NHS
Enfield
Clinical Commissioning Group

Enfield CCG Governing Body Meeting 11 May 2016
Questions and answers relating to items on the Governing Body agenda

Q1. **Agenda item 1.1 Chair's report GP engagement event**. Can we be told how many GPs attended; how many of Enfield's 49 surgeries were represented; and are we any nearer establishing a unified structure so that all Enfield GPs work together in the interests of all Enfield residents.

A1 Response: 35 GPs attended the GP member practices engagement event on 4 May. There was representation from 27 out of 49 GP practices i.e. 55%. GPs agreed at this meeting to explore working together in locality based networks.

Q2. Agenda item 4.1 Chief Officer's report lists three occasions on which the executive committee met between February and April discussing among other items, primary care, contract negotiations. To whom does the executive committee report and can the public be informed of their deliberations and decisions.

A2 Response: The terms of reference of the Executive Committee are available on the CCG website. It reports to the Governing Body. A summary of the Executive Committee deliberations are presented to the Governing Body in public.

Q3 Agenda item 6.3 Financial recovery plan mentions the CCG is an organisation " under direction". What exactly does this involve?

A3 Response: This means that NHS England is using formal powers laid out in legislation. It can use these powers of direction if it is satisfied that a CCG is (a) failing or (b) is at risk of failing to discharge its functions. In these rare circumstances the judgement should be that at least one component of assurance is 'not assured.' Formal intervention action would be proposed, as laid out in section 14Z21 of the NHS Act 2006 (as amended) to make key senior management appointments in the CCG. The CCG was "directed" to produce a Financial Recovery Plan and to appoint a Recovery Director.

Q4. **Can we be updated on the implications for patients of the financial recovery plan** you were required to produce by the end of April 2016?

A4 Response: The CCG is now required to produce this plan for further discussion with NHS England by the end of May. The plan is still under development. In terms of patient implications the plan will focus on the NHS Rightcare programme which aims to reduce unwarranted variation. It will also consider what is appropriate for health funding and areas where services are provided in both acute and community settings. No decisions have been made as yet.

Q5.**The financial report suggests** that the CCG savings target has now been raised from £7.2 million to £17.2 million which equals a 4.75% cut in the already under-funded CCG allocation from NHS England. In addition, the CCG is being asked to accept lower financial growth for the next three years and cuts of this size must affect patient care in the community. Will the CCG Board join the Enfield Over 50s Forum and Enfield Council in their Fairer Funding for Enfield Campaign being launched next month?

A5 Response: The savings target has increased from £9.9m to £17.1m. We are now 2.2% under our target allocation. This is considered well within acceptable limits. The lower growth in the next 3 years is national rather than specifically for Enfield. The CCG has received substantial growth allocations over the last 2 years.

Q6. **Agenda item 8.3** Can we be informed of the **reason for increasing lay membership from two members to three of the CCG Board**. What would be the role of the extra lay member; how will they be recruited: and should PPGs be asked their views before eliminating the practice manager representative on the CCG Board when they have proved so vital in establishing PPGs.

A6 Response: The reason for proposing an increase in the number of lay members is to address additional Statutory Guidance due to be published by NHS England in June of this year around the matter of conflicts of interest. This is expected to recommend / require an increase in lay member resources as NHSE sees this as a means of CCGs managing conflicts of interest.

In addition there are increasing calls on lay members' time being driven by additional responsibilities being handed down from NHS England for managing primary care. This could be increased if north central London CCGs decide to take on full delegation of functions next year. The CCG has a Procurement Committee whose membership comprises of non GPs with a heavy reliance on lay members and for some time has been trying to recruit external financial expertise onto the Finance Committee and this could also be a role that is combined with the lay member's responsibilities.

There is guidance on how the CCG recruits and appoints members to the Governing Body and this will be followed. As part of the process of seeking amendments to the Constitution the CCG will be further engaging with the CCG membership and other stakeholders. The CCG values the role of practice managers and is developing plans to increase practice manager representation through the 4 Enfield localities.

Q7 The governing body was told at its meeting on February 10 2016 that an **evaluation of the primary care urgent access pilot** - which ended on March 31 - would be presented to the GP transformation sub-group, the finance and procurement committees. Will you share that report with the public?

A7 Response: The evaluation will be presented to the GP Transformation Sub-Group on 1 June 2016 and other internal committees thereafter. The report will be available to the public from July 2016.

Q8. Following **the CCG letter of January 22nd to GPs urging them not to prescribe medicines that can be purchased OTC from pharmacies and supermarkets,** will you now make it clear that patients entitled to free prescriptions such as those on income support, job seekers allowance, aged over 60 or under 16 will not be refused free prescriptions

The Over 50s Forum is seeking an assurance that the most vulnerable people in our community and elderly patients with multi-item prescriptions that include an OTC purchasable medication will continue to receive them. This is particularly important in Enfield, now ranked as the 12th most deprived out of London's 32 Boroughs.

A8 Response: On 22nd January the CCG wrote to GPs stating the following:

The CCG Medicines Management Committee and Clinical Reference Group have agreed a list of medicines which patients should consider buying to keep as a home supply. We are asking you to review prescribing practice and consider stopping prescribing items on this list. Please note this list is not exhaustive and there may be other items which you consider could also be stopped. We realise that there are a small group of patients for whom not prescribing an Over the Counter (OTC) product may be counterproductive and we recommend that you use your professional discretion to identify patients for whom it may be necessary to prescribe occasional OTC items.

