Wandsworth Clinical Commissioning Group

Minutes of a meeting of the Board held on 14th October 2015

Present:	Nicola Jones (NJ)	CCG Clinical Lead (Chair)
	Graham Mackenzie (GM)	Chief Officer
	Hardev Virdee (HV)	Chief Finance Officer
	Stephen Hickey (SH)	Lay Member Governance
	Carol Varlaam (CV)	Lay Member Patient and Public Involvement
	Andrew Neil (AN)	Secondary Care Doctor
	Di Caulfeild-Stoker (DCS)	Registered Nurse
	Peter Ilves (PI)	West Wandsworth Locality Lead
	Mike Lane (ML)	Wandle Joint Locality Lead
	Seth Rankin (SR)	Wandle Joint Locality Lead
	Nicola Williams (NW)	Battersea Joint Locality Lead
	Sean Morgan (SM)	Director of Corporate Affairs, Performance and Quality
	Lucie Waters (LW)	Director of Commissioning and Planning
	Andy McMylor (AM)	Director of Primary Care Development
	Houda Al-Sharifi (HAS)	Wandsworth Director of Public Health
	Dawn Warwick (DW)	Wandsworth Director of Education and Social Services
In attendance:		
	Jamie Gillespie (JG)	Healthwatch Wandsworth
	Sandra Allingham (SA)	(Minutes)

15/109	**Apologies for Absence** All members present.	
15/110	**Declarations of Interest** None.	
15/111	**Minutes from the previous meeting held on 9th September 2015** 15/100 Planning All Care Together (PACT) Contract – p.8, first sentence to read – "The Board was asked to consider and approve award of the contract to the GP Federation **(Battersea Healthcare CIC)**." 15/101 NHS 111/Out of Hours Procurement – final bullet point to read – "**The contract would come back to the Board for approval.**" Subject to the above amendments, the Minutes were agreed as being an accurate record.	
15/112	**Matters Arising** 15/094 Community Adult Health Services Procurement (CAHS) – The work on the contract with St George's Hospital (SGH) for community services was being taken forward. A meeting was held with SGH to go through the process of specification and requirements for the next step of the CAHS development. Concerns and issues were discussed and it was agreed that further work was required in a number of areas before assurance could be provided to the Board.	
15/113	**Chair's Update** No Chair's Actions were taken.	

15/114	**Learning Disability** Lola Triumph (LT) and Tarlochan Ghale (TG) attended. The report outlined the programme of reform in response to the significant amount of external guidance published following the Winterbourne View exposure, and the work in the CCG to develop the commissioning programme for Learning Disability (LD). The report outlined the demographic profile in Wandsworth, the wide spectrum of care required, with a small number of people having a high level of need. Although the data available was not comprehensive, it was noted that people with LD have a shorter life expectancy. Current spend and achievements were noted in the report. The Commissioning Intentions relate to treating LD as a lifelong health condition, with improved access to services – universal, tailored, and specialist – and improved patient experience and outcomes, through integration of services. Comments and questions were invited from members of the Board: • Personal budgets – There was a requirement for a process to be in place by the end of the year for people to access personal health budgets (PHB). A Steering Group had been set up to look at the current requirements, describe how these could be opened up to the full spectrum of people with LD, identify the right care planning tool, and how to learn from the Local Authority (LA) in the use of personal budgets. • This was identified as a key priority for the CCG, responding to a national issue; current performance was rated green on the scorecard; further development was likely to have more cost implications. How would this be managed going forward, and with the reduction in CCG resources, how would this continue to be a priority? - Development of the service was in response to Winterbourne View but also as part of the CCG's commissioning programme to improve patient experience and outcomes. There would be an increase in health needs within the population and there was recognition that there was a real challenge within the market place as well. The CCG was working closely with the LA to focus on intervention and prevention, identifying those at risk and shaping community services to respond in the most appropriate way. • Assurance and monitoring of care from a multiplicity of out of borough providers – The CCG has a dedicated team of assurance managers for LD and Mental Health (MH), with the intention to support people in lower settings of care to enable them to live as independently as possible. A nurse assessor was also in place for LD. • Priority to address ethnic minority differential issues - This was an area of work that could be taken forward in the future. • Potential risks in rolling out of PHB – One challenge as PHBs are rolled out is that money would be taken out of block contracts so that bespoke services can be commissioned to address individual needs. It was essential to ensure continuity of services and ensure that there was a robust, vibrant market. Notice had been given to the provider and work was being done with them around the setting up of PHB for children as the initial focus. • Primary Care support – Only two practices had not currently signed up to the enhanced service – work was being done to ensure that the population of those practices are being cared for. Feedback was being received from users and carers regarding issues relating to waiting times, which was currently under review. • Overlap of services and relationship for joint assessments between CCG/LA – The system for joint assessments was working well. More work would be done around overlapping areas, and a joint review service was currently being	

