NHS
Enfield
Clinical Commissioning Group

Minutes of the Executive Committee Meeting

Date **15 February 2017**

Venue: **Enfield CCG Chair's Office, Holbrook House**

Chair:	Sarah Thompson	Enfield CCG, Chief Officer	SFT
Members	Mo Abedi Dr Fahim Chowdhury Mark Eaton Dr Janet High Dr Alpesh Patel Deborah McBeal Jane Pike Karen Trew Rob Whiteford	GB Chair ad member (NE Locality) GB Member (SE Locality) Director or Recovery Governing Body GP South West Clinical Vice Chair & GB Member (NW Locality) Deputy Chief Officer & Director of PC Commissioning Director of Performance & Corporate Services Lay Vice Chair Chief Finance Officer	MA FC ME JH AP DMB JP KT RW
In Attendance	Bridget Pratt Alison de Metz Brenda Thomas	Assistant Director of Quality Governance & Risk Deputy Director, IFR Board Secretary (Interim) (Minutes)	BP AdM BT
Apologies	Dr Jahan Mahmoodi Graham MacDougall Carole Bruce-Gordon David Triggs	Medical Director Director of Commissioning Acting Director of Quality & Integrated Governance Board Secretary	JM GMac CBG DT

The minutes have been recorded following sequence on the agenda and not sequence of discussion at the meeting.

		Action
1.	**Apologies for absence and introductions**	
1.1	The Chair welcomed everyone present at the meeting and introductions were made. Apologies for absence were noted, as recorded above.	
2.	**Declarations of Interest**	
2.1	a) The following declarations were made in relation to the agenda: • All Directors (excluding the Chief Officer) declared an interest in item 4 - North Central London (NCL) Commissioning arrangements, as their roles would be directly impacted. • All GPs declared an interest in item 5 - Primary Care update, due to their membership at GP practices. Due to the nature of discussion, conflicted members would not be required to leave the meeting when these items are discussed. b) Members of the Committee signed the attendance record and confirmed their entries in the Register of Declarations of Interest.	
3.	**Minutes, Action Log & Matters Arising**	
3.1	**Minutes of 18 January 2017 & Action Log** The minutes of meeting held on 18 January 2017 were considered and the following amendments made:	

	• Page 4, 5th bullet point: - replace 'However, in view of the points raised……..' to read 'It was suggested to raise these concerns at the public meeting'. - Page 4, 5th bullet point, last paragraph to read 'and to make more prominent the fact that the organisation development work needed more work'. **RESOLVED that the minutes of the meeting held on 18 January 2017 be agreed as an accurate record of the meeting, subject to the above amendments.**	**VP**
3.2	**Action Log** The action log to be revised to include actions recorded in the minutes but not included in the action log. Progress on actions are noted on the Action Log.	**VP**
3.3	**Matters Arising** There were no matters arising from the previous meeting.	
4.	**North Central London Commissioning Arrangements**	
	<u>Shaping the Enfield CCG Response - Proposal</u> The Chief Officer tabled a paper on the proposed structure for Enfield CCG on the NCL Commissioning Arrangements. The Director of Strategy and the Director of Performance and Commissioning posts for NCL have been advertised. Chief Officers were asked to commence a process on the CCG's response (both in the short and long term) to the emerging landscape of the NCL commissioning arrangement. The draft proposal for Enfield CCG has been carried out in consultation with Directors. The Committee was strongly advised to not share the structure outside of the meeting, as it requires the Accountable Officer's (AO) review and approval. The proposed structures were discussed. The Enfield structure for the short term has been developed to ensure the status quo is maintained to ensure deliverability. It was suggested that some contracting functions should remain at a local level, and the management accounting function would work better if localised. Given the CCG is in special measures, senior finance leadership is required in the foreseeable future. It was agreed that the Medical Director role should be reviewed. The other functions with their sub structures were also noted. The quality function was deemed to be working well across the five CCGs, therefore, the proposal is for current arrangement to remain unchanged. The assumption for the quality component in relation to the main acute commissioning is that CCGs would be lead commissioners for the acute contracts. It was noted that the AO is yet to agree to these arrangements. The start date for the AO is yet to be confirmed. Appointment to the NCL Chief Finance Officer (CFO) would be made in March. Advert for the and Chief Operating Officer (COO) (Enfield) to go out during the course of the week. Appointments to other Executive posts would shortly be made. The Executive team could be in post by end August 2017. The roles had been cross-referenced for the Enfield COO, CFO, Director of Strategy and Director of Performance and Commissioning. It was noted that there is no element of the NCL delegated commissioning included in the JDs for the roles advertised. This was raised at the Remuneration Committee in Common meeting and the CCG Chair would raise at the Chairs meeting. The Chief Officer had briefed members of staff that a piece of work on the proposed structure was ongoing. The proposal is the best known position, pending review by the AO. **RESOLVED that the proposed Enfield CCG structure be noted.**	

