North East Essex HEALTH FORUM

NHS North East Essex Clinical Commissioning Group

Local Health Matters Tendring (Clacton)

Come and be involved
in patient issues that affect you

Sams Hall, CVST, Rosemary Road, Clacton, CO15 1NZ
Wednesday 13th December 2017
2:00pm to 4:00pm

MINUTES

Present:

Brian Mckeown	**JBM**	**Chair, Tendring (exc. Harwich) Representative (Elected) to the Health Forum Committee & Chair, East Lynne Patient Participation Group (PPG)**
Sherry Ally	SA	Deputy Director of Services, Community Outpatients
Daniel Coleman	DC	Senior Service Manager, Community Outpatients
Paula Martin	PJM	Patient Engagement Officer, North East Essex Clinical Commissioning Group (NEECCG) (Minutes)
Anthony West	AW	Head of Transformation – Planned Care, North East Essex Clinical Commissioning Group (NEECCG)

In Attendance:

Marcelle Hagger	MH	Health Forum Member & Epping Close Patient Participation Group (PPG)
Hazel Harris	HH	Health Forum Member & Walton Patient Participation Group (PPG)
Jenny Heard	JH	Health Forum Member
Myrna Liles	ML	Health Forum Committee Tendring (exc. Harwich Representative (Elected)
Michael Pheasant	MP	Health Forum Member
Cate Thompson	CT	Health Forum Member

Apologies:

Ann Watson		Health Forum Committee (Harwich Representative)

Item		Action
127.0	**Welcome, Introductions, Minutes of Tendring Local Health Matters meeting held at Clacton on 8th November 2017 and Matters Arising:** The Chair welcomed everyone to the meeting and the minutes of the 8th November 2017 Local Health Matters meeting, held in Clacton, were approved. There were no matters arising.	
128.0	**New Community Dermatology Service:** The Chair welcomed Anthony West (AW), from the NEECCG and Sherry Ally (SA) and Daniel Coleman (DC) from Community Outpatients. Their slide presentation is appended to the back of these minutes as Appendix 1. AW began by explaining that he looked after planned care services, which were of a non-emergency nature such as outpatients, community care and patient transport. Another such service is dermatology. He had been asked to come along to speak about this particular service after a member had written to the Health Forum raising some points. As well as addressing the raised points, AW thought it would also be helpful to provide an overview of the service and some of the recent changes to it. SA explained that Community Outpatients (COP) is a provider of NHS services and worked with many CCGs to run services in the community, closer to patients and providing a quicker turnaround. DC's role within COP is to run the service on a day to day basis and is responsible for organising clinics and staff. Referring to his slides, AW explained that the dermatology speciality relates to conditions of	

the skin. The service had to be re-commissioned because Colchester Hospital (who used to run the service) had given notice on their contract in March 2016, as they did not wish to deliver the service any more. AW stated that, under the terms of the contract, this was allowed. The NEECCG, however, had a responsibility to re-commission the service and it order to do so formed a group, with various clinical expertise and patient representatives, to shape how the new service should run. AW went on to say that, although, it was somewhat unexpected to receive notice from Colchester Hospital, it also provided the opportunity to create a new service better designed to meet the needs of North East Essex patients.

AW then explained that, historically, there had been some issues with dermatology; there is a shortage of 450 dermatologists across the country and very few consultants within North East Essex, so there was a need to commission a service with a different clinical skill mix. It has been shown that dermatology is a speciality that can safely be delivered in a community setting and this tied in well with the NEECCG Care Closer to Home strategy. An increasing demand on the service also needed to be considered, along with a need to ensure that referrals to the service were appropriate. 30% of the population will, at some time in their lives, have cause to use the service. The older population, which is growing in the North East Essex area, tend to have more skin related conditions. AW explained that skin cancers also go through the service.

He then mentioned that another objective was to work with the provider to educate GPs in order to prevent people having to attend hospital. Additionally, as everyone is aware, the NHS budget is shrinking in real terms meaning there was a need to come up with innovative ways to deliver the service. It is essential to streamline pathways to ensure a good patient experience and avoid being passed, unnecessarily, around the system. He then stressed that the decision to re-commission the service was not one made by the NEECCG but was brought about by Colchester Hospital's decision to service notice on their contract.

