Enfield CCG Governing Body Meeting 19 July 2017
Questions and answers relating to items on the Governing Body agenda

Question 1:

We note that the Governing Body has been requested that, as part of the process of submitting changes to the Constitution, it was necessary to set 'by urgent action' a financial limit for the authority of the Procurement Committee. Under the recommendation of the Chief Finance Officer the Chair agreed that this authority be limited to £500k. Why is this necessary?

Response by GB Chair:

It is necessary to define the authority given to the Procurement Committee. Following advice from the Chief Finance Officer it was agreed to define the limit of the Procurement Committee's authority to £500k, the same as the level that exists for the Finance and Performance Committee. The urgent decision was made by the CCG Chair ahead of the next Governing Body meeting to enable changes to be submitted to NHS England.

Question 2:

At the Governing Body Workshop held on 14 June it was recommended that changes to the Constitution should seek the Practice view on any change(s) and will not assume approval if there is no response, and will require a minimum of 51% of practices to be in favour or against a proposal (currently this would be 25 practices) before there is a clear decision, and it can either proceed with changes and seek approval from NHSE or if against then the proposal can be set aside as not approved.

Does the Governing Body agree that this is the only acceptable way for a representative public body to proceed?

Will the Governing Body therefore revisit the recent changes to the Constitution that did not meet these basic criteria for approval, namely the prolonging of the Chair's tenure and the delegation of procurement decisions concerning the award of healthcare contracts to the Procurement Committee?

Response by Lay Vice Chair:

The proposal set out in the report of the Chair is designed to be a basis for engaging with the CCG Membership and seek feedback on what should be put in place moving forward. Changes made to the CCG Constitution have been conducted following engagement with the CCG Membership and are in accordance with NHS England Statutory Guidance.

Question 3:

The CCG managed to deliver a staggering £13.65m of efficiency savings (against a target of £17.1m) in 2016/17. However this still meant that the CCG achieved an in-year deficit of £3.8m, and it appears, from searching through your 468 pages of papers, that it had to be supported by neighbouring CCGs to the tune of £3.6m and by the release of a 1% (£3.859m) uncommitted reserve to meet its Control Total. This takes the CCG's cumulative deficit to £37.2m. External auditors gave an unqualified opinion on the financial statements but a qualified regularity opinion due to the in year deficit. They were also obliged to issue a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 on 30 May 2017 in respect of breaches of the CCG's financial performance targets, because they had reason to believe that the CCG, or an officer of the CCG had made, a decision which involved or would involve the body incurring unlawful expenditure. This indicates how tough the financial regime is.

However the future gets even tougher with the plan asking for a £2.1m surplus in 2017/18 and then for a £9.4m surplus in 2018/19. In order to deliver the planned surplus of £2.1m for 2017/18 the CCG must save an even more staggering £22.5m.

The CCG do not hold any acute reserve. You say you have planned on realistic levels of activity in 2017/18, but further unplanned growths, which have been evident in previous years, is a material risk. The number of emergency admissions has increased this year as well as the number of days lost to delayed discharges from hospital, particularly with more people in hospital due to mental ill-health. I note further difficulties you have highlighted: i) that many of the QIPP (cost-cutting)

Schemes within the plan are new and therefore likely to place additional pressure on delivery in 2017/1; ii) the rapid pace of change associated with the Sustainability and Transformation Plan (STP) for NCL and the difficulties in trying to ensure that the requirements of Enfield are maintained whilst also ensuring the CCG remains aligned with its partners; iii) that many of the schemes are not within the contracts with Acute Providers and as such have both a lower priority for delivery as well as a lower value if realised.

Do you believe at any level that you can achieve these financial targets without avoidable (that is avoidable if the 'eye-watering' centrally set financial targets were removed) physical or mental harm to the residents of Enfield? If so, then can you detail how you plan to do this and how you will provide evidence that there has not been any such harm?

