Wandsworth Clinical Commissioning Group

Notes of a meeting of the Clinical Commissioning Group held on 12th December 2012

Present:	Nicola Jones (NJ)	CCG Lead (Chair)
	Graham Mackenzie (GM)	Chief Officer (designate)
	Tom Coffey (TC)	PEC Chair
	Hardev Virdee (HV)	Chief Financial Officer (designate)
	Stephen Hickey (SH)	Lay Member Governance (designate)
	Jeremy Ambache (JA)	Lay Member Patient and Public Involvement (designate)
	Peter Ilves (PI)	West Wandsworth LCG Lead
	Rod Ewen (RE)	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
	James Olweny (JO)	Director of Corporate Affairs, Performance and Quality
	Andrew McMylor (AM)	Director of Delivery and Development
	Houda Al-Sharifi (HAS)	Joint Director of Public Health
	Dawn Warwick (DW)	Director Wandsworth Adult Social Services

In attendance:

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

12/133	**Welcome and Introductions** NJ welcomed everyone to the meeting and asked members of the Board to introduce themselves with a brief explanation of the role on the Board. NJ welcomed James Olweny to his first meeting of the Board as Director of Corporate Affairs, Performance and Quality covering Sandra Iskander who was currently on maternity leave. NJ reported that confirmation had been received that the CCG had now been approved as fit for purpose to take on the statutory duties with effect from 1st April 2013. Two conditions had been attached to the approval, which were required to be fulfilled before the end of March 2013: • Registered Nurse member of the Board to be in post. • Safeguarding processes to be firmly in place and embedded in the organisation. Thanks to all members of the Board and staff for this successful outcome were recorded.	
12/134	**Declarations of Interest** No new declarations were received.	
12/135	**Minutes of the previous meeting held on 10th October 2012** 12/122 Quality, Improvement, Prevention and Productivity Report – fourth bullet point from bottom of p.4 – "… of two Intermediate Care Wards at **Ronald Gibson**	

	House and Dawes House ..." 12/124 Register of Interests – Action to be included for Register of Interests to be available on the website. Subject to the above amendments, the Minutes were agreed as being an accurate record.	
12/136	**Matters Arising** 12/119 Finance Month 4 Report and Focus Discussion – HV reported that the Risk Sharing Arrangements were still in discussion and, once finalised, these would be presented to the Chief Officers and National Commissioning Board (NCB) for discussion. The final paper would then come to the Board for consideration. All other actions were noted as completed.	
12/137	**Chair's Action** NJ reported that, following discussion at Management Team (MT), a letter was sent in response to a request from the North West London Shaping a healthier future Programme Board, stating that Wandsworth CCG were in agreement with the decisions made following the consultation, on the direction of travel.	
12/138	**Commissioning Intentions** LW presented the high level framework to set the strategic intent for commissioning in 2013/14. The framework provided information on the direction of travel for stakeholders and reflected the work done throughout the year and how this would be taken forward. LW stated that, if the Commissioning Intentions (CIs) were approved, the Operating Plan would spell out how the intentions would be achieved. LW noted the following points: • The CIs had been built on a lot of work done throughout the CCG and drafts of the document had been shared at MT, Localities and patient forums. It was the intention to embed these firmly in the Joint Health and Wellbeing Strategy, (HWBS) reflecting the previously agreed priorities. • A small number of objectives had been identified on which to focus: prevention; integration of health and social care; collaboration with other CCGs. • The aim of the CIs was to improve outcomes for the residents of Wandsworth. The appendix maps out the work that the CCG wanted to do next year and outcomes. The next step would be to develop the Operating Plan and more work would be done to define how we want to improve, which would enable us to be held to account. HV noted that the high level financial Framework was due to be published next week. This would set out the allocations for the CCG, Public Health (PH) and Local Authority (LA) for 2013/14. This was an important milestone which would have an impact on how the CIs would be delivered. The following comments were noted: • Good document that clearly linked with Joint Strategic Needs Assessment (JSNA) and HWBS.	