AW then moved on to speak about what was actually commissioned, saying that the NEECCG was responsible for buying healthcare for 340,000 patients in the region and there was a real need to ensure that a dermatology service was available to everyone. All healthcare services commissioned by the NEECCG are available to any person residing in, or registered with a GP, in North East Essex. When Colchester Hospital delivered the service, other CCGs were also included as the hospital also provided services for some residents in other parts of the County. However, the new service excludes other areas and has been commissioned solely for North East Essex patients.

Talking about the new service, AW explained that it combined different levels of care numbered 1 to 4. Level 1 related to self-care and management of conditions; the provider would be expected to give information to patients through GPs, education events, sign posting etc. to enable people to manage their condition. Level 2 refers to primary care meaning that COP will be expected to build and maintain a relationship with GPs in order to educate staff and be available to answer questions before referrals thus avoiding inappropriate referrals. Level 3 is where the bulk of patients fall; it refers to treatment that can safely be given in a community setting rather than a patient having to see a hospital consultant. It has been made clear to the provider that, over the lifetime of the contract, as many referrals as possible must be made into a community setting. AW also mentioned, at this point, that the contract was for 5 years and 9 months.

The final level is level 4 which relates to a lower proportion of patients that can only be safely treated within a hospital setting. These would be patients with more complex needs. However, it is essential that there is integration between the hospital and COP to ensure a smooth pathway for patients.

Moving on to the contract and what it encompasses, AW explained that it includes all dermatology, skin cancers, required relevant medication and PUVA. PUVA stands for "pulsed ultra-violet A" which is used to treat extreme cases of eczema and psoriasis. It involves the use of ultra-violet light, either directly or through a gel in which the patient is immersed. It can, in some cases, provide a 60% improvement but can only be given in short controlled courses to avoid the risk of skin cancer developing. AW commented that, although PUVA is a speciality in its own right, it was important to include it in the dermatology contract to provide a seamless pathway for patients.

MH asked when the new contract began. AW replied that it had commenced in April 2017. HH asked where COP were based. SA replied that their head office is in London but the North East Essex service had locally based clinics.

Moving on to cancer, AW explained that this, too, was included as part of the new contract and COP are the only independent sector provider employing consultants in the dermatological cancer speciality. Including this ensures a seamless pathway is provided for the patient and any required medication can also be provided by COP if appropriate.

AW stated that the ultimate aim of the new service was to see the right patient, in the right place, at the right time. By doing this it was hoped to deliver good outcomes for patients and the new contract enabled outcomes to be measured through patient experience, as well as traditional Key Performance Indicators (KPI). COP are incentivised to produce good patient outcomes and experience through Quality Incentive Indicators (QII) which are linked to a financial payment meaning that it they fail to achieve them they will not receive part payment. AW briefly mentioned that this method was now being applied to other commissioned services such as patient transport and Care Closer to Home.

ML asked how the required information to measure outcomes was acertained. AW replied that this would be addressed later in his presentation. He then mentioned that another aspect of the contract required the new provider to work in partnership with others, predominantly GPs. Evidence that this was happening was required.

As part of the commissioning process a group had been formed to look at how the service should operate; patient representatives were included in this group. 5 objectives were developed which are detailed on slide 5. A QII was based on these objectives as follows:-

80% of patients must rate their experience as “good” or “positive”.
There must be a post-operative inflammation rate of 5% or less.
Over the lifetime of the contract at least 90% of patients must have a care plan put in place.
Work with GPs and used of technology is measured.
How well and appropriately patients are signposted is measured.

Additionally COP are also incentivised to work with the voluntary sector.

AW then moved on the management of the contract, explaining that it was a standard NHS contract encompassing different components, including the requirement to recognise all types of quality standards and safeguarding areas. Regular contract meetings attended by the NEECCG and provider are held to ensure that this is achieved.

If the provider is not performing as they should, AW explained that there is generally an ability to put a remedial action plan in place. For the NEECCG this contract was the first time a whole speciality had been re-commissioned. Naturally, things were still in a, somewhat, transitional phase, meaning there were some issues needing resolution. The Chair asked if a member of the Health Forum Committee could attend these regular contract meetings. AW agreed to take this back to the next meeting and ask whether it would be possible. Although he did feel that this might be more useful once the new contract was firmly established and not in a transitional stage. SA agreed, saying that, at present, finer details were still being worked through. The Chair stated that, although he accepted this, he still felt it would be useful for a patient representative to be involved, particularly as the original issue, resulting in today’s presentation, had come via a patient. AW re-iterated that he would take this back to the next meeting and also mentioned that COP would be setting up patient groups.

