ATTACHMENT 1

SOUTH WEST LONDON STRATEGIC COMMISSIONING BOARD

Minutes of meeting held on Monday 12th June 2014, 18:00 – 20:00,
Rooms 6.2 & 6.3, 120 The Broadway

PRESENT:

NAME		JOB TITLE	ORGANISATION
Tony	**Brzezicki (TB)**	**Chair**	**Croydon Clinical Commissioning Group**
Paula	Swann (PS)	Chief Officer	Croydon Clinical Commissioning Group
Tonia	Michaelides (TM)	Chief Operating Officer	Kingston Clinical Commissioning Group
Eleanor	Brown (EB)	Chief Officer	Merton Clinical Commissioning Group
Jacqui	Harvey (JH)	Interim Chief Officer	Richmond Clinical Commissioning Group
Chris	Elliott (CE)	Chief Clinical Officer	Sutton Clinical Commissioning Group
Graham	Mackenzie (GMk)	Chief Officer	Wandsworth Clinical Commissioning Group
Jane	Fryer (JF)	Medical Director South London	NHS England - South London
Penny	Emerit (PE)	Delivery Director (South) NHS England - London	NHS England – South London
Simon	Williams (SW)	Director of Community & Housing	LB Merton
David	Knowles (DK)	Lay Member (Governance)	Kingston Clinical Commissioning Group
Carol	Varlaam (CV)	Lay Member (PPI)	Wandsworth Clinical Commissioning Group
Hardev	Virdee (HV)	Chief Finance Officer	Wandsworth Clinical Commissioning Group
Dan	Burke (DB)	Director	PwC
Rory	Hegarty (RH)	Director of Communications	SWL Collaborative Commissioning
Toby	Hyde (TH)	Assistant Director	SWL Collaborative Commissioning
Charlotte	Joll (CJ)	Programme Director	SWL Collaborative Commissioning
Sue	Loseby (SL)	Director	PwC
Ginny	Morley (GMo)	Assistant Programme Director	SWL Collaborative Commissioning
Marilyn	Plant (MP)	Medical Director	SWL Collaborative Commissioning

Tim	Thomas (TT)	Senior Advisor	2020 Delivery
Sarah	Tunkel (ST)	Director	Ernst & Young
Tony	Young (TY)	Project Manager (minutes)	SWL Collaborative Commissioning

APOLOGIES:

NAME		JOB TITLE	ORGANISATION
Sally	Brearley (SB)	Lay Member (PPI)	Sutton Clinical Commissioning Group
Adi	Cooper (AC)	Strategic Director for Adult Services and Housing	LB Sutton
Adam	Doyle (AD)	Director of Commissioning	Merton Clinical Commissioning Group
Alison	Frater (AF)	Head of Public Health and Offender Health	NHS England - South London
Howard	Freeman (HF)	Chair	Merton Clinical Commissioning Group
Brendan	Hudson (BH)	Chair	Sutton Clinical Commissioning Group
Naz	Jivani (NJav)	Chair	Kingston Clinical Commissioning Group
Nicola	Jones (NJon)	Chair	Wandsworth Clinical Commissioning Group
Graham	Lewis (GL)	Chair	Richmond Clinical Commissioning Group
Gillian	Norton (GN)	Chief Executive	London Borough of Richmond
Caroline	Reid (CR)	Specialised Commissioning	NHS England - South London
David	Smith (DSmi)	Chief Officer	Kingston Clinical Commissioning Group
David	Sturgeon (DSto)	Head of Primary Care (South London)	NHS England - South London
Dagmar	Zeuner (DZ)	Director of Public Health	LB Richmond upon Thames

MINUTES:

	ITEM	ACTION
1.	**Welcome & introductions** TB opened the meeting and welcomed all members.	

