Islington CCG Governing Body meeting – Wednesday 14 November 2018

Questions from the public (received in advance of the meeting)

Question 1 relates to agenda item 3.1, points 3.1.2 and 3.1.5 of the Governing Body minutes of 12/09/2018

- What is the current situation re: CHINs in Islington?

Answer: The North CHIN continues to develop a moderate-frailty model and the CCG has agreed to fund this until March 2020 in order to enable evaluation. The atrial fibrillation and hypertension work from the South CHIN is in the process of being rolled out across Islington and is currently operational across two CHINs.

The Chronic Obstructive Pulmonary Disease Multi-Disciplinary Team clinics have been operating borough-wide since July. Physical health checks for people with Serious Mental Illness continue in the South CHIN and will be rolled out throughout Islington in the next few weeks once recruitment to all nursing posts is complete. This work contributes towards the CCG's goal of achieving the NHS England mandated target for delivering these health checks.

Question 2 relates to agenda item 4.2.1 of the Governing Body minutes of 12/09/2018

- "There were two 12 hour mental health emergency department breaches at Whittington Health in July 2018".
- I believe that one also involved Barnet, Enfield and Haringey Mental Health Trust, was it the same partner in the second?

Answer: The second mental health breach involved Camden and Islington NHS Foundation Trust and Whittington Health NHS Trust.

Question 3 relates to agenda item 3.1 of the Governing Body papers for 14/11/2018

a) Pages 5, 33 and 192 - when will the "Plain English version" be available and to whom?
b) Pages 6, 34, and 192 - could this please be explained to me in plain English?

Answer: The North Central London CCGs wish to improve and strengthen general practices' services. The five CCGs in North Central London have a history of collaborating on primary care, including producing strategies for primary care. The CCGs made a commitment to collaborating again to produce this draft strategy for general practice for north central London.

This draft builds on the aims and achievements of earlier strategies and sets the collective direction of travel for general practice. The early draft was developed by a task and finish group with representation from each of the five CCGs in north central London. This group also included representation from Healthwatch (Healthwatch Enfield) representing Healthwatch in north central London, the North Central London GP Federations and a nursing representative. The group was supported by the North Central London Health and Care Closer to Home programme.

We then used this early draft to further develop the strategy during a period of engagement which ran from May to October. Engagement was determined locally, and was largely locally-led.

Once the strategy has been approved, we will develop a Plain English/summary version for wider use and each of the CCGs will develop local implementation plans. The local plans will depend on local resourcing and context and the CCGs will engage locally on their own implementation.

We are committed to commissioning high-quality general practice for people living in north central London and are developing plans to invest in primary care. These include investment into Care and Health Integrated Networks and Quality Improvement Support Teams and recruitment of newly qualified and international GPs.

We know we need to work differently in order to preserve the strengths of general practice. This will include more practices collaborating, or practices sharing back office functions, such as HR or finance. This could also include a wider skill mix so more services can be offered in general practice (e.g. pharmacists, physicians associates).

We are also committed to reducing unwarranted variation in general practice, including moving towards ensuring that all patients in north central London are able to access the same range of locally commissioned services. This work is not about reducing GP services and patients will still be able to make appointments to see their GP.

c) Page 41 - "Alcohol related issues are most prevalent in Haringey and Islington so efforts on alcohol prevention need to be focused on these areas" - does the highlighted mean drinking of alcohol or total abstinence? Or is there possibly another meaning?

Answer: We are sorry but we don't quite understand this question. We will have a chat with you to clarify and then make sure we get you an appropriate response.

d) Pages 15, 43 and 192 - could the sources be clarified/amplified?

Answer: We are sorry but we don't quite understand this question. We will have a chat with you to clarify and then make sure we get you an appropriate response.

e) Pages 23, 51 and 192 - is it possible that "more alignment of terms and conditions for general practice staff" could result in pay reductions and/or worse conditions?

Answer: The North Central London Strategy for General Practice aims to improve terms and conditions for staff by developing a resilient, sustainable and thriving general practice.

To achieve the transformation required to the way services are delivered to patients, it is imperative that we are proactive in sustaining and developing a workforce to support this. North Central London faces a significant challenge in its current and future GP workforce, and the need to value the existing workforce and attract and retain new professionals is rooted in current initiatives.

f) Pages 25, 53 and 192 - "Face to face appointments should be offered to those who need them, making sure there is an opportunity for a senior clinician to assess the need, where appropriate, similar to the approach used to triage out of hours demand" - will this restrict, in any way, the right of a patient who wants an appointment to see their GP?

