NHS
North West London
Collaboration of
Clinical Commissioning Groups

NW London CCGs' Shadow Joint Committee

Minutes of the meeting held on Thursday 1 November 2018,

Bourge Room, Novotel Hammersmith, Shortlands, London W6 8DR 15.00–17.00hrs

Members of the Committee:

Name:	Role:
Marcia Saunders (MS)	Independent interim chair
Mark Easton (ME)	Accountable Officer, NW London CCGs
Dr Andrew Steeden (AS)	Acting Chair, West London CCG
Caroline Morison (CM)	MD, Hillingdon CCG
Christine Vigars (CV)	Healthwatch Representative
Diane Jones (DJ)	Chief Nurse/ Director of Quality, NW London CCGs
Dr Genevieve Small (GS)	Chair, Harrow CCG
Dr Ian Goodman (IG)	Chair, Hillingdon CCG
James Cavanagh (JC)	Vice-Chair, Hammersmith & Fulham CCG
Javina Sehgal (JS)	MD, Harrow CCG
Lindsey Wishart (LW)	Lay member, audit and finance
Louise Proctor (LP)	MD, West London CCG
Dr M C Patel (MCP)	Chair, Brent CCG
Dr Martin Lees (ML)	Secondary Care Consultant
Mary Clegg (MC)	MD, Hounslow CCG
Melanie Smith (MeS)	Director of Public Health and Community Wellbeing, Brent Council
Dr Mohini Parmar (MP)	Chair, Ealing CCG
Neil Ferrelly (NF)	Chief Finance Officer, NW London CCGs
Dr Neville Purssell (NP)	Chair, Central London CCG
Nicholas Young (NY)	Lay member, patient representation
Dr Nicola Burbidge (NB)	Chair, Hounslow CCG
Philip Young (PY)	Lay member, audit and finance
Sheik Auladin (SA)	MD, Brent CCG
Tessa Sandall (TeS)	MD, Ealing CCG

Non-members in attendance:

Alex Harris (AH)	Corporate Governance Officer, NW London CCGs
Ben Westmancott (BW)	Director of Compliance, NW London CCGs & Senior Responsible Officer, NW London Governance Programme
Huw Wilson-Jones (HWJ)	Interim Director of Acute Medical Commissioning
Juliet Brown (JB)	STP Director
Rory Hegarty (RH)	Director of Communications and Engagement

Apologies:

Graham Hawkes	CEO, Healthwatch Hillingdon
Jules Martin	MD, Central London CCG

General business	Action for
1. Introductions, apologies and declarations of interest The meeting was opened by the Independent Chair of the Shadow Joint Committee, Marcia Saunders. It was noted that a previous meeting that was due to be held on 4 October had been cancelled in order to hold a special meeting of the NW London Finance Committee. The Chair also gave her heartfelt thanks on behalf of the committee to the Chief Financial Officer, Neil Ferrelly, as this was the last Shadow Joint Committee meeting in which he would be attending before his retirement after forty years service in the NHS. The Chair also noted that this would be her last meeting as Chair, and noted that the NW London Collaboration of CCGs had appointed Alan Wells OBE FRSA to the role of Independent Chair of the Joint Committee. **2. Minutes of the previous meeting held on 6 September 2018** • The minutes of the previous meeting were approved as an accurate record of the proceedings. **Declarations of Interests** The Chair reminded members to keep the interests register up-to-date, as well as declaring them for specific agenda items. This included those attending in place of a member. There were no other declarations of interests. **3. Actions Log** • The action log was noted – all items were either on the agenda or listed for the next meeting of the Committee. **4. Report of the Accountable Officer** The report was introduced by Mark Easton as an update and overview of the past month in the NW London CCGs collaboration. Points raised included the following: • The next meeting of the Committee would, pending approval of the harmonised constitutions by NHS England, no longer be operating in shadow format, and would be a fully-fledged Joint Committee of the CCG governing bodies. • The Accountable Officer gave thanks to Neil Ferrelly for his service in the NHS and for the NW London collaboration of CCGs. • Congratulations were also given to Juliet Brown, who had been appointed as the Strategy & Transformation Partnership Director; the STP would now also be referred to as the Health and Care Partnership. • The NHS 10-year plan was due to be published soon – it was expected that the arrangements made in NW London would be reflected in the recommendations of the plan. • There were not expected to be any significant reductions in hospital beds in the	

