Attach 1

NHS
Wandsworth
Clinical Commissioning Group

Minutes of a meeting of the Board held on 10th June 2015

Present:	Nicola Jones (NJ)	CCG Lead (Chair)
	Graham Mackenzie (GM)	Chief Officer
	Hardev Virdee (HV)	Chief Financial Officer
	Stephen Hickey (SH)	Lay Member Governance
	Andrew Neil (AN)	Secondary Care Doctor
	Di Caulfeild-Stoker (DCS)	Registered Nurse
	Nicola Williams (NW)	Joint Battersea LCG Lead
	Mike Lane (ML)	Joint Wandle LCG Lead
	Seth Rankin (SR)	Joint Wandle LCG Lead
	Lucie Waters (LW)	Director of Commissioning and Planning
	Andrew McMylor (AM)	Director of Primary Care Development
	Tom Coffey (TC)	Board Advisor
	Dawn Warwick (DW)	Director of Education and Social Services

In attendance:

Jamie Gillespie (JG)	Healthwatch Wandsworth
Sandra Allingham (SA)	(Minutes)

15/060	**Apologies for Absence** Received from Carol Varlaam, Sandra Iskander, Peter Ilves, and Houda Al-Sharifi.	
15/061	**Declarations of Interest** None.	
15/062	**Minutes from the previous meetings held on 15th April and 27th May 2015** 15th April 2015 15/046 Indicative Budgets 2015/16 – first bullet point – "**0.15**% had been allocated for the London Health Commission." 15/053 Open Space – question from S Balding – "How many times has **SWL and St George's Hospital** had to refer ….." Subject to the amendments, the Minutes were agreed as being an accurate record. 27th May 2015 The Minutes were agreed as being an accurate record.	
15/063	**Matters Arising** 15th April 2015 15/046 Indicative Budgets 2015/16 – The level of Mental Health investment was clarified to the Finance Resource Committee (FRC), noting that the level of investment was greater than the required additional level of 1.94%. 15/053 Open Space – question from G Horner – The sequence of events regarding the loss of beds at the Mental Health Trust (MHT) was explained. At the Joint Health Overview and Scrutiny Committee (JOSC) in December 2014, the MHT had stated that no patients had been transferred outside of SWL and St George's Hospital (SWLStG). This statement had been repeated at the CCG Board meeting in March 2015 - the information reported at the Board meeting was that which had been provided to us. Further enquiries from G Horner identified that	

	this information was incorrect. Following further discussion with the MHT (Mental Health Trust), the CCG was able to clarify that eleven patients had not been admitted to the Trust. Although the number of transfers was low these do occur, however, the MHT do not routinely report this to the CCG. The CCG has requested that this information be reported on a monthly basis. Question regarding patient and public involvement - It was confirmed that the different ways of patient and public involvement was being taken forward following discussion. Remaining actions will be followed-up with Sandra Iskander. 27th May 2015 None.	
15/064	**Chair's Update and Chair's Actions** As detailed in the Executive Report, Chairs Action was taken to sign off the final Operating Plan prior to submission.	
15/065	**Forward View of community and primary care services** Katie Denton (KD) presented the paper. The Board had previously received a paper outlining the challenge for general practice in Wandsworth, with reference to local and national drivers for change, co-commissioning and other factors. The paper had outlined the need for the current model of general practice to evolve to make the best use of funding providing high quality care for patients and to appropriately move care out of hospital settings. In March 2015, the NHS Five Year Forward View was published stating the need to integrate services more around patients. This would be done through Multi-specialist Community Providers (MCP), where groups of GPs would work together to coordinate care for patients outside of hospital. Work has been done with clinical locality leads and commissioners of local services to develop a locality-based hub model. The hubs would have virtual and physical components and would provide access to out of hospital (OOH) services. A presentation provided information on the following areas: • Services expected to be present in locality based environments • Benefits of the proposed model • Timeline Comments and questions were invited from members of the Board: • Good development. • Good direction of travel – diagnostic services were critical to moving care into the community. • Would the proposed model affect the financial basis of secondary care providers? • Would this embrace everything that is in community services or would there be other services from elsewhere? - The proposed model would involve all of adult community services. Through the Community Adult Health Services (CAHS) redesign programme, services were starting to be based in locality settings. Other services could also be added into this model. • Would the MCP be an entity to commission services from and does this already exist? - Development of the MCP is in progress and would involve a procurement process which could lead to one lead provider with a range of	

services behind it.