	finalised. More could be done around joint commissioning – a range of alternative options were already being commissioned. • PHB checks and balances – For social Personal Care Budgets, users now get a pre-paid card as part of a pilot programme. The pre-paid card will provide information regarding spend and an on-going review is in place. Personal packages are put in place in response to assessment of individual needs with users and carers. The Board noted the issues highlighted in the report, the proposed work programme, and Commissioning Intentions for 2016/17.	
15/115	**Performance and Assurance Focus Report** It was acknowledged that the previous year had been challenging for the NHS nationally and locally, and this year was as challenging if not more. The report focused on three standards: A&E four-hour waits; Referral to Treatment (RTT) waits; and Cancer waits The report notes that there are some significant performance issues with a number of providers. The report includes a specific focus on SGH as the local main provider for Wandsworth and with WCCG being the host commissioner, but it was acknowledged that a lot of Wandsworth patients are treated by other providers. SGH - Performance at SGH was not as good as hoped – this was a specific focus in the CCG Assurance process reflecting the role of Wandsworth CCG as the lead commissioner for SGH. Contract Performance Notices had been issued to SGH in June – a joint investigation was put in place with an action plan agreed. The process to work through the Recovery Plan and agreed action plan had been established with SGH. It was noted that the Recovery Plan did not identify quick fixes and some actions would take time to address issues. There was no precise timetable set for recovery and the CCG was working with SGH on this. A trajectory was in place for improved performance in Cancer waits. A&E waits – SGH had not achieved this standard in the last six quarters. Improved performance was normally expected over Spring/Summer but this had not been seen this year. Although nine out of ten patients were being seen within four hours, the Trust was not achieving the 95% standard as required. An analysis of the breaches were done and reported on a daily basis, some of which were due to acuity of patients which affect length of stay, and capacity issues on wards. A delay in specialist opinion in A&E was also a contributing factor – implementation of the Surgical Assessment Unit had slipped to next year. Issues around physical capacity in the emergency department were also acknowledged. These and other issues have contributed to the deterioration in performance. Additional winter pressures will be challenging and the focus was to do everything possible to improve the situation. Referral to Treatment (RTT) – The main standard for incomplete pathways was not being achieved. Joint investment had been made available with a series of actions identified, some of which had not yet happened. A range of issues had been identified across specialties in SGH – meetings and Summits had been held with clinical leads to review the issues, which differ between specialties, including capacity, management of outpatients, and data quality. Work was currently being done to work through the agreed action plan and to understand the drivers. The Trust was looking at improving pathways with a move to more one-stop clinics if possible. Use of independent sector capacity at national tariff rates was also being explored – information on current waiting times at other providers had been sent to GPs to discuss with patients to inform choice.	

Cancer:

- Performance issues at SGH were noted around the GP urgent referral to treatment (sixty-two days) target. This was due to some capacity and demand issues, and a significant number of patients transferred between providers, which also contributes to increased waiting times. SWL providers were now working together more on pathways and tracking of patients, which should improve the process. A recovery plan had been agreed with the Trust and the target should be achieved from this point.
- GP urgent referrals seen within two weeks – There had been an increase in the number of referrals and performance had dipped in the summer. A range of issues had been identified, including capacity and staffing, and the Trust was putting some additional clinics in place.

It was noted that performance in Mental Health and Learning Disability was doing well. There had been a dip in performance for one MH standard but performance had improved and the standard was now being achieved.

Performance on the Improving Access to Psychological Therapies (IAPT) access standard was marginally below for Q1 – the Mental Health Trust has a plan in place to increase awareness. The standard for recovery rates was being achieved.