next five years. • The NW London Shadow Quality & Performance Committee had its first meeting on 18 October. • In response to questions from CV, ME confirmed that Shaping a Healthier Future had made no comment with regard to mental health beds and addressed only acute beds. There were also no plans to currently close hospitals, but if there were then that would require a full public consultation. The proposed changes to Ealing and Charing Cross hospitals, however, had been through a long engagement and consultative process, but more work had to be done and interdependencies had to be examined. A full public consultation would be required in the event of a new and substantial service change, but this was not what was currently being proposed. ➢ **The Committee noted the report of the Accountable Officer.**	
Joint commissioning and finance	***Action for***
5. Month 6 financial report The item was introduced by the Chief Finance Officer, NW London CCGs, Neil Ferrelly, and summarised the financial position of the NW London CCGs in the sixth month of the financial year, with the Committee being asked to note the report. Other points raised included the following: 1. Only Hammersmith & Fulham and Central London were forecast to be delivering less than 75% of their QIPP (Quality, Innovation, Productivity & Prevention; efficiency savings & quality improvement programme) plans at the year-end. 2. The most recent special meeting of the NW London finance committee had discussed the principles of development of the financial recovery plan, and this was due to be reported to NHS England. 3. The Financial Recovery Plan was to be linked up with performance and quality targets. **Discussion** 1. LW commended the finance teams for working up a robust recovery plan. She noted that the recovery actions were not new ideas, but were about making sure that the things that had been planned were deliverable. ME agreed, and noted that the plan was focused on assurance that the work committed to at the beginning of the year was being carried out as rigorously as possible. 2. ME also stated that if there were any "heroic" turnaround assumptions (i.e. those which were so ambitious as to be questionable), these would be analysed and appropriately risk-rated. He did not, however, think that there were any. 3. NF noted that part of the review had been looking at assumptions around back-ended QIPP; there has been a great deal of scrutiny to see if there was sufficient evidence for the delivery of those programmes. ME added that six of the eight CCGs had underlying deficits. When the new financial allocations could be seen, there would be a view of the scale of the challenge. ➢ **The Committee reviewed and noted the report.**	
6. M6 QIPP Update 1. The CFO noted that the majority of the discussion on this item had been addressed in consideration of the previous paper. He noted, however, that there had been	

scrutiny undertaken on the Phase 2 programs, and there would be a deeper dive with the diabetes programme at the beginning of the week. ➢ **The Committee reviewed the report.**	
7. Business Planning Update The item was introduced by the Interim Director of Acute Commissioning, Huw Wilson-Jones, as an update on Business Planning priorities for the current year, with the Committee being asked to review and endorse the approach outlined in the report. Other points raised included the following: 1. Growth values were on-track to be shared with providers. Local intelligence had been sought around changes in services and how payment-by-results was being funded, so that there was a clear understanding of local growth values, which could potentially track with those nation-wide. 2. The Outpatient Programme was a key programme in terms of QIPP. HWJ and NF had been looking at the principle of how potential benefits of reductions in activity and providers reducing costs could be shared going forward. 3. QIPP workshops were being held to meet with key provider leads to see if any funding for projects could be released. The NHS England Operating Plan may come with financial risks for NW London. **Discussion** 1. MP noted that the market forces factor combined with flat allocations would present challenges. HWJ stated that NF had taken feedback and responded to the payment-by-results questionnaire which was currently in draft. There were letters from providers, commissioners and STPs highlighting the risk in London from this. 2. ME noted that finance officers across London were writing to NHS England about potential difficulties they might face with the revised market forces factor proposed. 3. NY stated that there was a need to look at changes to services and asking what this would mean, as this would likely differ depending on location. HWJ noted that any substantial change would have to go through an EqIA (Equality Impact Assessment). If there were any QIPP or other projects to be run jointly then they would also have to go through an EqIA. 4. PY noted that the other side of QIPP (commissioner schemes) was the Cost Improvement Plans (provider schemes). HWJ noted that there were currently high-level views of these available. One of the issues was in trying to identify details of the whole system and how we make sustainable cash releasing savings thus reducing overall cost, 5. PY added that if we were going to make this work, there needed to be greater trust between providers and commissioners. ME stated that this would be worked up through the integrated care system and partnership work being carried out in the context of the Health and Care Partnership. ➢ **The Committee endorsed the approach to business planning outlined in the report.**	
Joint strategy	***Action for***
8. NHS in NW London: Overview of Strategic Developments since 2012 and next steps	

The item was introduced by the Director of Acute Care Transformation, Kevin Nicholson. He summarised the key developments that had been implemented since 2012. Points raised in discussion included the following:

1. IG noted that Hillingdon CCG's organisational development seminar had brought forth the view that the paper was lacking the fuller narrative and context of the Whole Systems Integrated Care and Mental Health work. It was also inner London-centric as opposed to extolling the advances that had been made more widely across NW London.
2. ME agreed that there needed to be greater thought given to describing some of the good work that had been done locally. For instance, many people were under the impression that Shaping a Healtheir Future was just about acute services reductions, but it was in reality about more appropriate primary and community services as well.
3. ME also highlighted the need to think about local engagement, and pointed out the distinction between engagement more generally and consultation – the latter of which has a distinct legal meaning.