- Was there a danger that the proposed direction for community services could undermine links with the acute sector? - A further paper would come to the Board for discussion in July. It was not anticipated that this development would be at the expense of secondary care links. There would be some specialities and pathways within the MCP which would bridge the gap between primary and secondary care.
- Would changes in bordering CCG services, across SWL and the wider environment complement our approach to primary care? Would some of those changes help shape some of the specification? - The proposed Wandsworth model may help to influence changes within SWL.
- The right approach to patient and public involvement (PPI) was required to make sure the model was developed appropriately going forward at both practice and general levels.
- Additional column suggested for the next paper to outline the proposed communications plan for the programme.
- Risk to the plan was around manpower and resources in a changing environment. – A workforce development plan was being developed alongside this –training would be available and potentially some adaptation of roles. The main issue would be around recruitment which was a national problem – some initial plans were in place locally. There was also a significant workforce work stream in SWL. The majority of skills required already exist in the current workforce.
- A shared patient record between primary care and community services was vital to improve patient care.
- Was the timescale ambitious enough? Should the timeframe be accelerated to ensure there was sufficient level of control? - The proposed model looks to enhance primary care to work in a different collaborative way which was a major shift for practices. Further papers would come to Management Team around governance, detailed work plans, metrics, and planned pathway work. An operational plan could be developed indicating changes that were expected to be implemented in each year of the programme.
- Benefits for patients should be clearer with a baseline of the current position against which improvements can be monitored.
- A business case would need to be developed to underpin the programme, outlining the financial implications. – This was currently in development.
- Social Care – The complexity of the Local Authority (LA) arrangements and developments would be required to support components of the model.
    - The LA was already engaged in the Planning All Care Together (PACT) and Frailty work and it would be important to evaluate the effectiveness of social work within that.
    - Caution was noted regarding the changing landscape around Children's services which would need to be considered.
    - Mental Health – The LA was taking back operational responsibility for MH social workers and links with primary care would need to be strengthened.
- Potential for the Voluntary Sector to be included in this.
- Visibility of District and Practice Nurses should be included.

Comments and questions were invited from members of the public:

- K Robinson, Community Empowerment Network (CEN) – Community networks should also be included in this.
- B Qureshi - Diagnostic services at Queen Mary's Hospital (QMH) were important and should be included. – It was noted that the services at QMH had been included in the proposed hub locations.

	• S Rolph – An evaluation on the different cultures of hospital reporting to GPs was a crucial aspect, particularly for vulnerable patients. Could a pilot evaluation be undertaken? – patient groups could help with test cases. – This aspect was already taken into account when looking at communications received from hospitals and crossed all communication, not just that which was relevant to this transformation work.. • M Squires – Hospitals are centres of excellence – ambulatory care to OOH settings was the wrong direction. Specialised care should move back into hospitals not taken out. Would a choice of OOH care still be available? - Acute centres should be able to focus on further development of hospital-based services to ensure these were available when required – there were other things that can be done in local settings that should not have been put into a hospital setting. The MCP model would ensure that people requiring expensive secondary care services would have better access to them because all care that could safely and more appropriately be provided in the community would be. The CCG has a duty to commission the best care for patients with the resource available and a lot of engagement would be done with the public and stakeholders to develop the best specification. Patients have a choice in which GP practice they are registered with – it was only possible to have one community services provider. In summary of the discussion, the Board supported the direction of travel acknowledging that, although there were still some gaps, this was a transformational change. Some areas were not yet fully described and the questions and comments received from this discussion would assist with the development. Some issues had been raised by the Board particularly around: • Diagnostics impact on acute providers • Timelines to be as ambitious as possible • Operational milestones to be included • Financial implications and risks to be clearly understood • Link with other parts of the system need to be described – existing links with acute should be optimised and not lost • Movement of planned care should be done in a sensible way. The Board approved the development of the MCP model and noted the impact on general practice.	
15/066	**Re-procurement of NHS 111 and GP Out of Hours Services** The Board had previously approved Chair's Action to sign off the SWL tender documents for the 111/Out of Hours specification, which had passed a formal gateway assurance process with NHS England (NHSE). SWL was the only area to have passed through this process. An initial pause in the process had been required as the national team stated that one integrated contract across SWL should be put in place – originally three SWL CCGs had agreed to an integrated service, with two CCGs agreeing a 111 only service. One integrated contract was now proposed with different schedules of services included – this has been subject to legal consideration which had led to some further delays and a change to the tender process. Further national guidance received now states that CCGs should acknowledge 111 as the gatekeeper for urgent and emergency care and that this should be endorsed and reflected within plans. This would put the timelines for procurement at risk as the current contract had been extended until February 2016. There could be a	

