NORTH CENTRAL LONDON ('NCL') JOINT COMMISSIONING COMMITEE
Minutes of the meeting held in public on Thursday 2 May 2019, 15:00-16:25
The Main Hall, Cypriot Centre, Earlham Grove, London N22 5HJ

Voting Members Present:	
Ms Karen Trew (Chair)	Governing Body Vice Chair and Lay Member, Enfield CCG
Dr Charlotte Benjamin	Governing Body Member, Barnet CCG
Ms Sorrel Brookes	Governing Body Lay Member, Islington CCG
Dr Peter Christian	Governing Body Chair, Haringey CCG
Ms Kathy Elliott (Vice Chair)	Governing Body Lay Member, Camden CCG
Mr Simon Goodwin	Chief Finance Officer, Barnet, Camden, Enfield, Haringey and Islington CCGs
Dr Neel Gupta	Governing Body, Chair, Camden CCG
Dr Fawad Hussain	Governing Body Secondary Care Clinician, Enfield CCG
Ms Helen Pettersen	Accountable Officer, Barnet, Camden, Enfield, Haringey and Islington CCGs
Dr Jo Sauvage	Governing Body Chair, Islington CCG
Ms Sharon Seber	Nurse Representative Haringey CCG
Mr Adam Sharples	Governing Body Lay Member, Haringey CCG
Non-Voting Members Present:	
Ms Parin Bahl	Healthwatch Enfield
Ms Sharon Grant	Healthwatch Haringey
Attendees:	
Ms Alev Cazimoglu	Councillor, Enfield Council
Dr Dee Hora	NCL Clinical Lead for Planned Care (Primary Care)
Mr Rob Hurd	Chief Executive, Royal National Orthopaedic Hospital NHS Trust and Joint SRO, Adult Elective Orthopaedic Services Review
Mr Will Huxter	NCL Director of Strategy and Joint SRO, Adult Elective Orthopaedic Services Review
Mr Ian Porter	Director of Corporate Services, NCL CCGs
Mr Paul Sinden	NCL Director of Planning, Performance and Primary Care,
Ms Anna Stewart	NCL Programme Director
Apologies:	
Dr Mo Abedi	Governing Body Chair, Enfield CCG
Ms Janet Burgess	Councillor, Islington Council
Ms Pat Callaghan	Councillor, Camden Council
Mr Richard Cornelius	Councillor, Barnet Council
Dr Tamara Djuretic	Director of Public Health, Barnet Council
Ms Eileen Fiori	Director of Acute Commissioning, NCL CCGs
Professor Fares Haddad	Chair, Clinical Orthopaedic Network
Ms Sarah James	Councillor, Haringey Council
Mr Ed Nkrumah	Director of Performance, NCL CCGs
Ms Sarah Rothenberg	NCL POD Director, Northeast London Commissioning Support Unit
Mr Dominic Tkaczyk	Governing Body Lay Member, Barnet CCG
Minutes	
Mr Andrew Tillbrook	Deputy Board Secretary, NCL CCGs

