NHS
Richmond
Clinical Commissioning Group

NHS Richmond Clinical Commissioning Group (CCG)

Governing Body

22nd Meeting in Public

Tuesday 21 June 2016
13:15 – 14:20

The Salon, York House
Richmond Road
Twickenham
TW1 3AA

NHS
Richmond
Clinical Commissioning Group

22nd MEETING IN PUBLIC OF THE NHS RICHMOND CLINICAL COMMISSIONING GROUP (CCG) GOVERNING BODY

TUESDAY 21 JUNE 2016
13:15 – 14:15

in the Salon, York House, Twickenham

PART 1 AGENDA

No	Time	Item	Executive Lead	Attachment
1.	13:15	Welcome and apologies for absence Confirmation of meeting quoracy	Chair	
A	**STANDING ITEMS**			
2.		Declaration of interests in matters covered on the agenda • GP members: Richmond General Practice Alliance participant *To note*	Chair & Members	
3.	13:20	Minutes of the CCG Governing Body meetings on: • 17 May 2016 • 24 May 2016 *For approval*	Chair	Ai
4.	13:25	Matters arising and rolling action log Board Assurance Framework one-page summary (*for reference*) *To note*	Chair	Aii Aiii
5.	13:35	Items taken in private on 17 May 2016**:** • Operating Plan 2016/17 – Finance • Award of Outcomes Based Commissioning Contract for Physical Health *To note*	Chair	Verbal report
B	**GOVERNANCE/BUSINESS**			
6.	13:40	Estates strategic framework *For approval*	Director of Corporate Affairs	B

7.	13:55	Medicines Optimisation review *For approval*	Director of Nursing & Quality/ Chief Pharmacist	C
C.	**TO NOTE**			
8.	14:10	Any other business		
9.		Date of next meeting: **Tuesday 19 July 2016, 12:30 – 15:30,** Salon, York House, Twickenham		
10.	14:15 – 14:20	Members of the public present are invited to ask questions of the CCG Governing Body relating to the business being conducted. Priority will be given to written questions that have been received in advance of the meeting.		

NHS
Richmond
Clinical Commissioning Group

Attachment Ai

20th MEETING IN PUBLIC OF THE RICHMOND CLINICAL COMMISSIONING GROUP'S GOVERNING BODY

HELD ON TUESDAY 17 MAY 2016
IN THE SALON, YORK HOUSE

MINUTES

Attendance Log:

Members:		**17.5.16**	**24.5.16**					
Dr Graham Lewis (GL)	Chair	A	A					
Kathryn Magson (KEM)	Chief Officer (CO)	A	A					
Charles Humphry (CH)	Vice Chair and Lay Member, Governance	A	A					
Bob Armitage (BA)	Lay Member, Governance	A	SA					
Susan Smith (SS)	Lay Member, Patient & Public Involvement (PPI)	A	A					
Richard Thomas (RT)	Chief Finance Officer (CFO)	A	A					
Dr Kate Moore (KM)	Vice Clinical Chair (VCC)	A	A					
Dr Branko Momic (BM)	GP	A (from item 13)	A					
Dr Nicola Bignell (NB)	GP	A	A					
Dr Stavroula Lees (SL)	GP	A	A					
Dr Sean Gallagher (SG)	GP	A	SA					
Dr Alex Norman (AN)	GP	A	A					
Julie Sobrattee (JS)	Director of Nursing & Quality	A	A					
Cathy Kerr (CK)	Director of Adult & Community Services (DACS), LBRuT	A	SA					
Dr Anne Dornhorst (AD)	Secondary Care Doctor	A	SA					
Non-voting members:								
Victoria Otley-Groom (VOG)	Director of Commissioning (DoC)	SD	A					
Vicki Harvey-Piper (VHP)	Director of Corporate Affairs (DoCA)	A	A					
Anna Raleigh (AR)	Director of Public Health (DPH)	A	A					
Julie Risley (JR)	Joint Healthwatch Member	A	SA					
Kathy Sheldon (KS)	Joint Healthwatch Member		SA					
In attendance:								
Elizabeth Youard (EY)	Contracts Programme Director (for the Director of Commissioning)							

KEY: A = Attended, DNA = Did not attend, SA = Sent Apology, SD = Sent Deputy

		ACTION
1	**WELCOME, APOLOGIES FOR ABSENCE AND QUORACY** • The Chair welcomed all members present to the 20th meeting in public of the Richmond Clinical Commissioning Group's governing body. • Apologies for absence were received from Victoria Otley Groom (Elizabeth Youard	

		ACTION
	attended in her place). • It was confirmed that the meeting was quorate.	
A	**STANDING ITEMS**	
2	**DECLARATION OF INTERESTS IN RESPECT OF ITEMS ON THE AGENDA** The standard declaration of interest from GP members as participants of the Richmond General Practice Alliance (RGPA) was noted.	
3	**MINUTES OF THE CCG GOVERNING BODY ON 15 MARCH 2016** The minutes were agreed as a correct record	Attachment Ai
4	**MATTERS ARISING AND ROLLING ACTION LOG** • **GB38 – South West London Collaborative Commissioning (SWLCC) programme update: Governance proposals for next phase of programme to deliver five year strategy:** The DoCA reported that she had followed up the reported lack of representation from Richmond on clinical workstreams across the sector and found that there had not been a good response to the invitation for people to put their names forward, however RCCG was represented. Julie Risley reported that she had offered further representation from Healthwatch for the workstreams but this had not been taken up. She would provide further information for the CCG to follow up. • **GB40 - Quality & safety summary:** The VCC agreed to follow up circulating the pan-London survey on children's services. • **GB41 - Finance & performance summary**: The CCG was in the process of reviewing activity in Hounslow and Richmond Community Healthcare NHS Trust (HRCH) and Richmond rapid response team (RRRT) and would share data with the practices. Practice data for RRRT, RAT and Geriatrician of the day had not been taken to April Membership due to pressure on the agenda but it would be taken in July. The VCC would provide the data to the CFO and he would liaise with the DoCA and DoC regarding its presentation to the July Membership. All other matters arising and actions were on the agenda or in hand. **Board Assurance Framework (BAF) Summary** The governing body noted the board assurance framework (BAF) summary.	Attachment Aii Healthwatch VCC VCC/CFO DoCA/DoC July Mship agenda
5	**ITEMS TAKEN IN PRIVATE ON 15 MARCH 2016** It was noted that the following items were taken in private on 15 March 2016**:** • OBC contract award • Operating Plan 2016/17 • Locally Commissioned Services (LCS) 2016/17 Update	Verbal report
6	**CHAIR AND CHIEF OFFICER REPORT** The governing body received the Chair and Chief Officer's Report and particular attention was drawn to the following points: **1) Sustainability and Transformation Plan (STP) Update:** There was a very tight timescale for final sign-off of the STP, by 28 June. A draft of the plan would be circulated to the CCG on 27 May for comment by 8 June. The CCG's membership and governing body would be engaged during this process. A final STP would then be circulated for CCG governing bodies to sign off by 28 June. The CCG had organised an additional GB meeting in public on 21 June to accommodate this. The gap in finance was significant for Richmond CCG similar to other parts of SW London.	Attachment B

		ACTION
	2) Outcome of the CCG Stakeholder Survey 2015/16: The CCG had invited a range of stakeholders to take part in the annual CCG 360° stakeholder survey, and there had been a 59% response rate. Overall the results showed improvements on last year in the areas of engagement, commissioning services, leadership, clinical leadership, and plans and priorities. EMT would will review the results in detail and address areas for improvement. It was agreed that the findings of the stakeholder survey would be shared with Susan Smith as lay member for PPI. **3) Medicines Optimisation Team update:** Following a review of the CCG's medicines optimisation team, the clinical executive team had considered the options and agreed to second staff to the RGPA under a single tender waiver. They would form a primary care pharmacists' service and operate under a three-year contract. Details of the service and contract were being drawn up and a report would be brought back to the additional GB meeting on 21 June for approval. **4) Urgent care/NHS 111 update:** Northern Doctors Urgent Care had been appointed as the provider following the conclusion of the scoring process. Croydon and Richmond had only signed up for the NHS 111 service, while maintaining their respective OOH providers. The new contract meant that more services were provided in the community so that patients did not have to travel so far. JR commented that Healthwatch had conducted surveys in GP practices and had found that many patients were confused by the different emergency services. Healthwatch would be recommending improved communication on these services. **5) Operating Plan 2016/17:** The draft operating plan had shown the CCG planning for a £16m deficit in 2016/17. Although the CCG was gaining an increase in its funding allocation of £6.7m, this was offset by additional funding commitments, activity growth and an increased contingency requirement. The CCG was planning to make QIPP savings of £6.4m, but would face a difficult financial position for the coming year. The 2016/17 plan outturn was still to be agreed with NHSE following which the plan and budget would be brought back to a governing body meeting in public. The CCG had to produce a financial recovery plan showing how it would achieve break even for the 2017/18 financial year. RSM had been commissioned to prepare the plan which was due to be presented to the June governing body meeting for approval. There would be work at scale across SW London as other CCGs were in a similar financial position. **6) Local Commissioned Services Update:** Discussions were underway with practice managers, the local medical committee (LMC) and the RGPA on the finalisation of the first phase of locally commissioned services for 2016/17. The majority of services commissioned for patients in 2015/16 were continuing and had not been affected. The CCG was working with public health on LCSs and a joint primary care strategy. Progress would be reported to the July GB meeting. The first PCCC in public had been held on 10th May. SS and JR were looking at how to improve working between the CCG and the patient participation group (PPG). The week beginning 9th June was awareness week for PPGs.	DoCA
B	**GOVERNANCE/BUSINESS**	
7	**Annual Report & Accounts 2015/16 plus month 12 finance summary** The governing body received attachment C. • The CFO reported that there was a tight timetable of 27 May for the submission of the annual report and accounts. It had been presented at the Audit Committee that morning but was still in draft as the auditors had suggested some changes to be made. Further information needed to be added about the CCG's financial position and its future financial strategy. Clinical input was needed into the wording and this would be sought at the clinical executive team on 24.5.16.	Attachment C

