NHS
Enfield
Clinical Commissioning Group

Enfield CCG Governing Body Meeting 13 July 2016
Questions and answers relating to items on the Governing Body agenda

Q1 (Reference item 9.4 Procurement Committee terms of reference)
I feel that the proposed change to the remit of the Procurement Committee, to give it delegated powers to approve the award of healthcare contracts without recourse to the Governing Body, may not avoid the Conflicts of Interest Issue. It unfortunately may unintentionally obfuscate the problem and therefore make it difficult to challenge any unfairness. The GPs in the CCG, including those with Conflicts of Interest, supply the clinical expertise about the Procurement pros and cons with members of the Procurement Committee, they thus rightly should influence any decision. They will not vote at the award of the contract so it will appear that all is fair. But is it? If a representative from a potential external provider were to have access to a member of the committee, beyond the presentation of the business case, then this would be seen as unfair and probably illegal. Surely only GPs with no conflicts for a particular procurement should be allowed to advise members of the Procurement Committee?

Response: The proposal to delegate authority to the Procurement Committee is about extending the powers to a non- conflicted Committee of the Governing Body. The intention is to retain the clinical involvement in developing the specification but to limit the situations that currently exist where the non-conflicted Committee makes a recommendation to the Governing Body and all or almost all the GPs have a conflict and have to leave the meeting.

In developing specifications the CCG conducts stakeholder, provider and patient engagement and the specification is approved by the Clinical Reference Group (CRG). The CRG has a clinical membership. The Procurement Committee has a role to approve the procurement route and the CCG publishes its procurement decisions on its web site.

Q2 (Reference items 7.2/ 7.3 and 11.1b) Recovery Plan.
There is a lot in the papers mentioning the extra £7.2 millions savings requested by NHSE with suggestions of Pipeline Schemes, Options under consideration, “hard choices” and the need for GP leads for each of the proposed savings options. When will we know what is actually in the revised Recovery Plan?

Response: The recovery plan to deliver £7.2m of additional savings will be shared when agreed with NHSE. At present we have identified schemes to the value of £1.8m in this financial year. This includes £0.9m of savings from reducing the number of Procedures of Limited Clinical Effectiveness (PoLCE) undertaken, £0.5m from the repatriation of inpatient Mental Health service users from other areas and £0.2m from reducing medicines wastage.

The CCG is implementing corporate vacancy control measures, together with post sharing with partner CCGs.

To address the remaining gap the CCG is focussing on clinical service transformation informed by best practice and outcomes.

Each scheme as the question correctly identifies has a clinical lead, as well as a Senior Responsible Officer and a project lead.

Q3 (Reference to "Committee in Common" under the Primary Care item 8.2 and the STP under item 8.4). If a "Committee in Common" is created so that all five of the NCL CCGs work together to achieve the STP and its associated targets, how much control do our CCG representatives think they will have over service changes and procurement that will affect Enfield? Will our CCG representatives be able to veto any "Committee in Common" plans that they feel are to the detriment of Enfield residents-perhaps due to different levels of need etc.? Will we be able to hold our representatives responsible for changes in our local health service provision or will we have to address the larger organisation?

Response: NHS Enfield CCG has been working in collaboration with NHS England and Barnet, Camden, Haringey and Islington CCGs in respect of co-commissioning of primary care services since 1st October 2015. Each CCG has three representatives on the Joint Committee currently and in future on the Committee in common and it is these representatives who vote, along with NHS England, on Enfield specific items whilst having the opportunity to discuss them more broadly with neighbouring CCGs.

Q4 (Ref to item 8.5 MSK procurement):
I note the decision to stop the MSK procurement, a development that could have improved the treatment and prevention of musculoskeletal disorders in Enfield residents, enhancing their quality of life and perhaps maintaining more people in the community for longer-in particular regard to older people. Was this decision taken because of the extra financial savings requested by NHSE?

Response: This decision was not linked to the requirement for additional savings. There was material uncertainty over the projected level of activity and associated finances in the original case. The CCG remains committed to improving care for MSK patients.

Q5 (Ref item 7.3 Finance and Contracts Report) I note that **BMI Health Care** have a contract with the CCG of about £4.7 millions but I cannot find any information on your website about what this money buys. Please could you clarify what we get for this money and whether or not the CCG believes this to be cost-effective?

