South West London

Notes of a meeting of the Clinical Commissioning Group held on 7th December 2011

Present:	Nicola Jones (NJ)	CCG Lead (Chair)
	Graham Mackenzie (GM)	Borough Managing Director
	Tom Coffey (TC)	PEC Chair
	Stephen Hickey (SH)	Non-Executive Director
	Godfrey Allen (GA)	Non-Executive Director
	Houda Al-Sharifi (HAS)	Director of Public Health
	Peter Ilves (PI)	West Wandsworth LCG Lead
	Rod Ewen (RE)	Interim Battersea LCG Lead
	Mike Lane (ML)	Joint Wandle LCG Lead
	Jeremy Ambache (JA)	Wandsworth LINk
In attendance:		
	Stephen Warren (SW)	Head of Commissioning
	Andrew McMylor (AM)	Head of Consortium Development
	Sandra Iskander (SI)	Head of Performance and PPI
	Alison Lyons (AL)	Assistant Director of Finance
	Mary Evans (ME)	Wandsworth Children's Services
	Sandra Allingham (SA)	(Minutes)

11/032	**Apologies for Absence** Received from Gillian Ostrowski, Dawn Warwick and David Avis.	
11/033	**Declarations of Interest** JA – Board member of the Trustees of Age UK Wandsworth, and family member employed by PricewaterhouseCoopers. GPs present – primary care contractors.	
11/034	**Minutes of the previous meetings held on 12th October and 2nd November 2011** 12th October 2011 11/002 Declarations of Interest - "... Trustees of Age UK **Wandsworth ..."** Subject to the above amendment, the Minutes were agreed as being an accurate record. 2nd November 2011 11/026 Health Visitor Review Group Report and Recommendations – final bullet point in first section – "... Aim to have seven **senior** posts in place ..." Subject to the above amendment, the Minutes were agreed as being an accurate record.	
11/035	**Matters Arising** 12th October 2011 11/007 Patient and Public Engagement Strategy – Work was still on-going to understand what evidence would be required to fulfil the requirements for authorisation. 11/011 Process for Expression of Commissioner Support – Kingston Hospital	

	Foundation Trust Application – SW reported that a letter of intent had been received from the Chief Executive at Kingston Hospital. There were still some remaining issues which were currently being worked through and conversations were on-going. All other actions were noted as completed. 2nd November 2011 11/021 'Your personal best' Long Term Conditions Campaign – NJ confirmed that this was to be discussed at the CVD meeting the following day. 11/022 Chronic Obstructive Pulmonary Disorder (COPD) Progress Report – NJ to chase J Gray re the link with the NHSL COPD Pathway. 11/023 Sickle Cell Disease Service Improvement Update – NJ confirmed that the comments had been fed back to the Working Group and also that a meeting had been held regarding the pathway. 11/024 Cancer Screening Report – HAS confirmed that the kit has to be obtained through the hub in order for the individual kit codes to be tracked. HAS agreed to circulate the message to GPs. 11/031 Out of Hours Procurement – AM confirmed that the procurement was proceeding for Wandsworth alone. All other actions were noted as completed.	**NJ** **HAS**
11/036	**Commissioning Strategy Plan (CSP) and Commissioning Intentions** NJ acknowledged the significance of this document for the Clinical Commissioning Group (CCG) and the authorisation process. SW stated that the document, driven by the Joint Strategic Needs Assessment (JSNA), had the ownership of the CCG. The document tried to show how the priorities fit together strategically with high level milestones for next year. The Wandsworth CSP would feed into the Cluster CSP. The Commissioning Intentions run in parallel and were aligned with the CSP. The document signalled to providers the impact in the following year. The next phase would be to develop the Operating Plan, the template for which had just been received. The following points were noted from the discussion: • Timescale for consultation on the document was extremely tight. GM apologised for the short timescale and confirmed that the Borough was required to operate within the SWL timescale. • Short summary document to be available to the public. SI reported that a summary of the goals and principles had been sent out via the patient email list and input would be welcomed on how this could be improved. • The shift of care reference in the Commissioning Intentions should also apply to MH, drugs and alcohol services as well as physical care. SW stated that this was included in the general practice section of the document. Work was currently being done to look at Community Mental Health Teams (CMHTs) and the wording could be more explicit. • Work on next year's plan should start now to include public involvement in this and further refreshes of the strategy. • Wandsworth LINk would have a powerful role to play regarding readability and understanding.	