		ACTION
	• The external auditors had stated that, from their point of view, despite the fact that the CCG had not achieved its financial target the auditors were still issuing a good value for money (VFM) report as they recognised that the organisation had strived to keep spending under control, develop OBC and had taken action to mitigate the poor management of continuing care by the CSU. • The governing body expressed its thanks to the finance team and staff for their hard work. The governing body noted and commended the improvement in the staff sickness record. Healthwatch was pleased to report that stakeholder involvement had improved significantly over the last year. • Approval of the annual report & accounts 2015/16 would be deferred to an extra GB meeting on 24.5.16. • In line with the report recommendation, governing body members confirmed that they were not aware of any relevant audit information that had been withheld from the clinical commissioning group's external auditors, and that they had taken all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors, where appropriate.	
8	**Report from the Audit Committee Chair (including the approved Internal Audit Plan 2016/17)** The governing body received attachment D, the approved Internal Audit Plan 2016/17, and the audit committee chair gave a verbal report on the audit committee. The following points were noted: • The internal audit plan 15/16 was rated 100% green. • In the Internal Audit progress report, there was a red rating for partnership arrangements relating to the governance around the contract with PwC. • Public and Patient Engagement was rated amber/green. • The follow up report on LCS and post payment verification was favourable. • Internal audit plan 16/17: The audit into governance and working arrangements with RGPA was not due to start until September. • In relation to the audit into continuing healthcare, the DoNQ asked whether the dates could be negotiated as she felt that September would be too soon to evaluate the new arrangements. It was agreed to move this. • It was also agreed to defer the audit relating to RGPA, the PMCF contract and the medicines optimisation team to allow a reasonable period of working prior to the audit.	Attachment D CFO
9	**RCCG Corporate Objectives 2016/17** The governing body received attachment E detailing the updated corporate objectives which had been refreshed for 2016/17 to reflect the CCG's present situation and priorities as well as its future strategic aims. They would be used as a framework for team and individual objective setting and for monitoring of progress on key initiatives.They had been shared with staff for comment and discussed at the CCG's Ways of Working group. During discussion the following points were noted: • The corporate objectives were not publicised externally but they supported the achievement of the organisation's vision and values which were the external facing statements. • It was noted that the objectives were not meant to be in any priority order and it was agreed to take the numbers off so that the objectives were listed as bullet points. • There were a number of members who felt that the first objective on the list should not be finance but should be working in partnership with local health providers. There was a lengthy debate over whether to amend the order. It was commented that it was important to highlight the importance of finance to partners and staff as it was crucial to bring the CCG back into financial balance.	Attachment E

		ACTION
	• In order to widen the scope of the partnership objective it was agreed to amend it to read: *"to work in partnership with all health providers and commissioners to commission quality integrated services that achieve good health outcomes, are accessible and promote equality for local people"*	
10	**Staff Survey Results 2015/16** The governing body received attachment F. The DoCA explained that Richmond CCG had participated in the national annual staff survey for the first time in 2015/16. The response rate had been 73.2% which compared favourably to an average response rate of 70%. She outlined areas where Richmond CCG was doing well compared to other CCGs, areas where Richmond CCG was doing less well compared to other CCGs, and steps that the CCG was already taking to address the areas highlighted for improvement. During discussion the following points were noted: • The healthy workplace charter being launched in September was an important initiative as it not only would improve the health of NHS staff but because the NHS was one of largest employers in the country it would improve the health of our communities. The interim DPH had been championing the healthy workplace charter in the local authority and it had been well received. • It was agreed to expand the healthy workplace charter beyond CCG staff to primary care.	Attachment F DoCA
11	**Award of outcomes based commissioning contract for physical health** The governing body received attachment G. Elizabeth Youard (EY), Contracts Programme Director, reported that this was an update from the discussions at the February GB where it had been agreed in principle and subject to conditions to award a contract for up to 10 years to HRCH as the host of a proposed joint venture (JV) agreement for OBC. At present the partners in the joint venture were HRCH and the RGPA, as the acute partners were participating in a different capacity. The commissioning team was working with the GB lay members to ensure due process was followed. During discussion the following points were noted: • It had been anticipated that work would have finished on the financial basis, however this was still ongoing but should be completed by the end of the week. • The CCG was working with HRCH and RGPA as the JV towards having the 2016/17 Heads of Terms agreements in place in the near future. A target date of mid-June has been set for full contract agreement. • An update report would be included in the CO/chair report to the July GB.	Attachment G July GB CO/chair report
C	**QUALITY, PERFORMANCE & FINANCE**	
12	**QUALITY & SAFETY SUMMARY** The governing body received and noted attachment H, which dealt with the matters considered at the Quality & Safety (Q&S) meeting on 19.4.16 in accordance with the committee's annual work plan. These covered serious incidents, PALS and complaints, children's services Q1 report, freedom of information, HRCH quality priorities and learning disability issues. The DoNQ had been liaising with primary care colleagues about how incidents were managed and the importance of keeping her informed of any incidents.	Attachment H

13	**FINANCE & PERFORMANCE SUMMARY** The governing body received and noted attachment J, which dealt with the matters taken at the F&P meeting on 19.4.16 in accordance with the committee's annual work plan. This covered acute contracts, the month 11 finance report, the independent financial review, a financial assurance discussion with NHSE, contracts review and QIPP. During discussion the following was highlighted: • It was noted that although the CCG had not achieved its QIPP, the auditors had expressed an opinion that the CCG had performed well on value for money as they had managed risks well, spent money wisely, and the management had moved from interim arrangements to majority permanent staff which provided more stability and continuity for the CCG. • It was raised that a great deal of work had been carried out on budget reviews to help staff understand their budgets better, which was crucial to achieving the QIPP targets. This budget review exercise would be repeated quarterly and would include QIPP. In addition, executive directors were invited to audit committee meetings on a regular basis to discuss budgets. • A review had been carried out of QIPP lessons learnt, and these would be communicated throughout the organisation.	Attachment J
D	**TO NOTE**	
14	**Estates strategy** The DoCA reported that the development of the estates strategy had been outsourced but it was still not ready. It would be discussed at EMT on 23.5.16 and shared with GB in draft form and brought back to the extra GB meeting on 21.6.16.	DoCA June GB agenda
15	**Any Other Business** There was no other business.	
16	**Date of Next Meetings:** **Tuesday 24 May 2016** (extra meeting) **Tuesday 21 June 2016**, 13:00-14:15 in the Salon, York House (extra meeting) **Tuesday 19 July 2016,** 12:30–15:30 in the Salon, York House	
E	**PUBLIC QUESTION TIME**	
17	1. A member of the public stated that he was trying to resolve an issue around a continuing health care retrospective historical claim but had not received a response to his correspondence. It was explained that the service had been commissioned from the CSU but had been poorly managed and subject to delays. The management had changed from 1st April and the CCG would have much improved oversight in the future. It was agreed that the member of public would give the details to the DoNQ and she would take forward resolution of the issue. 2. Alan Macmillan, member of the public, drew attention to the CCG's financial pressures and recovery plan and queried how the CCG would decide which services should be rationalised and decommissioned, and what public relations programme would be put in place by which the patients would be informed of progress. The chief officer replied that a programme was underway whereby the governing body was reviewing budgetary spend, statutory spend and non-statutory spend to look at where efficiencies could be made and to collectively challenge which efficiencies or decommissioning would be appropriate. The CCG would benchmark spending against similar CCGs and identify which areas to target. There were various options, including decommissioning, using different pathways and rationalising services that were of limited clinical value. All discussions were clinically led and, depending on the recommendations of the governing body, may	DoNQ

	need to be discussed with the wider membership. Patients and public would be consulted, depending on the scale and significance of the planned efficiencies. The CCG would ensure that communications and engagement were robust by working with the community involvement group and PPGs and bringing regular updates to future governing body meetings in public. 3. Christine Berry, member of the public, was interested in hearing about continuing care packages and personal health budgets (PHBs) and how they were allocated. The DoNQ stated that the CCG was commissioning a new continuing care service which included putting in place a more robust process for personal health budgets, working jointly with the local authority. There were very few PHBs in Richmond at the moment. It was agreed that the DoNQ would discuss further with the member of public outside the meeting.	DoNQ

The meeting finished at 2.30pm.

