THE SUTTON CONSORTIUM

MANAGEMENT BOARD MEETING

Wednesday 6th April 2011, 1:00pm-3:00pm

Good Shepherd Centre
Queen Mary's Avenue, Carshalton Beeches, Surrey SM5 4NP

Present:
Dr Mansoor Ahmed  
GP, Wallington Family Practice
Dr Mohamed Amjad  
GP, Manor Road Practice
Jonathan Bates  
Chief Executive, The Sutton Consortium
Dr Muneeb Choudhry  
GP, Wandle Valley Health Centre
Dr Jonathan Cockbain  
GP, Chesser Practice and Joint-Chair, The Sutton Consortium
Dr Adi Cooper  
Director of Social Services, London Borough of Sutton
Dr Simon Elliott  
GP, Dr Elliott, Grice & Partners, Old Court House Surgery
Dr Rohit Goel  
GP, Carshalton Fields Surgery
Marion Gower  
Practice Manager, Green Wrythe Surgery
Dr Tapan Halder  
GP, Wallington Medical Centre
Dr Amer Hafeez  
GP, Sutton Medical Centre
Dr Brendan Hudson  
GP, Grove Road Practice & Joint-Chair, The Sutton Consortium (Chair)
Dr Heather Lings  
GP, Shotfield Medical Practice
Gillian McCarry  
PM, Bishopsford Road Medical Centre
Dr Ashraful Mirza  
GP, Faccini House Practice
Dr Dino Pardhanani  
GP, Mulgrave Road Practice
Dr Idress Said  
GP, Green Wrythe Surgery
Karol Selvey  
Nurse Practitioner, Old Court House Practice
Dr Ravi Seyan  
GP, Robin Hood Lane (Dr Seyan)
Dr Kalangalingam Sugumar  
GP, Maldon Road Surgery
Dr Raza Toosy  
GP, Park Road Surgery

Apologies:
Dr Chandrika Carroll  
GP, Dr Madina’s Practice
Dr Usha Kargupta  
GP, Maldon Road Practice (represented by Dr K Sugumar)
Dr Rashid Moola  
GP, Dr Moola’s Practice
Dr Shilen Pattani  
GP, Beddington Medical Centre
Dr Chandra Perera  
GP, Bishopsford Road Medical Centre (represented by Gillian McCarr)
Dr Marion Rodin  
GP, Robin Hood Lane (Seyan) Practice (represented by Dr Seyan)

Observers:
Dr David Coldrey  
GP, Old Court House Surgery
Dr Alastair Eakins  
GP Registrar, Robin Hood Lane (Dr Seyan)
Sian Hopkinson  
Acting Senior Performance & Information Analyst, The Sutton Consortium
Jason Nash  
Service Implementation Manager, The Sutton Consortium
Dr Tahir Toosy  
GP, Park Road Surgery
Jillian Slade-Thornett  
Acting PA, The Sutton Consortium (minutes)
1 Welcome and Apologies

Dr Brendan Hudson welcomed those joining the meeting as observers, namely – Dr D Coldrey, Dr T Toosy and Dr A Eakins and Jason Nash.

2 Minutes of the Previous Meeting – 2nd March 2011

The minutes of the previous meeting were agreed as a correct record.

3 Matters Arising from the Minutes of the Previous Meeting

Pathfinder Foundation Trust Workshop

It was noted that, due to the low numbers able to attend, the workshop had been cancelled. However, it is hoped that a similar event could be arranged on a day more convenient to the majority in the future.

Conflict of Interest Register

Due to annual leave, completed forms are still being collated. A complete Register of Interests will be available at the May Management Board.

Following discussion, a general consensus for dealing with conflicts of interests, as they may arise depending on the topic in question, was that a member will need to step outside the room to allow a decision to be made. This decision-making would be at the Chair’s discretion.

Furthermore, at a point in time in the future the Conflicts of Interest registers for GP Consortia may be placed in the public domain and this would be complied with by The Sutton Consortium. Until this time the register would remain internal although any request to view the register should be taken through the Joint-Chairs.

It was also proposed that members should continue to declare any conflicts of interests pertaining to the agenda of a meeting and these would be minuted accordingly.

Action: All Board members to complete Conflict of Interest Register by the end of April.

