NHS
North West London
Collaboration of
Clinical Commissioning Groups

NW London CCGs' Joint Committee

Minutes of the meeting held on Thursday 6 December 2018,

Board Room, Westminster University, 309 Regent Street, Marylebone, London W1B 2HW

Members of the Committee:

Name:	**Role:**
Alan Wells OBE FRSA	Independent 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
Dr 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
Lynn Hill (LH)	Chair, Healthwatch Hillingdon
Dr M C Patel (MCP)	Chair, Brent CCG
Mary Clegg (MC)	MD, Hounslow CCG
Dr Mohini Parmar (MP)	Chair, Ealing CCG
Dr Neville Purssell (NP)	Chair, Central London CCG
Nicholas Young (NY)	Lay member, patient representation
Paul Brown (PB)	Chief Finance Officer, NW London
Philip Young (PY)	Lay member, audit and finance
Sheik Auladin (SA)	MD, Brent CCG
Tessa Sandall (TS)	MD, Ealing CCG

Non-members in attendance:

Alex Harris (AH)	Corporate Governance Officer, NW London CCGs
Ben Westmancott (BW)	Director of Compliance, NW London & Senior Responsible Officer, NW London CCGs Governance Development
Jo Ohlson (JO)	Interim Director of Acute Commissioning, NW London CCGs
Juliet Brown (JB)	Health and Care Partnership Director, NW London CCGs
Lizzy Bovill (LB)	Director of Performance, NW London CCGs

Apologies:

Jules Martin	MD, Central London CCG
Dr Martin Lees	Secondary Care Clinician
Dr Melanie Smith	Director of Public Health & Community Wellbeing, Brent Council
Dr Nicola Burbidge	Chair, Hounslow CCG
Dr Tim Spicer	Chair, Hammersmtih & Fulham CCG

North West London Collaboration of Clinical Commissioning Groups

General business	*Action for*
1. Welcome, introductions and apologies for absence The meeting was the inaugural one for the Independent Chair of the Committee, Alan Wells OBE FRSA. He began by noting that as NHS England had approved the harmonised constitutions of all eight NW London CCGs, the Committee was now officially out of shadow operations, and thus a fully-fledged Joint Committee of the NW London CCGs' governing bodies, with decision-making powers in the following areas: 1. Matters relating to the strategic direction of the CCGs in line with the Health and Care Partnership. 2. Multi-borough commissioning plans when these are determined to be in the best interests of the residents of NW London. 3. Services that cross borough boundaries, are delivered by providers to NHS organisations across multiple boroughs, and are best commissioned on a multi-borough basis such as secondary care, acute and mental health services. 4. The joint financial strategy. 5. Those which fall within the Committee's remit in accordance with the CCG governing documents. 6. The NW London-wide policies of the Planned Procedures with a Threshold team. Voting would be by unanimous agreement of all present voting members. The members with a vote are: • Each CCG Chair **or** their deputy. • Accountable Officer **or** their deputy. • Chief Finance Officer **or** their deputy. • Independent Clinician **or** their deputy. • Director of Quality and Nursing **or** their deputy. • Lay members **or** their deputy. **Post-meeting note:** Deputies will be considered to have the vote transferred to them if the secretariat has been notified beforehand **and** there is no conflict of interest present. If the secretariat has not been notified of the deputisation arrangements, the vote will be considered transferred **only** if there is **unanimous** agreement amongst all other voting members present with regard to the deputisation arrangements. **2. Register of Interests** The Chair reminded members to keep the secretariat notified of any changes to their declarations of interests, and for their entries on the register to be updated at least every six months. The Chief Financial Officer, Paul Brown, noted that as he was newly in the post, his declarations had not yet been captured on the register, however he outlined his interests at the start of the meeting: • Previous equity partner and shareholder of RSM, who provide internal audit services to the CCGs (May 2002 – April 2017 – all shares have since been sold)	

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- Previous non-equity partner at Carnall Farrar who have provided consulting services to the CCGs in the past (April 20187 – November 2018)
- Previous non-executive and unpaid chairman of a social enterprise, Greenwich Primary Care Collaborative CIC that until September 2018 provided primary care services to Greenwich CCG (March 2009 – September 2018).

3. Minutes of the previous meeting – held on 1 November 2018

➢ **The minutes of the previous meeting were approved as an accurate record of the proceedings.**

4. Actions log

➢ **The Chair, with the consent of members present, deemed all the actions on the log as closed.**

5. Report of the Accountable Officer

The NW London CCGs' Accountable Officer, Mark Easton, introduced the item. He began by noting that there has been less on quality matters on this agenda than usual, but that this would in future regularly feature in agendas and reports of the Committee. He also noted that the Joint Health and Care Partnership Board had agreed three short-term areas of work, which were: 1) intravenous antibiotics in the community; 2) catheter care in nursing homes; and 3) eligibility for community services across boroughs.