NHS
Richmond
Clinical Commissioning Group

Attachment Ai

21ST MEETING IN PUBLIC OF THE RICHMOND CLINICAL COMMISSIONING GROUP'S GOVERNING BODY

HELD ON TUESDAY 24 May 2016
IN ROOM 7, YORK HOUSE

MINUTES

Attendance Log:

Members:		**17.5.16**	**24.5.16**					
Dr Graham Lewis	Chair	A	A					
Kathryn Magson	Chief Officer (CO)	A	A					
Charles Humphry	Vice Chair and Lay Member, Governance	A	A					
Bob Armitage	Lay Member, Governance	A	SA					
Susan Smith	Lay Member, Patient & Public Involvement	A	A					
Richard Thomas	Chief Finance Officer (CFO)	A	A					
Dr Kate Moore	Vice Clinical Chair (VCC)	A	A					
Dr Branko Momic	GP	A (from item 13)	A					
Dr Nicola Bignell	GP	A	A					
Dr Stavroula Lees	GP	A	A					
Dr Sean Gallagher	GP	A	SA					
Dr Alex Norman	GP	A	A					
Julie Sobrattee	Chief Nurse	A	A					
Cathy Kerr	Director of Adult & Community Services (DACS), LBRuT	A	SA					
Dr Anne Dornhorst	Secondary Care Doctor	A	SA					
Non-voting members:								
Victoria Otley-Groom	Director of Commissioning (DoC)	SD	A					
Vicki Harvey-Piper	Director of Corporate Affairs (DoCA)	A	A					
Anna Raleigh	Director of Public Health (DPH)	A	A					
Julie Risley	Joint Healthwatch Member	A	SA					
Kathy Sheldon	Joint Healthwatch Member		SA					
In attendance on 24.5.16:								
Sheila Jennings	Governance and Business Lead							

KEY: A = Attended, DNA = Did not attend, SA = Sent Apology, SD = Sent Deputy

		ACTION
1	**WELCOME, APOLOGIES FOR ABSENCE AND QUORACY** • The Chair welcomed all members present to the 21st meeting in public of the Richmond Clinical Commissioning Group's governing body. • Apologies for absence were received from Bob Armitage, Sean Gallagher, Anne Dornhorst, Kathy Sheldon and Cathy Kerr (Anna Raleigh attending as a voting member in her place). • It was confirmed that the meeting was quorate.	
A	**STANDING ITEMS**	
2	**DECLARATION OF INTERESTS IN RESPECT OF ITEMS ON THE AGENDA** The standard declaration of interest from GP members as participants of the	

		ACTION
	Richmond General Practice Alliance was noted.	
B	**GOVERNANCE/BUSINESS**	
3	**ANNUAL REPORT AND ACCOUNTS 2015/16** The draft annual report and accounts had been presented to the governing body at its meeting on 17 May 2016. Various amendments had been recommended by the Audit Committee which took place on the morning of the same day. A decision was therefore taken to bring a final amended draft of the annual report and accounts to an additional meeting of the governing body to be held in public on 24 May 2016 before final submission to NHS England on 27 May 2016. The final draft which had been agreed with the CCG's auditors was now presented for governing body discussion and approval. The governing body took this opportunity to make further minor amendments/ corrections relating to the following sections: • Strategic priorities • Scorecard target relating to C Difficile • Governing body members' biographies **Subject to the above amendments the governing body approved the annual report and accounts 2015/16.**	
4	**Any Other Business** There was no other business.	
5	**Date of Next Meeting:** **Tuesday 21 June 2016, 12:30 – 15:30,** Salon, York House, Twickenham	
C	**PUBLIC QUESTION TIME**	
6	There were no members of the public present.	

ACTION LOG for Richmond CCG GOVERNING BODY meeting - LIVE ACTIONS

Commenced: March 2014

Date of next meeting: 21.06.16. Last updated 16.06.16

Action No.	Action	Owner	Date raised	Date due	On track / Overdue / More than 4 weeks late	Comments (i.e. why action is not resolved / completed)
GB33	**Safeguarding children annual report:** In terms of the proportion of the split of children in different age groups, the chief nurse would provide a further breakdown of the age groups.	Chief Nurse	19/01/2016	July 2016	On track	To be reported in the July Q&S summary report.
GB39	**Quality & safety summary:** The GP urgent care lead would discuss and review how the system for children's referrals to the hubs could work better, also liaising with the children's commissioning lead.	GP UC Lead & Children's commissioner	15/03/16	17/05/16	More than 4 weeks late	No update received
GB40	**Quality & safety summary:** The VCC drew attention to a survey on children's services previously carried out and would re-circulate.	VCC	15/03/16	17/05/16	More than 4 weeks late	The VCC agreed to follow up circulating the pan-London survey on children's services.
GB42	Action arising from GB26: CFO to report on management of primary commissioning finance back to Governing Body.	CFO		19/07/16	On track	NHSE still managing this at present and will come back to CCGs when ready to transfer.
GB43	**4.Matters arising and rolling action log - GB38 – SWLCC programme update: Governance proposals for next phase of programme to deliver five year strategy:** Julie Risley reported that she had offered further representation from Healthwatch for the clinical workstreams but this had not been taken up. She would provide further information for the CCG to follow up.	Health-watch rep / DoNQ	17/05/16	21/06/16	Completed	Julie Risley has now been invited to a session next week for clinical workstream members with an acceptance that the MH workstream has not yet met.
GB44	**4.Matters arising and rolling action log - GB41 - Finance & performance summary**: Practice data for RRRT, RAT and Geriatrician of the day had not been taken to April Membership due to pressure on the agenda but it would be taken in July. The VCC would provide the data to the CFO and the CFO would liaise with the DoCA and DoC regarding its presentation to the July Membership.	VCC/CFO /DoCA / DoC	17/05/16	20/07/16	On track	Logged for July Membership
GB47	**8.Report from the Audit Committee Chair (including the approved Internal Audit Plan 2016/17):** It was agreed to move the audit into continuing healthcare from September to a later date. It was also agreed to defer the audit relating to RGPA, the PMCF contract and the medicines optimisation team to allow a reasonable period of working prior to the audit.	CFO	17/05/16	19/07/16	On track	RGPA work split with most to be carried out in November. QIPP audit put back til September. Other timings still to be agreed with RSM.

GB49	**11.Award of outcomes based commissioning contract for physical health:** An update report would be included in the CO/chair report to the July GB.	DoC	17/05/16	19/07/16	**On track**	For July GB
GB50	**14.Estates strategy:** The estates strategy would be discussed at EMT on 23.5.16 and shared with GB in draft form and brought back to the extra GB meeting on 21.6.16.	DoCA	17/05/16	21/06/16	**Completed**	On agenda for 21.6.16
GB51	**17.Public question time**: It was agreed that the member of public would give details of the continuing health care retrospective historical claim he was trying to resolve to the DoNQ and she would take forward resolution of the issue.	DoNQ	17/05/16	21/06/16	**Overdue**	
GB52	**17.Public question time**: It was agreed that the DoNQ would discuss further with Christine Berry, member of public, about continuing care packages and personal health budgets (PHBs) and how they were allocated.	DoNQ	17/05/16	21/06/16	**Overdue**	

