill set and stock results etc. (e.g. smears) Sally advised the group that PICs information given will be put in rota and then can be sent out so that Practices can see where the gaps lie. Sally explained the system and how the appointments run. PICs have a bolt on to log on, especially for patients of a different practice; and book appointments. It was added that every consultation comes with a task (e.g. bloods, smears etc.) that the original patient's practice should do. Sally highlighted that governance has been carried out in PICS around data being shared and the full access to records. The federation held a vote and agreed to 1 in 6. It was also suggested that a compilation of questions that has been compiled to be shared with members. Sally reiterated that the members can use PICS for further support where needed.	

	The federation members also discussed if they would want CCG officers present at Federation meetings to help shape. The group agreed that they would want this to be an independent provider group and to invite them where applicable. JH raised that in the new structure there are locality elements to help support federative working where needed. A discussion took place around funding administration support for federation meetings.	
CC 18/043	**Reports** JH invited Clinical Cabinet members to query the information in the following report, no queried were raised. a) NNE Performance Report April 2018 b) Nottinghamshire Health and Wellbeing Board Summary June 2018 The Clinical Cabinet **acknowledged** the reports.	
CC 18/044	**Risks identified during the course of the meeting** No risks were identified.	
CC 18/045	**Any Other Business** **GN Referral Support Service:** Kirsten Owen presented the GP support referral system to the Cabinet. It was informed that a system is being created so that all pathways are standardised. The process is currently being developed for this. CK added that the administration office is purely administrative as there is no current clinical oversight. KO added that the team are looking to expand the clinical assessment services that CCGs currently have. There is also an admin triage in the City and Rushcliffe and will be looking to expand for acute referrals. This will also endeavour to ensure that all correct information is completed on the referral forms and giving patients the choice and to help book appointments. This will also help to centralise the process and support GPs with links to F12 project and using right forms. KO advised that in the initial months, the team will be advising them of the correct referral form. This is planned for the 30th July 2018. A patient leaflet will also be produced as an easy read so they	

	understand the referral process but this has not gone live yet. It was added that this will help to embed F12 into practices. There will also be minimal referral requirements so support will be provided in this. A question was raised how this fits in with MSK and ophthalmology. KO confirmed that these will continue as they are but with potential changes to names in order to be uniform. An issue was highlighted regarding referring for something that the CCG doesn't offer and how to overcome this. KO informed the group that the F12 project is looking into how to only show what is in your CCG to eliminate this potentially happening. KO confirmed that the provider will be the CCG with City CCG using NEMS. It was advised that going forward there will be a procurement opportunity. The issue around problems of getting hold of patients etc. was raised. KO added that this is being reviewed but there is assurance in the system as Rushcliffe CCG has been doing this for a while. KO added that the team are reviewing the process of where patients do not attend appointments. Urgent referrals are also completed by Rushcliffe and City and therefore the pathway is being reviewed. The group agreed that this is a great change in administration and previously the number phone lines was underestimated and queried if there will be enough capacity to deal with demand. KO to feed this back. A cabinet member queried of there if there is a support service if practices are unsure on referrals. KO informed the group that she would be going out to localities to support.	**KO**
	Date, Time and Venue of Next Meeting 18th July 2018, 1.30pm-4.30pm Chappell Room, Civic Centre, Arnot Hill Park, Nottingham, NG5 6LU **SIGNED: …… (Chair)** **DATE: ……..**	