Response by Chief Finance Officer/ Director of Recovery:

The CCG has a very large and challenging savings (QIPP) programme. Delivery of this will require concerted efforts both within the CCG and across the whole of North Central London via the STP. The Governing Body is very aware of the need to ensure that patient safety is not affected by making these efficiencies, and monitor this very closely. Every potential QIPP scheme undertakes a Quality Impact Assessment which is reviewed before the go ahead is given.

Question 4:

As part of your work on integrating care you invited your North Central London CCG colleagues to join in with this process but only Barnet CCG expressed an interest in MSK and Urology and therefore you issued a Prior Information Notice (PIN) consisting of three lots: MSK for Enfield and Barnet; Urology for Enfield and Barnet; and Gynaecology for Enfield only. Through this process you identified that only one of the four expressions of interest was compliant with all elements you were seeking to commission and that the provider with the compliant response was Royal Free Hospitals London (RFL). The expectation is that when you agree the changes the contracts will be issued to the Lead Provider who will then manage the entire budget and clinical model for each of the three areas we are considering.

Is this not a significant problem with the 'hospital-chain model', for which RFL has taken a National lead, that it reduces or completely removes the presence of alternative compliant providers to compete for tenders locally?

Response by Director of Recovery

The proposal put forward by RFL was a collaboration across a large number of different providers with RFL simply acting as a Lead Provider (meaning that the Trust will manage the contracts and budgets for a number of other providers). As such, this is unrelated to the concept of a hospital chain given that there was no mention of, or requirement for, any further integration across providers. The fact that RFL had built such a strong and wide reaching collaboration is a key reason as to why they were deemed to be the only viable provider.

Question 5:

Which independent specialist organisation will carry out the AEBM analysis? Will you please make their full analysis public before any further decisions are taken?

Response by Director of Recovery:

The analysis of the consultation feedback is being undertaken by The Campaign Company (TCC) on behalf of Enfield CCG. They will provide a detailed and comprehensive report in relation to what happened in terms of Patient and Public Engagement and an independent view of the feedback received. It should be noted that a consultation is not the same as a vote and TCC are simply providing an independent view of the feedback received. This feedback will be reviewed by clinicians within the CCG who will also revisit the evidence (and all additional evidence identified both by the CCG and others) during the consultation period before coming to a final decision about next steps. The final report along with the recommended changes, updated list of evidence, final Equality Impact Assessments and the report by TCC is currently expected to be presented to the public at the September 2017 Governing Body meeting. Given that the consultation period has ended there is no intention for any draft of the final report to be made public before the final recommendations are presented at the September meeting.

Question 6:

Is Enfield CCG itself working to a 'Capped Expenditure Process' because it is in 'special measures'? If so, what does this entail that is different from the other CCGs?

Response by Chief Finance Officer:

The CEP process applies at the North Central London (NCL) Sustainability & Transformation Plan level and Enfield are not being treated differently due to them being in special measures.

Question 7:

It is stated that where the CCG is participating in a joint committee alongside other CCGs, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating CCG. This policy is apparently also applicable to all member practices of the CCG as listed in the CCG's Constitution, and extends as far as is possible to all GP partners and any individual directly involved in the business of the CCG.

When will a complete single record of 'Conflicts of Interest' for all NCL CCG officers, member practices, GP partners and STP officers be made available for public scrutiny?

Response by NCL Accountable Officer:

The NCL Conflicts of Interest Policy can be found on the CCG's web site
http://nww.enfield.nhs.uk/Docs/Policies/Conflicts%20of%20interest%20policy.pdf

The Policy is being updated to take into account the latest NHS England Statutory Guidance
https://www.england.nhs.uk/commissioning/pc-co-comms/coi/

Whilst the five NCL CCGs are working closer together each CCG is required to complete its own register(s) of conflicts of interest. The Enfield CCG Web Site details registers for Governing Body Members, Clinical Leads and staff. Registers for GP partners and practice staff involved in decision making are being compiled in line with the statutory guidance.

