NHS

Southwark Clinical Commissioning Group

The best possible outcomes for Southwark people

Southwark CCG

Report to HASC Overview & Scrutiny Committee

18 September 2012

4 September 2012

The report addresses the request of the Chair of the Southwark HACS Overview & Scrutiny Committee for updates on the following areas of CCG business:

1. Copy of the CCG Draft Constitution
2. Information on the recruitment of CCG Governing Body Members
3. Information about how GPs respond to patients with mental health needs out of hours
4. A report of the development of the CCG's QIPP programme for 2013/14

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1. CCG Constitution

1.1. The CCG Constitution has been developed in collaboration with member practices, discussions and input from the London-wide and local LMC representatives and has been approved at the Southwark Clinical Commissioning Committee in August 2012.

1.2. The draft Constitution is the result of work over the last five months, during which practices provided over 50 pages of comments and suggestions. The CCG has run a Southwark-wide forum in July which over 100 GPs and practice managers attended to discuss and refine the Constitution document.

1.3. It is attached as Appendix 1

2. Southwark Clinical Commissioning Committee / CCG Governing Body Members

2.1. Over the last 18 months the CCG has worked with its members to define the composition of the Governing Body and the senior management team.

2.2. The CCG has ensured that clinical leadership is drawn from across all borough localities, represents a mix of partners and sessional clinicians and includes a local general practice nurse.

2.3. The Governing Body will be chaired by a clinician and its membership includes a registered nurse and a secondary care clinician, recruited in line with national guidance. All Governing Body members have a clear role outline, job description and objectives aligned to national guidance and local priorities.

2.4. Our Governing Body brings together a cohesive team of clinicians, senior managers (including the Chief Officer and Chief Financial Officer) and Lay Members as outlined below. In addition the CCG has placed importance on the representation of the Local Authority, Southwark LINK (*Healthwatch* in future) and Public Health on the Governing Body.

2.5. Details of members of the Governing Body and the recruitment process they completed ahead of their appointment are included in the section below. The roles and portfolios held by CCG clinical members are summarised as table 1.

Clinical Leadership

2.6. Commissioning in Southwark has drawn upon the leadership of local clinicians for many years adopting a model of involvement with clinical representatives for a number of Southwark localities. This representative model has been retained by the CCG and in April 2012 the management team engaged practices in the

development of a process for appointing a clinical leadership team to become members of the CCG's Governing Body post-authorisation (and throughout the remainder of the transition).

2.7. As a result of our engagement the CCG commissioned the Electoral Reform Society to independently administer a selection/election process in the months of May and June 2012 for the eight GP members and the local Practice Nurse member of the Governing Body (this process is outlined in the Constitution).

2.8. The selection/election process has resulted in the appointment of eight GP members (drawn from across the localities and containing a mix of partners and sessional GPs) and a local Practice Nurse member. Each clinical member of the Governing Body holds and provides leadership for a clinical portfolio (see table 1, below).

2.9. As part of the CCG's selection / election process the appointed clinical Governing Body members elected a Chair, Dr. Amr Zeineldine.

Table 1: Southwark CCG Clinical Leadership Team

Clinical Lead	Tenure	Clinical Portfolio	Corporate Portfolio
Dr Zeineldine	*2 years*	Chair - Leadership	Governance
Dr Bradford	*3 years*	Staying Healthy	Information Governance
Dr Holden*	*2 years*	Unplanned Care	Health & Wellbeing
Dr Heaversedge	*3 years*	Engagement & Quality	Health & Wellbeing / Public Health
Dr Durston**	*2 years*	Planned Care	Information Technology
Dr Fradd**	*2 years*	Finance	Safeguarding Adults
Dr Bhatia***	*3 years*	Mental Health	Integrated Care
Dr Howell*	*3 years*	Medicines Management	Safeguarding Children
Linda Drake (Practice Nurse)		Community Services	Nursing

* Dr Holden and Dr Howell will share a joint role for the commissioning of Guys and St Thomas' Hospital NHSFT
** Dr Durston and Dr Fradd will share a joint role for the commissioning of Kings College Hospital NHSFT
*** Dr Bhatia will undertake the role for the commissioning of South London & The Maudsley NHSFT

2.10. The recruitment process for the registered nurse and secondary care clinician positions on the Governing Body commenced, via national advert, in July 2012 and the process will be completed by October 2012.

Lay Membership

2.11. The CCG has undertaken a recruitment process in line with national guidance to appoint Lay Members to the Governing Body of the CCG. In addition to the two roles prescribed for governing bodies, the CCG took the decision to appoint a third Lay Member with a lead role for quality and standards in commissioned services.