Richmond CCG Board Assurance Framework

Corporate objectives April 2016

NHS Richmond Clinical Commissioning Group

Area	Corporate objective	Priority areas	Target score	Current score	Last month	Change	Clinical lead	Exec lead
1. Commissioning	Work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people	a. Out of hospital & LTC (Community) / OBC	*High*	*Extreme*	*Extreme*	↔	*SG*	*VOG*
		b. Mental health	*Moderate*	*High*	*High*	↑	*SL*	*VOG*
		c. Learning disabilities	*Moderate*	*Moderate*	*Moderate*	↔	*AN*	*VOG*
		d. Primary care commissioning & development	*High*	*High*	*High*	↑	*KM*	*VHP/VOG*
		e. Urgent & emergency care and system resilience	*High*	*High*	*High*	↔	*BM*	*VOG*
		f. Planned care	*Moderate*	*High*	*High*	↔	*NB*	*VOG*
		g. Better Care Fund	*Moderate*	*High*	*High*	↑	*SG*	*VOG*
		h. Children, young people & maternity	*Moderate*	*High*	*High*	↔	*SI/NB*	*VOG*
		i. Continuing Health Care	*Moderate*	*High*	*Extreme*	↑	*GL*	*JS*
2. Clinical leadership	Use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services	a. Clinical networks	*Low*	*Moderate*	*Moderate*	↔	*KM*	*VHP*
		b. GP practice & membership & engagement	*Low*	*Moderate*	*Moderate*	↔	*KM*	*VHP*
		c. Development of CCG GPs	*Low*	*Low*	*Low*	↔	*KM*	*VHP*
3. Governance & partnerships	Ensure appropriate constitutional and governance arrangements are in place to enable the CCG to become a highly effective membership organisation	a. Commissioning team	*Low*	*Moderate*	*High*	↑	*GL*	*VHP*
		b. Performance management	*Low*	*Moderate*	*Moderate*	↔	*GL*	*VHP*
		c. Governance and assurance framework	*Low*	*Low*	*Low*	↔	*GL*	*VHP*
		d. Organisational Development Plan	*Low*	*Moderate*	*Moderate*	↔	*GL*	*VHP*
		e. Medicines Review	*Low*	*Moderate*	*Moderate*	↔	*GL*	*VHP*
		d. Partnerships	*Low*	*High*	*High*	↔	*GL*	*KEM*
4. Finance	Ensure the most efficient use of resources to get the best value for patients	a. Achieve financial balance for FY15/16	*High*	*Extreme*	*Extreme*	↔	*GL*	*RT*
		b. QIPP	*Moderate*	*Extreme*	*Extreme*	↔	*GL*	*RT*
		c. SWL Financial Strategy	*Moderate*	*High*	*High*	↔	*GL*	*RT*
		d. OBC (finance)	*High*	*High*	*High*	↔	*GL*	*RT*
		e. Procurement strategy & contracts register	*Low*	*Moderate*	*Moderate*	↔	*GL*	*RT*
5. Quality & Engagement	Engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on improving quality and safety of services	a. Equality and diversity	*Low*	*Low*	*Low*	↔	*GL/AN*	*JS*
		b. Patient experience & safety	*High*	*High*	*High*	↔	*GL/AN*	*JS*
		c. Safeguarding	*High*	*Moderate*	*High*	↔	*GL/AN*	*JS*
		d. Resilience	*Moderate*	*Moderate*	*Moderate*	↔	*GL/AN*	*JS*
		e. Development of public and patient engagement	*Moderate*	*Moderate*	*Moderate*	↔	*GL/AN*	*JS*

NHS
Richmond
Clinical Commissioning Group

Richmond Clinical Commissioning Group Report Summary

Meeting Title:	Governing Body in public		**Date:**	21 June 2016	
Report Title:	Richmond CCG Estates Strategic Framework				
Agenda Item:	6		**Attachment:**	B	
Purpose: *(please indicate with X)*	Approval/ Ratification	**X**	Discussion / Comment		Information	
Author: *(name & job title)*:	Vicki Harvey-Piper, Director of Corporate Affairs		**Executive Leads (Clinical and Officer)** *(name & job title)*:	Vicki Harvey-Piper, Director of Corporate Affairs	
Presented by: *(name & job title)*:	Vicki Harvey-Piper, Director of Corporate Affairs		**Further Information contact** *(email address)*:	Vicki.harvey-piper@richmond.gov.uk	
Executive Summary:	In June 2015 the Department of Health and NHS England wrote to CCGs to request they develop a local approach to estates issues in order to respond to the NHS Five Year Forward View. The CCG has developed an estates strategic framework to address the challenges and opportunities associated with implementing its out of hospital strategy. The framework will evolve throughout 2016 and will be refreshed to reflect the SWL Sustainability and Transformation Plan.				
Financial/Resource Implications:	The CCG will need to invest in project support to develop an estates implementation plan (estimated 50k).				
Communication plan and stakeholder involvement:	The draft strategy has been shared for comment with the GP Premises group (which includes representatives from the Council and NHS Property Services) and the Local Medical Committee.				
Committees that have previously discussed/agreed the report and outcomes:	The strategy was discussed at EMT on 13 June.				
Equalities Analysis	The CCG is dedicated to ensuring that equality, diversity and inclusion are central to the way it commissions and delivers healthcare services and supports its staff. It aims to reduce inequalities in health and healthcare for the people of the borough of Richmond.				
Report Recommendation:	To approve the Richmond CCG local estates strategic framework. To ensure continued access to estates advice and procure resources to deliver the implementation plan.				

	To authorise the production of an estate implementation plan.	
Next Steps:	To set up an estates working group. To establish resource to develop the implementation plan. Revise the framework to reflect the content of the SWL Sustainability & Transformation Plan (STP) due to be finalised in the summer.	
STRATEGIC OBJECTIVE(S) ***(please indicate with X against relevant strategic objective)***	**Clinical Leadership**:	
	Use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services	
	Commissioning:	
	Work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people	**x**
	Quality:	
	Engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on improving quality and safety of services	
	Governance:	
	Ensure appropriate constitutional and governance arrangements are in place to enable the CCG to become a highly effective membership organisation	
	Finance:	
	Ensure the most efficient use of resources to get the best value for patients	**x**

BOARD ASSURANCE FRAMEWORK (BAF)	**Area(s):**	n/a						
	Priority Area(s):							
Current Risk Status: ***(please indicate with X)***	**Extreme**		**High**		**Moderate**		**Low**	
Movement since last month: ***(please indicate with X)***	↑		↔		↓			
Current position including action required:								

NHS
Richmond
Clinical Commissioning Group

Richmond CCG

Estates Strategic Framework: 2016-21

Updated June 2016

Version No: 0.5

Issue Date: 13.06.2016

DRAFT

1. Executive summary

1.1 In June 2015 the Department of Health (DH) and NHS England (NHSE) wrote to all clinical commissioning groups in England to request that they develop a local approach to estate issues in order to respond to the challenges set out in the *NHS Five Year Forward View.*

1.2 Richmond CCG has an established working group, through which this strategic framework has been developed to respond to and act on the opportunities associated with implementing the strategic principles of Richmond CCG and from which a subsequent implementation plan can be developed.

1.3 The framework and associated implementation plan will provide Richmond CCG with a route map for the future development of the primary care and community services estate in Richmond. One of the key drivers for developing this strategic framework is our out of hospital strategy – *Better Care, Closer to Home*, where we see more health services based in the community rather than hospitals, closer to where people live and providing more direct access to diagnostic testing for primary care clinicians.

1.4 This document provides a high level review of the current primary care estate, community estate and acute estate, as well as detailing the principles we can apply when determining the future estate and future approach to delivering this strategy. Included in the document is an outline of the principle approach that will be applied when considering future investment opportunities; this includes confirming that:

- Investments meet the needs of our local population;
- There are no significant financial implications to the CCG; i.e. revenue costs;
- It enables the CCG to utilise local estate to deliver our *Better Care Closer to Home* strategy;
- It ensures future investment in sustainable sites/primary care infrastructure.

1.5 The development of the strategic framework should be seen as the first point in developing our approach to managing and developing healthcare estate in Richmond and as such will be regularly reviewed; a process led by the estates working group, to ensure that it takes into account any changes in the healthcare landscape or priorities within the CCG.

1.6 The main drivers for developing this framework are to:

- Improve patient care;
- Outline our strategic direction, in relation to estates development, including our Transforming Primary Care programme and implementing our *Better Care Closer to Home* strategy;
- Ensure efficiency and cost effectiveness;
- Support the delivery of national policy.

2. Introduction

2.1 In June 2015 the Department of Health and NHS England wrote to all clinical commissioning groups in England to request that they develop a local approach to estate issues in order to respond to the challenges set out in the *NHS Five Year Forward View.* The DH/NHSE letter stated that a substantial improvement in the local management of the NHS owned and occupied estate was required in order to help commissioners deliver their commissioning intentions and ensure that patients receive the right care, at the right time, in the right setting, from the right provider.

2.2 In particular, the letter identified considerable opportunity for the NHS to:

(1) use the existing estate more effectively;
(2) reduce running and holding costs;
(3) reconfigure the estate to better meet commissioning needs;
(4) share property (particularly with social care and the wider public sector);
(5) dispose of surplus estate to generate capital receipts for reinvestment; and
(6) ensure effective future investment.

2.3 In response to the DH/NHSE request, Richmond CCG will develop its existing GP premises group into an estates working group (EWG) to support our commissioning intentions by identifying and supporting opportunities to manage and modernise the whole health estate in Richmond. The EWG will be responsible for the co-ordination of projects and prioritisation of investment in the local health estate and the identification and management of estates issues and risks.

2.4 The CCG has developed this framework to respond to and act on the opportunities identified above. It will support the delivery of the CCG's commissioning intentions and outline the overarching strategic principles on which a detailed estates implementation plan will be based. It is vital that service and estates planning are integrated to ensure the best estate is available to deliver the best healthcare services, based on well-founded investment decisions providing an opportunity to ensure that the estate is fit for purpose and suitable to the needs of our populations.