ML stated that she had heard about issues with the new service, but her experience had been a very positive one. She wondered how COP and the NEECCG got to hear about the positive as well as negative comments. DC replied that people did not often comment about good experiences but by looking at the complaints they could see what particular areas needed improvement and could also therefore ascertain what was running well. He then mentioned that in the last month just over 700 responses to their patient survey had been received. He also planned to check that as well as being handed to patients, they were available in waiting areas.

JH asked whether referrals into the service would still be made via a patient’s GP. AW confirmed they would. SA explained that GPs had to refer through an electronic referral system that they could access whilst seeing a patient. This would give options for available

appointment times and locations meaning that the GP could ask the patient for their preferences during the consultation. Some attendees commented that this not happened in their cases and JH felt that GPs needed to be educated regarding this. She felt that they may not be aware of the fact that this could be done during the consultation meaning that many GPs completed the referral after the patient had left the surgery. SA and DC will look into this. JH asked whether consultants worked for COP. SA confirmed they did saying that quality was closely monitored. JH then asked where surgery and follow up treatment, such as radiotherapy would be carried out. SA replied that less complex elements of the treatment would come under COP. However procedures requiring general anaesthetic would be referred into the plastics department and COP would track and monitor the referral via a cancer nurse specialist and oncology nurse specialist who would liaise during the patient's care. The patient would then be referred back to the community dermatology service if necessary. JH asked how a recurrence would be dealt with. SA replied that if a patient had been discharged they would have to return back to the GP for a new referral but patients under the 5 year review plan would deal directly with COP. SA also mentioned that multi-disciplinary teams (MDT) met regularly to discuss and review patients on the cancer treatment pathway.

CT asked who COP actually were. SA replied that it was an independent company but only worked with NHS Trusts and CCGs and was NHS funded.

Moving on to quality management AW explained that issues were bound to be raised when taking a complete speciality out into a community setting. One such issue was around data; work was being done to ensure that required information and data was readily available. He went on to say that most of the issues that had arisen had been for the NEECCG to resolve outside of the contract. Complaints were discussed in contract meetings to ensure that they were being dealt with. Compliance with mandatory training was also required and this was monitored through these meetings.

The Chair asked what liaison there was with NEECCG PALS. DC replied that because COP had previously worked closely with Colchester Hospital there had always been a close relationship with PALS teams and this had continued through to the NEECCG. SA also mentioned that they had learnt that it was essential to keep PALS up to date so that they were aware of unforeseen circumstances such as clinic cancellations. JH asked if there was any literature on the service available, as she felt it would be helpful for people to have. AW mentioned that because referrals were electronic and had to go through a GP, literature had not been produced. He also mentioned that paper referrals would not be accepted and ultimately, paper referrals would be withdrawn for all specialities as it was an aim of the NHS to become paperless by 2020. HH asked what would happen if systems failed. AW replied that it was necessary to put contingency plans in place, but paper systems could fail too. JH still felt that literature on the service would be useful as it would help patients to know what to expect. SA commented that it was clear that education of, and communication with, GPs was essential particularly around ensuring patients were given the choice of appointments whilst in the consultation room. AW agreed saying that the NEECCG would communicate this to GPs.

MH stated that after seeing her GP she had been referred into the service and had been seen initially at Abbeyfields, but a subsequent appointment had been made at Tollgate. She was concerned that travelling between locations could be very difficult for some patients, particularly those in the Tendring area. DC replied that this issue had been raised before and, in order to prevent it recurring, new cryotherapy treatment equipment had been purchased enabling it to be delivered at more locations. This should be up and running in approximately 3 weeks. MH asked whether she would be able to be treated at Clacton in the future; DC confirmed she would. He went on to say that the electronic referral system would allow a patient to choose where they wanted to be treated and would then give details of available appointments. The only caveat to this is in the case of fast track cancer patients who have to be seen in 14 days; although, if possible, there is still a choice. It is, however, preferable for the patient to be seen at the location that can offer the soonest appointment. MH asked how she would go about transferring to Clacton. DC agreed to organise this for her.