	• Collaboration with other CCGs was not just about BSBV. • Collaboration with NCB was also important and should be reflected – a lot of outcomes that we aspire to would require high level of collaboration with them. • Mental Health was one of the priorities for West Wandsworth, particularly, Children's Mental Health, which would continue into 2013/14. • CRGs were a powerful platform for developing and moving projects forward, however, resource within CRGs should be kept under consideration. • Many of the intentions would likely be reliant on other organisations in the new world – how would these be taken forward to deliver collaboratively next year? LW responded that this was part of the integration agenda and goals would be set for next year, which would demonstrate a successful track record. The process for this was being started, including development of staff. DW noted the importance of the delivery plan and making sure that all parties were engaged in designing and understanding the intentions to ensure delivery. • Rehabilitation and Hospital Hostels – The CCG would need to look at the implications for all parts of the system and where resources would be best employed to do this. • A number of patient comments were received regarding arrangements for discharge of mental health patients in the community - how could this be improved? Interest was also received regarding Children and Young Adults Mental Health Service (CAMHS). PI reported that the CAMHS was currently being restructured in a few locations within London, which would then be rolled out, and this should improve the service. PI stated that the Mental Health Trust had held a transformation event during which a number of positive statements were made on how various elements would be developed including effective discharge. • Would other areas of prevention, such as Diabetes, screening and health checks for all groups be included? HAS stated that a lot of the functions identified would move to the responsibility of the LA. Screening and immunisations were included in plans to deliver collaboratively with NCB and the Health and Wellbeing Outcomes Framework would also look at how to deliver the functions to deliver the commitment and CIs. • Had any specific issues been identified from secondary care providers? AN commented that this was an overview document, which would be under-pinned by a number of action plans. This was the start of the process to ensure engagement around the detail of delivery as part of the next steps. • Level of engagement and consultation with patient groups had been impressive given the short timescales. NJ acknowledged that there had been more effective consultation this year and that the process would continue to improve as a result of work being done throughout the year. The Commissioning Intentions were ratified.	
12/139	**Operating Plan Guidance** LW stated that the Operating Plan would build on all of the work that had gone into developing the CIs. The process would collate, define and identify decision making points as the plans for 2013/14 were refined. This was a significant piece of work to be done and it was important to be clear on which of these outcome measures the CCG would want to focus – this was an opportunity to spell them out as subsets of the performance measures. A lot of work had already been done on the development, clinical and financial decision making process to spell out in detail how to deliver the CIs, financial implications and how to measure success. Discussions would be held with acute	

	providers throughout the process on what this could mean as part of the development. SH commented that a number of important strategies relied on one-off budgets, were there any key programmes identified that would need to move to recurrent finance? HV stated that this issue was currently being looked at to ensure that recurring funding for key initiatives, however, the financial modelling showed that if financial commitments were made this could potentially compromise financial sustainability, which would require a level of savings to be delivered. LW confirmed that there was an opportunity for further comments to be received until the end of February.	
12/140	**Property transfer: Social Education Centre/Joan Bicknell Centre** HV referred to the paper on the proposal to transfer two properties, currently owned by Wandsworth PCT. Due to new arrangements in the system, estates could possibly transfer from existing PCTs to Property Services, however, there was an opportunity to transfer the properties concerned to the Mental Health Trust (MHT) as part of their redevelopment programme. This had previously been considered but the MHT were not in a position to pursue the proposal at that time. This was now an opportune time for the transfer of these assets to the MHT to take place. The PCT had been working closely with the MHT and Social Services colleagues, who were aware of the intentions in the paper. Work had also been done with partners and NHS London as key stakeholders to make this transaction happen. The cost of the transfer would be cost neutral to the PCT. The LA would gain the advantage of a more robust planning process to develop the Learning Disability service. The MHT would be able to deliver their proposed development plan. It was important that the financial process for the proposed transfer was correct and a joint business case with the MHT would be developed for presentation to the Finance Resource Committee to ensure a transparent process. GM confirmed that this responsibility remained with the PCT Board and had not been delegated to the CCG, however, this related to borough business and it was appropriate for the CCG Board to consider the proposal with the final decision to be made by the PCT Board. The CCG Board supported the recommendation for the detail of the business case to be worked through for consideration by the Finance Resource Committee for final decision by the PCT Board.	
12/141	**Board Assurance Framework** JO reported that the corporate objectives had been discussed at the Board Seminar in November to help shape the Board Assurance Framework (BAF), which would be aligned to the operating risks and Vision statement. The corporate objectives had been discussed and agreed at MT and the Integrated Governance Committee (IGC). Development of the BAF was still a work-in-progress and work would continue to review the risks. One extreme risk was identified in the paper. This had been discussed at the IGC meeting the previous day and it had been reported that much of the identified risk had now been mitigated and the risk scoring would be reviewed. GM stated that the corporate objectives had been mapped across the identified	

