SOUTH WEST LONDON
COMMITTEE FOR COLLABORATIVE DECISION MAKING
27 March 2018, 17:30 – 19:30
Rooms 6.2/6.3 120 the Broadway, SW19 1RH

MINUTES

Members in attendance

Name	Designation	Organisation
Carol Varlaam	**Convener**	Wandsworth CCG
Roger Eastwood	Lay Member CCG Committee Chair	Croydon CCG
Elaine Clancy	Clinical Member	Croydon CCG
Andrew Eyres	Managerial Member	Croydon CCG
Dr. Agnelo Fernandes	Non-Voting Clinical Member	Croydon CCG
Clare Gummett	Lay Member CCG Committee Chair	Merton CCG
Julie Hall	Clinical Member	Merton CCG
Sarah Blow	Managerial Member	Merton CCG
Susan Gibbin	Lay Member CCG Committee Chair	Sutton CCG
Dr. Chris Elliott	Managerial Member	Sutton CCG
Dr. Les Ross	Clinical Member	Sutton CCG
David Knowles	Lay Member CCG Committee Chair	Kingston CCG
James Murray	Managerial Member	Kingston CCG
Dr. Naz Jivani	Non-Voting Clinical Member	Kingston CCG
Susan Smith	Lay Member CCG Committee Chair	Richmond CCG
Fergus Keegan	Clinical Member	Richmond CCG
Stephen Hickey	Lay Member CCG Committee Chair	Wandsworth CCG
Sam Page	Clinical Member	Wandsworth CCG
James Blythe	Managerial Member	Wandsworth CCG
Dr. Nicola Jones	Non-Voting Clinical Member	Wandsworth CCG

Attendees

Name	Designation	Organisation
Adrian Attard	Director	Healthwatch Sutton
Jamie Gillespie	Vice Chair	Healthwatch Wandsworth
Josephine Baxter	Public Representative	
Zoli Zambo	Project Manager	SWL STP PMO
Louise Fleming	Director of Quality and Governance	SWL Alliance
Jonathan Bates	Director of Commissioning Operations	SWL Alliance
Lucie Waters	Managing Director	Sutton CCG
Paul Linehan	Interim Head of Governance	SWL CCG Alliance
Emma Haran	Governance Support	SWL CCG Alliance

Apologies

Name	Designation	Organisation	Deputy attending
None received.			

Item	Title	Action
1.	**Welcome, Introduction and Apologies – Carol Varlaam**	
1.1.	The convenor welcomed all to the meeting. No apologies were received for this meeting. The meeting was quorate. The convenor explained that the meeting was being filmed for uploading onto CCG websites. The convenor informed the Committee that, following the Committee's decision, questions will be invited on today's agenda. Priority is usually given to written questions received in advance of the meeting; however, no written questions were received for this meeting. Members of the public are usually invited to ask questions on the agenda; however, no members of the public were in attendance for this meeting.	
2.	**Declarations of Interest – Carol Varlaam**	
2.1.	All members and attendees may have interests relating to their roles. These interests are declared on the register of interests. While these general interests do not need to be individually declared at meetings, interests over and above these, where they are relevant to the topic under discussion, should be declared. No other declarations of interest were received from the Committee.	
3.	**Funding to Deliver Extended Access and Primary Care at Scale in 18/19 – Lucie Waters**	
3.1.	The Funding to Deliver Extended Access and Primary Care at Scale in 18/19 paper was presented by Lucie Waters. The main points from the discussion were as below: • There will be £8m of funding available for SWL which will be going to the STP rather than directly to CCGs. SWL have flexibility in using the money as a system, as long as assurance is regularly given on the system's compliance with the specification • This funding is to be used to deliver the Extended Access specification for 18/19, and make tangible progress towards delivering Primary Care at Scale • SWL are delivering the GP Forward View (GPFV) Primary Care extended access requirements of 8am – 8pm • The Healthy London Partnership have done some good work to explain what is meant by delivering Primary Care at Scale; this includes a focus on quality, patient outcomes and improvements, shared corporate functions and effective governance and stewardship • SWL have a Transforming Primary Care Delivery Group (TPCDG), which meets monthly, with membership from across SWL: a CCG Chair as clinical lead; the SWL Primary Care Transformation Senior Responsible Officer (SRO); CCG Primary Care leads and the SWL Transformation team • The TPCDG are working through the granularity of the requirements of delivering Primary Care at Scale and what it means to SWL; as well as how the system will start to make progress against the maturity framework • This is a build on, not a substitution of, funding – regulators will want regular assurance it is being used as per the framework.	