	• QIPP financial assumptions for 2012/13 may be different from local assumptions and there may be other parts of the contracting cycle that Wandsworth may not previously have been part of. AL stated that work was currently being done regarding how QIPP savings were being used. The CSP and Commissioning Intentions were approved. NJ recorded her thanks to all those who had participated in this work.	
11/037	**Priority Focus Area – Alcohol** NJ commented that, following discussions regarding the Joint Strategic Needs Assessment (JSNA) and QIPP workshop, some emerging themes had been identified for presentation at CCG meetings to provide the opportunity to think about and create a strategy, looking at what had been achieved to date, current position and how to take work forward. Martin Penfold (MP) attended the meeting to provide a summary of the progress to date and future priorities. Progress to date: The strategy had been launched three years previously with very little available resource. The priorities of the strategy were around poor treatment, capacity and access, which was less than 3%. Access to treatment was now above 10% with a target to increase over the next three years. Work had been done over the last three years to build capacity and two Fresh Start clinics had been established in Putney and Battersea for moderate alcohol dependence. This had resulted in reduced waiting times at the specialist clinics. It was hoped that a further Fresh Start clinic would be opened next year in Wandle. To reduce hospital admissions a Drug and Alcohol Liaison Team had been commissioned in SGH to identify repeat offenders and provide treatment in the community. The Drug and Alcohol system had been redesigned and procured to improve access. Future Priorities: • How to identify alcohol related risk and early intervention. • How to work with general practice and secondary care. • How to support families and children affected by alcohol issues in discussion with colleagues in Children and Family Services. Alcohol affects all aspects and the PCT was working with all partner agencies and communities to deliver that partnership and integrate services. From the discussion the following points were noted: • This was a potential issue for discussion with stakeholders at the Health and Wellbeing Board. • How could the services be sustained through mainstreaming financial resource? • Services had significantly improved over the last three years. • Bye-laws were available for Local Authorities to employ. Wandsworth Council was committed to addressing alcohol issues and these issues had been raised by the Overview and Scrutiny Committee (OSC). • More evaluation was needed on how successful the initiatives had been. MP stated that the Fresh Start clinics had been evaluated and there was a very high completion rate. Other services had also indicated positive reports. Early Intervention was the most challenging with particular regard to resources for	

	investment. • Was case management used for severe drinkers with repeated A&E attendance? MP confirmed that SGH were doing case management for alcohol related attenders. Evaluation showed that there had been a 50% reduction in ambulance calls and significant reduction in A&E re occupied bed nights. • What was the predominance of mild/moderate/high risk drinkers? MP stated that there were no accurate statistics but the majority of cases were moderate dependent. • Reference regarding the social impact from alcohol abuse should be strengthened around specific intervention regarding children. • What was the local evidence to target young people more effectively at an early stage? MP responded that work was being done with children and young people regarding the Family Recovery project and how to identify families early. A separate piece of work was also being led by the LA to bring the two areas of work together as a whole community. • What were the recurrent cost implications? MP stated the need to invest to build a primary care base, for which scoping was currently being done. GM noted that the QIPP program was also being developed and cost pressure areas had been identified and would be included in the investment process developed for consideration in the New Year. SW stated the need to demonstrate the evaluation data and impact on acute services as part of an invest to save bid. NJ stated the role of the CCG was to support this work going forward and the need to involve all practices to achieve significant change. It was agreed that an update would come back to CCG in three months.	
11/038	**2012/13 SWL Effective Commissioning Initiative (ECI)** TC reported that this was the fifth year of the process, the system for which had been developed with secondary care clinicians to provide guidance to commissioners regarding appropriate effective treatment. The document set out the proposed changes from 2011/12. The system was not about saving money but about effective clinical commissioning. The following comments were noted from the discussion: • Reference to cost savings across SWL to be removed from front sheet summary. • Second bullet point in the Summary should read “Procedures where initial conservative therapy is appropriate.” • GPs and patients should be made aware of the system and procedure. • Information would be available on the GP website in the next couple of weeks and this would also be part of the Referral Management program. • Need to embed this as part of the active referral process. • GPs often ask for opinions from consultants prior to a possible referral. It was noted that the feedback process for Individual Funding Requests (IFR) would need to be tightened up. It was agreed that this would be fed back through the Localities to make GPs aware of the changes to the process. The updated form, ECI and IFR local criteria would be emailed to practices. The proposed amendments were approved.	**Leads** **HAS**

