MEETING OF THE
RUSHCLIFFE CLINICAL COMMISSIONING GROUP
CLINICAL CABINET
HELD ON THURSDAY 1 OCTOBER 2015 AT 1.30PM
EASTHORPE HOUSE, 165 LOUGHBOROUGH ROAD
RUDDINGTON, NOTTINGHAM NG11 6LQ

All attendees should be aware of NHS Rushcliffe CCG’s participation in the Freedom of Information Act. The minutes and papers from this meeting will be published in the Publication Scheme with all names included, unless notified to the Chair before the meeting commences or included in a pre-agreed confidential section due to the sensitive nature of the debate.

Membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Shortt</td>
<td>Clinical Leader (GP Chair)</td>
</tr>
<tr>
<td>Jeremy Griffiths</td>
<td>Governing Body GP member – Health &amp; Wellbeing</td>
</tr>
<tr>
<td>Gavin Derbyshire</td>
<td>Governing Body GP member – Membership</td>
</tr>
<tr>
<td>Ram Patel</td>
<td>Lead - Primary Care Quality</td>
</tr>
<tr>
<td>Neil Fraser</td>
<td>Lead - Long Term Conditions</td>
</tr>
<tr>
<td>Alex Macdonald</td>
<td>Lead - Prescribing</td>
</tr>
<tr>
<td>Lynn Ovenden</td>
<td>Lead - Community Services Commissioning</td>
</tr>
<tr>
<td>Matt Jelpke</td>
<td>Lead - Acute Specialist (elective)</td>
</tr>
<tr>
<td>Tim Daniel</td>
<td>Lead - Acute Specialist (non-elective)</td>
</tr>
<tr>
<td>Nick Page</td>
<td>Lead - Mental Health</td>
</tr>
<tr>
<td>Ann-Marie Stewart</td>
<td>Lead - Education</td>
</tr>
<tr>
<td>Sean Ottey</td>
<td>Lead - Clinical Innovation</td>
</tr>
<tr>
<td>Louise Bevan</td>
<td>Lead - Children &amp; Young People</td>
</tr>
<tr>
<td>Vicky Bailey</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>Helen Griffiths</td>
<td>Assistant Chief Operating Officer</td>
</tr>
<tr>
<td>Jonathan Gribbin</td>
<td>Consultant in Public Health</td>
</tr>
<tr>
<td>Jonathan Bemrose</td>
<td>Director of Finance or nominated deputy</td>
</tr>
<tr>
<td>Clive Rix</td>
<td>Governing Body Lay Member Representative</td>
</tr>
<tr>
<td>Carol Wilson</td>
<td>Practice Manager Representative</td>
</tr>
<tr>
<td>Liz Yeatman</td>
<td>Practice Manager Representative</td>
</tr>
<tr>
<td>A</td>
<td>A Denotes absence</td>
</tr>
</tbody>
</table>

In attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Chris Hawkey</td>
<td>Secondary Care Doctor, Nottingham University</td>
</tr>
<tr>
<td>Richard Stratton</td>
<td>GP, Belvoir Health Group</td>
</tr>
<tr>
<td>Neil Shroff</td>
<td>GP, Keyworth Medical Practice</td>
</tr>
<tr>
<td>Jag Rai</td>
<td>GP, Ruddington Medical Centre</td>
</tr>
<tr>
<td>Linda Kandola</td>
<td>GP, Gamston Medical Centre</td>
</tr>
<tr>
<td>Nigel Cartwright</td>
<td>GP, Orchard Surgery</td>
</tr>
<tr>
<td>Stephen Andersen</td>
<td>Head of Finance</td>
</tr>
<tr>
<td>Andy Hall</td>
<td>Director of Outcomes &amp; Information</td>
</tr>
<tr>
<td>Andrew Wrench</td>
<td>GP, East Leake Health Group</td>
</tr>
<tr>
<td>Karon Glynn</td>
<td>Assistant Director Mental Health and Learning Disabilities</td>
</tr>
<tr>
<td>Imran Arshad</td>
<td>GP, East Leake Health Group</td>
</tr>
<tr>
<td>Nayna Zuzarte</td>
<td>Head of Prescribing</td>
</tr>
<tr>
<td>Caroline Stevens</td>
<td>Governance Officer (minutes)</td>
</tr>
</tbody>
</table>