Answer: Please see the response to Question 3.

g) Pages 76 and 192 - judging by the engagement log, there was only one occasion when Islington appears to have had any contact/consultation with patients or public regarding the strategy - is this correct?

Answer: Healthwatch was involved throughout the process of developing the draft strategy. Healthwatch Enfield (representing the five Healthwatch in north central London) was a member of the task and finish group, and also sit on the overall Health and Care Closer to Home programme board. Engagement was determined locally, and was largely locally led.

Once the strategy has been approved, we will develop a Plain English/summary version for wider use, and each of the CCGs will develop local implementation plans. The local plans will depend on local resourcing and context. The CCGs will engage locally on their own implementation.

Question 4 relates to agenda item 4.2a

a) Pages 2, 86 and 192, item 4.2a, point 2.1 - A&E - Moorfields Eye Hospital "Performance August 18" is shown as 99.7%, what is this in the actual number of patients?

Answer: This equates to 21 breaches from a total of 6,864 attendances.

b) Pages 5, 126 and 192 - Am I correct in believing that "Enhance focus on reducing LOS through" and "Review escalation processes and triggers, including for DTOCs and MOs" are not separate points (as shown) but part of the same point?

Answer: Managing Delayed Transfers of Care (also known as DTOCs) and numbers of patients who are medically optimised are key aspects of managing appropriate length of stay. However, escalation processes and triggers also include measures such as bed occupancy, the number of people in A&E who require admission to a ward, staffing levels and the number of patients in the A&E department.

Performance against these measures contributes to an OPEL score (a measure of overall system pressure in place across London). If an escalated OPEL Score (three or above) is reached, partners including acute Trusts, local authorities and community health services work together on mitigating actions to reduce pressure.

Question 5 relates to agenda items 4.3 and 5.1a

- Pages 149 and 192 - "JCC 13" insofar as staff, patients and the public are concerned, will the reported shortage of the flu vaccine have a negative effect on the winter plan?

Answer: In primary care, all practices have confirmed that they have ordered sufficient vaccines for their patients. For the first time, the vaccine is being delivered in stages from September to November 2018. The manufacturers have confirmed there is enough vaccine supply available to the NHS in England to meet expected demand. By mid-November, the complete orders will have been delivered to GP practices, pharmacies and other providers.

Question 6 relates to agenda item 5.1a

- Pages 149 and 192, Risk 18 - what action will Capita be taking during the patient list cleaning process?

Answer: Capita is the company that is commissioned by NHS England to undertake the list cleansing process to make sure that practice lists are up to date and that payments made to practices, on a capitation basis, only include current patients on practice lists.

List maintenance should be carried out as a continuous rolling programme, for example by working through the practice registers alphabetically over a one to three-year period. This can also include phased targeting of specific patient cohorts. Examples of this approach include:

- *choosing a patient cohort that supports a screening programme e.g. childhood immunisations, flu or cytology*
- *addresses with apparent multiple occupancy*
- *practices with particular circumstances that dictate a local bespoke approach to maintaining accurate lists e.g. university practices.*

The patient list cleansing process is usually undertaken every three years. We are planning to begin list cleaning in North Central London CCGs in early 2019.

Question 7 relates to agenda item 5.1b

- Pages 152 and 192, Risk 423 re: LUTS – can it be confirmed that this is the present position following the deputation from the LUTS Clinic patient group to JHOSC on 05/10/18?
- However, is the Board aware that the deputation also expressed dismay at the treatment (or lack of it) for adults by Whittington Health NHS Trust?
- Can you please report what you understand the up-to-date position to be in respect of the Whittington Health NHS Trust?

Answer: The CCG is aware that the Lower Urinary Tract Service (LUTs) patient group took a deputation to the last Joint Health and Overview Scrutiny Committee (JHOSC) in October 2018. The JHOSC is sighted on the work carried out to date by health partners to ensure appropriate referral pathways are in place for adults and children requiring specialist treatment from a lower urinary tract service.