	After a 10 minute break, the meeting reconvened and DC re-iterated that GPs should be able to offer appointments whilst patients are in the consultation room. COP and the NEECCG will work with GPs to ensure that this was happening. He then moved on to staffing and explained that COP employ 4 registered dermatologists, 3 nurses, one of which is a cancer nurse specialist and the others, dermatology nurse specialists of which one is a skin surgery nurse specialist. 7 healthcare assistants were also employed. DC mentioned that dermatology tended to be seasonal with more patients being referred during warner weather. Because of this, locums would be employed when necessary in order to run extra clinics. Often the locums used had worked for COP before. Generally first appointments were under 4 weeks and in cases of suspected skin cancer, 3 days. More details about referral times and targets can be found on slide 9 at the back of these minutes. He then stated that they had been asked to look into fluctuations of treatment targets, which they had done. Investigation had shown that extra resources were still needed towards the end of the summer so this would be put in place for the future. Referring to treatment locations, DC reported that clinics were run at Fryatt Hospital, Harwich, Clacton Hospital, Abbeyfields and Tollgate Surgeries in Colchester and Colchester Hospital. Another treatment centre was being sought between Colchester and Clacton. PUVA is only offered at Harwich at the moment due to the cost of the equipment. However, it will be relocating to Colchester Hospital following some building works. DC also mentioned that, unusually, some clinics had been cancelled over recent months due to staff sickness. Additional healthcare assistants had now been recruited to ensure that this did not continue. Referring to patient feedback, DC commented that this was very useful tool and the Friends and Family Test had shown that 92% of patients would recommend the service. Although this was an excellent figure, COP were striving to improve it. All complaints are investigated by service management and a governance team to ensure that problems are identified and resolved where possible. A “one-stop” model is also offered so that excisions can be performed immediately if necessary. MH asked whether patients could ask for a second opinion. DC confirmed they most certainly could, saying that if they were not comfortable asking the specialist they were seeing, they could contact the admin team and place a request through them. DC then spoke briefly about Telederm, explaining that this involved a healthcare assistance photographing the condition and sending it to a consultant to look at. The consultant would then indicate the most appropriate treatment. By working in an innovative way, such as this, more patients could be treated in a much quicker timeframe. The Chair thanked AW, SA and DC for coming along to talk about the new dermatology service, saying their presentation had been most informative. All those present re-iterated this and felt that it had been very useful and interesting.	
129.0	**Open Forum for Attendee Comments & Queries on Local Health Issues:** Referring to the notice given by Colchester Hospital to stop running the dermatology service, MP asked whether this was allowed. AW replied that the NHS standard contract did allow for notice to be served by either party. However, there were some essential services such as A&E that they would not be able to serve notice on. There was short discussion on audiology and JH reported that a working group had been set up to look at the issues that had arisen. It was generally agreed that many of these came down to a lack of communication. HH voiced concern about so many services being run by Anglian Community Enterprise (ACE), particularly the requirement for physiotherapy referrals to be done through the Community Gateway. AW replied that the Community Gateway involved clinical triage to ensure that the patient was referred appropriately. The aim was to encourage less referrals to go through Colchester Hospital as evidence had shown that many treatments could be safely and better delivered outside of a hospital setting. It was, however, important that people did let the NEECCG know if communication was not effective. They could do this via the Health Forum.	

	MP asked if the closure of Essex County Hospital would have impact on Tendring residents. The Chair did not feel it would. Finally there was a brief discussion on ear syringing and PM confirmed that only one Colchester surgery was not offering it at all. The Chair then thanked everyone for attending, wished all present a Happy Christmas and New Year and closed the meeting at 3.50pm.	
130.0	**Date of Next Meeting:** Wednesday 10th January 2018. CVST, Rosemary Road, Clacton on Sea, CO15 1NZ 2.00 pm to 4.00 pm. Topics will include a presentation on Health Champions in North East Essex..	

Appendix 1 – New Dematology Service:

COMMUNITY OUTPATIENTS

NHS North East Essex Clinical Commissioning Group

Local Health Forum

Integrated Dermatology Service
December 2017

Anthony West, North East Essex CCG
Sherry Ally, Community Outpatients

Agenda

- Why we re-commissioned the service
- What did we commission?
- How the CCG manages the contract
- How the provider reacts to issues in regards to quality improvement
- Q&A

Why a new Service?