‘A’ Denotes absence

(A) Rain Patel
(N) Neil Fraser
(P) Alex Macdonald
(L) Lynn Ovenden
(M) Matt Jelpke
(T) Tim Daniel
(N) Nick Page
(AMS) Ann-Marie Stewart
(SO) Sean Ottey
(LB) Louise Bevan
(VB) Vicky Bailey
(HG) Helen Griffiths
(JoG) Jonathan Gribbin
(JB) Jonathan Bemrose
(CR) Clive Rix
(CW) Carol Wilson
(LY) Liz Yeatman

(A) Richard Stratton
(RS) Neil Shroff
(JR) Jag Rai
(LK) Linda Kandola
(NC) Nigel Cartwright
(SA) Stephen Andersen
(AH) Andy Hall
(AW) Andrew Wrench
(KG) Karon Glynn
(IA) Imran Arshad
(NZ) Nayna Zuzarte
(CS) Caroline Stevens

CH Professor Chris Hawkey
(RS) Richard Stratton
(NS) Neil Shroff
(JR) Jag Rai
(LK) Linda Kandola
(NC) Nigel Cartwright
(SA) Stephen Andersen
(AH) Andy Hall
(AW) Andrew Wrench
(KG) Karon Glynn
(IA) Imran Arshad
(NZ) Nayna Zuzarte
(CS) Caroline Stevens

NHS Rushcliffe Clinical Commissioning Group
1 October 2015 - Minutes
Chair – Dr. Stephen Shortt
CS/NHS Rushcliffe CCG Clinical Cabinet
### CC/15/197 Welcome
SS welcomed everyone to the meeting of the Clinical Cabinet. It was noted that KG, IA and NZ would only attend for the items they were presenting. SS welcomed LY to the Cabinet, Practice Manager at Ruddington Medical Practice attending with CW for this meeting. SS also welcomed and introduced AW, GP Fellow working at East Leake Health Group.

### CC/15/198 Apologies for Absence
Apologies were received from Nick Page, Richard Stratton and Ram Patel.

### CC/15/199 Declarations of Interest
A standing general declaration of interest was acknowledged in respect of:

1. All participants who have provider contract(s) with the Clinical Commissioning Group (CCG).
2. All participants with membership of Nottingham Emergency Medical Services.

### CC/15/200 Minutes of the Last Meeting held on 3 September 2015.
The minutes of the previous meeting were agreed as a correct record with the following post meeting note:

CC/15/179. Whilst there was nothing that JH felt was new or specific messages given by PMs to pass to the Clinical Cabinet relating to the Anti-coagulation service update, a number of Practice Managers have in the past raised concerns around the financial modelling of the service. These have been addressed directly to commissioners by Practice Managers and also at Practice Manager meetings with commissioners present.

### CC/15/201 (i) Action List
The following updates were noted:

**CC/15/175** - Tracey would attend the November meeting as the Community Services re-procurement process was in the standstill period and so unable to announce outcome. SS reported that subject to final Governing Body approval at a neighbouring CCG that afternoon the successful bidder would be notified the following day. SS explained that there was a period of standstill which gave unsuccessful applicants the opportunity to review the decision, therefore, the successful bidder would not be announced in the next two weeks.

All other actions were noted as complete.

### CC/15/201 (ii) Matters Arising not elsewhere on the agenda
No other matters were noted.
CC/15/202 Business Case for a Rushcliffe CCG ‘Lifestyle Fund’

JG presented the Business Case for a Rushcliffe Lifestyle Fund to the Cabinet for approval. The paper proposed that the fund (which was yet to be named) would be provided by NHS Rushcliffe CCG and be administered by Rushcliffe Borough Council, to support local initiatives that aimed to improve health and wellbeing as well as reduce health inequalities for the residents of Rushcliffe. The financial implications of the project would be £30,000 non recurrent funding from Transformation Funds or other reserves from April 2016 to March 2017.

JG noted that this initiative required only a small amount of funding that alongside the individual beneficial projects funded by the scheme would provide the opportunity for joint working with Rushcliffe Borough Council and greater visibility of commissioning for the public.