Comments and questions were invited from members of the Board:

- A&E:
    - Systems to assure that no patients come to harm – A number of meetings, including the Clinical Quality Review Group (CQRG) chaired by Wandsworth CCG, are in place to review clinical quality and safety issues. This target was the subject of clinical discussion at each CQRG meeting, as well as review of Serious Incidents and patient experience. There had been no significant increase in Serious Incidents over the past six months. There was evidence that the main issues were around processes and discharge of patients. There was a very efficient throughput of minor illness through the Minor Injury Unit and the majority of issues were related to getting patients out of A&E on to wards.
    - Surgical Assessment Unit – The Trust was now planning to open the unit in February 2016 and further slippage was not expected. The main reason for the delay was around reconfiguration and refurbishment of the building which had taken longer than expected.
    - Messaging for GPs, patients and the population – The A&E four-hour wait target was 95%, it may be more useful for information on the average wait times to be made available for members of the public, with achievement against 100% rather than a timeframe.
    - Sharing of good practice – A lot of work had been done, including the National team providing input to the Trust. A new programme (Emergency Care Improvement Programme) was currently being set up by NHS England (NHSE) with areas where performance was struggling being clustered. This programme will look at the challenges and share good practice. An independent review across the emergency and urgent care system was also being done to look at the current issues – more information on this should be available for the next Board meeting.
- Clinical implications for Cancer wait times – Under 4% of the total number of referrals under the two-week rule result in a cancer diagnosis. Two-week referrals were being actively promoted with GPs and there was a threshold risk tool in place for referrals. Inappropriate referrals were on the radar for all

	Clinical Reference Groups (CRGs) and it was important for referrals to be looked at on a case by case basis through GP practices. • Link between performance and financial position of providers – There may be some areas where shortfalls are identified and the CCG would need to understand this. The CCG has funded additional tariff activity on RTT, so funding should not be an issue in achieving that performance. Some additional things may be flagged up around improving pathways and best practice, such as wider system issues, and there may be some issues around Cancer that would require a review of benchmarking information with similar providers. SGH will review all services currently provided, which may have some consequences. There was no single factor at the moment to identify reasons for over-performance in Trusts. • CCG Assurance – This information links to the CCG Assurance, which was not at the level anticipated at this point in the year. The CCG was subject to a new set of assessment arrangements and measurements. At the Assurance meeting with NHSE last week, the main focus had been on SGH performance rather than CCG performance. The outcome was not yet known but given the SGH performance the CCG was anticipating that the rating may be less than would normally be expected. This performance profile should be of significant concern to the Board and would become a predominant area of focus for the CCG as an organisation. It was important to manage the expectations to make some tangible difference as soon as possible, particularly for winter and to improve performance to achieve targets as well as deliver that turnaround. A lot of work was already being done and ways to step up leadership and drive across the local health economy. Comments and questions were invited from members of the public: • Bibi Qureshi – There had been some complaints that 111 were directing patients to go to A&E as GPs were not available to see patients. – Contract mechanisms were in place to monitor 111 performance, which was steady. Work was being done to look at the 111 triggers to see if patients can be managed in primary care rather than A&E, which should decrease the number of patients being directed to A&E. • Mike Squires – This month SGH had approached Monitor for a loan and there was indication that the Cost Improvement Programme would not be achieved in any of the divisions within the Trust. Unless money was made available to Trusts, some will go under. The Board noted the current performance, acknowledging that this was a challenging position and was a similar position for other CCGs. It was essential that everything possible was done to address winter pressures and ensure sustainability. The risks to the CCG were noted, however, it was also important to ensure the right balance to enable the CCG to take forward the work required in other areas. The continued focus on quality was also important and this should be monitored through all aspects.	
15/116	**Wandle Locality Annual Report** Claire Frampton (CF) and Marion Endicott (ME) attended. Wandle Locality was the largest locality with innovative practices providing opportunities and addressing challenges. The population of Wandle was the most diverse and the locality shared boundaries with both Merton and Lambeth. The number of registered patients in the locality was significantly higher than the number of residents, which results in some issues regarding access to services for those out of boundary patients.	