2.5 Some of the Richmond healthcare estate may no longer be suitable for the delivery of healthcare services or may be underutilised, vacant or used to deliver back office functions. Conversely there may be other areas where estate is under pressure to deliver more services, possibly as a direct impact of delivering our future commissioning intentions. The aim of the framework and subsequent plan will be to identify where these opportunities may exist and align our future estates requirements.

2.6 Richmond CCG already meets the costs of running the estate in its area, either directly or indirectly through commissioning contracts. Estate running costs represent the third largest cost to the NHS after staff costs and medicines. Better use of the estate will enable significant savings for potential reinvestment in patient care.

2.7 In order to realise the benefits outlined in the DH/NHSE letter, the CCG will engage with local health and other public sector partners in the process of developing the detailed estate implementation plan to ensure that a truly holistic approach is taken to estates planning. The implementation plan will include plans for:

(1) primary and community care estate;
(2) non-clinical estate, such as office/administrative bases;
(3) secondary and tertiary care estate; and
(4) wider public sector estate.

2.8 The detailed plan will be formulated during 2016 as a dynamic planning tool for identifying and managing changes to the healthcare and social services estate in Richmond. It will include the current context, vision, gap analysis, initiatives, clear delivery plans and an achievable timescale for delivery. The first step in this process is to develop a service optimisation plan for primary care and community care. The estate optimisation plan including non-clinical estate will follow the clinical plan during 2016.

2.9 The framework and implementation plan will also need to feed into the development of the wider south west London estates strategy and service development plan.

3. Scope

3.1 The purpose of the framework and plan is as follows:

(1) to evaluate the current condition, suitability and usage of the existing estate in Richmond;

(2) to identify the ideal quantum of estate required given:

- the CCG's commissioning intentions;
- the changing NHS landscape (e.g. the move to transfer more services out of hospital into the community);
- changes in population demographics (e.g. the ageing population);
- opportunities to increase utilisation of existing facilities (e.g. through seven days per week working), taking account of the NHS Property Services analysis of utilisation of the current estate;
- technological factors (e.g. telehealth);
- initiatives to bring about closer working between the NHS and local authorities; and
- other factors not included above but which may appear to be relevant in the future.

(3) to identify and quantify the gap between the current and desired positions;

(4) to identify the steps required to close the gap between the current and the desired positions (e.g. by identifying detailed data required to maximise opportunities for the increased utilisation of estate);

(5) to advise on property investments and disinvestments to reach the desired position;

(6) to provide a structured method to evaluate investment, disinvestment and reinvestment bids;

(7) to ensure that new estate is fit for purpose in terms of its location, quality, affordability and likely utilisation;

(8) help to ensure that NHS services are delivered in premises that are:

- capable of meeting increasing demand;
- flexible to accommodate changing service models; and
- clinically safe and sustainable; and

(9) enable Richmond CCG to evaluate bids for capital investment which may be funded through increased rents, NHS capital (including the Estates and Technology Transformation Fund), developer Section 106 funds, or Community Infrastructure Levy (CIL) capital.

3.2 The framework and plan will provide the CCG with a route map for the primary care and community services estate over the next 5-10 years. Assumptions will be made concerning primary care, community services, acute facilities and opportunities for co-location of health and social care service delivery and administration.

3.3 The implementation plan will identify where further work is required and how the plan should be monitored to ensure that the relevant investment cases are developed and implemented at the appropriate times.

4. London Borough of Richmond: population profile

4.1 The last decade has seen the population in the borough of Richmond increase from 172,335 at the 2001 Census to 187,527 by the 2011 Census; this represents an 8% increase in 10 years.

4.2 The borough has 28,900 people over the age of 65. This represents 15% of the total Richmond population, compared to an average of 11% across London (Census 2011). By 2025 it is anticipated that there will be an additional 8,400 people over the age of 65, an increase of 29%.

4.3 At 51% Richmond already has the highest level of over 75s living alone. If the population continues on current trends more services will be required closer to home.

4.4 With a projected increase in population size, population density will increase. This will result in an increasing demand for statutory services, including schools, housing, health and social care. Limited English-speaking abilities among a more ethnically diverse population will have implications for health promotion and service planning, particularly awareness programmes for screening, and conditions such as diabetes and circulatory disease.

5. NHS commissioning intentions

Primary care

5.1 General practices in Richmond range in size from 13,423 registered patients with 7 GPs at 1917 patients per FTE to 1,980 registered patients at a single GP. Practices with four or fewer GPs with lists below 7,200 patients make up nearly 46% of the providers across the borough. Smaller practices may lack resources and capacity to flex their workforce in the same way as larger ones and therefore may be less able to take on additional services and engage with quality initiatives. (See the **General Practice Commissioning Strategy Development** document.) Facilitating the formation of larger practices over time will have estate implications, requiring a programme of disinvestments and new developments.

5.2 The GMS Contract Negotiations letter published by NHSE in November 2013 (Gateway Ref. 00698) contains a strong indication that GP working patterns are likely to change in the future, in the direction of extended opening hours:

> "The extended hours' enhanced service will be adapted to promote greater innovation in how practices offer extended access."

5.3 Seven day per week working could have a dramatic effect on available service capacity and estates utilisation, which in turn will impact on the quantum of estate required to deliver the required services.

5.4 The *Transforming Primary Care in London: A Strategic Commissioning Framework* states that "All CCGs in London will become more involved in the commissioning of primary care services in 2015/16." Richmond CCG took on the role of commissioning primary medical care services via delegation from NHSE from April 2016.

5.5 Demand for additional GP facilities is driven by population growth, which in turn is largely determined by housing growth. Estates planning for primary care facilities should therefore keep track with Richmond Council's Local Plan (core strategy) and its implementation over time (see below).

Community and out-of-hospital services

5.6 A shared vision across south west London is for community buildings to become catalysts for health and wellbeing in their local communities operating to:

- Act as a central hub for an integrated range of health-related services
- Be at the heart of the community
- Be able to engage with patients and the wider community and
- Co-produce and shape the services to meet their needs

5.7 Richmond CCG wants to see more health services based in the community rather than hospitals, closer to where people live (including direct access diagnostic testing for primary care clinicians). Richmond CCG, in line with the *Five Year Forward View* and CCG strategy, will continue to work with the joint venture (JV) between Hounslow & Richmond Community Healthcare NHS Trust (HRCH) and the Richmond General Practice Alliance (RGPA) to develop outcomes based commissioning of

services to maximise patient wellbeing. The CCG's requirement of the JV is to establish local multi-disciplinary hub teams with multi-disciplinary teams (MDTs) providing integrated case management. Four local MDTs serving a population of approximately 50,000 people would be set up across the borough and include a range of health and social care professionals e.g. GPs, practice nurses, healthcare assistants, allied health professionals, third sector support, social workers and community matrons. Services would include end of life care, management of people with long term conditions and falls prevention & management.

5.7 Richmond CCG is establishing options to increase the use of digital technology where appropriate (including providing medical appointments online).

5.8 A focus in Richmond is to consider the use of assistive technology in patients' homes to support increasing levels of self-care and telehealth for people with long term conditions, for example:

- People at risk of frequent hospital admissions due to heart or lung conditions;
- People managing diabetes;
- People with dementia;
- People who need support with medicines management;
- People who are at risk from falls, isolation or increasing frailty in old age linking with the falls and bone health service.

5.9 The increased use of technology could have an effect on the amount of estate space required over the longer term as more care can be transferred to the patient's own home.

5.10 These shifts could potentially impact on the size of community healthcare facilities required by reducing the need for fixed facilities.

5.11 The gains these initiatives may create could offset the impact of population growth reducing the need for further estate growth.

6. Joint Health and Wellbeing Strategy

6.1 The Richmond Joint Health and Wellbeing Strategy (2013-2016) identified a clear intention to shift resources away from specialist health and care services in favour of primary and community care. Richmond Council and Richmond CCG are united around four core priorities:

- Child to adult transition;
- Physical and mental health services;
- Health and social care services;
- Hospital to community services.

6.2 These priorities support three goals:

- Giving children a good start;
- Increasing independence of older people with long term conditions;
- Reducing hidden harms and threats to health.

6.3 One area where closer cooperation between the Council and the NHS is critical is in providing a more integrated service to people with long term conditions. This has coalesced into the reconfiguration of services around three themes for older people:

- Prevention and early intervention
- Targeted care and support
- Longer term care and support

6.4 The requirement to accommodate more services in the community will necessarily have estate implications. Co-locating services has the potential to improve the utilisation of existing facilities and therefore to reduce the overall amount of public sector estate, or to relieve pressure in the system and free up space for providing alternative services.

6.5 Information technology will also support improved communications between services to ensure that the CCG and Council priorities including integrated health and social care and integrated physical and mental health services can be delivered in both the home and in healthcare facilities.

7. CCG drivers and challenges

Context and clinical drivers

7.1 Both the *NHS Five Year Forward View* and *Transforming Primary Care in London* (NHSE 2015) highlight the importance of the GP held registered list being central to moving activity out of acute hospitals and into community settings.