The Cabinet discussed relevant criteria for agreeing funding for projects and evaluation of success following project end. The Cabinet agreed that the project panel should be responsible for ensuring process for reviewing projects for funding and that the level of evaluation should be proportionate to the size of the project with assessment of its value. The Cabinet also agreed that there should be not be a limit of £2000 funding for each project.

The Clinical Cabinet APPROVED the business case.

CC/15/203 Improving Access to Psychological Therapies (IAPT) Tariff 2016/17

KG presented the IAPT Tariff for 2016/17 paper to the Cabinet for approval. At the July 2015 the Cabinet requested further details and a modelling paper regarding an increase in spend for IAPT services.

The contract was due for re-commissioning in anticipation of 2016/17 and Monitor had issued new guidance for the tariff for psychological therapies going forwards. The CCG was required by 2017 to commission psychological therapies services according to Payment by Results (PbR) on a 50% outcomes basis. The paper proposed to commission around 25% outcomes to test out the Monitor guidance and to enable the clustering of patients to become robust to enable Rushcliffe CCG to move to the 50% outcome based commissioning going forward. It was anticipated that the new tariff would encourage new market entrants into Rushcliffe.

KG explained that the new proposed tariff would see just over a 7% uplift in the current tariff model, this had been modelled by Julia Delaforce and tested based on 2014/15 activity. The final proposed model presented at this meeting needed the Cabinet’s final sign off to enable commissioners to commence the tender process.

In answer to a question, KG explained that £570 was the cost per patient for up to 10 sessions of treatment and that appointment uptake was between two and ten. The Cabinet discussed the variation in value dependent on number of treatment sessions for each patient. KG explained that patient access would form part of the

The Cabinet noted that clinicians were encouraged to refer into this service and that guidance suggested 15% of patients suffer with anxiety and depression and should be referred for treatment.

The Cabinet noted that this service was delivered by two providers that were performing differently in terms of access, however, were paid the same. KG explained that patient access would form part of the
future outcomes based payment approach.

**Action:** KG to attend future meeting to present patient activity levels for IAPT services including returning patients

The Clinical Cabinet **APPROVED** this paper.

### CC/15/204 Business case for standardised follow up protocol for hip and knee arthroplasty

LO presented the business case for standardised follow up protocol for hip and knee arthroplasty to the Cabinet for approval. LO explained that Nottingham University Hospital (NUH) in partnership with local GPs and commissioners had developed a standardised follow up protocol for hip and knee arthroplasty in line with clinical guidance to reflect best clinical practice. The Clinical Cabinet was recommended to support this protocol. There was no investment required and a recurrent annual saving of £24,513 in Years 1 & 2, reducing to £14,472 in years 3 -5 across Nottingham City & South CCG’s. LO also highlighted the hidden savings not calculated through reduced numbers of more complex repeat procedures following complications and complex operations.

The Cabinet discussed the evidence base for the guidance and noted that the community orthopaedic service would provide greater support in managing patients. The Cabinet queried the differing costs for x-rays by primary care and secondary care as performed in the same clinics.

**Action:** SL to confirm costs with contracting team

The Cabinet queried whether the savings identified would be realised and whether this would have an impact on workforce plans but agreed with the pathway and so were happy to support.

The Clinical Cabinet **APPROVED** the business case.

### CC/15/205 Care Home Pharmacist

AM presented the Care Home Pharmacist paper to the Clinical Cabinet for approval. The report provided an overview of the work undertaken during the initial three months of the Care Homes/ Primary Care Pharmacist role. This role was created to coincide with the Rushcliffe CCG ‘Enhanced Support to Residents in Older Peoples’ Care Homes’ Service Specification and was currently being undertaken by a 0.8WTE pharmacist on secondment for 12 months working approximately 25% as a primary care pharmacist and 75% in the care homes role. Clinical Cabinet was requested to agree to this role being made permanent.

The role of the Care Homes Pharmacist was to work with care homes staff, GPs, community nursing staff, Age UK, dieticians, residents, carers, Dementia Outreach Team (DOT) staff and other stakeholders to complete robust medication reviews and start to identify ways of optimising medication through the review of systems and processes around prescribing, ordering, storing and administering medication with the aim of promoting safety and reducing waste. A number of benefits were identified within the report, including improving quality for vulnerable and risky group of patients.