He noted that the new NHS 10-year plan was anticipated before the winter break. There was an expectation that there would be a period of public engagement on the plan, and a report on the 10-year plan would be brought to the Committee next year.

➢ **The Committee agreed to note the report of the Accountable Officer.**

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<tr><td>Joint strategy</td><td>Action for</td></tr>
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6. Winter preparedness 2018/19

The item was introduced by the Chief Nurse & Director of Quality, Diane Jones, as part of an update from the earlier meeting of the Shadow Quality and Performance Committee. The NW London Director of Performance, Lizzy Bovill, also answered questions from Committee members. The purpose of the item was for the Committee to be assured on the winter preparedness plans outlined in the report.

Update from the Shadow Quality and Performance Committee

The earlier Shadow Quality and Performance Committee had discussed issues around fractured hips – a paper would be going to the clinical and quality board to discuss the matter as part of a wider consideration of the Health and Care Partnership. Issues around national reduction of *E. coli,* and a deep dive into cancer care had also been discussed.

Discussion & questions on winter preparedness

1. LW raised a question with respect to integrated urgent care. When patients knew what integrated urgent care services were, they seemed to like them, but there was a lack of knowledge about how these could be accessed. There was a need to be clear

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to patients about how they could make best use of services. NY also reiterated this point, asking what the strategic approach to signposting for integrated urgent care was and how effective was the communications strategy in changing behaviour. LB stated there was a national communications campaign which would be based around encouraging people to use self-care strategies where possible, through using 111, health apps and other appropriate avenues such as local pharmacies. Media organisations such as the Evening Standard were also being engaged with. Communications strategies were evaluated but it was difficult to fully quantify the impact of the messaging and the extent to which it influenced behaviour.

2. CV noted that in the three central boroughs there had been work done by Healthwatch on the use of urgent care. It was clear from this work that people did not know what was available. A year-end evaluation was necessary, and CV therefore asked what role patient experience would play in this evaluation. DJ stated that this would be built into the reporting that is presented to the key committees, such as the Joint Committee and other governing bodies. Patient experience would be part of the evaluation of how well the plan has materialised throughout the winter. LB added that a number of pieces of work had been co-produced with patients from the beginning.
3. GS asked what plans there were to review the winter preparedness over the winter in order to respond to emerging themes. LB responded that the plans would be evaluated in the new year to understand how services had performed in the pressure-point areas around Christmas and the Bank Holiday period.
4. LH stated she did not understand from the report how providers would be encouraged to work together over the winter so that pressures could be shared out. LB responded there were four A&E delivery boards across NW London where providers joined-up their efforts. There had been further conversations regarding how systems in NW London could work together to assist individual areas that are in need.
5. AW also asked how content the NW London CCGs were that there were sufficient beds to deal with the winter pressures. LB stated that it was important to be mindful of demand in the totality. There was a need to understand how many people who went to A&E required emergency care but did not need to be admitted. For those who do need to be admitted, additional beds had been opened up to deal with the additional demand. One measure which had been implemented focused around the efficient use of those beds and ensuring they were protected through the Emergency Care Pathway, so that patients could go home when they needed to do so.
6. CM asked how much of the £240m that had gone to local authorities had been made available to NW London boroughs. LB stated that across NW London there had been £8m of extra funding which local authorities had received. Discussions at the A&E delivery boards had been ongoing about the best use of those funds. Some boroughs had a good understanding of how to use them, however others were less clear. This matter had been presented at the Joint Health Overview and Scrutiny Committee, and they had agreed that transparency around how this funding was used was important.