	operational risks, which included a number of legacy risks. The risks would need to be continually reviewed and updated to establish a comprehensive risk register for the CCG for the future. The following comments were noted: • Work on the organisation development needs would be slotted in to the risk register. • Objective 4 understated what was required to make sure that primary care in Wandsworth evolved and thrived and the wording would need to be strengthened to include transformational improvement. • Capacity within primary care should be included within transformational improvement and not be under-estimated. • Objective 2 needs to translate into the sub-objective regarding value for money and use of resources and how this could be demonstrated. • When would the examples become tangible and how would we ensure this happened? GM stated that for 2013/14 this would link back to the Operating Plan outputs. JA requested engagement with patients and public before sign off of examples. NJ commented that the Commissioning Intentions should also reflect primary care transformation. AM stated that a primary care quality plan was to be developed by June 2013. NJ acknowledged that this was a good start in the development of the BAF and the comments would be fed into the document.	**JO**
12/142	**Wandsworth Public Health core offer to the Wandsworth Clinical Commissioning Group** JR attended the meeting to present the paper. NJ stated that, as PH transferred to the LA, it was important to define the relationship and support that would be provided to the CCG. The proposed offer had been discussed by the MT and comments had been included in a revised offer. JR presented the paper, which described the healthcare and PH service that would be provided to the CCG and Joint Commissioning Unit (JCU) for commissioning of NHS services and to the Commissioning Support Unit (CSU) for commissioning of services at St George's Hospital. The specification was based on Department of Health guidance and included details of activity through the commissioning cycle, capacity to deliver and Key Performance Indicators (KPIs). The agreement would be reviewed jointly by the CCG and LA after twelve months. The following comments were noted: • The offer did not define the capacity to be provided on a numerical basis. JR stated that the whole time equivalents (wte) had been included in previous drafts. The function to be provided was very broad and whilst there would be a core team as listed on p.4 of the document, each of which were 1.0 wte, all members of the PH team would contribute to the work in some part. • Who would champion health issues on behalf of the CCG, particularly with regard to issues such as the Nine Elms Development? HAS stated that this would have resource implications and would need further consideration. The Health and Wellbeing Board would also have an involvement in these areas. • Was there clarification on how PH staff would access NHS information? JR stated that there were on-going discussions regarding a data sharing	