AM explained that the investment required for an annual cost of a 0.8 WTE Band 8a Pharmacist (mid-point including on cost) was £42,320, savings to date for a five month period were £23,400, therefore, the projected annual savings were £56,160, giving a net saving of £13,840.
The Cabinet queried how the savings had been calculated, NZ explained that the savings were a challenge to calculate as based on prescribing costs, however, savings would also be made in GP time and costs associated with potential falls and strokes etc. had the reviews not been completed.

The Cabinet also queried the projected number of reviews to be completed in a 12 month period. NZ explained that the reviews were very detailed and included information seeking and communicating with clinicians for example community matrons. The Cabinet discussed that the pharmacist needed to work more autonomously, however, noted that it would take time to build these relationships initially.

The Cabinet also noted that dietician support was needed for this area to focus on sip feeds.

The Cabinet agreed with the business case in principle, however, noted that the service needed to be more productive as £100 cost per review with capitation per patient £88 was not viable. The Cabinet also agreed that the pharmacist must be visiting care homes quarterly and acting as an autonomous practitioner.

The Cabinet APPROVED the business case.

CC/15/206 Prime Minister’s Challenge Fund Evaluation

IA presented the Prime Minister’s Challenge Fund (PMCF) Evaluation to the Cabinet for discussion.

The pilot service had proved hugely popular with patients, receiving excellent feedback, however, was noted to not be currently financially sustainable given the relationship between the delivery costs and the modest levels of patient activity.

The benefits of the pilot were largely non-quantifiable, but included increased IT functionality, positive culture change, federated and inter-practice working, organisational development and new governance frameworks. The service could not claim to have had any direct impact or causation on Emergency Department (ED) activity given the current pathway through 111, though anecdotally a few hospital admissions have been saved.

The project found that the majority of Rushcliffe patients needing primary care services at the weekend required home visits or transport, neither of which were offered by the PMCF pilot. The Cabinet noted that patient activity might be optimised by moving the service a few hours later in the day and more proactive advertising of the service could increase activity, however, this needed to be balanced with concerns about inflating demand. This had been protected during the pilot by two triages from 111 and NEMS and managing patient expectations in relation to a temporary service.

The Cabinet noted that the pilot had been extended to the end of December 2015. The service had been developed to also include advice for pharmacists, care homes, and Walk In Centres (WIC), however, activity was still low.

The Cabinet noted that the cost per patient had been very high and that the use of service correlated to access to the site, with mainly West Bridgford and Gamston practice patients attending. IA also highlighted that only one pre-bookable appointment had been used in nine months of the pilot so far and that practice engagement had been variable, 62% of GPs had participated, however, this was falling.

The Cabinet discussed medico legal issues and enhanced fees to Medical Defence Unions (MDU) in order to support weekend working and that MDU fees including weekend working were dependent on the
union.

The future of the pilot was unknown, and would be determined by availability of resource and the pending policy directive regarding seven day working. The Cabinet noted that potential cost savings could be made for the pilot to enable the service to become more financially viable and the potential for the service to deliver other needs such as home visits. This would be considered further post December 2015 if national direction had not been provided.

SS thanked IA for attending to present the report. The Cabinet acknowledged that the pilot was an excellent service with many benefits and had evaluated well by patients however, was not economically sustainable in its current model form.

The Clinical Cabinet **NOTED** the evaluation

---

**CC/15/207 GP prescribing variation**

AM presented the prescribing variation across practices and future of the medicines management team paper to the Cabinet for discussion and agreement.

The Medicines Management Team working with practices had historically always achieved QIPP and saved on the allocated prescribing budget. Year on year there had been an increase both nationally and locally of items and cost. This increase now posed a financial risk and in order to mitigate this risk the team and practices needed to address any variation of prescribing that may exist and look at ways of reducing the projected overspend.

To reduce the projected overspend and variation in prescribing the paper identified two options that needed to be explored and considered and long term strategies need to be put in place.

- **Option 1**
  Practices within Rushcliffe used their own resources with facilitative support from the medicines management team

- **Option 2**
  Further investment in the medicines management team looked at short term and long term strategy to ensure medicines optimisation is safe and cost effective.

