NHS
North Durham
Clinical Commissioning Group

Pre-notified Questions to the North Durham CCG Governing Body 2013/14

Date of Meeting: 24 April 2013

Question 1:
With regard to joint working between the CCG and the pharmaceutical industry, Merck Sharp and Dohme Limited was keen to engage with the CCG and assist in work regarding clinical practice to ensure the best interest of patients and to break down historic barriers between the NHS and the pharmaceutical industry. - **Andrew Williams, NHS Development Manager, Merck Sharp and Dohme Limited**

NO'B responded that Ian Davidson, Director of Quality and Safety for the CCG, had informed him that a report regarding joint working had been considered by the quality research and innovation (QRI) sub-committee in November 2013. The NECS medicines management pharmacist had prepared a further report for consideration at the QRI in May 2013 that outlined joint working arrangements for approval. A project had already been commenced with regard to chronic obstructive pulmonary disease (COPD) with Glaxo Smithkline and it was felt that outcome of that work would help to determine future working arrangements.

Mr Williams stated that joint working could go beyond the use of medicines to include clinical pathway, service redesign and social marketing. AG asked if the pharmaceutical companies still provided a resource for clinician training and Mr Williams responded that although medical education was still offered, there was more a focus on joint working.

NO'B highlighted that a consistent and open approach would be essential and it was agreed that representatives from the CCG would meet with Mr Williams to discuss the issue further.

Action: meeting to be arranged between the CCG and Mr Williams to discuss joint working with the pharmaceutical industry further.

KB reminded the members of the public present at the meeting that there was an opportunity for them to pose a question to the governing body prior to the meeting to enable a full and clear response to be provided.

1. It was raised that the advert for the governing body had appeared late in the week in the Durham Advertiser and unfortunately not until the deadline to pose questions had passed. The CCG would ensure the governing body meetings were advertised in a timely manner.

Action: AM to ensure adverts were placed in the local press in a timely manner.

Date of meeting: 22 May 2013

Question 1:
Does the panel have accurate figures relating to the public's use of the 111 number and are they satisfied that the 111 service adequately covers the needs of the public out of hours and at weekends? – **Mr Stephen Hann**

Response:

MH responded to the question and explained that the 111 service was provided by North East Ambulance NHS Foundation Trust (NEAS) and covered the area of County Durham and Darlington which had been an early pilot for 111 for the previous two to three years. The idea had originally been developed in County Durham and Darlington in response to comments from patients about their needs with regards to out of hours care. It was explained that the CCG received comprehensive information about 111 on a monthly basis via a performance report including details of the number of calls made to 111, times of the calls, information on the triage of calls and where those patients were forwarded to as a result of the calls. It was felt the CCG received adequate information to be assured that the service was being delivered well.

A monthly contract meeting was held between the CCG and NEAS to consider the performance information and to discuss any issues of quality and patient safety in addition to activity information. MH reported that in 2012 there had been 329,000 calls to 111 in County Durham and Darlington with a population of 700,000. He assured the governing body and members of the public that the CCG was able to plan the service requirements to meet demand across 24 hours of the day. With regard to recent reports in the press, it was noted that data had suggested that only 2% of patients who call 111 ended up being referred to accident and emergency and only 0.75% of those were transferred to the 999 number.

The low percentage of transfers indicated that calls were being directed correctly.

Mr Hann highlighted that 111 calls were being answered by people who were not medical specialists and was that reason down to cost. He felt that members of the public would want to speak to someone who could make an informed, clinical decision about their situation and was pleased that the 111 service in the North East was being managed by NEAS as an NHS organisation. Mr Hann asked the governing body members why they thought there was an increase in patients attending accident and emergency. KB highlighted that that was part of the work of the urgent care board that had been established in County Durham and Darlington to improve urgent care services. NO'B asked Mr Hann why he thought there were more attendances at accident and emergency and he felt that a person would be guaranteed to see a clinical professional if they attended accident and emergency rather than calling 111 and speaking to a non-medical call handler. He felt NHS Direct had been successful due to the fact that it had nursing staff triaging the calls. NO'B said he would welcome the national review of 111, he felt the idea and concept of having an easy to remember number to call was appropriate but that it needed further work and development.

