Minutes of the Healthy Staffordshire Select Committee Meeting held on 5 August 2015

Present: Kath Perry (Chairman)

Attendance	
Michael Greatorex (Vice-Chairman)	Conor Wileman
Chris Cooke	Colin Eastwood
Ian Lawson	Brian Gamble
David Loades	Janet Johnson
Shelagh McKiernan	David Leytham
David Smith	Stephen Smith

Also in attendance:

Apologies: Charlotte Atkins, Philip Jones, Christine Mitchell, Trish Rowlands, Diane Todd, Ann Edgeller, Barbara Hughes and Andrew James

PART ONE

96. Declarations of Interest

There were no declarations of interest

97. Minutes of the last meeting held on Monday 8 June 2015 were confirmed and signed by the Chairman.

Note to clerk; a member asked for a date within twelve months to be stated in the Work Programme of when the review of change to the Hearing Aid Policy will be brought back to Committee.

98. Improving Lives Programme

Dr Charles Pidsley, Chairman East Staffordshire Clinical Commissioning Group (CCG) gave a brief overview of the CCG, he advised members that it was a statutory body, had been in existence for three years and was a clinically led organisation.

Dr Pidsley presented the Improving Lives programme, and explained that "Improving Lives" had arisen from a review of current services when it had been identified that staff and patients wanted something different and that benchmarking had provided evidence of high costs with poor outcomes for the people of East Staffordshire. It was also recognised as important to align the CCG's commissioning strategy to the Staffordshire Health and Wellbeing Strategy and that the increased demand presented serious challenges to overall sustainability. These findings and other contributory factors had resulted in recognition of a need to improve community care as a means of preventing hospital admissions.

He explained to members the process undertaken to determine the choice of the "Prime Contractor", and that the organisation selected is Virgin Care. The contract is for 7 years and worth £270m in total. The advantages of the Partnership and the contractual implications for both partners were outlined. He informed members that the process of co-production through "Competitive Dialogue" was in accord with European Legislation.

The role of Virgin Care as "a like-minded and trusted partner" was outlined and it was pointed out that they had considerable experience and expertise in the area of transformation. He advised that the CCG and Virgin Care shared the same priorities, including improving patient and carers' experience, reduction of unnecessary admissions, integrated services, maintaining public engagement and shared the vision of care in the community. Dr Pidsley explained what a future care model would look like and how the partnership would achieve its priorities.

Members were informed that since the contract had been awarded a number of actions had followed in particular, continued engagement, ongoing sub-contractor negotiations, voluntary and public sector meetings, community events, and that work is now being done on the establishment of the Citizens Panel. He added that what mattered most was that patients, carers and families felt supported, confident, safe and informed as a result of the "Improving Lives" programme.

Dr Vivienne McVey, Commercial Director at Virgin Care introduced herself to the Committee advising that until she started Virgin Care 9 years ago she had been a General Practitioner. She added that they provided NHS services countrywide, with a work force recruited from the NHS and Local Authorities of 5500, that Virgin Care had not had a contract terminated and, that they had undergone 106 Care Quality Commission (CQC) inspections, 103 of which were good or outstanding and that the remaining three had been remedied within the months allowed for improvement.

Dr McVey explained the actions Virgin Care would take to improve patient and carers experience and of the intention to reduce unnecessary admissions to hospital by integration and to improve existing IT systems. She advised of work to improve communications in some areas, and she highlighted recognition of need for an educational pathway and the creation of a Carers Club for East Staffordshire CCG patients. Members were informed of the considerable experience that Virgin Care had in care in the provision of community services and in the prevention of unnecessary admissions. The role of "Age UK" in East Staffordshire and the introduction of the "Care Coordinator" as a focal point for care were explained. She acknowledged challenges around mental health integration and recognised the ongoing work with Burton Hospitals to address the issue.

Members were advised of the core competencies required as the basis for Community Services and the importance of a proactive response in early identification of persons at risk to ensure effective intervention. The importance of a single point of access for Health and Social Care, the importance of the integration of health records the need to embrace innovation and the value of carers to the process overall was emphasised. Dr McVey advised of the recruitment and role of Care Co-ordinators to manage the frail and vulnerable together with work with the public to determine the shape of future services and that contract with Virgin Care would go "live" in April 2016.She explained

that they had successfully pioneered “Net Promotor Score” a means of measuring patient feedback that had been taken up by the NHS as their “Friends and Family Test” – and that this will be one of the many ways Virgin Care will use to assess patient feedback.

A member referred to the conduct of risk assessments of frequent service users, the provision of proactive community care and the role of the “Care Co-ordinator” and asked would it integrate into other systems such as Social Services.