5.	**Primary Care**	
	Primary Care Update & QIPP update Deborah McBeal (DMB) provided the Committee with an update on NCL CCGs' intention to move to fully delegated commissioning of primary care (PC) services. The Governing Body, at its meeting on 18 January 2017, approved the recommendation that the five NCL CCGs (Barnet, Camden, Enfield, Haringey & Islington) mobilise delegated commissioning assuming NHSE (London region) and the NCL CCGs agree to the outcome of the NHSE Organisational Development (OD) review of staffing. The key elements of the update are the issues to be resolved ahead of the CCG entering into delegated commissioning arrangement. It was recognised that significant amount of work is to be undertaken. The key elements are: • Resourcing - additional staffing identified for North West London; • Ensuring financial risks are captured; • Precedent of PC Joint Committee and governing bodies to be resolved. This would be taken back to NHSE. This would be raised with Andrew Spicer/ Alison Blair. The draft Memorandum of Understanding (MoU) between NHSE and CCGs was being reviewed by NHSE, with the updated version to be received week commencing 6 March. This is an extremely challenging position due to the timetable for meetings, and the expectation for the Delivery Plan and actions to be delivered by the due date. **Action: Delivery Plan to be discussed and signed off at the Directors meeting.** DMB and Rob Whiteford (RW) are to review the delegated agreement which had been received shortly before the meeting. RW advised that all assumptions had been taken account of to arrive at the £39m allocation for the CCG over the next five years. This figure is correct, should calculations hold true. The draft agreement would be submitted to NHSE subject to governing body approval in March. It is important that the documents are thoroughly reviewed and that it be ensured that all five CCGs are signed up to it. It was flagged that there is a sense that relevant information was not circulated to the right people in the other NCL CCGs. It was therefore proposed for information to be circulated through Chief Officers for consistency. It was noted that EY had carried out a piece of work which identified 200k+ NCL risks, equating to approximately 45k risks per CCG. **Action: Meet to discuss the key elements of the process and issues related to delegated commissioning** **RESOLVED that the contents of the report be agreed and the work of the primary care team in transforming primary care in Enfield be supported.**	**DMB** **SFT/ DMB**
6.	**Quality Premium**	
	Quality Premium Report Jane Pike (JP) presented a paper which describes the two sets of options CCGs are required to choose from as part of the 2017-19 Quality Premium incentive scheme. These relate to mental health services and the Right Care programme. CCGs are required to select one mental indicator from the options provided by NHSE and one local indicator from the Right Care suite of indicators as set out in the Commissioning for Value (CfV) packs. Extracts from the technical guidance describing the mental options and methods of measurement were noted. The value of the Quality Premium is approximately £1.6m. The Clinical Reference Group (CRG) at its meting on 8 February, discussed these options and have recommended for approval to the Executive Committee: • Reducing Out of Area Placements as the mental health option. This carries a significant risk but is still considered the best option of the three; and • Increasing Atrial Fibrillation diagnoses and reporting as the RightCare option. The CCG's choices would require agreement with NHSE Regional Team as per national guidance.	