Question 2:
What information can the governing body of the CCG give us regarding the fifty streams of community services that are being put out to tender? What principles are being followed? There was concern about destablisation of CDDFT, hospitals and other NHS organisations as a result of that. **- Carole Reeves**

Response:

NO'B stated that of the fifty service lines within the community contract, some of those were being commissioned by other NHS organisations other than CCGs including the NHS England Area Team and the local authorities. The community contract comes to an end in March 2014 and it was felt that gave an opportunity to review the contract. Due to the contractual arrangements, formal notice had to be given to CDDFT of the CCGs' intention to review the community contract. The work would include review of various services including the district nursing service, the provision of community specialist nurses, urgent care GP services and physiotherapy. The reviews would be undertaken across County Durham and Darlington and will involve the three CCGs, clinicians, commissioners and providers to understand the level of change required. It was confirmed that meetings had been held with staff to reassure them that formal notice had not been issued with the intention to to reprocure services, the CCGs are keen to work with the current providers to change or alter services together if this is required.

NO'B explained that a prioritisation exercise would be undertaken as all of the services could not be reviewed in 2013/14. The other service reviews would be rolled over to 2014/15.

Carol Reeves highlighted that there was concern about the review and that the community services would not be considered as a whole. NO'B provided assurance that the CCG would look at the total picture and would consider how changes to the community services would impact on other services.

Date of meeting: 26 June 2013

Question 1:
I am very concerned about the number of private operators engaged in the NHS and would like to know where our medical records are kept and who has access to them. What assurances can the CCG give that they would not be used for non-medical purposes. **Mr Hann.**

Response:
The response was provided by ID who confirmed that as the Caldicott Guardian for the CCG, he had responsibility to ensure data and information was kept confidential and only used for purposes agreed in advance. He stated that medical records were held in secure electronic systems that met information governance requirements and confirmed that the CCG took its responsibilities in relation to the Data Protection Act seriously.

Mr Hann asked if it would be possible for patients to keep their own medical records in future and ID confirmed that the issue had been considered but that it was felt untenable due to a number of reasons such as a patient being so ill that medical staff might have difficulty accessing records quickly. He felt it was something that might be considered in the future.

Mr Sudder stated that a recent press article had stated that private care providers could purchase a patient's medical records for £140 and asked if that was true. ID confirmed that that would not occur as the records would need to be provided from general practice and that would not be allowed under the constraints of the Data Protection Act.

Question2:
Why is the Governing Body so secretive?
He felt that the term 'open and transparent' was not being adhered too and that there was not enough information being provided to patients about the CCG. He highlighted issues with regard to patient choice and accessibility of a patient to see their GP of choice and expressed concern about confidential meetings and pre-meetings of the governing body being held. Mr Sudder asked how the CCG would promote a culture of openness and if there were any plans for privatisation of the NHS. - **Mr Sudder**

Response:
NO'B stated that the governing body did not have a pre-meeting to discuss items on the agenda of the governing body meetings held in public. He explained that the governing body held seminar sessions on various areas of corporate responsibility that the governing body members needed to be aware of such as finance, contracting, safeguarding etc.

It was confirmed that the confirmed minutes of each governing body meeting would be published on the CCG's website and that North Durham CCG was exceptional in County Durham and Darlington in that it held every governing body meeting in public. Durham University had been commissioned to undertake work on how the

CCG could improve its patient and public involvement and a discussion would take place at the next governing body meeting about that.

NO'B confirmed that privatisation was not an issue for the CCG although he acknowledged that there were discussions ongoing nationally in certain areas of the country where there were high numbers of private providers. He felt that there were not a lot of private providers in the North Durham area and the CCG did not have a strategic direction to put work into the private sector.

The governing body agreed to consider further the issue raised with regard to secrecy although it was felt that the CCG continued to strive to provide the public with as many involvement opportunities as possible.

Question 3:
What is the CCG's rationale for the decommissioning of the palliative care service for terminally ill children? Who would be replacing the dedicated clinical team which had previously provided that service?- **Carol Reeves.**

Response:
NO'B said that when the governing body received the question, there had been concern as the CCG was unaware of any plans to decommission that service. Following discussions with NECS it had been clarified that there were no plans in that regard.
Carol Reeves reported that staff currently delivering the service had concerns and it was felt that if those staff were community nurses, the issue might be related to the community services review that was underway.