Delegation

- Prescribing

Jonathan Bates reported that The Sutton Consortium would take responsibility for prescribing from 1st April 2011 with Dr Simon Elliott as Prescribing Lead and supported by two aligned prescribing leads from NHS Sutton and Merton.

- Mental Health

NHS Sutton and Merton have only been able to offer 1.5 equivalent aligned staff to support the mental health work in progress which is
insufficient to cover the full workstream and the same applies to the Wallington Local Care Centre workstream.

The difficulties with the aligned staff allocation have been highlighted at the PEC meeting and Jonathan Bates said he would continue to press South West London Primary Care Trust (SWL PCT) for an adequate level of resource and if that was not feasible then this would be taken up with NHS London. The need for sufficient aligned staff would be supported by the London Borough of Sutton.

Community Services

The Royal Marsden Hospital NHS Trust has taken over Community Services from 1st April and neither the clustering of nurses nor the line management is expected to change immediately although Karol Selvey said these areas are under review to ensure improved outcomes in the future.

4 Matters Arising

Conflict of Interest Register

This discussion was taken up under the Matters Arising from Previous Meeting.

For Decision

5 Organisational Structure

Cluster Development

A workshop facilitated by Ann Hepworth, Healthskills, had taken place to discuss clustering arrangements and the process for practices. Following dialogue between practices a configuration had been proposed for three clusters and a map was shared showing the proposals. Dr Hudson opened the discussion to members to share their views.

Key messages from the discussion:

- The Wallington cluster would be quite a large group and it was suggested that maybe there should be two cluster leads who would sit on the Management Board.

- It is important to encourage GP engagement from the wider group and to reach out to clinicians who may be keen to be involved with the development of clinical commissioning.

- The outcome from the workshop was that practices would go with a ‘like-minded’ majority.

- It is vital to continue to build on the good working relationships already in place between practices and to be seen to be proactively engaging in all aspects and levels of clustering.
A query was raised as to whether practices can move to another cluster and Dr Hudson responded that as long as there were no objections and as a 'like-minded' majority had been the consensus for decision-making for clustering arrangements this would be possible. There may also be job shares for cluster leads. The biggest challenge is to make improvements in the NHS and manage within available financial resources.

### Cluster Lead Job Description

A draft Cluster Lead job description has been drawn up to facilitate the process for practices to choose a cluster lead. This item was presented to the Management Board for approval.

The key messages from discussion were:

- Jonathan Bates had attended a Practice Manager Forum yesterday where concerns had been expressed re the tenure for the role. The tenure was proposed as one year.

- Marion Gower said that Practice Managers were also keen to ensure that there would be a selection process which would show that a candidate met the criteria for the role.

- It was suggested that the Cluster Lead role could be held on a rotating basis.

- This is work in progress particularly in view of the leads identified as part of the QIPP programme and how this will fit in with the workstreams of clusters.

- It was proposed that candidates interested in putting themselves forward for the Cluster Lead role should provide a summary of why they wish to take on the role and the skills they have that match the required criteria to both their cluster and the Consortium Chairs.

- There will be back-fill reimbursement – candidates must be a GP partner, nurse or associate GP from the practice cluster.

- It was agreed that the Cluster Lead role could be performed as a job-share, if the candidates met the person specification.

- The Cluster Lead role is also about making sure that practices perform against a whole range of commissioning related activity.

- The amount of work and the commitment the Cluster Lead will do has been identified and the clusters, however, areas of work maybe delegated to others.

- A half day a week has been allocated to the role, however, Jonathan Bates said that as a first-wave pathfinder, The Sutton Consortium, is allowed to experiment and innovate – it is important to show we are getting good value for money and people are working for the benefit of the practices they represent and the wider group.
• Clusters will have degree of autonomy so it is important to ensure there is a named person who has a line of responsibility to manage internal operations within a cluster.

• At some point pathfinder group structures will be in the public domain and it is important that clustering arrangements are transparent and supported by robust governance.

• Within these criteria, practices would be encouraged to self-organise their cluster arrangements as a first step in demonstrating the skills to lead themselves.

• Unless agreed otherwise by the Management Board, voting rights are at Board level.