	RESOLVED that the two recommended options be approved: **i. Reducing Out of Area Placements as the mental health option; and** **ii. Increasing Atrial Fibrillation diagnoses and reporting as the RightCare option.**	
7.	**Emergency Preparedness, Resilience and Response (EPRR)**	
	Action Plan JP presented a paper providing an update on the CCG's EPRR. The CCG achieved a compliance score of substantial based on its self-assessment submission to NHSE in September 2016 and the work undertaken during the course of 2016. The NCL Health Resilience Partnership will be reviewing the outcomes of the assurance process for London Trusts and CCGs in early 2017. As a result of this future review, an action plan has been drawn up to ensure the CCG meets the EPRR annual assurance process and address any gaps in assurance identified by NHSE's EPRR team. The Action Plan has been provisionally submitted as a draft to NHSE's EPRR team and a final approved version is expected to be submitted in February. It identifies that the CCG needs to develop and approve a stand-alone Plan for the Management of Flu Pandemic which would form part of the overarching EPRR Policy. JP was confident the flu pandemic would be delivered by March. Dates on the plan are to be reviewed for accuracy. **Action: Flu Pandemic Plan to be discussed at the Committee meeting in March.** **RESOLVED that:** **i. It be noted that the draft action plan has been submitted to NHSE's Assurance team;** **ii. the Action Plan be approved and current gaps in assurance relating to the management of Flu Pandemic be noted;** **iii. it be noted that a Flu Pandemic Plan is currently in the process of being developed with the support of the Borough's Public Health Directorate; and** **iv. it be noted this Plan will be submitted for approval in April 2017.**	**JP**
8.	**Picker Institute (Europe) - Staff Survey 2016**	
	Survey Results & Action Plan JP presented the key findings of the Staff Survey carried out independently by the Picker Institute Europe (PIE), on behalf of the CCG. The report has not yet been finalised, and therefore embargoed until 7 March. Until this embargo is lifted, the survey results could only be discussed and shared with the CCG's Executive and Management team. The CCG would be informed when the embargo is lifted. The Senior Management Team (SMT) would take forward delivery of the plan and the opportunity would be presented to staff to present ideas for areas improvement could be made. The Chief Officer had met with the SMT and had tasked them with ensuring the broader spectrum of staff are involved in the action plan development. 2016 was the first year the CCG took part in the PIE Staff Survey therefore the report does not provide any historical comparative data. **RESOLVED that:** **i. the full Report from PIE be noted;** **ii. it be noted that further detailed analysis of the full Report are still being undertaken by the PIE;** **iii. it be agreed that the SMT has been asked to develop an Action Plan to address the gaps identified in the Report;** **iv. it be noted that the Action Plan will be considered by the Directors and Executive Committee later in March 2017; and** **v. it be noted that once the embargo has been lifted by the NHS Co-ordination Centre, the report can be shared to all CCG staff and stakeholders.**	