The highlights from the report were noted:

- There was significant clinical and management lead at Board level from the locality, with half of the CRGs chaired by Wandle GPs.
- The locality was active in looking at succession clinical leadership.
- Wandle was important for the delivery of core services and commissioning decisions, and instrumental in achieving delivery of the Quality Premium outcomes, Dementia diagnosis, and IAPT targets.
- Work was being done around health inequalities, with a lot of core commissioning work leading to need based commissioning, much of which was done through PACT.
- Practices work together to agree how to spend locality investment funding. Specific patient needs were identified around COPD, Diabetes, Dementia, Obesity and Childhood Obesity.
- There was good engagement with practice members and robust patient engagement with practices at Members Forum. There was a very active Patient Participation Group, providing input on investments, delivery of services etc.
- Patient and Public Involvement was very active, with the programme of events and speakers reviewed periodically to ensure that these were timely and relevant. An audit of skills among representatives had been undertaken to ensure the resource was properly valued and used appropriately to ensure involvement and input was retained. The representatives actively report back to practices and patient groups to establish a mutually beneficial network with dissemination of information, Minutes etc to all practices. A number of workshops had been held on issues such as Co-commissioning, Primary Care Transformation, Wandsworth Health and Wellbeing Hub, and the CCG Strategy. The Patient Participation Group values the support from the Locality Manager and Locality Leads to assist and provide advice and counsel.
- Local projects initiated:
    - Advice and Community Referral Service – Referral to specific experts, eg housing, benefits, with feedback provided to GPs on advice given for future reference. There had been good take-up of the service which has proved to be valuable, with four hundred patients seen as a result.
    - Children Obesity (four/five year olds) – A large number of children in Wandle had been identified as being obese. An opportunity was identified when children attend for pre-school booster immunisation, to measure and weigh children in order to identify potential issues at the earliest opportunity.

Comments and questions were invited from members of the Board:

- The work of the Wandle Patient Group and locality efforts were commendable and an excellent example.
- Investment areas – Member practices and patient groups were asked to consider areas of focus for investment this year. Input had also been received from Public Health. The two focus areas were agreed as a locality.
- Were members still happy to retain a single Wandle locality? - This had previously been discussed with GPs and the membership decided to stay as one locality.
- Practice Support Team – The team provides support across all three localities as part of the Members Development Programme. Practices that were deemed to require support to achieve CQC were identified and support provided.
- Recruitment in primary care – There was a shortage of Practice Nurses and a national shortage of GPs but there was a stable workforce within Wandle.

	There were a number of Training Practices in Wandle and a lot of trainee GPs continue to remain in the locality. NJ thanked the team for their presentation of the Wandle Locality Annual Report.	
15/117	**Commissioning Intentions** There was no requirement for a refresh of Commissioning Intentions within national guidance but development of the Commissioning Intentions enables the CCG to communicate priorities and engage with stakeholders to shape initiatives for the Operating Plan. The proposed Commissioning Intentions have been developed in line with commissioning priorities, and refers to the Five Year Forward View, the significant cross-over in work with the LA, and the SWL Collaborative Strategy Commissioning Intentions. The next part of this process will be to publish the document on the website and send out to major providers – an engagement programme with patients and community groups on the outlines priorities would also be undertaken. Comments and questions were invited from members of the Board: • The life expectancy gap being among the highest in London was a stark reality – was this multi-factorial? - Inequalities in Wandsworth were narrowing. A lot of work was identified in the Health and Wellbeing Strategy to identify areas that could have more impact on life expectancy. • Not all acute areas were represented in the graph included in the report. – Areas such as Maternity and key elective surgical areas, although acknowledged elsewhere in the document, had not been reflected in the graph as they were not Wandsworth generated programmes. The document only identifies particular initiatives, not the totality of commissioning. • Prioritisation of programmes – Feedback would be invited from stakeholders and the community regarding their view of prioritisation. There would be a specific programme of events to undertake prioritisation within the more challenging environment this year to reflect external pressures and meeting key government targets. The document sets out the areas that the CCG would like to take forward and would be based on available resources. In summary of the discussion, it was noted that the Operating Plan should include a diagram to reflect everything that we do in totality. It was acknowledged that the work to develop the Commissioning Intentions was very clinically led. The Board approved the proposed Commissioning Intentions.	
15/118	**Healthy London Partnership** The Healthy London Partnership included a series of programmes of work, the approach for which had been endorsed by Wandsworth and other CCGs in order to take forward the work identified in the London Health Commission Report once across London. The report provides an update on the progress to date. A number of lead roles and engagement with the programmes had been provided from people within Wandsworth. The Board was asked for commitment to support the governance, over-arching support for the programmes, and continued financial contribution to the transformation fund over the next two years. Board support had previously been agreed for one year but it was recognised that the programme of work was still in the early stages of development and required a longer term programme of support to continue. The previous financial contribution had been 0.15% of the finance resource into a single London Transformation Fund to support the thirteen	