7.2 In addition there is increased acknowledgement that the barriers that exist both within health care (e.g. between primary care and secondary care) and across sectors (e.g. between health and social care) need to be removed.

7.3 In order to facilitate this change it is imperative that GP and community health care settings are fit for purpose, flexible and are utilised to their full potential to drive efficiencies.

Challenges

7.4 The proposed closure by South West London & St George's Mental Health Trust (SWLStG) of Richmond Royal and Barnes Hospitals may result in mental health services being provided from other settings (including sessional space).

7.5 The *Transforming Primary Care in London* programme is supporting all practices to achieve standards in providing accessible, proactive and coordinated care

7.6 The *Prime Minister's Challenge Fund* project has supported the GP federation to deliver all aspects of the Enhanced Access and Systems Transformation in Richmond (EASTIR) project including 8 until 8 working across seven days per week access.

7.7 Outcomes based commissioning (OBC) will result in workforce shifting to out of hospital settings therefore the CCG needs to ensure that suitable primary care and community infrastructure are available to accommodate these services.

7.8 Investment in GP premises has been varied in Richmond with some practices receiving investment whilst others need further investment to support the CCG strategies.

7.9 There is a need to deliver appropriate GP coverage in localised pockets where high population growth is expected.

7.10 The CCG has identified the following four GP premises as key priority issues:

- North Road Surgery;
- Park Road Surgery;
- York Medical Practice; and
- Kew Medical Practice.

8. Richmond Council core strategy

8.1 Richmond Council adopted a Core Strategy in 2009 and a Development Management Plan in 2011. The policies in both plans are currently being reviewed and consolidated into a single Local Plan, which is anticipated for adoption in spring 2018.

8.2 The borough's housing target is 3,150 homes for the period 2015-2025, as set out in the London Plan. As at April 2015 the housing land supply in the borough potentially provides for 2154 units over the next five years and another potential 1875 units in years six to ten. The borough is therefore on course to meet the strategic dwelling requirement.

8.3 At Richmond's historic occupation rate of 2.3 inhabitants per household (ONS 2011 Census) this translates into an increase in population of 7,245 in the planning period (2016-27).

8.4 At 1,800 to 2,000 registered patients per GP the new population would require c.3.5-4 additional GPs in the planning period (2016-27).

8.5 A major component of future development is likely to be urban intensification incorporating residential and commercial developments in Richmond and Twickenham centres, with smaller scale development in the borough's other centres including Teddington, East Sheen and Whitton. Major transport infrastructure improvements, such as the proposed Crossrail 2, could potentially lead to additional development in the Teddington and Hampton areas.

8.6 Two Section 106 Agreements are in place for the creation of new health facilities in the Kew and North Sheen areas.

8.7 Early engagement with all developers should become the norm to identify opportunities to obtain suitable premises at the design stage of developments. This can be addressed via the estates working group.

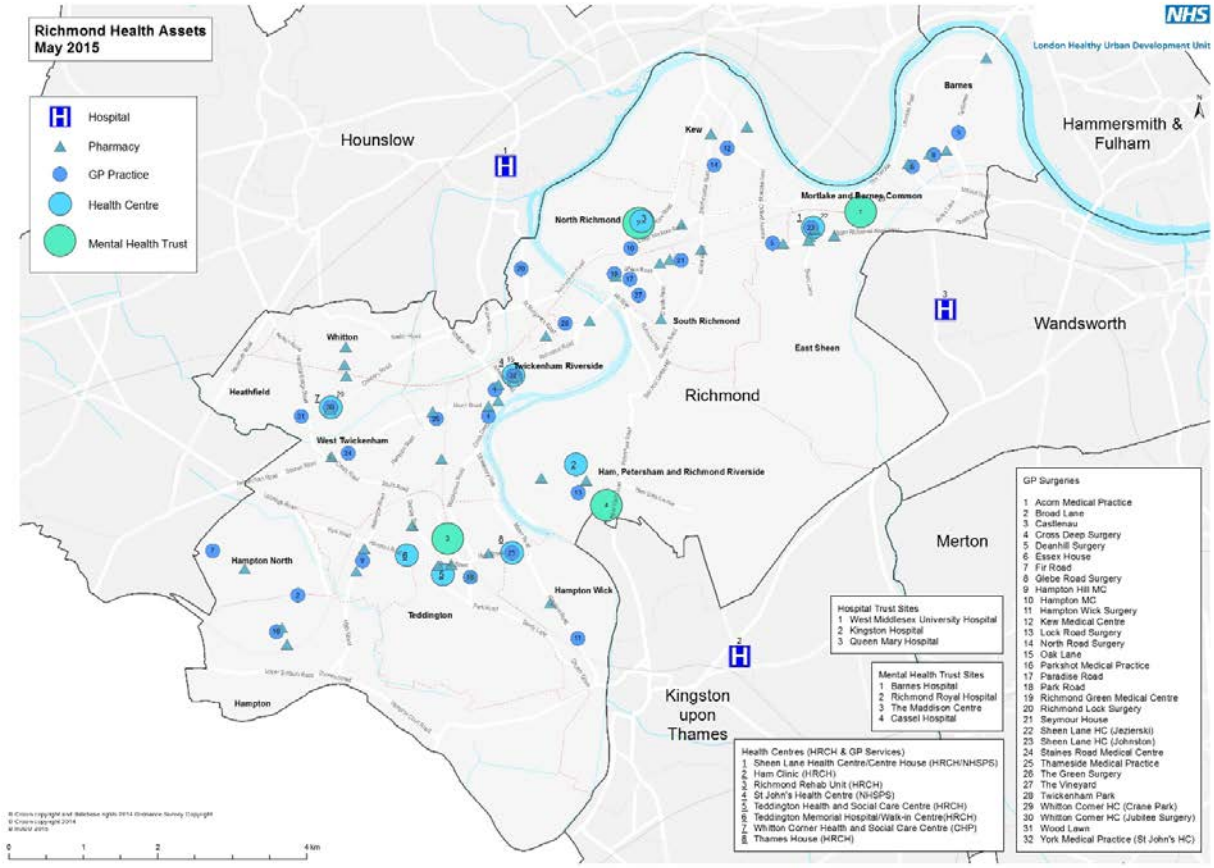
8.8 The Community Infrastructure Levy (CIL) has been introduced in Richmond. However, the current Regulation 123 List (November, 2014) does not include funding for health care improvements. The CCG will endeavour to gain CIL for health.

9. Current primary care estate in Richmond

9.1 A review of current GP properties in Richmond has been undertaken by NHS Property Services as part of their baseline study and the schedule is attached at Appendix 1 Section 3.

9.2 Richmond CCG consists of 28 GP Practices, with over 207,000 registered patients. The CCG is divided into two localities:

- Richmond and Barnes (East Sheen and Barnes and Richmond, Ham and Kew)
- Twickenham, Teddington, and Hampton (Teddington and Hampton; Twickenham and Whitton)



9.3 The East Sheen and Barnes locality is a discreet area between the River Thames to the north, Richmond Park to the south, Barnes Common and Roehampton University campus to the east and North Sheen to the west. Housing is relatively dense and the area includes a wide range of levels of health and wellbeing with some more deprived areas located in the north Barnes peninsula.

9.4 The area is unlikely to see significant changes to the housing stock and it is anticipated population growth will be limited and may involve a decline in population up to 2025 in the north Barnes area balanced by limited growth in East Sheen.

9.5 The area includes the Sheen Health Centre.

9.6 Richmond, Ham and Kew is an area bounded by North Sheen to the east, Kew Gardens and the Thames to the north and west and Richmond Park to the south and east. The area includes Ham which is an isolated and relatively deprived riverside community surrounded by the Thames on three sides and is bounded by the northern suburbs of Kingston to the south. Most of the area is expected to grow in population by 2025 with growth of less than 1000 persons per ward.

9.7 The locality has a community clinic in Ham and the Richmond Rehabilitation Unit in Richmond.

9.8 Two development sites have been offered to the CCG in the area at the Kew Inland Revenue office site and the Dairy Crest site in North Sheen.

9.9 The Teddington and Hampton area also includes a wide variation in health and wellbeing with the least deprived in the Teddington area and most deprived in the Hampton area. The area is expected to grow by under a 1000 person per ward by 2025. However, Teddington and Hampton include four stations that will be included in the Crossrail 2 scheme which is due to open in 2030. Experience with other transport schemes indicates that growth can start to increase prior to the opening of new transport corridors. It would be prudent to start planning for growth related to the scheme as soon as possible.

9.10 The Teddington and Hampton area is divided by Bushy Park and the Fulwell Golf course at the eastern edge of Hampton Hill. There are no community health service facilities in the Hampton area. However, there are two sites in Teddington (Teddington Clinic and Teddington Memorial Hospital).

9.11 The Twickenham and Whitton area is also varied with greater levels of deprivation in the west. The locality has the highest anticipated population growth with up to 2500 new residents in the Twickenham and St. Margaret’s area.