Future investment in the medicines management team was recommended by AM and the team as the viable and sustainable option and clinical cabinet was requested to agree and approve this. The financial implications for this investment were identified within the paper.

The Clinical Cabinet noted that all practices in Rushcliffe were below the national spend, however, there was a variable range of spend. The Cabinet discussed the need for practices to work together to support and improve prescribing between practices through peer review and behaviour changes.

SS noted that there was potential that the Partnership of Partners (POP) could be given delegated authority for the prescribing budget and so members needed to consider how reducing variation in prescribing could be reduced.

NZ noted that there were two aspects of the work, achieving the short term QIPP financial savings and the longer term quality improvement. In order to achieve the longer term quality improvement further resource was needed in the Medicines Management Team.
The Cabinet discussed the variation in prescribing between dispensing and non-dispensing practices as this could reduce variation. The Cabinet noted however, that there was variation between dispensing practices in Rushcliffe and that not all dispensing practices were identified as the higher prescribers, therefore, agreed that this should not be considered as a solution to the variation.

SA noted that prescribing overspend had been the largest area of overspend for the last ten years and suggested that some resource was needed to prevent this continuing. SA also highlighted to the Cabinet that Rushcliffe’s prescribing spend was increasing faster than neighbouring CCGs.

SS summarised that the Cabinet supported the paper presented and the funding requested, however, would expect to see changes to variation quickly and requested regular updates on progress. The Cabinet would also like to see an educational approach with practices working together to optimise medicines and improve quality, rather than just supporting the cheapest medicines.

The Clinical Cabinet NOTED the paper and AGREED the investment.

**CC/15/208 Transforming Care Briefing**

KG presented the Transforming Care briefing to the Cabinet for discussion.

The Cabinet heard that Transforming Care for people with a learning disability was a key national priority. It required alternative support to be available to enable people who had challenging behaviour to be supported to live in the community reducing stays in hospitals. Within Nottinghamshire this had resulted in 15 people being discharged from long stay placements by June 2014.

From October 2014 comprehensive full day reviews of all patients were required to confirm
  - Was the person getting good care now?
  - Was the person safe?
  - What were their plans for the future?
  - Did the person need to be in hospital?

These were completed by the December 2014 deadline and reviews had now become business as usual. Pre-admission reviews were now also required as well as blue-light (urgent) reviews to explore if admission could be avoided. Data on admission was submitted to HSCIC monthly, Rushcliffe had four patients in Learning Disability hospital care and all had discharge plans.

NHS England had published trajectories with the expectation that the inpatient cohort would be reduced by March 2016. For Rushcliffe, this indicated a reduction of two patients. Nottinghamshire has been identified as one of 5 national ‘Fast-Track’ sites to establish comprehensive alternatives to in-patient care. There was £10m non recurrent money available but this had to be match funded by CCGs. Transformational plans needed to be submitted by September 7th 2015. Nationally the view was that these developments were cost neutral, however, local data showed that Transforming Care in Nottinghamshire had resulted in an increase spend of £1million, this information was being shared with the national team.

The main issues and risks to the work programme were:
  - Capacity to carry out the considerably increased workload.
  - Linked to the above, the ability and capacity to carry out Care and Treatment (CTR) reviews within the prescribed timescales.
  - Recruitment – it had been identified that recruitment was proving problematic for some of the community services the Local Authority were developing and this had the potential for causing
delays to patient discharges.

- Housing – it was often necessary to develop bespoke housing solutions for this cohort of patients. This was obviously expensive but could also take a considerable amount of time (it was not unusual for it to take 18 months or more), particularly if a new build was required. There were difficulties identifying appropriate houses for adaptation or building sites for development, particularly as some patients have some very specific needs that affected the location of any property.
- Deprivation of Liberty Safeguards (DoLS) – Many of the patients would need authorisation from the Court of Protection for their care in the community. A recent judgement had lowered the threshold of requiring DoLS authorisation so that it now applied to many more patients than previously. Obtaining authorisation from the Court of Protection was a lengthy and potentially costly process.
- Responsible commissioner issues – it could sometimes be difficult to identify who this should be for patients that have spent long periods in hospital and may not be clear for patients in placement that were currently commissioned by NHS England Specialised.
- It was not possible to identify a clinical lead from Nottinghamshire County CCGs to sit on the Fast Track Board.