Haringey and Islington CCG Governing Bodies receive a regular update on the position of the adult and child pathways via the joint Haringey and Islington CCG Quality and Performance Committee. The Committee is satisfied that the CCG is taking appropriate actions with Whittington Health NHS Trust and the new clinical lead to address the waiting times for tertiary referral of adults into the LUTs service . The Trust has confirmed that referrals into the adult LUTs service are triaged and appointments issued based on clinical risk. Whilst work is in hand to address the waiting time, commissioners have requested that patients receive written advice from the service to seek advice from their GP / secondary care consultant should their condition deteriorate whilst waiting for their first appointment.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is the designated provider for the tertiary referral of children. Whittington Health NHS Trust has no plans to provide a pediatric LUTs service.

The CCG has secured an arrangement with GOSH for the small group of children identified though the LUTs patient group to be accepted for review, subject to their GP / lead secondary care consultant making a tertiary referral. GOSH has received the names of these children and their parents are committed to providing a timely appointment. It would not be appropriate for the CCG to comment further on these cases.

Question 8 relates to agenda item 5.3

- Pages 2, 170 and 192 (item 4.8) - how will "cohorts of patients" be considered in "commissioning intentions" or will they not be?

Answer: The Individual Funding Request (IFR) process and panel does not have the remit to make funding decisions for cohorts of patients. Where we become aware, through the IFR process, of a cohort of patients we will bring this to the attention of the local CCG so that it can be addressed through local arrangements.

Question 9 relates to agenda item 5.3

- Page 171 (item 6.5) - even if it is a remote possibility is there a chance that a majority of the Joint BEHI IFR Panel could vote contrary to the Islington member(s)?
- Bearing in mind that the "relevant CCG remains the statutory decision maker", how would the matter be decided?

Answer: This is technically possible given the membership of the panel. However, it is unlikely, as decisions are based on evidence and follow very clear criteria. The nature of panel decision making is also collaborative with the panel endeavoring to come to a joint view.

It might be helpful to describe the panel process. The Individual Funding Request panel decision making is guided by a set of common principles that focus panel members on the evidence

submitted and the clinical case for exceptionality i.e. How this patient is clinically different from others with the same diagnosis.

In the proposed arrangements with five voting panel members there will always be a clear majority so it could be the case that a Haringey panel member is outvoted. However, it is unlikely that the panel members will know the CCG as all non-clinical information that could have a bearing on the decision will be redacted from the information the panel members receive.

The panel members will have a wide ranging discussion of the issues that are both relevant and not relevant to the individual case ensuring that all members have an equal voice. Having heard all the arguments the decision is usually by a vote. The chair has the casting vote and if anyone is outvoted there will be further discussion to ensure there is a broad consensus and ownership of the decision.

The relevant CCG remains the statutory decision maker. In theory, Governing Bodies could override any decision of a panel where they have statutory responsibility for a patient. However, this is highly unlikely as decisions have been delegated to the panel and cases are evidence based and decided by following clear criteria.

Question 10 relates to agenda item 5.3

- Pages 11, 179 (item 2.2.4) and 192 - how can the public access the NCL IFR Policy?
- N.B. Although I've not looked at all the C.C.G. websites, those I have checked refer to the North and East London CCGs VO5 (2014 - 17).

Answer: The North Central London CCGs and the seven CCGs in the NEL Commissioning Alliance Sustainability and Transformation Partnership area have the same Individual Funding Request policy in the interests of equity and fairness. The policy is currently being updated following the recent updating of the national NHS England policy.

- Will there be an increase in IFR requests as a result of implementing POLCE (either the North Central London version or the NHS England version)?
- How much more time will G.Ps and hospitals have to spend in submitting IFRs because of POLCE?

Answer: Individual Funding Requests (IFR) and Procedures of Limited Clinical Evidence (PoLCE) are different. However, both aim to ensure that funding decisions are based on the most up-to-date evidence of clinical effectiveness and maximise equity and fairness in terms of access to NHS funded treatments. We want to make sure that patients have access to the most effective treatment/drugs/procedures that will give the best outcome. We don't want to fund treatments that we know from the evidence are not effective, that is not a good use of resources

We have worked with other CCGs that have implemented changes to their PoLCE access thresholds and introduced a requirement for 'prior approval' before the treatment can go ahead. In these cases we haven't seen an increase in the number of IFRs being submitted.

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