	national requirement for a different sign off process for this procurement which could result in a further delay. The Board was asked to note the issues regarding the potential delays, to endorse one contract for SWL, and to review 111 as the gatekeeper for emergency and urgent care, with acknowledgement of potential risks. Comments and questions were invited from members of the Board: • Gatekeeper role – Information currently received indicated that procurement of the 111 service would be done initially with a wider integrated system enhancement to the model. SWL has pushed back the request for a delay as the current contract ends in February. The delay in procurement would pose potential risks. CCGs have a formal responsibility to provide 111/OOH services and discussions have been held with NHSE on the need to go to procurement soon. • Timelines – Recommendations from the Keogh consultation on an integrated service were not anticipated to be available until the end of September - if the SWL procurement goes out before that date it was important to make sure that the specification was in tune with an integrated 111/OOH system. • The procurement process had previously been delayed to reflect guidance but this was now ready to proceed following the formal approval process. Any further delay would require a further extension of the current contract. Everything had been done to take into account the Keogh Review in the specification. • Contract holder – Sutton would in principle hold the contract as the lead for CCG emergency care as part of the collaborative work. Legal advice was being taken regarding this proposal as Sutton CCG was not participating in the integrated service – this will be reported back to CCGs. • How would this integrate with the proposed MCP? - This would depend on the national timelines required, however, functionality with primary care and other services was at the heart of this. Comments and questions were invited from members of the public: • Bibi Qureshi – GPs should always go to see patients. – From the Keogh Review there was evidence that the Wandsworth model was the best approach and would be replicated across London and nationally. In summary of the discussion, the Board was asked to approve the development of one contract, to endorse the direction of travel, and agree Chair's Action to sign off the final tender documents. The Board agreed the recommendations.	
15/067	**Board Assurance Framework** The Board Assurance Framework (BAF) had been shared with Internal Audit as part of their review from which a level of assurance was provided that this was a comprehensive list of risks, with actions and controls in place. A deep dive of the following risk was presented: Risk 16 – Failure to receive the appropriate level of funding allocation – This was one of the highest areas of risk, which influences utilisation of the CCG allocation (£400m approximately). If any unplanned adjustments were made to the allocation the CCG would be required to make adjustments to the financial plan. This was rated as the highest risk because no formal assurance had been received	

	from NHSE regarding the draw-down of the surplus of approximately £6m from 14/15 into 15/16. Assurance of that draw-down had now been received which would therefore help to mitigate the risk and enable planned investments to proceed. Other potential risks were noted: • Specialised Commissioning – Responsibility for Specialised Commissioning, and other areas of work, would revert back to the CCG. • Transformation work in line with Health Commission reporting. • Providers across London were facing significant financial pressures. • Further integration with health and social care. Mitigating actions in place to address the potential risk of change to allocation in-year including: • Delivery of 1% surplus to provide a level of flexibility. • Level of reserve funding. • Continued scrutiny through FRC (Finance Resource Committee). • Review by Internal and External Audit, who were aware of national and local issues. If the risk materialises, it will be possible to release the level of reserves. Information on risks was regularly reported to FRC. Comments and questions were invited from members of the Board: • FRC Reporting – The FRC regularly received information regarding risks, with in-year month by month controls. The FRC was confident that the CCG have the capacity to manage those issues, however, it was acknowledged that in the longer term the pressures will continue to worsen. • Risk around providers – There was a specific risk included in the risk register regarding the St George's Hospital (SGH) financial challenge. For providers in general, there was a risk (risk 75) which sets out the financial case for change to reflect the financial challenges for providers. The work across SWL was on track to recognise that challenge, however, the risk was very real. The content of the report was noted.	
15/068	**Executive Report** The content of the report was noted.	
15/069	**Finance Report** The paper reported the 14/15 year end position, which had now been approved by External Audit who submitted an Unqualified opinion and confirmed delivery of the financial targets. The paper also set out the risks for 15/16. <u>*Question received from M Squires*</u>: Could it be confirmed that the total shortfall in the financial year 2014/15 was £13,874,000? What was the total amount taken out of reserves for the financial year 2014/15? <u>*Response*</u>: The full level of reserves has been used to balance the final year-end position. The reserves of £13.874m was made up of a number of components:	