The Clinical Cabinet was asked to note the on-going work in respect of Transforming Care for people with a learning disability and the implications of Nottinghamshire being identified as one of five national ‘Fast-Track’ sites.

VB noted the national high profile of Transforming Care and that Rushcliffe CCG had been identified as an outlier for this area.

The Clinical Cabinet NOTED the briefing.

### CC/15/209 Fracture Liaison Service Protocols

AMS presented the Fracture Liaison Service Protocols to the Cabinet for information. AMS explained that to enable the Fracture Liaison Service to go live, the two protocols presented had been developed:

- Guideline for assessment of clinicians performing cannulation
- Policy and assessment for clinicians in the administering of IV drugs

The protocols had been reviewed and agreed by the Director of Quality and Secondary Care and were now being shared with the Clinical Cabinet for assurance purposes. The protocols would be saved within the Clinicians area of the website.

AMS noted that the assessment and competency of practice was transferable for anyone providing future services. In answer to a question, AMS explained that the guidance was intended for Practice Nurses where cannulation and administering IV drugs was not part of their normal clinical duties.

The Clinical Cabinet NOTED the protocols.

### CC/15/210 Principia Multi-specialty Community Provider (MCP) Value Proposition

SS presented the Principia MCP Value Proposition to the Cabinet for information.

The Value Proposition was submitted to NHS England as part of the MCP process. The document set out the intentions for the MCP and detailed how Rushcliffe would deliver the service.
The paper explained that the MCP had five clinical goals:
- Create a far more cost efficient and clinically effective model of care
- Fully integrate all local health and social care providers
- Transfer all care to the right place
- Focus on prevention, early diagnosis and management of risk factors
- Target resources more effectively based on detailed understanding of population need

SS explained that the Value Proposition had been submitted by the CCG in name of Principia. The content was not final as yet and NHS England was agreeing the amount of money that would be awarded to deliver that afternoon. £4.2m had been requested for 2015/16.

SS and VB thanks FC and the team for co-ordinating the submission and noted that if the bid were successful in achieving the significant income it would allow delivery of vast transformation in Rushcliffe. The proposition had focussed on primary care development with an emphasis on a shift in responsibility and accountability.

The Clinical Cabinet NOTED the Value Proposition

**CC/15/211 Finance Report**

SA presented the Finance report to the Clinical Cabinet for information.

SA noted that the CCG had kept expenditure within the Revenue Resource Limit for the period April 2015 to August 2015 and was forecasting to deliver the annual QIPP plan by year end. The CCG was on target to be within the running cost allowance and all budget holders would need to ensure that invoices were paid in line with Better Payment Practice Code (BPPC) requirements in order to achieve all four BPPC targets by year end.

SA stated that there were still a number of risks that the CCG faced. These included:
- Increased variance against plan at NUH
- Increased variance against plan at Circle
- Increased variance against plan for Continuing Care
- Increased levels of Prescribing expenditure
- Delivery of the QIPP plan.

SA highlighted that the CCG had needed to draw down £0.6m at month five in order to balance books, however, the contingency remaining was still better than expected mainly because of performance at acute trust. SA noted as per earlier item that prescribing was one area where the CCG was experiencing more pressure than in previous years.

The Clinical Cabinet NOTED the financial position of the CCG for April 2015 to August 2015

**CC/15/212 QIPP Group Highlight and Exception Report**

SA presented the QIPP Group Highlight and Exception Report to the Clinical Cabinet for information. The Cabinet noted the following update:

- At the end of August 2015, the CCG was forecasting achievement of the QIPP Target of £4.5m which was supported by £0.9m of non-recurrent reserves (this was a worsening of the position
since month three of £0.6m).

- The Continuing Care QIPP was a risk for this financial year as there was now a backlog of 750 cases across the County. The service had moved to a new provider but any savings would not be realised until late in the financial year.