We are asking you to consider stopping prescribing items on the attached list at the earliest opportunity. We are producing posters and leaflets which can be displayed in practices to inform patients that they will be unable to get OTC preparation on prescription.

This states that for most patients we are asking GPs to stop OTC prescribing, this is likely to include patients who would be exempt from prescription charges. For vulnerable and elderly patients receiving multi item prescription it is only the OTC items which may be affected.

Q9 **Mortality Rates among patients admitted at weekends?**

Will Enfield CCG please take the opportunity to reassure local residents that the often alleged "weekend effect" on mortality in respect of hospital admissions is being disproved and may NOT exist

Background: The first study to be published is attached as a pdf
The report of a second "Oxford" study is published in today's press at
http://www.dailymail.co.uk/health/article-3580548/The-weekend-effect-hospitals-NOT-exist-Expert-claims-figures-skewed-admissions-aren-t-recorded-correctly.html#comments

A9: Response: North Middlesex Hospital has reviewed their mortality data by day of admission and reported no weekend effect. Whilst we are unable to offer a view on all the studies on this matter, we can assure residents that the CCG continues to closely monitor mortality rates and hold discussions with providers at the monthly Clinical Quality Review Group meetings where necessary.

Q10 I would wish to ask Enfield CCG to mark the occasion and offer support to the reopening of negotiations between the DOH and the BMA

A10: Response: We note that the Department of Health and the British Medical Association have started negotiations. The NHS exists to care for and treat patients, so we always would prefer to avoid industrial action and for negotiations to continue until a workable solution is reached. We await the outcome of these discussions.

Q11. The Recovery Plan: I note that the CCG has been successful in managing its “financial recovery” but it is with some concern (and some sympathy for the CCG) that I also note the unexpected extra financial savings that NHSE has imposed -an apparent £7.2m plus the 2% Resource Limit. On the 18th April 2016 these savings were yet to be identified. Options were to be drawn up and then discussed with NHSE prior to implementation. **When will the revised Recovery Plan be made available for local residents to see? What happens if the CCG determine that these extra savings cannot be made at this juncture because of an unacceptable deterioration in local services and possible risk to patients?**

A11 Response: Please see the answer to question 4. The plan will be developed internally, shared with NHS England and a joint view reached on what it is sensible to progress to the next stage. Those schemes will then form part of a proper process. This will include an evaluation of the impact

on services. The CCG is a clinically led organisation – decisions will not be made without clinical support.

Q12. Change to the CCG Constitution: I note that there is ongoing work around the functioning of the CCG, in particular on how it might better manage decision making in those situations where the majority of GP Governing Body members have to declare an interest and leave the meeting. Clearly delegation of work to appropriate committees where, I assume, Conflict of Interest is not such an issue makes complete sense i.e. the Remuneration and Nomination Committee to approve changes to Governing Body remuneration and allowances, and the Audit Committee to approve the CCG Annual Report and Accounts. However it has been suggested that the composition of the Governing Body should be altered by increasing the lay member resources from the current two to three, and that this was in part to meet the requirement for "independence from GP involvement in matters of procurement". **I may be missing the point but I thought that the whole idea of CCGs was so that local GPs, with their unique knowledge of available resources and the clinical needs of patients, could be heavily involved in procurement and therefore get it right. If GPs have to absence themselves from such important decisions because of their Conflicts of Interest, would it not be better to employ only GPs without such conflicts on the Board?**

A12 Response: In December 2014 NHS England issued a paper "Managing Conflicts of Interest: Statutory Guidance for CCGs". As part of the north central London group of CCGs a Conflicts of Interest Policy was adopted by Enfield CCG and this seeks to address the matters referred to in the statutory guidance. This paper refers to additional guidance expected from NHS England in June 2016. However, the expectations have not changed in so far as GPs on the Enfield CCG Governing Body are required to declare interests in line with the CCG Constitution and where a matter arises on the agenda of a meeting in which a GP has a direct or indirect interest in which they benefit or may be perceived to benefit then the GP is required to declare this interest and take appropriate action which in many cases will require them to leave the meeting.

The question suggests that there is a pool of GPs working in GP member practices who want to be elected onto the Governing Body and who have no conflicts of interest. NHS England guidance requires the CCG to consider potential conflicts of interest of GPs prior to an election. However, the CCG is required to conform to the composition requirements set out in its Constitution – i.e. 8 GPs being elected (two from each of 4 localities) to the Governing Body.

Q13. Could we see **the serious incidents at North Middlesex University Hospital (NMUH) Trust** by theme and hospital ward? Why is this no longer shown in the meeting papers?

A13: Response: The serious incidents (SI) sections of the Integrated Performance and Quality Report was reviewed recently to improve legibility and align contents to the Governing Body's statutory responsibilities. The report still gives a breakdown of the serious incident themes for the reporting month in the narrative. Serious incidents are reviewed in detail at the North Central London Serious Incident Review Panel, CCG Quality and Risk sub group and through the Trust own internal governance processes. The Clinical Quality Review Group meetings provide oversight and scrutiny of provider serious incidents. Please contact North Middlesex University Hospital NHS Trust if you require further details on this.