9.12 The Twickenham and Whitton locality includes the St. John’s Health Centre and the Whitton Health Centre.

9.13 The borough is split between the east and west sides of the River Thames and only has two road bridges and a rail route linking the east and west of the borough.

9.14 The borough has significant areas of green space and the communities are generally located around the railway network. The borough has 14 railway stations of which

two are also London Underground stations. The London Underground stations are in some of the least deprived parts of the borough.

9.15 Crossrail 2 will serve the Teddington and Hampton area.

9.16 Some of the most deprived areas are distant from public transport which provides access to employment and services.

9.17 GP practices are spread across the borough in a distribution pattern providing reasonable access within 1 mile of most homes.

10. GP practices - immediate priorities

North Road

10.1 North Road Surgery is based in Kew, an area of need in terms of GP access, as highlighted in the Core Strategy 2009. The practice is housed in a converted bungalow which is no longer fit for purpose or large enough to service the 7000 list size. Additionally, the remaining practicing GP owner wishes to retire and so the GP partners were given notice in 2014. The practice had much difficulty finding an alternative site, however they have now secured a development within Kew that will be purpose built and available from 2017 at the Inland Revenue office site adjoining Kew Retail Park.

Inland Revenue site, Kew /North Road Surgery	Residential development with s106 delivery of health premises. Funding required for fit out. Terms to be agreed with developer. Unit is larger than required for GP (even allowing for population growth) and an additional tenant will be required - possibly a pharmacy. Fit out to be carried out by NHSPS or by a private landlord.	Relocation of North Road Surgery into the new premises. Current premises are GP owned. North Road Surgery currently is under target size and low cost - there will be revenue implications associated but the space shortfall will be reduced by this proposal.

Extract from NHSPS Report to Richmond CCG

10.2 Capital funding for the fit out of this site has been secured through NHSE. The CCG has agreed to fund the additional rent contributions that inevitably will be incurred when moving from a small residential conversion to a purpose built new build, in line with the NHS Premises Directions. Further work will be developed on the implementation of the scheme.

Park Road

10.3 Park Road is currently significantly below the minimum GIA target, in a building that is no longer fit for purpose. Additionally, two of the partners are due to retire and wish to relinquish their share of the current property. The current partners do not wish to acquire the existing site, because it is not fit for purpose, and are therefore reviewing local options.

Park Road Surgery	End of terrace house converted for use as GP surgery with no scope for expansion. Very low space per 1000 patients, a long way below target size. Relocation to alternative premises therefore required in short to medium term. Options include: 1 New development on local council owned land, 2 Existing space within a church owned property managed by Blue Land (?development partner of the church)	Current list size is approx 13,000, giving target GIA of 1,100 sqm (HBN11) or 780sqm at the 'minimum' target. Headline cost assumptions are included in section 7 The project is being led by the practice itself. The CCG and NHSE are monitoring and advising where required. It is recommended that suitable professional advice is employed to minimise risks and ensure realistic and deliverable assumptions are used in all appraisals and the business case.

Extract from NHSPS Report to Richmond CCG

Further work is being undertaken to establish deliverable options for the practice.

St. John's Health Centre/ York Medical Practice

10.4 York Medical Practice is based in St John's Health Centre, a property currently owned by NHSPS. The practice has had a number of concerns about the general state of the premises, dating back to 2009 and the practice is increasingly facing issues relating to the building. NHSPS has agreed to some remedial fixes to the building and is reviewing the options highlighted in the 2014 feasibility study, with a view to producing a business case.

St John's Health Centre, Twickenham	NHSPS owned 1960s health centre at end of economic life. Main occupier is a GP practice. A number of other services have small units of space. Immediate necessary repairs will be completed to allow time to agree way forward. Options are : 1 To develop new health centre nearby or 2 To decant temporarily while existing building is redeveloped. Workable decant option has been provided via local authority.	Target for a decision within six months and project (either relocation or rebuild on the current site) complete by end 2017.

Extract from NHSPS Report to Richmond CCG

Further feasibility work is being developed.

Kew Medical Practice

10.5 Kew Medical Practice has put in an application to the PCIF for a first floor extension on their existing building. The outcome of this bid is currently unclear and NHSE are seeking clarifications. The practice is also looking at the possibility of relocation within the Kew area and is currently looking at options.

10.6 Work has been undertaken to establish whether the Section 106 site at the Dairy Crest site may be suitable.

The Surgery, Castlenau, Barnes

10.7 This practice is owned by the current partner and is on the ground floor of a residential building. The building is not DDA compliant and so will not meet all requirements of a CQC inspection.

The practice submitted a Business Case Improvement Grant application to NHSE and completed a PCIF bid in January 2014, which was successful. However, when the practice became aware that they would need to fund 33% of the bid (as it had been classed as an Improvement Grant) they withdrew from the process. Therefore, this site remains a priority for the CCG as it remains significantly under the target GIA.

11. Current NHS community health estate in Richmond

11.1 The community estate in Richmond has been rationalised over the period leading up to 2013. Consequently, the operational community health estate, excluding mental health hospitals consists of eight clinical sites:

	Name	Location	Content	Ownership
1	Centre House, Ground and First Floor, Sheen Lane Health Centre 68 Sheen Lane	East Sheen and Barnes	GP+ Community Health services	NHSPS
2	Ham Clinic	Richmond, Ham & Kew	Community Health services	HRCH
3	Maddison Centre	Teddington & Hampton	Community Mental Health services	SWLSGMHT
4	Richmond Rehabilitation Centre and land at Kew Foot Road	Richmond, Ham & Kew	Community Health services	HRCH
5	St. John's Health Centre, Twickenham	Twickenham & Whitton	GP+ Community Health services	NHSPS
6	Teddington Health and Social Care Centre Thame House	Teddington & Hampton	GP+ Community Health services	HRCH Leasehold
7	Teddington Memorial Hospital	Teddington & Hampton	Community Health and Intermediate Care services	HRCH
8	Whitton Health Centre	Twickenham & Whitton	GP+ Community Health services	CHP (LIFT)

11.2 Of the eight sites, two are owned by NHS Property Services (NHSPS), three are owned and one is leased by Hounslow and Richmond Community Healthcare (HRCH), one is owned by South West London & St George's Mental Health Trust (SWLStG) and one is a Community Health Properties (CHP) Local Improvement Finance Trust (LIFT) site.

11.3 The CHP building is the only long term estates commitment in the Richmond CCG area as all other properties are either freeholds within the NHS or shorter term leaseholds.

11.4 The CCG operates from Richmond Council's offices in Twickenham where health and social care commissioners are able to work together.

12. Current acute NHS health estate in Richmond

12.1 There are no acute medical hospitals in the borough of Richmond. Acute hospitals are located in Kingston to the south (Kingston Hospital Foundation Trust), Isleworth to the north west (West Middlesex University Hospital) and in Roehampton to the east (Queen Mary's Hospital).

12.2 The borough includes three mental health hospitals in Richmond, Barnes and Ham Common providing local and outreach services.

12.3 Richmond Royal and Barnes Hospital are operated by South West London and St. George's Mental Health Trust (SWLStG) whilst the Cassel Hospital at Ham common is owned by the West London Mental Health Trust (WLMHT).

12.4 Part of the Cassel is used for specialised services whilst other parts of the hospital have been converted to private flats.

12.5 SWLStG are focusing on redeveloping their facilities at Tolworth Hospital in Kingston and Springfield University Hospital in Wandsworth to provide modern safe and secure facilities for mental health services.

12.6 As part of these developments, surplus land no longer required for healthcare will be vacated and sold. SWLStG will reinvest the proceeds from these sales in better mental health services and facilities in order to:

- modernise community mental health services to provide more care closer to people's homes;
- develop new, first class mental health hospitals to support patients who clinically need a bed; and
- establish a network of mental health services that are affordable to the NHS in the long term.

12.7 These plans will ensure development of an extensive network of community services to treat people closer to home whenever possible, as well as new, state-of-the-art inpatient facilities for patients who are most in need.

12.8 SWLStG are exploring options for the Richmond Royal and Barnes Hospital sites as part of the ongoing programme to ensure the trust can provide the best mental health services for the people of south west London for generations to come. Inpatient accommodation has not been provided at either site for many years, and the buildings are not suitable for modern inpatient mental healthcare.

12.9 Both Richmond Royal and Barnes Hospital need to be treated carefully from a development perspective. Parts of Richmond Royal have a listed status, and both sites have limited accessibility, with their age making it impossible to develop an environment for inpatient care which meets modern standards. In light of these conditions, the local NHS needs to explore options for the sites to determine how best they can be used in the future and secure the most value for the NHS.

12.10 As part of this process, the Richmond Royal site has been declared surplus from 1 December 2015. This declaration does not impact on services, but enables the NHS to progress discussions around options for the site's future use and design. Outpatient healthcare continues to be provided from the site, and the ongoing work to develop options for its future will continue to involve stakeholders, including staff, patients, site tenants, and local representatives.