Question 4:
As close co-operation and integrated practice is essential to ensure speedy hospital discharges and prevent unnecessary admissions, will the CCG give full consideration to retaining NHS community provision? If after public consultation any decision is taken to incur the costs of competitive tendering will the CCG ensure that the tender documents specify that the range of community services is from one provider with a track record of multidisciplinary working? Can you reassure me as a patient that I will not have to allow access to several providers for the support I need? - **Edith Flett** who was not in attendance at the meeting.

Response:
NB confirmed that the CCG did not have an intention to reprocure community services and was working with CDDFT to improve the current service provision. It was however, highlighted that if the current provider did not wish to work with commissioners to deliver a service that was expected of the commissioners, the CCG reserved the right to reprocure. NO'B stated that the CCG did not wish to fragment the current system.

Date of meeting: 24 July 2013

Question 1:
A question was asked by Mr Frederick James Sudder. He said that there had been a statement of invoices over £25,000 on the CCG's website. He believed that it had since been removed prior to the meeting, and wondered if that had been because he had notified the CCG of the question he intended to ask. Mr Sudder asked that the CCG to inform him of services which were due to be de-commissioned before May 2015, particularly but not exclusively, the high value services. He also asked that there be a regular agenda item on the governing body to state which services had been re-commissioned or rolled-over from the preceding month. He said that publication of such information was in the public interest given that public money was involved. – **Mr Sudder**

NB said that she was not aware that the information on the website had been removed but would look into that to make sure that the information was still available to the public.

In responding to the question MH said that the information on the website about invoices of over £25,000 was updated on a monthly basis. He explained that the vast majority of the contracts for services commissioned by the CCG were rolled over. An annual plan was produced which outlined any services that were going to be reviewed but that list was very small. Examples of services that the CCG had indicated it would review in the current year included children's occupational therapy, children's speech and language therapy and community based dermatology. MH said that no changes would be made to contracts until April 2014. The changes would be part of the planning process and would be included in the documentation considered by the governing body and so would be discussed in public.

Mr Sudder said that information should be available about all of the contracts that the CCG entered into including their length, start and end dates, and their total value. MH said that some of the information might be commercially sensitive to the organisations involved and that the CCG would be unable to share information about services that were in the process of being procured. Mr Sudder said that he would only want to see information about contracts which had already been agreed. He asked about the length of the contracts that the CCG agreed. MH said that that would be no more than three years. MH said that he would look into what additional information could be shared via the website.

During the discussion the CCG's website had been checked and it was noted that the statement of invoices over £25,000 was still available.

Action: MH to look into what additional information about the contracts agreed by the CCG could be shared via the CCG's website.

Date of meeting: 25 September 2013

Question 1:
During the course of the County Durham Residents Association conference on 17 July 2013 reference was made to the reliability and veracity of the recent reports into health and care provision throughout the country. The Francis and Keogh reports were both referred to either directly or by inference.

Mention was made that these reports should be made with a certain degree of scepticism given that a possible consequence of such negative findings may lead to a 'justifiable' takeover of NHS services by private companies; something of which the British public is intensely suspicious.

The British public would benefit from being able to access reliable and trustworthy data relating to health and care provision. They need to be able to make a comparative study with the standard of healthcare provided in other, modern, western (preferably European) economies.

With that in mind would it be possible to ask NDCCG to look into the feasibility of establishing a 'twinning' arrangement with specified regions in both Germany and France that have very similar socio-economic backgrounds to our own region?

Being in a position to compare data with neighbouring countries would surely help identify any shortcomings (or indeed, exemplary practise) quite swiftly and would help to initiate any necessary changes. **Stephen Hann**

A response had been provided by NB by email which was re-stated at the meeting as below:

North Durham CCG had considered an option to formally twin with other similar areas in Europe and elsewhere but had decided at this point that it was not something it would wish to progress. The CCG did however make extensive use of information and research as well as using comparative data from areas within the UK and internationally that had a similar socio economic and population profile to the CCG. The CCG used a number of sources of information and research that supported its planning work including the NHS benchmarking club, the National Institute for Health and Care Excellence, the Organisation for Economic Co-operation and Development and others, all of which would enable the CCG to compare its performance, health outcomes and best practice with other similar areas. Through the County Durham Partnership, the CCG worked with Durham County Council and partners to use benchmarked information at local authority level using either ONS classification (industrial hinterlands) or by a new classification used by Public Health England in 'Longer Lives'. The CCG also receives comparative information as a CCG via the NHS England National Indicator Set and Public Health England's GP Profiles and a new national primary care tool. The CCG tried to use all available research and evidence of best practice to inform its commissioning decisions and plans. However, if as a CCG, it felt that the additional benefits it could get from twinning with another region internationally would be significant and would offer good value for money, it is something the CCG would reconsider in the fullness of time. At this point however the actual costs of twining with another area might

prove prohibitive in light of the type of visits and arrangements that the CCG would have to undertake.

Mr Hann stated that the majority of the public did not know how much information the CCG was given to determine its commissioning intentions. He stated that European health systems were generally good and wondered what the doctor/patient ratio and cases of health care associated infections were in the other European countries. NS stated that work had been done with regard to cancer survival rates and that compared to other similar countries the UK was not performing as well in that area. It was also noted that if the survival rates in Durham were as good as the national UK standard there would be 200 extra lives saved per year.

Carole Reeves, a member of the public stated that County Durham was already twinned with other towns in Europe and felt connections could be made with those areas.

Question 2
The CCG's targets for clinical outcomes appear to stop at age 75. Why is this? Could we have some appropriate targets for patients of 75 and older, please? **- Carole Reeves**

The response was provided by DS and he assured the governing body members and public present at the meeting that CCG targets were not only focussed on patients under 75 years of age although it might appear to be the case as many of the NHS and public health targets were set at that age range.

The focus of targets for CCGs and the NHS as a whole had moved to 'clinical outcome' targets. The ultimate 'outcome' was death and so a number of outcomes were set on death rates for particular chronic diseases such as heart disease or cancer. It was not possible to set death rate targets without an age reference as all people would die some time. To measure and compare death rates through the NHS, NHS England had decided to use under 75 year old death rates. This was the age cut-off used by public health over the past several years and was now one of the five outcome targets for the NHS as a whole to reduce the number of people dying under the age of 75 years.
Although 75 years was used as a target, it did not mean that any treatment or care provided stopped at 75 years and there was no discrimination of people aged 75 years or older. If a treatment was clinically indicated for a patient it would never be withheld on age grounds.

If life expectancy continued to increase, it was almost certain that NHS England would change the age used as a reference point to 80 or 85 years of age in the future but until then national data was based on 75 years old for comparison of outcomes.

Question 3
Last week a GP from another area in the North East, when asked about her local CCG, replied that she thought they were being replaced. Could this be true? In

what circumstances might that happen and who will then take responsibility for commissioning?

I look forward to some clarification on the likely lifespan of CCGs, bearing in mind the NHS seems to go through a change every three or four years. – **Roger Hancock**

The question was addressed by KB who acknowledged that there had been many re-organisations in the NHS in recent years and that the latest one had been the largest change. The Government was keen to make clinical commissioning work and CCGs were striving to do the best they could within their areas to ensure it was preserved for the future. It was noted that no CCGs had been replaced to date.

DE highlighted that clinical commissioning had originally been a Labour Government initiative via practice based commissioning and it was felt if there was a change in Government it would not change the current clinical commissioning arrangements.

Date of meeting: 23 October 2013

Question 1:
Carole Reeves, representing 'keep our NHS public' asked for an update on the procurement of speech and language therapy services (SALT). **– Carole Reeves**

MH responded by saying that SALT services were in the procurement process and that tenders were currently at the evaluation stage. At this stage bids were evaluated against the tender documentation such as the service specification, quality, service delivery, performance and finance. MH explained that this was a confidential part of the process and for that reason there was little information that could be shared until the process had concluded. All those involved in the process were required to sign a confidentiality agreement in order to maintain the integrity of the process and to ensure a fair and consistent approach. The procurement process was due to conclude within the next few weeks. MH stressed that whilst the procurement process was in place the CCG ensured that current providers continued to deliver services to patients. The CCG also continued to hold contract meetings with current providers in order to monitor delivery.
Carole Reeves expressed concern that members of the public were not aware of what was happening, especially when it involved tax payers' money. She acknowledged that they would be informed of the outcome of the process but thought that it was unsatisfactory that they could not see what was happening at this stage of the process or be given the details of what the different providers were offering.