11/039	**Clinical Commissioning Group Development Plan** AM confirmed that the paper included two updates: current position in the establishment of the CCG as a statutory body; Capsticks Development Plan. <u>Current position</u> – The following key points were noted: • Ceiling of £25 per head had been agreed to cover running costs. • Requirement for full shadow state by April 2012. • Establishing principles for the CCG to develop as much as possible in-house. • Collegiate or economies of scale should be clear with Service Level Agreement (SLA) specifications in place with Key Performance Indicators (KPIs). • Establish form and how many people would be required to fulfil roles. • Organisation map to be developed by end December for senior posts and individual teams to deliver strategic functions. • Self risk-assessment toward authorisation rated as green. The SWL Cluster was happy for work to proceed. • Engagement of clinicians had been mapped to key priorities, with Clinical and PH Leads aligned to the development action plans. <u>Development Plan</u> – The following key points were noted: • Capsticks Alliance had been appointed to provide organisational development support. • The process would include internal and external consultation including stakeholders. • Statement of work done regarding domains of authorisation, with four agreed areas. • Locality teams would have a dedicated relationship manager. • GP Lead identified in each practice. The following points were raised during the discussion: • Guidance on conflicts of interest – AM stated that the guidance was expected to be available in January. Initial guidance issued the previous week stated the need for transparency. • PPI domain was not just about the strategy. Practices may require additional support to make public engagement as added value to commissioning. AM stated that this would be included in a number of sessions not yet detailed around PPI at practice level. • PPI steering group was working through some of those issues and the action plan would include how this could be built into structures. • How would communications in the CCG and with GPs be achieved? AM stated that it was expected that a general communications workshop would be held possibly in the New Year. Work would be done with individual practices on internal communications. • With the shadow state being in place by April 2012, consideration would be required on how the CCG would need to operate in the wider environment. The CCG development would need to be considered with other elements of transition, eg CSO and PH. AM stated that from April 2012, the Cluster office would split into the NHS Commissioning Board, with responsibility for primary care contracting, and the CSO to deliver functions for CCGs on a Cluster basis. AM reported that guidance on the roles and responsibilities for the Secondary Care Clinician and Nurse members would be available in the New Year and it was hoped	

	to appoint to these posts. The Organisational Development Plan was approved.	
11/040	**South West London Acute Commissioning Unit (ACU) Report** Carmel Harrington (CH) attended the meeting and presented the Month 7 report based on Month 6 year to date. The following headlines were reported: • Over-performance worsened from Month 5 (2.6%) to 3.4% in Month 6. Cluster over-performance was currently 7%. Overall variance of £6.5m at Month 6. • Key over-performing contracts: St George's Hospital (SGH) £3.4m; Kingston Hospital (KH) £900k; Queen Mary's Hospital (QMR) £450m. • SGH – Most significant change was over-performance increased by £1m from Month 5, particularly in outpatients, critical care and high cost devices. • KPI performance was detailed in Appendix 1, however, it was still early in the year regarding a final indicative assessment. • Demand Management – There had been some increase in acute SLAs. • Four claims had been made by the ACU with some recovery achieved to date. The following challenges were noted: • A&E tariffs migration. • Day case/electives/outpatients all contribute to the position on 18 weeks. • KH - High cost patient in critical care, which was not flattening out therefore the rate of increase should reduce. • QMR – Inpatients, elderly care and neurorehab. No other major issues were highlighted. There had been some under-performance in Foundation Trusts (FTs) but this was not expected to continue to the year end. CQINS – SGH had met most of the agreed CQINS in Q2 and were expected to achieved 85+% at year end. A contract query had been issued to SGH regarding 18 weeks with particular reference to long waiters, sustainability and forward plan. TC reported that work was being done to support SGH to hit the 18 weeks target in a clinically safe way, ensuring sustainable performance and treatment of patients in a chronological order. AL stated that consideration was being given to invest surplus funds in the SGH wait list or to waive the penalties. There was still a lot of uncertainty and it was more likely that the penalty for Q2 would be waived to help them resolve the wait list. GM agreed that the details of the contract should be applied and then a separate agreement could be made to re-invest rather than continually waive the penalty.	
11/041	**Commissioning for Quality and Innovation 2012/13** SW presented the paper noting that for next year there would be an increase from 1.5% to 2.5%. The paper outlined the first cut of contracts with SGH, QMR, Community Services Wandsworth (CSW) and the Mental Health Trust (MHT), and further work would still be required. The SGH CQINS Trust-wide were £6m-£11m, with £1.8m-£3m for Wandsworth. All current CQINS were outlined in the paper, with some of the mandated and some as	