7. IG asked how the plan to reduce the number of beds occupied by long-stay patients by 25% was measured, and how frequently would this be done. LB responded that this was a national target, based on daily reporting that trusts submitted to NHS England. A plan was being worked on to reduce bed occupancy for patients who were currently at home. The targets were purely for patients who were ready to leave. Progress had been made, but it was not yet complete. Investment had been at both a CCG level and a Better Care Fund (joint local government and NHS healthcare pooled budget) level. ➢ **LB stated that she would update the Committee outside the meeting on the baseline future of reduction in beds occupied by long-stay patients.** ➢ **The Committee considered itself assured by the report and subsequent discussion.**	**LB**
7. Health and care partnership progress update The item was introduced by the Health and Care Partnership Director, Juliet Brown. She began by noting that the report had, in accordance with actions agreed at the September meeting of the shadow version of this Committee, been adopted to focus on outcomes. In particular, a heavy focus had been given to improving and developing services. She also noted that there was a national ambition for all Sustainability and Transformation Partnerships (which was also the former title of the Health and Care Partnerships) to become Integrated Care Systems in the future. **Discussion and questions** 1. MCP noted that GPs had found online engagement with patients to be very effective, but noted that this was still in the early days of implementation. 2. DJ asked how patient activation measures (PAMs) had improved quality of care. JB responded that the measures were designed to understand the extent to which a patient was able to manage their own care. There was national evidence which suggested that PAMs had reduced the amount of patients who had received urgent care. 3. In response to a question from DJ on perinatal health, JB stated that it was not unusual for funding to be received in order to commence work on a project. There was, though, still a need to evaluate this and make sure it was delivering the intended outcome, so then an understanding could be developed as what could be done further to take this on. ➢ **JB responded to a question from MCP, and stated she would update him outside of the meeting on the number of patients who declined to do a PAM score.** 4. LW asked what tests had been carried out to make sure that money was received and allocated properly. JB responded that there had been discussions with Chairs and MDs to make sure that governance was strong and that money was being spent wisely. It was important that models which had been previously proposed were still relevant. This work would be carried out between now and March 2019. The next	**JB**

step would be moving from strategic outline cases to outline business cases. 5. CV noted that the papers showed disparity between the CCGs. In explaining to the public why the Joint Committee was being established, having consistency across the eight CCGs was a key justification factor. Therefore, where disparity is present there should also be explanation of why that is. 6. NY asked if there was any combined health and social care voice-operated model for how to navigate the NHS service. JB responded that the health app was being rolled out across NW London, and provided information that would be developed with the social prescribing offers. There was, though, still more listening to do. 7. PB stated that the relationship between the hubs and hospitals was crucial. There was a need to make sure that there were changes in the acute and primary care side. ➢ **The Committee agreed to note the next steps outlined in the report.**	
8. NW London Board Assurance Framework The report was introduced by the NW London Director of Compliance, Ben Westmancott. The purpose of the item was to outline the risks to the NW London CCGs' strategic objectives and assure the Committee on their management, with the Committee being asked to consider the extent to which it was assured of the risks described within the report. **Discussion & questions** 1. AW asked how the Committee could be assured that the risks were being managed effectively. BW stated that each risk had been assigned to a senior person across the CCGs, who was responsible for managing and owning the risks. The paper also outlined which Committee would manage it. Risk leads were worked with closely to make sure that the scores and contentwere accurate and up-to-date. The BAF was also examined by the senior management team. 2. LW noted that with regard to the Outpatient Transformation Programme, there had been a lot of work done at CCG level on managing referrals from GPs. She suggested that greater reference be given to this within the report. LP stated that the outpatients provider has a joint outpatient and CCG programme board, which aimed to treat all referrals the same. Consultant referrals would be examined at January governing body meetings and this consideration would be captured in future versions of the BAF. 3. LW also suggested that there be more of an outcomes focus, particularly in the mental health and workforce elements of the BAF. 4. MCP asked with regard to AOF 3 (Development and delivery of a North West London outpatient transformation programme), whether the acute trusts were ready to run the soft triaging from 2 January 2019. LP responded that all trusts had been charged with being ready and had committed to being ready. This would be reported at the next meeting of the programme board. This item was also taken to the provider programme board on a monthly basis to ensure equality of challenge. ➢ **LP to respond to committee members via e-mail outside of the meeting on the soft triaging system.** 5. AW commented that the Board Assurance Framework was a good quality report and noted the general high quality of the papers for this meeting.	**LP**