	programmes. The same level of contribution was proposed for the next two years. A review of the programmes would be undertaken next year to ensure that the priorities were appropriate. Comments and questions were invited from members of the Board: • Contribution linked to potentially increased finance resource – The 0.15% contribution would be based on recurrent allocation to be announced. In addition to the CCG contributions, NHSE also contributed more than 0.15%. With the possible move to delegation of primary care commissioning and potential increase in CCG funding allocation, it was anticipated that the NHSE share could reduce and the CCG contribution increase. • Scrutiny of investment in programmes – Funding was considered on a business case basis. A Payments and Funding Group had been set up which reports into the over-arching Transformation Board. • SWL Transformation Programmes – A matrix of programmes covering all of the different levels – CCG/SWL/London – sits behind the programmes. There could be a risk of overlap between programmes but this has been discussed both by the SWL group and within the London programme. The programmes will be reviewed as part of the refresh of the plan. • Provider engagement/collaboration – The approach for the partnership is governed by commissioners, however, provider collaboration feeds into the separate work streams. • PPI representation – The proposed representation from one single individual would not be sustainable. This would be taken back as specific feedback. The Board approved support for the two year commitment to the Healthy London Partnership, proposed planning process and on-going governance arrangements, and the financial planning assumption.	**GM**
15/119	**360º Stakeholder Survey** This annual process, organised by NHSE, was required to be undertaken by all CCGs. The survey was sent out in March/April with fifty-two responses out of seventy-seven received - this was a similar response rate to the previous year. Where possible the responses have been benchmarked against responses received last year, and comparisons made with all CCGs, and clustered CCGs. The main issues identified were set out in the report. Wandsworth was set in the top third for three of the areas. Some individual issues had been highlighted around engagement with organisations on planning and stakeholder priorities. Comments and questions were invited from members of the Board: • The report indicated a stable position with some areas identified for further work. • Individual responses were provided but these may not reflect the perspective of the organisation and could be open to interpretation. • Stakeholder engagement on plans and initiatives – More engagement could be done with stakeholders but it was important to acknowledge that in the current environment decisions taken by the CCG may not be appreciated and there are likely to be more difficult conversations than in the past. The Board noted the content of the report and acknowledged that the Communications and Engagement Group would take this work forward.	

15/120	**Board Assurance Framework** The Board Assurance Framework reported on ten corporate risks, three of which were rated very high and four rated as high. There had been one change from the previous report: Risk 68 relating to performance had been increased from a risk score of 12 (4x3) to a risk score of 16 (4x4) – the increase reflected the previous discussion around Performance and Assurance. More in-depth reviews of the following risks were received: • Risk 33 Failure to have sufficient plans to cater for surges in activity and growth in population caused by local community developments – Work was currently being undertaken to develop an Estates Strategy for the CCG, with an action plan and framework. A review of primary care estates would be done within the context of patient cohorts, and management of patients more holistically through Multi-Disciplinary Team hubs. Work would also be done on how to use IT better to enable care in the community. Possible use of the Doddington site would also be considered. An Estates Group had been established, chaired by an Associate Lay Member, to review the data and refresh the recommendations of the strategy. A report would be presented to the Board early next year. The risk score of 12 (3x3) remains as currently there were a lot of plans in place but it was anticipated that with the completion of some of the work this would be reduced. • Risk 75 Sustainable health economy – A collaborative approach had been established across the six SWL CCGs. If this was not delivered, there was the risk that financial pressures would appear across the health economy. There was a Case for Change and clinical strategy for five years across SWL approved by CCGs and providers. Work was in process to implement the strategy with providers, however, the position across the main acute providers had deteriorated, and would continue to deteriorate. The risk still remains but progress was being made in implementing the changes. Actions were in place but there were still a number of hurdles to deliver the five-year strategy. The risk will continue to be revised on a monthly basis and it was likely that this would increase in the short term. Further clarity was expected in November which would impact on this risk. Comments and questions were invited from members of the Board: • The top three rated risks around finance, the overall health economy, and Out of Hospital strategy were agreed as being an appropriate reflection of the main risks. • Merger of financial risks – Wandsworth CCG was currently on track to achieve the financial target; providers were reporting a deficit financial position; there was concern that going forward Wandsworth CCG would receive the minimum level of growth to reflect the current distance from target and pace of change, which would mean that the same level of investment would not be available. Any change in allocation will have a negative impact on the CCG going forward, therefore, the financial risks should remain separate at the moment. • SWL strategy timetable – A timetable had been set out. Providers would be required to step up to deliver the strategy and further discussions will be held. The timescale will be tight, but it was expected that changes will happen sooner rather than later. The content of the report was noted.	