	local recommendations. The value of the CQINS next year would go up but 20% were still mandated. Some would be rolled-forward from this and SGH had expressed the wish to continue with some of the patient specific ones. Section 2.5 outlined the areas most likely to have CQINS next year but there was scope for other areas. During the discussion the following points were noted: • A high level of dissatisfaction had been expressed from the LINks review of hospital discharge and the CQINS should be linked with this area for both SGH and KH. TC commented that this had been taken into account for outpatients and requested JA to forward a copy of the report. • Consideration should be given linking the potential roll-over of CQINS with the CSP. • Should also be linked with the JSNA priorities. • The same emphasis should be in place for both the SGH and CSW community contracts. • Would better engagement be achieved if there were a small number of high value CQINS? • General principles need to be manageable and realistic. • If CQINS were achieved these should be included in KPIs. • Locality discussions and input required from GPs. SW noted that further work was still to be done on CSW and MH CQINS. The Quality Review Group (QRG) and QMH Commissioning Board would provide final agreement of CQINS. From the discussion it was agreed that: • There would be fewer high value CQINS. • Link with JSNA and CSP. • CQINS for SGH and CSW to be linked. • Need to embed achieved CQINS in KPIs.	**JA**
11/042	**Mental Health and Community Services Wandsworth Performance Quarterly Report** SW presented the first quarterly report, which highlighted particular issues around the Psychological Intensive Care Unit and single sex accommodation. The paper noted that Improving Access to Psychological Therapy performance had seen a reduction in waiting times. Initial outcomes from the Productive Community Services had seen an improvement in hospital contact for community nursing. SH queried the values of the patient facing time with District Nurses and Health Visitors. SW stated that this did not include travel time, writing notes or case meetings etc. JA asked about improving performance regarding lack of care planning with reference to the CQC report around inpatient care. SW reported that a comprehensive plan was being implemented, which had reduced the use of agency staff on the ward. JA asked whether a proposed reduction in the Community Psychotherapy Geriatric Team had been included in the plan. SW stated that a plan was in place to combine two older people Community Mental Health Teams (CMHTs) but this would not result in a reduction in resource. A GP working group had been established to look at Older People's care pathway.	