	agreement. RE commented that a solution to this issue had almost been developed and a paper would be presented to MT for discussion and consideration. Following on from the discussion, NJ asked if the Board were happy to agree the key principle of how this would work, subject to work being finalised on the Information Governance issue, details of the review process and championing of health issues. The Board agreed the core offer on the basis outlined by NJ.	**HAS**
12/143	**Draft 2013/14 South West London Effective Commissioning Initiative Policy** Josephine Ruwende (JR) attended the meeting to present the policy. The paper provided a summary of the commissioning criteria of procedures and treatments, developed by the South West London Public Health Network throughout the year in conjunction with secondary care colleagues, with the aim to reduce variation in activity and practice within general practice. The four acute hospitals had been involved in consultation of the draft criteria for 2013/14. The 2013/14 draft criteria were presented to the Board for approval. The following comments were noted: • Had primary care been involved in the development of the criteria? JR stated that primary care had not been consulted, however, it was noted that there was primary care input in the CEMMAG (Clinical Effectiveness and Medicines Management Group) as well as public representation. NJ proposed that the policy should come back to the Board following consultation with other clinicians. • Was there a potential for an increase in applications? JR confirmed that there could be more applications on an individual funding basis but this would be on exceptionality only and there would be more control regarding access to funding. • Policy referred to PCTs rather than CCGs. • There was a level of uncertainty within primary care regarding the referral process. JR stated that discussions had been held regarding Referral Management on how this could be integrated with the Referral Management programme. • Clinical input and perspective would be required before the financial perspective could be assessed. JR commented that it was difficult to have one policy across all five boroughs, particularly where funding implications were different. • Equality Impact Assessment (EIA) required. JA stated that an EIA had been completed and was available. • Concern that local agreement arrangements could reintroduce postcode differences. JR stated that there were Individual Funding Requests (IFR) routes for each sector but referrers may not have a feeling for what was appropriate. IFRs may look at rarity but clinicians may not be clear what this could be and could therefore lead to a flood of applications. • Was there sufficient capacity to handle an increase in applications? RE stated that applications would normally go to CEMMAG first and there may be a requirement for this group to meet more frequently. • Wording of the policy may raise issues around expectations. • Implementation was important, however, there was some confusion among clinicians around referrals and clarity on the process was required. JR noted that approval of the policy would be required by the Joint Boards by 28th	**HAS**

	February. NJ stated the need to have approval from the CCG Board and the need to ensure an appropriate balance with this policy. NJ asked that revisions be made to reflect the discussion and that the revised version be brought back to the CCG board February meeting.	**JR**
12/144	**Diabetes Integrated Specification** Jane French (JF) and Neil Bamford (NB) attended the meeting to present the item. NB stated that the paper set out the next step to commissioning St George's Hospital (SGH) and Community Services Wandsworth (CSW) to deliver diabetes care in the community. The specification was set out on page five of the report, based on a tiered model and recommended by Healthcare for London for CCGs to adopt. The five tiers were noted as being: • Tier 0 – patient self-management • Tier 1 – standard GP care for people with diabetes • Tier 2 – additional support for practices to deliver for people with complications • Tier 3 – patients with complications, such as Type 2, requiring specialist input • Tier 4 – hospital based care. Tier 4 would be delivered at SGH and Queen Mary's Hospital (QMH). Clinics for Tier 3 would be held in community centres, e.g. St John's Therapy Centre, QMH, Brocklebank Heath Centre, and possibly at additional sites according to prevalence. The following comments were noted: • Could Tiers 2 and 3 be combined as one level of service? NB commented that Tier 3 would be consultant led; Tier 2 would include a dietician and community specialist nurse and provided an enhanced primary care not currently included in the General Medical Service (GMS)/Professional Medical Service (PMS) contract. • More work was required around prevention and early identification. JF commented that work was about to commence on identification of patients. • 80% of costs relating to diabetes are incurred by management of complications – would the proposed model help to avoid expensive complications? NB responded that by delivering better care through Tiers 0-4 complications should decrease. • Prevention should be included in all Tiers. NB stated that through the PACT initiative GPs would be trained up in all aspects of prevention, delivery and care. • Were there any details regarding the contractual mechanism yet with SGH? JF commented that there had been some capacity issues at SGH but there was now a permanent project manager in place who would provide the data to determine the quantity of the projected activity and current costs. LW agreed to follow this up with SGH. • At which location would the Tier 3 hub for Balham, Tooting and Furzedown be? NB stated that the location had not yet been identified and it was agreed that this would be an important issue to consider. • How would the programme work with voluntary and community groups particularly around self-management? Had the role of community pharmacies been considered in these Tiers? NB stated that Tier 1 referred to community pharmacies for medicines management. Patient groups had been involved in the development of the programme but an over-arching plan was required	**LW**