- **The Committee noted the current strategic developments since 2012 and noted the next steps relating to the wave four capital process outlined in the report.**

9. Health and Care Partnership governance refresh

The item was introduced by the STP Director, Juliet Brown. She introduced the new way that the programmes of work were now being described and the new governance arrangements. The reason for doing so was to better articulate our goals and describe the plans in a more meaningful way to residents. Governance changes were intended to improve clarity on the roles of different groups and emphasise accountability back to individual statutory bodies. Points raised in discussion included the following:

1. Strengthening Health and Care Partnership governance processes would strengthen our ability to deliver improvements to outcomes and to be able to provide assurances on the work being carried out. There would be no perfect way to describe programmes of work, but this would enable greater clarity.
2. A big focus of the STP had been on older people and this had been a Delivery Area – in the new arrangements older people's care featured in a number of different programmes what was also important was the ability to look at different stages of people's lives.
3. CV welcomed the involvement of lay partners but stated that there still needed to be explanation of lines of accountability and decision-making.

- **The Committee discussed the report and recommended the steps outlined above.**

10. Integrated Care in NW London

The item was introduced by the STP Director, Juliet Brown. The purpose of the report was to update the committee on the progress in making the NW London health and care system an integrated care system, and seek the Committee's assurance on the next steps identified in the report. A previous integrated care workshop had identified seven key recommendations / areas of focus to take forward and develop the integrated care development programme, which were:

1. Developing relationships and building trust.
2. An agreed system-wide clinical and care strategy.
3. Identify and deliver key landmark programmes to demonstrate the benefits of working

as an integrated care system.
4. Agreed, system-wide enabling strategies.
5. System-wide finance and contracting focus.
6. Using our Whole Systems Integrated Care information system to drive our population health analysis and integrated care programmes.
7. Establish the robust system-wide governance for an integrated care system.

Discussion

1. IG stated that he felt everyone would welcome the simplification of the STP process, and that integrated care was the way forward. One of the important tasks was to make sure that good practise in every CCG was picked up. Adopting centrally-decided initiatives would not always be the best way forward.
2. JB added that one of the reasons for strengthening the areas of focus was because better results could often be achieved from working at scale, but there was often a lot to learn from borough-based systems.
3. LW noted that almost everything that local government did would have an impact on the wider determinants of health. The funding situation in local government was quite severe, which entailed risks in improving health and social care; nonetheless, local government were still a key partner in this area of transformative work. There was therefore a need to strengthen partnerships between the NHS, local government and the voluntary sector. JB responded that the Chief Executive of Harrow London Borough Council, Tom Whiting, was the STP lead across NW London, and he had been very actively engaged with this.
4. JB also stressed the need to place more emphasis on prevention and self-care. It had been a stated aim of the STP but it hadn't been delivered upon.
5. ME added that with regard to the relationship with local government, the eight CCGs were mostly coterminous with local government. Therefore, the relationship between the NHS and local government would most meaningfully take place at the borough level. It was also important to recognise that nobody from one local authority could speak on behalf of the other. The question was then what was the appropriate level to do the work that was required – the answer to which was that it would likely be at borough level.
6. MP raised the issue of Health Education England's reduced budgets and the potential impact on staff education and training and quality and implementation.
7. In terms of finances, JB stated that the key issue was about doing the right thing for our patients and residents and doing so in the context of the finite money available.
8. LP stated that the practical governance at a local level was hard to put right in terms of delivery of integrated care, and that this may be stopping the ambition and pace of integrated care.

- **The Committee discussed the report and recommended the next steps outlined above.**

11. Update from the NW London Shadow Quality & Performance Committee

The item was introduced by the Chief Nurse / Director of Quality, Diane Jones. The Committee had held its first meeting in "shadow" (i.e. trial) format on 18 October. The terms of reference for the Committee were still in draft for and would be finalised at the January Governing Body meetings. The purpose of the Committee would be to have a NW London oversight of shared quality and performance issues, and to recognise & agree an approach to seek improvements.