Dr McVey responded and explained that the risk assessments were intended to identify and understand from the data, who was at risk of illness or admission to hospital. As at the moment, most community services recognise risk following an admission. It was their intention to intervene “upstream” in order to prevent illness or admission by the timely administration of appropriate care and support in relation to care co-ordinators that they would be fully supported and would come from a variety of backgrounds. She explained that they would function as a “buddy” to help with the management of appointments and she gave examples of the frail and elderly suffering from illnesses such as diabetes, heart disease, asthma and arthritis that may have had upwards of 100 visits to outpatients, blood tests or visits to the home each year. If a patient also had the presence of slight dementia these patients could become unable to manage appointments or act on the separate elements of advice given. She explained that co-ordination as a whole team would be required. She recognised for different patient groups there was a need for different types of co-ordinators and that they were working with Age UK in this area. She further clarified that some would be professional employed by community services, some would be trained volunteers and skills could extend through to specialist trained nurses and that they all would be known to GPs, hospitals and community care. In more complex cases the attendance of a highly trained professional such as a Community Matron would be required.

A member asked if Virgin Care would be able to commission care on behalf of patients. Dr McVey responded that as the Prime Contractor, Virgin Care could sub-contract over a range of services but could also provide services.

In relation to integrated care records a member asked who would hold the records, would it be the patient, GP or Virgin Care? The Committee was informed that in an ideal world it is recognised that ideally patients would hold records but at the present they were spread across different organisations. Although they were NHS records, subject to NHS governance and quality standards, in the future it was intended that all professionals would be in a position to view the same record. She explained that Virgin Care’s biggest investment would be in staff training and in IT, focusing on the ability to view patient records and information from a single place.

A member referred to the East Staffordshire CCG and asked if there would be plans for all CCGs to come together across Staffordshire. Dr Pidsley explained that this is not currently planned due to different commissioners in the area and that the CCG was coterminous with the Districts and Boroughs of East Staffordshire. He advised that there was working group ongoing between the 6 CCGS across Staffordshire to prevent duplication of work but that there were no plans to merge.

One member expressed concerns in relation to the budget of £270m and asked if it would be spread over the 7 years in equal amounts and would payment be based on performance and achievement? Members were advised that whilst the contract was spread out over 7 years, as the contract advanced more of the payment would be determined from when outcomes were met.

A member acknowledged the need for flexibility when dealing with contractors and asked was the CCG confident that they had the measurement and control in place to ensure the delivery of the commissioned services and if not, was there a means of sanction, for instance stopping payment.

Dr Pidsley informed members that he was confident that they had a framework of development of outcomes and standards .He confirmed that there was a mechanism in an extreme case to cease the contract.

In response to a question members were advised that none of the GPs in East Staffordshire had links with Virgin Care. Tony Bruce, Accountable Officer, explained that as a clinically led organisation that the governing body was made up of more GPs than other professionals. He advised that it was a statutory public body and that members were expected to make declarations of interest, and as an organisation they were diligent in the application. He explained that the principal place for decision making within the CCG was the Governing Body. All decisions, including those that could be contentious decisions would be referred to a steering group of 19 member practices. There was a Programme Board responsible for implementing the programme on behalf of the Governing Body that was also made up largely of clinicians who were also expected to meet the statutory responsibilities. Overall that they followed a robust policy around declaration of interest.

A member referred to the ongoing negotiations with Burton Hospitals and accepting there was an issue of commercial sensitivity, asked for more detail. In particular as there was a significant spend what was the percentage expenditure for elective and community care. Also could the Committee be advised of the make-up of the negotiating team?

Dr Pidsley said that the scope of the contract between the CCG and Virgin Care covered emergency care, some aspects of planned long term and outpatient care. That the CCG would continue to negotiate directly with the hospital for services outside of the scope of the improving lives contract and that the CCG would continue to negotiate on behalf of other CCGs for the commissioning of services in the lead commissioning arrangement. There would be continued involvement of Burton Hospitals and Virgin Care as the Prime Contractor to determine the future model.

Dr McVey advised the Committee that the scope was around all care for frail elderly and long term conditions care. She outlined that discussions with hospitals in East Staffordshire and Derbyshire were ongoing because they took patients from East Staffordshire. She outlined that approximately 25% of the income for Burton Hospitals will sit within this contract. She confirmed that there was ongoing negotiation with Acute hospitals in East Staffordshire and those outside Staffordshire, in particular Derbyshire, who take admissions from Staffordshire. This is to determine the best model of care to

ensure the most effective and positive patient experience. She outlined a move to introduce consultant involvement in teams to achieve the best outcomes.

In respect of the expenditure of the overall seven year budget of £270m, members were advised that approximately two thirds would be on acute type services and the remaining third would be allocated to care in the community. Looking at the contract over the 7 year period she advised that there would not be very much obvious change because of the necessity to absorb the growth in the elderly population, who would require more acute services. She also confirmed that they would be looking at the use of A&E services in order to reduce unnecessary admissions, when other alternative services were available. Work in this area would include inside A&E with the triage information to determine reasons for admission and discharge of persons with the appropriate support was explained to members.