1.	**Introduction**
1.1	**Apologies for absence**
1.1.1	Apologies had been received and noted and recorded as above. The Chair welcomed all attendees and members of public, in particular to Dr Dee Hora and Mr Rob Hurd. Members noted that the meeting was quorate.
1.2	**Declarations of Interests**
1.2.1	There were no additional declarations of interests made to the Register, nor any declarations made relevant to the agenda.
1.3	**Declarations of gifts and hospitality**
1.3.1	There were no declarations of gifts or hospitality offered or received.
1.4	**Opening Remarks**
1.4.1	The Chair advised that the NCL Joint Commissioning Committee had met on Wednesday 24 April 2019 as part of a wider Committee-in-Common with other CCGs from London and Hertfordshire to consider the pre-consultation phase of the proposal to relocate Moorfields Hospital from the City Road site to the St Pancras Hospital site. The Committee-in-Common approved the following: • The pre-consultation business case; • The consultation mandate; • To launch the pubic consultation – which would commence on 24 May 2019 (following the European Parliament elections to accommodate purdah rules) and end on 16 September 2019.
1.5	**Questions from the public**
1.5.1	The Chair referred to three written questions about the Adult Elective Orthopaedic Services review received from Defend Enfield NHS prior to the meeting which were relayed to the meeting and answered. The questions and responses were: • Noting that NCL would be using the London Choosing Wisely Policy criteria to manage demand for hip and knee replacement, concern was expressed that there had been no consultation with the public on this approach and assurance was sought whether such an exercise would be undertaken about orthopaedic surgery and the clinical consequences might be to the quality of life for some patients. In response, the meeting noted the following clarifications and assurances: ○ Elective orthopaedic surgery is not being restricted in north central London for those patients that require this treatment. The number of these surgeries is predicted to rise, in line with the requirements of a growing and ageing population. Demand for orthopaedic surgery is anticipated to increase by 2.2% by 2023, an average increase of 0.38% per annum. ○ The policy update wording relates to the point at which it is clinically appropriate to have surgery, following shared decision-making between the patient and their clinician, and after first using appropriate non-surgical interventions, as set out in NICE recommendations. ○ We can reassure concerned residents that a significant number of local clinicians were involved in reviewing the revised referral thresholds for hip and knee replacement. The changes are based on latest clinical evidence and the input of subject matter experts.

	○ We also undertook equality impact assessments to consider any impact for protected groups, which concluded there is no reason why those residents meeting the clinical criteria wouldn't receive the treatment they require. ○ We have presented regularly at the NCL Joint Health and Oversight Committee over the past year to ensure we are meeting our duty to communicate and engage with residents on any changes in an appropriate way. We will continue to communication and engage with residents with regards to any future updates.
1.5.2	• Note was made of a 'Commercial Board' (or Boards) that would be established, and that elective centres in NCL would be allowed to admit patients from out of area and private hospitals, to further support the business case for the clinical service delivery model. Assurance was sought that clinical need would be the only factor when deciding who received orthopaedic surgery, and that no patients would be able to pay to gain fast-track access to elective surgery. It was clarified that: ○ The JCC decided at its January 2019 meeting, that services under the newly configured clinical delivery model will remain within the NHS by way of variations to existing annual contracts; This will ensure services are safe and that there are no adverse implications for interdependent orthopaedic trauma services. ○ The reference to 'commercial principles' relates to how money will be distributed between NHS providers and a 'joint commercial board' would comprise representatives from each NHS service provider. Its purpose would be to provide financial governance across the NHS system. ○ The board would not have a role in determining the proportion of privately funded patients accepted by individual organisations.
1.5.3	• Consideration with regard to patients with severe perioperative anaphylaxis should be admitted to Level 3 critical care, according to findings from the Royal College of Anaesthetists. In addition, patients resuscitated from cardiac arrest, often require vasopressor infusions, sometimes requiring critical care for more than two days. Assurance was sought as to how appropriate and safe care can be maintained for this patient group identified as having a 'high risk of an adverse outcome from severe perioperative anaphylaxis. • In response it was confirmed that: ○ Under the proposed model of care, all patients undergoing elective orthopaedic surgery will have a comprehensive pre-surgical assessment. Those identified as high risk will be assessed by an anaesthetist to determine individual clinical needs and post-surgery care planning to occur. Those identified as potentially requiring level 3 critical care intervention prior to surgery will receive surgery at the most appropriate site. For those who require level 3 care unexpectedly post-surgery, there will be appropriate protocols and systems in place to ensure safe transfer to the most clinically appropriate NCL site. ○ All prospective providers are required to provide level 2 critical care as a minimum. Potential sites for the elective centre may already be co-located with a level 3 critical care facility. Critical care provision will be assessed as part of the options appraisal, with all providers asked to determine the case mix they can safely and effectively manage.