Question 8:

Whilst LAS geo-tethering represents a possible way forward for the improvement of local ambulance performance, does it not also represent the end of any notion of a National ambulance service, and also open up the probability of 44 privately provided ambulance services?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning:

The geo-tethering proposal provides opportunity to ensure that response vehicles remain within a geographic boundary. This means that response vehicles will be closer to the incident and will reduce the time taken to respond to a call. This is important to ensure that the outer London boroughs achieve similar performance to that of the inner London boroughs. We will continue to work across London boroughs with the London Ambulance Service to deliver ambulance services. Given that we need to ensure sustainability of NHS services, it is unlikely that services could be delivered more efficiently by a larger number of smaller organisations.

Question 9:

It is disappointing to discover that even though Mental Health Services are seen as a priority for improvement in the Five Year Forward View (FYFV), they still need to demonstrate 'an improvement plan for reduced length of stay' in order to receive investment for the care needed by extremely unwell patients (the local PICU will mean that the Trust does not have to send patients across the country, miles away from friends and relatives, in order to receive urgent inpatient care). Do you feel as commissioners that this request for financial savings, in order to be able to develop services to what could be seen as a 'basic standard', is justified in what have been historically under-resourced services?

Response by Director of Commissioning:

The CCG is committed to a major programme of transformation of mental health services in line with FYFV. We want to ensure that for different pathways of care we are commissioning services that are evidence based and of a high standard, meet individual needs with clear treatment plans and goals, and are cost effective, In some areas, for example PICU and rehabilitation services, we know that the length of stay in units outside Enfield and in some cases outside London, are longer than recommended. We believe that by developing local provision and community services we can better care for Enfield patients closer to home. For example in relation to the female PICU we are currently looking to re-provide the service within the North Central London area by the end of the year, and for complex care rehabilitation, we are working with BEH MHT, to develop a local inpatient rehabilitation unit on the Chase Farm site.

Question 10:

We note the proposal 'to approve the procurement of a Walk-in Service to cover all localities in Enfield in principal, subject to confirmation that the new proposed tariff seen has been benchmarked and demonstrated value for money'. Is this an extension of the Edmonton Walk-in service run by Medicare Medical Services LLP? If not, then which company will be receiving this contract? For what particular Conflict of Interest did Dr Hetul Shah have to leave when this procurement was being discussed?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning:

The walk in centre contract with Medicare Medical Services LLP is due to expire and has been extended to 30th September 2017 whilst we undertake a procurement to re-provide these services from 1st October 2017. The procurement has commenced and we will notify the outcome of the procurement when the procurement process has completed.

Dr Hetul Shah's conflicts are published on the CCG Web Site
http://www.enfieldccg.nhs.uk/Downloads/Enfield%20CCG%20Governing%20Body%20declaration%20of%20interests%20-%20updated%2028.06.17.pdf

Question 11:

We note that there is support for the proposal to launch a 'restricted list-based procurement' for delivery of the Enfield single Locally Commissioned Service (LCS) from a federated model of General Practice, with the CCG seeking to consolidate all care closer to home schemes into one Enfield Locally Commissioned Service offer. The intention is to offer this service delivery opportunity to a federated model of general practice, where some elements may be delivered by individual practices and others are delivered via 'hubs' on behalf of groups of practices. Is there not concern that by only making one offer, monopolistic control may be taken by any well informed, prepared and organised medical grouping? For what particular Conflict of Interest did Dr Hetul Shah have to leave when this procurement was being discussed?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning:

The rationale for commissioning a single contract is to:

- ensure that all Enfield residents will have access to all services commissioned under this contract. At the moment it is voluntary for practices to provide services over and above core contract. This means that not all Enfield residents have equitable access to the range of services commissioned
- address the workforce challenges in primary care, i.e.: shortage of GPs. Sharing workforce resources will help practices deliver additional services in primary care, reducing the need for patients to attend the hospital for services such as dressings, prostate care, etc.
- support extended access to services for all Enfield residents. It would not be possible for all practices to be able to deliver all services as they would not have the workforce, nor would it make sense to deliver some services from all 48 practices
- Enfield GPs voted last year to develop a pan-Enfield federation and the CCG is supporting Enfield GPs to deliver this approach by planning to commission a single pan-Enfield contract