Members were advised of the proposed IT programmes with an emphasis on compatibility between hospitals and GPs and a solution to upgrade existing systems and of an intention that in the future patients would hold their own records.

A member asked what safeguards were in place should there be a breach of contract by Virgin Care. Tony Bruce informed the Committee of built in contractual safeguards in the event of the breaking of the whole or part of the contract and the sanctions available to the CCG.

A member referred to the work with Voluntary Organisations and asked what form it took. Dr McVey explained that Virgin Care worked with voluntary organisations in a number of ways and the importance of this to patients and to them as the Prime Contractor. Members were informed of local networking to provide a local feel and the possibility of commissioning services from a volunteer organisation and the importance of tapping into their subject matter expertise.

As a result of a question arising from the meeting of the Committee 5 December 2015 in relation to the development of Peer Support Groups for persons suffering from long-term conditions and the effects of isolation. Members were assured that the introduction of a Peer group type programme would be progressed during the next financial year and that the importance of the programme had not slipped down the agenda since the meeting mentioned.

In respect of financial and contractual implications a member asked for more detail. In particular the role of Virgin Care, following the notice given to present providers for contracts ending on 31 March 2016. Would they enter into new contracts, supply the services themselves and ultimately were they confident that Virgin Care could provide the services? The Committee was informed that the CCG was confident that Virgin Care could and would deliver the requirements of this contract. The role of the Prime Contractor and its relationship with the CCGs and hospitals was outlined together with financial arrangements. Dr Ajitha Prasad, Governing Body Member, explained that from a GP's perspective, the system in terms of finance or patient numbers in its current form could not be sustained. GPs in East Staffordshire had embraced the model and despite the shortage of GPs were driving change.

In relation to the change to services and when it would they take place? Members were informed that portfolios of service were being prepared, that Virgin Care would commission existing and new providers including those from the voluntary sector and that recruitment would follow. In terms of the timetable for the changes, members were informed of ongoing negotiation with various organisations and that the CCG would hold Virgin Care to a timetable of implementation. It was expected that they would be in a position to advise further by mid-autumn. In the event of a substantial change of service which may require formal consultation or engagement, Tony Bruce advised that he would bring it back to the Committee for consideration.

A member referred to the £274m budget and asked was it intended to provide services or did it also include a management element and if it was not spent what would happen to the remainder. Tony Bruce explained that £274m was the totality of the contract with Virgin Care to drive improvement, improve care and patient experience and that there would not be further money. It doesn't change over the life of the contract. He explained that Virgin Care was a commercial organisation that must make a return on investment. That it had already committed to making considerable upfront investment in IT, staff training and development and had a target profit figure that the CCG was aware of and comfortable with. He also explained the gain share arrangement in the event of profits above an agreed level, and there was an agreement in place to divide it between the NHS and Virgin Care.

Discussion followed in relation to complaints procedures, in particular complaints made against the Prime Provider or GPs by service providers. Members were advised that the system was the same as for complaints about the NHS and that it would be the duty of Virgin Care to hold sub-contractors to account and have systems in place to identify themes and trends.

Acknowledging that there are issues of recruitment across the whole of the NHS, a member asked how confident was Virgin Care of recruiting particularly for community care the right quality of staff. The Committee was advised of a skilled recruitment team, targeting for areas of hard recruitment, in house training and liaison with universities to attract recruits.

Discussion followed in respect of areas co-terminus to East Staffordshire and the practical and clinical issues arising when patients crossed boundaries to receive care.

A member expressed concern that if a GP was commissioned to carry out additional work outside of existing contracted role that payment may be duplicated or paid twice. Dr Pidsley explained that GPs could receive payment for work in their area of special interest, which effectively would mean a split portfolio, but that there would not be any duplication of payment.

In response to a question from a member in relation to the number of similar schemes implemented by Virgin Care across the country. Dr McVey informed members that everything that was included in the contract was already being done by Virgin Care elsewhere in the country, but that this was the first time they would be doing it all in one CCG..

In relation to the Programme a member asked that if it proved to be a success across the East Staffordshire CCG that did the Committee have the authority to cause it to be implemented across the remainder of the County. He was advised that the Committee would only be in a position to make recommendations.

Tony Bruce, Accountable Officer said that there was national interest in this Improving Lives programme and that the CCG and Virgin Care would be working together to make this happen with patients. He emphasised that it was the rigorous procurement process that had been followed meant that the CCG had a Prime Contractor with the determination and skills to do this work.

Tony Bruce also asked the Committee that if any Member thought that the CCG should do more to, or should adopt a different response in order to engage the local community, that CCG would be pleased to know as they would be happy to share any ideas they might have.

RESOLVED:-a) that the Committee note the progress of the Programme to date
b) that the Clinical Commissioning Group update and report the progress of the Programme to the Committee in November 2015, or sooner in the event of a major re-configuration of services.

Chairman