KB highlighted that members of the Governing Body had that morning attended a seminar session on NHS procurement. She said that the CCG had taken the lead for this procurement half way through the process. In future the CCG would be involved in the pre-procurement stage and would be able to set the strategy for a particular service. She said that once the procurement started a specific process had to be followed in order to protect the NHS from any possible legal challenge. The CCG recognised that there appeared to be a lack of transparency with regard to the procurement process but accepted the reasons for this.

Question 2:
Edith Flett asked if the CCG would ensure that any provider not currently subject to the Freedom of Information Act be obliged, both in the bidding process or as a service provider, to be totally open in sharing information with the CCG. She believed that this should cover not only past performance but full details of how NHS funding was spent in order to enable the CCG to improve its scrutiny of providers. In asking the questions Mrs Flett referred to the recent experiences Winterbourne and Castlebeck. – **Edith Flett**

MH responded to the question by saying that the Freedom of Information Act applied to all public bodies and the information they held. As part of the CCG's contractual arrangements it ensured that service providers were made aware of the CCG's duties under The Act and that the CCG was obliged to share the information it held that may relate to that particular organisation. He said that there were some

exclusions under The Act which the CCG was legally obliged to consider eg personally identifiable information, protective patents etc.

Date of meeting: 27 November 2014

No questions were put forward for this meeting.

22 January 2014

Question 1:
Mr Sudder had notified the CCG that he would like to ask the CCG to explain the basis of the new funding settlement and the effect this would have on the budget for 2014/15, including the total funding, the percentage increase or decrease, the administration cost (with increase/decrease) and the amount of 'efficiency saving' which has been returned to the Treasury. He asked how the settlement compared with the national average and with other CCGs in the North East. - **Mr Sudder**

Mr Sudder felt that most of the above questions had been addressed in the presentation given earlier in the meeting and asked in addition if the CCG had an allocation for £306m for 2013/14 and had to produce a 1% surplus, whether that meant the actual budget was only 99% of that original budget. RH stated that that was the case but that the CCG was forecasting just over 1% surplus this year which would be added to the funding for the following year. It was explained that the need for a surplus was a historical arrangement which also had to be achieved by the former primary care trust.

RH explained further that the efficiency saving was now referred to as efficiency minus 4% and would be built into the tariffs paid to providers and that each provider would have to deliver a 4% efficiency. LH stated that the National Quality Board requested all provider trusts to give assurance that delivery of the efficiency saving would not impact on patient care. It was noted that a process was in place called a Star Chamber that involved lead clinical directors and directors of finance to ensure patient care was not being compromised. Mr Sudder asked if the only way to make savings was to reduce staff. LH said that if a provider stated that that was the case, the CCG could challenge that and provide help on identifying other ways of making savings. RH stated that the 4% efficiency would be invested elsewhere in healthcare and would not be lost to the NHS.

DG left the meeting at 12.45pm.

Question 2:
Kathryn Boothroyd said that she recently had cause to make complaint regarding two providers that the CCG commissioned from and had been dismayed to be informed that locum doctors as part of the out of hours service could not be compelled to come to the meeting as part of the local resolution or partake in the complaints process. She asked if that was the case and what could I do about complaining about the fact that they did not take part in the complaints process. - **Kathryn Boothroyd**

ID stated that prior to the meeting he had understood that Ms Boothroyd's complaint had involved two providers and there had been an issue about difficulty receiving a single response. ID said that it had been enshrined in statute in the 2009 NHS Complaints Regulations that the provider was duty bound to ensure a complainant

received a single response to a complaint. The CCG was working with providers to ensure there was an overview and knowledge of complaints within their organisation and if a complainant was unhappy with the procedure they could raise that with the CCG who would take that up on their behalf.

With regard to locum doctors partaking in the complaints process, ID confirmed that the General Medical Council (GMC) had produced guidance about good medical practice which outlined that all doctors were required to partake in the complaints process and if they consistently refused to do so could make themselves liable to a referral to the GMC. ID felt that part of being a good doctor was about being involved and co-operating with complaints. ID offered to speak to Ms Boothroyd further out with the meeting.

