LAY MEMBER'S HEADLINE FEEDBACK FROM THE WANDSWORTH PCT PROFESSIONAL EXECUTIVE COMMITTEE (PEC) MEETING WITH THE PCT MANAGEMENT TEAM 22 APRIL 2008

These headlines are for rapid briefing purposes about the lay/user issues arising in the meeting. It is not a full report from the meeting.

PEC and PCT Board papers are available on the WPCT website: **www.wandsworth-pct.nhs.uk**

The contents of this briefing note are for information only and are solely the responsibility of Andrew Craig, PEC Lay Member, including errors and omissions. They do not necessarily represent the views of the PEC or Wandsworth PCT.

Declaration of Interest

I made the following formal declaration: The Moore Adamson Craig Partnership LLP was part of the successful bid by Wandsworth Care Alliance (WCA) which had been awarded the contract by Wandsworth Council for three years to be the Local Involvement Network (LINk) Host for Wandsworth. MAC had agreed a SLA with WCA to deliver a range of services to support WCA's role as the LINk Host. The Local Authority was satisfied with the arrangements.

Matters Arising

Henderson Hospital
The Henderson Hospital would close temporarily on Thursday 24th April pending the outcome of the consultation on its future. There were no Wandsworth clients at the hospital and two people from Wandsworth being assessed would be offered the Cassel Hospital as an alternative.

Polyclinics
See March feedback report for local background. Dr Tom Coffey is the NHS London lead for the polyclinic pilots. Progressing the PCT's two proposed polyclinic pilots is complicated by the government's national requirement for a "GP led health centre" to be created in every PCT. This objective has decreased relevance here as Wandsworth is the best doctored area (in terms of GPs per head of population) in London. Polyclinic activity is "planning only" at this stage. The pilot stage cannot commence until after 12 June when NHS London takes its decision about the way forward on polyclinics as part of Healthcare for London consultation outcome. After that a formal process of engagement and consultation must take place before approval of any schemes.

Given the creation of the Local Involvement Network (LINk) and the commencement of Section 242 duties from 1st April, it is essential that the local community and service users likely to be affected by polyclinic developments are integrated into the PCT's deliberative process without delay. I will be asking for evidence that this has happened.

Local Involvement Network (LINk) for Wandsworth

Ann Radmore said her office was pulling together information about how the LINk could interact with the PCT. Once that is done, she will seek meetings with LINk if they are ready to engage at that level. This will include briefings about the PCT's financial and commissioning strategies.

I welcomed this and said I would ensure that this message was passed to the LINk Host for action.

18 Weeks Targets

The PCT, including Queen Mary's Hospital, had achieved its 18 week targets for both admitted and unadmitted patients at 31st March. St George's Hospital had exceeded its target and provided much improved quality data. Chelsea and Westminster Foundation Tust had achieved its 18 weeks targets, but Guys and St Thomas' Foundation Trust just missed the target for Wandsworth patients. Kingston Hospital also failed to meet its target for Wandsworth patients .

The PCT will publicise these positive messages to patients with thje objective of raising expectations about a high level of choice and low waiting periods. The advent of "Free Choice" from 1st April and the development of NHS Choices as the Choose and Book portal will be promoted. Complaints locally about waiting have declined significantly. Patients will be encouraged to report unacceptable or perverse behaviour from Trusts, such as claiming "slot unavailability" if not able to book in 4 weeks. This practice is not allowed by Department of Health.

Items for Discussion

World Class Commissioning
The PCT had identified objectives for itself under the WCC competencies, of which user and public involvement was an integral part (see 3 below). The World Class Commissioning programme is framed around 11 core competencies that require commissioners to:

1. Be recognised as local leaders of the NHS
2. Work collaboratively with community partners to commission services that optimize health gains and reductions in health inequalities
3. **Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health**

4. Lead continuous and meaningful engagement with clinicians to inform strategy and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable delivery of priority outcomes

The key message was about the quality of the overall commissioning process, not just parts of it. Practice based commissioning would have the same tests and assurances applied to it as to the PCT's commissioning. The PbC commissioning success depended on clinical engagement in the practices and clusters. PbC would have to raise its game beyond just taking defined areas of work out of secondary care and doing them more conveniently/cheaper in primary care. It would have to start commissioning into secondary care so that beneficial service redesign would occur and be sustained there to produce gains for primary care and for patients. From now on, PbC would have to encompass not only practices, but also patients, secondary care providers and social services, the latter to reflect the transformation of adult social care and the growing momentum towards individual budgets which could span health and social care. It was hard to overestimate the challenges this presented.