9.	**Data Services for Commissioners Regional Offices**	
	Data Confidentiality Action Plan JP presented the Data Confidentiality Plan, noting that the CCG was required to submit a letter to NHSE on 5 December 2016 providing assurance that it implemented controls in accordance with the Data Services for Commissioners Information Security Controls (DSCROs) for all recipients of data within the CCG from NHS Digital by 31 March 2017. The North East London Commissioning Support Unit (NELCSU) developed up-to-date guidance for all NEL CCGs following directions from the Secretary of State in relation to data disseminated by the Data Services Commissioners Regional Office in October 2016. It was noted that the CCG does not have the ability to manage patients data, but the CSU does, due to a change in requirement. This presents significant limitations for GPs. **Action: Check whether all CCGs have the same arrangement for managing patient data, particularly Camden CCG.** **RESOLVED that:** **i. the Assurance Statement that was prepared by NEL CSU on behalf of the CCG submitted to NHSE on 5 December 2016 as required by the CCG's SIRO be noted;** **ii. it be noted that NEL CSU's IG Team is responsible for ensuring that the framework is adhered to at all times and report any information security breach relating to commissioning data to the Information Commissioners Office and NHS Digital; and** **iii. the Assurance Plan which forms part of the IG Framework and is reviewed on a quarterly basis be approved.**	**JP**
10.	**NCL Individual Funding Requests**	
	NCL Individual Funding Requests Panel Arrangements Alsion de Metz attended the meeting to present a paper, which proposed recommending for approval to the Governing Body, operationalising a single joint Individual Funding Request (IFR) Panel for NCL CCGs to replace the current arrangement of individual CCG IFR panels by 1 April 2017. The Committee is also requested to approve a statement for delegating decision making on behalf of the CCG. The paper set out the background to the change and the change needed to the governance arrangements. There has been a consistent downward trend in the number of IFRs that go through individual panels, resulting in infrequent individual panel meetings. The proposal has gone through a collaborative process with CCG representatives and NCL CSU Service Level Agreement (SLA) Monitoring Group. Individual CCG Panel members were mainly supportive and provided practical considerations. NCL Chief Officers also supported the recommendation which is consistent with STP working arrangements and would increase the quality, consistency and robustness of decisions, with more frequent meetings. The proposed membership was noted, with each CCG having a vote. The Panel would be supported by non-voting members of the IFR team. The NCL Panel must have full decision making authority delegated from the individual CCGs. The IFR Policy has been revised to reflect the governance changes to enable the panel to function effectively. Overall, it is envisaged this new arranagment would not have an adverse impact on any CCG, as there has been no change to the Procedures of Limited Clinical Effectiveness (PoLCE) access criteria and no change to decision making principles that guide the Panel. The Committee discussed and raised a number of issues: • Governance: - there is no specificity on representation from individual CCGs – representation to be specified for Enfield CCG; - lack of clarity on the panel's reporting lines to individual CCGs. The current wording suggests chair of the panel is accountable to all CCGs; - clarity required on the Constitutional Appeals Panel (4.6)	

	- clarity is required on the voting structure, as the Chair was not a voting member in previous panel arrangements; - thought to be given to training for Lay Members who would Chair the Panel, as not all lay members are trained; - governance leads were not consulted to provide governance input; - inconsistency in the way the Policy is written - some of the wording suggests this was written for a single CCG; - to ensure consistency, it is important to have deputies coming from the same CCG; - financial thresholds to be introduced for what the value of decision making is likely to be to ensure compliance with governance arrangements. • Operationalising the system: - there would be a potential increase in the number of public health cases, partly due to Enfield changing its POLCE Policy and partly due to the move towards evidence based medicines, which could create an increased workload and potential for increase in complaints and appeals; - there are new conditions coming up, therefore discussion is needed in the near future on what conditions the panel would be dealing with, otherwise, it would become unmanageable; - to ensure there is a robust process for dealing with IFR rejections and feeding back to patients – this has been raised by GPs for POLCE rejections and would reflect on IFR rejections, as what is being done for POLCE is consistent for IFR; - to ensure we are fully utilising minor surgery pathway to ensure reduction on the impact on POLCE, which could come through as an IFR; **RESOLVED that the proposal to recommend the NCL IFR Panel to the Governing Body be NOT approved.** The following actions were agreed: • Revise the NCL IFR Policy and paper in view of issues raised and present a refreshed version at the Committee meeting in March; • Review document to provide views from a governance perspective;	**JM** **CBG/ BP**
11.	**Board Assurance Framework & Corporate Risk Register**	
	Bridget Pratt (BP) presented the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), for the Committee to review and moderate on the four BAF risks and eight corporate risks which required its attention. There are currently 10 open BAF- level risks and 19 open corporate risks. <u>BAF</u> ***Risk ID13 (Risk score = 12): Failure to comply with the CCG's Policy and statutory guidance on Conflicts of Interest (COI).*** Even though there is reasonable assurance that steps are being taken to ensure compliance with the COI Policy and statutory guidance, the Committee agreed for the risk score to remain at 12, in light of NHS England's new guidance on managing COI published on 9 February 2017. In addition, the COI action plan drafted on the framework of the COI statutory guidance issued in June 2016 is yet to be fully implemented. Failure to comply with the CCG's Policy and statutory guidance on COI could lead to reputational damage, legal challenge and slowing down of processes. The legal direction imposed on the CCG was predicated on governance and financial failure. *Risk score to remain at 12.* ***Risk ID342 (Risk score = 12): Risk to the delivery of Primary Care Transformation Programme.*** The ability of commissioners to be in the position to commission services for the population has been recognised as significant. There has been discussion on the ability of primary care to respond to the requirement of the system and the support CCGs can provide. The Committee agreed for the risk rating to remain at 12, but for the causes of the risk to be updated in light of the discussions. *Risk score to remain at 12.*	