- Notice was given to CCG by main provider
- Multiple providers
- Drivers:
  - National challenges with dermatology staffing, including consultant dermatologists
  - National move towards delivery of a number of dermatology services in the community
  - Increasing demand
  - There is a an opportunity to manage inappropriate referrals
  - The older service model unsustainable
  - Integrated links with plastics and cancer pathways

What did we commission?

- The CCG is responsible for "buying" healthcare service for its population.
- This new service combines different levels of care into a single model
- Dermatology, PUVA, Cancer, Drugs
- A Service that sees the right people at the right time and in the right place
- Delivers good outcomes for patients
- We will expect the new service to work very closely with other parts of the NHS – such as GP practices
- Dermatology including cancer

Objectives of new service (hand-out provided)

- **Timely, accessible and responsive**..... *There is a shared and understood goal for each contact and decision you have across the overall care pathway. The information, advice, and care you receive will enhance the outcome you receive.*

- **Safe and high quality**.... *This means your care is safe, personalised and delivers good clinical outcomes. Quality will continually improve wherever possible. The care you receive shall be consistent and meet national and local independent quality standards*

- **Appropriate to the care you need**.... *You will be managed at a level appropriate to the severity and complexity of your condition. The service acknowledges that this may vary over time. Your care will be patient-centred which means the service will respond to you in individual care decisions*

- **Continually improving quality by embracing innovation and new ways of working...**. *The service will be sustainable and changes the way it delivers care where this offers a benefit to do so. This will be supported by a good organisational culture with strong leadership*

- **Encouraging collaborative working to maximise the resources it has to offer value for money**..... *The service will work in partnership with others to get things done. This includes determining how best to use skilled staff, information, and where it see you to improve decision-making and outcomes.*

Managing the contract

- Management of provider in line with NHS National Standard Contract
  - Managed like other providers
  - National standards and other NHS standard contracted area – IG, safeguarding
- Ensure the provider maintains compliance in line with national indicators for cancer targets and 18 week waiting times
  - If fail can put in Remedial Action Plans (formal)
  - Other forms of recovery plans can be used (informal)
- The role includes managing Contract Review Meetings
  - Monthly meetings
  - Attended by various subject matter experts (Quality, Finance, Contract, Business manager)
  - Two way meeting provider can raise concerns also
- Review of local performance indicators agreed within contract
  - Outcome based service
  - Poor performance trajectories

Managing quality

- Currently working with Concordia on obtaining the right data to monitor quality, as requested as part of the contract monitoring
- Understanding what the data tells us, how they've obtained the data and whether it indeed gives us what we're looking for
- Continuing to develop the patient outcome data, this includes patient experience data and will tell us what patients think of the new service
- Monitoring their incidents and complaints reports and ensure we understand what the data is telling us. Help them develop their reporting on this so that we get the full picture.
- Ensuring they comply with all the necessary mandatory training

Community Outpatients

- The New service
- How we react to issues
- How we focus on quality improvement

Community Outpatients

The New service

- ERS directly bookable service (2WW and routine)
- Clinical staffing 4 dermatologist, 3 nurses, 2 plastic surgeons 7 full time equivalent HCA's
- Average wait for routine appointment is under 4 weeks from date of referral.
- Patients with a suspected skin cancer are seen for their first appointment in an average of 3 days from date of referral and seen for treatment within 62 days of Decision To Treat.

July	14 days = 93%, 62 days = 100%
August	14 days = 90%, 62 days = 100%
September	14 days = 94%, 62 days = 93%
October	14 days = 95%, 62 days = 96%

- Multiple community locations across NEE

How we react to issue and make quality improvements

- Cancelled clinics - We have cancelled a number of clinics due to sickness over the last few months therefore in early December we recruited 3 new HCA and have added additional capacity for F2F before and after Christmas.
- ERS slot availability – issues with providing sufficient slots across our sites for each type of appointment. We have now calculated the demand for the slots across the geography and have sufficient slots open
- Patient feedback – we received >700 feedback forms and are reviewing comments to make improvements (new Dermatology waiting area in Tollgate as requested by a patient)
- Complaints received – trends are analysed by service management and governance teams monthly
- One stop model – surgeon on site most days so we can try to offer urgent excisions when required.