Dr Hudson thanked members for their contribution to the discussion and sought agreement that practices will progress the process to select a cluster lead by a week before the May Management Board, gathering evidence to support the decision and sharing this with the Consortium Chairs. The Cluster Lead job description was approved as was the process for selecting a Cluster Lead by individual clusters, with reporting back to the Joint-Chairs. **Action: ALL**

**Developing the Management Board - Workshop 11\textsuperscript{th} May**

The government has announced a pause in pushing forward the new clinical commissioning initiatives. As a first-wave pathfinder group, The Sutton Consortium has developed quite rapidly and this pace of change has seen a range of developments take place.

In view of this a workshop to bring clinicians together to share the current strategy and clinical initiatives has been arranged for Wednesday 11\textsuperscript{th} May, 1:00pm-3:00pm at The Good Shepherd Centre.

Following this, it has been proposed through the work undertaken with Ann Hepworth, Healthskills Relationship Manager, that an awayday/overnight stay for Working Group/cluster leads is held at a suitable date in June.

Jonathan Bates asked members to diarise 11\textsuperscript{th} May and share this date with all staff at their practices. **Action: ALL**

6 **QIPP**

**The Local Better Value Programme**

Jonathan Bates tabled a set of slides (att.4a) and drew attention to the financial challenge of £23.4m (slide 8) faced by NHS Sutton and Merton and GP commissioning groups will face a share of this. The paper describes how the PCT expects to make savings and the highest proportion is by a reduction in staff. Savings from managing ‘Right Care’ are estimated at £2.5m and a breakdown analysis shows steps to achieve this (slides 19-21) and the PCT leads supporting the workstream.
Clinical and Managerial Leadership

The Clinical and Managerial Leadership table (att.4b) endeavours to map a primary care clinical lead with a PCT lead. Some clinical commissioning leads have already been confirmed and Sian Hopkinson is in discussion with other nominees. The role will be resourced and it is expected to take approximately one hour per week. The scale of the challenge to balance books should not be underestimated.

Dr Jonathan Cockbain has made up some resource packs and a pack can be emailed on request via Jillian (email: jillian-slade-thornett@nhs.net).

It was proposed that primary care leads make contact with the PCT lead and to hold a brief discussion/meeting to talk through the key points for associated QIPP plan component.

Dr Adi Cooper said that as there are no longer any jointly funded posts between the NHSSM and the Borough there may be gaps in communicating workstream flows so it is important, as these programmes develop, to build an interface and not to work in isolation. Dr Cooper said she would flag up any areas where the Borough could be more involved, such as, Long Term Conditions.

Karol Selvey confirmed that Dr Jane Vernon has withdrawn her nomination as lead for End of Life Care.

The new Borough Managing Director, Adam Wickings, is taking a lead in this work and will keep the Consortium informed of next steps and clarify both the process and the PCT leads in place.

Jonathan Bates invited nominations to take over the areas that he and Dr Brendan Hudson have covered namely ‘Right Care’ and ‘Acute Contract Management’ which would give a broader clinical input into the workstream.

Action: ALL

7 Budgets 2011/12

Indicative GP Consortia Budgets

Jonathan Bates presented a slide pack describing the budgets that the GP Consortium has taken over for 2010/11 and the areas that these cover. It is possible that the Consortium may take on more formal delegation for prescribing.

A table was presented on slide 3 showing the apportionment of fair shares from the Department of Health (DoH) for 2010/11. The pace of change is over four years – 2011 being year two. However, it is recognised that this may change as the DoH is altering the formula for calculating clinical commissioning fair shares.

Some budgets are excluded such as Primary Care / Public Health, as they would create a conflict of interests within primary care.
The QIPP challenge amounts to £23.4m and following meetings with the PCT Finance Director and key leads agreement on the budget setting methodology has been reached for approval of local GP Consortia.

Sian Hopkinson said that once this year’s toolkit has been agreed and endorsed by GP Consortia, groups can expect to receive financial data that can then be checked and analysed accordingly.

In response to a query from Dr Hudson, Sian Hopkinson confirmed that this year’s prescribing methodology has been agreed. Dr Elliott said that prescribing for patients in nursing homes would be closely monitored.

The Management Board was asked to approve the budget setting methodology for GP Consortia and agreement was duly given.