	Risk ID343 (Risk score =16): Performance and quality risk arising from non-delivery of NHS constitutional standards*.** The significance of the current position of the A&E target, which is yet to be under control was raised. It was however noted that there are other contributory factors, including cancer waiting times and London Ambulance Service (LAS) performance. The Committee agreed for the risk rating to remain at 16, but for the causes of the risk to be updated in light of the discussion. *Risk score to remain at 16.* ***Risk ID400 (Risk score =12): The evidence base underpinning the NCL STP is not robust enough to inform transformation of services and support delivery*.** The Internal Auditors had confirmed Enfield CCG is the only CCG with this risk on its BAF. The sustainable delivery of the STP was questioned and it was recognised that the current plans in place are high level, with little or no assurance. Further discussion on risk 400 was done in parallel with risk 436 below. ***Risk 436 (New risk) (Risk score = 20): Risks Associated with aligning the STP, Operating Plan, QIPP Plans and Contract. In view of this risk being a part of the delivery of STP, it was noted that this risk should not be rated higher than the STP risk (risk 400). The question raised was whether risks 436 and 400 should be aligned or whether there is one risk with two elements. The accountability for aligning and operating contracts rest with the CCG, but the CCG is not in a position to make judgement on the wider risk around the STP. From a Finance Committee point of view, the severity of risk 436 should remain unchanged at 4, but the likelihood reduced to 4 (from 6) and the severity of risk 400 increased to 5 (from 4), with the likelihood remaining unchanged at 4, as the financial risk could not be bigger than the STP risk in its entirety. **Action: Increase risk scoring for risk 400 to 20 (4x5), and reduce risk scoring for risk 436 to 16 (4x4).**	**VA**
	<u>CRR</u> ***Risk ID5 (risk score =8): CSU's inability to deliver key CCG functions in line with CCG performance and SLA.*** The Committee agreed for the risk score to remain at 8 and for the causes to be reviewed from time to time. *Risk score to remain at 8.* The Committee discussed the relevance of the CSU in the NCL STP arrangement. There is a renegotiation of a 2 year contract with the CSU across NCL, led by Sarah Price, Chief Officer for Haringey CCG, with defined benefit savings target for all 5 CCGs. Enfield CCG stands alone in its quest to radically change the CSU offer, as the CCG has failed to get traction with the other NCL CCGs to see a change in the CSU service. Jane Pike is compiling a letter to Sarah Price, detailing the key elements from Enfield CCG's perspective in the renegotiation of the contract, one of which is the inclusion of clauses at specific timeframes and having transparent costs. **Action: Provide an update on the CSU contract renegotiation at the next meeting.**	**JP**
	Risk ID33 (risk score =12): Re-commissioning of long stay dementia beds- potential legal issues arising from transfer of care from hospital to community setting. The CCG is undertaking individual patient assessment, which had proved to be complex and taking longer than anticipated. Even though there are processes in place, there could be significant challenge from families. In addition, the Local Authority (LA) had commissioned a new care home, with no provider to operate it and therefore no access to beds. *Risk score to remain at 12.* ***Risk ID297 (risk score =12): Risk to delivery of current CAMHs services due to proposed funding reduction by Enfield Borough Council.*** The final decision is unconfirmed. This risk was deescalated, as agreed at the Directors meeting on 7 February from 15 to 12. *Risk score to remain at 12.* ***Risk ID397 (risk score =10): PMS Reviews will impact core PMS funding which may impact on the delivery of patient services and destabilisation of practices.*** *Risk score to remain at 10.*	