	possibly led by Local Authority (LA) or Public Health (PH). AM stated that a Task and Finish group would be set up in the new few weeks for each Tier and the membership would be established in the Terms of Reference – this will enable discussions around engagement to be held. • What was the Council's role in this work? NB stated that intention to start a dialogue – with the PH transfer to LA it was unclear at this stage where some of the responsibility would fall. • More clarity was required regarding insulin management and how quality would be monitored throughout the Tiers. • Further financial information was required, particularly regarding the increase in activity for which funding had not been identified. AM stated that the paper set out the clinical model and direction of travel only and further work would need to be done to understand activity levels. • Would patient education be integrated into the program? AM stated that this would be included as part of PACT across all conditions. NJ welcomed the amount of work done and the additional detail of the specification, noting that further work would be required on financial modelling and patient flows. It was noted that this work would be considered as part of the Long Terms Conditions (LTC) and PACT programme. The operational action plan would come back to the Board for consideration.	
12/145	**Dementia Pathway** Alison Kirby (AK) and Dr Aryan Lawe (AL) attended the meeting to present the item. AL stated that this was the first time that this pathway had been put into a tiered model, with appropriate care from diagnosis and support for patients and carers through to End of Life Care (EOLC). The work to produce the tiered model looked at the step change to improve experience, diagnosis and outcomes. Section 2.2 of the report summarised the feed back from patients and users from a number of engagement work-streams, including workshops and stakeholders meetings. In 2012 the focus was on Tiers 1-3 and the acknowledgement that primary care awareness was paramount. An anti-psychotic prescribing audit was carried out work done on how the outcomes could be translated into good primary care. Tier 3 looked at formalising specialised care in the community – a funding business case had been submitted for the Memory Assessment Service. It was envisaged that Tier 0 would be delivered through the Planning All Care Together (PACT) programme and collaborative work had been done with external agencies and an action plan developed for 2013 onwards. Social Services had also put in place training schemes for carers. The following comments were noted: • There was a need for a programme of education within primary care on how to deal with these issues, as too much was being done in secondary care which was not the appropriate setting – the approach to early diagnosis needed to be strengthened. AL stated that work was being done and it was hoped that the tiered system would assist diagnosis. • Self-management and early diagnosis can often be difficult with patients reluctant to engage with clinicians – how could carers and family members be supported to access services for enable a diagnosis to be made? AL	

	commented that the apprehension and breaking down of barriers was included in the aims, however, there was a risk that if the gap was closed too quickly the service could be overwhelmed as the provision was a finite resource. • A lot of work had already been done on dementia training and with home care provider sector, however, there was a need to understand the trigger points and this should be included in the model. • Where does nursing care fit into the commissioning model and how does it link to continuing healthcare to ensure that a dignified service was commissioned? AL stated that the bulk of patients diagnosed were seen through the Mental Health service and would have a case manager. Referrals would be assessed as part of the triage system and the PACT programme would be key to this work. • Early diagnosis was critical, could we be more creative in how this could be raised with patients and would there be a public health advertising campaign? AL stated that there was much discussion around this at the moment and this was beginning to happen. • There was no clear carer/user representation on the Clinical Reference Group (CRG). • Would there be sufficient resource to deliver the development and action plan over the next year? AL stated that the action plan was ambitious and the demands would escalate. AK stated that the Memory Assessment business case identified the available funding and potential requirements for this step change process, which would focus on one/two areas only. NJ acknowledged the significant amount of work that had been done and noted that there was still further work to be done around financials, modelling priorities and Commissioning Intentions. It was noted that the business case would come to the Management Team for consideration.	
12/146	**Executive Report** SH queried the Procurement section of the report, noting that some procurements had been identified in the finance report. HV stated that the finance report reflected Month 6 and the Executive Report related to the period since the previous meeting in October. The content of the report was noted.	
12/147	**South West London Acute Commissioning Unit Report** The content of the report was noted.	
12/148	**Finance Report** HV commented that the report reflected Month 6 and an interim report for Month 7 due to a timing issue. The report referred to the potential for the PCT control total to increase from £10.5m to £15.5m – further work was to be done regarding deliverability but this could have a positive benefit for the CCG in 2013/14 as it was likely that approximately 70% would come back to the CCG.	
12/149	**Quality, Innovation, Productivity and Prevention Report** JO confirmed that overall there had been good progress and the programme was on track to deliver. Work had started on planning for the 2013/14 process.	
12/150	**Performance Report** JO reported that the main issues identified were around Immunisations and IAPT. Work was being done to look at the underlying issues.	