➢ **The Committee considered itself assured by the Board Assurance Framework.**	
9. Report from the collaboration development programme board The item was introduced by the Accountable Officer, Mark Easton, with the Committee being asked to note the report. The Accountable Officer also noted that as the new structures resulting from the programme were now largely in place, the work to be implemented now was mostly fine-tuning. The work undertaken in 2019, therefore, would represent the close-down phase of the project. A further challenge to the collaboration would be the 20% reduction in administration costs for CCGs recently announced by NHS England. ➢ **In response to a question from CV, ME responded that Healthwatch membership on the Quality and Performance Committee would be discussed at the next "shadow" meeting of that Committee.** ➢ **The Committee agreed to note the report.**	**DJ**
Joint commissioning	***Action for***
10. NW London CCGs' M7 financial position The Chief Finance Officer, Paul Brown, introduced the item, for the purposes of seeking the Committee's assurance on the reporting of the M7 financial position. He noted that he had been very pleased to see the degree to which NW London finance officers took their financial responsibilities seriously. There were, though, a number of areas of variation that could be improved. **Discussion & questions** 1. Providers needed to be worked with in order to address non-elective care. One assumption was that GP at Hand's cost would be fully recovered. 2. It was conceivable, but unlikely, that the CCGs would be able to meet their overall control total. 3. AW asked if the overspend on out of area acute provider hospitals was similar to overspend in other areas of London. PB responded that this was a national trend, and this would be useful to discuss with other London CFO colleagues. ➢ **The Committee considered itself assured of the figures contained in the report.**	
11. NW London CCGs' financial recovery plan The item was introduced by the Chief Finance Officer, Paul Brown, with the aim of the Joint Committee ratifying the plan as approved by the NW London Finance Committee. PB reiterated that it was likely that the control total would be missed, but it was not impossible to meet it. Harrow CCG had the most significant financial problems, and a turnaround in that case could take two to three years, which would have implications for the NW London CCGs' collaboration. **Discussion & questions** 1. LW noted that the previous meeting of the finance committee which had approved the plan had been constructive and positive. Officers also recognised that there was still a lot of work to be done. PB confirmed in responding to a question that the tasks outlined in slide 40 of the agenda papers were all on task. 2. PY asked how the major cultural changes required by this financial recovery plan	

would be achieved. ME stated that the incentives were likely to be drivers of behaviours, and the system had to be re-designed in such a way to encourage the cultural change. The paper indicated a change in direction, but not one which would be entirely unfamiliar. Finally, his observation was that the CFO group was functional and there were honest and engaging conversations there. 3. MP noted that NW London CCGs had typically been in surplus, but were now in a position of an overall deficit. She stated that unless the system could work together cohesively, there would be a real risk to patient care. 4. In response to a question from AW on trust refunding allocations, PB responded that market forces factors were being adjusted as there was a view that London providers were over-rewarded. London providers were, however, lobbying quite strongly on this point to ensure they were no worse off. ➢ **The Committee agreed to ratify the financial recovery plan, as was agreed for submission to NHS England by the Joint Finance Committee on 15 November 2018.**	
12. Principles and operating model for the 2019/20 contracting round The item was introduced by the Interim Director of Acute Commissioning, Jo Ohlson, with the Committee being asked to support the recommendations of the report and note the next steps. MP and ME both agreed that the paper should include quality more specifically. **The Committee:** ➢ **Supported the proposed governance arrangements for the 2019/20 contracting round.** ➢ **Supported the proposed system approach in line with integrated care systems development and likely national planning guidance.** ➢ **Considered the principles and key objectives adequate.** ➢ **Noted the next steps:** **1. To review the NW London CCGs' financial recovery plan and include relevant actions in the contracting round.** **2. The paper to be discussed at the CFO group and partnership operational group for consideration.** **3. The CFO group to develop detailed proposals for the partnership operational group to consider.** **4. The outputs to be taken to the Joint Committee and Trust Boards for decision.** **5. A detailed project plan to be developed, including key decision points in the local planning timetable, and agreed at the January governing bodies.** **6. To provide a further update to the next and subsequent Joint Committee meetings.**	
13. Any other business 1. NY noted that Communications and Engagement could be included in more detail on future agendas, perhaps as a standing item. 2. MP stated that it would also be useful to discuss narratives at future meetings of the Committee. 3. DJ added that engagement would be useful to discuss in relation to equalities and protected characteristics. Quality and equalities should be included as part of future	

agendas. 4. AW suggested that some future meetings of the Committee could take the form of more informal seminars which would encourage candid discussion and exchange of ideas.	
Total meeting time (including questions): 115 minutes **The meeting was closed at 16:55** • **Date of next meeting:** 7 February – venue TBC.	

Questions from members of the public

The following questions had been submitted in advance by notifying the secretariat and were answered by appropriate officers at the meeting, with attendees invited to ask follow-up questions:

1. **Question from James Grealy, NW London Collaborative estates strategy:**

What is the NW London Collaborative's estate strategy? Do you plan to sell off any NHS land? And do each of the 8 CCGs have their own estates strategies. If so, where can the public access these strategies?

Answer from the Accountable Officer, Mark Easton:

A NWL STP Estates Strategy has been drafted and this re-states the vision for NW London and the Shaping a Healthier Future Strategy (SaHF) and also provides oversight in relation to acute, community, mental health and primary care services. The publication of the document, likely to be in a summary form, is envisaged for early 2019, subject to internal approvals.