Dr Hetul Shah's conflicts are published at:
http://www.enfieldccg.nhs.uk/Downloads/Enfield%20CCG%20Governing%20Body%20declaration%20of%20interests%20-%20updated%2028.06.17.pdf

Question 12:

The Enfield Referral Service (ERS) that was apparently established in 2005 to reduce orthopaedic outpatient referrals as part of the national musculoskeletal project, has undergone several changes and reviews but remains central to the CCG. There were 4,973 referrals in May 2017 compared to 4,808 in May 2016, based on working days however this is a YTD increase of 5.6%.

The service has a total of 17.21wte (whole time equivalent) posts and referrals have continued to increase, with extra hours having been put in to deal with the backlogs arising due to the volume of referrals and staffing shortages (there are currently two unfilled vacancies which are looking to be filled). The backlogs arise due to the volume of referrals and staffing shortages and create challenges in receiving referrals back on time for some of the services. Apparently a number of changes were made to the Procedures of Limited Clinical Effectiveness (PoLCE) in September 2016, which resulted in an increase in the 'decline' rate, currently at 43%. Due to this strict adherence to following the PoLCE policy, the number of complaints has apparently risen and an audit is taking place to establish whether there is any correlation between the two. Discussion has started on having an Appeals Policy. Members of staff are working six days a week under a pressured environment, which evidently 'impacts on them'. There is a suggestion 'that patients are being asked to request a private referral to Kings Oak through choose and book' but the ERS team do not appear to be aware of this. It was decided to take the discussion of this particular point outside of the documented meeting.

The ERS has 17 posts plus GPs to triage. It is struggling with an increasing workload and acting to 'decline' an increasing number of referrals, and has a growing number of complaints. It does not yet appear to have an Appeals Policy. Now there are rumours that patients are being asked to request private referrals to Kings Oak. It seems that we have to pay for people to monitor our GPs in order to counter our GPs decisions to refer us for specialist opinions, but we then may be given the alternative suggestion of private health care provision.

How can such additional expenditure on staffing the ERS be justified? Will Kings Oak actually accept patients denied referral by the NHS when that denial is not about cutting expenditure but is supposed to be in the patients' best clinical interest?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning:

Enfield Referral Service (ERS) provides a signposting and triage system for patients and GPs to ensure that routine referrals are triaged to the most appropriate service and the one closest to home for the patient. ERS assists the GPs with providing Choose and Book (now called e-Referral) element of the patient journey, should it be required. The ERS team provide patients with up to 5 choices of service provider for their appointment, if not already provided by the GP.

If patients are declined treatment for a condition which is covered by the Procedure of Limited Clinical Effectiveness (PoLCE) Policy, the patient can re-visit the GP and ask for their referral to be sent for consideration by the Individual Funding Request (IFR) team.

ERS do not facilitate or ask patients to request a private appointment at any service provider and do not refer patients for private treatment, but may refer patients to private providers who offer treatment to NHS patients

Question 13:

The Medicines management team overachieved against its QIPP target by £475k, which is commendable and considerably better than neighbouring CCGs. Could this be because GP localities were incentivised by earning 50% of any prescribing savings against their locality budget? Data has shown an increased prescription volume of lower cost drugs. How have you measured any impact on clinical outcomes as a result of this change in prescribing practice?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning:

GP localities worked with the Medicines Management team to deliver an overachievement of the QIPP target. The GP localities were incentivised to do so by being able to use savings to re-invest into areas of agreed investment to provide patient care and improve practice delivery of patient services.