2.	**Apologies** Apologies were noted.	
	ITEMS FOR REVIEW	
3.	**Minutes of the meeting held on 19th May 2013** The minutes were reviewed for accuracy and **approved.**	
4.	**Action log** ***Action 1***: PWC item on governance was on the meeting agenda. ***Action 4***: This action was part of the financial case for change item, again on the agenda. HV will be meeting NHS England on Monday 16th June.	
5.	**Matters Arising** No matters arising.	
	ITEMS FOR AGREEMENT	
6.	**South West London 5 Year Strategic Plan** **Finalising the plan:** • ***To agree any changes required in response to issues raised at Governing Body meetings*** CJ gave a short presentation reviewing the Part 1 and 2 papers that went to Governing Bodies (GB) earlier this month. It was reported that there had been feedback and that most GBs had had a query over the projected level of financial challenge in the 5 Year Strategic Plan for both commissioners and providers. CJ reiterated that the ability of closing this financial gap by CIPs alone was going to be a large ask. More work was needed to be on the delivery mechanisms of the plan. Work has been done around the implementation costs, but the work on IT and workforce enablers work stream remains embryonic. A specific query came from Wandsworth CCG with regard to the estates chapter in the plan. Reference to an alternative baseline case scenario was needed as there were questions over the deliverability of proposals around the reductions in length of stay at St George's. The following gaps were identified in the plan; • End of Life Care was not highlighted sufficiently and had potential to deliver considerable quality and patient experience benefits while reducing dependence on secondary care. • There needed to be recognition of the emerging primary care standards, whilst accepting that they had not yet been formally agreed. • The strategy needed to build community resilience through full involvement of the third sector, carers, families and myriad local initiatives to encourage	

	individual behaviour change and maximise self-management. The Board was asked if they wanted anything to be changed in the body of plan. PE asked that for part of the implementation submission it would be helpful to flag what the to-do list was. GMck thanked the SWL Collaborative Commissioning team for helping deliver the plan and said that there was huge amount of appreciation of the work undertaken. **The Board accepted that approach and approved the plan submission.** • ***Restated financial case for change*** DB guided the Board through the financial case for change. He reported that there was a funding gap of £210m for commissioners and £360m for providers at the end of 2018/19 and as a result the steps that needed to be taken were an absolute priority. It was stated that closing this financial gap by just savings alone was unrealistic. GBs had appreciated it was about taking steps to reduce cost pressures, rather just taking costs out. TB made the point that the Board should be considering quality, not cost. PS stated that it was important to clarify that £210m was the aggregate plans of the CCGs and that it was not a funding issue of 11%, but of 7%. SW made the point there had to be a link with quality and money. It could be made clearer how south west London could save money. It is hard for even well-informed people to see how initiatives come together to close the gap. MP queried about the focus of cost pressure being on the system. DB clarified it was cost pressures and reducing cost that need to be seen in parallel. He progressed the discussion by looking at the 67 CDG initiatives and what the financial value and benefits would be to SW London. HV noted that was a lot of work to be done on identifying the costs; CCG plans the first 2 years were robust, although the next 3 years were less clear. In reference to on-going savings (slide 6), HV expected that the trajectory would be steeper than presented. The numbers cannot yet be quantified at this stage, but years 3, 4 & 5 along with their benefits need to be pinned down further. MR asked for considerations to include increasing investment in the local authorities' initiatives to help reduce needs for healthcare. DB supported this and noted that these proposals were a first run through, so there was more work to be done. DK added that radical ideas are good, but that we do need to recognise that there were only finite resources. • ***Progress on developing high level implementation plan including key milestones and critical path and process for sign off*** DB continued with the presentation to the Board, looking at the implementation plan and what needed to be mapped out in detail for the next 5 years; describing the focus for service transformation and enablers with early focus on implementing	'To do list' to be submitted with the implementation plan – **CJ** **[embed slide deck]**

	integrated care models and developing primary care networks in 2014/15, under pinned by new governance and agreed contracting models. This would be a large amount of work over the next 6 months. The features of the implementation plan included; • A whole system transformation programme – all commissioners, all providers • Hugely ambitious • Will require 'industrial' scale delivery • Organised around 5-6 key, interlocking workstreams • Will need to drive and monitor progress at LHE and local level • Focuses on enabling strategies as well as clinical model change • Includes continual measurement of progress towards outcomes • Requires a lot of work between July & September before being finalised • Needs to be supported by a simple narrative HM asked about the savings in relation to local authorities. To get full collaboration, then savings need to be seen there too as there was a real danger of cross shifting costs from one system into another. The benefits have to be tracked and mapped. HV reminded the Board that the assumptions were based on the Better Care Fund. Each CCG knew how that was set up and how it played into local authority plans. There was significant work already happening now, and would happen anyway, without the 5 Year Plan. PS accepted HM's point and that CCGs do need to surface the work going on at local level for local authorities to understand what was going on. GMcK wanted to make it clear that the Board was making a commitment to the approval process, not binding into an agreement on the detail of the implementation plan.	
7.	**Feedback from part 2 discussions at Governing Bodies** Each of the south west London CCGs gave feedback on their GB. ***Croydon CCG (PS):*** There were a number of questions that we were asked to consider and there was a positive discussion. And we were highly supportive of the collaborative approach with other CCGs. But concern was expressed that this would be our last attempt at large system transformation. It was important that we demonstrate leadership across the whole system. The GB was in favour of a Joint Committee and understood exactly what that would mean. We need to work together and trust that system would work and recognise that we would need a plan to go to consultation next summer. Concerns expressed were in regard to the alignment of levels of activity in local plans with the Director of Public Health and local authority. They were worried about the financial position and that the potential solutions could result in significant scrutiny of Croydon's position and therefore impact on its autonomy. ***Kingston CCG (TM):***	