1.5.4	Questions were then invited from the public attending the meeting on the report and on the questions presented in advance of the meeting. The following observations and comments were made: • An opportunity to discuss PoLCE would occur at an over 50s forum meeting in Enfield in autumn 2019. ***Action: Will Huxter to provide details to Noelle Skivington, Healthwatch Enfield;*** • The suggestion to change the name of the 'Commercial Board' to lessen the perception of it having 'profit making' connotations was agreed (it was clarified the Board only existed to have oversight of financial flows across NHS providers); • It was noted that the review would draw on current arrangements for specialist providers of orthopaedic care. Level 2 providers of care, such as the RNOH, were able to flex and increase the level of care when required for a short period of time to enable safe patient transfer to a level 3 facility within recognised protocols. Unexpected changes in care levels required from level 2 to level 3 are rare occurrences. Nevertheless, providers such as the RNOH were experienced in managing such instances. In developing the clinical delivery model, the review had also drawn on the established model of care at SWLEOC (South West London Elective Orthopaedic Centre); • It was noted that the clinical delivery model is not prescriptive about the number of elective orthopaedic centres required in north central London. The process of seeking submissions of options may determine that there should be more than one elective centre. If this is the case, each centre may manage different levels of medical and orthopaedic complexity.
	AGREED: to note questions from the public
1.5.5	**Supplementary questions**
1.5.6	The Committee was invited to clarify the continuing perception that the updated PoLCE policy could give rise to indirect discrimination toward some patients for particular conditions given differential prevalence according to their ethnicity. This linked to the reference in the clinical delivery model and options appraisal process making reference to the PoLCE policy as a 'demand management' tool. In response it was noted that: • Knee and hip operations are evidence-based procedures and would be carried out for all residents meeting the criteria in line with the policy approved by the Committee earlier in 2019 • That the reference to PoLCE in relation to demand management was unhelpful and that the drafting should be clarified in the final draft put forward for agreement by the chair.
2.	**Commissioning**
2.1	**Adult Elective Orthopaedic Services Review: Clinical Delivery Model and Options Appraisal Process**
2.1.1	Work on the service review to date was outlined noting: • The focus on improving the quality of care and outcomes through provider collaboration across base hospitals and elective centre(s); • The extensive engagement process with patients, stakeholders and staff to arrive at the approved clinical design principles, which had been built into the clinical delivery model. This was acknowledged by the Committee;

	• Aligned to the integrated service model the development of an integrated workforce approach across sites and Trusts to best ensure continuity of care for patients across the base hospital sites and elective centre(s), introduce a multi-disciplinary approach to patient care, to accommodate changes in demand, and to ensure best care in the optimum setting for the patients; • The clinical delivery model would also account for the interdependencies of different sites, particularly the impact of trauma, spinal and paediatric services; • The service model set out essential criteria for providers to become an elective centre including a critical mass of procedures, access to essential and interdependent services including critical care, and the ring-fencing of bed and theatre capacity for elective care; • Providers were encouraged to specify in their responses to the clinical delivery model how they would deliver some of the services such as intensive rehabilitation, patient education, care co-ordination; • The above demonstrated that feedback from stakeholder engagement with patients and clinicians had influenced the clinical delivery model.
2.1.2	The Committee then noted the options appraisal timeline and process: • The final Clinical Delivery Model would be shared with NHS providers of orthopaedic surgery later on in May, with providers being formally asked how they would want to contribute to the model of care; • Subject to the NHS England assurance process and completion of the pre consultation business case (PCBC) and discussions with the NCL Joint Health Overview Scrutiny Committee (JHOSC), the Committee (or a joint arrangement with other commissioners if required) would be scheduled to receive and approve the PCBC in the autumn 2019; • Consultation on the preferred option would commence post Committee approval; • To ensure there was a robust process to carry out the options appraisal, two assessment panels would be established covering clinical and quality criteria (with patient and resident representatives and the support of the independent clinical advisor) and the financial assessment (again with independent support); • The finance hurdle criteria specify the cost of the new service would demonstrate a favourable income and expenditure impact for the system after two years of operation, against a counterfactual that includes growth and cost of growth. • Finance returns from providers would set out their contribution to the service model including collaboration with other providers reflecting the system-wide clinical delivery model for NCL to improve care and outcomes. The financial assessment would inform a financial narrative for each option, which would sit alongside the outcome of the options appraisal process.
2.1.3	A range of questions were raised and clarifications issued in response to the report and presentation: • To address concerns about financial pressures for those providers who might lose activity to elective centres a system-wide view of proposals would be taken by CCGs. Providers not intending to become an elective centre in the new arrangements would be asked to provide information about the financial impact and any mitigations, for consideration. Collaborative submissions were also being encouraged from across multiple providers; • Developing the clinical delivery model, and associated cost implications, was supported by a finance steering group (composed of finance directors from various