Part of the work of the medicines management team is to encourage cost effective prescribing meaning that where there are therapies which have the same effect, GPs are encouraged to prescribe the most cost effective one. This led to a reduction in the cost of medicines prescribed but not an overall reduction in the number of medicines prescribed. Before a change in practice is recommended, trials involving the medicine will be reviewed to ensure that no differences in patient clinical outcomes have been seen. Clinical outcomes of any changes are assessed by considering patient enquiries, Quality Outcomes Framework data, hospital admissions and attendance, GP and hospital doctor comments.

Question 14:

In the papers distributed at the meeting (in public) of the Enfield CCG Governing Body, 17/5/17, we direct your attention to agenda item 11.1 for which there is an appendix P(a)(i) showing some redactions to the minutes of 30th November 2016 Audit Committee and similarly appendix P(a) (ii) indicating redactions to the minutes of the same committee held on 15/3/17.

Further redactions appear in appendix P(b)9i), minutes of Executive Committee dated 15/2/17, and a whole further series of redactions are shown in minutes from the Finance and Performance Committee of 29/3/17 and Quality and Safety Committee dated 1/3/17. Given the dates of all these redactions, the explanation provided to Question 1, as to why there are 5 sets of redacted minutes among the papers, cannot be accepted that is “the CCG has reviewed the approved minutes and has agreed that in view of the rules surrounding the pre-election period a small numbers of items in the respective committee minutes should be redacted”. How can minutes of meetings held as far back as 30th Nov 2016 be subject to such rules, minutes of meetings that took place well before the date that the election was announced? For the sake of transparency we urge you to remove these redactions now and highlight to the public what has been redacted.

Response by Chief Operating Officer:

The CCG currently has agreed to publish all approved Committee minutes with its Governing Body papers. The minutes referred to above were published alongside the Governing Body agenda for 17 May 2017 and it was the timing of publication of the Governing Body papers just ahead of the June General Election that meant that parts of the minutes were redacted under the pre-election rules (or Purdah). The unredacted minutes will now be made available on the CCG web site.

Question 15:

The current practice is for the papers of the CCG GB to be made available on your website six days before the meeting. Any written questions from the public must be submitted two days before the meeting takes place. In the service of improved public engagement can the CCG please review this time-line? Extra time would allow more members of the public the opportunity to read the papers and consider questions they may wish to submit.

Response by Accountable Officer:

The Governing Body papers are published in line with the CCG Constitution. We will review the current timings and report back to the Governing Body.

Q16 (Agenda Item 5.1):

a) As the Over 50s Forum representative to the Stakeholder Involvement Group which met on June 7 2017 to interview candidates applying for the post of Enfield CCG Chief Operating Officer, can you clarify whether the two candidates the Group identified from Newham and Hounslow CCGs withdrew their applications or were they interviewed and you ruled them out as being unsuitable?

b) Ms Noreen Dowd is now variously described as Interim Chief Operating Officer and Chief Operating Officer. Should the CCG Governing Body not have before it a full report on this appointment, by whom and when was it made, and why was the Stakeholder Involvement Group not invited to discuss Ms Dowd's candidature with her?

Response by Chair / Accountable Officer:

We did not make an appointment to the substantive role of Chief Operating Officer following the interviews in June. We have appointed Noreen Dowd on a temporary basis and as is normal in these circumstances do not run a stakeholder group for a non-permanent appointment. A panel of 3 Governing Body members appointed Noreen.

We intend to go to advert for a permanent appointment in the Autumn and will ask stakeholders to be involved in the process.