Indicative Running Costs

Dr Raza Toosy presented a document making recommendations as to how the internal ‘running cost’ budget for 2010/11 will be set to ensure best use of limited resources.

It was recognised that the Sutton and Merton PCT was a top-down organisation and it is important to find innovative ways – with a strategic / operational balance - to manage the resources of the new clinical commissioning Consortium.

A table (page 5) showed a breakdown of two options based on £5 per head for 2011/12 to run the Consortium and deliver the organisation’s programme.

Key points summarised as follows:

- The budget for the Joint-Chair and Vice-Chair roles has been allocated to the ‘strategic’ expenditure and everything else is placed in the ‘operational’ section
- Option 1 proposed that cluster leads have joint responsibilities and Option 2 separated out the cluster lead roles and the QIPP clinical leads.
- Vice-Chair role is a separate allocated resource.
- Need to look at how much is operational and how much is strategic as this evolves over the next few months.
- Office space within Sutton may provide a dedicated meeting room rather than using external venues.
- £1 per head practice support – there are currently only three substantive staff.
- Although the budget is not based around prioritisation it is important that the Management Board can take a view of the options presented. Jonathan Bates said it is important to fulfil governance.
The Awayday in June would be an ideal forum to give thought to whether the organisation should be operational or strategic.

Information Management & Technology (IM&T) – Wallington LCC mentioned frequently.

In summary, Dr Raza Toosy said that option 2 looks at capitation per head whereas Option 1 is more complex and will need to be debated. A resource will be allocated to our clusters plus QIPP and it will be necessary to work out how that will roll through.

Following debate at the Working Group, the preferred option is Option 1.

In response to a query from Dr Lings as to where other workstreams fit into the current plan such as Mental Health Services, Intermediate Tier Services and other areas that may be developed in the future, Dr Raza Toosy said the organisation has a provider arm and it is important to clarify if it is provider or commissioning.

Dr Lings also highlighted that there may be some areas that are also part of QIPP that the organisation is trying to develop in order to avoid more costly hospital care which may be with private providers and need to have some provision for that.

Jonathan Bates said that a range of services has been set up as part of service redesign and where these are 'housed' in future needs to be further defined. Jonathan Bates said he was pleased that Jason Nash could join the meeting today as he will be coming into post soon to lead these services which is helpful for GP leads in terms of avoiding conflicts of interests. Commissioners will need to find a way to take forward services based on good ideas and until a better solution is found this is a reasonable compromise. The critical point is that the primary care services see 3000 patients a year and are valued by patients. They make savings so it is important that all practices use them and they need to be nurtured for the future.

QIPP lead and cluster lead roles - overall these will be implementation focused but need to look at how best to allocate resource to achieve outcomes.

Dr Ahmed commented that there will be top-slicing of budgets to consider.

Dr Elliott asked if the Vice-Chair role was entirely necessary and whether retaining the role was more of a diplomatic gesture as the role would be rotating on a regular basis and this would free up £33k.

It was noted that the role of the Chair is challenging in terms of time and effort required. Dr Cockbain commented that a 'rotational' role was a good way to introduce others to strategic working and succession. Jonathan Bates agreed that succession planning is key to develop the leads of the future as well and important that other people are involved in the external face of the organisation such as in meetings with local MPs and the Local Authority.

Jonathan Bates confirmed that the backfill rate was taken from the
recommendation from Londonwide LMCs of £85 per hour.

Dr Mirza commented that succession planning plays a key role to inspire and support new people to become involved to lead and develop future health care plans.

It was noted that the management resource allocation will grow over time.

Dr Hudson asked the Management Board which recommendation they sought to approve. It was agreed to support Option 1.

Dr Hudson thanked Dr Raza Toosy, Dr Tahir Toosy and Dr Dino Pardhanani for their hard work and expertise in writing the paper.

8 Wallington LCC Vision

Dr Ahmed presented an update on the work in progress on the Wallington Local Care Centre (WLCC) and shared a set of photos and floor plans which illustrate the developments and revisions as described in the working document.

- The ground floor consists of rooms for Dr Ahmed’s practice – Wallington Family Practice and Dr Lings’ practice – under the new name Shotfield Medical Practice. There is a main common entrance door way and a joint reception area.