	• 0.5% contingency reserve • 1.0% reserve • Over-performance reserve (£4m) • Number of other smaller items. The planning for 14/15 reflected the ability to manage the position, with over-performance reserves being utilised. The planning also included a number of investments in services. The level of reserves was reported and reviewed monthly through FRC. The over-performance reserve of £4m was used to balance the acute over-performance. The content of the report was noted.	
15/070	**Assurance Framework Scorecard** The report was provided for information – an in-depth report would be presented for discussion at the July meeting. The Q4 Assurance meeting with NHSE was scheduled for two weeks' time and this would also be reported at the next meeting.	
15/071	**Summary Minutes** The content was noted.	

15/072	**St George's Hospital NHS Foundation Trust**
	Miles Scott (MS), Chief Executive Officer, attended. The presentation included information on the following key areas:
	
	• Context – inclusion of information from the NHS Provider Surveys of the last two years. Overall across providers there had been a shift from surplus positions to planning of deficits in the current financial year. System pressures, both operationally and financially, had been seen, with an increase in activity, loss of income, and increased costs.
	• Impact since December 2014 – The sharp movement away from a planned surplus was identified in the last four months of the year moving the Trust from a surplus/break even position to a significant deficit.
	• What drove the deficit – Areas of contribution were around income, pay, and non-pay, resulting in an overall variance.
	• Income and Expenditure trends – Comparison between 13/14 and 14/15 income and pay.
	• Plan – Four elements:
	  ○ Delivery of a deficit plan for the year
	  ○ Protect liquidity
	  ○ Turnaround programme
	  ○ Improve financial systems
	• Monitor investigation – An internal review and independent accounting review was being run alongside the Monitor analysis. A turnaround programme was also being implemented with a Director appointed to focus on delivery of recovery.
	• Quality and Safety – Maintenance of this within the organisation was essential. Support will be given to senior clinicians and clinical managers to make cost controls, with weekly Quality Indicator monitoring implemented which will provide the opportunity to make different choices if required.
	• Takeaway Messages – Although this was a national pressure, responsibility must be assumed for SGH. All staff would need to work together to deliver the plan. The Trust was working with the CCG around planning for the current year. Quality and safety were priorities for the organisation.	

HV presented the CCG paper providing an overview from a commissioning perspective, looking at three main aspects covering risk, CCG response, and assurance around finance, quality, contract and performance.

Finance – Much of the information had been covered in the previous presentation. This does have an impact on how the CCG manages finances and in SWL. It was important to maintain dialogue with the Trust and review information at senior level, with an agreed level of escalation. Mechanisms were in place to manage risk during the year.

Quality – There was concern regarding the current situation around quality of care for patients and families. The CCG has a critical role to ensure that services were good quality and safe. A good approach for quality assurance was already in place through the Clinical Quality Review Groups (CQRGs).

A process for more enhanced surveillance through the CQRGs was required for community and acute services. This would focus on patient experience, monitoring of safety, GP experience etc. An escalation process was in place.

Scrutiny of the CIP (Cost Improvement Programme) plans was currently in progress and monitoring the impact of the plans was important. The SGH team was open to sharing information with the CCG and this work would continue.

Contract – The contracting round had been difficult due to the pressures. It will be a challenging year in all aspects.

Performance – The CCG had discussed the challenges with the Trust, particularly around A&E, RTT (Referral to Treatment), and Cancer wait times. It was acknowledged that the system does need to be revised and further work was required on demand and capacity planning.

There was a significant amount of work to achieve delivery of the plan and a strong focus on quality and performance would be required.

Comments and questions were invited from members of the Board:

- The SGH team were extremely open and transparent with good information sharing.
- The review of CIPs was in process – it was acknowledged that the majority of plans reviewed so far were good. Further meetings to review the remaining CIPS were scheduled. Regular meetings were also held with Sarah Wilton, SGH NED (Non-Executive Director) with responsibility for Quality.
- Main area of concern was around Community Services Wandsworth (CSW) and the target CIP identified. A question was raised whether the target was proportionate to the overall budget, and greater scrutiny was required to make sure that the CIP was appropriate. – CIPs were applied to all budgets. Budgets had been uplifted against over-spend last year – CSW had been the most over-spent division and had received the largest uplift to the base budget.
- What was the impact on SGH from the loss of funding from Project Diamond, the new tariff system and Specialised Commissioning? - No funds were lost in the last year from those areas, however, funding was lost from the education tariff. This year the total loss was £30m.
- It was important to look at cost controls and impact on quality - historic evidence supports that creating efficiencies in the system can provide opportunities to save money.