12.11 SWLStG will retain a firm presence in Richmond, with 500sq m of outpatient facilities remaining on the Richmond Royal site, and will make improvements that will provide care closer to patients' homes as alternatives to hospital admission. Services and staff levels will not be reduced.

12.12 The trust is also retaining part of the Barnes Hospital site, which the Garden House building is located on. This building currently provides, and will continue to provide, outpatient mental health services.

12.13 The sites at Barnes and Richmond are not well located for high capacity services for a wider geographic population. However, the NHSPS space analysis identified a shortfall of GP floor space in Richmond, Ham and Kew of 228sq m and in East Sheen and Barnes of 170sq m.

12.14 The analysis indicates that redeveloping GP practices to the NHS HBN 11-01 standard would require an additional 1315sq m of floor space in each locality within new circa 3,700sq m buildings.

12.15 The sites may have the capacity for such schemes but the sites are not well located for access by public transport or by private motor car making them unsuitable for large high capacity multi-disciplinary healthcare facilities with large catchment areas.

Queen Mary's Hospital at Roehampton has good public transport and road links to the Richmond, East Sheen and Barnes areas.

12.16 Integrating the estate strategies of the acute hospitals will form part of developing the CCG's estate implementation plan during 2016 and beyond.

13. Principles for future estates development

13.1 The principal approach that will be taken when considering future investment opportunities will be to ensure that:

- It meets the needs of our local population;
- There are no significant financial implications to the CCG i.e. revenue costs;
- It enables the CCG to deliver the *Better Care Closer to Home* strategy;

- It ensures future investment in sustainable sites/primary care infrastructure.

13.2 As mentioned above, the local estate strategy and estate implementation plan will help to ensure that NHS services are delivered in premises that are:

- Capable of meeting increasing demand;
- Flexible to accommodate changing service models; and
- Clinically safe and sustainable.

13.3 The strategy and plan will enable Richmond CCG to evaluate bids for capital investment which may be funded through increased rents, NHS capital (including the Estates and Technology Transformation Fund (ETTF)), developer Section 106 funds, or Community Infrastructure Levy (CIL) capital if Health is included in the Richmond Borough Council Regulation 123 list (Appendix 2).

13.4 The ETTF will support proposals which improve access to services, transfer activity from acute to primary care, avoid admissions to hospital and support training.

13.5 The strategy and plan will provide a structured method to evaluate new proposed investment, disinvestment bids and reinvestment bids. The structured approach will establish local and strategic needs and evaluate proposals which meet these needs in part or in whole.

13.6 The bids will be evaluated through a cost/benefit analysis which will place small scale developments on the same footing as major developments. Bids will be scored against 11 criteria which include local and strategic components.

13.7 Strategic issues will cover demographic change and service design, whilst local issues will focus on compliance and sustainability.

13.8 Any scoring the cost/benefit analysis will include consideration of the following:

(1) Quality: privacy and dignity, reliability;
(2) Availability: timescale for implementation;
(3) Affordability: availability of funds.

13.9 When addressing future estates needs we will also consider the current investment proposals that have been developed in Richmond by our local GP practices as a way of ensuring that future requirements take stock of what has previously been approved or is currently in the pipeline. The Estate Working Group will provide strategic oversight of this process.

14. Next steps

14.1 Development of the estate implementation plan will proceed in collaboration with local partners including Richmond Council and other stakeholders. It is anticipated that further stakeholder events will take place to support the development of the plan.

14.2 It will also be necessary to develop site specific plans to improve utilisation of the existing estate and develop new schemes to meet existing capacity shortfalls and future growth requirements.

14.3 A financial planning model should be developed to support the strategic framework and implementation plan, to ensure that the implementation plan remains affordable and deliverable.

14.4 A review of the current estate should be conducted which should include a focus on areas where there are known pressures e.g. expiration of leases or undocumented tenancies. The review will also consider the use of community pharmacy premises.

14.5 Developing site specific plans which support the overarching principles as detailed in this framework will form part of our Estates & Technology Transformation Fund (ETTF) bid proposal which is to be submitted by the end of June 2016.

14.6 Continuing to pursue site specific options for delivering outcomes based commissioning working with the joint venture and key stakeholders to look at potential options.

Timescale

14.7 This updated framework document will be submitted to the CCG's governing body for approval in June 2016.

14.8 The development of the estates implementation plan will follow the approval of this updated estates strategic framework through 2016.

14.9 The development of an integrated NHS Estates Strategy for south west London is expected to be completed in the summer of 2016 as part of the Sustainability and Transformation Plan.

15. Recommendation

15.1 To approve the Richmond CCG local estates strategic framework.

15.2 To ensure continued access to estates advice and procure resources to deliver the implementation plan.

15.3 To authorise the production of an estate implementation plan based on the principles set out in this document and the content as set out in Section10, to be reported back to the governing body later in 2016.

NHS
Richmond
Clinical Commissioning Group

Richmond Clinical Commissioning Group Report Summary

Meeting Title:	Governing Body in public			**Date:**	21 June 2016	
Report Title:	Medicines Optimisation Review					
Agenda Item:	7			**Attachment:**	C	
Purpose: ***(please indicate with X)***	Approval/ Ratification	**Y**	Discussion / Comment		Information	
Author: ***(name & job title)*:**	Emma Richmond, Chief Pharmacist		**Executive Leads (Clinical and Officer)** ***(name & job title)*:**		Julie Sobrattee, Chief Nurse, Director of Quality and Safety	
Presented by: ***(name & job title)*:**	Emma Richmond, Chief Pharmacist		Emma Richmond, Chief Pharmacist		Emma.richmond@richmond.gov.uk	
Executive Summary:	During Q3 2015/16 the CCG's GP lead for medicines optimisation undertook a review of the CCG's medicines optimisation service. One of the findings led to the proposal to second a team of pharmacists from the CCG to the Richmond GP Alliance to lend medicines optimisation provider support. Two pharmacists (a deputy and chief pharmacist) would remain within the CCG and move within the Directorate of Quality and Safety. It is considered that formal tendering procedures may be waived in this circumstance. This is because the specialist expertise to support this team is only available from the one source in Richmond; also the GP practices hold the registered patient list for whom the primary care prescribing is undertaken. The secondment of this team is proposed for an initial period of a year, during which the performance will be evaluated against a set of performance indicators. If successful, the staff will be transferred for employment under protection by the Richmond GP Alliance. Otherwise the staff and service will return to the CCG. To date, the GP medicines optimisation lead for the RGPA, and the professional lead pharmacist have been recruited. Q1 2016/17 has been designated as the 'transition' period during which the roles and responsibilities are being risk stratified and shared between the two organisations. The performance indicators and terms of a three year contract are being worked up, and the recruitment of the remainder of the RGPA's primary care pharmacist team will commence shortly. This will take the establishment of the RGPA's team to 5 WTE (1 x band 8b professional lead, 2 x band 8a and 2 x band 7 primary care pharmacists). The outcomes of the review were discussed and agreed by the CCG's					

	Clinical Executive Team and Executive Management Team. It is presented the Governing Body for approval due to the value of the seconded staff over three years (~£900k).
Financial/Resource Implications:	~£300k pa for 3 years with first year on secondment and transferred under protection thereafter should the evaluation demonstrate the benefit of the service. At this point, consideration will be given to the possibility of devolving the ~£22m primary care prescribing budget to the Richmond GP Alliance.
Communication plan and stakeholder involvement:	The plan has been discussed by CET in Oct 2015 and Jan 2016, in addition to the clinical network meetings in March 2016 and recently by EMT. An email will go out in due to course to the membership outlining the updated plan.
Committees that have previously discussed/agreed the report and outcomes:	As above
Equalities Analysis	Not applicable – practice allocation of the primary care pharmacists' time will be according to their prescribing performance with an element of weighting for practice size and locality.
Report Recommendation:	To approve the proposal, prior to the enactment of the plan from Q2
Next Steps:	As above

STRATEGIC OBJECTIVE(S) ***(please indicate with X against relevant strategic objective)***	**Clinical Leadership**:	
	Use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services	✓
	Commissioning:	
	Work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people	
	Quality:	
	Engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on improving quality and safety of services	✓
	Governance:	

	Ensure appropriate constitutional and governance arrangements are in place to enable the CCG to become a highly effective membership organisation	✓
	Finance:	
	Ensure the most efficient use of resources to get the best value for patients	✓

BOARD ASSURANCE FRAMEWORK (BAF)	**Area(s):**	*2b, 4b*	*GP engagement and QIPP*
	Priority Area(s):	*3e*	*medicines review*

Current Risk Status: ***(please indicate with X)***	**Extreme**		**High**		**Moderate**	✓	**Low**	

Movement since last month: ***(please indicate with X)***	↑	✓	↔		↓	

Current position including action required:	Change has not yet been enacted and staff need to be recruited to the new model so risk has not altered yet.