- The full value of the share of the £22m QIPP identified as part of the contracting process had been transacted in the Circle contract, however the work on service redesign was progressing slowly. A meeting had taken place with Circle to discuss pathway redesign. Circle’s focus was on facilitated discharge of patients to reduce follow-ups, which would not generate a saving for the CCG (as there was a fixed price for outpatients based on an agreed first to follow-up ratio) unless the ratio could be renegotiated. The contracting team were working up a proposal for revised first to follow up ratios to be included in the contract for 2016-17. The 11 beds that opened in 2014-15 were still not attracting the anticipated numbers of private patients which was not generating the anticipated QIPP savings.

- There was an emergent pressure on the Category M savings within the prescribing plan with savings forecast to be £120k less than the QIPP plan. A contract had been awarded for the provision of stoma appliance reviews but due to staffing issues this was unlikely to realise savings in 2015-16 (£69k shortfall).

- Elective Care was forecast to be £214k under plan mainly due to slippage on schemes (including anti-coagulation £68k, community gynaecology £21k and Fracture Liaison £18k).

- Clinical Navigation was delivering savings for unplanned care with a significant reduction in GP emergency admissions compared to last year. The DVT pathway had been implemented but the anticipated had reduced by £45k. The anticipated savings associated with the better care fund had been scaled back due to issues with seven day working and the difficulties in recruiting social care staff to the pilot care delivery group, a QIPP reduction of £101k. There had been delays in recruitment of the pulmonary rehabilitation service which had caused the anticipated saving to slip by £46k.

The QIPP exception report showing schemes that had a red ‘Red, Amber, Green’ (RAG) rating was attached as Appendix 1(b).

SA noted that the QIPP report mirrored the finance report. The CCG were forecasting to achieve the QIPP target with assistance from the reserve, despite QIPP in certain areas not going to be achieved, including prescribing and non-elective care. The Cabinet asked how long the reserve would sustain position. SA explained that there was enough for this financial year and that Rushcliffe CCG was performing better than others.

SS noted that Standardised Activity Ratio (SAR) data demonstrated positive changes, including a reduction in the number of patients being admitted to hospital, a reduction in number of patients resident in a care home dying in hospital and reduction in number of ambulance call outs to care homes.

The Clinical Cabinet NOTED the report

---

**CC/15/213 Performance Report**

AH presented the Performance Report to the Clinical Cabinet for information.

AH reported that NUH’s Accident and Emergency (A&E) performance failed to meet required standards in September 2015, this was the third consecutive month. AH noted that if only looking at Rushcliffe data, standards were being achieved, however, as the service was commissioned collectively, this was how figures were reported and reviewed. AH suggested that the CCGs could expect some stricter measures
in place nationally and greater scrutiny of the CCGs’ actions as commissioners. It was possible that the CCGs would be expected to use contract levers and financial penalties to improve performance. AH highlighted that the System Resilience Implementation Group (SRIG) continued to discuss performance.

AH highlighted to the following Indicators out of trajectory –

**CCG**

- **Cancer** (page 3 of the report) – Performance for July 2015 highlighted that Rushcliffe CCG was below standard for the 2 Week Wait pathway for Breast Symptoms (75.00% against standard of 93%)
- **Referral to Treatment (RTT)** (Page 4 of the report) – Rushcliffe CCG achieved all three standards during August 2015, however, the following specialties were below standard:
  - Admitted - Cardiology
  - Non-Admitted - T&O, General Medicine, Gastroenterology, Dermatology, Thoracic Medicine
  - Incomplete - No specialties below standard

**NUH**

- **Cancer** (Page 6-8 of the report) – The following pathways failed to meet their respective standard during July 2015 -
  - 62 Day Urgent RTT — 83.90% (standard = 85%)
  - 2 Week Wait — 89.99% (standard = 93%)
  - 2 Week Wait - Breast Symptoms—86.36% (standard = 93%)

**EMAS (Page 25-30 of the report)** – Red 1 and Red 2 performance remains below standard for the 8 and 19 minute targets. Comparative performance and outcomes across ambulance trusts was shown on page 29 & 30 of the report.

SS enquired about the EMAS clinical audit of missed patients and harm caused. AH reported that this was with the EMAS contract panel and was expected to be published. EMAS performance would be discussed further by the Governing Body.

The Clinical Cabinet NOTED the Performance Report.