	• Workforce – CSW has a high vacancy rate – what was the workforce response to the plan? - It was important to retain staff and continue to recruit. One of the drivers is the tightened labour market in London for key groups of staff, which coincide with big increases in establishments providing significantly more demand for staffing. This resulted in a greater reliance on temporary/agency staff and a significant focus was to make sure that trend was reversed. Positive feedback had been received from staff. • Would there be a line by line item review and include benchmarking with other providers? A review would be done on each of the services to understand which of the services make/lose money and the profile of services can be changed, either in whole or in part. Future provision would be discussed with commissioners. • As part of the contracting round work was done collectively to try to look at the drivers and construct a contract to address some of those. Significant additional capacity had been put into the Trust from commissioners and all organisations would have to work hard to constructively hold each other to account this year to ensure that the capacity was used appropriately to ensure value. • Does the Trust's ten year strategic focus on specialised elements still hold going forward, or will there be a need to refresh this? - The Trust will have to revisit all of the plans going forward as part of the recovery – there was no plan to develop any services for which the Trust will not be paid. Specialised commissioning did not drive last year's deficit, and the opportunity for specialised services is part of the solution not the problem. The drivers of operational pressure came from local demand. The highest level of A&E attendance last year was for Wandsworth patients, with an increase in elderly admissions of 14% - this was not sustainable. • Would there be a sharing of good turnaround practice with other Trusts? Compulsory sharing of practice was required. The focus on agency staff in particular was important and the local implementation of national guidance by all NHS employers would be key to this. Comments and questions were invited from members of the public – responses were provided from MS: • B Qureshi – Personal experience regarding the appointments system was poor. – MS agreed to follow this up outside of the meeting. • M Squires – What guarantees are there that this year's CIP would succeed? - The Trust had struggled to deliver all of the CIPs last year – during the first eight months of the year the Trust was meeting the target. The position in January indicated that the year-end position would be break even or close – the deficit then emerged very rapidly. • T Pollak – What happens if the turnaround target was not delivered? – The Trust have to make this work. Some other organisations of similar size and with significant financial issues have managed to deliver turnaround, while some have not. The big challenge is to keep staff on board and engaged to deliver care each day. In summary of the discussion, the Board recognised the national context, reiterating that the overriding responsibility for the CCG was that patients receive the best quality of care. NJ thanked MS for attending the meeting.	
15/073	**Open Space** The following questions were received prior to the meeting:	

	Question from G Horner: The unprecedented revolt by members of N.H.S.Providers, [including St George's Hospital] when the 2015/2016 tariffs were first announced by N.H.S.England, saw the new efficiency savings of 3.8% described by the group as "impossible". The continued huge financial pressures from Government have led over a third of C.C.G.s in responding to a survey, say, that they were considering further limits on access or eligibility of patients to services as ways of coping with the situation. Is Wandsworth C.C.G considering any such plans in relation to the financial problems at our local providers? *Response*: It was confirmed that a written response to the question would be provided and reported at the next meeting. *Questions from M Squires:* 1. Kay McCulloch has been appointed as the interim Programme Director for South West London Collaborative Commissioning (SWLCC). Her salary is being paid by PricewaterhouseCoopers. Why has the appointment of PwC been made on a single tender waiver? What direct experience does Ms McCulloch have of the NHS? 2. Given the commitment to out of hospital, care how many extra health professionals will Wandsworth CCG be employing in the next financial year? 3. The responses to the questions submitted to the board meeting of Wandsworth CCG on 15 April were not received until 8 June. In future could written replies, like FOI replies, be received within 21 working days? 4. Could it be confirmed that the total shortfall in the financial year 2014/15 was £13,874,000? What was the total amount taken out of reserves for the financial year 2014/15? *Responses*: 1. A written response would be provided and reported at the next meeting. 2. A written response would be provided and reported at the next meeting. 3. NJ confirmed that it was appropriate that written responses should be provided to questions received in a timely way. 4. The response had been provided under 15/069. *Question from T Pollak*: 1. Can you confirm the purpose of the Chelsea and Westminster item in Part II? *Response*: The item related to the formal Transaction Agreement to which the CCG was party.	
15/074	**Any Other Urgent Business** None. There being no further business, the meeting closed at 12:30.	
Date of next meeting: 8th July 2015		