	NJ requested that any further information on the format of the report should be fed back to SW.	
11/043	**Finance Report** AL stated that the report was forecasting that the surplus of £14.5m would be achieved. A number of risks had been identified, which were currently being worked through: • Acute activity increasing. • SGH wait list. • 2% NR spend – Review with budget holders was currently being undertaken. • £3m of services not yet released. • Review of premises recharges. Putney capital receipt should happen of approximately £1m. Plans were in place to spend £450k with the possibility of £750k being brokered being pursued or schemes that could be mobilised quickly. TC raised a concern regarding capital spend and queried the potential to dome in a staggered way to release some funding this year and some next year. AL confirmed that this was currently being looked at. JA asked if decisions regarding capital spend could come to the CCG rather than MT. GM commented that it was necessary to distinguish between operational spend with big refurbishment decision coming to CCG.	
11/044	**Quality, Innovation, Productivity and Prevention (QIPP) Report** SI presented the report which included information on the 22 schemes to achieve QIPP savings of £7m. There had been a significant earlier in the year but more schemes had been identified to reduce the gap at Month 6 to £300k. Although this was below trajectory, it was expected that the target would be met by year end. Highlights of the patient level impact on the ground were included in the report with information on how the schemes were working. Planning for 2012/13 was still on-going and discussions on the target were still in progress.	
11/045	**Performance Report** SI reported that, at Month 7, performance was strong overall, with a number of targets being met including Chlamydia. Teenage Pregnancy had achieved the best quarter performance with significantly reduced numbers but the target was not yet met. Concern was noted around the 12 week Maternity Checks and Dental targets. There had been an increase in performance and actions were in place for some of the under-performing areas. SI confirmed that for some targets the majority of activity happened in Q4. GM reported that there were monthly review meetings with the Cluster as part of the performance process of review and explanation. SH commented that CCGs would be required to explain any under-performance of targets. JA asked if performance tables for general practice would be available. GM agreed	

	the need for this information and that responsibility for this rested with the Cluster. A programme of work was also being done across London to look at performance across the piece and scorecards would be made available to be published on websites. NJ noted that each practice received performance data and this was shared with the Patient Consultative Groups. HAS requested that any discussion on practice performance should be discussed at the CCG prior to an OSC discussion. SI agreed to look at the timing of performance reports to the OSC.	**SI**
11/046	**Intermediate Care Service – Interim Relocation Project** SW referred to the interim report for information on the short term relocation of 16 Intermediate Care beds at Dawes House to Ronald Gibson House. Viridian had withdrawn the service at Dawes House and a number of issues had been highlighted with the building. Work was on-going regarding the specification for the service to go live on 1st April 2012. The long term procurement exercise for Intermediate Care would link to the Reablement Strategy and provide a more integrated service. JA noted the importance of taking on board patient and carer opinions. The reported progress was noted.	
11/047	**Open Space** *Questions from Mike Squires:* 1. What was the current position regarding the advert for the Management Referral Unit, two year contract? 2. With reference to patient choice, who makes the final decision? 3. Which organisation would be providing commissioning support in Wandsworth? 4. Queen Mary's Hospital, as part of Wandsworth PCT, was developed under PFI. The last repayment of £22m for that scheme would not be made until 2035. Who would pay that? *Responses:* 1. NJ responded that an advert had been placed earlier in the year to stimulate the market and determine what providers were out there, however, this had not gone ahead. Work was now progressing on an education and facilitator approach for referrals in Wandsworth to include a number of aspects. 2. NJ confirmed that choice would always lie with the patient. 3. AM responded that PCTs would be abolished by April 2013 to be replaced by CCGs as part of the public sector. The CCG would be setting up in shadow state by April 2012 to mirror the PCT as a statutory body to test out assumptions. The NHS Commissioning Board will assess and award authorisation. Capsticks were only providing organisation development support for a six month period to April 2012 to support the authorisation process. NHS London had run the procurement for this support. GM commented that CCGs were clinically led bodies and, once authorised, would have choice regarding from where they engage commissioning support. Any testing of the market could be done in the first year of full authorisation and	

	therefore the commissioning support would predominantly be provided from the existing PCT. 4. GM responded that it was not yet known who would be responsible for the estate but it would not be CCGs. It was expected that responsibility would probably lie with some part of the NHS Commissioning Board.	
Date of next meeting: 11th January 2012		

Signed: .....

Date: .....

ACTIONS

Ref No.	Item	Lead
11//035	Matters Arising – COPD – NJ to chase JG re link with NHSL COPD Pathway. Cancer Screening – HAS to arrange for message to be circulated to GPS.	NJ HAS
11/038	2012/13 SWL Effective Commissioning Initiatives – Locality leads to feed information back to GPs re changes. Updated form, ECI and IFR local criteria to be emailed to practices.	LCG Leads HAS
11/041	Commissioning for Quality and Innovation 2012/13 – JA to forward copy of LINk Hospital Discharge report to TC.	JA
11/045	Performance Report – SI to look at timings of reports and OSC meetings.	SI