	The GB had a real appetite and support for what was being proposed in Phase 1. Detail was needed around the impact on the local population and that we need to ensure local synergy. We absolutely saw the requirement to have a new approach to governance beyond the current stage. ***Sutton CCG (CE):*** Sutton supports the alignment issues raised by Kingston CCG. There was a strong belief in a collaborative approach, although there was some wariness expressed about how it was currently working. The GB recognised that decision making would have to change, but there was no desire to go straight to a Joint Committee until it was known what authority would be delegated. There was some concern about the pooling of resources. ***Merton CCG (EB):*** There was recognition that we needed high level governance and knew the amount of work that would be needed going forward. ***Richmond CCG (JH):*** Richmond reported that they were very happy to collaborate. But need to have it noted that they have provider boundary issues too and that Richmond Council play into their workstreams and are funding their programmes. We do need new governance, but we need to see what that would involve. They were prepared to be part of a joint consultation and recognise the need to pool resources. They would like to see more alignment with NHS England as a co-commissioner. ***Wandsworth CCG (GMcK):*** It was reported that Wandsworth had a high appetite to keep to this collaborative programme going and it was important to think of the work up leading up to decision and not just the end point. There was willingness to pool resources. PE responded to some CCG GB comments saying that she recognised the issues around co-commissioning and that the finances were an important piece and needed to see how far the local health economy can go. **The SCB Board noted the level of general agreement for the collaborative process but understood the need to have strong governance.**	
8.	**Collaboration and governance: *report back from JCG meeting re progress on agreement of leadership principles, governance arrangements and proposed next steps*** GMck presented the report on the emerging leadership model; recognising that a lot of work still needed to be done. Referencing back to the industrial size of scale of work needed, he summarised the points below; • Recognise that this is a whole system transformational programme, however the accountability is held by the six CCGs. We've started exploring the way we transact our leadership in this new context and an example that emerged is to have one lead Chief Officer, with all six Chief Officers closely aligned and complemented by a transformation director to lead and direct the transformation and programme office. • Strong clinical leadership is essential to the effective delivery of this programme. • For our leadership coalition to work, we will extend beyond health commissioners to include local authorities and providers. • We see NHS England as part of the leadership as a co-commissioner.	

	• Deepening trust and defining the behaviours to drive the leadership is of paramount importance. An SPG OD programme will be required to work on leadership (clinical and managerial), collaboration, governance, and the behaviours that will support successful implementation of the programme. • The leadership model will be used for developing and harnessing the skills of our emerging talent, who will remain involved when the 5 year strategy is realised. • We need to be willing to make big and bold decisions, which may require compromise but yield local and regional gains. • CCG Boards need to meet together regularly to deepen relationships, continue to build alignment, and ultimately to lead this programme. For the emerging principles, the Chairs & Chief Officers (COs) wanted to have deep collaboration but not full integration, as there was no proposal for a merger. At a Joint Committee, we would want to be working to resolve the issues before taking anything to committee. With regard to governance, it was recognised that it was a commissioning collaborative, but we needed to be aware that providers were going through a similar process. We therefore need an organisational development programme. The roles of CDGs could become more accountable for delivery. SW welcomed the support around local authorities. SL continued with the presentation for the emerging governance. It was noted that the COs had not yet seen this model. There was recognition, especially from the Clinical Advisory Group (CAG), that there needed to be a single transformation programme and that the governance needs to lie across the whole programme. SL described the 'joint' effort of the commissioners, with or without a Joint Committee being created and the Clinical Leadership Group (formerly CAG) in the transformation programme looking at the 5 key strategic strands. The Clinical Implementation Group (formerly CDG) would look at the 67 initiatives. The support for this would come from the transformational office rather than a programme office. In discussing the type of collaboration, it was important to note that were partners to become part of the transformation programme, providers would need to be part of the conversation when it comes to agreeing contracting models. The COs **agreed** on this model. PE wanted to see a swap of the roles of the CLG and Transformation Programme Board. SL said that the model was supported by key directors from CCG and Local Authority teams. PS agreed with the role of LA and Commissioners but questioned if local authorities could become members of a Joint Committee. CV noted that there were some very positive aspects to the model, but the timescale for change was breath-taking. There needed to be extensive public information. MR stated it is it worth acknowledging the role of Health & Wellbeing Boards play in adding scrutiny. We need to ensure that there were fewer surprises. The councillors have just been re-elected and need time to set up Joint Scrutiny Committees. The Board acknowledged EB's point with regard to changing the names of groups as it would make the function of the groups change.	
9.	**Draft communications and engagement strategy** RH guided the Board through the Communications and Engagement Strategy which covered the period of June to September and recognised the need for engagement with providers, primary care, LA, patients and public by each CCG. The strategy supports CV's point around informing the public and was about getting messages out using existing networks rather than any 'Big Bang' approach. This would be ramped up as and when the	