- The first floor comprises of a number of consulting areas that the GP practices will share with the PCT and then a larger area for the PCT and a separate area for education/training and a library. The second floor comprise of rooms for office space.

- Service provision to include specialities such as Family Planning, Community Dentistry and Phlebotomy.

- Completion date is 22 January 2012 and the building work is currently reported to be currently five days ahead of schedule.

- Looking at designing services plus those specialities supporting Long Term Conditions and to offer a full range of services with consultant input. However, this would require a radiology diagnostic suite but the current plan only offers X-ray and rooms have been designed around medical equipment. Discussions are taking place with suppliers of diagnostics such as General Electric and in conjunction with the architect and contractor to establish what can be included and implemented on time.

Dr Pardhanani highlighted the outputs from the workshop held in August 2010 (page 2) to show the top four priorities for outpatient clinics and looking at this list and taking into account discussions at previous Board meetings some further analysis is needed to ensure that service redesign encapsulates the integrated care pathways that will both improve the patient journey/flows and, at the same time, make savings. The QIPP programme shows a good example where savings could be made and patient flows streamlined.
Following discussion, the Management Board was asked to approve the following recommendations:

1. The strategy to move as many high volume/high flow/high cost specialities into Wallington LCC (see appendix 2).

2. WLCC will open with ‘first wave’ specialists in Cardiology, Diabetes, Orthopaedics, Ophthalmology and Gastroenterology. St Helier is the preferred provider with the exception of Ophthalmology. There will be a procurement process.

Dr Raza Toosy said respiratory is a huge area to be considered and is part of the QIPP programme.

In response to a query from Karol Selvey, Dr Pardhanani confirmed that the high cost analysis being undertaken by Sian Hopkinson will feed into the speciality design pathway.

3. Leads to investigate further whether diagnostic facilities can be expanded and whether the Minor Surgery Suite could offer a full Day Surgery function.

4. The clinical leads for the project need a clear mandate from the Management Board that it will devolve decision-making of the project to the leads to implement the points noted above.

The Management Board agreed to all the above recommendations.

It was also agreed that a progress report should not only come to the monthly Management Board but also to the Working Group which meets more frequently on the 2nd and 4th Wednesdays of the month.

Dr Hudson thanked Dr Ahmed and Dr Pardhanani for their valuable contribution to progress the development of the Wallington LCC.

For Note

9 Finance – Month 10

Sian Hopkinson presented the Finance Report for January 2011 and said she was pleased to report that the Consortium is forecast to end the financial year £635k in surplus. Overall, there are 10 practices under and 11 over budget.

Adjustments have been made for list size changes and the analysis showed that the Consortium had gained £700k.

Jonathan Bates re-iterated the positive expectation that the organisation would be in balance at year end and this was important in terms of progressing to authorisation and the perception of the SWL Cluster.

10 Observer Questions and Comments

There were no questions put forward by the observers present. However, comments were made as to whether a single opportunity towards the end of
the meeting was the most appropriate way for observers to contribute to the discussions of the Management Board.

11 Any Other Business

Urgent Care Centre

It was reported that Epsom and St Helier NHS Trust submitted a bid on 31st March to run the future Urgent Care Centre. The proposal was reviewed by the Professional Executive Committee (PEC) and approved in principle. There is some work to undertake on the finer details of the application, however, the outlook is looking positive and an update on progress will be provided for the Management Board.

GP / Consultant Engagement Event

An evening event on Wed 4th May, 6:00pm-8:00pm in the Nonsuch Room, Post Graduate Medical Centre, St Helier Hospital, has been organised to bring together GPs, both from The Sutton Consortium and The Federation with secondary care consultant colleagues to facilitate strengthening working relationships in the new health economy.

An invitation from Keith Hider, Head of Strategy and GP Engagement will be circulated by email to practices to share with GP colleagues. RSVPs are politely requested by 27th April.

Dr Elliott commented that this would be a really useful forum to gain an understanding on healthcare developments from the point of view of secondary care colleagues.

12 Date and Venue of Next Meeting

Wednesday 4th May 2011, 1:00pm-3:00pm
St Bede’s Conference Centre, St Anthony’s Hospital, 801 London Road, North Cheam, Surrey SM3 9DW