IT Strategy

The challenge in the NHS's complex IT strategy was "keeping the patient central". But continuing instances of losing patient identifiable data from public services created understandable public concern. It was reported that uploading patient data to the national spine (see previous reports for background) would not happen locally for at least 12 months and possibly longer. Patients would have the facility to opt out of this if they specifically requested it.

I asked about the Data Protection Act implications of patients and carers having access to data held about them on clinical and other IT systems? The response was that plans were in hand to give patients access to their clinical records online, taking account of information governance requirements. Under DPA, individuals could already get a hard copy print out of information held about them. Patients could already get access to their EMIS records by logging in at their practices. Once they had their records, there was nothing to prevent an individual from

showing this data to a 3rd party, such as a care broker or advocate, if they wished. I also asked about the integration of health with social care IT systems given the extension of single assessments from older persons to people with disabilities and the capacity of IT systems to encompass direct payment and personalised budgets across the sectors. The response was that a common web interface was needed for this to happen; social care wasn't on EMIS Web and used an incompatible system to that used by the NHS.

Kingston Hospital FT Application

It was reported that because Kingston Hospital had failed the hospital acquired infection target, Monitor has delayed their FT application. They had also not achieved their 18 week target. These two areas of significant weakness led local PCTs to express concerns with the application. The outcome of Healthcare for London could also have an impact on their future planning and polyclinic developments centred on Queen Mary's Hospital and in Richmond and Twickenham PCT could have negative effects on the flow of urgent care patients into Kingston; "choice" could lead patients elsewhere.

PPI Strategy 2008/09

The focus in the strategy was specifically on how to develop patient engagement with issues of access, quality and patient safety in particular. The strategy acknowledged the need to work with LINk and social care as partners. £250,000 was available in 2008 for PPI activity within the PCT. PEC agreed the strategy and recommended it to the Board.

I welcomed the strategy but stressed the risk of the new LINk being overwhelmed by such high expectations. LINk would be as much about social care as about health and integrating these issues with users, organisations and the public would be a huge challenge in itself. Section 242 had to be taken account of in everything and there would be equivalent local authority legislation in 2009. The PCT's future role in user and public engagement could be described as holding the ring of symbiotic relationships: the LINk's success would reflect the statutory bodies' success in getting engagement with the commissioning process and vice versa. That's why it was essential not to send unintentional signals that decisions about what LINk should do had been taken already. This would be a matter for the LINk Executive to determine in light of guidance and advice from the LINk Host and Regulations.

Items for Decision

PBC Outline Commissioning Cases:

- Integrated Life Style Services (Roehill)

  The PEC supported the outline case.

  I commented that in this new cluster, the need was as much about getting early community buy in to the proposals as about professional coordination and synergy. The co-creation of the proposed service with local people being able to find solutions

to their own problems was essential. It was agreed that this approach would be taken to the Roehampton Forum.

- Dermatology (TLC)

PEC supported the cluster's objective of moving dermatology into the community, but with the caveats that the Southfields practice dermatology model must be evaluated and there should be an impact assessment on local providers and their educational provision. The shift must also not adversely affect health inequalities. Any new provider should be subject to tender and have Healthcare Commission approval.

Next meeting of the PCT Board: Wednesday 30th April at Balham Park Surgery, Balham High Road, beginning at 09h30.

Next Meeting of the PEC: Tuesday, 20th May 2008, Rooms 2/3, Wimbledon Bridge House, Wimbledon, beginning at 09h30.

Future PEC agenda items:

May
HfL discussion
Urgent Care Review
Safeguarding Vulnerable Adults (Wandsworth Council)

June
Primary Care Strategy

September
End of Life Care Strategy