15/121	**Executive Report** The content of the report was noted.	
15/122	**Finance Report** Performance was currently on track to deliver the surplus. Risks were noted around Prescribing, Continuing Health Care, and the significant deficit position of the main provider. It was still expected that the finance targets would be achieved. A focus report would presented at the December meeting.	
15/123	**Summary Minutes** The content was noted.	
15/124	**Open Space** The following questions were received: <u>*Questions received from G Horner*</u>: 1. What has been the outcome of a meeting between the Mental Health lead for S.W.L. C.C.Gs and South-west London Mental Health Trust about the demand from the Trust Development Authority for further cuts to be made at the Trust of over £1 million? The service providing a "Place of Safety" [S.136] for people apparently mentally disturbed in a public place and the E.I.S.targets are apparently amongst the aspects of service at risk. In fact, reports indicate, that the staffing of the S 136 suite needs MORE staff. 2. At what stage are the C.C.G.s in reviewing the feasibility of the reconfiguration of mental health services? The M.H.Trust are reporting increased levels of need for beds, as are Trusts all over London. Local adult patients have this year been placed in the Deaf Unit, when not deaf and in the O.C.D.unit, when not suffering from O.C.D. and more recently in the ward for the elderly. [Beds for the elderly are ,of course, planned to be reduced from 38 to 18 under the Plan.] This has been happening, because there are times, when there are no vacant beds on Adult wards. At other times, when there is less pressure, bed-occupancy is reported usually to be at 95%. One C.A.M.H.S.patient, who became very violent, was admitted to an Adult ward. 3. What does "Engagement with on-going S.W.L.and St G.estate modernisation plan and assurance of the impact on residents for all services" [Wandsworth Commissioning Intentions" p39] actually mean? <u>*Responses*</u> – It was agreed that a written response would be provided. <u>*Questions from Kate Swinburn*</u>: 1. Communication Disability – There is no specific coding currently for Communication Disability therefore there are difficulties in assigning personal health budgets. Can the CCG provide assurance that this is a real issue and impacts on access to services and wellbeing? 2. Healthy London Partnership – There is a focus on prevention, how can this strategy have an impact on issues such as Maternal Mental Health and life chances of children? The focus of the strategy was on people in work but there were a lot of people who were not in work. This was an area that was not seen as crisis but there was an undercurrent of deprivation, stress and common social factors that could be addressed to underpin the crisis work.	

	Responses: 1. In the work to expand PHB, one question would focus on which groups to expand this. It was proposed to go out to the GP membership and patient groups regarding potential areas where a care planning approach would be applicable. Communication Disability would not be excluded and this suggestion can be taken to the first meeting. 2. The work coming out from the programme was very broad but the comment would be taken back to the relevant program to check the scope. Perinatal Mental Health was an area of specific concentrated investment and work was being done with commissioners to agree a service specification for Perinatal Mental Health.	
15/125	**Any Other Business** None. There being no further business, the meeting closed at 12:35.	
Date of next meeting: 9th December 2015		

ACTIONS

Ref No.	Item	Lead
15/118	Healthy London Partnership – Comment regarding PPI representation to be fed back.	GM