Follow-up question from James Grealy:

This is about transparency and engagement. We don't yet know in NW London what has been considered for sale, nor who makes the decision to sell.

Response from the Accountable Officer, Mark Easton:

It is important to distinguish between an estates strategy and a land disposal strategy. CCGs do not own any land, but they do occupy buildings under a lease. When estate arrangements are changed this would generally be accompanied by consideration at a governing body meeting. This happened most recently at Brent CCG on 5 December 2018. Trusts are in a different position, but the NHS does re-evaluate the need for its estates for obvious reasons – as healthcare needs move on, our need for estates moves as well. The governance around this differs – some disposals require approval of the Secretary of State and others are covered under the devolution agreements, for instance. The Health and Care Partnership has a draft estates strategy which embodies the capital and estate elements of our Health and Care Partnership plans. This is in draft form and anticipated for publication in early 2019.

2. **Question from Merril Hammer, Shaping a Healthier Future remodelling:**

It has been reported that remodelling of the effects of reorganisations of acute care services are to be undertaken shortly. It is important that the scope of the remodelling and the parameters include all the necessary factors, including population growth, identified patient need, travel and transport factors, equality issues (to mention a few). What opportunity will there be for local authorities and for the public to be involved at the formative stage in commenting on and making input into draft proposals for the modelling? You will, of course, accept that in the interests of transparency, the modelling exercise should not be carried out behind closed doors.

Answer from the Accountable Officer, Mark Easton:

The remodelling exercise will be initiated when we get the capital for the Strategic Outline Case 1. It is aimed at predicting acute hospital activity for the NW London hospitals involved in the SaHF reconfiguration. From these activity projections, future bed capacity will be calculated. The principle stakeholders will be NW London Acute Hospital Providers and NW London CCGs. The over-arching governance is through the Joint Health and Care Transformation Group (JHCTG), and six of our eight local authorities sit on it. Those local authorities not on this group will nonetheless be invited to comment on our proposals. We are also exploring the option of inviting local authority directors of public health to engage with this work. We have always aimed to do this as transparently as we can.

Follow-up question from Alan Wells OBE FRSA:

Will the public be involved at the formative stage of these plans?

Response from the Accountable Officer

I would first draw a distinction between a technical modelling and planning exercise designed to satisfy an outline business case requirement and a more generalised discussion about service models and capacity. There will be a lot of dialogue with the public about the service models capacity in NW London but we would not consult on a technical document.

Follow-up question from Merril Hammer:

The fact that the two authorities not on the JHCTG are Hammersmith and Fulham and Ealing, is interesting and disturbing as they are the ones who are most affected by the original plans for downgrading A&E services.

Response from the Accountable Officer, Mark Easton:

We will be involving those local authorities in the modelling, they have merely declined to sit on the JHCTG. I have been involved in conversations with Councillor Ben Coleman (Cabinet Member for Health and Adult Social Care, Hammersmith & Fulham). We intend to come up with a draft specification that will involve all the councils in NW London. I will be more than happy to share proposals on modelling and be completely transparent about the underlying assumptions.

Follow-up question from Merril Hammer:

We were told that there were two modelling done before two A&E services were closed and there was a serious knock-on effect on other services in NW London. I have asked and been refused the modelling figures for that earlier. I would like to look at the parameters were used then to see why that error in modelling happened.

Response from Mark Easton:

I am more than happy to share any modelling with the public and be completely transparent.

Post-meeting note:

NHSE commissioned an independent review about a year after the previous closures of Hammersmith Hospital & Central Middlesex Hospital A&E to look at how well it was done and any impacts. Broadly, they found two key things in relation to A&E performance:

- Firstly, there was a bigger than modelled increase in patients at Hillingdon hospitals. However, when this was analysed, these patients came from a geographic area which meant they wouldn't have been going to Hammersmith Hospital or Central Middlesex Hospital. It is simply that there was an increase in attendances from Hillingdon that coincided with the closures.
- Secondly, there was a slight decline in performance across NW London immediately after the closures. The closures were in September so a dip in performance was expected due to winter. However, the comparisons were being made to winter 2013 and performance was a little lower than 2013. The analysis found, however, that performance across London and indeed nationally was lower in 2014 than previous years – it was a bad winter for performance. NW London actually did better on average than many other areas, including the rest of London. The brief decline in performance was therefore clearly not related to the A&E closures.

A more detailed version of the evaluation can be found in the report released to the public in 2015 at:
https://www.harrowccg.nhs.uk/download.cfm?doc=docm93jijm4n4544&ver=9580