NHS
North Central London
Clinical Commissioning Group

Questions submitted by Professor Sue Richards (All questions relate to Item 2.1.)	**CCG responses**
Question 1: **What is the planned staff complement for a) midwives, b) other nursing and health assistant staff and c) medical staff in each of the maternity units commissioned by the CCG**	All Trusts are working to achieve compliance with Birthrate+ and to be compliant with Ockenden requirements for the obstetric workforce. Detailed workforce information is held by Trusts.
Question 2: **What is the actual staffing situation for each of these groups of staff and for each of the units commissioned for each of the past four quarter years.**	As above.
Question 3: **If, as expected, actual staffing levels fall below the complement because of unfilled vacancies, how can the board papers say that there no financial implications on this matter.**	Ockenden has increased the establishment at maternity units. Recruitment is underway at all units. If there are bank and agency costs associated with filling these vacant posts and costs associated these are reflected in Trust overall financial positions. This Governing Body report is an update on the overall compliance with Ockenden and does not set out new proposals with a financial implication for the Board.
Questions submitted by Rod Wells, Haringey KONP (All questions relate to Item 2.2.)	**CCG responses**
Question 4: **Will the ICS include a commitment in the Constitution to arrange provision of a**	We are unable to accommodate this request. We are working to a nationally mandated Constitution model Constitution.

comprehensive, universal health services for all the residents of NCL, those residents from elsewhere temporarily in the NCL area, and those residents of NCL who need health care while temporarily in another ICS area?	
Question 5: **The organogram published is not very explicit about how the various boards and committees relate to each other, regarding reporting lines showing relative powers and accountability. We would like this clarified.**	The Integrated Care Board ('ICB') holds is accountable for discharging its statutory functions. It is proposed that the ICB's Board of Members will establish committees and sub-committees to assist it in discharging its functions. The proposed committee and sub-committee structure is being developed as are proposed Terms of Reference.
Question 6: **Will the ICB make a commitment to increase to at least two Local Authority representatives a as step to help deliver better collaborative working.**	The ICB Board of Members will have one voting Partner Member from a Local Authority which brings the perspective of the sector to the Board's deliberations. The ICB Board of Members will also invite an additional person to be a non-voting Regular Participant. If the Local Authority Partner Member is a Councillor the ICB would value the Regular Participant being a Chief Executive to provide breadth of perspective.
Question 7: **The quorum for the ICB does not include a Local Authority representative - will the ICB agree to amend this in the Constitution?**	The ICB Board needs to balance the need for sector insights into its deliberations whilst ensuring that it manages conflicts of interest appropriately. The current balance for quoracy achieves this. In addition, whilst we have included a Partner Member in the quorum we have not stipulated which Partner Members needs to be included. This allows the ICB maximum flexibility to manage conflicts of interest.
Question 8: **The Constitution states that all ICB and committee meetings will be held in public and that members of the public can ask questions at these meetings and submit deputations, and that papers will be published.** **However, the Standing Orders state that the public may be excluded from meetings where the matter is commercially sensitive – given that all the services**	The draft Constitution states: "ICB Board meetings and Committees or Sub-Committees composed entirely of Board members or which include all Board members will be held in public except: a) Where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest in accordance with section 17 of the Standing Orders; b) The Audit Committee and the Remuneration Committee shall not be held in public." This wording is in line with the nationally mandated model ICB Constitution. In addition, the provisions in the Standing Orders which allow the ICB to exclude members of the public from its meetings are reasonable and necessary to ensure the ICB is properly able to conduct its business. Reasons for exclusion include (but are not limited to) commercial sensitivity, identifiable patient etc etc.

are taxpayer funded and that value for money is important to members of the public, as well as for the ICS, it is unclear what the justification for exclusion is, if business is being transacted ethically and in the interests of the recipients of the services.	
Question 9: **We consider these exclusion criteria should be more precise and extremely limited, with a justification made public on a case by case basis. Will the ICS amend this?**	We refer you to the reply in Question 8 above.
Question 10: **Will details of questions and deputations raised by the public and the ICSs responses be published in the minutes and will all questions and deputations receive a response?**	Deputations and questions from the public will continue to be responded to and published as per current practice. There are no plans to change this approach.
Question 11: **We understand that the rules in the PSR allow the ICB to roll over existing contracts, award them directly, or arrange a tendering process. Will the ICB make a commitment in the constitution that it will use these provisions to use NHS providers as the default option?**	We are not able to add this into the Constitution. Integrated Care Systems have been established to allow greater co-operation and system working between all NHS organisations with an Integrated Care System area. However, the regulations required to introduce the Provider Selection Regime have not yet been introduced to Parliament and the proposed Provider Selection Regime has not been published. We are therefore operating under the current procurement regime until the law changes. This requires the ICB to treat all providers equally and not discriminate on the basis of ownership. Once the regulations changing the procurement regime have become law and the Provider Selection Regime has been introduced we shall review the law and the regime accordingly.
Question 12: **What mechanism and bodies will be involved in scrutinising the work of the UCL Health Alliance which appears to be a Provider Collaborative?**	The UCL Health Alliance is an alliance between all of the statutory NHS providers in North Central London. It also includes GPs representing General Practice across North Central London. As such, it will be held to account by its membership and, where appropriate, by the ICB.

Question 13: **Any disagreements that cannot be resolved by negotiation, are to be managed by a majority voting procedure in the ICB, but this will inevitably handicap Local Authority partners and public representatives. We suggest that such issues be subject to wider scrutiny within the ICS and such decisions not confined to the ICB. Will the ICS commit to this in the constitution?**	We expect decisions of the Board of Members to be unanimously agreed by Board members. However, where the Board is unable to reach a unanimous decision a vote will be held. This is a normal and reasonable mechanism for Boards to reach decisions. It would not be appropriate for Board decision making to be made by the wider Integrated Care System.

The following questions were also submitted by Rod Wells. As they do not relate to agenda items, we will be responding to them separately in due course and publishing our responses on the CCG website.

- Will the ICS operate a clear and automatic process of cross charging/recharge for cross border patients?
- What are the implications of the reorganisation for staff? Will they have to move between workplaces or be passported to other centres? There are concerns about potential disruption to staff, and therefore patient safety, and the need to reduce disruption and ensure thorough inductions for staff who do need to move between different centres.
- There is a Community Partnership Forum with representatives from Healthwatch and "public representatives". Who are they and what does this forum do?
- How were the 'public representatives' selected and who would they report back to?
- Given the increased remit of the ICS and increase range of services it is responsible for arranging, we believe the scrutiny arrangements need to be strengthened with local authority involvement at earlier stages of decision making and service design, and scrutiny given teeth to review, pause and require amendments to decisions. Will the CCG work with the local authorities in the NCL to ensure this?
- Are there minutes published of Boards and committees making decisions now and can they be made available? For instance, Quarterly Partnership Councils and Steering committees? (This would be in line with the process by which shadow CCG committees operated before Haringey CCG was formally established.)
- What is the structure that allows the community to raise issues and challenge decisions made by Health and/or the Local Authority?
- Given there is a capped budget and it seems no transitional funding, the existing deficits will be incorporated into the budgets, so can the CCG advise which service cuts are planned?