	Risk ID398 (risk score =9): Access to CAMHS Tier 4 beds. This has been ongoing for some time, with gaps in assurance and controls. Since the risk score is reflective of risks to Enfield patients, it was agreed for the risk score to be increased to 12 and for NHSE to be urged to move this forward. **Action: Increase r*isk scoring for risk 398 to 12.***	**VA**
	Risk ID427 (risk score =9): Lack of commissioning capacity to deliver directorate objectives. The Committee agreed for this risk to be closed, as the post has been recruited to. **Action: Close Risk 427.**	**VA**
	Risk ID430 (risk score =8): Risk of not finding appropriate accommodation within timescales to relocate ECCG. This risk was deescalated from the BAF to the CRR. Until a contract is finalised, the Committee agreed for the risk rating to remain at 8. *Risk score to remain at 8.*	
	Risk ID435 (new risk) (risk score =8): Increase in number of children waiting more than 13 weeks for an initial assessment for CAMHs. It was noted that the CAMHS waiting list is increasing. Money has been set aside and clinicians have been asked to come up with a plan to address this issue. *Risk score to remain at 8.*	
	RESOLVED that the new risk on the BAF, the new risk on the CRR, the eight high risks on the BAF, four high risks on the CRR and the de-escalated risks be noted.	
12.	**Enfield CCG Policy**	
12.1	**HR Policies** The following Policies were presented to the Committee for approval: Capability Policy, Disciplinary Policy, Raising a Concern Policy (formally Whistleblowing Policy), Secondment Policy and Temporary Promotion Policy. Coments were raised as follows: • Capability Policy - no explicitiсy on how capability should be assessed. • Temporary Promotion Policy - information on increment was queried, as it seemed counter productive for staff on temporary promotion, especially at senior level. It was noted that these policies are negotiated with staff side and NCL, with the CCG adopting them; therefore getting leverage for one CCG could prove challenging. However, comments would be fed back. **RESOLVED that the following policies be approved subject to the issues raised:** **i. Capability Policy;** **ii. Disciplinary Policy** **iii. Raising a Concern Policy (formally Whistleblowing Policy);** **iv. Secondment Policy; and** **v. Temporary Promotion Policy.**	
13.	**Any Other Business**	
	<u>Clinical Commissioning Committee</u> Janet High raised concern on the proposal for the formation of the Clinical Commissioning Committee, which would see the dissolution of the CRG and the Executive Committee. The size of the proposed Committee structure, its remit and the membership of the sub-group beneath the Committee were queried. It has been suggested that the new clinical leads attend the sub-group meeting to strengthen the skills. **Action: Review proposed terms of reference for the Clinical Commissioning Committee.** The current Committee structure would remain in place until a decision is taken.	**MA/ JH**

14.	**Date of Next Meeting**	
	Wednesday 22 March 2017, 10.00 – 12.00.	
15.	**Current items of work in progress**	
	Items for Executive Committee's attention include: • NCL Financial Strategy 2017 - 21: The CCG is leading on this and discussions would probably be at the Finance and Performance Committee meeting. • Enfield Systems Resilience Capacity Plan 2017 - 18 • Governance of the Annual Report 2016/17: The Communications team is leading on this. The Audit Committee has delegated authority to approve the Annual Report and Accounts; this would be done in April and May. It is important that Directors take responsibility to sign off areas of responsibility and also important for sufficient time to be factored into the process for editing.	