Q17 (Agenda Item 7.1):

To amplify the sparse Primary Care Hubs Report, can the Over 50s Forum be told how many of the 48 surgeries in the borough utilised the offer of GP appointments at the three hubs? How many patients travelled to any hub from the North East locality? Has any progress been made regarding the CCG's previous promise to report in June on a North East locality hub?
When the NHS says it wants every penny of expenditure to count, how much are GPs being paid to run Sunday appointments and is it right to continue with Sunday hubs if only 42% of available appointments are being utilised that day?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning

Patients from all 48 GP practices utilized the offer of GP appointments at the three hubs.
In total, 1,042 appointments have been provided to patients (16.5% of total activity) from the North East GP practices, and 50% of all patients seen at Carlton House Surgery were from a North East GP practice.
Enfield CCG is pleased to confirm:

• The service is valued and has high patient satisfaction rates
• Patients from across the whole of Enfield are accessing the hubs
• Utilisation of the hubs is increasing overall with weekday evenings being the most popular with patients

Enfield CCG advised that it would review how well the three hubs were being utilised in June 2017 to decide if a hub in the North East of the borough was required.

As previously confirmed in March 2017, a hub was not commissioned in the North East of the borough as an accessible surgery premises was not identified by the bidder.
This review has now been completed and a number of recommendations were considered and approved by the procurement committee at its meeting on 12th July 2017.

• Utilisation of weekday evenings is most popular and we will work with the hub providers to match increased capacity on a weekday by moving appointments not being used on Sundays to weekday evenings to improve access where the demand is highest
• Current utilisation rates of the three hubs does not support commissioning an additional hub in the North East of the borough at this time
• Patients registered with all thirteen practices in the North East of the borough are accessing these appointments at all three hubs, accounting for 50% of patients seen at Carlton House Surgery

The report which was presented to the procurement committee will be published in due course.

Enfield CCG will undertake a further review of the service in December 2017 to decide if a hub in the North East of the borough is required and if there are any other changes that would improve access for Enfield residents.

An outdoor advertising campaign that is still running includes:

- Southgate, Oakwood, Cockfosters tube stations – finishes 11 March 2018
- Escalator panel adverts – Southgate tube station – finishes 10 September 2017
- Bush Hill Park, Enfield Town, Edmonton Green train stations - finishes 10 September 2017

5 GP appointments on a Sunday will provide 7 weekday evening appointments, and 2 Sunday PN appointments will provide 3 weekday evening appointments.

Q18 (Agenda Item 7.5):

Can the Over 50s Forum be told the name of the organisation conducting the review of the AEBM programme, how much are they being paid and will their report be available to the public before the CCG Governing Body is asked to take any decisions?

Response by Chief Finance Officer/ Director of Recovery:

The name of the company is The Campaign Company and the agreed payment is £7.8k + VAT. Please refer to the answer to Question 5 for the answers to the other parts of this question.

Q19 (Agenda Item 9.2)

You report introducing a repeat prescribing policy without describing what it is. Can the Over 50s Forum be told as it would be helpful to all PPG members and the community at large?

Response by Deputy Chief Officer/ Director of Primary Care Commissioning:

As part of the GP Locality scheme for 16-17, localities were asked to agree an action plan showing actions taken to reduce third party ordering of repeat prescriptions and to improve repeat prescribing practice processes. Following engagement with patient groups, GPs, and pharmacists a leaflet was produced “Changes to how you order repeat prescriptions”. The leaflet detailed how patients would be encouraged to only request medicines they needed and gave options for ordering. These options included online ordering, using the paper copy of the prescription, “batch prescriptions” and pharmacist ordering for patients unable to order their own medicines.

Q20 (Agenda Item 9.2):

Can you provide any further details of the “Crisis Cafe” you propose to commission along with voluntary and community groups to help patients better manage a crisis.

Response by Director of Commissioning:

The Mental Health Needs Assessment (2016) reported the findings from a survey of 89 crisis service users. It identified the importance of community mental health services in supporting those in crisis or at risk of falling into crisis. With that in mind, we are seeking to establish a crisis/recovery cafe for local residents with mental health needs offering peer-led counselling and support; a café style environment offering drinks and food. Barnet Enfield & Haringey Mental Health Trust will provide inreach support via Crisis Recovery & Home Treatment Teams (CRHT). This will provide direct access to secondary care crisis support where appropriate. It is envisaged the premises would be open 6pm to 11pm weekdays, and midday to 11pm at weekends.