3.2.	Questions and comments **The Committee from Wandsworth asked if this is a one-off piece of work or an ongoing commitment. They added that they felt very comfortable with the proposals and recommendations in their CCG discussions; and asked for confirmation that, as well as the monitoring and assurance taking place in the SWL TPCDG group, Governing Bodies will also be able to review and discuss the monitoring and assurance.** LW responded that this will be a positive opportunity to transform Primary Care in SWL and SWL want to use this opportunity to make real inroads in Transforming Primary Care over the next 12 months. It is recognised that it is a big ask and significant change for Primary Care. The SWL Primary Care team have assurance from the London team that this will be recurrent funding and it is up to CCGs to decide how it is used. It can be used for non-recurrent spend to do with the delivery; e.g. interim Project Managers. There was an expectation for a modest increase next year set out in the original GPFV framework. The TPCDG will discuss how plans should develop over several years. The TPCDG will expect local ownership and for every CCG to monitor this work through their Primary Care Commissioning Committees and Governing Bodies. **Healthwatch stated that they felt that the biggest barrier to extended access is robust information sharing, and asked how much extra money will be going into I.T.** In terms of extended access; each service organises a process to ensure appropriate data sharing is in place. For Primary Care at Scale going forward, the principles of operating clinical and contracting models at scale may have Information Governance / data sharing challenges depending on what models CCGs choose. One of the workstreams in Transforming Primary Care is the development of digital platforms to access primary care. This work has additional funding associated with it. It is recognised that it is important that the digital platforms are integrated with the Primary Care at Scale plans. **Healthwatch asked if SWL are confident there is the man power to deliver the Transforming Primary Care workstream; e.g. are there enough GPs.** There is a separate workforce workstream in the Transforming Primary Care programme that looks at recruitment and retention, as well as the retirement of GPs and the Primary Care workforce as a whole. The principle of Primary Care at Scale is that the clinical and commissioning models are flexible, thus you get improvements in GP work-life balance and staff satisfaction. There is some evidence that where Primary Care at Scale operates already, GPs opt to remain in practice longer. This work will help to make sure that SWL are building a system that attracts and keeps GPs of the future and ensures a resilient General Practice, as well as attracting and keeping other Primary Care staff (e.g. nurses, Heath Care Assistants, pharmacists).	
3.3.	The Committee in Common were asked to consider approving the following approach for apportioning Delivering Primary Care at Scale funding across the SWL CCGs: • CCGs will all receive £5.41 per head funding in 18/19 • CCGs will follow local governance arrangements to oversee the development of local plans • The SWL STP will have a QA process aligned to the London process; money will be released upon evidence of investment and assurance that plans meet the London specifications and will deliver the required benefits • Spend and delivery will be monitored on an ongoing basis by the Alliance SMT. The STP will, in turn, be monitored at London level; 50% funding will be released upon demonstration of robust plans, and 50% will be released at Month 6, upon assurance that delivery is to plan	

	• The SWL TPCDG should review progress and options for accelerating primary care transformation over the next six months to get maximum advantage from 19/20 funding. The convenor asked the Committee members if they approve the recommended approach for apportioning the funding. Each Committee was asked to vote in turn: Croydon – support Kingston – support Merton – support Richmond – support Sutton – support Wandsworth – support. The Committee **unanimously approved** the recommended approach for apportioning the Delivering Primary Care at Scale funding across SWL CCGs.	
4.	**Developing a South West London (SWL) Individual Funding Requests (IFR) Triage Process and Panel – Jonathan Bates and Zoli Zambo**	
4.1.	Jonathan Bates and Zoli Zambo presented a paper on developing a SWL IFR Triage Process and Panel. The main points from the discussion were as below: • A SWL IFR triage process and panel would be streamlining what is currently done across SWL and would be a system-wide QIPP saving; it will also improve quality and consistency for patients • The proposal is to move to one triage panel process across SWL – there are currently three panels – and to move to one formal IFR panel; the frequency will be based on the current workload (there are currently weekly triage panels and fortnightly formal panels) • Having one panel with the same set of clinicians will raise expertise and consistency in decision making • One panel will reduce costs – 24 meetings a month will be reduced to six meetings a month • There will be greater service resilience by drawing on skills and personnel across SWL • Fertility cases will not be included • In November 2017 the SWL Committee in Common agreed a SWL-wide ECI policy; one of the consequences of implementing this policy is that a smaller group of patients will go through the SWL IFR panel process as they will instead go through prior approval • Next steps are set out as in appendix one of the paper. There will be workshops with current panel members to finalise the process. The plan is to have implementation by July 2018. This includes appointing panel members, governance and documentation.	
4.2.	<u>Questions and comments</u> **The Committee from Sutton asked if the proposed IFR panel will have an independent chair structure as it is an independent funding review panel; and whether there will be a rotation of clinical leads or someone from outside of the CCGs chairing.** It was clarified that the SWL IFR panel is not an independent panel. The panel membership proposed is set out in the paper. The team have checked with the current IFR panels and they feel that the membership proposed is right and they support it. Going forward, should the proposal be agreed today, it will be considered how other CCGs run their panels. For example, NWL and Kent rotate the chairs of their panel and NEL CSU provides the admin for the panel.	