2.12. Our recruitment process was undertaken against a national advertisement and clearly defined role outline and job description and was delivered in two parts. The first was undertaken independently of the CCG to shortlist and interview potential candidates to determine their competencies and skills for the roles. The second was conducted by the CCG leadership team and involved a further local interview.

2.13. Lay members will play a pivotal role in the Governing Body and the CCG more widely undertaking the following roles and sitting on each of the CCGs key committees:

- Lay member with a lead role in overseeing key elements of governance: Dr Richard Gibbs, who will also be the Vice-Chair of the Governing Body
- Lay member with a lead role in championing quality: Robert Park, who will also Chair the Integrated Governance and Performance Committee
- Lay member with a lead role in championing patient and public involvement: Diane French, who will be a member of the Engagement and Patient Experience Committee.

All Lay Members will engage in the Commissioning Strategy Committee of the CCG.

Senior Management Team

2.14. The CCG has also recruited a senior management team, including the recruitment of the Accountable Officer (May 2012) and the Chief Financial Officer (July 2012) following a local and the national processes for recruitment.

2.15. A CCG management leadership team has been in place throughout the transition and following the appointment of the Accountable Officer (Chief Officer Designate) the CCG has begun the process of appointment to the CCG directly employed team including a Director of Service Redesign and a Director of Client Group Commissioning. The CCG will also share a clinical director post with NHS Lewisham CCG in future.

3. Information on how GPs respond to patients at weekends and evenings, who are experiencing mental distress and are in need of support

3.1. Southwark Patients that are experiencing mental distress during the evenings or weekends are able to contact their GP out of hour service. At present this is provided by SELDOC (South East London Doctors). GPs will undertake a clinical assessment to establish how to support the patient presenting. Depending on the nature of the crisis the GP may either conduct a telephone or surgery consultation or a home visit.

3.2. Once this assessment has taken place the GP will decide with the patient how best to support them. If the person is already a patient of South London and Maudsly Trust, this may mean supporting the person to access specialist support or treatment from those services out of hours or by re- referral. In some circumstances – depending on the nature of the crisis – the GP may refer the patient to A&E. If the patient consulting the GP is not receiving any medical treatment or social support the GP will assess the patient and decide on the most appropriate support. This may include:

- A direct referral to A&E where specialist Mental Health liaison teams are place
- A next day consultation and potential referral to a SLaM service
- Treatment from the GP on call with a follow up consultation from their own GP practice.

4. CCG QIPP in 2013/14

4.1. The level of financial challenge facing the NHS over the next few years is unprecedented, especially when compared to the significant levels of financial growth experienced over the last decade. The challenge is therefore to secure significant efficiency and productivity savings over the course of the next three years to provide the financial resource to support delivery of our strategic goals and to make improvement in each of the CCG's seven priority areas.

QIPP Forward Planning

4.2. To close the forecast funding gap over the next three years, the CCG has developed a QIPP programme, which it is currently implementing in 2012/13. This plan has been shared with the Overview & Scrutiny Committee as a part of previous CCG reports.

4.3. The CCG begins its annual planning round for the year ahead in October. It is important for members to note that the **CCG will develop a final QIPP Plan for the year 2013/14 from October2012**, with further detailed modelling, risk-mapping and equality analysis completed between this month and March 2013.

4.4. In advance of the 13/14 planning round, the CCG has identified the size of the financial challenge based on a series of assumptions about rates of growth in our allocation, demographic change, growth in use of healthcare and inflation. Table 2 sets out the size of the QIPP challenge in future years based on these assumptions. Members will note the size of the QIPP challenge is larger in 2012/13 than it is projected to be in the following two years.

4.5. Our modelling shows a cumulative projected deficit in 2014/15 of £16.230m, so in order to achieve the statutory 1% surplus in 2014/15, QIPP savings totalling £22.087m will need to be delivered over the three year period, £11.04m of these are targeted in the current year.

Table 2: The Three Year Financial Challenge 2012/13 – 14/15 (draft model, August 2012)

	£'000
Forecast Surplus/ (Deficit) 2011/12	**5,857**
QIPP savings requirement 2012/13	(11,043)
QIPP savings requirement 2013/14	(5,865)
QIPP savings requirement 2014/15	(5,179)
Total QIPP savings requirement	**(22,087)**
"No Change" Forecast Surplus/ (Deficit) 2014/15	**(16,230)**

4.6. In advance of the 13/14 planning round beginning CCG officers have worked with clinicians to scope the QIPP opportunity available over the planning period and to establish a simple model to determine how the QIPP challenge can be addressed.