	providers and chaired by the Director of Finance of the North Middlesex University Hospital Trust); • The finance model was based on Payments by Results (PbR) as this is the currently accepted activity currency. Alternative models may need to be considered in the future. • Whilst elective spinal surgery was not part of the clinical delivery model proposals had been considered with the North London Spinal Network. The current service model for spinal surgery would continue; • Patient engagement would build on the approach used to date. There would continue to be regular updates to Healthwatch and other local groups. In addition, the review would be recruiting patient and resident representatives to participate in the options appraisal process. • The current risk register would be reviewed as part of the next stage of the review, particular attention would be paid to ensure sufficient consideration of risks relating to financial modelling; • An Equality Impact Assessment (EIA) would be commissioned once formal proposals were in place, the work for which would be subject to a formal tender exercise. The EIA would follow the pattern of the current assessment and take account of resident groups with protected characteristics, as well as looking more broadly to all groups who may be regarded as potentially vulnerable; • There was no additional capital expenditure available to support the clinical delivery model; the intention was to realign services within existing resources; • Care coordination and navigation roles were core component of the new service model, and would help patients return home post-surgery and provide patients with vulnerabilities or complex needs (non-medical) access the required health and social care packages; • Consideration of how to further patient representation in the governance of the elective centre would be considered; • Patient waiting times were included as a measure of effectiveness as part of the patient experience section of the clinical delivery model and options appraisal process; • Public transport networks, particularly for vulnerable patients, were a concern raised through patient engagement. A detailed analysis of patient travel times would be undertaken alongside the public consultation process; • GIRFT (getting it right first time methodology) underpinned the proposed model of care; • More detailed questions on the delivery model could be addressed outside of the meeting if members wanted to raise them; • Developments in relation to the above would be reported back to the Committee in subsequent reports.
2.1.4	Overall the process of engagement and development of the proposal was commended, exemplifying a model of working as a system – commissioners, providers, patient engagement, local authorities and other stakeholders.
2.1.5	The Committee noted that update to the final report, including any changes accruing from the Committee discussion today, could be agreed by the chair, under the authority delegated to her by the committee, and reported back to the Committee.
2.1.6	On behalf of the Committee, the Chair thanked the project team for work to date on developing the clinical delivery model and supporting engagement process, and for the innovative approach in adopting a system wide approach to enhance patient care.

	The Joint Commissioning Committee: • **AGREED the proposed Clinical Delivery Model and Options Appraisal Process;** • **AGREED that the chair, under the authority delegated to her by the committee, would agree the final areas of clarification which included matters raised at the meeting. This would be reported back to the Committee.**
3	**Any Other Business**
3.1	There was no any other business to conduct. The meeting closed at 4:25pm
4	**Date of Next Meeting**
4.1	The next Committee meeting would be on Thursday, 6 June 2019, 2:30 to 5pm, venue to be confirmed.