Discussion 1. PY asked how the committee could operate by only meeting five times a year when it was supposed to be reporting on all quality issues relating to acute and core mental health contracts. DJ responded that local committees would continue to meet and both local and joint committees would report to governing bodies. DJ also stated that little would change from one month to another and less frequent meetings would enable officers to carry out remedial work in between and report back on progress to the committee. ➢ **The Committee discussed the update from the NW London Quality and Performance Committee and noted the report.**	
12. Report of the Collaboration Development Programme Board ➢ **The Committee considered its level of assurance on the programme and noted the progress towards the joint committee receiving delegated powers from governing bodies.**	
13. Any other business There was none.	

Total meeting time: 100 minutes

The meeting was closed at 16.40hr

- **Date of next meeting:** 6 December – Board Room, Westminster University, 309 Regent Street W1B 2HW

Questions and Answers from the Public after the meeting closed:

1. **Shaping a Healthier Future; Councillor Ben Coleman, Cabinet Member for Health and Adult Social Care**

A question was asked if councils would be invited to be equal partners in terms of shaping demand for Shaping a Healthier Future, and specific focus was given to a perceived change in NW London CCGs' position on bed numbers and further calls to abandon the changes to Ealing and Charing Cross Hospitals set out in Shaping a Healthier Future. Furthermore, it was asked what is meant by the statement: "NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures"?

ME responded that there had been a change in position with regard to beds, but emphasised that we had always been committed to adapting our plans in the light of actual patient activity, and there would be no changes to either hospital until alternative provision was in place. The modelling process, furthermore, would be refreshed because it was done several years ago. There was a formal process of working with local authorities – there was the Joint Health and Care Transformation Board, but only six of the eight local authorities had signed up to it. That represented the formal engagement with councils, but there would also be other working relationships that would be developed and fostered.

A follow-up question noted that the STP had not been signed up to by Hammersmith & Fulham Council as it was believed to be merely an implementation plan for Shaping a Healthier Future – the only accurate modelling on which had been done by the Mansfield Commission (Independent Healthcare Commission for NW London – Chaired by Michael Mansfield QC). The Commission had said that the NHS had seriously underestimated the increase in population of NW London. ME responded that no council would be excluded. The Mansfield Report did not present any alternative analysis of bed requirements – it had merely made criticisms. The scale of engagement with councils would depend on the work currently being undertaken to decide how Ealing and Charing Cross hospitals would take shape. There was some misleading work which suggested that hospitals would close or be eliminated – that was not the case, there would just be a different future from what is currently happening.

It was noted in a follow-up question that the suggestion was not that Ealing and Charing Cross hospitals would close, but that they would cease to exist as acute hospitals. They would be instead re-branded as "local hospitals" which had no formal definition in the NHS. All that had been done was a delay in any decision to 2023. ME responded that this was a misrepresentation – there would be transparent analysis undertaken, and local councils and other stakeholders would be engaged.

2. **Non-reduction in hospital beds; Robin Sharpe – Brent Patient Voice**

A question was asked regarding the non-reduction of hospital beds – surely this was central to the strategy of Shaping a Healthier Future? Was this not an admission that the central strategy was wrong? ME responded that this was indeed a significant statement, but Shaping a Healthier Future was never primarily about reducing the amount of beds. It was instead focused on developing community and primary care.

3. **Charing Cross & Ealing Hospitals; Anne Drinkell – Save Our Hospitals**

A question was asked regarding the potential closure of Ealing and Charing Cross Hospitals. It was confirmed by ME that there are no plans to close either hospital. There were also distinctions to be drawn between Ealing and Charing Cross hospitals, which was why there had been Strategic Outline Cases 1 and 2.

4. Pembridge Hospice; Anne Drinkell – Save Our Hospitals

NP confirmed that the issues at Pembridge Hospice were due to a vacancy in the consultant post. There had been a great deal of difficulty in recruiting to the post as a locum position. A lot of the continuity for patients was built up by the community palliative care teams. There had no been no decision made about the future of Pembridge, and there was no guarantee that it would reopen, as it depended on being able to provide the right service with the right number of clinicians. All patients who had been moved had been interviewed by the quality and safety team and were happy with the service they received.

5. Integrated Care; Adam Moore, Integrated Lay Partners Group representative

A question was asked regarding plans for there to be a single NHS integrated health and social care system – what progress was there towards this ambition. ME responded that there was no plan to have a single statutory Health and Social Care body by 2020. Manchester's integrated system was not a single statutory entity, but comprised eight local authority areas and their constituent trusts and commissioners.

6. Ealing out of hospital contract; no name given

The final question asked what the impact of the preferred bidder for Ealing out of hospital contract was. TS responded that West London NHS trust were the preferred bidder. One of the intentions was to secure a provider of community services that could deliver integrated care within the borough of Ealing. There had been a three and a half year investment into general practice in Ealing. One of the compnonents in the Ealing Standard was around working in an integrated way with our local services provider.