4.7. Part of the scoping exercise has been to review the likely financial impact of planned programmes of service redesign (e.g. programme for admissions avoidance or Integrated Care Programme) and also to assess the potential opportunity for contractually-secured efficiency programmes with providers. Details of these programmes are included in the CCG's *Integrated Plan*.

4.8. Table 3 below is the high-level summary of potential QIPP initiatives for the period to 14/15. This model has been included in the CCG's financial and strategic commissioning plans (*CCG Integrated Plan*).

4.9. Further detail on QIPP initiatives planned for 13/14 and 14/15 included as table 4.

Table 3: Draft QIPP Savings Opportunity by Expenditure Area 2012/13 – 2014/15

Planned QIPP Savings After Risk Rating	2012/13	2013/14	2014/15	Total 2012/13 - 2014/15
Acute and Specialist Budgets	5,429	4,136	3,788	13,353
Corporate Budgets	1,503	400		1,903
Health Client Groups	899	1,000	1,000	2,899
Prescribing	600	329	390	1,319
Primary Care	2,613			2,613
Grand Total	**11,043**	**5,865**	**5,178**	**22,087**

4.10. The majority of the CCG's annual QIPP programme are secured as efficiency savings in provider contracts, with the basis of this comparative benchmarking indicators that situate local provider trusts with others in London. These QIPP targets are agreed with local trusts as a mechanism to incentivise them to work towards delivering optimal local processes comparable to the most efficient trusts in London.

4.11. The CCG's commissioning intentions have been developed in partnership with member practices and local patients and partner organisations. These are included in the CCG *Integrated Plan*. The commissioning intentions will be agreed by the Southwark Clinical Commissioning Committee and developed into comprehensive work programmes (with risk registers, detailed investment and savings plans and equality impact analyses) before January 2013. Initiatives included in the draft CCG commissioning intentions section of the Integrated Plan will make up both the contractually-secured and pathway redesign initiatives that make up the QIPP programme for the year ahead.

Table 4: Southwark CCG QIPP Opportunity 12/13-14/15

QIPP Initiative	Area of spend	Type of QIPP	QIPP SAVINGS OPPORTUNITY 2012/13 Plan	2013/14 Opportunity	2014/15 Opportunity
			£'000	£'000	£'000
New GP-initiated Outpatient Attendances	Acute	Pathway Improvement	1,193		
New GP-initiated Outpatient - Practice performance improvement	Acute	Pathway Improvement	150		
Reduce A&E Attendance and UCC front end	Acute	Pathway Improvement	355	425	78
Emergency Admissions / Reablement Programme	Acute	Pathway Improvement	665	399	399
PoLCE	Acute	Contractual Efficiency	113		
Reduction in Outpatient Follow Ups	Acute	Contractual Efficiency	1,552	1,035	1,034
Consultant to Consultant referrals	Acute	Contractual Efficiency	200	133	133
Emergency Admissions (A&E conversion rates)	Acute	Contractual Efficiency	636	532	532
Excess bed Days per spell	Acute	Contractual Efficiency	423	282	282
Acute Prescribing and Medicines Management	Acute	Contractual Efficiency	293	293	293
Other Productivity & Efficiency Measures	Acute	Contractual Efficiency	250	250	250
Primary Care Productivity Programme/ Procurement	Primary Care	Contractual Efficiency	50		
Primary Care Performance Management	Primary Care	Contractual Efficiency	38		
Primary Care Prescribing	Primary Care	Contractual Efficiency	600	329	390
PMS review	Primary Care	Contractual Efficiency	1,250		
SLaM Provider Efficiencies	Client Groups	Pathway Improvement	1,561	1,000	1,000
Estates Optimisation Programme	Corporate Budgets	Contractual Efficiency	234		
Corporate Budget reviews and efficiency project	Corporate Budgets	Contractual Efficiency	250	400	
GP Outpatient Shift Investment	Client Groups	Investment Fund	(956)		
Urgent Care Investment	Acute	Investment Fund	(191)		
Admission Avoidance Investment	Acute	Investment Fund	(412)		
APMS Review	Primary Care	Contractual Efficiency	200		
End of Life/Patient Participation Group Incentive Scheme	Client Groups	Contractual Efficiency	94		
PMS Review - Best Case Scenario	Primary Care	Contractual Efficiency	1,075		
UCC Front End of A&E - Enhanced Savings	Acute	Pathway Improvement	200		
Estates Optimisation - St Olaves	Corporate Budgets	Contractual Efficiency	188		
Running Cost Efficiencies Target	Corporate Budgets	Contractual Efficiency	832		
Community Services Productivity Target	Client Groups	Contractual Efficiency	200		
Integrated Care	Acute	Pathway Improvement		788	788
Total			**11,043**	**5,866**	**5,179**