---

**CC/15/214 Health and Wellbeing Board**

JG noted the Nottinghamshire Hoarders Framework that had been highlighted at the meeting, a link to this was included in the summary document and JG suggested colleagues review.

The Clinical Cabinet NOTED the Health and Wellbeing Board summary

---

**CC/15/215 Contract Clinical Board**

The Clinical Cabinet NOTED the Clinical Contract Board minutes

---

**CC/15/216 Individual Funding Review Panel**

This item was deferred to the Confidential Clinical Cabinet agenda

---

**CC/15/217 Prioritisation panel**

SO noted that there had not been a meeting of the Prioritisation Panel since last update at the September meeting.
CC/15/218 Messages to Practice Managers’ Forum, Governing Body and Patient Cabinet

The Cabinet agreed the following key items for the highlight report:

- **Business Case for a Rushcliffe CCG ‘Lifestyle Fund’**. The Clinical Cabinet APPROVED the business case for a Lifestyle Fund.
- **Business case for standardised follow up protocol for hip and knee arthroplasty**. The Clinical Cabinet APPROVED the business case for a standardised follow up protocol for hip and knee arthroplasty.
- **Care Home Pharmacist**. The Clinical Cabinet APPROVED the business case for Care Home Pharmacist secondment role to be made permanent.
- **Prime Minister’s Challenge Fund Evaluation**. The Clinical Cabinet NOTED the Prime Minister’s Challenge Fund (PMCF) Evaluation.
- **GP prescribing variation**. The Clinical Cabinet NOTED the GP prescribing variation across practices and future of the medicines management team paper and AGREED to further investment in the Medicines Management Team to look at short term and long term strategy to ensure medicines optimisation is safe and cost effective.
- **Transforming Care Briefing**. The Clinical Cabinet NOTED the Transforming Care briefing.

CC/15/219 Any Other Business

1. AM highlighted further to anti-coagulation update at last meeting that problems were still being experienced with INR Star as did not support the use of 3mg tablets. AM asked colleagues for agreement that Belvoir Health Group piloted the use of 3mg, 1mg and 0.5mg for warfarin maintenance from 5th October 2015 to 5th November 2015 whilst other practices continued using 3mg to maintain patient’s INR. Several Cabinet members expressed concerns for patient safety as a result of using different systems between practices and secondary care. AM noted that Nottingham was the only area that only used 3mg and 3mg split tablets and that use of 3mg, 1mg and 0.5mg was supported by the National Patient Safety Agency (NPSA). The Cabinet discussed whether this should be piloted in secondary care first.

**Action:** AM and Jacki Moss, Service Improvement Manager to contact hospital to discuss pilot further

2. SS noted further to update at last meeting that Nottingham West CCG did not appoint to their Chief Officer’s post following application process, therefore, VB would be supporting for longer than initially expected.

3. SS noted that this meeting was TD’s last clinical cabinet meeting. SS thanked TD for all his work on the Cabinet and in non-elective care. SS noted that the CCG would write to GPs shortly to invite interest in the replace role

4. SS reported that following NF’s visit to NUH last year, where NF had completed patient reviews on the wards with Lynn Hallam, Clinical Director, CHP Rushcliffe - Nottinghamshire Healthcare Trust for Rushcliffe, HG had been working with Caroline Shaw, Director of Operations, NUH to develop a new model for GPs to attend Health Care Older Persons’ wards to see frail elderly Rushcliffe patients admitted to hospital. The aim was that Rushcliffe GPs would attend three times a week with Community Matrons and the Community Geriatrician and would manage patient transfers back into community

**Action:** AM and Jacki Moss, Service Improvement Manager to put request to pilot service in writing to the CCG

Meeting closed at 3-45pm.
DATE OF NEXT MEETING
The next meeting will be held on:
Thursday 5 November 2015 at 1.30pm
Clumber Room
Easthorpe House
165 Loughborough Road
Ruddington
Nottingham
NG11 6LQ

Members should inform the meeting secretary of any apologies and deputies attending on their behalf at least 10 working days prior of the next meeting. This is to ensure that the meeting is quorate and any action from potential declarations of interest are handled appropriately in advance.

Signed by………………………………… Chair – Dr. Stephen Shortt

Date  ...........................................