	The Committee from Sutton asked if there had been any communication with member practice GPs about these proposals; there has not been any specific communications to the GP population or discussion through Medicines Management Committees. Yes – Jonathan Bates wrote out to all members of IFR panels, including GPs, asking for their views. These views have been collated and are in the paper with responses. The GPs will also be invited to the workshops with IFR panels; this is a second opportunity for panel members to be involved in the design of the process. For the wider GP population, this will be part of the mobilisation and communications plan if the paper is agreed here today. The team will adopt a similar approach to the ECI paper to ensure that the general GP membership is aware of what is proposed. Dr. Nicola Jones added that the new process has been discussed at Governing Body level. What tends to happen with the wider GP membership is that they do not get involved in the panel, as they are not the referring clinician, this is usually the hospital consultants / secondary care clinicians; but GPs will get feedback on decisions from the panels. As they do not get involved in the IFR process this should have no effect on the SWL GP population and there should be no changes to how the service is accessed by the patient. She added that GPs have complained about the current IFR process for many years and it has been bought by GP members to Governing Body meetings. She feels therefore that the SWL GP membership would support this new process. If a decision is made to implement the new process there needs to be communications to GPs and their feedback sought on the new system to ensure it is doing what they need it to do. **The Committee from Sutton asked what the role of the lay member on the IFR panel would be; is there a view as to who would be a preferred lay member and could they be the chair?** Zoli Zambo clarified that the lay member on the panel does not have to be a governing body lay member. He was not sure what input the lay member would provide as he is not a member of the panel; he said he presumed they would represent the patient view. **The Committee from Kingston asked about the implementation of the new IFR process and panel being monitored and managed by the Directors of Commissioning (DOCs) group; they asked would that group monitor the impact after the change? Can SWL evidence things such as improved timeliness and consistency of decision making? Can this be included in the group's remit?** It was confirmed that there is an agreement and plan to evaluate implementation at three and six months, including the above criteria and any enhancements SWL want to add e.g. CCG Governing Body reports. DOCs have said they will find this helpful. **The Committee from Wandsworth are hugely supportive of the new process but had two comments: in the pool of members, it is important to have the balance of a big enough group of people versus getting the right experts and a consistent approach – therefore training and policy must be tight; also there are concerns around the transition period. Historically it has been quite difficult for patients to go through this system; and the Committee would want to ensure patients are seen quickly.** The team completely agree; that is why there will be a workshop with all of the current panel members before anything new is implemented. In respect of the transition period, SWL have senior leadership and overview and senior resource involved in this; the STP PMO will be hiring a permanent manager to oversee the panels and process. The DOCs are a senior group monitoring the transition to manage it safely. There is also the option to default to the current process if needed but that is not the plan. Around 100 patients a year in SWL go through the IFR panel process, so the system should be able to manage these patients well and safely through the process in the paper.	

	The Committee from Merton added that the panel lay members provide a unique role and are selected from members of the public; they will have developed some unique skills and she is concerned that these skills could be lost. She asked how lay members will be integrated into one panel; e.g. rotations. There is no intention to lose the lay members' unique skills; this is why SWL are holding the workshops, to see how to draw on and retain that expertise, at the same time as making the process as efficient as possible. There would be a process after the workshops to agree the final set of arrangements to ensure the panel is drawing on those skills. However, moving from 24 to six meetings a month may mean that it is not possible to include all current members. It will make the panels more resilient as there will be a pool of lay members to choose from and will mean peer support is available. **Healthwatch asked if there is a central budget for IFR cases or would each CCG continue to meet the cost of any treatment agreed by the panel.** Clinician funding comes from individual CCGs; the administration element is provided by NELCSU and funding for this is pooled across SWL. Treatment payment remains with the CCG. CCGs may want to consider a pooled budget and risk share in the future; however, at this point that is not the proposal.	
4.3.	The convenor asked the Committee members if they approve the development and implementation of a SWL IFR Triage Process and Panel. Each Committee was asked to vote in turn: Croydon – support Kingston – support Merton – support Richmond – support Sutton – support Wandsworth – support. The Committee **unanimously approved** the development and implementation of a SWL IFR Triage Process and Panel.	
5.	**Public Questions**	
5.1.	Usually at this point in the meeting, any members of the public present are invited to ask questions of the Committee relating to the business being conducted, with priority given to written questions that were received in advance of the meeting. However, at this meeting, there were no members of the public present and no questions were received in advance of the meeting.	
6.	**Any Other Business**	
6.1.	No other business was raised at this meeting.	
7.	**Close of meeting**	
7.1.	The convenor thanked the members of the Committee for their attendance. The meeting closed at 18:16.	

Minutes agreed by: Carol Varlaam
Role: Convenor
Date: 12/04/18