Response: BMI Healthcare mostly provides elective inpatient activity. The contract is a cost per case arrangement at nationally set tariff rates. These set prices apply to NHS and Non NHS providers - we pay the same for each operation at BMI as we do at NHS Hospitals. The usage of BMI has allowed us to reduce waiting times for patients at a time when NHS capacity is fully utilised.

Q6 (Ref Agenda item 3.1 – minutes of last meeting)
Following our concerns regarding the January 27 directive to **GPs regarding prescribing medicines that can be bought over-the-counter** - which the Over 50s Forum raised at

the May 11 CCG Board meeting - on July 5 the CCG issued further guidance to GPs which went some way to meeting our anxieties. The Forum, however, whilst appreciating the CCGs difficult financial position, is now asking the Board to:

a) Launch a borough-wide publicity campaign to spread the self-care, self-help message to ALL patients. It should seek to involve pharmacists, GPs, PPGs, voluntary organisations and the wider public in seeing that people get the most appropriate medication, instead of trying to save money by simply targeting the poorest and most vulnerable people currently entitled to free prescriptions.

Response: The Medical Director and The Head of Medicines Management met to discuss the CCG position statement on prescribing of medications available over the counter (OTC). Reducing OTC prescribing is part of the self-care agenda. The Over 50's forum is asking that the CCG provide more publicity to support this. The Medicines Management team have discussed the provision of leaflets and posters for practices.

b) Reject the bureaucratic approach taken by NHS England in disregarding Enfield CCG being 4.8% underfunded because it is below their arbitrary 5% level and urges the Board to draw the attention of the three Enfield MPs to the comparable and higher funding for Camden and Islington although our needs as the 12th most deprived borough in London are more pressing.

Response: Enfield is 2.2% under its target budget for 2016/17. This is £8.4m. Enfield has benefitted over the last 2 years through increased growth funding, receiving 7.9% and 5.1% uplifts in 2015/16 and 2016/17 respectively. Camden and Islington have received smaller uplifts as the national formula aims to reduce the funding gap in a managed way over time.

Q7 (Ref Agenda item 3.1 – Minutes of the last meeting)
Primary Care Urgent Access Pilot

Has the report of the above £612,000 project been published, If so, can copies be made available at the CCG Board meeting together with the Board's objectives and evaluation of its success. Have any lessons been learned for the future? Can we be assured that in future all surgeries will be the beneficiaries of any increased funding for primary care, instead of selecting just two sites involving difficult travel for both elderly patients and mothers with young children.

Response: The Primary Care Urgent Access evaluation report will be published at the end of July.

It should be noted that any future access initiatives commissioned by the CCG must be delivered on an at-scale basis to a geographical locality population, in line with Simon Steven's Five Year Forward View and more recently in the GP Forward View. The CCG will build upon the evaluation of the pilot scheme to ensure that any future service is delivered in accessible a way as possible to meet the needs of patients, given the strategic imperative for services to be delivered at scale, rather than an individual surgery basis.

Q8 (ref item 6.1 Quality and Safety Report)- North Middlesex Hospital A & E Crisis
Do Enfield CCG plan to be represented at the upcoming MPs meeting? *[Details of the meeting with Kate Osamor MP were enclosed with the email: Monday, 25 July 2016 from 19:00 to 20:30 at Green Towers Community Centre]*

Response: The CCG meets with all Enfield MPs regularly in a face to face session and this is our preferred way to communicate. We respect that all MPs must meet with their constituents on a regular basis as part of the democratic process but the CCG will not be attending this meeting.

Q9 (ref item 6.1 Quality and Safety Report) - North Middlesex University Hospital

a) Will the Enfield CCG confirm the following appointments? It is understood that Elizabeth (Libby) McManus has been appointed Interim Chief Executive (previously Chelsea and Westminster Hospital) and that David Sloman is the Interim Accountable Officer (also reported in the Nursing Times)

b) In the promised verbal report, perhaps Enfield CCG will indicate any further resources being recruited on an emergency basis?

Response:
9a - Yes

9b: We will provide a verbal update on any latest information for the publication the public GB meeting.