	programme has clearer implementation plans. For each CCG there should be a briefing session for local authorities as there are new councillors elected. A south west London Primary Care event would be good to hold at some point in the future and it would be aimed at CCGs and Primary Care staff. RH described the critical need to work with NHS staff and unions as we need to talk about workforce. With regard to new key messages, one area we need to focus on is explaining clinical standards better to the public. Minutes for SCB meetings should be published on the website. CV supported this and reiterated the need for the public to be informed about the process going forward. TB asked CV if they would like to the TORs revised to increase the advisory role of the PPESG, CV reported that they would work with Comms via PPESG to continue to carry out their role and help develop presentation packs that anyone can pick up and use. SW made reference to the engagement with NHS staff and that they were key to transformational change, ensuring that communicating the sequence of change was made clear. It was also important to include LA comms teams in discussions too. TB made the point that 10% of the south west London population work in the NHS and local authority, so this engagement is important. JH reported that she was concerned about the suggested timescales. There was reference in the strategy that we have not agreed the deliverables, but public and patients will want to know more details. After submission on the 20th June we will still not know what the implementation plan is, making it difficult to speak to the public. CV responded by agreeing that we do not have a large scale implementation plan in place, but that we do need to talk about the problems of healthcare delivery in order to set the context for the public. DK noted that when we do have a definitive proposal, then a different approach is need to consultation.	**RH** to add Local Authority Comms into the Comms & Engagement Strategy
10.	**Primary Care co-commissioning** EB presented the paper on the proposal for Primary Care co-commissioning describing the principles and benefits of co-commissioning for south west London. PS reported that they had discussed the proposal at another forum and that we do need to communicate challenges, ambitions and the processes that would now need to be followed to get to a decision point. A pro forma has been sent out and requested questions to go back to GMcK by 15th June. Under risks and mitigations, it was noted that it was important to understand what was meant by 'pooling budgets'. The point was made, however, that at this stage it was only about expressing an interest in co-commissioning and that we could change what was being described. BH said that he was very happy with this approach and it was one of Sutton CCG's pillars for Commissioning Collaborative. He would like the proposal to go through to his plenary.	**[embed slide deck]** CCGs to feedback to McK
11.	**AOB** PPESG: CV asked on behalf of PPESG if there could there be greater representation of members from PPESG here and at SWL Forum, including Healtwatch and the voluntary sector? And was the SCB meeting to be held in public?	

	TB responded that the issue of membership of the SCB had been discussed at length when the governance of the programme was debated. PPESG reps and the programme's Communications and Engagement Director attend SCB meetings and will feed back on behalf of the PPESG. The SCB is already a large meeting and is an internal planning meeting, rather than a decision-making body. GMcK added that the terms of reference for SCB was that it was not making binding decisions and it should not be held in public. All decisions are made at individual CCG level at meetings and these are held in public. The SCB agreed that it should be a priority to ensure that its minutes are published online as soon as possible after they are ratified. EB thanked the Board for their support to Howard Freeman over the last few days.	
ITEMS FOR INFORMATION		
12.	**Date of Next Meeting:** Tuesday 8th July, 14:30- 16:30, Drake House	

ATTACHMENT 2 **SOUTH WEST LONDON STRATEGIC COMMISSIONING BOARD**

ACTION LIST of meeting held on Monday 19th May 2014

Point	Action	Owner	Progress
1	'To do list' to be submitted with the implementation plan on 20th June	CJ	Completed
2	Comms & Engagement Strategy to amended to include; • Working with Comms departments in local authorities	RH	Continuing
3	Feedback on the pro forma on Primary Care Co-Commissioning to GMcK.	CCGs	Completed