	SH commented on the level of frustration across the Cluster on the overall position regarding Immunisations, noting that there had not been much progress and a high level of review should be maintained.	
12/151	**Minutes** The content of the Minutes were noted. PI and JA left the meeting.	
12/152	**Open Space** *Questions from Mike Squires* 1. The papers for the meeting had not been available on the website, what assurance would be given that these would be available for future meetings? 2. Details of items for inclusion on the Part II Agenda were not available. 3. Personal details had been passed on to In-Health, however, permission had not previously been obtained. 4. The Finance Report set out details of the expected cost savings to be made in the hospital sector of approximately 24% between now and 2016, but did not include similar information for CCGs. If Wandsworth CCG were expected to make the same level of savings this could be approximately £36m – why was there no details included in the report to plan against that possibility? *Responses* 1. GM apologised for the papers being available late on the website – the CCG had been experiencing a number of IT issues recently and papers would be available for future meetings within the stated timescale. 2. GM noted that there were no new substantive items on the Agenda for discussion in Part II of the meeting. Items for future meetings would be noted. 3. NJ responded that usual practice would be for a GP to discuss the place of referral with a patient prior to forwarding patient details to the provider. 4. HV acknowledged the level of stress for acute providers regarding the plan for next year. The allocation for CCGs would be published next week. Modelling work had been done to reflect a number of different scenarios and potential options, however, the formula base for CCG allocations was not the same as for provider Trusts. For 2016/17 CCGs were working with provides on the level of challenge, but the challenge for commissioners was very different and the Better Services Better Value programme would look at how to meet that challenge to make sure there was no destabilisation. *Questions from member of Long Term Neuro Conditions Group* 1. What would be the best route to raise issues identified through the user group? *Response* 1. NJ stated that there were a number of ways that issues could be raised: • Questions to the Board • There were a number of patient groups at all levels of the organisation. • Through Jeremy Ambache as Lay Member for Patient and Public Involvement. • Through the Patient and Public Involvement team. GM noted that contact details for the appropriate lead were included on the front sheet of papers presented to the Board.	
12/153	**Any Other Urgent Business**	

	None. There being no further business the meeting was closed at 12:50.	
Date of next meeting: 13th February 2013		

Signed: .....

Date: .....

ACTIONS

Ref No.	Item	Lead	Timescale
12/141	Board Assurance Framework – Comments to be fed into document.	JO	February 2013
12/142	Wandsworth Public Health core offer to Wandsworth Clinical Commissioning Group – Issues regarding Information Governance, details of review process and championing of health issues to be included.	HAS	February 2013
12/143	Draft 2013/14 South West London Effective Commissioning Initiatives Policy – Policy to be revised following clinical consultation and amendments as discussed to be incorporated. Policy to come back to Board for further consideration.	HAS	February 2013
12/144	Diabetes Integrated Specification – Contractual mechanism with SGH to be followed-up.	LW	February 2013