Ms Boothroyd asked if there was an audit process to review how the different service providers handled complaints. It was confirmed that there was a statutory return that each organisation had to provide in terms of how they handled and responded to complaints which would enable the CQRG process to drill down into the issues raised via a complaint. It was not a formal audit mechanism but trusts had to comply. Ms Boothroyd stated that the complaints process had left her feeling as if she was being held in contempt and that those involved did not have to partake in the process.

Ms Boothroyd also highlighted that the out of hours service did not readily supply information on how to complain. LH stated that she had been made aware of that and had put a process in place to change that.

Date of meeting: 26 February 2014

Question 1:
Mr Sudder had submitted a question to the CCG about the steps the CCG was going to take to prevent the uploading of patient records to the 'care database'. Mr Sudder stated that he had asked the question previously at the June 2013 meeting of the Governing Body and the response received by Dr Neil O'Brien was that patient records were safe with the CCG. - **Mr Sudder**

NB responded and stated that the question asked in June 2013 had been specifically about patient's medical records being sold to private companies. She highlighted that the better information/better care work underway was about a care data programme where all people registered with a GP were asked if they were prepared to have their annonymised data, ie date of birth, postcode and NHS number uploaded to an information centre that would use the information to identify health needs across the country. NB said that the database had been scheduled for implementation in April 2014 and that the public were able to opt out. However, due to concerns raised by the British Medical Association and Royal College of General Practitioners
among others, NHS England had decided that implementation should be deferred to the Autumn of 2014. It was felt that awareness of the database needed to be significantly increased in terms of public knowledge and there needed to be more clarity about how patients could opt out.

NB reported that a number of practices (not in County Durham) had agreed to undertake a pilot of the scheme which would be evaluated in the next couple of months. NB explained that the issue was about better information and better care and should be agreed between the patient and the practice without the CCG's involvement. It was noted that the CCG was unable to influence the decision and was unable to advise patients or practices.

Mr Sudder said he felt he should write to all practices in the area and quoted figures about the number of GPs that had opted out of having their own records uploaded on the database. He felt the implementation had been postponed due to the influence of '38 Degrees' that planned to officiate a mass opt out. He felt that although the CCG stated that it could not act on behalf of practices, it could advise practices unofficially. He felt practices would need legal advice which NB stated would come via the NHS England Area Team as commissioner of those services. NB said the CCG would support practices but it was not the role of the CCG to instruct them in relation to the database.

Mr Sudder suggested that practices should advise patients exactly what the implications of uploading information to the database would be and felt it would be a failure of the CCG not to tell patients what was really happening. He stated that the leaflet which had been issued to patients did not state that the patient had options and did not tell the patient how to opt out. He felt practices and the CCG had a duty to tell patients that they had two options.

ID stated the issue was about where the boundaries of the CCG's responsibilities were in relation to the work and felt that practices already had an extensive source of

legal advice. He felt the responsibility lay with NHS England and would be conducted through practices. He felt any further advice given by the CCG could confuse matters and stated that it was the individual choice of practices about how they dealt with the situation.

Date of meeting: 26 March 2014

Question 1:
Ms Reeves asked for an update regarding the procurement of SALT and OT services. - **Carole Reeves**

MH responded that the report received at the meeting earlier for information had outlined the changes that had been made following a revision of the procurement process. Ms Reeves asked what kind of provider the CCG was looking for and MH stated that the specification had been developed in a way to maintain a high quality of service and to address issues about waiting times and equity of access to the service. He stated that some bids had been received as a result of the recent procurement but that they had not been felt to be suitable.

Ms Reeves asked about the current provider of the services and MH stated that those services would continue until a new service was procured and in place. It was noted that the length of the contract had been changed from three years to three plus two years following comments received from providers.

Ms Reeves asked if the new contract would cost more than the old one. MH stated that the main priority of the CCG was to ensure a good quality service was delivered. Agreement had been made to include a small amount of additional funding to ensure that there was no compromise on quality.

Ms Reeves asked about the future prospects for the staff currently delivering the service. MH confirmed that process was in place to apply transfer of undertakings and employment protection regulations (TUPE) which would aim to preserve the employment rights of those staff. If appropriate the staff would transfer to the new organisation via a TUPE process.